

**POST-TRAUMATIC STRESS DISORDER
AND TRAUMATIC BRAIN INJURY AS
EMERGING TRENDS IN FORCE AND
VETERANS HEALTH**

HEARING

BEFORE THE

**COMMITTEE ON
VETERANS' AFFAIRS**

HOUSE OF REPRESENTATIVES

SUBCOMMITTEE ON HEALTH

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POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY AS EMERGING ISSUES IN FORCE AND VETERANS HEALTH

THURSDAY, SEPTEMBER 28, 2006

U.S. HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The Committee met, pursuant to call, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Henry Brown [Chairman of the Subcommittee] presiding.

Present: Representatives Brown of South Carolina, Moran, Michaud, Michaud, Filner, Snyder. Also Present: Representatives Bostwick, Cantrell.

MR. BROWN. The Subcommittee will now come to order. Good morning, and welcome to today's hearing on an issue that is very important to all of us. I am pleased to have assembled, with the help of Ranking Member Mr. Michaud, the panel that we have in front of us here today.

As most of you here today know, much has been written and discussed relative to Post Traumatic Stress Disorder, or PTSD, since the beginning of Operations Enduring and Iraqi Freedom. We are fortunate to have before us some of those who are responsible for providing us critical data on this mental health condition, and I am eager to take this opportunity to learn more about the nature of the disorder and its prevalence amongst our returning servicemen and women.

And while PTSD seems to have captured a majority of the headlines over the last few years, an equally challenging condition is being seen in increasing numbers at the VA; Traumatic Brain Injury, or TBI. Due to the concussive nature of many of the war-related injuries being seen in Iraq and Afghanistan, TBI can take many forms, ranging from quite mild, almost undetectable, to very dramatic.

We will be interested in hearing how the VA is meeting the increased demand, how the four polytrauma centers are handling that

workload, and what best practices are being shared with other VA medical centers to ensure that the best care is being provided all around the nation for those who have suffered some form of TBI. In addition, we are going to examine some of the similarities between PTSD and TBI in terms of how the conditions manifest, how they are identified and ultimately how they are treated.

The important point I would like to add to this is that these injured servicemembers, in particular those with PTSD, can be treated and a sense of normalcy can be attained. Having said that, in the absence of in-theater risk mitigation techniques, effective early identification, and aggressive outreach and treatment, normalcy and appropriate adjustment may be difficult to realize for some returning from theater.

This is an important topic and I want to again thank those assembled before us today for taking the time to help us better understand some of the emerging health challenges that both DoD and VA will continue to face.

[The statement of Mr. Brown appears on p. 38]

MR. BROWN. I now yield to the Ranking Member, Mr. Michaud, for an opening statement.

MR. MICHAUD. Thank you very much, Chairman Brown, for holding this very important oversight hearing. Fatalities to our troops in Iraq and Afghanistan from blast-related injuries are lower than in previous conflicts, due to improved protective combat equipment and advances in the delivery of medicine on the battlefield.

However, those who survive blasts are at great risk for Traumatic Brain Injury, or TBI. Severe, moderate and even mild TBI can affect veterans and their families for the rest of their lives. Brain injuries can impair functions including short-term memory, concentration, judgment. As well, many TBI cases experience degrees of impaired vision. It can also affect a veteran's ability to return to work.

The emotional and behavioral changes that result from TBI can place a tremendous burden on families and friends. Many veterans with mild TBI may have their symptoms misdiagnosed as a mental health disorder. These veterans need targeted care to help them function better. Post traumatic stress disorder (PTSD) is also a wound that many of our returning veterans carry home.

Unfortunately, the stigma of mental illness often leads veterans to ignore or deny that they had any problems, even when they see their relationships and lives crumble under the weight of the symptoms of PTSD. Untreated PTSD is linked with substance abuse, severe depression and unfortunately, even suicide. Sadly, we have already seen too many Vietnam veterans—and now veterans from Iraq—go down this tragic path.

Access to VA's mental health programs and TBI programs, and the

quality of these programs depend on adequate funding. VA mental health care experts have recognized that VA's program have gaps in quality. In response, Secretary Principi rightly adopted a mental health strategic plan with initiatives to address the gap in VA's mental health care efforts. The Administration promised to commit \$100 million in fiscal year 2005 and \$200 million in fiscal year 2006 to fund these mental health care initiatives.

Last fall, Ranking Member Lane Evans and I asked GAO to study whether the administration fulfilled this commitment to fund the new mental health initiatives. Today, GAO's testimony provides its preliminary findings of the study. Sadly, the Administration is far short of fulfilling its commitment. VA did not provide \$100 million in fiscal year 2005 for new mental health care efforts. VA only funded approximately \$53 million.

VA claimed to GAO that it also provided \$35 million in funds generally distributed to VA hospitals and clinics. GAO found, and VA concedes, that VA never told medical facility directors that the \$35 million was to be used to rebuild mental health services. GAO also found that some of the \$53 million went unspent. The preliminary findings for fiscal year 2006 were also disappointing. VA allocated, at best, \$158 million of the promised \$200 million. Again, GAO found that some of this money might not be spent.

Gaps in mental health care services remain. The mental health strategic plan is good. However, without real commitment to funding, the plan will not become a reality. Members on both sides of the aisle want and need to address this very important issue. We must keep our promise to our veterans and dedicate mental health care staff who want to help them recover from the psychological wounds of war.

Funding and implementation of VA's mental health plans will require vigorous oversight from this Committee. That is why I am pleased, Mr. Chairman, that we are holding this hearing. Further, it is my intention to continue to press for passage of Lane Evans' Comprehensive PTSD Bill, H.R. 1588. It is also my intention to re-introduce an updated version of this legislation in Lane Evans' name in the 110th Congress to ensure that his noble efforts are carried on in order to meet the critical mental health challenges that we face.

So with that, Mr. Chairman, I want to thank you very much, and I also would like to welcome both Representative Pascrell, and Representative Boswell. And I want to thank Chairman Brown for allowing them to join us at this hearing, because I know they have a deep commitment to veterans' issues, and they definitely will add a lot to this discussion. So thank you very much, Mr. Chairman.

[The statement of Mr. Michaud appears on p. 41]

MR. BROWN. And thank you, Mr. Michaud, for the opening state-

ment. And I know both of the other gentleman from other committees, and they have got other responsibilities, so if it is the will of the Committee to allow them to speak out of order, and to speak for two minutes?

[No response.]

Okay, without objection. Okay, Mr. Pascrell?

STATEMENTS OF HON. BILL PASCRELL, JR., A REPRESENTATIVE IN CONGRESS FROM THE STATE OF NEW JERSEY, AND HON. LEONARD BOSWELL, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF IOWA

STATEMENT OF HON. BILL PASCRELL

MR. PASCRELL. Thank you Mr. Chairman and Ranking Member Micauda, and also Committee members, for dedicating so much of your time to this very critical issue. I salute the Veterans Committee. Your work many times goes unnoticed, I understand that.

I would like to ask that my entire testimony be inserted into the record, if you would?

MR. BROWN. Without objection.

MR. PASCRELL. As a cofounder of the Congressional Brain Injury Task Force, I am committed to improving the lives of individuals with Traumatic Brain Injury, TBI. I would like to focus on an issue that has gained more and more publicity over the last year; dramatic brain injury in our nation's servicemen and women, past and present.

Traumatic brain injury is defined as a blow or jolt to the head, or a penetrating head injury that disrupts the function of the brain. This has been called the "silent epidemic." A million five-hundred-thousand people are affected in the United States every year. When I first learned of this, seven years ago, and I want to tell you, Mr. Chairman, I was just shocked out of my wits. I never thought, until folks in my own district came to me, you know, we need to be educated on these things, and certainly members of Congress should be, if we are going to talk about it.

Military duties increase the risk of sustaining TBI. For our armed forces, TBI is an important clinical problem in peace and war, and its consequences may extend for many years. Over 1500 military personnel involved in the global war on terror have been seen and treated by DVBIC. At Walter Reed alone, over 650 soldiers with brain injuries from Iraq and Afghanistan have been treated. That represents 40 percent of all the troops evacuated to Walter Reed Medical Center so far. About 10 percent of the servicemembers in Iraq, 20 percent of the troops on the front lines returned from combat tours with concussions.

DVBIC, the Defense and Veterans' Brain Injuries Center, was es-

tablished in 1992, after Desert Storm. Until then, there was no overall systematic program for providing brain injury-specific care and rehab within the department of defense, or the Veterans Administration for that matter.

The changing nature of warfare demands corresponding improved and specialized medical care. It has been estimated that 50 percent of all combat injuries are blast injuries. So as part of the recently-passed blast injury prevention and mitigation and treatment initiative, the DVBIC is leading the effort to illuminate patterns of brain injury from blasts including providing guidelines for the assessment.

I must say, Mr. Chairman, the last five years has seen more advancement in this area than probably in the past couple of hundred years, so that parts of the brain that have not been affected in a negative way can be developed, so that we can compensate.

These are great times. You know, I tell kids in the schools, “Don’t let your parents tell you, oh, for the good old days.” These are the times when we can address these very serious injuries in terms of modern warfare. The Defense and Veterans’ Brain Injury Center’s mission is to serve active duty military, their dependents, and veterans with TBI, through state-of-the-art medical care, innovative clinical research initiatives, and educational programs.

In order to better recognize TBI, the DVBIC has begun to employ improved diagnostics, increase brain injury training of battlefield medics, and clinical research on blast injury.

Now, what I want to emphasize in concluding, Mr. Chairman, is the need to improve and expand the Special Committee on Post Traumatic Stress Disorder. And the Committee on Care of Veterans with Serious Mental Illness recommended to the Veterans Administration, under the Secretary of Health, that VA establish a screening process to identify veterans with mild TBI. I recommend that we look into that screening process.

Also noted was the need for the VA to establish a TBI registry that can be used to create more sophisticated evidence-based, cost-effective assessment and treatment strategies. We have passed general legislation to do this throughout the nation for civilian TBI. We need to do it in terms of the special situation that we face as Americans.

In July 2006, the Veterans Administration Inspector General’s office reported on a lack of consistency in VA case management, citing that the effectiveness of case managers ranged from outstanding to inadequate. The Inspector General also reported on a major weakness in the VA’s TBI care, and its participation in the DVBIC program. The number of TBI beds—I was shocked to find this out—in head-brain injury treatment resources do not correspond to the scope of the problem. That was the case since 1999; it is the case today, also.

And very briefly, Mr. Chairman, I would ask you—beg you—to

look at the funding. According to a recent study by researchers at Harvard and Columbia, the cost of medical treatment for individuals with TBI from the Iraq war will at least cost \$14 billion over the next 20 years. This is a sustaining situation; not going to be hit or miss. Without our support, DVBIC's congressionally directed mission of co-ordinating clinical health care, executing research that will result in better characterization and management of the problem, and education of both military and civilian communities will come to a halt.

This is one of TBI tasks force's primary mission. As such, in conclusion, the task force along with other concerned members request an additional \$12 million for the DVBIC in the Military Quality of Life, and Veterans Affairs Appropriations Bill for fiscal year 2007, for a total of 19 million.

I know the Committee shares these sentiments, and I am absolutely thankful for the fact that you have let me testify.

[The statement and attachment of Mr. Pascrell appears on p. 45]

MR. BROWN. Well, let me also thank you, Mr. Pascrell for taking your time to be part of this discussion. We have got assembled a great panel that I am sure has listened very intently to some of your recommendations, and thank you for coming. You can stay for the whole meeting if you would like, but we wanted to afford you the opportunity to speak first.

And Mr. Boswell, if you could take a couple minutes, so we can proceed.

STATEMENT OF HON. LEONARD BOSWELL

MR. BOSWELL. I heard the "couple minutes," and I will try to do that, sir.

And I do thank you kindly, you and Mr. Michaud, for allowing us to do this. As Congressman Pascrell has already said, very kind of you. I have been respecting your work on this for a long time, and I salute you too, sir, because I know your heart is in this, you are focused, and we cannot thank you enough. There are probably over a hundred of us here in this room and otherwise that are veterans. And so we thank you. I feel very fortunate.

I would like to share with you before I start, I have a veteran that is from Iraq that is on my staff, and I would like to introduce you to this veteran. She is standing right over there, Alexis Taylor; she has joined my staff, an Iraq veteran.

MR. BROWN. Glad to have you with us today.

MR. BOSWELL. Again, Mr. Chairman, I would say this, that we all know it has been said that for more and more veterans are returning from tours of duty in Iraq and Afghanistan, there are many new issues and we have heard some of them. But it is an issue that I don't

think we can't ignore, and I am not suggesting that we are.

The number of veterans returning with post traumatic stress disorder is alarmingly high. A recent study found that 17 percent of soldiers and marines returning from Iraq screened positive for PTSD. Our men and women in uniform returning from combat are fighting a different type of war, and a different type of enemy. I thought maybe I had seen it all in Vietnam. It was different, and there is no front line there, either. I helped to put too many of our young men and women in body bags, and it makes a lasting impression.

The National Center for PTSD found several things associated with individuals diagnosed with PTSD, such as physical pain, sleep disturbance, nightmares, substance abuse, self-harm, or suicide. I believe obviously there is a connection between PTSD and suicide. Some estimates have found that almost one thousand veterans receiving care from the Department of Veterans Affairs commit suicide each year, and research shows that one out of 100 veterans who have returned from Iraq have considered suicide. I find this very disturbing.

Since March 2003, 80 individuals who have served in Iraq or Afghanistan have committed suicide. Our young men and women serving our country have kept us safe for so long, it is our job, as you know, to protect them. A few months ago I learned of a young man from my district, Joshua Omvig, who experienced undiagnosed PTSD after returning from an 11-month tour in Iraq. His family and friends did not know how to help him. Goodness knows they tried. Then in December of last year Joshua tragically took his life. He was only 22 years old.

His parents were very close. They knew something wasn't right, and they were trying everything they could think of. He was staying with them, going to work, and trying to get adjusted. And one morning, his mother felt the intensity, and she stayed right with him as he went out to get in his pickup to go to work, and he shot himself in front of his mother, in the pickup.

After I heard his story I was shocked to find one in a hundred Operation Iraqi Freedom veterans have reported thinking about suicide. I knew something had to be done, as anybody would feel. That is why we have introduced H.R. 5771, the Joshua Omvig Veterans Suicide Prevention Act. This legislation will mandate the Department of Veterans Affairs to develop and implement a comprehensive program to regularly screen and monitor all veterans for risk factors for suicide within the Veterans Affairs system.

At any point in a veteran's life, if they were found to have specific risk factors for suicide they would be entered into a tracking system; ensuring they do not fall through the cracks. Then they would be entered into a counseling referral system to make certain those veterans receive the appropriate help. It would provide education for all VA staff, contractors, and medical personnel who have interaction

with the veterans. In addition, it would make available 24-hour mental health care for veterans found to be at risk for suicide.

Currently, the Department of Veterans Affairs regularly screens veterans for depression, PTSD, and substance abuse, but not suicide specifically. I am saddened by the circumstances that this legislation grew out of, but I know that if enacted, this program could save lives. We treat their physical injuries, which goodness knows we should. Now it is time to treat the wounds that are not visible. It is my hope that a comprehensive veterans bill will result from this hearing and that any bill considered will include provisions for the Joshua Omvig Veterans Suicide Prevention Act. This important issue cannot go another day without the attention it needs.

And Mr. Chairman, I say this and I am looking you square in the eye, and I am very, very serious: it is not important to Leonard Boswell to have my name on that Bill. It is not. We are in the political season, and we know that. It is important that this need be taken care of, and I would be delighted if you, Mr. Chairman, Mr. Michaud, wanted to take this and make it your bill. I don't care. I know there is a need, and I think we all know that. And that is the way I deeply feel about it.

It unfortunately came to my attention the manner it did. We stayed very close to the family, very close. When we built this idea, we went and talked to them about it, because they have come out in a sense. They want to help others. They are in their grief, and their shock, and it will go on the rest of their lives, but they want to do something to help others.

And so we felt like we could, so I very carefully, very quietly went and talked to them with staff that was working on it, and said this is what we had in mind, what would they think about it? And after a few tears, they said this would be wonderful. I said, "Now, it is up to you. If allowed, I will name this the Joshua Omvig Bill." And they looked at each other and they said that they would be honored. So that is the reason that it is on there.

And I seriously don't care who gets credit for sponsoring this bill. I want you to know that, Mr. Chairman. I say this in all sincerity: it needs action, and I have confidence that you and Mike will give it your attention.

And I thank you very, very much for allowing me to make this testimony, and I will leave this for the record.

MR. BROWN. And we will certainly, with unanimous consent, allow the statement to be submitted for the record.

[The statement of Mr. Boswell appears on p. 60]

MR. BROWN. And Mr. Boswell, I really do appreciate you and Mr. Pascrell coming and being a part of this discussion. This has been a Committee hearing that has been late coming, and I am grateful

for you all's input. I know we have all got stories we can tell about personal involvement. I know last July, I had my appendix taken out in Bethesda on the fifth floor, and had a chance to interact about four or five days with those young men and women coming back from harm's way. And you know, you could see some visible injuries, you know, if so many came back without an arm or a leg, those were easily identifiable.

I went into a room for this young guy from Florence, South Carolina, and it had half of his skull actually blown away, and they have got the computer technology to replace the image of that skull, and they all could draft hair on it, you know, to make a kind of look back like it was normal. But you could tell, as you look at that young man's eyes and you talked to him, that you knew that he was going to have a lasting problem with that brain injury.

And so this is a major concern, and we are grateful for you all's input. And you can stay as long as you would like, if you would like.

MR. BOSWELL. Thank you what you just said. And you know, with today's technology, we do the battery of tests when the young men and women leave the service. We have got the ability to see what is going on in their minds, and we have just got to do something about it. And we thank you. We wouldn't ever think about doing something for the physical injury, as you well know.

MR. BROWN. Right.

MR. BOSWELL. We would do everything we possibly could. And the mental injury is just as important.

MR. BROWN. That's right. Thank you so much.

And our Ranking Member, acting Ranking Member, do you have an opening statement?

MR. FILNER. Yes, I would like to submit my opening statement for the record.

Let me just thank Mr. Pascrell and Mr. Boswell not only for your expertise, but for your passion. We need that energy, and I would say to the panel something I generally say after you all have testified: please don't hide behind statistics and bureaucrat-ese and written statements. Let us know that you have some passion for doing this, for solving this issue. I think we want to hear that more than anything else; more than any defensiveness about what you're doing, about things that you want to point out. We want to make sure that you have the passion that many of us have from personal experiences. I know you all do, too, but in these Committee hearings, it doesn't always come out.

And let me say, I think we are letting our veterans down today. The young men and women who are, as you have shown one of us here, Mr. Boswell, coming back, are the bravest young people in the world. And yet we are not giving them the attention or the expertise that we have as a society. We don't do outreach sufficiently. We don't make

sure that the mental, as has been said here, is seen as important as the physical health. The mental scars will last probably longer or at least equally, and may have a deeper impact.

And yet, when these young men and women come back, they don't even know what they got. And when we have diagnoses of PTSD, the first thing the VA does, instead of saying, "We have got to have more facilities, and more resources to deal with it," the first thing they do is investigate why we have so many diagnoses of PTSD. That is disgraceful, that that is the response that these two men and women get, and the doctors who are dealing with him.

And the tragedy, as I think both of our guests have said, is that we know how to deal with these issues today better than we ever have. And we watch the same things for these returning Iraqi vets that we saw in Vietnam, when we knew less. They come home without knowledge of what is going on. The family doesn't have any idea. There is violence in the family, perhaps spousal abuse, kids run away, alcohol and drug abuse, loss of job, homelessness, suicide.

I think the figures that I have seen, Mr. Pascrell, are much higher. I have seen figures of several hundred suicides, and a much higher rate, as you point out, than either in the general veterans' population, or in the general population. This is a tragedy. The administration says, "Support our troops, support our troops, support our troops." When they come home, we don't have the outreach for them, we don't have the resources for them. We know that whatever percentage it is, whether it is one-half or one-third of our veterans that have PTSD, we don't have the resources to deal with it. I have been at the PTSD clinics in San Diego. They are wonderful. We know how to deal with it. But we are not getting these services to all the people that need them. And we are not given the resources to make sure that we can handle them if we did.

We even have now, as I think you pointed out, ways to perhaps—knowledge of the brain that says we can physically identify who has certainly a higher risk of PTSD.

So let us as a nation commit ourselves. We made a tremendous moral mistake by not dealing with these issues for Vietnam. It is not too late, by the way. Half of the homeless on the streets tonight are probably Vietnam vets, probably with intense mental situations. We need to bring them back, if we can. But let us not lose more, who are returning from Iraq, to this terrible situation.

So we want to give you all the resources that you need as professionals, but we have to look at this in a passionate way like our two guests have shown, and we have to, as a nation, say we are going to support our troops, we are going to treat these mental illnesses with the knowledge that we have, and we are not going to let them be lost and unable to further contribute to our society.

Thank you Mr. Chairman.

[The statement of Mr. Filner appears on p. 43]

MR. BROWN. Okay. Thank you, Mr. Filner.

Dr. Snyder, do you have an opening statement?

MR. SNYDER. I do not, Mr. Chairman, thank you.

MR. BROWN. Okay, thank you very much.

We are absolutely impressed that we have got such an outstanding panel before us today, and let me introduce our panel.

I welcome Dr. Gerald Cross, the Acting Principal Deputy Under Secretary for Health at the VA. He is accompanied by Dr. Katz, the Deputy Chief Patient Care Services Officer for Mental Health, and Dr. Sigford, VA's National Program Director for Physical Medicine and Rehabilitation.

Representing the United States Army, we are pleased to have Colonel Elspeth Cameron Ritchie and Colonel Charles W. Hoge. Doctor Ritchie is the Psychiatry Consultant to the Surgeon General of the United States Army, and Doctor Hoge is the Director of the Division of Psychiatry and Neuroscience at the Walter Reed Army Institute of Research.

They are accompanied by Colonel Labutta, the Chief of the Department of Neurosurgery at Walter Reed.

We will now proceed with Dr. Cross.

STATEMENTS OF GERALD CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY IRA R. KATZ, M.D., PH.D, DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH; BARBARA SIGFORD, M.D., PH.D, PROGRAM DIRECTOR, PHYSICAL MEDICINE AND REHABILITATION SERVICES; COL. ELSPETH CAMERON RITCHIE, M.D., M.P.H., PSYCHIATRY CONSULTANT TO THE U.S. ARMY SURGEON GENERAL, UNITED STATES ARMY; COL. CHARLES W. HOGE, M.D., DIRECTOR, DIVISION OF PSYCHIATRY AND NEUROSCIENCE, WALTER REED ARMY INSTITUTE OF RESEARCH, UNITED STATES ARMY, ACCCOMPANIED BY COL. ROBERT J. LABUTTA, MC, CHIEF, DEPARTMENT OF NEUROLOGY, WALTER REED ARMY MEDICAL CENTER

STATEMENT OF GERALD CROSS, M.D.

DR. CROSS. Mr. Chairman and members of the Committee, good morning. I am accompanied by Dr. Arthur Katz, Chief Patient Care Services Officer for mental health, and Dr. Barbara Sigford, director of physical medicine and rehabilitation service.

At first, let me say I can assure you, Mr. Chairman, we from VHA do have passion, and we have that passion in caring for our veterans.

I would like to submit my written testimony for the record.

In beginning my testimony, I would like to address an issue that I know is of concern to many members. Recently, VA's Inspector General issued a report on our ability to care for patients with traumatic brain injuries. While the report identifies areas in which we can improve on our performance, its executive summary is very clear. It states that our patients have very similar outcomes when compared with a matched group of TBI patients from the private sector.

Given that our patients have more severe injuries than the average patient, and given that it takes longer for them to begin rehabilitation because of the complexity of their wounds, and because of the distance they must travel from the theater of war to begin treatment for those wounds; the fact that our patients do as well as those in the private sector demonstrates that we are doing an outstanding job in supporting their recovery, and that we are providing the exceptional care Congress and all Americans expect of our department.

VA is succeeding in treating many TBI patients with multidisciplinary approaches that include a sensitivity to the physical, cognitive, emotional, functional, and behavioral manifestations of brain trauma. Our polytrauma system of care includes four primary polytrauma rehabilitation centers, which provide exemplary care for veterans with multiple injuries, including brain injuries, and fully involves their families in their care and treatment.

Twenty-one new polytrauma network sites are opening this fall, enhancing access, and ensuring lifelong coordination of care for these men and women. And a hotline for all polytrauma patients, and their families, is staffed 24 hours a day, seven days a week, 365 days a year.

To ensure that we identify every veteran with TBI, VA clinicians are receiving additional training in recognizing both acute and delayed symptoms of brain trauma, and then providing the prompt identification, and multidisciplinary evaluation and treatment, which is essential for their successful recovery.

We are improving our ability to coordinate the care of TBI patients by assigning a permanent social worker-case manager to every patient we have seen at our polytrauma centers. And we recognize the need for family support in caring for loved ones.

Our intent is to restore every patient to his or her fullest possible level of functioning. We will not fail in that effort.

Mr. Chairman, members are also concerned that we have the capacity and the funds to treat OIF-OEF veterans with PTSD. Let me assure the Committee that we do. Among our accomplishments, we have been adding 100 OIF-OEF veterans to our vet center staff to

provide clinical peer support. We have expended substantial funds to expand mental health services at our community-based outpatient clinics, and we have added tele-mental services to serve remote locations.

Altogether, VHA now operates approximately 200 specialized PTSD programs in addition to our 207 vet centers which, by the way, will increase in number to 209 by October of this year.

Working closely with our colleagues in DoD and other federal agencies, our researchers are working on new pharmacological, psychological, and other treatments, and we are finding ways to harness these technologies to extend our ability to care for veterans with this illness. And we are placing a special emphasis on finding more effective ways to treat veterans—including women veterans—at risk for PTSD.

Mr. Chairman, today's veterans with PTSD and TBI are receiving state-of-the-art care throughout VHA. We are committed to improving our abilities to address TBI and PTSD, and to meet the specific needs of veterans returning from the global war on terror, who have earned and are receiving the best care available anywhere.

Thank you for your time, sir.

[The statement of Gerald Cross, M.D. appears on p. 62]

MR. FILNER. Sure glad I gave that lecture on passion, Mr. Chairman.

MR. BROWN. Thank you very much, gentlemen, for being a part of this, and thank you for your passion and for your understanding, and for your expertise.

And with that, I will ask Colonel Ritchie to testify.

STATEMENT OF COL. ELSPETH CAMERON RITCHIE

COLONEL RITCHIE. Mr. Chairman, distinguished members, Mr. Michaud, thank you for the opportunity to be here and to share with you our concern and our passion about taking care of our soldiers and veterans.

Going to war affects all soldiers. The number of soldiers with Post Traumatic Stress Disorder, PTSD, has gradually risen. Since 911, the Army medical department has taken care of soldiers at the Pentagon during 911, in Afghanistan, in Iraq, and throughout the world. We take care of soldiers with physical wounds, and with psychological issues from combat.

We are committed to providing and ensuring that all returning veterans receive the physical and behavioral health care they need. An extensive array of mental health services has long been available. However, since 911, we have augmented and improved behavioral health services throughout the world, especially at Walter Reed

Army Medical Center and the other Power for Vets projection platforms and major army installations, where we mobilize, train, deploy, and demobilize army forces.

We anticipate that the need for these services will not decrease. We are committed to providing the necessary help. The Army medical department has performed behavioral health surveillance in an unprecedented manner. There have been four mental health advisory teams, three previously in Iraq, one in Afghanistan, and currently one in Iraq at this time. Charles Hoge, Colonel Hoge, will present his research.

We have also performed several epidemiological consultations, called EPICONS, at installations in the United States, such as the assessment following the cluster of suicide-homicides at Fort Bragg in North Carolina in 2002.

There are numerous other initiatives for us to learn from the war. We held a workshop on updates in combat psychiatry at the Uniformed Services University of the Health Sciences, in 2004, where we gathered together those who had been in theater with academicians and policymakers. We have used the results of all of these assessments to improve the behavioral health services that we offer our soldiers.

The Army Deputy Chief of Staff for Personnel, and the Army Surgeon General, share responsibility for the prevention and screening for PTSD for soldiers, both active and Reserve, from the global war on terror. Derived partly from the EPICON results from Fort Bragg, we have come up with a new deployment cycle support program that has been in place for several years to help our soldiers and their families.

Since the beginning of the war, there has been a robust combat and operational stress control presence in theater. Today, more than 200 behavioral health providers are deployed in Iraq, and another 25 in Afghanistan. The mental health assessment team reports have demonstrated both the successes and some of the limitations of these combat stress control teams. As a result of learning of the limitations, we have improved the distribution of behavioral health providers throughout the theater. Access to care and quality of care have improved as a result.

Before deployment, soldiers are screened for medical issues including family problems. Then, as part of the reintegration process, soldiers are briefed on what stressors to expect, the common symptoms of post-deployment stress, such as hyper-arousal, and ways to mitigate these symptoms.

The post-deployment health assessment, when soldiers are coming home, is used to screen the soldiers again for physical complaints and psychological complaints. And then last year, the Assistant Secretary of Defense for Health Affairs directed an extension of the current pro-

gram so that we now have a post-deployment health reassessment; and the army requires that all soldiers redeployed from combat zone, whether they are active or Reserve, complete this new PDHRA screen at three to six months following deployment. The PDHRA program was fully implemented in January of 2006.

If a soldier has post traumatic stress disorder, or other psychological difficulties, they will be further evaluated and treated, using well-recognized treatment guidelines, including psychotherapy and pharmacotherapy.

Traumatic brain injury is also a focus of our attention. TBI, as it is often called, is a broad grouping of injuries that range from mild concussions to penetrating head wounds. Many of these symptoms are similar to post traumatic stress disorder, especially the symptoms of difficulty concentrating, and irritability. I have Col. Labutta here, chief of neurology, with me today to answer any questions you may have on screening, diagnosis, and treatment of TBI.

We recognize that there is a perceived stigma. Therefore, we are moving to integrate behavioral healthcare into primary care, wherever possible. Our pilot program at Fort Bragg, Respect.Mil, has been very successful, and we are moving to implement it throughout the Army.

There is a legitimate concern about our isolated Reserve component soldiers. The Army one-source program was put into place, and is now becoming the military one source to provide free confidential counseling. Our physically wounded soldiers have also been the focus of attention.

Finally, we have been working on improving our suicide prevention programs. Every suicide is a tragedy. The DCSPER is the proponent for suicide preventions, while the chaplains conduct suicide prevention classes, and behavioral health is also doing surveillance. However, several years ago we leveraged a new report, the Army Suicide Event Report, the ASER, to improve our surveillance. All suicides and serious suicide attempts require this report to be filled out, and we are in the process of setting up a new suicide prevention office within the Army medical department.

So continuing to assess the quality of our services, we learn. Lieutenant General Kiley is a co-chair of the Department of Defense Mental Health Task Force, with a report due in May of 2007.

We are ongoing training of our leadership in numerous venues. You have already heard about after the soldier leaves and goes to the VA, it is critically important also that we provide education to our civilian providers; that they learn to ask, "Are you a veteran?" and, "Have you been exposed to a blast injury?" And we have numerous efforts.

In summary, we have been at war for five years. War challenges the psychological health of our troops and their families. We have been in continual process of improving our efforts. This is not just

an army issue, it is not just a VA issue, it is a national issue. We have the tools that we need to recognize and treat soldiers and their families.

Thank you very much for your attention.

[The statement of Colonel Elspeth Cameron Ritchie appears on p. 72]

MR. BROWN. And I thank you, Colonel Ritchie, for your service. And at this time, we would hear from Colonel Hoge.

STATEMENT OF COL. CHARLES HOGE, M.D.

COLONEL HOGE. Thank you, Mr. Chairman and distinguished members. Thank you for inviting me here.

I direct a research program focused on assuring that soldiers who serve in Iraq and Afghanistan get the best mental health services that we can provide. And since my testimony to this Committee in July of 2005, we have continued to collect data, and continue to try to refine our programs and improve our programs, based on the lessons learned from the data that we collected.

Soldiers are remarkably resilient. They are doing heroic things day after day for a year or longer. Some of them are going back for their second or third rotation. They are working in highly dangerous and unpredictable environments. And it is normal to experience symptoms after these combat experiences. Most soldiers transition very well when they come home, and have resolution of those symptoms. Some need help, and that has been the primary focus of the research that we have been conducting.

Based on the data from several sources, and we now have robust data from a number of different sources, we estimate that 10 to 15 percent of Army soldiers develop post traumatic stress disorder after deployment to Iraq. Another 10 to 15 percent have significant symptoms of PTSD, depression, or generalized anxiety, and may benefit from care. Alcohol and family problems can add to these concerns.

The Army has a comprehensive strategy to encourage soldiers to seek help early, before these symptoms become severe, or interfere with their lives, seriously interfere with their lives, such as the example that we heard earlier today.

We learned that soldiers may not express mental health concerns until several months after they returned from deployment, and as a result, the post deployment health assessment now includes the reassessment that Dr. Ritchie discussed earlier. So far, over 60,000 soldiers who have returned from Iraq have completed this health assessment. Of these, 35 percent reported some sort of mental health concern on general screening questions. And after speaking with a health care professional, about 18 percent were recommended to seek

assistance from one of the many mental health sources of care.

One new finding from post-deployment health reassessment program is that Reserve component soldiers—that is, National Guard and reservists—report higher rates of mental health concerns, and higher rates of referral, compared to active component soldiers. It is important not to misinterpret these data as suggesting that they are in some way less mentally healthy than the active component soldiers. Reserve component and active component soldiers have nearly identical rates of mental health concerns in theater and immediately post deployment. And these differences don't appear to emerge until several months after they return home.

We don't know exactly why this is, but potential factors that could relate to this include concerns about ongoing access to health care among Reserve component soldiers after they have been home for some period of time, and the fact that active component soldiers stay with their unit, and they continue to work full time with their unit, with the peers who they have shared their combat experiences with, and that provides a very supportive environment for resolving symptoms when they have been home.

So far, we are not seeing higher rates of mental health concerns among soldiers who are deployed more than one time to Iraq, compared to those who have deployed once. However, it is difficult to measure the effect of multiple deployments, because the rate of leaving military service is somewhat higher for those who have been to Iraq one time. Although we have data indicating that our efforts are working to encourage soldiers to get help for combat related mental health problems, our surveys indicate that many soldiers with mental health concerns still don't seek care, and perceive that they will be stigmatized if they do; that is, viewed or treated somehow differently by their peers or leaders.

The data on stigma have led to new approaches to improve the availability of mental health in primary care settings and training for soldiers and leaders to improve their recognition of mental health issues, reduce the perception of stigma, and assure successful transitions throughout the deployment cycle.

In the area of training, my team has developed and tested a new training program called BATTLEMIND, with these goals in mind. This new training highlights the skills that help soldiers survive in combat, and how to transition the skills when they get home. The training has been incorporated into the army deployment cycle support program, and is being utilized in a variety of ways, including at VA facilities and VA vet centers. Further information on the training materials can be obtained at www.BATTLEMIND.org.

Thank you very much for your continued interest in our research, and your support for the men and women who are serving in Iraq and have served in Iraq and Afghanistan, and other locations.

[The statement of Colonel Charles W. Hoge appears on p. 79]

MR. BROWN. Thank you, sir, for your testimony and for your involvement in this program.

My first question would be that understanding that the post deployment health assessment, and the post and limit health reassessment are self-reporting tools, are you personally convinced that they are powerful sufficient to be used as predictable tools? and if not, how can they be improved?

COLONEL HOGE. The post-deployment health assessment and the post-deployment health reassessment include a self-report portion of the survey, but basically, all individuals sit down with a primary care professional to review the answers that they have put on those surveys. So in essence, the survey questions are really just prompts to help the primary care professional identify what issues need to be discussed further.

COLONEL RITCHIE. If I may add to that, it is also important to recognize that the soldiers have a number of other venues to seek help, and we encourage the unit—and I believe the unit leaders are very much doing this—to provide outreach and education. And then there is a number of other efforts, such as the combat stress control teams, to provide outreach, education, and treatment if necessary.

MR. BROWN. But I assume that all the young men and women leaving service are leaving the battlefield, they have this battery of tests, or this observation; and I guess the ones that show signs, I guess they are sort of put into the system. But is there a process to later go back and reevaluate the ones not detected early on after they leave the battlefields, to see if there is a later-developing problem?

DR. CROSS. Sir, that is one of the main reasons that the post-deployment health reassessment was established, to be done three to six months after the soldier has returned from combat. I think it is very important that we have numerous opportunities in our system and in the VA system for the soldier to seek treatment, because we do recognize that many soldiers will not seek treatment right away.

MR. BROWN. And if I might ask, how are the service chaplains being integrated into the theater-based assessment team? Do you bring those chaplains on board to help do the assessments?

COLONEL RITCHIE. If I understand the question correctly, you ask how the chaplains are integrated into theater, and also after the return home?

MR. BROWN. My question is just how are they integrated in the assessment of the troops after they leave the battlefields?

COLONEL RITCHIE. Chaplains are an integral part of our system. In general, each battalion has its own chaplain who will work very closely to the soldiers, and this is extremely important because it provides a non-stigmatizing, confidential way for the soldier to seek

help. Chaplains have also been part of our mental health assessment teams. In terms of after they come back, again, the chaplains will be present, and in every battalion. And as a result of the evaluations, the post-deployment health assessment or reassessment, the soldier can either seek out a chaplain or a behavioral health provider. So again, they are very well integrated, and we really could not do our mission without them.

MR. BROWN. Do you have some thing to add, Dr. Hoge? Do you have anything further to add on that question about the chaplains, or are you pretty satisfied?

COLONEL HOGE. I agree completely. They are very well integrated, and a very important part of the well-being of soldiers in every unit.

MR. BROWN. Okay, thank you. We will probably come back for some other questions, and I will also offer the other members of the Committee to question later. But let me further my question to Dr. Cross and Dr. Katz, if I could.

One of the biggest challenges that we continue to hear a lot about is the transitional rehab capacity of the VA for those with TBI. Dr. Cross, Dr. Katz, or Dr. Sigford, please describe the resources available to our men and women after they have been discharged from a VA facility.

DR. CROSS. If I understood your question, sir, it relates to the resources available to them after separated from the military?

MR. BROWN. Right.

DR. CROSS. For both PTSD and TBI, we have very significant programs available. I wanted to highlight particularly both in the programs that we have to address their needs, and in outreach, our vet centers. Our vet centers are a unique resource within our organization, and I wanted to point out a couple of things about them.

As of August, counseled 16,933 outreach services for 111,000-plus, and also counseled with 1215 families. A unique resource, where the new veteran can just walk in, no wait, say "hello," be welcome, say "Have a cup of coffee, take it easy, let's talk," and I think that is very important.

We also have a comprehensive system of primary care. We are training our primary care providers to make sure that they understand, in addition to all of their other training, that they can recognize TBI or PTSD. We have put out this training manual, and an online course that we now mandate for our primary care providers working with polytrauma patients and others.

And of course, our PTSD programs, 112 inpatient and over 200 specialty service programs. And I will ask Dr. Katz to expand on that.

DR. KATZ. The first task is to overcome the barriers to veterans getting into our systems. For that, their interactions with DoD, vet centers are also very important sources of outreach. In our medical centers and clinics, we also run outreach programs. Over recent years,

we have funded 84 outreach providers to go out to the community, Reserve, and Guard units, and also to do in-reach; to work with the veterans in primary care, and rehabilitation programs after physical injury, to educate veterans and families about mental health conditions, and to give the message the treatment works. We are working very hard to get patients somewhere. The no-wrong-door theme that we have learned from the vet centers applies all over the system. Our goal is to get people in treatment, knowing the treatment works, and that it can prevent disability.

MR. BROWN. Let me follow up on that if I could. What type of collaborative arrangements exist with the DoD to providing continued care for these folks? The September 2004 GAO report stated that VA lacks the information it needs to determine whether it can meet an increasing the demand for VA PTSD services. VA stated that it planned to aggregate, at the national level, the number of veterans receiving PTSD services at VA medical facilities and vet centers, and share this information with GAO. Has this been achieved?

DR. CROSS. Sir, with regard to collaboration with DoD, we are making remarkable efforts in that area. We put our own staff in the eight military treatment facilities where returning service numbers are most likely to come. We are collaborating on information exchange to make sure that data that is found, obtained in the DoD system, is conveyed over to us.

I have observed personally an interaction between our Tampa facility for polytrauma, Walter Reed in Bethesda, talking about a patient online on video teleconference, simultaneously with a doctor in Baghdad, who had actually treated that patient initially. A remarkable degree of communication.

MR. BROWN. Is that a seamless transferring of information, or is that a manual transfer of information? Do you have, like, is your computers compatible, and can you share those records electronically?

DR. CROSS. We are receiving electronic information from DoD, but we are also, on a patient-by-patient basis, making sure that we talk to each other, to compare notes.

MR. BROWN. Okay.

DR. CROSS. And we are talking about the very, very seriously injured polytrauma patients.

MR. BROWN. Right, okay. I thank you very much.

Mr. Michaud, do you have some questions?

MR. MICHAUD. Thank you very much, Mr. Chairman. Once again, I want to thank the panel for your testimony.

Colonel Hoge, your research shows real differences in how the National Guard members and reservists respond to PTSD screening questions three through six, most after deployment, as compared to active components of servicemembers. Is this because the National

Guard and Reserve members do not have the same access to mental health services, or support?

COLONEL HOGE. Sir, we are not really sure. This is new data. The PDHRA program has just been implemented, and this is the first time we have seen this. To date, all of our data has shown very comparable rates between active component and Reserve component. So something is happening in terms of the level of concern rising in Reserve component soldiers, among Reserve component soldiers, after they have been home for several months. And I don't know if that is concern that they may have issues that may be ongoing and whether they have concerns about getting health care on an ongoing basis.

Also, we have a relatively small sample of Reserve component soldiers who have completed the post-deployment health reassessment, and that sample may not be representative of all Reserve component soldiers. So this these to be continued to be studied. But we were asked specifically about what we are seeing on the PDHRA, and I felt like it was important to share those data, even though they are fairly preliminary.

MR. MICHAUD. Thank you.

Dr. Cross, what challenges do you see in helping families of veterans with TBI to navigate the VA and the DoD health care systems? And what is the VA doing to help?

DR. CROSS. Sir, the greatest challenge that we have faced, in my opinion, is communication. It has been so very important for us to make those family members feel and actually be a part of the treatment care team, to be involved in making the decisions that will affect their loved one. We are learning to do that better and better, but this is something that we have really put a great deal of effort in. Communication I think is at the core of success; not only of treating the patient himself, but the family as well.

MR. MICHAUD. Also, we have heard that mild TBI can go undiagnosed or misdiagnosed. What is VA doing to ensure that veterans with mild TBI are correctly diagnosed? Dr. Cross?

DR. CROSS. We are working with our primary care providers and all of our staff to deal with polytrauma in any of its forms, to make sure that in addition to their education that they already have, their medical education for instance, that they receive supplemental training to make sure that they understand those fine distinctions. Not just to recognize the severe cases, but the mild and moderate, as well.

MR. MICHAUD. Okay. Why is it that VA is not using the brief traumatic brain injury screen development by the Department of Defense in the Veterans Brain Injuries Center to screen veterans for mild TBI?

DR. CROSS. We are vitally interested in screening. We take great interest in the work that DoD is doing with the screening in the Veterans Brain injuries Center. We want to make sure that any screen

that we adopt is evidence-based and applicable to the population, the much larger population that we serve. We are following this with great interest, and we are doing research of our own.

MR. MICHAUD. But Col. Labutta, has a brief traumatic brain injury screen been validated as a screen for mild TBI?

COLONEL LABUTTA. The screening questions are validated to the point of the mid-80s, 85 percent or so, of sensitivity at this time. Some of those questions have been asked to redeployed returning units, and have not been wider applied until we know more about that, and to apply them both for more redeployed units, and to apply those or modified versions of those questions, into the VA system.

MR. MICHAUD. So it has been 85 percent validated? That is a pretty high percentage. So why isn't VA using it? Are you looking for a hundred percent?

DR. CROSS. We are not looking for a hundred percent. We are looking to make sure that it is applicable to the patient population that we serve. I have read the study that has been referred to—I believe it is one study—and as I said, we want to make sure that we don't inappropriately label, that we don't expose to imaging studies that are unnecessary. We want to make sure that we have a test that works for our population. Dr. Sigford?

MR. MICHAUD. Are you testing it right now?

DR. CROSS. No, Sir. We are doing research on developing tests.

MR. MICHAUD. And how long will that be?

DR. CROSS. We are expecting research grants on those subjects this year.

MR. MICHAUD. So you will have some results on that research this year?

DR. CROSS. I can't promise you that, sir. We will do the research this year.

MR. MICHAUD. Okay. I know Dr. Ritchie made a statement that you have the tools. You might have the tools, for those that can access those tools. My concern is talking to a lot of veterans, they do not have access to those tools, and that is a big difference. The tools are no good if a veteran cannot access them. And that is my major concern, particularly for veterans that live in rural areas who have even a greater problem of accessing tools when you look at, under the CARES process, a lot of the recommendations have not even been implemented to make the tools available to rural areas.

So I am really concerned with that. I am also very concerned that the VA did not provide the \$100 million that Secretary Principi had talked about for fiscal year 2005 for new mental health care efforts. As well as the additional \$35 million that VA said that they would be using, and they sent out to the VISNs; they never stipulated that it was for mental health care areas, which they can use to make up shortfalls in a lot of different areas.

And the other area that I am really concerned about is the fact that when you look at Iraq and Afghanistan veterans, and what is happening with them with TBI and PTSD; the war over in Iraq and Afghanistan is triggering effects of veterans from Vietnam. Will they be able to get the access, because they might fall into category eight? And because of the current war, it is really having a negative effect on them.

These are a lot of concerns that I have, and when you mention that you have the tools, I beg to differ. Everyone does not have access to those tools, and we are not doing our job to make sure that they are. I think it is incumbent upon each and every one of us here at this table, in Congress, and each and every one of you at that table, to make sure that we provide these services for our veterans.

I realize that you are in a different situation, that you have to get your statements approved, but I do not have to get my statements approved. I can tell you, having heard from veterans yesterday, and having heard from other veterans in the past, Blake Miller, Mrs. Pelkey, who lost her husband to suicide; veterans are not getting the help that they need. I would implore each and every one of you to do what you have to do to convince your boss and your superiors to do what they have to do to provide the resources, so our veterans can get it.

This is a family values issues. It doesn't affect only the veteran; it affects their families. And if you care about family values, and if you care about veterans, you will do everything in your heart and soul to convince your superiors to do what is right, and that is to take care of the veterans.

Thank you Mr. Chairman.

MR. BROWN. Thank you, Mr. Michaud.

Mr. Filner, do you have a question?

MR. FILNER. Yes, thank you. Thank you for your statement, Mr. Michaud.

Can anyone there tell me how many suicides we have had from returning Afghanistan-Iraqi troops?

DR. CROSS. Sir, I don't have that number—

MR. FILNER. I'm sorry, can you speak a little louder?

DR. CROSS. Sir, I don't have that number with me, but I will take it for the record and get you that information.

MR. FILNER. Give me a guess, Mr. Cross. Come on. You don't have it with you? Is it in the thousands? Is it in the millions? Is it 10, is it 100? Come on.

DR. KATZ. We have requested information from the National Death Index, which records—

MR. FILNER. Nobody there knows how many suicides there have been from returning Iraqi soldiers? Nobody there knows? This is disgraceful. You guys are the experts. Many people have attributed sui-

cides—not everyone, but the connection between PTSD and suicide is very clear. Surely you would want to know how many suicides there are, to see if this is a problem or not.

COLONEL RITCHIE. Perhaps I can answer that question. I believe that the number of suicides in active duty soldiers after they have returned from Iraq is about 78. However, I will need to confirm that exact number.

MR. FILNER. I have seen higher, much higher estimates. I don't know, you have—you have hedged it with "active duty." I don't know what that means. I have seen in the hundreds. I have also seen—and if you dispute this, let me know—that the suicide rate is much higher in this population than in either the normal veteran population or the normal civilian population; is that true, or not?

COLONEL HOGE. Sir, no, the suicide rate actually consistently has been lower in the military than civilian populations that are comparably matched in terms of the age and demographics.

MR. FILNER. I am saying the returning Iraqi- Afghanistan soldiers. Use my language. You take whatever I say and use your own language, and which gives all kinds of caveats and bureaucratic—I said one thing, you said "the military." That means everybody, now, in the military, including all the guys at the desks, right?

So is the suicide rate of returning Iraqi and Afghanistan soldiers, Marines, and anybody who is involved there, even civilians, higher or not, than the general population?

COLONEL HOGE. No, sir.

MR. FILNER. I have different information. I think that is at least a matter of debate.

But, as I think Col. Ritchie said, any suicide would be important. Of course, you cloak that concern with all kinds of—suicidal events, what the hell is a "suicidal event?" It's an attempted suicide or a real suicide, probably, but the way you talk about them dehumanizes it, it takes the passion out, takes the emotion out.

Okay, whatever the rate is, let's say it is 83, somebody said 83 earlier. You said 78. I have seen hundreds. Have we done everything we could to prevent those, is what I want to know. Every one of you said what a great job we are doing. I don't question that we are doing a lot. I don't question your own commitment to this. I don't question your own sincerity in this.

But you have an opportunity here, in front of people who have said they are concerned and control the resources that you get. What do you need to do your job better? Tell us. What resources do you need? Not one person has said "We need additional resources," or "We would like to have additional this." You have said "Everything is fine." Col. Ritchie said, "We have all the tools that we need." Everybody else, "Oh, we are doing such remarkable things."

How come every one of us here, and I'm sure you, too, have heard

story after story after story that we are not doing our job? Because we are doing part of it, but we are not doing a lot. To whom much is given, much is required. We are the richest nation in the history of the world. If we can't devote the resources we need to do this, to take care of every single person who needs the help, we are not doing our job.

So what else do you need to do your job? Not one of you has said that to us. You have got some very sympathetic people here. We want to give you resources. What would you do? How would you do your job better? Every one of you, how would you do your job better if you have more resources?

DR. CROSS. Sir, we are committed to doing the best job that we can—

MR. FILNER. Oh, come on, DR. CROSS. Tell me what you need to do the job better.

DR. CROSS. I screen every single patient that we have for depression—

MR. FILNER. But as Mr. Michaud said, maybe half—we don't know, maybe half the people aren't even coming in to you. How do we reach out to them? Do you need any more outreach help?

DR. CROSS. We are making a tremendous effort in outreach.

MR. FILNER. I can't believe you guys.

DR. CROSS. Can I tell you about some of—

MR. FILNER. I can't believe you, all of you. We are giving you a chance to say what you need. Let us see, we have 150,000 troops in Iraq now, probably several hundred thousand have come back, probably another couple hundred thousand are going. I would say that adds up to maybe a million children of families. What are we doing for the children to tell them about PTSD when their daddy comes home and their mommy comes home? What do we tell them about the nightmares that their parents are going to have? What do we tell them about why they are being slapped in the face, or why their father tried to kill himself? What are we doing for the children?

COLONEL RITCHIE. Perhaps I can address that one. We have got a number of new educational products, which is part of the solution, but not all of the solution.

MR. FILNER. You held up a training manual, one of you. Where is the comic book that will help kids understand what is going on?

COLONEL RITCHIE. Well, there are those products out there. There is a new Sesame Street video for children of deployed families, there is a new "Mr. Poe Goes to War" educational product—

MR. FILNER. Tell me about those. Those sound very interesting. Is everybody given one? How do they get them?

COLONEL RITCHIE. Okay. They are available in a number of sites from our Army community service—

MR. FILNER. Does anybody go to the families and deliver the—

COLONEL RITCHIE. The Army community service has been very active in outreach to families, and they are hung on a number of websites—

MR. FILNER. And everybody who would need this has gotten their hands on it? Would you say that?

COLONEL RITCHIE. No, I would not—

MR. FILNER. So what would you do to make sure that everybody gets access to them?

COLONEL RITCHIE. Well, I think we are in the process of doing that right now, but we are not there yet.

MR. FILNER. So what do you need to do the job better? How many times do I have to ask it?

COLONEL RITCHIE. I think, sir, if I could say in my personal opinion, my personal opinion—

MR. FILNER. I know, is not approved by OMB. That is what I would love to hear.

COLONEL RITCHIE. The area that I am very concerned about is the family members of the deceased, and the family members of the wounded. And the family members of the deceased in many cases move off our installations, off our posts. And I think we need to, as a system, continue to do more.

Now, the vet centers do offer them counseling through their readjustment centers. But I am not sure if everybody knows about that. So that is one area where personally, I think we need to do more. Over the long term, not just the short term.

MR. BROWN. Mr. Filner, I think you much for your questions. Your time has expired.

MR. FILNER. Are we going to have another round, Mr. Chairman?

MR. BROWN. We will have another opportunity.

MR. FILNER. Thank you.

MR. BROWN. Okay. Mr. Moran, do you have a question?

MR. MORAN. Mr. Brown, thank you very much, Mr. Chairman. Thank you for convening this hearing. I think this topic is one that is of significant importance. And I apologize for not hearing your testimony, although I have read at least in part your testimony, and I apologize for not hearing the other questions.

The reason that I wanted to make certain that I was here was this question in particular. I have been reading these statistics, the press stories of increased post-traumatic stress syndrome, that the numbers are growing, and which our servicemembers are suffering from this condition.

My question is, is there any statistical evidence related to the length of deployment and the number of times that a serviceman or woman is deployed in Iraq or Afghanistan? One of the things that I am greatly concerned about is the request that we are making of our servicemen and women to serve longer and longer periods of time,

deployed in the war on terror, and the number of times that they are redeployed back to those theaters. And my question is, is there a relationship between the presence of post traumatic stress syndrome symptoms and the number of deployments, and the length of deployment?

COLONEL HOGE. Yes, sir. In the early part of the war, there were combat units that were from the Army that were rotated into Iraq for varying periods of time. Some were there for less than six months. Others were there for longer, between six months and a year. And others were in fact there for longer than a year.

Among those, looking at those data, we did see a linear increase in the rate of concerns of post traumatic stress symptoms, and other mental health concerns was increased for those who had been there longer. Now in the Army, most units are rotating for a year, so we really can't look at that at this time.

MR. MORAN. What about the number of deployments? And this is perhaps more National Guard and Reserve units, but again, it appears to me that we are—no, it doesn't appear; it is true—we are utilizing our Guard and Reserve in significant increases in number of deployments. And I know from time to time that our servicemen and women are returned home, they in some cases believe that they have completed their service in theater, and only a matter of a few weeks later, learned that they are being redeployed. Is there a mental health consequence to that redeployment, or that series of redeployments?

COLONEL HOGE. We have some data from the post-deployment health reassessment, and from some of our other surveys that we have done, that actually shows that soldiers who have rotated two or more times to Iraq have similar rates of mental health concerns, compared to soldiers who have rotated only one time to Iraq.

But that is difficult to study, and that doesn't really answer the question, because we also know that soldiers who have been to Iraq the first time, for one rotation, have a somewhat higher rate of leaving military service than soldiers who have in, for instance, to Afghanistan or other deployment locations. So there may be a multiple deployment effect that we can't measure because there is a higher rate of attrition from service among those who have been to Iraq.

MR. MORAN. Well, commonsense, at least my commonsense tells me that there would be a relationship, and that being redeployed has to be a significant event in one's life and their family's life, with what I would think would be just necessary mental health components to that redeployment.

COLONEL RITCHIE. Sir, if I could add to that. We agree with your interest and concern, and we are looking at that closely. The Army leadership is very interested in that. I mentioned before that we have a mental health advisory team in theater again right now for

the fourth time in Iraq, and they are looking at that very issue, the post-deployment health reassessment is looking at that. I expect that we will have more data emerge over time, as multiple deployments continue.

MR. MORAN. What kind of time frame do you think that you would have more data in which we could better analyze the answer to these questions?

COLONEL RITCHIE. In general, the results of the mental health assessment teams have been coming out yearly. We have the results from the mental health assessment team sometime this fall, the current MHAT three, the ones from MHAT four will probably be next summer or fall. So over time.

In addition, we have the results of the post-deployment health reassessment, which is coming out continually. So I would say over the next year, there will be a number of different sources of data.

MR. MORAN. Anyone else? Thank you very much for your response. I just had a genuine concern about what we are doing to soldiers and their families, and today's circumstances that they face. And my guess is this is one component, one symptom of the results of multiple deployments, and long periods of deployment. And any information that you garner in the short run which is of value to us in making decisions and encouraging the Department of Defense to do things differently—in other words, sooner knowing that information is better, before it is no longer relevant.

Thank you very much. Thank you, Mr. Chairman.

MR. BROWN. Thank you, MR. MORAN. Dr. Snyder, do you have any questions?

MR. SNYDER. I do.

Colonel Ritchie, following up on your bringing up the family members, and I appreciate you bringing up the family members: if a base and a family, a spouse get notice—and they are living on the base—that their active-duty member has died overseas, what is the time period in terms of notification, and having to be out of the housing and off the base?

COLONEL RITCHIE. I believe that the answer to that is one year. I would need to double check for you. That doesn't directly fall into the medical lane, but I believe that it used to be six months, and now it is extended to a year. And I will take that for the record, also, to confirm.

MR. SNYDER. Because we talk a lot about the support network, that they lose that support network, at some point.

Dr. Hoge, on page nine of your written testimony, you say that there are gaps in mental health research. You say, quote, "specifically, research is limited in the areas of establishing standardized treatment strategies for combat related PTSD, long-term longitudinal studies, and studies on the impact of deployments on military

families," end of quote.

Why is the research limited? Do you all need more medical research dollars from us? Could you benefit from more medical research dollars? Do you have some estimate on how many additional dollars you need, or are there other factors? What is the limitation here?

COLONEL HOGE. I am only speaking for research within DoD among our soldiers, among our men and women who are serving. And in general, I think we have done a good job with identifying the problems, and reducing stigma barriers to care, but I think there is a lack, a potential lack of standardization of the treatment that soldiers receive, in that soldiers really speak—there is a way of communicating with soldiers about mental health issues.

MR. SNYDER. So you are describing the problem, but what is it going to take to solve the problem? I appreciate what you are saying there, but what kind of money, or what is it that is keeping you from doing that kind of study?

COLONEL HOGE. I hesitate to quote a specific dollar figure, because I don't think I am allowed to do that. But I would take that for the record, and I would be happy to provide—

MR. SNYDER. We can read the First Amendment to you, Colonel. It applies in this building.

Without quoting a specific amount, would it be helpful if you had additional dollars?

COLONEL HOGE. Absolutely. Absolutely. We really do not have any—we really have very few treatment studies within DoD that focus specifically on what medications are effective for troops in the combat environment; for instance, what are the best cognitive behavioral techniques that speak the language of the soldiers?

And we are doing a lot. We know a lot. We know that pharmacological interventions are effective. We know that cognitive behavioral therapy are effective. And we rely on a lot of good research studies that have been conducted outside of DoD. But I think more could be done in the area of specific treatment studies for our soldiers, you know, within the military, before they leave service.

MR. SNYDER. Thank you.

Dr. Cross, in your testimony, on page six of your written testimony, you talked about research collaboration between NIH and DoD, and you mentioned 55 proposals were received, and that "those with merit are expected to start later this year." Of the ones that you considered to have merit, were all of them funded? And again, obviously it is a bottom line question.

DR. CROSS. For this year, we plan to fund at least six new major scientific projects related to TBI in fiscal year 2007. Spending for fiscal year 2007, including research on polytrauma, neurotrauma, amputation, prosthetics, I would estimate to be approximately 75 million.

MR. SNYDER. That wasn't my question. My question was, do you

have proposals—of these 55—this is your statement, I am just reading from your statement.

DR. CROSS. Yes, sir.

MR. SNYDER. You said you have 55 proposals you received, and that those with merit are expected to start later. My question is, do you have funding to start all the ones that have merit? Or were some of those 35 not able to be started even though you considered them to have merit, because you did not have adequate funding? Could you have benefitted from some more research dollars?

DR. CROSS. We are going to fund them based on their methodology. We are not going to fund them all. Those that meet the criteria that we set, those are the ones that will be funded.

MR. SNYDER. I should have become a dentist. Sometimes you have to pull teeth around here, don't you?

DR. CROSS. Sir, honestly I don't know where the line is going to be drawn on that, in terms of the methodology.

MR. SNYDER. Is money part of your methodology? Is that on your—I mean, we have had previous testimony. This is not a mystery. We have had previous testimony that there was not—matter of fact, it was in somebody's written statement from the VA, I think, was it from the VA? That there was not enough money to fund all the traumatic brain injury studies. And that was several months ago, and I am just trying to get a follow-up. We can't help you if we don't have information.

DR. CROSS. I have with me Dr. Kupersmith, who is heading our research effort. If I could introduce him?

MR. SNYDER. Sure.

DR. KUPERSMITH. We often have a category of meritorious but not funded. I don't have the numbers for you on that particular review. Our general funding rate is about 20 to 25 percent, and that is where we target the meritorious proposals. We work with people who are below those levels to try to upgrade their proposals, usually, and you know, we review them on the next round. But I don't know in that particular review whether there was a category of meritorious but not funded. I will get that information for you.

MR. SNYDER. Yes, we would like it. We have had previous testimony to that effect, but more good work could have been done if there was adequate funding.

Thank you, Mr. Chairman.

MR. BROWN. Thank you, Dr. Snyder. And we will entertain a second round of questioning, and I have got a question of Dr. Hoge.

It is often reported that 30 percent of servicemembers returning from Iraq and Afghanistan suffer from PTSD. That is an alarming statistic. As a recognized leader in research in this area, what do you think—this is true incident rate of PTSD among those returning from OEF or OIF?

COLONEL HOGE. I am sorry, I misunderstood the question, sir, the last part of your question?

MR. BROWN. Is 30 percent the right number, or is there some other number?

COLONEL HOGE. Thirty percent is certainly the right number, at least for individuals who experience symptoms. But that doesn't mean that they have the disorder of PTSD. Our estimates based on a variety of data sources is that about 10 to 15 percent of soldiers who return from Iraq have the disorder of PTSD, and need treatment. And then there are additional soldiers who experience symptoms to a varying degree, that may need some assistance but don't necessarily reach the criteria for actually having the disorder.

COLONEL RITCHIE. And if I could add to that; by "symptoms," what we are seeing very commonly is hyper-vigilance, the increased arousal, nightmares, and sort of just being on edge all the time. And that should in most cases resolve on its own over time. The message we are trying to put out to our troops and our leaders is that if that doesn't resolve, if it gets in your way with either your family life or your work life, come in and see us. And "us," we include is chaplains, behavioral health, primary care, military one-source. So we try to offer a really wide range of options, low-stigma ways that people can come and get the help that they need. In many cases, just the education that this is normal is helpful to the soldier.

I would like to add, too, that I think an important push for us that we are doing right now with the aid of Colonel Hoge and his troops is BATTLEMIND training for spouses and family members, and parents of soldiers, how can we make sure they are educated in these symptoms?

I had a mother of a soldier tell me a very eloquently how shocked she was when her son came home for R&R, and he was just not acting right. And she felt she needed more education on that issue, to realize their son might not a very nice guy when he came back for the R&R. So that again is part of our increased educational effort to the whole collective military family.

MR. BROWN. Do you find that most of the cases coming back, are they treated with medicine, or just by coming back in and having the community support and family support, that tends to help them overcome that, you know, that stress?

COLONEL RITCHIE. I think Committee support is absolutely essential. I do not have hard data for you on that, but anecdotally, it makes a lot of difference to have the uniform be recognized, to have people be thanked for their service. Tremendously important.

MR. BROWN. Then what percent would you say would have to be treated with some medicine, or—

COLONEL HOGE. I think the question is, what percent need to be treated? Is that correct, sir?

MR. BROWN. Yeah. I know there are all sorts of treatments, and I guess going, having sessions, and—but I am just thinking, if there is some long-lasting treatment that would have to be on some, you know.

COLONEL HOGE. Among the soldiers who have come back from Iraq, about a third have received some sort of mental health evaluation or treatment. A lot of this is preventative, educational type services, and not necessarily treatment for disorders. About 12 percent of the troops who come back from Iraq have been diagnosed with some sort of mental health problem. That is within the year of return, and within our military treatment facilities.

Once they leave the military and go into the VA system, I think the VA has data as well on what percent of individuals who access the healthcare system at the VA receive a diagnosis of a mental health problem or presumptive diagnosis of a mental health problem. And their overall data that I have seen that has been made public, the overall rate of accessing care for mental health issues is actually fairly similar, though there is a lot higher use of mental health diagnoses.

I don't know if that is clear, but it is about a third of individuals access care, and somewhere in the neighborhood of at least 10 percent receiving a diagnosis of a mental health problem within the first year of coming home.

MR. BROWN. Dr. Cross, is that a similar number with you? I am really just looking to see how many are long-term users of some kind of corrective medicine?

DR. CROSS. Sir, I would ask that Dr. Katz answer that, but if I might just—I wanted to say one word on how much I appreciate our BATTLEMIND technique that has been brought forward by DoD. We have adopted this. We are using it in our vet centers. We are finding it to be very practical, and very effective, and I want to thank my DoD colleagues for their work on that.

And now I will ask Dr. Katz to respond to your specific question.

MR. BROWN. Thank you, okay. Doctor?

DR. KATZ. In terms of the number of people we are seeing—VA sees about 31 percent or so of returning veterans—about a third of them have mental health concerns or diagnoses. 15 percent have PTSD. Other conditions, as Dr. Hoge suggested, like depression, anxiety, alcohol use problems, are also common.

Information from our National Center for PTSD suggests that among those exposed to a significant trauma in military or civilian life, about 25 percent will exhibit significant symptoms over time. Most of them, though, will recover on their own, or with brief interventions. About eight to 10 percent will require more extended treatment. And about 60 percent of those that receive either medications—certain antidepressants, for example—or certain forms of psychotherapy, will respond.

MR. BROWN. Okay, thank you very much.

Mr. Michaud, you have a follow-up question?

MR. MICHAUD. Yes, thank you, Mr. Chairman.

Dr. Cross, what happens to the mental health care initiatives that are supposed to be beefed up, VA resources for mental health care, when the allocated funds sunset? What happens to those initiatives? And when does it sunset?

DR. CROSS. The enhancement funds that I believe you are talking about? The enhancement funds?

MR. MICHAUD. Yes.

MR. MORAN. We are still fully committed to using the full amount of those enhancement funds. Here is what we are doing: we want to make sure that every one of those dollars that are put forward for that is used appropriately. It is taking a bit longer to do that, but we want to make sure that those dollars go to the very best purpose, to actually make a difference for each of those veterans. So we are doing this carefully. We are taking some time, but we are doing it as expeditiously as we can, while making sure that it is used very effectively.

MR. MICHAUD. So when those funds sunset, what happens to the initiatives? And when does it sunset?

DR. KATZ. We have been talking about 2008 funding. We can't speak about funding until you speak about funding. I was hired four months ago to implement the strategic plan; and empowered to do it, we will do it.

Programs are out there, but it is more than spending money. Implementing the strategic plan really involves culture change. Issues like Dr. Ritchie and Dr. Hoge were talking about, integrating mental health and primary care is a matter of money, but not just a matter of money. Reorienting the specialty mental health sector to provide rehabilitation and recovery-oriented care is a matter of cultural change that we are working intensively on. It will be done, but it will take time.

MR. MICHAUD. Okay. Okay, actually I was just told that once the money runs out, then the facilities will have to pick up, so—

DR. KATZ. Yes. One of the conditions of the money going to a facility or a VISN, or regional network, is a commitment that staff hired will be permanent staff. And when designated funds run out—if they do—the programs and the positions will be continued by the facility, or the VISNs.

MR. MICHAUD. So if a VISN is running low on money, and they see this program, then they probably will not want to accept it, knowing that they will have to pick up the cost.

DR. CROSS. Sir, for the VISNs on mental health, we are putting out enough money to make sure that they can carry out whatever program they need to carry out. Looking at 2005 to 2006, and on to

2007, we are looking at about a 30 percent increase in funding for that period of time. The service enhancements are going to make a difference. We are going to carry them out. We are going to do good things for these veterans, and we are going to make sure that those programs that we fund are actually effective, and make a difference.

MR. MICHAUD. Well, I respectfully disagree, because I know some VISNs that were supposed to have a CBOC within the VISN, they refused to submit a business plan because they know they don't have the money to implement it. So I can't see them doing this.

What steps is the VA taking now to be able to release funds quickly for the new mental health initiatives for 2007?

Are you doing anything now for the 2007?

DR. CROSS. Sir, we have already got a great deal of work done, and we are working on a mental health primary care initiative. You talked about stigma. We want to make sure that that is not an issue. People are comfortable in coming in to, usually, a primary care facility, and seeing people that they already know.

What we want to do is to make sure that when we do detect any mental health condition, especially things like depression, we want to make sure that when we detect it, that we then follow through, and have the capability in those primary care clinics. So we have brought forward a mental health primary care initiative on which we are going to expand very substantial funds, over the coming years.

MR. MICHAUD. And my last question is, how many and how much?

DR. KATZ. Our talk about the primary care initiative is roughly a \$40 million program. We received 85 responses to requests for proposal, and we will be funding the overwhelming majority of them. Other plans for the year are to target specific needs, both in established programs where there are gaps, and also in new programs. For example, part of our plan for the year includes suicide prevention counseling very much like the ones that Mr. Boswell spoke about.

Another plan is to put recovery and rehabilitation coordinators in the field, really to facilitate, at the local level, the transformations discussed in the strategic plan.

MR. MICHAUD. Thank you. Thank you Mr. Chairman.

MR. BROWN. Thank you, MR. MICHAUD. Mr. Moran?

MR. MORAN. Thank you Mr. Chairman.

The issues surrounding brain rehabilitation, traumatic brain injury, what is the status of the ability for Bethesda and Walter Reed Army Medical Center to meet those needs of our military men and women? Do we have sufficient capacity?

COLONEL LABUTTA. I think your question was, do we have the capacity to meet the rehabilitation needs at Walter Reed and National Navy Medical Center?

MR. MORAN. Yes, sir.

COLONEL LABUTTA. Thank you. We could certainly do more inpa-

tient rehab at both those facilities for traumatic brain injury. I think that when we have a soldier there who has had a brain injury and is there for prosthetic care for a year, and also had a brain injury; the prosthetic care and the prosthetic rehab seems to take first place. When there isn't another injury, what we usually do is try to have that soldier transferred to one of the VA polytrauma centers, where they have active traumatic brain injury rehab.

So hopefully, to answer one of the questions of what is a need, there is a gap, if you will, for those soldiers who need some inpatient rehab during their acute care, while they are getting acute care, at the MTFs.

MR. MORAN. Is that gap caused by lack of dollars, lack of personnel, or lack of physical space?

COLONEL LABUTTA. I think the answer to that question, sir, would be yes.

MR. MORAN. And I guess also what you are telling me, though, is aside from the inpatient treatment that is occurring during the immediate return and medical care and treatment at the Bethesda or Walter Reed; then, we are utilizing the VA system to help meet that gap in other circumstances?

COLONEL LABUTTA. Yes, sir.

MR. MORAN. And the capacity within the VA?

COLONEL LABUTTA. I am sorry?

MR. MORAN. Is there sufficient capacity within the VA for this treatment?

DR. CROSS. Sir, looking at our polytrauma treatment centers, the floor of them, 12 beds each; occupancy rate about 71 percent.

MR. MORAN. I thank you. Thank you Mr. Chairman.

MR. BROWN. Thank you, MR. MORAN. Mr. Filner?

MR. FILNER. Thank you Mr. Chairman. Thank you for having this hearing today, I think it is very important to our nation.

I am not going to get too much—with questions. Let me just briefly say I am more than a little disappointed from the testimony today. I said in my opening statement that we are letting our veterans down. That judgment is based on representing San Diego, California, probably the biggest military and veterans community in the country. If not the biggest, one of the biggest. And I talk to my constituents every day. We had a lot of statistics from Dr. Katz. I appreciate that, but I assume those statistics are based on the patients that come in. I mean, two thirds of the almost 600,000 returnees from Iraq and Afghanistan don't access that system, so I am not sure if you have—whatever your statistics are, we are missing an incredible amount of our population.

And what saddens me is that we have the expertise—and I don't question your expertise—we have the expertise and the resources not to let these young men and women—and some older men and wom-

en—down. We know that whatever your statistics say, the Guard and Reserve forces who are taking a much more prominent role, as you know, in this war; when they get those papers that they have to check boxes on, all they want to do is get home. And they can check anything that stops that, and if they had to go for a medical inquiry for two or three days, they ain't going to check that box. And they are going to have those problems.

Treating our veterans, as you know, should be seen as a cost of the war. We are spending \$1 billion every 2 and a half days in Iraq. If we can't take the money that you all need to do your job better, we ought to be ashamed of ourselves. We have the money.

And Mr. Chairman, maybe you and some of the other leaders of the Committee could talk to their bosses—I hope they talk to their bosses. Talk to the Secretary of Defense, talk to the Secretary of Veterans Affairs. The rules under which you are here, and the kind of statements that you are allowed to make, are not helping our veterans. Personally, I know you want to help them. You are not doing it with this kind of testimony, and the way you responded to our questions. You are simply not doing the job that you can do, and if we have to change the rules, Mr. Chairman, and make those arrangements with their secretaries, we ought to do that. These people know a lot more, need a lot more, then they are telling us here. And you have lost an opportunity for our veterans. We have lost an opportunity to use your expertise. That saddens me, and I wish we could find a way to talk more freely, because as Dr. Katz says, you know, we have the money. You have the expertise. Let us join those two together. We want to give you the money. We want to make your arguments, but you are not helping us, and I wish you could find a way to do that in a better way.

And I thank you, Chairman.

MR. BROWN. Thank you, Mr. Filner.

Mr. Michaud, for a brief statement.

MR. MICHAUD. Thank you very much, Mr. Chairman, once again for having this hearing. I also want to thank the panel, for your willingness to come here, and I look forward to working with you. I want to thank Mr. Filner, as well.

In closing, Mr. Chairman, I just want to say that actually, Mr. Filner's remark actually reminded me, yesterday, we actually heard from two veterans that came back from Iraq, and one of them, exactly how they answered the question, made a difference in whether or not they get home immediately or not. So it forced them to answer the question in such a way that they could go home to see their loved ones. So there are problems out there, and as Mr. Filner has mentioned, and others, hopefully that each and every one of you will look down deep in your heart, and really—because I know you know what is going on out there—and encourage your bosses to come forward

and put forward an aggressive program that is funded. You have the tools, but we have got to make sure that each and every veteran has access to those tools, and that you don't have to wait for services.

So once again, I want to thank the panel for coming today. And thank you especially, Mr. Chairman.

MR. BROWN. Thank you, Mr. Michaud. And let me tell you, I want to thank you and Mr. Filner and the other members for their participation today, and certainly thank the panel for what you do with the resources that are available to you, for solving such a pressing problem, that we feel like we need to reach across all lines to help our young men and women in their time of need.

Without further ado, I would like to ask unanimous consent that all members have five legislative days in which to submit an opening statement, or to revise the extent of their remarks.

And with nothing further, the hearing stands adjourned, and thanks to you all again for your service.

[Whereupon, at 11:50 a.m. the hearing was adjourned.]

APPENDIX

Opening Statement
Honorable Henry E. Brown, Jr.
Chairman, Subcommittee on Health

Hearing on Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI): Emerging Trends in force and Veteran Health

September 28, 2006

The Subcommittee will come to order.

Good Morning and welcome to today's hearing on an issue that is very important to us all. I am pleased to have assembled-- with the help of the Ranking Member, Mr. Michaud--the panel that we have in front of us here today.

As most of you here today know, much has been written and discussed relative to Post Traumatic Stress Disorder, or PTSD, since the beginning of Operations Enduring and Iraqi Freedom (OEF/OIF). We are fortunate to have before us some of those who are responsible for providing us critical data on this mental health condition and I am eager to take this opportunity to learn more about the nature of the disorder and its prevalence amongst our returning service men and women.

And while PTSD seems to have captured a majority of the headlines over the last few years, an equally challenging condition is being seen in increasing numbers at the VA—Traumatic Brain Injury, or TBI. Due to the concussive nature of many of the war-related injuries being seen in Iraq and Afghanistan, TBI can take many forms, ranging from quite mild (almost undetectable) to very dramatic.

We will be interested in hearing how the VA is meeting the increased demand, how the four polytrauma centers are handling that workload and what best practices

are being shared with other VA medical centers to ensure that the best care is being provided all around the nation for those who have suffered some form of TBI.

In addition, we are going to examine some of the similarities between PTSD and TBI in terms of how the conditions manifest, how they are identified and ultimately how they are treated.

The important point I would like to add to this is that these injured servicemembers, in particular those with PTSD, can be treated and a sense of normalcy can be attained. Having said that, in the absence of in-theater risk mitigation techniques, effective early identification and aggressive outreach and treatment, normalcy and appropriate readjustment may be difficult to realize for some returning from theater.

This is an important topic and I want to again thank those assembled before us today for taking the time to help us better understand some of the emerging health challenges that both DoD and VA will continue to face.

I now yield to the Ranking Member, Mr. Michaud, for an opening statement.

Thank you, Mr. Michaud.

Let me now introduce our Panel. I welcome

Dr. Gerald Cross, the Acting Principal Deputy Under Secretary for Health at the VA.

He is accompanied by Dr. Katz [CATS], the Deputy Chief Patient Care Services Officer for Mental Health and Dr. Sigford, VA's National Program Director for Physical Medicine and Rehabilitation.

Representing the United States Army, we are pleased to have Colonel Elspeth Cameron Ritchie and Colonel Charles W. Hoge. Doctor Ritchie is the Psychiatry Consultant to the Surgeon General of the United States Army and Doctor Hoge is the Director of the Division of Psychiatry and Neuroscience at the Walter Reed Army Institute of Research.

They are accompanied by Colonel Labutta, the Chief of the Department of Neurology at Walter Reed.

I thank all our witnesses, and our Subcommittee Members, for their participation and attendance today. This has been a very helpful and informative hearing. We thank you all for attending.

I ask unanimous consent that all Members have five legislative days in which to submit an opening statement or to revise and extend their remarks.

With nothing further, the hearing stands adjourned.

Statement of Ranking Member Michaud
House Committee on Veterans' Affairs
Subcommittee on Health
Oversight hearing on PTSD and TBI
September 28, 2006

Chairman Brown, thank you for holding this important oversight hearing.

Fatalities to our troops in Iraq and Afghanistan from blast-related injuries are lower than in previous conflicts – thank God – due to improvements in protective combat equipment and advances in the delivery of medicine on the battlefield. However, those who survive blasts are at great risk for Traumatic Brian Injury (TBI).

Severe, moderate and even mild TBI can affect veterans AND their families for the rest of their lives. A brain injury can impair cognitive functioning, including short-term memory, concentration, judgment and impulsivity. Many TBI cases experience degrees of impaired vision. It can affect a veteran's ability to return to work. The emotional and behavioral changes that result from TBI can place a tremendous burden on families and friends.

Many veterans with mild TBI may have their symptoms misdiagnosed as a mental health disorder. These veterans need targeted care to help them function better.

Post-traumatic Stress Disorder (PTSD) is also a wound that many of our returning veterans carry home. Unfortunately, the stigma of mental illness often leads veterans to ignore or deny that they had any problems even when they see their relationships and lives crumble under the weight of the symptoms of PTSD. Untreated PTSD is linked with substance abuse, severe depression and even suicide. Sadly, we have already seen too many Vietnam veterans – and now veterans from Iraq – go down that tragic path.

Access to VA's mental health and TBI programs, and the quality of those programs depend on adequate funding. VA mental health care experts have recognized that VA's program has gaps in quality. In response, Secretary Prinicpi rightly adopted a mental health strategic plan with initiatives to address the gaps in VA's mental health care efforts. The Administration promised to commit \$100 million in FY 2005 and \$200 million in FY 2006 to fund these new mental health care initiatives.

Last fall, Ranking Member Lane Evans and I asked GAO to study whether the Administration fulfilled this commitment to fund the new mental health initiatives. Today, GAO's testimony provides its preliminary findings of the study. Sadly, the Administration is far short of fulfilling its commitment. VA did NOT provide \$100 million in FY 2005 for new mental health care efforts. VA only funded half that amount, or \$53 million. VA claimed to GAO that it also provided \$35 million in funds generally distributed to VA hospitals and clinics. GAO found – and VA concedes – that VA never told medical facility directors that the \$35 million was to be used to rebuild mental health care services.

GAO also found that some of the \$53 million went unspent. The preliminary findings for FY 2006 are also disappointing. VA allocated, at best, \$158 million of the promised \$200 million. Again, GAO found that some of this money might not be spent.

Gaps in mental health care services remain. The mental health strategic plan is good. However, without a real commitment to funding, the plan will not become reality.

Members on both sides of the aisle want and need to address this issue. We must keep our promise to veterans and the dedicated mental health care staff who want to help them recover from the psychological wounds of war. Funding and implementation of VA's mental health plan will require vigorous oversight from this Committee. That is why I am pleased, Mr. Chairman, that we are holding this hearing.

Further, it is my intention to continue to press for passage of Lane Evans' Comprehensive PTSD bill, H.R. 1588. It is also my intention to re-introduce an updated version of this legislation in Lane Evans' name in the 110th Congress to ensure that his noble efforts are carried on in order to meet this critical mental health challenge.

Thank you again, Mr. Chairman.

**STATEMENT OF CONGRESSMAN BOB FILNER
before the
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES**

**Oversight Hearing on Post Traumatic Stress Disorder and
Traumatic Brain Injury: Emerging Trends in Force and Veteran Health**

September 28, 2006

Chairman Brown, thank you for holding this hearing on Traumatic Brain Injuries (TBI) and Post-traumatic Stress Disorder (PTSD). It is vitally important that Congress exercises its oversight role over the diagnosis and care for these truly life-altering afflictions.

We need to be certain that the Veterans' Affairs Department (VA), first, can meet the urgent needs of returning veterans and, second, will continue to help these veterans and their families over the long haul. It is unacceptable that many families of returning veterans are frustrated and feel they must fend for themselves to navigate the VA and Department of Defense health care and benefit systems.

I am very concerned that the VA Office of Inspector General (VA IG) has found the VA program of care for the Traumatic Brain Injury program inconsistent and wanting.

Before the war, in 1999, the VA IG raised the concern that VA's 100 beds for Traumatic Brain Injury patients were not adequate to meet the demand at that time.

Now, news reports on Department of Defense research state that 10 to 20 percent of our troops may have some level of TBI. With TBI becoming the signature wound of this war, we must ensure that VA's capacity for acute care and extensive rehabilitative care adequately grows to meet the demand.

The VA needs a good system for screening, evaluating and treating veterans for both severe and mild brain injuries. I am also concerned that many veterans with mild TBI may NOT be properly diagnosed and may not be getting the care they need.

Veterans are also returning home with psychological wounds. More than one in three veterans who have returned from Iraq and Afghanistan and have come to the VA have received a diagnosis of a mental health disorder. That translates into more than 34,000 veterans from Iraq and Afghanistan – who have come to VA hospitals and Vet Centers since FY 2002 - have a diagnosis of PTSD.

I know that the Administration cautions that these veterans have a "possible diagnosis" of PTSD. But, after several years, the VA should be able to determine with accuracy whether tens of thousands of veterans have a PTSD diagnosis.

If the Administration cannot track how many enrolled veterans returning from the war actually have a diagnosis of PTSD, then how can we have confidence that the Administration can budget or plan for their care?

Last week, the Government Accountability Office (GAO) issued a report which revealed the depths of the Administration's inability to plan for veterans' health care during the past two fiscal years. The GAO found that "unrealistic assumptions, errors in estimation and insufficient data" were key factors in the budget debacles of FY 2005 and FY 2006.

Throughout this budget shortfall debacle, the Administration professed that it had the capacity to meet the mental health care needs of veterans. Top VA officials promised \$100 million in FY 2005 and \$200 million in FY 2006 for new initiatives to close the gaps and deficiencies in mental health care services.

But we hear preliminary findings from GAO that VA failed to address these gaps as planned. VA did not allocate the \$100 million promised in FY 2005. It allocated roughly half that amount.

VA claims it spent another \$35 million through general funds for health care. However, VA officials failed to notify medical center directors about those funds or that they should be used only for mental health care initiatives.

In FY 2006, VA allocated only \$66 million to continue efforts from FY 2005 and \$92 million for new mental health care initiatives. \$158 million is not the same as the promised \$200 million.

The Administration has once again broken its promises to veterans. The Administration's failure to actually fund and spend the \$300 million it said was needed for VA mental health care programs is unacceptable.

Mr. Chairman, thank you again for scheduling this extremely important oversight hearing to hold the VA accountable and to help ensure that our nation's veterans and their families get the services they need.

Congressman Bill Pascrell, Jr.
Testimony before the Veterans Affairs Committee
Subcommittee on Health
334 Cannon HOB
September 28, 2006

Good morning. I would like to begin by thanking Chairman Brown, Ranking Member Michaud, and all the subcommittee members for dedicating so much of their time to hear public and member testimony. I would like to ask that my entire testimony be inserted into the hearing record.

As a cofounder of the Congressional Brain Injury Task Force, I am committed to improving the lives of individuals with traumatic brain injury (TBI). This morning I would like to focus on an issue that has gained more and more publicity as of late: Traumatic brain injury and our nation's servicemen and women, past and present.

What is TBI?

Traumatic brain injury (TBI) is defined as a blow or jolt to the head or a penetrating head injury that disrupts the function of the brain. It is often called the "silent epidemic" despite being a leading cause of death and disability among young Americans. Every year 1.5 million Americans suffer a TBI. This is eight times the number of people diagnosed with breast cancer and 34 times the number of new cases of HIV/AIDS. Military duties increase the risk of sustaining a TBI, and we have seen an ever growing number of our armed service personnel become victims of TBI.

TBI and the Military

For our armed forces, TBI is an important clinical problem in peace and war, and its consequences may extend for many years. Military doctors are naming Traumatic Brain Injury the signature wound of the war in Iraq and Afghanistan.

Over 1,500 military personnel involved in the Global War on Terror have been seen and treated by Defense and Veterans Brain Injury Center. At Walter Reed alone, over 650 soldiers with brain injuries from Iraq and Afghanistan have been treated. That represents 40% of the all troops evacuated to Walter Reed Medical Center so far.

About 1 in 10 service members in Iraq - 2 in 10 troops on the front lines - return from combat tours with concussions. Experts say the real total is much higher because closed-head injuries – in which there may be no obvious wound – often go undiagnosed.

DVBIC

The Defense and Veterans Brain Injury Center was established in 1992 after Operation Desert Storm. Until then, there was no overall systemic program for providing brain injury specific care and rehabilitation within Department of Defense (DoD) or Veterans Administration (VA).

Program founders were motivated in particular by the troops who suffered TBI in Vietnam but were never properly diagnosed or treated. Many ended up in mental hospitals or prison, and they suffered high divorce and suicide rates. In Vietnam and previous 20th century wars, brain injuries were just 12 percent of injuries. In Iraq and Afghanistan, it is almost double -- 22 percent.

The changing nature of warfare demands corresponding improved and specialized medical care. Blast injuries, particularly those causing brain injuries, are becoming the primary injury of the conflict in Iraq. It has been estimated that 50% of all combat injuries are blast injuries. Unit operational readiness is compromised by individuals with all any form of TBI.

As part of the recently passed Blast Injury Prevention, Mitigation and Treatment Initiative, the DVBIC is leading the effort to elucidate patterns of brain injury from blasts, including providing guidelines for the assessment and follow-up care after blast-related TBI within the military environment.

The Defense and Veterans Brain Injury Center's mission is to serve active duty military, their dependents and veterans with TBI through state-of-the-art medical care, innovative clinical research initiatives, and educational programs.

To date, DVBIC staff has accomplished the following:

Clinical Care

- Developed the Military Acute Concussion Evaluation (MACE) for use in all operational settings, including in-theater.
- Developed management guidelines for mild, moderate, and severe TBI in-theater.
- Established a telemedicine network linking DVBIC's military and VA sites.
- Initiated a care coordination capacity for persons with TBI in regions remote from one of the DVHIP core sites. Still needed (and planned if funding is available) are greater treatment capacity, particularly at the community reentry level, and an expanded care coordination system that meets the special needs of persons with TBI and is widely distributed across the country.

Research

- Commenced multiple new projects and collaborations focused on defining and understanding blast-related TBI.
- Continued active medication treatment trials for TBI-related symptoms.

- Presented preliminary scientific reports on patterns of TBI emerging from OIF and OEF.
- Initiated development of a clinical platform for the testing of a promising novel rehabilitation intervention for TBI based on animal experiments with environmental enrichment.
- Still needed (and planned if funding is available) are more DVBIC-based investigators and other research personnel to address further the many TBI-related issues emerging from OIF and OEF.

Education and Training

- Developed a syllabus for training first responders in the management of moderate and severe TBI in-theater.
- Developed the first two modules of a course for first responders and other clinicians in the assessment and management of mild TBI.
- Initiated a public awareness campaign on TBI called “Survive, Thrive, & Alive,” the centerpiece of which is a documentary on TBI in military and veterans.
- Developed an outreach team to train clinical personnel at non-DVBIC sites in the assessment and management of mild TBI.
- Still needed (and planned if funding is available), is to build on the public awareness campaign and develop a broadly available multimedia educational capacity for military and veteran TBI patients, their families, clinicians, and all other persons who are touched by this significant public health problem.

In order to better recognize TBI, the DVBIC has begun to employ improved diagnostics, increased brain injury training of battlefield medics and clinical research on blast injury. Ongoing DVBIC research is linked to clinical care programs to ensure that information learned from caring for these individuals will be disseminated to military and veteran treatment facilities and added to the medical literature. Continuing collaboration with military experts on blast injuries, working with preclinical subjects, also will help to better understand the injuries our troops sustain.

DVBIC provides a unique and necessary collaboration between the DoD and the VA Healthcare system. The program also coordinates with other federally funded research projects to assure that our troops get the best care our nation can offer.

However, that does not mean we cannot improve.

Need to Improve and Expand

In August, the Armed Forces Epidemiological Board commended the Army and Marine Corps for recognizing TBI as a significant health and operational concern. However, the Board found the DoD system-wide approach to TBI to be lacking.

The Special Committee on Post Traumatic Stress Disorder and the Committee on Care of Veterans with Serious Mental Illness recommended to the Veterans Administration Under Secretary for Health that VA establish a screening process to identify veterans with Mild TBI.

Also noted was the need for the VA to establish a TBI registry that can be used to create more sophisticated evidence-based, cost effective assessment and treatment strategies. This has proven to be tremendously useful tool in the civilian world. The Centers for Disease Control and Prevention makes grants to States operate traumatic brain injury registries and allows academic institutions to conduct research to support the development of the registries.

In July 2006, the Veterans Administration Inspector General's Office reported on a lack of consistency VA case management citing that the effectiveness of case managers ranged from outstanding to inadequate. One of the greatest challenges the military health care and veterans systems face is to assure that no one falls through the cracks.

The Inspector General also reported on the major weakness in the VA's TBI care and it's participation in the DVBIC program: The number of TBI beds and head brain injury treatment resources do not correspond to the scope of the problem. That was in 1999, but it remains true today.

Future Funding

There is no cure for brain injury. That is why the research being carried out by DVHIP is critical. We must find a way through research to help our injured soldiers with brain injury to return to as near normal life as possible. Because brain injuries can require lifelong care, the need for treatment and care, for the victim and their family, does not stop when injured troops are discharged from the hospital.

According to a recent study by researchers at Harvard and Columbia, the cost of medical treatment for individuals with TBI from the Iraq war will be at least \$14 billion over the next 20 years.

The DVBIC provides continuity of care from the battlefield to rehab and back to active duty or civilian life. Continued congressional support is vital. We are in a time of war. Due to the increased number of injuries from blasts and the need for strategically placed trained brain injury specialists, it is imperative to ensure that all troops are counted and served.

Without our support, DVBIC's congressionally-directed mission of coordinating clinical care, executing research that will result in better characterization and management of the problem, and education to both military and civilian communities will come to a halt.

Adequate funding for the DVBIC is one of the TBI Task Force's primary missions. As such, the Task Force, along with other concerned Members, requested an additional \$12 million for the DVBIC in the Military Quality of Life and Veterans Affairs Appropriations bill for FY 2007 for a total of \$19 million.

I know the Committee shares these sentiments.

And thank the Committee for the opportunity to speak here today.

Congress of the United States
Washington, DC 20515

September 20, 2006

The Honorable James T. Walsh
Chairman
Military Quality of Life, Veterans Affairs
and Related Agencies Subcommittee
House Appropriations Committee
H-143 U.S. Capitol Building
Washington, DC 20510

The Honorable Chet Edwards
Ranking Member
Military Quality of Life, Veterans Affairs
and Related Agencies Subcommittee
House Appropriations Committee
1016 Longworth HOB
Washington, DC 20510

Dear Chairman Walsh and Ranking Member Edwards:

As you prepare for a conference with the Senate Defense Appropriations Subcommittee, we urge your support for \$19 million for the Defense and Veterans Brain Injury Center (DVBIC) under Health Affairs, Operation and Maintenance, as contained in the Senate passed Defense Appropriations bill for FY2007. As \$7 million is already in the Defense Health Program POM, this \$12 million plus up would fund the program at a total of \$19 million for the year, to be administered by the U.S. Army Medical Research and Materiel Command at Fort Detrick.

Established in 1992, the DVBIC is a component of the military health care system that integrates clinical care and clinical follow-up, with applied research, treatment and training. The program was created after the first Gulf War to address the need for an overall systemic program for providing brain injury specific care and rehabilitation within the Department of Defense and the Department of Veterans Affairs. It provides a unique and necessary collaboration between the DoD and the VA Healthcare systems to provide continuity of care from the battlefield to rehab and back to active duty or civilian life.

Traumatic brain injury (TBI) is now the signature injury of the conflict in Iraq, and some 28% of casualties involve TBI, many caused by blast injuries from improvised explosive devices. The DVBIC is leading the effort to elucidate patterns of brain injury from blasts, including providing guidelines for the assessment and follow-up care after blast-related TBI within the military environment. Ongoing DVBIC research is linked to clinical care programs to ensure that information learned from caring for these individuals will be disseminated to military and veteran treatment facilities and added to the medical literature. Continuing collaboration with military experts on blast injuries, working with preclinical subjects, also will help to better understand the injuries our troops sustain.

In addition to supporting and providing treatment, rehabilitation and case management at each of the eight primary DVBIC centers,¹ the DVBIC includes a regional network of additional

¹ Walter Reed Army Medical Center, Washington, DC; James A. Haley Veterans Hospital, Tampa, FL; Naval Medical Center San Diego, San Diego, CA; Virginia NeuroCare, Inc., Charlottesville, VA; Minneapolis Veterans Affairs Medical Center, Minneapolis, MN; Veterans Affairs Palo Alto Health Care System, Palo Alto, CA; Hunter McGuire Veterans Affairs Medical Center, Richmond, VA; Wilford Hall Medical Center, Lackland Air Force Base, TX.

secondary veterans hospitals capable of providing brain injury care and rehabilitation which are linked to the lead centers for training, referrals and consultation.

Continued strong congressional support is vital, particularly due to the increased number of injuries from blasts and the need for strategically placed trained specialists to assure that all troops are counted and served.

We respectfully request funding of \$19 million for the Defense and Veterans Brain Injury Center (DVBIC) as contained in the Senate passed Defense Appropriations bill for FY2007.

It is critical that we continue to support our active duty military men and women sustaining brain injuries, and respectfully request \$12 million be added to the Defense Health Program for this program.

Sincerely,

Bill Russell Jr.

Fredd R. Blatt

Ron Eaton

Maryann D. Day

Bob Kline

T. Hold

Shawn Brown

Carolyn B. Maloy

Alaine Waters

Jim Oberstar

Henry A. WatsonSandy LewinDonald M. PayneWilliam C. McNameeJ. SaxonBonnie BakerWally HeigerLynn WoosleyDale E. GildemeisterRita DeFoyBill AtchisonGolds of RushTom LantosMary KepplerKaren KaysakTom Daniels

Jerald NaderGene TaylorWm AtchisonZane EvansGeorge MillerSue KellyColt C. PalmerJames E. CuffmanTammy BaldwinJim McRaeBrad ShawBetty McCullumJohn W. OliverTom AllenLis BrinkleyD. Brinkley

<u>Aaron A Davis</u>	<u>Loretta Sanchez</u>
<u>Ruben E. L.</u>	<u>Vic Gunderson</u>
<u>Chris Van Hollen</u>	<u>Don Kind</u>
<u>John Sopko</u>	<u>Earl Blumenauer</u>
<u>Randy Hult</u>	<u>Art Randolph</u>
<u>Norman D. Hunt</u>	<u>Michael Fitzpatrick</u>
<u>Virgil Goode</u>	<u>Danny K. Davis</u>
<u>Nicholas J. Lampert</u>	<u>Bob Stump</u>

Jim DavisCaleb S. SchiffMick DoyleTyler J. HyndMike ThompsonMike RossDale SmithJed L. BlackTim RyanTom SimmonsMike FergusonRobert WexlerChris DavisMark MurphyAnna EshooHyl Doyle

C.A. Dutch Ruppert Evan J. Giambrone

Gregory W. Miller

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Dennis J. Kulinich

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Robin Hayes

Jim Langewin

Jeff Miller
Tom Gray

John F. Tierney
DeGuerin

Tif Tif
Hilda Adams

John Johnson

Tom D. Dawson

Tom P. Morris
~~Just like we sonce~~

Andrew J. Sarsay

John Lindley

Michael Maffunda — Carly McCarty

Cc: Chairman Lewis
Ranking Member Obey
Chairman Young
Ranking Member Murtha

Defense and Veterans Brain Injury Center FY07 Signers: 106

Allen, Tom	Kildee, Dale	Schiff, Adam
Andrews, Robert	Kind, Ron	Schwartz, Allyson
Baldwin, Tammy	Kucinich, Dennis	Sherman, Bradley
Bean, Melissa	Kuhl, Randy	Simmons, Rob
Blumenauer, Earl	Langevin, James	Smith, Adam
Bordallo, Madeleine	Lantos, Tom	Snyder, Victor
Bradley, Jeb	Lee, Barbara	Solis, Hilda
Brady, Bob	Levin, Sander	Spratt, John
Brown, Sherrod	Linder, John	Stupak, Bart
Burgess, Michael	LoBiondo, Frank	Taylor, Gene
Butterfield, George	Lynch, Stephen	Terry, Lee
Capuano, Michael	Maloney, Carolyn	Thompson, Bennie
Christensen, Donna	Marshall, Jim	Thompson, Mike
Cleaver, Emanuel	McCarthy, Carolyn	Tierney, John
Clyburn, James	McCollum, Betty	Van Hollen, Chris
Davis, Artur	McDermott, Jim	Waters, Maxine
Davis, Danny	McGovern, James	Waxman, Henry
Davis, Jim	McNulty, Michael	Wexler, Robert
Davis, Lincoln	Meehan, Martin	Woolsey, Lynn
Davis, Susan	Meeks, Gregory	
Davis, Tom	Millender-McDonald,	
DeFazio, Peter	Juanita	
Doggett, Lloyd	Miller, George	
Doyle, Mike	Miller, Jeff	
Duncan, John	Murtha, John	
Emanuel, Rahm	Nadler, Jerrold	
Eshoo, Anna	Oberstar, James	
Etheridge, Bob	Olver, John	
Evans, Lane	Pallone, Frank	
Ferguson, Mike	Pascrell, Bill	
Filner, Bob	Payne, Donald	
Fitzpatrick, Michael	Peterson, Collin	
Gerlach, Jim	Platts, Todd Russell	
Goode, Virgil	Rahall, Nick	
Grijalva, Raul	Reichert, Dave	
Hayes, Robin	Renzi, Rick	
Herger, Walter	Ross, Michael	
Higgins, Brian	Ruppersberger, C.A. Dutch	
Hinchey, Maurice	Rush, Bobby	
Holden, Tim	Ryan, Tim	
Honda, Michael	Sanchez, Linda	
Jefferson, William	Sanchez, Loretta	
Kaptur, Marcy	Sanders, Bernie	
Kelly, Sue	Saxton, Jim	

Testimony for the Record
Representative Leonard Boswell
9-28-06

Mr. Chairman and Members of the Committee, thank you for the opportunity to submit testimony concerning the emerging trends regarding veterans' mental health. With more and more veterans returning from tours of duty in Iraq and Afghanistan, many new issues have arisen regarding veterans mental health that have not received attention in the past. This is an issue that Congress cannot ignore and I am pleased that this Committee is holding hearings on this important issue.

The number of veterans returning with Post Traumatic Stress Disorder (PTSD) is alarmingly high. A recent study found that 17 percent of soldiers and Marines returning from Iraq screened positive for PTSD. Our men and women in uniform returning from combat are fighting a different type of war and a different type of enemy. The National Center for PTSD found several things associated with individuals diagnosed with PTSD, such as physical pain, sleep disturbance and nightmares, substance abuse, and self-harm or suicide.

I believe that obviously these is a connection between PTSD and suicide. Some estimates have found that almost one thousand veterans receiving care for the Department of Veterans Affairs commit suicide each year, and research shows that one out of 100 veterans who have returned from Iraq have considered suicide. I find this number disturbing.

Since March 2003, 80 individuals, who have served in Iraq or Afghanistan, have committed suicide. Our young men and woman serving our country have kept us safe for so long; it is now our turn to protect them.

A few months ago I learned of a young man from my district, Joshua Omvig, who experienced undiagnosed PTSD after returning from an 11-month tour in Iraq. His family and friends did not know how to help him. They tried. Then in December of last year Joshua tragically took his life. He was 22 years old. After I heard Joshua's story I was shocked to find one in a hundred Operation Iraq Freedom veterans have reported thinking about suicide.

I knew something had to be done. That is why I introduced H.R. 5571, the Joshua Omvig Veterans Suicide Prevention Act. This legislation will mandate the Department of Veterans Affairs to develop and implement a comprehensive program to regularly screen and monitor all veterans for risk factors for suicide within the Veterans Affairs system. At any point in a veteran's life, if they were found to have a specific risk factors for suicide they would be entered into a tracking system; ensuring they do not fall through the cracks. Then they would be entered into a counseling referral system to make certain those veterans receive the appropriate help. It would provide education for all VA staff, contractors, and medical personnel who have interaction with the veterans. In addition, it

would make available 24-hour mental health care for veterans found to be at risk for suicide.

Currently, the Department of Veterans Affairs regularly screens veterans for depression, PTSD, and substance abuse but not for suicide specifically.

I am saddened by the circumstances that this legislation grew out of, but I know that if enacted, this program could save lives. We treat their physical injuries, now it is time to treat the wounds that are not visible.

It is my hope that a comprehensive veterans bill will result from this hearing and that any bill considered will include provisions of the Joshua Omvig Suicide Prevention Act. This important issue cannot go one more day without the attention it needs.

Mr. Chairman and Members of the Committee, thank you again for this opportunity to share some major concerns regarding the quality of mental health care our veterans' are receiving.

**STATEMENT OF
DR. GERALD CROSS
ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SUBCOMMITTEE ON HEALTH
HOUSE COMMITTEE ON VETERANS' AFFAIRS
THURSDAY, SEPTEMBER 28, 2006**

10:00 am

Good morning Mr. Chairman and Members of the Committee.

Thank you for this opportunity to discuss ongoing efforts in the Veterans Health Administration (VHA) to improve the quality of care we provide to veterans suffering from post-traumatic stress disorder (PTSD) and traumatic brain injuries (TBI). Accompanying me today is Dr. Ira R. Katz, Deputy Chief Patient Care Services Officer for Mental Health and Dr. Barbara Sigford, Director for Physical Medicine and Rehabilitation Service.

VA offers comprehensive primary and specialty health care to our enrollees, and the quality of our care is second to none. We are an acknowledged leader in providing specialty care in the treatment of such illnesses as PTSD and TBI. By leveraging and enhancing the expertise already found in our four TBI centers, which have served for over a decade as primary referral sources for Military Treatment Facilities (MTFs) seeking specialized care for brain injuries and complex multiple trauma; VA has created a Polytrauma System of Care which includes four Polytrauma Rehabilitation Centers to meet the needs of seriously injured veterans returning from operations in Iraq, Afghanistan, and elsewhere. The changing face of warfare has necessitated adaptations in our approaches to care for those brave men and women returning home from combat. We accept

the challenge of adapting VA's existing integrated system to provide this care. The focus of my testimony today will be on PTSD and TBI, emerging treatment modalities, and VA's initiatives to increase access to our veterans who use these services.

IDENTIFYING TBI AND PTSD

An important first step is identifying symptoms due to TBI or PTSD because the symptomology can be similar. The human brain is incredibly complex and each individual's thought patterns and emotions are unique. This complicates the diagnostic process; however, clinicians have devised a number of assessment methodologies for detecting even mild versions of TBI or PTSD. It is important to note the differences between these two conditions.

TBI is the result of a severe or moderate force to the head, where physical portions of the brain are damaged and functioning is impaired. PTSD is a psychological condition that affects those who have experienced a traumatizing or life-threatening event such as combat, natural disasters, serious accidents, or violent personal assaults. Therefore, while physical tests, such as brain imaging, may be able to support a diagnosis of TBI, there are currently no comparable tools for PTSD.

The two conditions also manifest themselves differently, although there is some overlap. Those who experience TBI may behave impulsively because of damage that removes many of the brain's checks on the regulation of behavior. Without the limits provided by these higher brain functions, these individuals may overreact to seemingly innocent or neutral stimuli.

The effects on individuals with TBI can vary depending on which region of the brain is injured. The manifestations of mild TBI can mimic those of mental disorders, and individuals with TBI may have associated, co-occurring mental

disorders. TBI does, however, have a unique physical origin that sets it apart from mental illness and is best addressed by a multidisciplinary approach that includes a sensitivity to the cognitive, emotional, and behavioral manifestations of brain trauma.

To effectively identify TBI, clinicians follow a general approach:

- First, clinicians evaluate the patient's medical history for previous instances of head trauma. Clinicians are looking for even the slightest changes in function because these changes may develop into something much more serious later in life.
- Second, clinicians assess for potential cognitive deficits. Executive function and memory are the two most commonly affected areas, but the exact nature of the condition will vary from individual to individual depending upon the location of the injury. There will always be individual variation in thoughts, behavior, and dispositions, and discriminating between this natural fluctuation and mild effects of head trauma is difficult.

As with TBI, individuals with PTSD may also be hyper-responsive to experiences related to the trauma. The defining symptoms of PTSD can be clustered into three groups: re-experiencing (intrusive memories, flashbacks), avoidance or emotional numbing (disinterest in hobbies, feelings of detachment), and increased arousal (difficulty sleeping, irritability or outbursts of anger).

PTSD may occur in association with other mental illnesses including substance abuse, anxiety, and depression. It may also be associated with physical illnesses including chronic pain, migraines, and sleeping disorders.

Screening procedures are in place for suspected cases of PTSD, and screening is done throughout VHA. For example, clinical reminders and prompts are included in the electronic health record to alert providers to screen veterans for behavioral health issues, such as PTSD, depression, and substance abuse.

DATA AND TRENDS

According to the August 2006 Analysis of VA Health Care Utilization among US Southwest Asian War Veterans: Operation Iraqi Freedom/Operation Enduring Freedom, 184,524 veterans have sought care from a VA Medical Center since the start of OEF in October 2001 through May 2006. During this time, 1,304 OIF/OEF veterans were identified as having been evaluated or treated for a condition possibly related to TBI. There is no medical code specific to TBI, and a patient may carry more than one diagnostic code, but the most prominent injuries included fracture of facial bones, concussions, and/or brain injury of an unspecified nature. Also, the August 2006 analysis reports 29,041 of the enrolled OIF/OEF veterans who visiting VA Medical Centers or Clinics had a probable diagnosis of PTSD.

PTSD. VA's approach to PTSD is to promote early recognition of this condition for those who meet formal criteria for diagnosis and those with partial symptoms. The goal is to make evidence-based treatments available early to prevent chronicity and lasting impairment.

Available treatments such as certain antidepressant medications and specific forms of cognitive and behavioral therapy are demonstrably effective. Ongoing pharmacological research is evaluating the utility of other approved medications that can block the actions of the stress hormones. Findings from a recently completed study of a behavioral treatment are currently being analyzed. Ongoing research is also evaluating the most effective ways to make specific psychotherapies available to those requiring care. Preliminary research suggests that certain medications can facilitate emotional learning and that they may accelerate and amplify the effects of behavioral therapy, and a large majority of patients respond to these available treatments; however, some patients continue

to have residual symptoms, and rehabilitation to support the veteran's functioning in the family, work or school, and the community may be required.

TBI. Imaging of both the structural and functional aspects of the brain is an emerging diagnostic tool for TBI; however, it is too early to assess whether population based imaging is practical versus its use on an individual basis.

The newly implemented Polytrauma System of Care is integral to not only initial rehabilitation processes but to assure the mitigation of long-term outcomes of patients. This system of care includes the already established four primary Polytrauma Rehabilitation Centers and the 17 new Polytrauma Network sites that are moving toward full implementation this fall. These locations will enhance access, ensure lifelong coordination of care including specialized clinical care and case management, and serve as resources to other facilities.

CLINICIAN SUPPORT

In 2004, VHA developed an independent study guide for health care providers entitled "Traumatic Brain Injury." VA has taken steps to raise awareness of TBI issues by requiring training of primary care, mental health, spinal cord injury, and rehabilitation care providers via this web-based independent study course. The course advises practitioners that brain trauma causes both acute and delayed symptoms and that prompt identification and multidisciplinary evaluation and treatment are essential to a successful recovery.

Supplementary information is under development. For example, in January 2006, an Under Secretary for Health Information Letter about the screening and clinical management of TBI was released to the field to address cognitive, behavioral, and affective disorders following TBI. A group is now working to identify data-driven and appropriate screening questions to improve assessments for TBI.

VHA has also sponsored or supported national conferences on TBI and PTSD that offer training and guidelines for health care professionals. Since July 2005, VHA has produced five satellite broadcasts and materials for returning veterans and their families.

Families are an essential component of the recovery process for both PTSD and TBI. To assist family members, VA has:

- Required all Network Sites to develop an inventory of TBI specific services;
- Established a 24-hour, seven-day a week Polytrauma Helpline Service for patients and families that can answer questions regarding health care problems, including emergencies and administrative or benefits issues;
- Prepared a satellite broadcast titled, "Serving our Newest Generation of Veterans," that addresses the unique needs of patients with TBI or PTSD, the needs of families, and the rehabilitation environment;
- Helped establish Fisher Houses at each of the Polytrauma Rehabilitation Centers; and
- Assigned a designated case manager for each family of a polytrauma patient.

COORDINATION WITH THE DEPARTMENT OF DEFENSE

The VA/DoD Deployment Health Working Group (DHWG), with representatives from VHA, Veterans Benefits Administration (VBA), Department of Defense (DoD), Health Affairs, Centers for Disease Control (CDC), and others, has met and will continue to meet on a monthly basis to explore how we can enhance our responses to military and veteran health issues, including TBI. The DHWG is a source of outreach and education to veterans and military populations as well as to their VA and DoD healthcare providers on health issues such as diagnosing and treating TBI , and will continue to serve in that capacity.

Research collaborations are essential to assure progress for treatment VA, the National Institutes of Health (NIH) and DoD jointly issued a Request for Applications (RFA) in late 2005, to enhance and accelerate research on the identification, prevention and treatment of combat related post-traumatic psychopathology and similar adjustment problems. The goal is to encourage studies involving active-duty or recently separated National Guard and Reserve troops involved in current and recent military operations (e.g., Iraq and Afghanistan). This RFA specifically encouraged participation of clinicians and researchers who screen, assess or provide direct care to at-risk, combat exposed troops, and emphasized interventions focusing on building resilience for veterans suffering from mental health problems, including PTSD, and developing new modes of treatment that can be sustained in community-based settings. Among the approaches being considered are novel pharmacological, psychosocial and combination treatments as well as the use of new technologies (e.g., World Wide Web, DVD, Virtual Reality, Tele-health) to extend the reach of VA's health care delivery system. Fifty-five proposals were received earlier this year in response to this RFA, and those proposals deemed to have scientific merit and relevance to veterans are expected to start later this year.

VET CENTERS AND OTHER SUPPORT

VA's 206 Vet Centers, located throughout the VA system, provide counseling and readjustment services to veterans. Vet Centers also offer tele-health services to expand the reach to an even broader audience. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses, and social workers. Vet Centers address the psychological and social readjustment and rehabilitation process for veterans with TBI or PTSD and are instituting new programs to enhance outreach, counseling, treatment and rehabilitation to support ongoing enhancements under the VA Mental Health Strategic Plan.

Other support for patients with mental health diagnoses includes the development of a mental health portal for MyHealtheVet to help veterans and their families understand their own behavioral health concerns and/or diagnoses and treatments and to promote active participation of veterans with mental illness in their care. The portal will include: information/education on mental illness/health and mental health problems; self-assessment screens for symptoms of mental health problems to facilitate early identification and early intervention; and self-monitoring tools to be used in conjunction with care from a mental health professional to facilitate recovery and rehabilitation. Future plans include incorporation of relevant outcomes data into the electronic health record.

FUTURE

VA continues to plan for the future. In November 2005, VA issued a program announcement to stimulate research in the area of combat casualty neurotrauma. This research initiative seeks to advance treatment and rehabilitation for veterans who suffer multiple traumas from improvised explosive devices and other blasts. Proposals for future projects are currently under review.

To assure that research such as this is translated into the clinical practice, VA has devoted its newest Quality Enhancement Research Initiative (QUERI) center to polytrauma and blast-related injuries with a focus on using the results of research to promote the successful rehabilitation, psychological readjustment, and community reintegration of these veterans.

Other VA scientific studies are currently underway to identify geographic areas where the need for rehabilitation is greatest, and to characterize these injuries and delineate their outcomes and costs. Such information is critically important in helping VA redesign its care delivery system to meet the needs of our newest veterans.

In the area of PTSD research, initial findings of a joint VA/DoD project to assess the pre- and post-deployment neurophysical status of veterans compared to non-veterans were recently published. This is an ongoing study that is expected to provide important insights about the effects of combat on mental status.

Because of women's new roles in the military and subsequent combat experiences, VA and DoD are also studying the use of psychotherapy for treatment of PTSD in women veterans and active duty personnel. A randomized clinical trial, part of VA's Cooperative Studies Program, has recently been completed and results are currently being analyzed, with a report expected in 2007. Those results will inform additional research and implementation activities across VHA. VHA has an ongoing solicitation for research about women veterans, and is working closely with clinicians to build a robust portfolio of women's health research, including combat-related topics.

CONCLUSION

VA has a long history of providing both TBI and PTSD care and has responded decisively to the increased demand for these services and care. An expanded system of care is available today providing more services and developing new, innovative approaches to addressing these potentially debilitating conditions. VA is committed to the goals of the Polytrauma System of Care to enrich the therapeutic environment to meet the needs and preferences of the combat injured veterans and their families, with specific attention to issues involving TBI and PTSD.

Further work and research are required. We can still improve the nature of our treatments for PTSD by better understanding the interactions between medications and behavioral therapies and by developing new strategies for care. We need a better understanding of the effects of stress and trauma on the brain

and how complications arising from PTSD can impact the patient's overall health. We also must devise new interventions to improve recovery for patients suffering from TBI. While VA is pursuing a more detailed and thorough identification process for mild cases of TBI, there is still more to be done.

Today our clinicians and researchers are providing state-of-the-art care and constantly evaluating their efforts to find better way to treat this patient population. I want to assure you of VA's commitment today and in the future to address the broad issues of TBI and PTSD, and especially the specific needs of veterans returning from OIF/OEF.

Thank you for your time and I will be glad to respond to any questions that you or other members of the committee may have.

Statement By

Colonel Elspeth Cameron Ritchie, MD, MPH

Mr. Chairman, distinguished members of the committee, thank you for inviting me to testify on current trends and initiatives in the treatment of Soldiers with post traumatic stress disorder. I am currently assigned as the psychiatric consultant to The Army Surgeon General. In that role, I assist in the development of Army policies on a wide range of issues from the accessions, training, privileging, and assignment of psychiatrists to coordinating policies, with my counterparts in psychology and social work services, on the treatment of Soldiers with a wide variety of behavioral health problems.

Going to war affects all Soldiers. The number of Soldiers with Post Traumatic Stress Disorder (PTSD) and other war related symptoms has gradually risen. The Army Medical Department has been supporting our Soldiers at war for five years, during 9/11 at the Pentagon, in Afghanistan, in Iraq and around the globe. We take care of Soldiers with physical wounds, and with the psychological issues from combat.

The Army is committed to ensuring all returning veterans receive the physical and behavioral healthcare they need. An extensive array of mental health services has long been available. Since 9/11, the Army has augmented behavioral health services and post-traumatic stress disorder (PTSD) counseling throughout the world, but especially at Walter Reed Army Medical Center and at the major Army installations where we mobilize, train, deploy, and demobilize Army forces. We anticipate that the demand for these services will not decrease and we are committed to providing the necessary help to respond.

The Army Medical Department is performing behavioral health surveillance and research in an unprecedented manner. There have been four Mental Health Advisory Teams performing real time surveillance in the theater of operations, three in Iraq and one in Afghanistan. Another team is in Iraq at this time. COL Charles Hoge has led a team from the Walter Reed Army Institute of Research in a wide variety of behavioral health research activities, some of which have been published in the New England

Journal of Medicine, the Journal of the American Medical Association and other publications. His research shows that generally the most seriously affected by PTSD are those most exposed to frequent direct combat.

The Army Medical Department has also performed several epidemiological consultations (EPICONS) at installations in the United States, such as the assessment following the cluster of suicide-homicides at Fort Bragg, North Carolina in 2002. We held a workshop on updates in Combat Psychiatry at the Uniformed Services University of the Health Sciences in 2004, where we gathered together practitioners who had been in the field with academicians and policy makers. We have used the results of all these assessments to continuously improve the behavioral health services that we offer our Soldiers and their families. Some of these initiatives follow below.

The Army Deputy Chief of Staff for Personnel (DCS PER) and The Army Surgeon General (TSG) share responsibility for the prevention and screening for PTSD for both active and reserve component Soldiers serving in the Global War on Terrorism (GWOT). Derived partly from the results of the Fort Bragg EPICON, the DCS PER has responsibility for the Deployment Cycle Support Program (DCSP) aimed at Soldiers and family members. US Army Medical Command provides behavioral health services at Army medical centers around the world for Soldiers and family members with PTSD and other behavioral health issues.

Since the beginning of Operation Iraqi Freedom (OIF) in 2003 there has been a robust Combat and Operational Stress Control (COSC) presence in theater. Today, more than 200 behavioral health providers are deployed in Iraq and another 25 are deployed in Afghanistan. The Mental Health Advisory Team reports have demonstrated both the successes and some of the limitations of these combat stress control teams. As a result of learning of the limitations, we have improved the distribution of behavioral health providers and expertise throughout the theater. Access to care and quality of care have improved as a result.

Before deployment, Soldiers are screened for medical issues, including family problems and behavioral health issues. If the screening is positive, they receive further evaluation by a primary care and/or behavioral health care provider, to ensure their fitness to deploy. If they have symptoms which will interfere with their health or their ability to perform their job, they may receive a profile to allow them to continue to

receive treatment at their home station or a military treatment facility. In some cases the diagnosed disorder may require the Soldier to undergo a Medical Evaluation Board.

As part of the reintegration process, Soldiers are briefed on: what stressors to expect on homecoming; the common symptoms of post-deployment stress such as hyper-arousal and friction; ways to mitigate these symptoms; how to recognize when further professional help is needed; and how to access treatment services. The briefings are tailored to the specific unit and what unit members experienced during the deployment. Again these briefings have improved over time based on feedback from providers and Soldiers. In addition each demobilization site now has care managers who manage the behavioral health aspect of care and ensure behavioral health referrals are made.

The Post-Deployment Health Assessment (DD Form 2796), is used to screen for physical complaints, PTSD, major depression, family issues, and concerns about alcohol abuse. The primary care provider reviews the form, interviews the Soldier, determines the need for a physical examination, and refers the Soldier to a behavioral healthcare provider or specialty providers as required. The primary care provider may make referrals to on-site counselors or to military treatment facilities. Current data shows that 4-6% of returning Soldiers receive referrals for mental health concerns.

On March 10, 2005, the Assistant Secretary of Defense for Health Affairs directed an extension of the current Post-Deployment Health Assessment Program to provide a Post-Deployment Health Reassessment (PDHRA) of global health with a specific emphasis on mental health. The Army requires all Soldiers redeployed from a combat zone, whether they are active or reserve component, to complete a PDHRA screening 90 to 180 days post-deployment. The PDHRA was fully implemented in January 2006. So far, over 70,000 screens have been performed. The Office of the Surgeon General (OTSG) staff is monitoring referral rates as implementation of PDHRA continues

If a Soldier has post-traumatic stress disorder or other psychological difficulties, they will be further evaluated and treated using well-recognized treatment guidelines. These include psychotherapy and pharmacotherapy. These treatments may be delivered in a variety of venues, to include in theater and garrison, in an outpatient or inpatient setting, and individually or in a group.

Traumatic brain injury (TBI) is also a focus of our attention. TBI is a broad grouping of injuries that range from mild concussions to penetrating head wounds. An overwhelming majority of TBI patients have mild and moderate concussion syndromes with symptoms not different from those experienced by athletes with a history of concussions. Many of these symptoms are similar to post-traumatic stress symptoms, especially the symptoms of difficulty concentrating and irritability. It is important for all providers to be able to recognize these similarities and consider the effects of blast exposures in their diagnosis. Colonel Robert Labutta, Chief of Neurology at Walter Reed Army Medical Center, and Dr. Louis French from the Defense and Veterans Brain Injury Center at Walter Reed are with me today to answer any questions you may have on the screening, diagnosis, and treatment of TBI.

We recognize that there is a perceived stigma associated with seeking mental health care, both in the military and civilian world. Therefore we are moving to integrate behavioral health care into primary care, wherever feasible. Our pilot program at Fort Bragg, Respect.Mil, which provides education, screening tools, and treatment guidelines to primary care providers, was very successful. We are in the process of implementing this program at thirteen other sites across the Army.

There is legitimate concern about our isolated Reserve Component Soldiers. The Army One Source program was developed to support these Soldiers and their families. Now adopted by all the Services and called Military One-Source, this program offers 24/7/365 telephonic support and availability of referrals for six or more no-cost confidential counseling sessions for Soldiers and their family members.

Our physically wounded Soldiers also have been a focus of attention. All Soldiers evacuated to Walter Reed, for example, receive a behavioral health evaluation and, if needed, therapy. The Army Wounded Warrior program offers extensive physical and psychological support to Soldiers and families. Additionally, psychological support to wounded Soldiers and families at the Community Based Health Care Organizations (CBHCOs) has been expanded.

We have been focusing on improving our suicide prevention efforts and adapting our traditional garrison model to the theater environment. The DCSPER is the proponent for suicide prevention. Chaplains usually conduct suicide prevention classes.

Behavioral health providers perform interventional counseling and treatment when a Soldier is identified as a suicide risk. The AMEDD also does surveillance. Several years ago we developed and fielded a new tool, The Army Suicide Event Report (ASER), to improve our surveillance of suicides and serious suicide attempts. All suicides and serious suicide attempts require this report to be completed by a behavioral health care provider. The data is compiled quarterly to help identify trends. We are in the process of standing up a new medical component of the Suicide Prevention Program to compliment the other work being done, with real time analysis and feedback to commanders and the medical system.

We continue to assess the access to and quality of our services. We utilize both internal and external methods. The Army Medical Command is in the process of hiring an outside independent contractor to assist us with this process. They will be reviewing about twenty of our installations. Lieutenant General Kiley, The Army Surgeon General, is the Co-Chair of the Department of Defense Mental Health Task Force created by the Fiscal Year 2006 National Defense Authorization Act. This Task Force, comprised of military, civilian and Department of Veterans Affairs' representative is conducting site visits around the world to evaluate mental health systems, identify trends and to recommend changes to our mental health services. The Task Force will complete its work and submit its report to Congress in May 2007. Lieutenant General Kiley has also made management of PTSD and other behavioral health concerns a priority for his subordinate commanders. He has hosted two General Officer level Behavioral Health summits to discuss research data, emerging treatment initiatives, and lessons learned. All of Army Medical Command's General Officers and other key medical leaders participated in these summits.

Training of our leadership in behavioral health issues is ongoing in numerous forums. For example, the AMEDD Center and School has developed training programs on small unit leader recognition of combat stress for use in other Army career development courses such as Officer Basic and Advanced Courses and in the Non-Commissioned Officer Education System. The Combat and Operational Health Course taught at the AMEDD Center and School has been updated to include emerging

changes in our combat stress control doctrine. The revised training also includes training on detainee mental health care management and treatment.

Another question that is often asked is, what about after Soldiers leave the Army? The transition to the Department of Veterans Affairs health system or other health care systems is critical. The Department of Defense and Department of Veterans Affairs have had numerous conferences and other meetings to share information, research, and emerging best clinical practices. Soldiers who leave the Army are informed of their benefits and on how to obtain care through both the Department of Veterans Affairs and the TRICARE Network, if eligible. The Transition Assistance Management Program (TAMP) provides extended periods of TRICARE coverage for reserve component Soldiers and family members. This coverage applies when the member's Active Duty service was in support of a contingency operation for more than 30 days.

It is critical that civilian providers get educated in how to evaluate and treat our veterans; I personally have conducted Grand Rounds lectures at numerous academic institutions, to include Columbia University, Massachusetts General Hospital, and University of Texas at San Antonio. My colleagues have been doing the same, at the American Psychiatric Association, the American Psychological Association, and numerous other venues. In conjunction with the Department of Defense, the Substance Abuse and Mental Health Services Administration (SAMSHA), within the Department of Health and Human Services, sponsored a major conference this spring, entitled "The Road Home", to help educate civilian providers on the recognition and treatment of combat-related behavioral health problems.

In summary, we have been at war for five years. Unquestionably, war challenges the psychological health of our troops and their families. The overwhelming majority of them continue to demonstrate resilience and dedication. PTSD is not a debilitating disease and can be managed effectively if diagnosed and treated early. The Army and our sister services have been adding to and augmenting our behavioral health assets and programs, applying emerging treatment guidelines, and sharing our research with the Department of Veterans Affairs (VA) and civilian behavioral health providers. We have been in constant dialogue with our counterparts in the VA and other civilian health

care organizations. This is not just an Army or Department of Defense issue, and not just a Veterans Administration issue. It is a national one. Thus it is an area that requires the attention of leaders at all levels. But it is manageable with early intervention, accessible counseling assets, and command emphasis on reducing stigma.

I would like to thank the Congress for your continued support of our Soldiers and veterans and I would especially like to thank this committee for its continued interest in the psychological health of our veterans and our future veterans alike. Coordination of care with the Department of Veterans Affairs and sharing research to improve of clinical treatment of Soldiers and veterans with PTSD has always been a top priority for Army Medicine. Thank you for inviting me to testify today. I look forward to answering your questions.

STATEMENT BY

COLONEL CHARLES W. HOGE, M.D., UNITED STATES ARMY
DIRECTOR OF DIVISION OF PSYCHIATRY AND NEUROSCIENCE
WALTER REED ARMY INSTITUTE OF RESEARCH

COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES

SECOND SESSION, 109TH CONGRESS

HEARING ON POST TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN
INJURY

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COMMITTEE ON VETERANS' AFFAIRS

Mr. Chairman and Members of the Committee, thank you for the opportunity to discuss the Army's research efforts to improve the mental health and well-being of our service members returning from combat duty in Iraq and Afghanistan, including our studies on post-traumatic stress disorder (PTSD). I am Colonel Charles W. Hoge, M.D., director of psychiatric research at Walter Reed Army Institute of Research. Since my testimony to the House Veterans' Affairs Committee in July 2005, my team has continued to assess the impact of combat on the mental health of service members. By and large our findings remain consistent with what I presented last year. I will briefly review findings from four sources of data on the percent of service members identified who might need mental health support after transitioning home from combat. In addition I will discuss key initiatives to reduce stigma and improve access to care for those with deployment related mental health concerns. My comments focus on Army data and initiatives among Soldiers involved in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) deployments.

The first set of data on the mental health impact of OIF is from the Walter Reed Army Institute of Research Land Combat Study. Initial findings from this study were published in the New England Journal of Medicine in July 2004, and additional results were presented to this committee last year. The study involves anonymous surveys using standardized clinical instruments for PTSD and other mental health conditions administered to Soldiers from multiple brigade combat teams before, during, or after returning from deployment. This study has shown that overall 15-17% of Soldiers from combat units screen positive for PTSD when surveyed 3-12 months after returning from deployment to Iraq. When we added one additional question related to functional impairment at the end of the 17 question PTSD scale, we found that 10% of Soldiers surveyed 12 months after deployment reported that PTSD symptoms have made it very

difficult to do their work, take care of things at home, or get along with other people. The inclusion of screens for major depression and generalized anxiety raise the rates of screening positive to approximately 20%; 16% of Soldiers surveyed 12 months after returning from Iraq screened positive for PTSD, depression, or anxiety and reported that there was functional impairment at the “very difficult” level.

The second major source of data is from the Post-Deployment Health Assessment (PDHA), which all service members undergo at the time that they return from deployment. The PDHA involves a brief self-administered screening questionnaire that is then reviewed with a health care provider to determine if there are any deployment-related health concerns that require referral or follow-up. In March of this year we published data in the Journal of the American Medical Association (JAMA) from over 300,000 PDHA assessments conducted among Soldiers returning from OIF1. In brief, we found that 19% of Soldiers returning from Iraq reported some sort of mental health concern, compared with 11% of Soldiers returning from Afghanistan and 9% of Soldiers returning from other deployment locations. The PDHA includes a brief 4-question screen for PTSD; 10% of Soldiers who returned from Iraq endorsed 2 or more of these 4 questions, and 5% endorsed 3 or more of these questions. The rate of endorsing these questions increased with increasing deployment length among Soldiers involved in OIF1 when the deployment length of Army units varied widely; 8% of Soldiers deployed for less than 6 months endorsed 2 or more of the 4 PTSD questions compared with 11% of those deployed 6-11 months and 13% for 12 or more months. Overall, 4% of Soldiers who returned from Iraq were referred for further mental health evaluation or treatment.

The third source of data is from the Post-Deployment Health Reassessment, or PDHRA. The PDHRA was initiated Department of Defense (DoD)-wide after it was recognized that

service members may not express mental health concerns until several months after returning home from deployment. The PDHRA is intended to be administered at 3-6 months post-deployment. Like the PDHA, it involves a self-administered questionnaire that is then reviewed by a health professional. We have analyzed the results of over 70,000 PDHRA assessments from Soldiers who have returned from Iraq (n=64,000), Afghanistan (n=8,000), or other deployment locations (n=1,400). As predicted, the PDHRA has shown higher rates of mental health concerns than the PDHA. Overall, 35% of Soldiers who returned from Iraq reported some sort of mental health concern on at least one of the general screening questions related to PTSD, depression, alcohol use, relationship / interpersonal concerns, or suicidal ideation. This compared with 27% after return from Afghanistan and 25% after return from other deployment locations. It is important to recognize that it is normal to experience symptoms related to combat and deployment, and many individuals who express concerns do not have a mental disorder or need referral for further care. Overall, 11% of Soldiers who completed a PDHRA after return from Iraq were referred for further follow-up with a mental health professional, compared with 8% among those who returned from Afghanistan and 7% after other deployment locations. Military One Source offers an additional option for receiving confidential care outside of the military health care system, particularly for relationship problems or life stressors, and is listed as one possible source of referral on the PDHRA. When Military One Source is included, the referral rate reported on the PDHRA among Soldiers who had returned from OIF was 18%. Among the 64,000 PDHRA assessments from Soldiers who returned from OIF, 35% reported any mental health concern; 19% endorsed 2 or more of the 4 PTSD questions, 11% endorsed 3 or more of the 4 PTSD questions, 11% reported concerns about depression, 13% felt that they had used

alcohol more than they meant to or wanted to cut down on their drinking, 16% reported relationship concerns, and 1% reported suicidal thoughts.

Another important finding from the PDHRA assessments pertains to differences in endorsement rates of mental health concerns and referral rates among Active Component (AC) and Reserve Component (RC) Soldiers (including National Guard and Reservists). Previous data from the PDHA and the Mental Health Advisory Team assessments in Iraq indicated that AC and RC Soldiers had comparable rates of mental health concerns during and shortly after deployment. In contrast, the PDHRA data indicates that rates of mental health concerns and referral rates are higher among Soldiers from RC units than they are among Soldiers from AC units at 3-6 months post-deployment. Thirty-two percent of AC Soldiers reported a mental health concern on the PDHRA compared with 41% among Reserve Component Soldiers. Nine percent of AC Soldiers endorsed 3 or more of the 4 PTSD questions, compared with 15% of RC Soldiers. Nine percent of AC Soldiers had a referral to mental health noted on the PDHRA compared with 16% for RC Soldiers. With the addition of Military One-Source, total rates of referral were disproportionately higher among RC Soldiers (33%) compared with 13% among AC Soldiers. It is not known why the rates are higher among RC than among AC Soldiers, but it is important not to misinterpret these data as suggesting that RC Soldiers are in some way not as mentally healthy as AC Soldiers. It has been shown that RC and AC Soldiers have comparable rates of mental health concerns during and shortly after deployment, and the differences are observed only several months after return home. Potential factors that could relate to these differences that require further study include demographic differences among those who have completed the PDHRA or concerns about ongoing access to health care among RC Soldiers after they have been home for some time period.

The fourth source of data is from the Army's health care system including the number of visits to mental health among Soldiers who returned from deployment. These data showed that 35% of Soldiers who returned from Iraq accessed military mental health services at some time in the year after return, most often in the first two months. This includes any care by a mental health professional for evaluation, prevention, and treatment services; 12% of all Soldiers who returned from OIF1 were diagnosed with a mental health problem in the first year after return (JAMA, March 1, 2006) (or about one-third of those who utilized mental health services). The diagnoses for the remainder of those who accessed mental health care was not specific enough to measure how many of the visits involved treatment of PTSD or another defined mental health problem. It is not yet known how many service members who access care will go on to need longer term treatment, although some data are now becoming available from the Department of Veterans Affairs. One important goal of the DoD efforts involving earlier identification and intervention is to reduce the longer term need for mental health treatment.

Among Soldiers referred for mental health care from the PDHA, 50-60% are documented to receive medical services in a military treatment facility. It is likely that a higher percentage of Soldiers who are referred receive care through sources that are not captured in the electronic medical records system, such as chaplains, Military One Source, and family assistance programs.

Rates of mental health concerns and PTSD are very similar among Soldiers who have completed a PDHRA or Land Combat Survey after their second deployment to Iraq compared with Soldiers who completed these assessments after their first deployment to Iraq. These data suggest that multiple deployments to Iraq do not necessarily result in higher rates of PTSD compared with a single deployment. However, these data do not rule out the possibility that there are cumulative effects of multiple deployments because Soldiers are more likely to leave

military service after their first deployment to Iraq than other deployment locations, and Soldiers who report mental health concerns after their first deployment are also more likely to leave military service than Soldiers who don't report mental health problems.

In summary, it is normal to experience symptoms related to combat experiences, and most returning Soldiers make a successful transition from deployment. Having symptoms is not the same thing as being diagnosed with a mental disorder. There are now robust data from different sources that indicate that approximately 10-15% of Soldiers develop PTSD after deployment to Iraq and another 10% have significant symptoms of PTSD, depression, or anxiety and may benefit from care. Alcohol misuse and relationship problems add to these rates. Conditions often overlap.

Although there has been an increase in use of mental health services soon after returning from combat, surveys indicate that many Soldiers with mental health issues still don't seek care, and many Soldiers perceive that they will be stigmatized if they do. Army Commanders and medical leaders are engaged and proactive in ensuring the well-being of unit members and addressing mental health issues throughout the deployment cycle. A key strategy is to encourage evaluation and treatment for deployment-related mental health concerns early before they become severe, chronic, or interfere with work or social functioning. The PDHA and PDHRA are designed to facilitate access to care for deployment-related concerns, including mental health issues. The data indicate that the expansion of the post-deployment assessment program to include the PDHRA was warranted due to the higher rates of mental health concerns 3-6 months post-deployment, as well as the recognition of potential RC and AC differences that were not evident from earlier data.

Another strategy is aimed at training Soldiers and leaders to improve their recognition of mental health issues, reduce the perception that they will be stigmatized if they receive help, encourage help-seeking when necessary, and ensure successful transitions throughout the deployment cycle. The Walter Reed Army Institute of Research has developed a training program with these goals in mind called “BATTLEMIND”. Prior to this war there were no empirically validated training strategies to mitigate combat-related mental health problems, and we have been evaluating this post-deployment training using scientifically rigorous methods with good initial results. This new risk communication strategy was developed based on lessons learned from the Land Combat Study and other efforts. It is a strengths-based approach that highlights the skills that helped Soldiers survive in combat instead of focusing on the negative effects of combat. Two post-deployment training modules have been developed, including one version that involves video vignettes, that emphasizes safety and personal relationships, normalizing combat-related mental health symptoms, and teaching Soldiers to look out for each other’s mental health. The acronym “BATTLEMIND” identifies ten combat skills that if adapted will facilitate the transition home. An example is the concept of how Soldiers who have high tactical and situational awareness in the operational environment may experience hypervigilence when they get home. The post-deployment BATTLEMIND training has been incorporated into the Army Deployment Cycle Support Program, and is being utilized at Department of Veterans Affairs Vet Centers and other settings. We have also been developing pre-deployment resiliency training for leaders and Soldiers preparing to deploy to combat using the same BATTLEMIND training principals, as well as training for spouses of Soldiers involved in combat deployments. Further information on these training materials can be obtained from the WRAIR website at www.battlemind.org.

Although we have discovered a lot in the last three years about how combat is affecting the mental health of our Soldiers and have developed new training modalities, there are gaps in research. Specifically, research is limited in the areas of establishing standardized treatment strategies for combat-related PTSD (such as medication regimens, psychotherapy modalities specific to Soldiers' experiences), long-term longitudinal studies, and studies of the impact of deployments on military family members.

Thank you very much for your continued interest in our research and your continued support for our veterans, both those who have left active duty and those who continue to wear the uniform. I look forward to answering your questions.

GAO**Testimony****Before the Subcommittee on Health,
Committee on Veterans' Affairs, House of
Representatives**

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VA HEALTH CARE**Preliminary Information on
Resources Allocated for
Mental Health Strategic
Plan Initiatives**

Statement for the Record by Laurie E. Ekstrand
Director, Health Care



GAO-06-1119T

September 28, 2006

G A O
Accountability Integrity Reliability
Highlights

Highlights of GAO-06-1119T, a statement for the record for the Subcommittee on Health, Committee on Veterans' Affairs, House of Representatives.

Why GAO Did This Study

The Department of Veterans Affairs (VA) provides mental health services to veterans with conditions such as post-traumatic stress disorder (PTSD) and substance abuse disorders. To address gaps in services needed by veterans, VA approved a mental health strategic plan in 2004. VA planned to increase its fiscal year 2005 allocations for plan initiatives by \$100 million above fiscal year 2004 levels. VA also planned to increase its fiscal year 2006 allocations for plan initiatives by \$200 million above fiscal year 2004 levels—composed of \$100 million for continuation of fiscal year 2005 initiatives and an additional \$100 million identified in the President's fiscal year 2006 budget request.

GAO was asked to provide preliminary information on VA's allocation and use of funding for mental health strategic plan initiatives in fiscal years 2005 and 2006. A report on this work will be issued later in the fall of 2006.

GAO reviewed VA reports and documents on mental health strategic plan initiatives and conducted interviews with VA officials from headquarters, 4 of 21 health care networks, and 7 medical centers. VA delegates decision making to its health care networks for most budget and management responsibilities regarding medical center operations, and medical centers receive most of their resources from the networks.

www.gao.gov/cgi-bin/getpt?GAO-06-1119T

To view the full product, including the scope and methodology, click on the link above. For more information, contact Laurie E. Ekstrand at (202) 512-7101 or lekstrand@gao.gov.

VA HEALTH CARE

Preliminary Information on Resources Allocated for Mental Health Strategic Plan Initiatives

What GAO Found

In fiscal year 2005, VA headquarters allocated \$88 million of the \$100 million VA officials intended for mental health strategic plan initiatives. VA allocated about \$53 million directly to medical centers and certain offices based on proposals submitted for funding and other approaches targeted to specific initiatives. VA solicited submissions from networks for specific initiatives to be carried out at their individual medical centers through requests for proposals (RFPs). In addition, VA headquarters officials said that VA allocated \$35 million for this purpose through VA's general resource allocation system to its 21 health care networks on a retrospective basis. VA made this decision several months after resources had been provided to the networks through the general allocation system. Moreover, VA did not notify network and medical center officials that these funds were to be used for plan initiatives. Health care network and medical center officials interviewed told GAO that they were not aware these allocations had been made. As a result, it is likely that some of these funds were not used for plan initiatives. Moreover, VA did not allocate the approximately \$12 million remaining of the \$100 million for fiscal year 2005 because, according to VA officials, there was not enough time during the fiscal year to do so. Medical center officials said they used the funds allocated directly to their medical centers for plan initiatives that included new mental health services and more of the services they already provided. For example, two medical centers used funds allocated to them through RFPs or other targeted approaches to increase the number of mental health providers at community based outpatient clinics. One of those medical centers also started a new 6-week PTSD day treatment program. However, some medical center officials reported that they did not use all funds allocated for plan initiatives by the end of fiscal year 2005, due in part to the length of time it took to hire new staff.

In fiscal year 2006, as of September 20, 2006, VA headquarters had allocated \$158 million of the \$200 million planned for mental health strategic plan initiatives. VA allocated about \$92 million of these funds directly to medical centers and certain offices to support new initiatives, using RFPs and other targeted funding approaches. VA also allocated about \$66 million to support recurring costs of the continuing initiatives from the prior fiscal year. As of September 20, 2006, about \$42 million of the \$200 million for fiscal year 2006 had not been allocated. Officials from seven medical centers we interviewed reported that they had used funds for plan initiatives, such as the creation of a new intensive mental health case management program. Officials at some medical centers reported that they did not anticipate problems using all of the funds allocated to them through RFPs and other targeted approaches in fiscal year 2006. However, officials at other medical centers were less certain that they would use all of these funds for plan initiatives by the end of fiscal year 2006.

GAO discussed the information in this statement with VA officials who agreed that the data are accurate, and provided updated data which are incorporated as appropriate.

United States Government Accountability Office

Mr. Chairman and Members of the Subcommittee:

We are pleased to have the opportunity to provide preliminary information from our work on the Department of Veterans Affairs (VA) resource allocation for mental health strategic plan initiatives for fiscal years 2005 and 2006 and how those funds were used by selected medical centers in those 2 fiscal years. VA provides a range of inpatient and outpatient mental health services to veterans with conditions such as depression, post-traumatic stress disorder (PTSD), and substance abuse disorders. In November 2004, the Secretary of VA approved a mental health strategic plan that identified additional services that VA planned to add to the baseline of mental health services that it already offered to meet veterans' mental health needs.¹ This mental health strategic plan was intended to help VA's leadership identify the actions and resources needed to begin eliminating the gaps between mental health services VA provided at the time of the plan's formulation and those additional services VA anticipated it would need in the future.

VA indicated at a 2005 congressional hearing² that it would provide \$100 million above fiscal year 2004 levels for mental health strategic plan initiatives in fiscal year 2005 from available resources. In addition, in a 2005 executive decision memo VA indicated its intent to increase its fiscal year 2006 funding levels to \$200 million above fiscal year 2004 levels for mental health strategic plan initiatives. This \$200 million in funds for fiscal year 2006 was to be composed of \$100 million for a continuation of fiscal year 2005 initiatives plus an additional \$100 million included in the President's budget request for fiscal year 2006, according to the executive decision memo. However, these additional funds represented only a portion of the overall funds available to support VA mental health services in those 2 fiscal years. VA's appropriation for fiscal year 2006, for example, included more than \$31.5 billion for its medical programs,³ of which VA expected to spend more than \$2 billion on mental health services. VA headquarters allocates most of these resources to VA's 21 regional health

¹The plan is known formally as A Comprehensive Veterans Health Administration Strategic Plan for Mental Health Services. In this statement, we will refer to it as the mental health strategic plan.

²Full Committee Hearing on the Continuum of Care for Post Traumatic Stress Disorder Before the House Comm. on Veterans' Affairs, 108th Cong. (July 27, 2005).

³Total includes medical care collections, but does not include certain other amounts, such as appropriations for construction.

care networks⁴ through a general resource allocation system and the networks in turn allocate resources to their medical centers.

VA officials have stated that funds for mental health strategic plan initiatives are to be used to address priorities such as the expansion of PTSD services, postdeployment mental health services for veterans returning from combat in Iraq and Afghanistan and other areas—Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), respectively, and expansion of programs for the treatment of substance abuse disorders. Concerns have been expressed by members of Congress and others regarding the adequacy of resources that VA is devoting to provide mental health care for OIF and OEF veterans while also continuing to provide services for veterans who are currently receiving mental health care.

In this statement we are providing preliminary information on VA's spending for mental health strategic plan initiatives in fiscal years 2005 and 2006. We are currently examining the allocation and use of these additional funds targeted to mental health strategic plan initiatives. Therefore, we focus on the increase from fiscal year 2004 targeted on these initiatives—\$100 million in fiscal year 2005 and \$200 million in fiscal year 2006. In this statement we provide (1) information on how much of the \$100 million for mental health strategic plan initiatives in fiscal year 2005 was allocated and how those funds were used by selected medical centers, and (2) information on how much of the \$200 million for mental health strategic plan initiatives in fiscal year 2006 was allocated and how those funds were used by selected medical centers. A more detailed report concerning these issues and how VA tracked the use of the funds allocated will be issued later in the fall of 2006.

To provide information on how much of the \$100 million for fiscal year 2005 and \$200 million for fiscal year 2006 for mental health strategic plan initiatives was allocated to networks, medical centers, and certain offices, we reviewed the plan itself as well as reports and other documents related to the development, implementation, and funding of the mental health strategic plan. We also conducted interviews with VA headquarters

⁴VA headquarters delegates decision making regarding financing and service delivery for health care services to its 21 health care networks, including most budget and management responsibilities concerning medical center operations. Medical centers typically include one or more hospitals as well as other types of health care facilities such as outpatient clinics and nursing homes.

officials with responsibilities related to mental health services, budgeting, and the allocation of financial resources. We used a September 20, 2006, cut off date for reviewing VA's allocation of the \$200 million for implementing the mental health strategic plan in fiscal year 2006. We took steps to ensure that the data VA provided to us on the funding allocated in fiscal years 2005 and 2006 were sufficiently reliable for our purposes. We reviewed the data for internal consistency and compared the data to other VA information as well as information we obtained through interviews with VA officials. We did not independently verify the accuracy of the data. To describe how funds were used by selected medical centers, in May and June 2006, we conducted site visits to 2 of VA's 21 health care networks and 3 medical centers located in those networks, and we also conducted phone interviews with officials in 2 other networks and 4 medical centers located in those networks.⁵ We selected these 4 networks because VA had identified them as having gaps in substance abuse and/or mental health services prior to the implementation of the mental health strategic plan, and because they received varying levels of funding—from relatively high to relatively low—in fiscal year 2005 for mental health strategic plan initiatives. We interviewed clinical and administrative officials at these networks and medical centers, and at 3 community based outpatient clinics (CBOC)⁶ associated with these medical centers and 5 Vet Centers.⁷ The findings from our site visits and phone interviews with network and medical center officials cannot be generalized to other medical centers or networks. We discussed the information in this statement with VA officials who have responsibilities related to mental health services, budgeting, and the allocation of financial resources. These officials agreed that the data are accurate and they also provided updated data which we incorporated as appropriate. We performed our work from January 2006 through September 2006 in accordance with generally accepted government auditing standards.

⁵Throughout this report, the phrase "how funds were used by medical centers" refers to information provided by medical center officials regarding the hiring of staff, purchase of certain equipment, and other purposes. These activities would be expected to result in obligations and expenditures of funds either immediately or in the future.

⁶CBOCs provide medical services, which may include mental health services, on an outpatient basis in local communities. VA has about 800 CBOCs nationwide.

⁷Vet Centers provide mental health services, including readjustment counseling and outreach services, to all veterans who served in any combat zone. There are 207 such centers that operate in all 50 states, the District of Columbia, Guam, Puerto Rico, and the U.S. Virgin Islands.

In summary, VA headquarters allocated \$88 million of the \$100 million VA officials said would be used for mental health strategic plan initiatives in fiscal year 2005 by using several approaches. VA allocated about \$53 million directly to medical centers and certain offices based on proposals submitted for funding and other approaches targeted to specific initiatives. VA solicited submissions from networks for specific initiatives to be carried out at their individual medical centers through requests for proposals (RFPs). In addition, VA headquarters officials said that they allocated \$35 million for mental health strategic plan initiatives through VA's general resource allocation system to its 21 health care networks, which, in turn, could allocate these resources to individual medical centers. VA's decision that \$35 million of the funds allocated through its general resource allocation system was for plan initiatives was a retroactive decision. VA made this decision several months after resources had been provided to the networks through the general allocation system. Moreover, VA did not notify networks and medical centers that these funds were to be used for plan initiatives. Network and medical center officials we interviewed in 4 networks told us that they were unaware that any portion of their general allocation was to be specifically used for mental health strategic plan initiatives. The approximately \$12 million remaining of the \$100 million was not allocated by any approach because, according to headquarters officials, there was not enough time during the fiscal year to allocate the funds. Officials we interviewed at 7 medical centers in 4 networks reported using resources allocated directly to their medical centers for plan initiatives that included new mental health services and more of the services they were already providing. Some medical center officials told us that they had not been able to spend all of the funds provided for mental health strategic plan initiatives during the fiscal year in part because of the length of time it takes to hire new staff.

As of September 20, 2006, VA headquarters had allocated \$158 million of the \$200 million VA planned for mental health strategic plan initiatives in fiscal year 2006 by using several approaches. VA allocated about \$92 million of these funds directly to medical centers and certain offices to support new mental health strategic plan initiatives, using RFPs and other approaches targeted to specific initiatives. VA also allocated about \$66 million to support the recurring costs of continuing mental health strategic plan initiatives that were funded in fiscal year 2005 through RFPs and other targeted approaches. About \$42 million of the \$200 million for fiscal year 2006 had not been allocated as of September 20. According to VA officials, a portion of the \$42 million not allocated is a result of partial-year allocations made for projects that were funded later in the fiscal year and that are expected to receive 12-month allocations for fiscal year 2007.

Officials we interviewed at 7 medical centers said they had used funds to implement plan initiatives such as a new mental health intensive case management program. However, officials at some medical centers told us that they were uncertain that they would be able to use all the funds for plan initiatives by the end of the fiscal year.

Background

VA provides health care services to more than 5 million patients annually. This care includes mental health services to veterans in inpatient and outpatient settings in a variety of VA health care facilities including medical centers, CBOCs, and Vet Centers. Mental health services are provided for a range of conditions such as depression, PTSD, and substance abuse disorders. Resources for these and other health care services are allocated by VA headquarters through a general resource allocation system—the Veterans Equitable Resource Allocation (VERA) system—to its 21 health care networks. Although the VERA system is used to allocate funds, it does not designate funds for specific purposes or prescribe how those funds are to be used.

In November 2004, the Secretary of VA approved the mental health strategic plan. This mental health strategic plan contained recommended initiatives for improving VA mental health services by addressing a range of issues, including, for example, improving awareness about mental illness and filling gaps in access to mental health services. Some of the service gaps identified were in treating veterans with serious mental illness,⁶ female veterans, and veterans returning from combat in Iraq and Afghanistan. Within VA, the Office of Mental Health Services (OMHS) is responsible for coordinating with the networks and medical centers on the overall implementation of the mental health strategic plan. This includes formulating strategies for allocating funds to medical centers and certain offices for plan initiatives. Such strategies include, for example, the use of RFPs to decide how the mental health strategic plan funds are to be allocated to medical centers.

⁶For the purposes of the mental health strategic plan, VA defined veterans with serious mental illness to be “those who currently or at any time during the past year: (1) have a diagnosed mental, behavioral or emotional disorder of sufficient duration to meet the Diagnostic and Statistical Manual of Mental Disorders (Fourth Edition) criteria, that (2) results in a disability (i.e. functional impairment that substantially interferes with or limits one or more major life activities).” This definition included adults who would meet these criteria during the year without the benefit of treatment or support services.

VA Allocated \$88 of the \$100 Million Planned for Mental Health Strategic Plan Initiatives in Fiscal Year 2005, but Officials Reported That Not All Allocated Funds Were Used for Plan Initiatives

VA Allocated Approximately \$53 Million Directly to Medical Centers and Certain Offices

VA headquarters allocated \$88 million of the \$100 million that VA officials said would be used for mental health strategic plan initiatives in fiscal year 2005 by using several approaches. About \$53 million was allocated directly to medical centers and certain offices and \$35 million was allocated through its general resource allocation system to its health care networks, according to VA officials. The remaining \$12 million of the \$100 million was not allocated by any approach, headquarters officials said, because there was not enough time during the fiscal year to allocate the funds. Officials we interviewed at 7 medical centers in 4 networks reported using allocated funds to provide new mental health services and to provide more of existing services. However, some medical center officials reported that they did not use all allocated funds for plan initiatives by the end of the fiscal year, due in part to the length of time it took to hire new staff.

VA headquarters allocated about \$53 million directly to medical centers and certain offices based on proposals submitted for funding and other approaches targeted to specific initiatives related to the mental health strategic plan in fiscal year 2005. VA headquarters developed and solicited submissions from networks for specific initiatives to be carried out at their individual medical centers through requests for proposals (RFPs). VA made resources available through these RFPs and other targeted approaches to medical centers for plan initiatives to support a range of specific mental health services based, in part, on the priorities of VA leadership and legislation for programs related to PTSD, substance abuse, and other mental health areas, according to VA headquarters officials. Nearly \$20 million of the \$53 million allocated by using RFPs and other targeted approaches was for mental health services related to legislation, according to VA officials.⁹

⁹The Veterans Health Care, Capital Asset, and Business Improvement Act of 2003, Pub. L. No. 108-170, §108, 117 Stat. 2042, 2046-47, required VA to allocate a minimum of \$25 million in each of fiscal years 2004, 2005, and 2006 to carry out a program to expand and improve the provision of specialty mental health services for veterans, including PTSD and substance abuse services. Congress also required VA to ensure that after these allocations, total expenditures related to treatment of substance abuse and PTSD were not less than \$25 million above the total expenditures on such programs in fiscal year 2003, adjusted for increases in the costs of delivering those services. The Homeless Veterans Comprehensive Assistance Act of 2001, Pub. L. No. 107-95, §2043, 115 Stat. 903, 913, authorized VA to establish up to 10 new domiciliary programs for homeless veterans.

Most of the approximately \$53 million allocated—about \$48 million—went to VA medical centers. PTSD services and OEF/OIF veterans' mental health care received an allocation of about \$18 million, with Compensated Work Therapy (CWT) receiving the second highest total—nearly \$10 million. Other initiatives receiving funding included substance abuse services, mental health services in nursing homes, domiciliary expansion, and psychosocial rehabilitation for veterans with serious mental illness.

VA headquarters issued five RFPs from October 2004 to January 2005 that described the specific types of services for which mental health strategic plan funding was available. Review panels headed by mental health experts within VA reviewed the proposals, ranked them, and provided their rankings to VA's leadership. Once funding decisions were made, VA allocated funding directly to the medical centers for the mental health strategic plan initiatives. VA also used other funding approaches targeted to specific initiatives. For example, headquarters officials allocated funding to medical centers to expand mental health services at CBOCs that had fewer mental health visits than a standard VA identified for this purpose. VA also used other targeted funding approaches to determine which medical centers would receive some of the funds for PTSD, OIF and OEF veterans', and substance abuse services. In addition, VA targeted funds to mental health initiatives in Polytrauma Centers—centers within certain VA medical centers that provide specialized treatment for veterans of OIF and OEF who have complex rehabilitation needs.

VA headquarters officials said that allocations made for initiatives in fiscal year 2005 through RFPs and other approaches targeted to specific initiatives would be made for a total of 2 to 3 fiscal years. These officials said they anticipated that medical centers would hire permanent staff whose positions would need to be funded for more than 1 year. The expectation of VA leadership was that after funds allocated through these approaches were no longer available, medical centers would continue to support these programs using their general operating funds received through VA's general resource allocation system.

VA Allocated \$35 Million through Its General Resource Allocation System to Its Health Care Networks on a Retrospective Basis

VA allocated \$35 million for mental health strategic plan initiatives in fiscal year 2005 through its general resources allocation system to its health care networks, according to VA headquarters officials. The decision to allocate these resources to VA's networks for mental health strategic plan initiatives was retrospective and VA did not notify networks and medical centers of this decision. Although VA headquarters made fiscal year 2005 general resource allocations to the networks in December 2004, the

decision that \$35 million of the funds allocated at that time were for mental health strategic plan initiatives was not finalized until April 2005, several months after the general allocation had been made. VA headquarters officials said that they made the decision to allocate \$35 million from the general resource allocation system because these resources would be more rapidly allocated than if they had been allocated through RFPs. However, other VA headquarters officials told us that the decision was also made, in part, because VA did not have sufficient unallocated funds remaining after the December 2004 general allocation to fund \$100 million for mental health strategic plan initiatives through RFPs and other targeted approaches.

VA headquarters officials, as well as network and medical center officials, indicated that there was no guidance to the networks and medical centers instructing them to use specific amounts from their general fiscal year allocation for mental health strategic plan initiatives. Network and medical center officials we spoke with were unaware that any specific portion of their general allocation was to be used for mental health strategic plan initiatives. Several VA medical center officials noted, however, that some of the funds in their general allocation were used to support their mental health programs generally, as part of their routine operations. However, because network and medical center officials we interviewed did not know that funds had been allocated for mental health strategic plan initiatives through VA's general resource allocation system, nor did VA headquarters notify networks and medical centers throughout VA of this retroactive allocation, it is likely that some of these funds were not used for plan initiatives.

VA Did Not Allocate About \$12 Million Planned for Mental Health Strategic Plan Initiatives

VA did not allocate the approximately \$12 million remaining of the \$100 million planned for mental health strategic plan initiatives in fiscal year 2005 because, according to VA headquarters officials, there was not enough time during the fiscal year to allocate the funds through the RFP process or other approaches targeted to specific initiatives. Officials said that when resources were allocated later in the fiscal year through an RFP rather than at the beginning, the amount allocated was only a portion of the annualized cost. The full annualized cost could be supported in the next fiscal year. For example, if a project with an annual cost of \$4 million was allocated mid way through the fiscal year, only half the annual cost was allocated at that time—\$2 million. The expectation was that the full \$4 million would be available for the project over 12 months in the next fiscal year. The \$12 million that VA did not allocate for fiscal year 2005 was intended for certain mental health strategic plan initiatives based on an

allocation plan developed by VA for the \$65 million it planned to allocate through RFPs and other approaches. VA headquarters officials said that funds not allocated for mental health strategic plan initiatives were allocated for other health care purposes.

Medical Center Officials Reported Using Allocations for Mental Health Strategic Plan Initiatives, but Not Using All Funds Allocated for Plan Initiatives

Officials we interviewed from seven medical centers in four networks reported using funds allocated to them for mental health strategic plan initiatives through RFPs and other targeted approaches, but they said that some of these funds were not used for plan initiatives in fiscal year 2005. Officials said they used funds allocated to provide new mental health services and to provide more of existing services included in plan initiatives. For example, two medical centers used funds to increase the number of mental health providers available at CBOCs. One of those medical centers also implemented a new 6-week PTSD day treatment program in which veterans live in the community but come to the medical center daily for counseling, group therapy, and other services.

Officials at some medical centers reported that they were not able to use all of their fiscal year 2005 funding for plan initiatives by the end of the year as planned and cited several reasons that contributed to this situation. The length of time it takes to recruit new staff in general and the special problems of hiring specialized staff, such as psychiatrists, were cited. In some cases the need to locate or renovate space for programs contributed to delays in using mental health strategic plan funds, according to medical center officials.

Medical centers varied in how they treated fiscal year 2005 funds that were allocated by VA for mental health strategic plan initiatives but not used for those initiatives. Some reported that they carried over the funds for use in the next fiscal year.¹⁰ Officials at some medical centers reported that they used these funds for other health care purposes. For example, officials at one medical center said they used funds that they did not spend on mental health strategic plan initiatives to support other mental health programs. VA headquarters officials advised participants from networks and medical centers in a weekly conference call in August 2005 that if they were unable

¹⁰VA may carry over from one fiscal year to the next unobligated balances of funds made available without fiscal year limitation and other funds appropriated for multiple fiscal years.

to hire staff for initiatives in fiscal year 2005, they should use the funds allocated only for mental health services.

As of September 20, 2006, VA Had Allocated \$158 Million of the \$200 Million Planned for Mental Health Strategic Plan Initiatives in Fiscal Year 2006, but Some Officials Were Uncertain If All Funds Would Be Used for Plan Initiatives

VA Allocated about \$158 Million Directly to Medical Centers and Certain Offices

As of September 20, 2006, VA headquarters had allocated \$158 million of the \$200 million to be used for VA mental health strategic plan initiatives in fiscal year 2006 by using several approaches. About \$92 million of these funds was allocated directly to medical centers and certain offices to support new mental health strategic plan initiatives for fiscal year 2006. VA also allocated about \$66 million to support the recurring costs of the continuing mental health initiatives that were funded in fiscal year 2005. The remaining \$42 million had not been allocated as of September 20. Officials at some medical centers expected to spend all of the allocations they received during fiscal year 2006. However, officials at some medical centers were uncertain that they would spend all their allocations for plan initiatives during the fiscal year.

VA headquarters had allocated about \$158 million directly to medical centers and certain offices by September 20, 2006, through RFPs and other approaches targeted to specific initiatives related to the mental health strategic plan in fiscal year 2006. About \$92 million was for new mental health strategic plan activities, and about \$66 million was to support the recurring costs of continuing mental health strategic plan initiatives that were first funded in fiscal year 2005. As in fiscal year 2005, the new resources went to support a range of mental health services in line with priorities of VA's leadership and legislation, according to VA officials. Funding for services for PTSD, OIF and OEF veterans, substance abuse, and CBOC mental health services accounted for nearly three-fifths of the funds allocated for new initiatives. As of September 18, 2006, VA had not allocated resources for mental health strategic plan initiatives through its general resource allocation system and VA headquarters officials said VA was not planning to do so.

VA Did Not Allocate about \$42 Million for Mental Health Strategic Plan Initiatives	<p>As of September 20, 2006, VA did not allocate about \$42 million of the \$200 million planned for mental health strategic plan initiatives in fiscal year 2006 by any approach. VA officials said that a portion of these unallocated funds are related to the timing of allocations that were made for plan initiatives through RFPs and other funds targeted to medical centers. Specifically, some of the allocations through RFPs were made well into the fiscal year. VA allocated only the amount of funds through these approaches for fiscal year 2006 that would fund the projects through the end of the fiscal year, and not the full 12-month cost which VA expects to fund in fiscal year 2007. Because some of these allocations were made in the later part of fiscal year 2006, these allocations were smaller than they would be on a 12-month basis and accounted for part of the \$42 million not allocated. VA officials said they anticipated that these funds would be available in fiscal year 2007.</p>
Medical Center Officials Reported Using Allocations for Mental Health Strategic Plan Initiatives, but Were Uncertain Whether All Funds Allocated Would Be Used for Plan Initiatives	<p>Officials from seven medical centers we interviewed in May and June of 2006 reported using funds allocated to them through RFPs and other approaches to support new 2006 mental health initiatives and to continue to support the initiatives first funded in fiscal year 2005. For example, one medical center used funding for a new mental health intensive case management program. Officials at some medical centers reported that they did not anticipate problems using all of the funds they had received in fiscal year 2006. However, others were less certain they would be able to use all of the funds. Officials at several medical centers were not sure they would be able to hire all of the new staff related to mental health strategic plan initiatives by the end of the fiscal year. In May 2006, officials at two medical centers that we interviewed said that they did not know whether they would receive additional funds through RFPs to spend in fiscal year 2006, and as a result they were uncertain whether they would be able to use all of their fiscal year 2006 funds for plan initiatives by the end of the fiscal year.</p>
Concluding Observations	<p>Our preliminary findings show that VA allocated additional resources for mental health strategic plan initiatives in fiscal years 2005 and 2006 to help address identified gaps in VA's mental health services for veterans. VA intended to allocate \$100 million for plan initiatives in fiscal year 2005. The allocations that were made resulted in some new and expanded mental health services to address gaps, according to officials at selected medical centers. However, approximately \$12 million of the \$100 million was not allocated by any method and \$35 million was allocated through VA's general resource allocation system on a retrospective basis and without</p>

notifying networks and medical centers that resources for plan initiatives had been allocated in the general allocation that networks received several months earlier. Finally, some portion of the approximately \$59 million that was allocated directly to medical centers was not used for plan initiatives in part because the timing of the allocation of the funds did not leave time to hire needed staff by the end of the fiscal year. As a result, it is likely that a substantial portion of the \$100 million intended for mental health strategic plan funds in fiscal year 2005 was not used for plan initiatives. A larger amount of the planned mental health strategic plan funds was allocated in fiscal year 2006, although as of September 20, 2006, about a fifth of the \$200 million planned for these initiatives was not allocated. However, it is unclear whether medical centers will be able to spend all of the fiscal year 2006 mental health strategic plan funds for plan initiatives by the end of the year, in part because of how late in the year the funds were allocated.

GAO Contact and Staff Acknowledgments

For further information about this statement, please contact Laurie E. Ekstrand at (202) 512-7101 or ekstrand@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. James Musselwhite, Assistant Director, and Robin Burke made key contributions to this statement.

STATEMENT OF
CATHLEEN C. WIBLEMO, DEPUTY DIRECTOR
VETERANS AFFAIRS AND REHABILITATION DIVISION COMMISSION
THE AMERICAN LEGION
TO THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
POST-TRAUMATIC STRESS DISORDER AND TRAUMATIC BRAIN INJURY

SEPTEMBER 28, 2006

Mr. Chairman and Members of the Subcommittee:

Thank you for affording The American Legion the opportunity to submit testimony on these very important issues. A majority of the servicemembers who suffer from injuries such as Traumatic Brain Injury (TBI) and Post-Traumatic Stress Disorder (PTSD) will require lifelong care, not just from a clinical standpoint, but from the social aspect as well. Family members, too, must not be forgotten. They are inextricably intertwined in the ongoing rehabilitative process of these injured servicemembers and will themselves need training, counseling and care.

Post Traumatic Stress Disorder (PTSD)

The Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV) defines PTSD as:

PTSD always follows a traumatic event that causes intense fear and/or helplessness in an individual. Typically the symptoms develop shortly after the event, but may take years. The duration for symptoms is at least one month for this diagnosis.

Symptoms include re-experiencing the trauma through nightmares, obsessive thoughts, and flashbacks (feeling as if you are actually in the traumatic situation again). There is an avoidance component as well, where the individual avoids situations, people, and/or objects that remind him or her about the traumatic event (e.g., a person experiencing PTSD after a serious car accident might avoid driving or being a passenger in a car). Finally, there is increased anxiety in general, possibly with a heightened startle response (e.g., very jumpy, startle easy by noises).

Psychological treatment is considered the most effective means to recovery from PTSD, although some medications (such as antianxiety meds) can help alleviate some symptoms during the treatment process.

Prognosis ranges from moderate to very good. Those with the best prognosis include situations where the traumatic event was acute or occurred only one time (e.g., car accident) rather than chronic, or on-going trauma (e.g., ongoing sexual abuse, war).

Servicemembers from past wars have long suffered the mental stresses of combat. From shell shock, to battle fatigue to PTSD, veterans returning home have struggled through the process of readjusting back to civilian life. What has changed over the ensuing years is the acknowledgement and treatment of traumatic stress.

Current research shows that the returning veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) suffer from a high percentage of mental health stresses to include PTSD.

The all-volunteer operations in Iraq and Afghanistan differ from previous conflicts in that the Reserve and National Guard make-up a higher percentage of those deployed; more women are deployed and experiencing combat conditions; and more troops are married. These differences present problems that heretofore were not addressed on the scale they present today. Reserve and National Guard personnel return home and attempt to reintegrate back into their communities without the direct assistance of the military support system that they have relied on for many months. This dynamic presents a considerable challenge to the Department of Veterans Affairs (VA).

National Guard and Reserve members are often lost in the transition from active duty to civilian status. Of the veterans that have come home from OEF/OIF only about 30 percent have sought care at VA. The remaining 70 percent may not realize that they are eligible for VA care and as a result seek care somewhere else. VA must keep track of these veterans and provide effective outreach to these troops upon their transition from the active duty ranks.

Providing Care

VA health care is highly regarded in the medical community and is considered the leader in treatment of PTSD. Through myriad programs, both inpatient and outpatient, veterans receive high quality mental health services.

VA's outpatient services include mental health clinics' day hospitals and day treatment centers. These settings often times negate the need for extended inpatient care or intensive case management. VA's specialized PTSD programs exist in all 21 Veterans Integrated Services Networks (VISNs) as well as PTSD Coordinators who not only facilitate PTSD services across their respective VISN but also act as a liaison with the Mental Health Strategic Health Care Group located in VA Central Office.

In December 2005, VA designated three new centers of excellence in Waco, San Diego, and Canandaigua that are devoted to advancing the understanding and care of mental health illness. Additionally, the VA's budget request for Fiscal Year (FY) 2007 included nearly \$3.2 billion for mental health services. Part of these funds will be used to help VA continue their ongoing efforts to implement the Mental Health Strategic Plan. The American Legion would like to

emphasize the importance VA must place on the tracking of the mental health dollars. VA must conduct vigilant oversight to ensure that these dollars reach the intended programs.

While there has been much attention on the treatment of PTSD, other mental health conditions such as depressive disorder, acute reaction to stress and abuse of drugs or alcohol can be just as devastating.

The American Legion has heard from some veterans on the difficulty of accessing VA mental health services. While the Community Based Outpatient Clinics (CBOCs) are supposed to be providing mental health services, many of these CBOCs are full and can no longer take new patients. The American Legion is concerned that VA does not possess the capacity to handle the new generation of veterans and the older veterans who still choose to receive their care at VA.

Outreach

The importance of a vigorous outreach program cannot be over emphasized. Effective outreach is critical to ensuring needed mental health services are accessed in a timely manner. Outreach conducted by VA and the Department of Defense (DoD) has improved considerably over the last few years and The American Legion supports the continued focus on effective outreach. Current outreach activities include:

- Transition Assistance Programs and Military Briefings (TAP)
- Reserve and Guard Briefings at the unit
- Veterans Assistance at Discharge (VADS)
- Letters to service members by the Secretary of VA
- Letters to Adjutant General by Secretary of VA
- Remote areas services and outreach
- Mental Health Screening at unit

Vet Centers

Vet Centers are an invaluable resource to veterans and VA. Given the protracted nature of current combat operations, the repeated deployments, and the importance of retaining experienced combat service men and women in an all volunteer military, it is essential to promote the readjustment of service men and women and their families. The mission of the Vet Centers is to serve veterans and their families including professional readjustment counseling, community education, outreach to special populations, work with community organizations, and is a key link between the veteran and other services available within VA. Vet Centers are located in the community and there are 209 throughout the country. 65% of the staff are veterans, and of those, over 40% are combat veterans.

Vet Center staff assists thousands of veterans and family members through demobilization sites and TAP briefings. The American Legion continues to be an unwavering advocate for the Vet Centers and their most important mission. We believe the Vet Centers are central to the mission of VA. The "veteran helping veteran" theme is a uniqueness of the Vet Center that has proven to

be a very effective and successful model for returning combat veterans in need of mental health services.

Early intervention such as that with the outreach efforts of the Vet Centers may help to mitigate the more debilitating onset of chronic PTSD and will help in the transition process from active duty to veteran status and ultimately reintegration into the community.

Traumatic Brain Injury

Traumatic brain injury (TBI) is generally defined by the medical community as a blow or jolt to the head or a penetrating head injury that disrupts the normal function of the brain. Not all blows or jolts to the head result in a TBI. The severity of a TBI may range from "mild," i.e., a brief change in mental status or consciousness to "severe," i.e., an extended period of unconsciousness or amnesia after the injury.

TBI is considered to be a "signature wound" of the current war. TBI veterans face many problems, similar to that of PTSD veterans. TBI is not easily diagnosed or identified in many and can be missed because there are often no physical signs like those suffering from gunshot wounds, amputations, etc. The American Legion has heard many stories of these veterans "falling through the cracks" as a result of their "hidden wounds".

TBI patients need special attention and may first present to psychiatry or a primary care clinic. Proper screening of all veterans concerning their veteran status and exposure to blasts will possibly help to identify a TBI patient earlier and get them the proper treatment. VA providers must be sensitive to the military history of all the patients they see. It is what makes VA and its health care so unique.

To address the growing needs of service members suffering from TBI and other blast trauma injuries, VA has established various mechanisms designed to provide seamless transition from the military's system of care to the VA's system of care for the service member and to provide relief for family members who must assist the injured service member through rehabilitation.

VHA established four Polytrauma Centers in June 2005 to treat those with multiple severe injuries. Each center has a social worker case manager and admission and follow-up Clinical Case Managers. Each OEF/OIF combat veteran seeking care at a VA medical facility is assigned a facility OEF/OIF case manager responsible for coordination of Veterans Health Administration (VHA) services, Veterans Benefits Administration (VBA) services and education for the service members and their families. A recent VA directive mandates that each facility select a point of contact to receive and expedite referrals and transfers of care for active duty personnel who were injured in a combat theater, as well as ensuring receipt of copies of military medical records from the referring military treatment facility.

To enhance knowledge of those who treat patients with TBI, VHA created educational tools to include a web-based module, regional training conferences facilitated by the War-Related Illness and Injury Study Centers, informational letters, and the web-based Veterans Health Initiative independent study course on TBI.

Other initiatives planned to promote seamless transition include: designating all VA medical facilities TRICARE network providers; making additional funds available for Polytrauma VISN sites to expand existing or establish new rehabilitation programs; establishment of a Quality Enhancement Research Initiative for implementing best practices in polytrauma and blast injuries; activation of a polytrauma call center (February 2006) to answer questions about rehabilitation, follow-up care and benefits. The VHA also plans to develop a polytrauma patient and family tool kit, and initiate a comprehensive polytrauma network to connect the four Lead Centers with each other and their respective VISN sites to improve access to care closer to home for the combat wounded veteran.

Since 2003, VA has gone through some growing pains with the transition process, the polytrauma centers and coordination of information with DoD. They have also made great strides in those areas over the last three years.

TBI Patients and Their Families

Families impacted by traumatic brain injury of a service member encounter overwhelming obstacles. The TBI patient needs constant care physically and providing this care can cause financial strain on the family. Because the patient may exhibit altered behavior as a result of the injury, family members may have difficulty relating to the change in personality that may result. Some TBI patients have no family to assist them through rehabilitation or recovery.

Even more tragic, while having to deal with all of the internal ramifications of the situation, some families still struggle with obtaining proper coordination of services for the patient. As highlighted in the July 12, 2006 report entitled *Health Status of Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation* prepared by the VA Office of Inspector General, some problems experienced by patients and families include inadequate or no communication with the case manager, lack of follow-up care, and being forced to pay out of pocket for necessary treatment and medication.

Family Involvement Through Outreach and Education

The American Legion believes VA must try to incorporate the family into the patients care more aggressively. VA listed family involvement as one of its top challenges in the transition process.

We also believe that intense outreach to both the servicemember and the family can be a very effective tool in helping to mitigate long-term mental health consequences for veterans. The less stressful the transition process is, the easier the adjustment period will be for both the family and the veteran.

In July 2006, The American Legion, along with DoD, launched the "Heroes to Hometown" program. At the national level, The American Legion signed a Memorandum of Understanding (MOU) with DoD and established a presence at the Military Severely Injured Center at the Pentagon. This office acts as a liaison to help those who are transitioning from the service to link up with their local Legion post that will then assist them in their process. We believe that

The American Legion post should be looked upon as a safe haven for the servicemember and their family – a place of comrades who care.

Through this program many resources are brought together with the help of the post Hero Transition Team (HTT). The HTT will facilitate the transition of the family and veteran back into the community. Examples of resources available are the Family Readiness Groups (FRG) contact list, VA claims and appointments, veterans' benefits, home loans and more. Assistance will be given in shopping, babysitting, transportation and other identified needs.

Additionally, the Washington State Department of Veterans Affairs, in conjunction with The American Legion Department of Washington and the Auxiliary, is kicking off a training conference called: **Building the Veterans Community from the Inside Out: A Pathway toward Developing Community Resources for Veterans and Their Families**. This training is designed especially for Veteran Service Organization (VSO) Auxiliary members. During the conference training will be conducted on a variety of topics that include veterans' benefits, homeless services, new programs available for recently separated veterans, PTSD and Operation Military Kids. This is an intense training and outreach event to try and educate the community about veterans' issues.

The American Legion would suggest that this type of training be expanded to include community leaders such as mayors, Chamber of Commerce, the civilian medical community, law enforcement and civilian mental health providers. Communities should be made aware of the issues facing the veteran and his or her family and the impact of the returning veteran on a community.

The care of these servicemembers does not stop once they return home. The American Legion is taking an active role in helping to ease the burden for these servicemembers struggling to adjust back into the community.

Again, thank you for this opportunity and we look forward to working with the Subcommittee on these very important issues.

THE BLINDED VETERANS ASSOCIATION
TESTIMONY

PRESENTED BY

THOMAS ZAMPERI Ph. D.
DIRECTOR GOVERNMENT RELATIONS

THE
HOUSE VETERANS AFFAIRS SUBCOMMITTEE
HEALTH



September 28, 2006

INTRODUCTION

Mr. Chairman and members of the House Veterans Affairs Sub-Committee on Health, on behalf of the Blinded Veterans Association (BVA), thank you for this opportunity to present BVA's legislative concerns on this topic of Force and Veterans Health Emerging Trends. BVA is the only congressionally chartered Veterans Service Organization exclusively dedicated to serving the needs of our Nation's blinded veterans and their families. This past year BVA has developed increasing concern over improving VHA's ability to provide the full continuum of blind outpatient rehabilitative programs, but also increasing resources on the major crisis facing the Department of Defense and the VA health care system, the issue of Traumatic Brain Injury (TBI). BVA appreciated this hearing as an initial first step in working on improving the system.

As of January 14, 2006, the Department of Defense reported more than 11,852 returning wounded had exposure to blast injuries, the most common IED's, which is astounding number when one considers the total of 19,989 traumatic injuries. TBI has become the "signature injury" of Operation Iraq Freedom OIF and Operation Enduring Freedom OEF operations. Blast-related injury is now the most common cause of trauma in Iraq, a recent study found that 88% of military troops treated at an echelon II medical unit in Iraq were from IED's, and 47% of those suffered TBI injuries. Data from screening of 7,909 Marines with the 1st Marine Division that 10% suffered from TBI related injuries ten months after returning from Iraq. At Fort Irwin, 1,490 soldiers were screened last May, and almost 12% of them had suffered concussions resulting in mild to moderate TBI injuries.

More than 1,750 of the total TBI injured have sustained moderate enough TBI to result in neurosensory complications, with epidemiological TBI studies finding that about 24 % have associated visual disorders of diplopia, convergence disorder, photophobia, ocular-motor dysfunction, inability to interpret print, with some TBI's resulting in legal blindness, and other manifestations known as **Post-Trauma Vision Syndrome (PTVS)**. BVA fully endorsed the recent defense senate amendment with funding \$ 19 million to continue this effort through the Defense and Veterans Brain Injury Center (DVBIC) for FY 2007. According to a recent study by researchers at Harvard and Columbia, it is estimated that the cost of medical treatment for those service members with TBI will be at least \$14 billion over the next twenty years.

BVA would like to stress to this Committee that in addition to the above, data compiled between March 2003 and April 2005 found that **16% of all causalities evacuated** from Iraq were due to direct eye injuries, and Walter Reed Army Medical Center has treated surgically treated approximately 670 soldiers with either blindness or moderate to severe significant visual injuries, and the National Naval Medical Center has lists of over 350 eye injuries requiring surgery. Several of these service members have attended the ten VA Blind Rehabilitative Centers, and others are in the process of being referred for admission but we fear many are mild to moderate injuries are unaccounted for and lost in the DOD system. The Severely Injured Service Center in July admitted to VHA representatives they have no central tracking system for eye injuries or TBI. We had requested that GAO investigate and report to this Committee what is being done about visual injuries and Seamless Transition back in February. It should be very obvious to members of this committee that a new generation of visually impaired, low vision, or blinded veterans are returning home from OIF and OEF both with unique TBI related visual PTVS neurological injuries and direct eye trauma from IED's and other blast related trauma.

The lack of proper diagnosis and treatment of these TBI and associated visual conditions may impair these veterans ability to perform basic activities of daily living, result in increased unemployment, failure in future educational programs, adding more dependence on government assistance programs, and resulting in depression and other psycho-social complications if early detection and treatment are not initiated.

Perception plays a significant role in our ability to live life. It aids in providing information about the properties in our environment, along with letting us act in relation to those properties. In other words, our perceptions let us experience our environment and live within it. We perceive what is in our environment by a filtered process that occurs through our complex neurological visual system. Although all senses play a significant role, the visual system is one of the most important. With various degrees of visual loss we are no longer able to clearly adjust and see our environment, resulting in increased risk of injuries, loss of functional ability and unemployment. Impairments range from loss in the visual field, visual acuity, to even a loss in the ability to recognize faces. There are numerous ways one can acquire visual deficits, but one leading cause is injury to the brain. Damaging various parts of the brain can lead to specific visual deficits. Numerous cases have reported spontaneous recovery, however complete recovery is unlikely and early intervention is critical. Current complex neuro-visual research is being examined in an attempt to improve the likelihood of recovery. The training of certain areas has been found to improve vision deficits in some disorders, but again, the extent of recovery is limited and may require long term follow-up with specialized adaptive devices and prescriptive equipment.

The brain is the most intricate organ in the human body, and the visual pathways within the brain are also very complex. Due to the interconnections between the brain and visual system, damage to the brain can bring about various cerebral visual disorders. The visual cortex has its own specialized organization, causing the likelihood of specific visual disorders if damaged. The occipitotemporal area is connected with the "what" pathway. Thus, injury to this ventral pathway leading to the temporal area of the brain is expected to affect the processing of shape and color. This can make perceiving and identifying objects difficult. The occipitoparietal area (posterior portion of head), is relative to the "where" or "action" pathway. Injury to this dorsal pathway leading to the parietal lobe will increase the likelihood of difficulties in position (depth perception) and/or spatial relationships. In cases of injury, one will find it hard to determine an object's location and may also discover impaired visual navigation. The most frequent causes for brain injury have been found to be strokes, trauma, and tumors. Also, it is highly unlikely that a person with TBI injury will only have one visual deficit, but usually a combination of them due to the complexity of the organization between the visual pathway and the brain. The most common cerebral visual disorder after brain injury involves the visual field loss. The loss of peripheral vision can be mild to severe enough to result in legal blindness.

BVA recommends that by encompassing the full spectrum of visual impairment services; Blind Rehabilitative Outpatient Specialists (BROS), Visual Impairment Center To Optimize Remaining Sight (VICTORS) a specialized Low Vision Optometry program, and the Visual Impairment Services Outpatient Rehabilitation Program (VISOR) all these various outpatient programs could screen those service members with high risk or history of TBI for neurological visual complications that might otherwise be undiagnosed. The need for timely implementation of the full continuum of outpatient services for all visually impaired veterans is now.

Blind Rehabilitative Centers

Blind Residential Centers (BRC) provide the most ideal environment to maximize a blinded veteran's to acquire the essential adaptive skills to overcome the many social and physical challenges of blindness, especially with the OIF and OEF service members, but the full continuum of outpatient services are required for the optimization of treatment. The BRC becomes even more important for many of these blinded service members because they suffer from multiple trauma's including Traumatic Brain Injury, Amputations, and other sensory loss. The BRC can bring the entire array of specialty care to bear on these severely wounded service members optimizing their rehabilitation outcomes and allowing for successful reintegration with their families and communities. Mr. Chairman, there is no better environment to facilitate the emotional adjustment to the severe trauma associated with the traumatic loss of vision and to provide comprehensive initial blind rehabilitation but follow-up in outpatient settings must exist and these centers need additional directed funding to bring staffing levels up to required levels.

Visual Impairment Services Outpatient Rehabilitation (VISOR)

This highly successful outpatient nine-day rehabilitation program called Visual Impairment Services Outpatient Rehabilitation Program (VISOR) offers screening, plus skills training, orientation and mobility, and low vision therapy. This new approach combines the features of a residential program with those of outpatient service delivery. A VIST Coordinator, with low vision credentials, manages the program. Staff consists of certified BROS Orientation and Mobility Specialists, Rehabilitation Teachers and Low Vision Therapists. The costs associated with expanding these new cost effective outpatient rehabilitation 12 VISOR programs would be \$5,474,733 for the initial year, but annual recurring costs to maintain these 12 VISOR programs would be \$4,700,883. This recurring cost works out to \$427,353 per VISOR facility for all staffing, equipment office supplies, and training.

Visual Impairment Center To Optimize Remaining Sight (VICTORS)

Another important model of service delivery that does not fall under VA Blind Rehabilitation Service is the VICTORS program. The Visual Impairment Center To Optimize Remaining Sight (VICTORS) is an innovative program operated by VA Optometry Service and also has been successful for over 15 years. This is a special low vision program designed to provide low vision services to veterans, who, though not legally blind, suffer from any visual impairments. Generally, veterans must have a visual acuity of 20 over 70 or less to be considered for this service. This typically is a very short (five-day) inpatient program wherein the veteran undergoes a comprehensive low vision evaluation. Appropriate low vision devices are then prescribed, accompanied by necessary training with the devices. VICTORS programs can be established in any VAMC outpatient eye clinic area. The Low Vision Optometrists found in these VICTORS programs are ideal for the specialized skills necessary for assessment, diagnosis, treatment, and management of those service members with TBI or other Low Vision injuries as discussed before. The Palo Alto VA Poly Trauma Center and Eye Clinic already initiated screening of TBI veterans. BVA recommends eight new VICTORS programs in FY 2007 are urgently needed and should be implemented to meet the growing demands from this war.

Programs such as VICTORS and VISOR are cost effective programs for screening, diagnosis, treatment, and follow-up of high need much-focused TBI population. BVA recommends these services should be fully funded by VHA initially. Our concerns are especially relevant now that younger OIF and OEF veterans are going to be needing referral for low vision services and these individuals will clearly need initially these additional outpatient diagnostic and treatment programs.

OVERSIGHT

The priority should be to ensure that VHA has the ability to provide the full scope of preventative and acute care services. The expansion of the blind and low vision specialized services provided by VHA are critical now to meet the demands from the OIF and OEF injuries, with TBI to maximize independence and prevent costly misdiagnosis. These critical new Low Vision and Blind outpatient programs must be funded. Mr. Chairman the TBI injury situation and the associated impact in terms of visual complications and blinded veterans being lost in the Seamless Transition process are already occurring. Again, the BRC's, BROS, VISOR, and VICTORS programs are now even more essential in screening, diagnosis, treatment, and follow-up for the OIF and OEF service members returning with a wide variety of visual injuries and neurological complications associated from TBI .

CONCLUSIONS:

Mr. Chairman, thank you for this opportunity to present our testimony for the record, BVA is extremely concerned that blinded veterans and service members from OIF and OEF are not able to have the full continuum of services discussed here today. The future strength of our Nation depends on the willingness of young men and women to serve in our military, and that depends in part on the willingness of our government to meet its obligation to them as veterans. Waiting will only increase the problems and expenses associated with this crisis. There are many things in life we take for granted, however, vision, along with its complexity, are probably the least recognized and understood. Without vision and visual perception, the environment would be nothing but sensation, sounds, and smells, and with TBI often these other senses are damaged along with associated mental health complications of depression. Despite the fact that studies have shown that some spontaneous recovery of cerebral visual impairments does occur, it is not likely to be complete. Specific training and rehabilitation have been focused on individual functions, allowing for more recovery, but much more research and help is needed. Other goals include the expansion of rehabilitative research services and public awareness. Vision loss is an extremely important issue, and hopefully with our advanced technology and research, we will one day be able to provide effective, long-lasting rehabilitative services to those who are visually impaired as a consequence of TBI.

Recommendations:

1. Authorize the \$ 9.4 million in additional funding for the expansion of the VISOR and VICTORS programs as outlined in this testimony and based on VHA documents, support the MILCOM/ VA Senate appropriations amendment with appropriations for FY 2007.

2. Support the \$ 19 million for the Defense and Veterans Brain Injury Center (DVBIC) for FY 2007 as adopted in the Senate Defense authorization amendment. BVA believes that Congress should ensure high quality ongoing screening of those at risk of TBI by their previous exposure history. Education of DOD and VA primary clinical medical staff on the identification, history, diagnosis, and appropriate consultation management of the TBI service member, and increased support for vital research, and enforce mandatory tracking for service members who have sustained a TBI diagnosis.
3. Direct VHA to identify strategies to develop research of TBI service members and veterans from OIF and OEF and authorize \$4 million for **Post-Trauma Vision Syndrome** (PTVS) proposed research with the VA/ DOD Traumatic Brain Injury Optometric Rehabilitation Program for Walter Reed Army Medical Center and Selected Department of Veterans Affairs Facilities.
4. Passage of H.R. 3579 is essential to provide the health care necessary to our blinded veterans, and the benefits for those with legal blindness.

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

Blinded Veterans Association

The Blinded Veterans Association does not currently receive any money from federal contract or grant. During the past two years BVA has not entered into any federal contracts or grants for any federal services or governmental programs.

The Blinded Veterans Association is a congressionally chartered non-profit membership organization and is an IRS 501-C-3 non-profit organization.

Mr. Thomas Zampieri Ph. D. is a graduate of Hahnemann University Physician Assistant Program in June 1978, obtained his BS degree from State University of NY, and graduated with a Master's in Political Science from University St. Thomas in Houston, May 15, 2003. Completed his Ph. D. dissertation from Lacrosse University in Political Science January 16, 2006, and is employed, as the National Director of Government Relations for the Blinded Veterans Association since April 22, 2005. He worked a clinical physician assistant for over 24 years prior to his blindness.

He served on active duty in the U.S. Army from 1972 to 1975 as an army medic, after PA school was Commissioned August 1978 as Warrant Officer reaching Chief Warrant Office CWO-3, before being Commissioned as Major in July 1998, he served from September, 1978 until August, 2000 as Army National Guard PA, retiring at the rank of Major. During this time, he was involved in several military medical training programs and schools, and was a graduate of the Army Flight Surgeon Aero-Medical Course at Fort Rucker in 1989, and the AMEDD Advanced Officer Course at Fort Sam Houston Texas in 1992. During this time from 1983 to 2001 he worked as surgical physician assistant in two different VA facilities in Richmond VA, and Houston Texas.

**STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
SEPTEMBER 28, 2006**

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting written testimony by the Disabled American Veterans (DAV), on behalf of our 1.3 million members, concerning active duty service members and veterans who may be suffering from Post Traumatic Stress Disorder (PTSD) or Traumatic Brain Injury (TBI). We are pleased the Subcommittee is examining the current data and treatment trends for PTSD and TBI to ascertain what initiatives are currently underway to mitigate long-term mental health consequences for these veterans. Also, we are mindful of emerging literature strongly suggesting that even "mild" TBI patients may have long-term mental and medical health consequences, a matter that we hope will be of rising interest to the Subcommittee as well.

This testimony will discuss the variety of specialized mental health programs administered by the Department of Veterans Affairs (VA), with a focus on the quality and availability of those programs to support the needs of older veterans as well as younger and newer veterans now returning from military service. The testimony also will review our concerns about the long-term obligations of VA in the care (including mental health care) and rehabilitation needs of our newest veterans who have been severely wounded with TBI.

Many DAV members have experienced catastrophic disabilities as a result of their military service and are war-wounded veterans of major conflicts, including World War II, Korea, Vietnam, the Persian Gulf War and the current wars in Afghanistan and Iraq, among other U.S. military engagements. Therefore, the government's responsibility to provide appropriate health care services, including mental health services, to veterans suffering from PTSD and TBI, is very important to DAV members as well as the American people in general.

Without question, the Veterans Health Administration (VHA) has the most comprehensive mental health programs in the nation to treat veterans with readjustment issues stemming from military combat including combat stress, and acute and chronic PTSD. The VHA is home to a cadre of highly skilled clinicians and researchers who specialize in and are dedicated to helping veterans deal with the unique mental health challenges they face as they return to civilian life from a military combat theater. For these reasons, the Department of Defense (DoD), the VA and Congress must remain vigilant to ensure that federal mental health programs are sufficiently funded and adapted to meet the unique needs of the newest generation of combat service personnel and veterans, as well as continue to address the needs of our older veterans with PTSD and other combat-related mental health issues.

Historically, VA has had a special obligation to veterans with mental health challenges, given both the prevalence of mental health and substance-use problems among veterans and the high

numbers of those whose illnesses were of military service origin. Although mental health services are a major component of VA health care, internal VA funding to underwrite a robust mental health program has been a continuing struggle similar to that which has been well documented and publicized in private sector health care.

Issues Affecting Our Newest Generation of Combat Veterans

The ongoing wars in Iraq and Afghanistan are difficult, dangerous assignments for American troops, whether they are regular active duty members, Reserve or National Guard. Adding to the stress, many service members have served multiple tours of duty in Operations Enduring and Iraqi Freedom (OEF/OIF). These soldiers, sailors, airmen and marines, along with their families, are making extreme sacrifices so that this nation can free the world from terrorism.

The VA and DoD are well aware that combat veterans of OEF/OIF are at high risk for PTSD and other mental health problems. The 2006 study conducted by Colonel Charles Hoge, MD of the Walter Reed Military Research Institute, published in the *Journal of the American Medical Association*, evaluated relationships between combat deployment and mental health care use in the first year following return from the war, lessons learned from the post deployment mental health screening efforts, correlation between screening results and use of mental health services, and attrition from military service.

The study found that 19 percent of soldiers and marines who had returned from Iraq screened positive for a mental health problem, including PTSD, generalized anxiety, and depression. Col. Hoge reported that mental health problems recorded on the post deployment self-assessments by military service members were significantly associated with combat experiences and mental health care referral and utilization. Thirty-five percent of Iraq war veterans had accessed mental health services in the year after returning home, with 12 percent diagnosed with a mental problem. According to study findings, mental health problems remained elevated at 12 months post deployment among soldiers preparing to return to Iraq for a second deployment. Col. Hoge concluded that although OIF veterans are using mental health services at a high rate, many soldiers with mental health concerns do not seek help, due to stigma and other barriers. Hoge reported finding that service members resisted care because of personal concerns over being perceived as weak—or having a negative impact their military careers. Finally, Col. Hoge noted that the high use rate of mental health services among veterans who served in Iraq following deployment illustrates the challenges in ensuring that there are adequate resources to meet the mental health needs of this group, both within the military services themselves and in follow-on VA programs.

We also see increasing trends of health care utilization among OEF/OIF veterans in the VA health care system. As of July 2006, according to VA, within the 588,923 OEF/OIF veterans who have separated from service, 184,524 have sought VA health care. VA reports that veterans of these current wars contact VA with a wide range of possible medical and psychological conditions, including mental health issues such as adjustment disorder, anxiety, depression, PTSD and the effects of substance abuse (to date, nearly 64,000 of these individuals have sought care for one of the above-noted mental health conditions or been provided a provisional mental health diagnosis). The VA has intensified its outreach efforts to OEF/OIF veterans and reports that the relatively high rates of health care utilization among this group reflect the fact that these veterans have ready access to VA health care following separation from service for problems possibly related to their wartime experiences. VA estimates that over 109,191 veterans of Iraq and Afghanistan wars will be seen in VA facilities in 2007 (1,375 fewer than it expects to see in 2006). With increased outreach and internal mental health

screening efforts underway we are concerned that VA's estimates are low and could result in a shortfall in funding necessary to meet probable increasing demand.

We recognize the many challenges that combat veterans face upon returning home to their families and communities. Some have been able to move forward with their lives following a normal and expected readjustment period. Others have experienced persistent and significant mental health and maladjustment issues related to their military experiences, resulting in personal and family crisis, job loss, new claims for VA service-connected disability compensation and other mental health consequences.

Most experts believe the problem of PTSD has been with us throughout the history of warfare. In the nineteenth century, PTSD was termed "war weariness," and in the twentieth century, it was known as "shell shock," and later "battle fatigue." In 1980, the American Psychiatric Association added PTSD to the third edition of its Diagnostic and Statistical Manual of Mental Disorders (DSM-III).

Regrettably Mr. Chairman, even today in the face of an abundant research portfolio of over 25 years, and with the full acceptance of the validity of PTSD by all American mental health authorities, insurance regulators and the federal government, a small minority of health policy analysts and clinicians has questioned PTSD in its chronic manifestation as a valid psychiatric diagnosis. Others argue that by financially compensating veterans for the disabling effects of chronic PTSD, VA is contributing to the problem by paying people to "stay sick" and exacerbating the challenges of clinical care that would improve these veterans' health. We believe that concern erroneously assumes that a veteran who has experienced a personal and traumatic event in a combat deployment later would be willing to embrace a label of chronic mental illness—with the stigma many in society still apply to the mentally ill—for the express purpose of receiving VA disability compensation. This argument also suggests either that these veterans have the internal strength to "will away" their disabilities when needed, or they are committing a fraud against the government. The argument also seems to expose a potential prejudice against health problems that result from psychological trauma as opposed to those that come from physical trauma—possibly suggesting another type of stigma. Leading experts on PTSD have cited objective data from recognized research to refute suggestions that substantial numbers of veterans with chronic PTSD discontinue their VA treatments to keep their distressing symptoms active for the purpose of remaining disabled and receiving disability compensation.

At a memorable hearing before this Subcommittee on March 11, 2004, a vigorous debate occurred among a number of witnesses who are experts in the field of PTSD. We believe Dr. Thomas Horvath, Chief of Staff at the Michael Debakey Veterans Affairs Medical Center in Houston, Texas, encapsulated in his remarks the essence of that discussion, as follows:

"To this day, some people confuse a set of political and cultural attitudes, the post-Vietnam syndrome, with a clinically coherent, statistically valid diagnostic entity, Code 309.81, 308.3 of DSMIV, which is triggered by a range of catastrophic stressors, including combat, ambush, carnage and rape. Yet to this day, many people regard this PTSD as a weakness, a yellow streak, and not the red badge of courage. This despite CT scan findings of the shrinking of a part of the brain involved in emotion and memory, which correlates with combat intensity scores. This despite persistent biochemical changes which eventually lead to higher rates of cardiovascular disease and of mortality in general, shown in World War II veterans, POWs and Holocaust survivors. PTSD is a persistent biological condition that maims the body as well as the mind. It correlates with combat intensity. But unit cohesion and warm homecoming support partly protects

from it. Regrettably, the VA 30 years ago did not provide these. However, we've come a long way. Twenty-five years ago we had no PTSD services, no [V]et [C]enters, no homeless programs. We did, however, have a set of substance abuse services that we no longer have. Still, the growth of PTSD programs has been gratifying, but not quite enough for the demand. These demands will now increase, especially by the many reservists who on their return from overseas are judged [RPGs] (unintelligible) while nation building, will be eligible for the VA. But PTSD is only one of the consequences of stress: Suicide, unexplained physical illness, depression, even the precipitation of psychoses and addictive disorders or others.

Overall, we are pleased with the direction VA has taken and the progress it has made with respect to its mental health programs. We are also pleased that DoD acknowledged it needs to conduct more rigorous pre-and post-deployment health assessments with military service personnel who are serving in combat theaters, and is working to improve collaboration with VA to ensure this information is accessible to VA clinicians in real time through electronic medical records transfer. Likewise, VA and DoD are to be commended for attempting to deal with the issue of stigma and the barriers that prevent service members and veterans from seeking mental health services when needed. Although we recognize and acknowledge DoD and VA's efforts—we are far from the universal goal of "seamless transition." Several months ago, the federal Health and Human Services Substance Abuse and Mental Health Services Administration sponsored a teleconference, "Stigma in the Military: Strategies to Reduce Mental Health Stigma among Veterans and Active Duty Personnel." The following statement associated with that event, sums up clearly our concern about the ongoing challenges we face in addressing the needs of our newest generation of combat veterans:

The impact of military reality on individual mental health is complicated further by the pronounced stigma associated with mental illness within military communities. Service members frequently cite fear of personal embarrassment, fear of disappointing comrades, fear of losing the opportunity for career advancement, and fear of dishonorable discharge as motivations to hide the symptoms of mental illness from colleagues, friends and family. This silence and the attitudes and perceptions perpetuating it pose a significant challenge to those charged with making sure that the United States' fighting force is improving itself and taking care of its own members.

All of the challenges mentioned here will require an unprecedented level of interagency cooperation. We recommend VA work more effectively with DoD to ensure it establishes a seamless transition of early intervention services to help returning service members from Iraq and Afghanistan combat to obtain effective treatment and follow up services for war-related mental health problems. Currently, once a service member departs from military service, he or she is eligible to receive cost-free health care and readjustment services through VA for any conditions related to their combat service for two years following active duty. Given the sometimes delayed onset or recognition of mental health symptoms related to TBI and PTSD, we believe this period should be extended to five years. Nevertheless, we believe with proper resources, clearly defined goals and determination to overcome institutional and social barriers our government can fulfill its commitment to providing the best care available to service members and veterans with mental health problems.

VA's Specialized Mental Health Programs for PTSD

VA provides readjustment counseling in 207 community-based "Vet Centers" located in all 50 states. Vet Centers provide a consumer-friendly, non-threatening environment for veterans in their communities, and offer a variety of services including counseling for veterans exposed to war trauma; those who were sexually assaulted during military service; and, those who need family counseling, community outreach, education, and social services. According to VA, in 2006, Vet

Center programs have experienced rapidly increasing enrollment in their programs. VA also operates a network of more than 190 specialized PTSD outpatient treatment programs in all 50 states, including 162 specialized PTSD Clinical Teams. In addition, VA has 33 specialized inpatient units for brief stays and long-term treatment and five outpatient Women's Stress Disorder and Treatment Teams.

In 1989, VA established the National Center for Post-Traumatic Stress Disorder, as a focal point to promote research into the causes and diagnosis of this disorder, to train health care and related personnel in diagnosis and treatment, and to serve as an information clearinghouse for professionals. The Center offers a monthly 5-day clinical training program to VA clinical staff, and maintains a web site (www.ncptsd.va.gov) with information about trauma and PTSD. The web site includes documents such as the Iraq War Clinician Guide to help clinicians diagnose and treat veterans returning from Operation Iraqi Freedom. Last year, the Center provided a guide for military personnel titled: *Returning from the War Zone*. This guide discusses common experiences in combat, post-deployment readjustment issues including the primary symptoms of PTSD, as well as other common stress reactions such as depression, anger, aggressive behavior, alcohol and drug abuse, shame, guilt, and suicidal ideation. The Center also offers guidance on effects of PTSD on family and work, and notes treatment modalities and common therapies used to treat PTSD. Included in the guide is a checklist of trauma symptoms for self-assessment, eligibility requirements for VA services and guidance for seeking further help.

Although VA has made a concerted effort to improve and expand access to mental health services at its community-based outpatient clinics (CBOCs), such services are still not readily available at all community sites. Likewise, we have been concerned about the decline in availability of VA substance-use disorder programs of all kinds, over time, including virtual elimination of detoxification treatment beds. Although additional funding has been dedicated to improving capacity in some programs, VA mental health providers continue to express concerns about inadequate resources to support, and veterans' rationed access to, these specialized programs. Based on current mental health utilization rates of OEF/OIF veterans, we agree with Dr. Frances M. Murphy, M.D., M.P.H., Deputy Under Secretary for Health Policy Coordination, in her statement on March 29, 2006, before the former members of the President's New Freedom Commission on Mental Health, that, "taken in combination, the findings of Hoge et al and the latest VA data suggest that substance abuse and the associated resources demands may be significantly higher than originally estimated."

President's New Freedom Commission on Mental Health

We are pleased that following the release of the report of the President's New Freedom Commission on Mental Health in July 2003, VA undertook an unprecedented, critical examination of its mental health programs. Like other institutions providing mental health care, VA found that it tended to focus on managing symptoms, rather than aiding patients' recovery and restoration. The New Freedom Commission found that many people with mental illness can regain productive lives, and the effort provided the President and the government a bold new blueprint for system change based on the goal of recovery. VA leaders learned the importance of achieving the mental health system change the Commission envisioned and developed an agenda for realizing that goal. The VA established a National Mental Health Strategic Plan as an outgrowth of the President's New Freedom Commission report, and has committed \$100 million annually to its implementation. Unfortunately, we understand that VA's internal policy on funding certain new initiatives to address gaps in services related to psychosocial rehabilitation and recovery oriented services included in the National Mental Health Strategic Plan will be limited to only two years. The expectation is that this "seed money"

provided to specific initiatives will generate sufficient creditable patient care workloads through VA's internal resource allocation system so that further centrally funded earmarks will not be necessary after the first two years. This is an untested concept that may dampen local interest in proposing or embracing these new initiatives. If a VA medical center director believes that a centrally controlled earmark is temporary, there may be temptation to limit activity in that program once the earmarked funding is no longer available. This two-year funding policy bears close scrutiny from mental health advocates and your Subcommittee, Mr. Chairman.

Under former VA Secretary Anthony J. Principi's leadership, the transformation that is now underway in VA mental health service delivery—built on an understanding that veterans with mental disorders can recover and lead productive lives—is vitally important to keeping faith with VA's obligations to America's veterans. We have urged current VA Secretary James Nicholson to follow Secretary Principi's example and maintain mental health reform as a major priority in his term of office. We are also encouraged that Dr. Ira Katz, a noted clinician-scholar in gero-psychiatry with a significant professional history in VA's Mental Illness Research, Education and Clinical Center in Philadelphia, has assumed the key position of VA's Chief Consultant in Mental Health. Dr. Katz fully embraces the New Freedom Commission concepts and is beginning a number of new initiatives that we believe will improve the lives of disabled veterans.

While VA and Congressional leaders have taken important initial steps to move VA toward better care for veterans with mental health problems, many serious challenges still face the VA system. Clearly, any transformation or major change—from eliminating the longstanding variability in VA mental health care to changing its mission from symptom-management to recovery—will take sustained leadership and support on the part of VA and Congress. Mr. Chairman, we urge your Subcommittee to play a strong oversight role in monitoring VA's work in mental health reform, and to help give VA the tools and resources it needs to achieve these worthy goals.

Mr. Chairman, in what should be a shared journey, VA must do its part to sustain VA mental health care as a high priority. The system must continue to improve access to specialized services for veterans with mental illness, PTSD, and substance-use disorders commensurate with their prevalence and must ensure that recovery from mental illness, with all the positive benefits this brings to veterans, their families and to our society, becomes the guiding beacon for VA mental health planning, programming, budgeting and clinical care. The DAV is committed to ensuring that the military and VA health care systems remain capable of receiving wounded veterans, whether they are active duty, Guard or Reserve, and can provide the highest quality and level of services to restore them, irrespective of the nature of their injuries.

Traumatic Brain Injury in Southwest Asia

With all the challenges we face in addressing the unique mental health concerns of our nation's veterans, it is clear that there are many professionals, certainly including Dr. Horvath quoted above, who are dedicated to improving the lives of this newest generation of war-disabled veterans. We were pleased that the Committee on Care of Veterans with Serious Mental Illness, in its Ninth Annual Report to VA's Under Secretary for Health, included a new recommendation concerning OEF/OIF veterans suffering from TBI, a serious condition resulting from physical trauma to the skull that damages the brain's structure and function. The Committee supported additional research in this critical area and noted that brain injuries may cause symptoms that mirror those of mental illnesses, and that it is important to recognize that the effects of this type of trauma may have a delayed onset

and be difficult to recognize. We fully support the Committee's recommendation for the VA Mental Health Strategic Health Care Group in VA Central Office to lead the development of an initiative to address the mental health needs of veterans with TBI.

Mr. Chairman, it has been said that TBI—caused by improvised explosive devices (IED), exploding mortars or artillery, military vehicle accidents, suicide bombers, gunshot or shell fragment wounds, falls, “friendly fire,” and other traumatic injuries to the brain and upper spinal cord—may be the signature injury of this, our latest war. Many of the current war’s TBI wounded result from blast injuries or powerful bomb detonations that severely shake or compress the brain inside the skull, often causing devastating and permanent damage to those brain tissues. Many service members who suffer skull, neck and facial injuries also experience moderate or severe brain injury, but other milder forms of TBI are sometimes not immediately detectable. It is very possible that many mild brain injuries and concussions have gone undiagnosed or that symptoms for others will surface later, as these veterans return to civilian life. The influx of OEF/OIF service members returning with brain trauma has increased opportunity for research into the evaluation and treatment of these injuries; however, this raises the question of the number of older veterans of past conflicts who may have also suffered similar injuries that went undetected, undiagnosed and untreated.

We believe more research into the long-term consequences of brain injury and best practices in its treatment are needed and are warranted by VA. Individuals suffering brain injury often present with complex, difficult and unique psychological and physiological pictures requiring a cadre of specialists to manage their medical and psychological care and rehabilitation. Most severely injured service members will require extensive rehabilitation and life-long personal and clinical support, including neurological and psychiatric services, physical, psychosocial, occupational and vocational therapies. Currently VA has designated facilities in Minneapolis, Palo Alto, Richmond, and Tampa as TBI “Lead Centers” to provide the full spectrum of TBI care for patients suffering moderate to severe brain injuries. Additionally, VA is expanding similar activity to other facilities in each of its Veterans Integrated Service Networks (VISNs) for follow-up care of TBI patients referred from the four lead centers.

Although VA has initiated new programs and services to address the needs of TBI patients—there are still gaps in services. The VA’s Office of the Inspector General (OIG) issued a report July 12, 2006, titled *Health Status of and Services for Operation Enduring Freedom/Operation Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation*. The report assesses health care and other services provided for VA patients with traumatic brain injury, and then examines their status approximately one year following inpatient rehabilitation.

The report found that there was room for improvement and that better coordination of care was needed to enable veterans to make a smoother transition between DoD and VA health care services. The report called for additional assistance to immediate family members of brain-injured veterans, including additional caregivers and improved case management. According to the report, the goal of achieving optimal function of each individual requires further inter-agency agreements and coordination between DoD and VA. We agree that the true measure of success is the extent to which those severely injured veterans are able to re-enter society or, at minimum, achieve stability of function at long-term care facilities or in their homes.

We are pleased that the VA has designated TBI as one of its special emphasis programs and is committed to working with DoD to provide comprehensive acute and rehabilitative care for veterans with brain injuries. We are also encouraged that VA has responded to the growing demand for

specialized TBI care and, fulfilling the requirements of Public Law 108-422, and established four Polytrauma Rehabilitation Centers (PRCs) that are now co-located with the existing TBI Lead Centers. However, we are especially concerned about whether VA has addressed the long-term emotional and behavioral problems that are often associated with TBI, and the devastating impact it has on veterans and their families. As noted in the July report, “these problems exact a huge toll on patients, family members, and health care providers.” The following excerpt from the OIG report is especially telling of the challenges we face in ensuring these veterans and their families get the care and support services they need:

In the case of mild TBI, the [veteran's] denial of problems which can accompany damage to certain areas of the brain often leads to difficulties receiving services. With more severe injuries, the extreme family burden can lead to family disintegration and loss of this major resource for patients.

The OIG conducted interviews with 52 patients to assess four areas: general well-being, functional status, social adjustment and behavior, and access to health care services. There were several key issues identified by patients and families we believe warrant action by VA and further oversight by this Subcommittee:

- Patients and families highlighted the importance of case managers in facilitating care but reported significant variances in the effectiveness of case managers, rating them from “outstanding” to “poor.” One family member interviewed indicated she did not have the help she needed to navigate the VA health care system and had to purchase items out-of-pocket for necessary equipment and services for her son.
- Access to care due to distance from a VA facility was perceived as a barrier for one family and patients living in remote areas found it more difficult to access the specialty care they needed
- One veteran interviewed reported significant problems with discharge planning when she left VA’s TBI center. One caregiver reported running out of medications and that they had not received needed therapy or an appointment for follow-up care.
- Some spouses who worked feared they would lose their jobs due to the demands of caring for their loved ones. Some families received the psychological support they believed they needed while others reported they did not.
- Spouses and parents reported feeling isolated and suggested the need for a support network for affected families.
- Many patients interviewed reported difficulty with behavioral problems including memory loss, disruptive acts, depression and substance abuse—common problems associated with TBI. Issues with anger, community reintegration and socialization were also reported.

To address some of these issues, we are pleased that VA requires a case manager be assigned to each OEF/OIF veteran seeking treatment at a VA medical facility. The case manager facilitates communication and coordination of VHA services, including benefits, education and health care services. Additionally, VA has created liaison and social work positions at DoD facilities to assist injured service members with transition to veteran status and help in accessing VA health care services and benefits. We commend VA for its outreach to these new veterans and for trying to improve the knowledge and skills of VA clinicians through educational initiatives defining the unique experience of this newest generation of combat veterans. We acknowledge VA’s dedication and commitment to meeting the needs of veterans with TBI through high quality services at its polytrauma and TBI Lead Centers, for ongoing research into this debilitating injury and establishing

effective services with academic and military affiliates to fill gaps in services where they are observed.

Unfortunately, in interviewing case managers, the OIG found continued problems related to: transfer of medical records from referring military facilities, difficulty in securing long-term placements of TBI patients with extreme behavioral problems, limited ability to follow patients after discharge to remote areas, poor access to transportation and other resources, and inconsistency in long-term case management for some TBI patients. The report found that while many of the patients they assessed had achieved a substantial degree of recovery, "...approximately half remained considerably impaired." Also noted was the difficulty of obtaining appropriate specialized services even on a fee basis for veterans living in geographically remote areas. It is also notable that VA TBI patients, when compared to a matched group of non-VA patients, had longer times from date of injury to entry into rehabilitation. The report concluded that improved coordination of care is necessary between agencies, including transfer of medical records, and that families need additional support in the care of TBI patients.

OIG recommendations included: improving case management for TBI patients to ensure lifelong coordination of care; improving collaborative policies between DoD and VA; starting new initiatives to support families caring for TBI patients; and ensuring that rehabilitation for TBI patients is initiated by DoD when clinically indicated. It is encouraging that VA concurred with the above-noted recommendations and reported it is revising its policies in response to the report.

Finally, we agree with the OIG that specific management approaches for TBI may be necessary but that supporting these patients for a lifetime of care will be the real challenge for VA.

Closing

Without question Americans are united in agreeing to care for those who have been severely wounded as a result of military service. This is a sad but continuing cost of national defense. Service members who have suffered catastrophic wounds with multiple amputations or severe burns draw great public sympathy and admiration for their sacrifices. But those that suffer the devastating effects of PTSD, TBI and other injuries with mental health consequences that are not so easily recognizable can also lead to serious health catastrophes, including suicide, if they are not treated. There must be early recognition and intervention of war-related mental health challenges to prevent, when possible, later onset of devastating chronic health problems. We can meet that challenge by ensuring a stable, robust VA health care system that is dedicated to the unique needs of our nation's veterans—one that will be there now for our aging veterans of World War II, Korea and Vietnam, and still be there for the newest generation of war fighters who will need specialized services for decades to come. Veterans should be guaranteed a system that *itself* is guaranteed sufficient funding to meet its mandated missions. VA must be sufficiently funded to treat newly returning veterans with acute and emerging mental health issues without displacing older veterans with chronic mental illnesses. Finally, we must also ensure that family members of veterans devastated by the consequences of TBI, PTSD and other injuries have access to appropriate services.

Our testimony calls for strong and continuing oversight on the part of your Subcommittee in a number of critical arenas of VA and DoD responsibility. Mr. Chairman, DAV stands ready to work with this Subcommittee and VA in addressing these issues as we move forward and we appreciate the opportunity to provide this statement.



IRAQ AND AFGHANISTAN VETERANS OF AMERICA

U.S. House of Representatives Subcommittee on Health Oversight Hearing PTSD and TBI: Emerging Trends in Force and Veteran Health

IAVA Testimony

Mr. Chairman and members of the House Subcommittee on Health, on behalf of the Iraq and Afghanistan Veterans of America (IAVA), thank you for this opportunity to address the needs of new veterans suffering with Traumatic Brain Injury.

IAVA is the nation's first and largest organization for Veterans of the wars in Iraq and Afghanistan. IAVA believes that the troops and veterans who were on the front lines are uniquely qualified to speak about and educate the public about the realities of war, its implications on the health of our military, and its impact on the strength of our country.

Traumatic Brain Injury has been called the hallmark injury of the Iraq war. Unfortunately, the military's red tape and the under-funding of the VA have left hospitals under-equipped to cope with patients with TBI. The story of the Behee family illustrates the compounded burdens faced by a military family as they struggle to overcome both the physical and mental limitations of their wounded veteran and the barriers to care caused by VA underfunding.

On May 25th 2005, 26-year-old Staff Sgt. Jarod Behee was on his second tour in Iraq. While on patrol that Wednesday, an insurgent sniper shot Jarod in the head. Jarod, a California National Guardsman, was critically wounded, suffering from severe brain swelling and damaged blood vessels which would require multiple surgeries. According to his wife, Marissa: "It is a miracle that he is alive."

After being transferred from Balad to Landstuhl to Walter Reed and then to the Palo Alto VA, he spent months recuperating, slowly becoming more responsive and regaining the ability to breathe and move on his own. For months, his wife Marissa was staying in a hotel near Jarod's VA facility in Palo Alto, six hours away from their family and their five-year-old daughter, Madison, who stayed with her grandparents.

In September of 2005, Marissa concluded that the VA facility that Jarod was in was "not up to par." Because of understaffing, Jarod received only about 3 hours of therapy a day. As Marissa reported at the time, "I know Jarod is capable of handling a much more rigorous schedule. He continually tells me that he is bored here. I could fight all day long for them to do more with Jarod, but bottom line, they don't have the means to do more here." The hospital was eager to transfer him to a sub-acute unit, a nursing facility that would put much less focus on rehabilitation.

In addition, Jarod's prolonged stay far from his home was limiting his chances to return to a normal life, the family was incurring flight, hotel and food expenses, and Marissa could not work while looking after her husband.

Marissa was left with no option other than to take Jarod to a private rehabilitation facility near their family. She found the Casa Colina Rehabilitation Center, only ten minutes from their home. Casa Colina is the number one brain rehabilitation facility in the nation, and like other private facilities, it accepts TRICARE. Any combat-injured soldier could make use of this facility and others like it, and yet troops with TBI are regularly sent to understaffed VA hospitals. As Marissa's father has said, "Until the VA can provide adequate care for these soldiers, troops with brain injuries should have the option of going to a private facility."

Thanks a rigorous 10-hour-per-day rehabilitation schedule, Jarod made dramatic improvements at the private clinic. Marissa remembers the first weeks at the new hospital:

His occupational therapist even said that there was definite movement in Jarod's left arm. She said that it is very weak, but there was movement and something to work with. Wow, that was a huge prayer answered because all I had been hearing for the past three months [at the Palo Alto VA] was that there was nothing there.

At this point in Jarod's rehab, the military had agreed to cover all medical expenses through TRICARE while Jarod was still in an acute-care hospital setting. The hospital also gave the Behees a house on hospital grounds, so that the family could live close by.

Jarod's physical health has improved dramatically, and on August 14th 2006, Jarod was discharged from the hospital. He can now walk totally unassisted and has specific jobs around the house, like making the bed, taking out the trash and doing the dishes. He also continues to go to the gym with his brother, Jason, two days a week for a few hours. This summer, sixteen months after Jarod's injury, the family was able to enjoy typical summer activities – a trip to the beach, and to San Diego's Sea World.

But the struggle of the Behee family continues. His family is seeking other private options to continue his cognitive therapy. But private care is expensive, and once Jarod is medically retired, TRICARE will not cover his cognitive rehabilitation or speech therapy – which can cost in excess of \$1300 a month. Now the Behees are looking for housing outside of the hospital, and waiting on word regarding Jarod's pension. In the meantime, a combat-injured soldier and a spouse that can't work because of those injuries will be living below the poverty line.

Traumatic Brain Injury is a tragedy takes its toll on the entire family. The understaffed and overworked VA hospitals are simply not able to give wounded troops the treatment they so badly need to get back to a "normal" life. Jarod and his family have sacrificed so much. They, and the hundreds of military families like them, deserve better.

Statement for the Record

Of
VIETNAM VETERANS OF AMERICA



Regarding
Traumatic Brain Injuries
and
Post Traumatic Stress Disorder (PTSD)
Diagnosis, Treatment, & Compensation

Submitted by

Thomas J. Berger, Ph.D., Chairman
VVA National PTSD & Substance Abuse Committee

Before the
Subcommittee on Health
Committee on Veterans Affairs
U.S. House of Representatives

September 28, 2006

Vietnam Veterans of America

House Veterans Affairs
Subcommittee on Health
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Mr. Chairman, Ranking Member Michaud, and distinguished Members of this Subcommittee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on the current state of the disability compensation claims process as accorded to our nation's veterans suffering from mental illnesses and/or traumatic brain injuries as a result of their military service.

First, Vietnam Veterans of America thanks this Committee for your concern about the mental health care of our troops and veterans, and your leadership in holding this hearing today. However, given the nature of the conflicts in Iraq and Afghanistan and the fact that many service members are serving multiple combat tours, VVA is again compelled to repeat its message that no one really knows how many of our troops in Iraq and Afghanistan have been or will be affected by their wartime experiences. Despite the much-touted early intervention by psychological personnel, no one really knows how serious their emotional and mental problems will become, nor how chronic both the neuro-psychiatric wounds (e.g., PTSD and Traumatic Brain Injury or TBI) and the resulting impact that these wounds will have on their physiological health, risk of suicide risk, and their general psycho-social readjustment to life away from the battle zone.

As we have stated before in Congressional testimony, Vietnam Veterans of America has no reason to believe that the rate of PTSD for veterans of OEF and OIF will be any less than that found for Vietnam veterans. What is beyond argument is that the more combat exposure a soldier sees, the greater the odds that soldiers will suffer mental and emotional stress that can become debilitating. And in wars without fronts, "combat support troops" are just as likely to be affected by the same traumas as infantry personnel.

This has particularly important implications for our female soldiers, who now constitute about 16 percent of our fighting force. Returning female OIF and OEF troops face ailments and traumas of other sorts. For example, studies conducted at the Durham, North Carolina Comprehensive Women's Health Center by VA researchers have demonstrated higher rates of suicidal tendencies among women veterans suffering depression with co-morbid PTSD. And according to a Pentagon study released in March 2006, more female soldiers report mental health concerns than their male comrades: 24 percent compared with 19 percent. In addition, roughly 40 percent of these women war fighters have musculoskeletal problems that doctors say likely

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are linked to lugging too-heavy and ill-fitted equipment. A considerable number - 28 percent - return with genital and urinary system infections. In addition, there are gender-related societal issues that make transitioning tough, psychologists who work with female veterans say.

Women are more likely to worry about body image issues, especially if they have visible scars, and their traditional roles as caregivers in civilian life can set them back when they return. In other words, they are the ones who have traditionally had the more nurturing role within our society, not the one who need nurturing. Additionally, the VA has, after much prodding by this subcommittee over the years, finally come to a place where there is pretty good coverage throughout the nation of services to women to treat PTSD and other after effects of Military Sexual Trauma (MST) at VA Medical Centers. However, there are very few clinicians within the VA who are prepared to treat combat situation induced PTSD as opposed to MST induced PTSD. Additionally, there are already cases where returning women service personnel have a combination of the two etiologies, making it extremely difficult for the average clinician to treat, no matter how skilled in treating either combat incurred PTSD in men, or MST induced PTSD in women. Because of the number of women who are de facto now combat veterans because of the nature of the conflicts in both Afghanistan and particularly Iraq, we have entered a whole new world of need.

Group therapy has proven in the last twenty-five years to be one of the most efficient as well as effective treatment modalities. However, you cannot mix the women with the men in these groups, as there are just some subjects that one gender will not generally share with the other and discuss, such as problems with intimacy or relations with one's spouse or significant other.

Medical experts say traumatic brain injuries (i.e., TBI) are the "signature wound" of the Iraq war, a by-product of improved body armor that allows troops to survive once-deadly attacks, but does not fully protect against the blast effects of roadside explosive devices and suicide bombers. They have become so common that special traumatic brain injury centers have been set up by the Army and by the VA.

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In addition, the Armed Forces Epidemiological Board (AFEBC) sent a memorandum (1) to the Honorable William Winkenwerder, Jr., M.D., Assistant Secretary of Defense for Health Affairs, in August 2006, which cited not only the evidence regarding the acute and long-term health implications of TBI, but also contained detailed recommendations on how the Department of Defense (DOD) should approach TBI prevention, medical management and research. VVA is not aware whether any of the AFEBC recommendations have been acted upon or implemented by DoD.

In any case, some physicians fear there may be thousands of active duty and discharged troops who are suffering undiagnosed. Our anecdotal experience bears this out, in that many active duty service troops, as well as Reservists and members of the National Guard, are chary of reporting problems, as they believe that doing so would effectively sabotage their military career. Symptoms include slowed thinking, severe memory loss, and coordination and impulse control problems.

The TBI injury is a physical loss of brain tissue that shares some symptoms with, but is markedly different than post traumatic stress disorder (PTSD), which is triggered by extreme anxiety, and permanently resets the brain's fight-or-flight mechanism. Battlefield medics and medical supervisors often miss traumatic brain injuries, and many troops don't know the symptoms or won't discuss their problems for fear of being sent home stigmatized with mental illness. The same is true for those who return to the Continental United States for garrison duty or who end their term of service, and exit the military to become veterans.

Certain TBI symptoms, such as seizures, can be treated with medication, but the most devastating effects of TBIs – depression, agitation and social withdrawal – are difficult to treat with medications, especially when loss of brain tissue occurs. In troops with documented TBIs, the loss of brain function is often compounded by other serious injuries that affect physical motor coordination and memory functions. These patients need a combination of psychological, psychiatric and physical rehabilitation treatment that is difficult to coordinate in a traditional hospital setting, even when it is properly diagnosed at an early date.

Furthermore, as more and more troops return home with brain damage, their families must contend not only with the shock of seeing the physical and psychological destruction to their loved ones, but also with how their own lives change dramatically. In cases of severely brain-damaged casualties, spouses, parents and siblings may be forced to give up careers, forsake wages and reconstruct homes to care for wounded relatives rather than consign them to a nursing home. Families say they also struggle with military and VA medical systems that were unprepared for these wounded. In some cases new equipment and the specially trained staff at VA needed for the rehabilitation of catastrophic cases has not kept pace with the advances in battlefield medicine that kept these service members alive and brought them home safely. In addition, there are issues about the intensity and drains of vitally needed family support that will be hard to sustain, as well as significant issues regarding the complexity of the medical and other specialized needs that have to be addressed.

Finally, VVA recognizes that there is a debate about the exact influence of combat-related trauma on suicide risk. For those veterans who have PTSD as a result of combat trauma, however, it appears that the highest relative suicide risk is observed in veterans who were wounded multiple times and/or hospitalized for a wound⁷. This suggests that the intensity of the combat trauma, and the number of times it occurred, may influence suicide risk in veterans with PTSD. Other research on veterans with combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt⁸. Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war. These thoughts can often overpower the emotional coping capacities of veterans.

Since combat began in Afghanistan in October 2001, nearly 20,000 American military personnel have been wounded in action, according to the Defense Department. Many of these injuries have been life threatening, requiring multiple surgeries, extensive rehabilitation and ongoing care. But the immediate financial and logistical challenges of coping with the thousands of severely wounded are just two of the problems military and civilian authorities (in addition to the servicemembers themselves) face.

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Since 2003, the Congress and the VA have directed several hundred million dollars to restoring organizational capacity in key networks that were most lacking because they laid off so many neuro-psychiatric clinicians in the 1990s. Some of these funds were directed toward hiring more clinicians, and some funds were directed toward establishing effective outreach programs to reach as many Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) veterans as early as possible. There appears to be widespread assent to the notion that the earlier that these individuals can be reached, the less severe and the less chronic their PTSD problems will be in the future.

Because the VA has still not moved forward and contracted to finish the National Vietnam Veteran Longitudinal Study (NVVLS), we do not know if that is accurate or not. VVA again urges the Committee on Veterans Affairs to strongly support insisting that the VA follow the law, and contract to get this study completed as soon as possible, as it will give you and all of us in the veterans' community some insight into the chronic PTSD and other socio-psychological readjustment problems of combat theater veterans may be, and when and how these problems will be likely to manifest in the current generation.

While the impulse to strengthen the organizational capacity of VA in mental health (particularly PTSD) and to do outreach programs aimed toward our newest generation of veterans is a laudable one, VVA is not certain that we have gotten the "bang for the buck" in expenditures of these taxpayer dollars. VVA encourages this committee to get an accounting of all of the funds allocated out to the Veterans integrated Service Networks (VISNs) on a competitive grant basis to determine who received these funds, what did they do with the funds (e.g., how many clinicians hired who did what with how many veterans served for what period of time), and what is the overall analysis of how effectively the VISNs used the funds for both short term (1 – 2 Years), and what appears to be the medium term or possibly permanent effect (e.g., more than two years). Reports from some areas in the country indicate that since virtually every VISN and every VAMC was kept running once again by using other than operational dollars, that these funds did NOT result in any meaningful outreach programs, and that no more clinicians were actually hired to handle the dramatically increased number of veterans seeking assistance and care.

Vietnam Veterans of America

House Veterans Affairs
Subcommittee on Health
September 28, 2006

Down the road, these active-duty, reservist and Guard military personnel will need employment, housing as well as both mental and physical health-care assistance for years to come. Accordingly, with the conflicts in Afghanistan and Iraq continuing with no end in sight, VVA believes that now is the time to address these issues, rather than later.

I thank you again for the opportunity to offer our views on these issues. Thank you for your kind consideration.

Vietnam Veterans of America

House Veterans Affairs
Subcommittee on Health
September 28, 2006

AFEB Memo Reference

Armed Forces Epidemiological Board Memorandum. "Traumatic Brain Injury in Military Service Members – 2006 – 02. August 11, 2006.

Questions for the Record

**The Honorable Michael H. Michaud
Ranking Democratic Member
Subcommittee on Health
House Committee on Veterans' Affairs**

September 28, 2006

Hearing on Post Traumatic Stress Disorder (PTSD) & Traumatic Brain Injury (TBI)

Question 1: VA Claims to monitor closely the workload of Vet Centers and the need to increase the number of Vet Centers and to augment staff.

Question 1(a) Please provide us with copies of all requests from the Office of Readjustment Counseling for additional staff and/or Vet Centers that have been submitted since October 1, 2001, which have been approved.

Response: The Office of Readjustment Counseling has submitted four requests that have been approved for additional staff or Vet Centers since October 1, 2001.

Attachment 1- February 3, 2004, request and authorization to recruit and hire 50 global war on terrorism (GWOT) veteran outreach specialists to augment the Vet Center ability to provide timely outreach to returning GWOT veterans.

Attachment 2- November 23, 2004, request and authorization to establish a new 4-person Vet Center in Nashville, Tennessee, a major underserved urban area.

Attachment 3- March 28, 2005, request and authorization for the Vet Centers to recruit and hire another 50 GWOT veterans to further enhance the program's outreach campaign to veterans returning from combat in Afghanistan and Iraq.

Attachment 4- April 18, 2006, request and authorization to establish two new Vet Centers (Atlanta, Georgia and Phoenix, Arizona), to augment staff in 11 existing Vet Centers, and career conversion of the 50 GWOT outreach specialists.

Question 1(b) Please provide us with copies of all requests from the Office of Readjustment Counseling for additional staff and/or Vet Centers that have been submitted since October 1, 2001, which have not been approved and the reason(s) for not approving the request.

Response: Since October 1, 2001, the Office of Readjustment Counseling submitted three proposed program enhancements. Two proposals were returned to the program office with instructions and guidance to further provide a demographic and needs analysis.

The third proposal was submitted twice, once in November 2005 and then again in December 2005, both times it was returned to the program office requesting additional analysis. It was resubmitted in April 2006 and approved.

Attachment 5- June 15, 2004, Vet Center Proposed Augmentations, request for an additional 49 full time employee equivalents (FTEE). This proposal was returned to the program office because it lacked supporting data.

Attachment 6- October 20, 2005, plan submitted to the Deputy Under Secretary for Health containing a request for 12 new Vet Centers and staff augmentation for direct service providers to include bereavement and sexual trauma counselors. This proposal was returned to the program office because it lacked supporting data.

Attachment 7- November 15, 2005, Vet Center Program Enhancement for 12 new Vet Centers, staff augmentation at 26 existing Vet Centers, and career conversion of the GWOT outreach specialists. This proposal was returned for further analysis and resubmitted on December 13, 2005. It resulted in the April 18, 2006 approval.

Attachment 8- December 13, 2005, revision of the November 15, 2005 Vet Center Program Enhancement request for 12 new Centers, staff augmentation at 23 existing Centers, and career conversion of the GWOT outreach specialists. December 13, 2005 request was returned for additional analysis and resubmitted and approved in April of 2006.

Question 1(c) Please provide us with copies of all requests from the Office of Readjustment Counseling for additional staff and/or Vet Centers that have been submitted since October 1, 2001, which are currently under consideration.

Response: **Attachment 9-** November 15, 2006, Vet Center Augmentation proposal for 2007 has been submitted. A decision is expected in the next 30 to 90 days.

Question 2: According to VA's own data, nearly 70 percent of the separated veterans returning from Iraq and Afghanistan are not turning to the VA for their health care. Army research suggests that one in three of returning OIF/OEF veterans may have mental health concerns. Army research also shows three to six months after deployment members of the National Guard and Reserve screen positive for mental health concerns, including PTSD, at higher rates than active military. Please describe in detail VA's efforts to reach out and educate veterans who have not come to the VA, and their families, about post-deployment stress reactions.

Response: The Department of Veterans Affairs (VA) has made extensive efforts to ensure that information is available to returning troops about VA services and their eligibility. Ultimately it is each veteran's decision regarding where he or she will seek health care, but VA wants that decision to be based on ample information about VA and its programs for veterans. The following is a summary of efforts to reach out and educate veterans and their families:

- a. The Office of Seamless Transition has partnered with the National Guard Bureau to establish 54 transition assistance advisors (TAA), formerly State benefit advisors. A TAA is in every State and territory. The TAAs are National Guard Bureau staff that work closely with VA medical centers and Vet Centers in outreach, education, and referral efforts.
- b. VA medical centers (VAMC) and Vet Centers are heavily involved in the Department of Defense's (DoD) post deployment health reassessment (PDHRA) program for National Guard and Reserve members. PDHRA is an outreach, education, identification, and referral program. Vet Center staff has participated in over 300 PDHRA screening events with National Guard and Reserve units. These screenings have resulted in over 10,000 service members, as of September 30, 2006, being referred to VA for follow-up care. In addition to providing this follow-up care, VA staff actively enrolls National Guard and Reserve members in health care.
- c. Recently VA has agreed to assign 22 Army Wounded Warrior (AW2) staff to VAMCs to work with seriously injured soldiers/veterans and their families. AW2 staff have all been medically

discharged from the Army with 30 percent or greater disability ratings. Over 20 percent of the soldiers/veterans in this program have a post traumatic stress disorder (PTSD) disability. An AW2 staff will be located in each Veterans Integrated Service Networks (VISN) (with two assigned in VISN 7. Eleven of the AW2 staff are currently in place with four more scheduled to begin their assignments by the end of January 2007. The remainder should be hired and on site by March 2007. The VA/AW2 partnership is a major step in the outreach initiative that will help VAMC and Vet Center staff reach out to seriously injured soldiers/veterans and their families.

- d. The Office of Seamless Transition is actively working with the Army Reserve and the Marine Corps to develop memorandums of understanding (MOU) to help promote outreach, education, and transition assistance.
- e. In response to the growing numbers of veterans returning from combat in Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF), the Vet Centers initiated an aggressive outreach campaign to educate returning service members of the VA benefits available to them. The Vet Centers hired 100 GWOT veterans to enhance their outreach services to GWOT veterans. Since the beginnings of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 177,000 OEF/OIF veterans, of which over 134,000 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites, usually in group settings.
- f. Returning veterans outreach, education and clinical (RVOEC) teams (funded and monitored through the Office of Mental Health Services) collaborate with readjustment counseling services and with State veterans affairs offices to provide information about VA services. A primary goal of the RVOEC program is to promote awareness of health issues and health care opportunities and the full spectrum of VA benefits. Some VAMCs began these outreach activities before RVOEC teams were funded as local initiatives, and they continue these services, now using the RVOEC teams as their agents.
- g. The National Center for PTSD has a number of informational pamphlets for returning veterans and their families on their web site (<http://www.ncptsd.va.gov/>). The specific information appears prominently on the Web site:
War in Iraq: Information
This section of the Web site contains the latest fact sheets and literature on the war in Iraq. Important links from the site are:
The Iraq War Clinician Guide, 2nd Edition, and two new guides on Returning from the War Zone: A Guide for Military Personnel and A Guide for Families as well as the VA Operation Enduring Freedom and Iraqi Freedom Seamless Transition Web site.
- h. In addition, VA provides briefings on benefits and healthcare services at town hall meetings, family readiness groups, and during unit drills near the homes of returning Guard/Reservists. Return and deactivation of Reserve/Guard units presents significant challenges to VA because rotation is irregular and the service members spend short periods at military installations prior to release to their Guard or Reserve components. For this reason, VA continues to refine and adapt traditional outreach efforts to meet the needs of those who are currently separating from service by focusing at the local armories or reserve centers in the months following deactivation.

- i. On March 8, 2005, as part of the Secretary's Letter Writing Outreach Campaign, over 644,000 letters were mailed to veterans informing them of VA's wide range of health care benefits and assistance to aid in their transition from active duty to civilian life.

In addition to the outreach activities mentioned above the National Center for Post-Traumatic Stress Disorder (NCPTSD) is directing multiple studies, supported by VA and other sources that will provide further details about the needs of OEF/OIF veterans.

Question 3: Please describe in detail the research VA is conducting, or plans to conduct. ... For each item, in addition to a detailed description of the research objective and initial findings, please identify the primary investigator, the amount of funds allocated for the research by fiscal year, and the projected conclusion date of the research project.

Response: VA is responding to the newest generation of returning combat veterans with active outreach, coordination of care and recognition of their unique injuries and problems, including mental health needs. PTSD is a major concern, and resources are being devoted to this as well as other mental illnesses experienced by OEF/OIF veterans. The overall goal of OEF/OIF related research is to understand the injuries and problems as well as possible and to use the newest scientific findings in order to return these veterans to their highest level of functioning. The focus on PTSD, for example, has lead to new promising funded research that is examining novel treatments (e.g., drugs and/or therapies) and treatment delivery (e.g., computer or telephone interventions).

Because VA's research portfolio pertinent to these questions is so extensive, the responses provided below list only some current research highlights (a complete list of studies is attached). It would be premature to provide initial findings prior to external peer review and publication by a scientific journal.

Attachment 10 provides a detailed listing of all relevant projects, but does not include externally funded research conducted by VA scientists.

Question 3(a) Assess the mental health needs of OIF/OEF veterans who have not sought care at the VA or Vet Centers.

Response: There are several important ongoing efforts directed at assessing mental health needs of OEF/OIF veterans regardless of source of care. This includes critical longitudinal studies that are aimed at determining mental health care needs following deployment. The following highlights some research which will provide information about the needs of OEF/OIF veterans.

- **Program Title:** *Comprehensive Needs Assessment for OIF/OEF Veterans*
- **Research Objective:** OIF/OEF veterans and their family members will be surveyed to determine their needs for clinical services, policies and research post-deployment.
- **Primary investigator:** K. Straits-Troster
- **Amount of FY 2006 funds allocated:** \$46,000
- **Projected conclusion date:** December 2007
- **Program Title:** *National Center for Post-Traumatic Stress Disorder (NCPTSD)*.
- **Research Objective:** NCPTSD investigators are directing multiple studies, supported by VA and other sources that will provide further details about the needs of OEF/OIF veterans, as well as other populations
- **Primary investigator:** Multiple
- **Amount of FY 2006 funds allocated:** \$18,000,000

- **Program Title:** Does PTSD Service Connection Affect Disease Course and Functioning?
- **Research Objective:** The only study ever to look at outcomes associated with receiving or not receiving VA disability benefits. The study will examine the disease course of severely disabled veterans with PTSD and explore the effects of receiving VA disability payments. In addition, this research will gather information about outcomes in women and minority veterans who seek disability benefits for PTSD.
- **Primary investigator:** Maureen Murdoch
- **Amount of FY 2006 funds allocated:** \$266,900
- **Projected conclusion date:** Completed

- **Program Title:** Barriers and Facilitators to PTSD Treatment Seeking.
- **Research Objective:** The first study to examine barriers to and facilitators of PTSD treatment-seeking among veterans. It will lay the foundation for understanding why veterans seek treatment and for improving access to and quality of PTSD services.
- **Primary investigator:** Nina A. Sayer
- **Amount of FY 2006 funds allocated:** \$148,900
- **Projected conclusion date:** December 31, 2007

Question 3(b) Determine the factors which contribute to National Guard members and Reservists reporting mental health concerns at higher rates than Active Components of the Army.

Response: While VA does not know whether national guard and reservist are reporting mental health concerns at a higher rate, VA is studying the factors that contribute to mental health concerns among all military personnel (national guard, reserve and active duty), one such study is the *Prospective Assessment of Neurocognition in future Gulf-Deployed and Gulf-Nondeployed Military Personnel* (listed below). In addition VA is conducting research as it relates to the mental health concerns of OEF/OIF veterans, examples of which are listed below:

- **Program Title:** Prospective Assessment of Neurocognition in Future Gulf-Deployed and Gulf-Nondeployed Military Personnel.
- **Research Objective:** A VA scientist at the New Orleans VAMC, working jointly with DoD, has obtained access to active military and National Guard personnel prior to deployment to Iraq to assess neurocognitive and emotional changes occurring between pre- to post-deployment timeframes. This unique work will help identify factors that contribute to mental health changes in both National Guard and active duty military personnel.
- **Primary investigator:** Jennifer J. Vasterling
- **Amount of FY 2006 funds allocated:** \$182,119
- **Projected conclusion date:** Completed

- **Program Title:** Health Risk Behaviors and Quality of Life among OEF/OIF Veterans and Implications for VA Health care.
- **Research Objective:** A retrospective study of OEF/OIF veterans who completed the national Survey of Health Experiences of Veterans after using VA health care services. This study will examine prevalence of health risk behaviors (e.g., smoking, alcohol use), quality of life, access to health care and satisfaction with VA health care during 2003-2005.
- **Primary investigator:** K. Straits-Troster
- **Projected conclusion date:** Completed

- **Program Title:** OEF/OIF Study Registry.
- **Research Objective:** Involves screening participants for mental health status such as PTSD, substance use disorders, depression, traumatic brain injury (TBI) and the banking of a blood samples for assessment of neurotransmitters and genetic markers of mental illness.

A newly constructed database enables web-based administration of psychiatric and health assessments to participating veterans.

- **Primary investigator:** Rajenda Morey
- **Amount of FY 2006 funds allocated:** \$214,000
- **Projected conclusion date:** No end date – registry is continuous
- **Program Title:** A Prospective Study of Functional Status in Veterans at Risk for Unexplained Illnesses
- **Research Objective:** A group of scientists is collecting information prior to deployment specifically from Army Reserve personnel. These personnel will be reassessed twice following deployment to Iraq to determine whether they have increased mental health symptoms, distress or increased use of healthcare services.
 - **Primary investigator:** Karen Quigley
 - **Amount of FY 2006 funds allocated:** \$241,000
 - **Projected conclusion date:** 2009

Question 3(c) Evaluate and compare treatment interventions for PTSD.

Response: Multiple ongoing studies use a variety of approaches to understand and treat PTSD, with the aim of restoring veterans to highest possible levels of activity and function. VA scientists are testing new drugs, therapies and novel interventions such as Internet- and telephone-based support systems. Some studies are intended to reduce symptoms, while others are directed towards prevention. VA is supporting pilot projects, small single-site trials and multi-site clinical interventions for PTSD. Important highlights include:

- **Program Title:** A Prospective Study of Functional Status in Veterans at Risk for Unexplained Illnesses
- **Research Objective:** A group of scientists is collecting information prior to deployment specifically from Army Reserve personnel. These personnel will be reassessed twice following deployment to Iraq to determine whether they have increased mental health symptoms, distress or increased use of healthcare services.
- **Primary investigator:** Karen Quigley
- **Amount of FY 2006 funds allocated:** \$241,000
- **Projected conclusion date:** 2009
- **Program Title:** Pregnenolone Augmentation Targeting Cognitive Symptoms in Veterans with PTSD.
- **Research Objective:** Pregnenolone augmentation in persistently symptomatic veterans with PTSD may have a significant impact on cognitive symptoms, resulting in improved quality of life and overall functioning in these patients.
- **Initial Findings:** Potentially promising approach for the treatment of cognitive symptoms in this disorder.
- **Primary investigator:** Christine Marx
- **Amount of FY 2006 funds allocated:** \$50,000
- **Projected conclusion date:** May 2007
- **Program Title:** Guided Imagery for Military Sexual Trauma.
- **Research Objective:** Randomized controlled trial of a self-administered guided imagery intervention for PTSD related to military sexual trauma (MST). The study will assess PTSD symptoms and potential biomarkers of PTSD.
- **Initial Findings:** Initial research showed that guided imagery leads to a reduction of PTSD and depressive symptoms in women veterans with MST.

- **Primary investigator:** Jennifer Strauss
- **Amount of FY 2006 funds allocated:** \$15,000
- **Projected conclusion date:** January 2008
- **Program Title:** Evaluating the Clinical and Neurobiological Effects of Guided Imagery for PTSD in Women Veterans.
- **Research Objective:** To assess the effects of guided imagery on PTSD symptoms, brain function associated with processing stress, and biological markers of stress.
- **Primary investigator:** Jennifer Strauss
- **Amount of FY 2006 funds allocated:** \$175,000
- **Projected conclusion date:** January 2008
- **Program Title:** Secondary Prevention with Paroxetine vs. Placebo in Subthreshold PTSD.
- **Research Objective:** To evaluate a secondary prevention strategy using the selective serotonin reuptake inhibitor paroxetine which might be effective in OEF/OIF veterans with early manifestations of PTSD symptoms.
- **Primary investigator:** Christine Marx
- **Amount of FY 2006 funds allocated:** \$45,000
- **Projected conclusion date:** December 2008
- **Program Title:** Cognitive Behavioral Therapy for Treatment of PTSD in Women.
- **Research Objective:** The largest PTSD psychotherapy study ever conducted, 284 female veterans and active duty personnel with PTSD were randomized to receive either exposure therapy or a therapy that focuses on current life problems.
- **Initial Findings:** Study demonstrates that it is feasible to deliver prolonged exposure in VA setting; data analysis is underway
- **Primary investigator:** Multi-site Cooperative Studies
- **Amount of FY 2006 funds allocated:** \$1,448,000
- **Projected conclusion date:** Completed
- **Program Title:** Quality Enhancement Research Initiative (QUERI) Center.
- **Research Objective:** Its mission is to promote successful rehabilitation, psychological adjustment, and community re-integration of individuals who have experienced polytrauma and blast-related injuries. The scope includes the range of health problems, health care system and psychosocial factors related to polytrauma, including care structures and processes within DoD, VA, and the community, as well as the transfer of care within and across systems. The research also will include family members who fulfill caregiver roles.
- **Primary investigator:** Nina Sayer
- **Amount of FY 2006 funds allocated:** \$350,000
- **Projected conclusion date:** December 2008

Smoking Related Studies- Because OEF/OIF veterans are at high risk for smoking and require special population-based tobacco cessation intervention, several studies address these specific concerns including ongoing work on neuroactive steroids that might have relevance to nicotine dependence, and studies of which cessation strategies might be best in veterans with PTSD and nicotine dependence. Examples of some of these studies are listed below:

- **Program Title:** Neuroactive Steroids and Nicotine Dependence.
- **Research Objective:** Study on neuroactive steroids that might have relevance to nicotine dependence.
- **Primary investigator:** Christine Marx

- **Amount of FY 2006 funds allocated:** \$35,000
- **Projected conclusion date:** November 2007
- **Program Title:** Optimizing Smoking Cessation Interventions in Post Traumatic Stress Disorder.
- **Research Objective:** Studying which cessation strategies might be best in veterans with PTSD and nicotine dependence.
- **Primary investigator:** Jean Beckham
- **Amount of FY 2006 funds allocated:** \$250,000
- **Projected conclusion date:** September 2009
- **Program Title:** Telephone Quit Line Tobacco Cessation for Veterans of Military Service in OEF/OIF.
- **Research Objective:** Study to determine whether telephone-based counseling is effective in reducing smoking in OEF/OIF veterans.
- **Primary investigator:** Jean Beckham
- **Amount of FY 2006 funds allocated:** \$75,000
- **Projected conclusion date:** December 2007
- **Program Title/Research Objective:** *The Effect of Smoking on Startle and Pre-pulse Inhibition in PTSD.*
- **Primary investigator:** Jean Beckham
- **Amount of FY 2006 funds allocated:** \$100,000
- **Projected conclusion date:** December 2008

Additionally, during fiscal year (FY) 2006, VA, DoD and the National Institute of Mental Health (NIMH) issued a joint inter-agency research solicitation entitled "Intervention and Practice Research for Combat Related Mental Disorders and Stress Reactions." VA and NIMH committed funding for this solicitation. This solicitation presents an opportunity for both VA and non-VA scientists to propose research studies related to deployment to Afghanistan and Iraq. Topics of some of the programs to be funded include an interventional trial of a drug and therapy combination to reduce PTSD, studies to assess ways to increase access to mental health treatment and use of virtual reality exposure therapy to reduce PTSD symptoms. These programs were viewed as innovative and scientifically meritorious, and will most likely start in FY 2007.

In full partnership with DoD, VHA has developed the Joint VA/DoD Clinical Practice Guideline for the Management of Traumatic Stress (http://www.opp.med.va.gov/cpg/PTSD/PTSD_Base.htm). Those guidelines represent a comprehensive review of the world literature combined with the clinical experience and recommendations of mental health and primary care experts across both agencies. The current guidelines will be due for review and revision within the next 2 years.

Question 3(d) Evaluate whether access to care is impacting rural OIF/OEF veterans with mental health concerns.

Response: Several ongoing research efforts are exploring whether novel treatment interventions may be beneficial in reaching those veterans in more remote locations. Telephone and computer-based interventions are being studied. Two examples are:

- **Program Title:** Telemedicine and Anger Management for Groups of PTSD Veterans in the Hawaiian Islands.

- **Research Objective:** To assess the clinical effectiveness of conducting an anger management therapy (AMT) group treatment intervention with veterans who have PTSD and reside in remote locations, using a video-teleconferencing modality as compared to the traditional in-person modality.
- **Primary investigator:** Leslie Morland
- **Amount of FY 2006 funds allocated:** \$267,348
- **Projected conclusion date:** March 2009
- **Program Title:** Telephone and Case Monitoring for Veterans with PTSD.
- **Research Objective:** A randomized controlled trial to assess whether adding telephone monitoring to usual care reduces PTSD symptoms and hospitalization.
- **Primary investigator:** Craig S. Rosen
- **Amount of FY 2006 funds allocated:** \$113,300
- **Projected conclusion date:** March 2011

Question 3(e) Evaluate the implementation of VA's screening, referral and treatment programs for OIF/OEF veterans with mental health concerns.

Response: VA has national performance measures with mandated screening and, when necessary, appropriate treatment and referral for OEF/OIF veterans. These performance measures track for PTSD, depression, and substance abuse. Additional research projects include:

- **Program Title:** Olfactory Sensory Processing in PTSD and TBI.
- **Research Objective:** Uses an 8-channel, magnetic resonance imaging (MRI) compatible olfactometer. The system enables precisely timed presentation of odors during functional MRI studies in veterans.
- **Initial Findings:** Our initial analysis of this system supports its use for studying the relationship of olfactory sensory processing to memory and emotional brain systems in patients with PTSD and TBI.
- **Primary investigator:** Rajendra Morey
- **Amount of FY 2006 funds allocated:** \$26,000
- **Projected conclusion date:** 2010
- **Program Title:** Effectiveness of Screening and Treatment for PTSD in Substance Use Disorder (SUD) Patients.
- **Research Objective:** To identify feasible and inexpensive methods to detect and treat co-morbid PTSD among VA SUD patients, thereby improving treatment outcomes.
- **Primary investigator:** Jodie Trafton
- **Amount of FY 2006 funds allocated:** \$109,000
- **Projected conclusion date:** December 2011

Question 3(f) Generally study the mental health concerns of OIF/OEF veterans.

Response: The VA mental health research portfolio includes ongoing work across all aspects of mental health disorders, including laboratory based investigations, clinical trials, services studies and vocational/rehabilitation research. A few specific examples of projects studying the mental health concerns of OIF/OEF veterans are highlighted below; a detailed listing is provided in Attachment 10. Attachment 10 provides a listing of ongoing studies relevant to mental health concerns of OIF/OEF veterans (although, not all work referenced is necessarily being conducted on OIF/OEF veterans). Work includes studies of specific mental disorders such as

PTSD, Schizophrenia, mood and anxiety, as well as functional recovery from physical trauma such as traumatic brain injury (TBI), spinal cord injury (SCI), amputation and chronic pain.

- **Program Title:** Neuroactive Steroid Alterations as Candidate Biomarkers of Suicidality Risk in OEF/OIF Veterans.
- **Research Objective:** To understand the neurobiological underpinnings of suicidal behaviors.
- **Initial Findings:** The preliminary data suggest that neuroactive steroid alterations may represent candidate biomarkers relevant to this important clinical symptom. Neuroactive steroid alterations may have clinical utility in predicting suicidality risk, potentially leading to effective interventions for the prevention of suicidal behaviors.
- **Primary investigator:** Christine Marx
- **Amount of FY 2006 funds allocated:** \$35,000
- **Projected conclusion date:** May 2007
- **Program Title:** Rapid Needs Assessment of VA Polytrauma Rehabilitation Centers (QUERI project).
- **Research Objective:** To determine the needs of the four polytrauma rehabilitation centers (PRCs); to characterize the structures and processes of care in place; to describe the variations across sites; to identify innovations in care processes that may promote better outcomes; to identify providers' perceptions of barriers and facilitators to patient care; to improve patient outcomes.
- **Primary investigator:** Freidemann-Sanchez
- **Amount of FY 2006 funds allocated:** \$44,420
- **Projected conclusion date:** Completed
- **Program Title:** Variations Across VA Polytrauma Rehabilitation Centers (QUERI project).
- **Research Objective:** To determine the demographic and clinical characteristics, treatment needs, and outcomes of OEF/OIF service members who received inpatient rehabilitation treatment in PRCs and to identify variations in patient characteristics, treatments and outcomes across the four PRCs.
- **Primary investigator:** Sayer
- **Amount of FY 2006 funds allocated:** \$49,454
- **Projected conclusion date:** Completed

Question 4: The Comprehensive Mental Health Strategic Plan includes several initiatives to reduce and prevent suicide among veterans. Specifically, the plan states that VA "will develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care." Please describe in detail the status of this initiative, including the specific timeline, milestones, allocated funds, and accountability for the implementation of this initiative for FY 2006, FY 2007, and FY 2008.

Response: Following guidance from its Comprehensive Mental Health Strategic Plan, VHA is working intensively to develop a program to prevent suicide among veterans. In this, one of the guiding principles is that enhancing the capacity, access, and quality of the mental health care system is necessary, but not sufficient to achieve significant reductions in suicide rates. In addition, it is necessary to target suicide directly, both in clinical activities and public health programs.

Following this principle, we are outlining VHAs evolving approach to suicide prevention, both enhancements in overall mental health care, and initiatives designed to address suicide directly. One component of our initiatives for suicide prevention (4b, below) will fund the appointment of suicide prevention coordinators in each medical center. Their responsibilities will include

systematic identification of veterans who have attempted suicide, a group at exceptionally high risk for completed suicide, and coordination of programs to ensure that they receive enhanced monitoring and care. The suicide prevention initiative as a whole is summarized below with brief descriptions of current activities, plans for the current year, and projections for future years:

1. Ongoing activities as of November 1, 2006
 - a. Enhancing overall mental health (MH) services
 - i. Increasing in overall funding for MH services
 - ii. Integrating MH and primary care
 - iii. Promoting recovery and rehabilitation in MH specialty care settings
 - iv. Expanding PTSD services
 - v. Enhancing services for homeless veterans
 - vi. Increasing the capacity of substance abuse treatment services
 - vii. Increasing the capacity and access for MH services in community based outpatient clinics (CBOCs)
 - viii. Increasing the availability of MH services in rural areas including use of telemental health
 - ix. Reaching out to returning OEF/OIF veterans
 - x. Developing MyHealthVet as a platform to enhance patient education, activation, and monitoring
 - b. Specifically targeting suicide
 - i. Participating in Federal partnership on MH suicide prevention workgroup
 - ii. Funding VISN 19 Mental Illness Research, Education and Clinical Centers (MIRECC) with its focus on clinical models for suicide prevention--Developing methods for sensitive and reliable identification of veterans who have survived suicide attempts
 - iii. Selection of leadership for the Canandaigua center of excellence (COE) with a focus on public health models for suicide prevention
 - iv. Ongoing education and training regarding suicide prevention
 - v. Expansion of opiate maintenance treatment programs
 - vi. Obtaining data to guide policy and planning
 - (1) Collaboration with National Violent Death Reporting System
 - (2) Obtaining National Death Index data on causes of veterans' deaths through the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC)
 - (3) Ongoing reporting of cases with suicide/parasuicide through National Center for Patient Safety
2. Evolving activities and proposed programs – Current year
 - a. Enhancing overall Mental Health services
 - i. Continuation and expansion of above initiatives
 - ii. Develop structures for expanding the delivery of evidence-based psychotherapies
 - iii. Explore enhanced partnerships with Substance Abuse and Mental Health Services Administration (SAMHSA) over public campaigns for destigmatization
 - iv. Expanding support and monitoring for programs addressing military sexual trauma
 - v. Supporting VISN efforts at developing programs using new technologies to support MH care coordination
 - vi. Promoting "gatekeeper" systems to enhance the identification and access of veterans with MH conditions. These will include:
 - (1) Chaplains and, through them, community clergy
 - (2) Mental health providers in the community
 - (3) Veterans Service Organizations
 - (4) Veterans Benefit Administration (VBA) staff
 - b. Specifically targeting suicide
 - i. Participation in National Alliance for Suicide Prevention
 - ii. Full implementation of Canandaigua COE

- iii. Roll out of training for cognitive behavioral therapy for suicide prevention
 - iv. Expansion of education to include mandatory training for all VHA employees
 - v. Specific sensitization of "gatekeepers" to issues of suicide prevention
 - vi. Partnership with SAMHSA's national network of suicide prevention hotlines to ensure that existing hotlines are aware of VA-related issues
 - vii. Designation of suicide prevention coordinators in each VAMC
 - (1) Functions will be developed by VISN 19 MIRECC, Canandaigua COE and Owensboro Medical Health System (OMHS). Activities will include:
 - (a) Maintenance of a "registry" of veterans at high risk for suicide (e.g., those who have survived attempts) and coordination of targeted care management and/or
 - (b) Coordination of education, "gatekeeper" development, and outreach with a focus on suicide prevention
 - (2) Ongoing supervision, support, and technical assistance from VISN 19 MIRECC and Canandaigua COE
 - viii. Creation of an ongoing leadership structure for suicide prevention
 - (1) Work group including membership from VISN 19 MIRECC, Canandaigua COE, SMITREC, and OMHS. The work group will serve as staff for VHA steering or executive committee on suicide prevention (see below). Its charge will include the ongoing review of scientific evidence on suicide prevention, VHA-specific data, and opportunities for action both within the VHA and in partnership with other entities. Its activities will include:
 - (a) Specific pharmacological approaches as possible strategies for suicide prevention, including use of clozapine, lithium, and opiate maintenance treatment
 - (b) Possible public health and clinical approaches to enhancing firearm hygiene (including approaches based on the Army's "Battlemind" program)
 - (c) Ongoing acquisition of data on Veterans' cause of death. Review of these and other data to identify Veteran-specific risk factors and hotspots for suicide, and development of strategies for addressing them
 - (d) Ongoing review of the impact and effectiveness of each component of the VA's approach to suicide prevention
 - (e) Ongoing recommendations for modifying programs
 - ix. Appointment of a VHA steering or executive committee on suicide prevention. Its charge will making recommendations to the Deputy Chief Patient Care Services Officer for Mental Health, the Chief Patient Care Services Officer, and the Under-Secretary for Health on policies and programs to prevent veteran suicides.
3. Evolving activities to be considered - Beyond the current year
- a. Sustaining the overall program
 - b. Ongoing implementation of approved recommendations from the executive or steering committee
 - i. Maintenance of effective programs
 - ii. Modification of ineffective programs
 - iii. Implementation of new approved policies and programs including those resulting from consideration of the issues and processes identified in 2.b.viii.(1)(a)-(e)
4. FY 2007 funding for specific suicide prevention activities include:
- a. \$6.4 million for funding suicide prevention coordinator activities in each medical center beginning in the third quarter of FY 2007 (\$12.8 annualized)
 - b. \$1.65 million for implementation of the Canandaigua COE
 - c. Over \$1 million for other suicide prevention activities including education and training for all staff, technical assistance for the suicide prevention coordinators, developing "gatekeepers" in the VA and the community who can facilitate help-seeking for those in need.

Question 5: For each fiscal year from 2003 through 2006, please state the number of unique enrolled veterans who have attempted suicide and the number of unique enrolled veterans who have committed suicide. For each fiscal year from 2003 through 2006, please state the number of unique enrolled OEF/OIF veterans who have attempted suicide and the number of unique enrolled OEF/OIF veterans who have committed suicide.

Response: VHA cannot provide the definitive quantitative information about rates of suicide, for the following reasons:

- 1) Not all veteran suicides are documented as suicides. For example, when the cause of death is not immediately obvious to the coroner or medical examiner the death certificate may list another cause of death such as heart attack.
- 2) Not all veteran suicides are reported to VA. A proportion of the events occur in the community and there is no requirement to report that information to VA.

Nonetheless, VHA is working on creating systems and procedures to obtain more complete information about suicides and suicide attempts in an ongoing manner as part of our efforts to develop an evidence-based approach to prevention, and to target care where it is most needed. Although VA does not have the systems in place at this time that would allow it to provide the requested information, it is working intensively to get more complete data, and to apply information on completed suicides and attempts in quality improvement, and, on attempts, in targeting care.

As part of VHA's efforts at suicide prevention, we have implemented two important projects. First, to obtain the best available estimates for rates and risk factors for suicide together with their geographic variation, VHA has obtained data from the National Death Index of the cause of death for all veterans who have stopped receiving care in recent years. This is intended to be a sustained activity, with data obtained each year to allow an evidence-based approach to suicide prevention. Second, MIRECC in VISN 19 has developed a systematic strategy for the identification of enrolled veterans who have attempted suicide. They have identified 170 attempts and 22 completed suicides in the past 2 years. The ratio of attempts to completed suicides, approximately 8 to 1, is within the range cited in an NIMH Fact Sheet (www.nimh.nih.gov/suicideprevention/suifact.cfm), and is consistent with what is expected for a population that is predominantly male and middle aged or older; this is preliminary evidence for the validity of their approach to identifying cases. VISN 19's methods for creating a listing of attempts is currently being replicated in other regions. The goal is to implement it broadly in late FY 2007 as a method for targeting care to those patients who may be at the highest risk for suicide, those who have already made attempts to harm themselves.

Question 6: Please provide the Subcommittee with a detailed breakdown of how the \$200 million VA budgeted for enhancing mental health programs and implementing the Comprehensive Strategic Mental Health Plan was spent in FY 2006. Please identify any monies that went unspent. Please identify any monies that were distributed through VERA.

Response: The following table represents VA allocation of funding to medical centers for mental health strategic plan initiatives by type of mental health services for FY 2006. None of the FY 2006 mental health initiative funds were distributed through veterans' equitable resource allocation (VERA). Please note that although the monies were allocated, facilities may not have been able to fully execute according to plan.

Type of Mental Health Service	Original Amount Allocated	Revised Allocation
New fiscal year 2006 initiatives		
<i>Related to legislation</i>		
Domiciliary expansion	\$7,260,193	\$7,437,593
<i>Not directly related to legislation</i>		
PTSD and OEF/OIF	\$17,356,562	\$18,772,089
Substance abuse	\$16,782,531	\$16,887,550
Community-based outpatient clinic mental health	\$13,451,302	\$16,782,344
Telemental health With EQ	\$5,022,399	\$5,063,987
Grant and per diem liaisons	\$4,700,000	\$4,700,000
Mental health intensive case management teams	\$3,625,432	\$3,749,029
Inpatient mental health services at two VA facilities in Tennessee	\$1,621,397	\$1,629,657
Mental Illness Chemical Addiction		\$69,517
Incarcerated Veterans Pilot		\$233,334
Peer Housing Location Assistance Group for Homeless Veterans		\$168,980
Psychosocial and recovery-oriented services		\$6,249,025
Development of educational programs	\$600,000	\$600,000
Additional Ed Programs		\$791,208
Stand Downs		\$467,665
Health E-Vet		\$5,000,000
RRTP Life Safety, Suicide Prevention		\$1,803,853
VISN 16 Special Needs		\$1,610,643
<i>Subtotal – new fiscal year 2006 initiatives</i>	\$70,420,190	\$92,016,474
<i>Initiatives initially funded in fiscal year 2005</i>	\$65,675,513	\$65,675,513
Total	\$136,095,703	\$157,691,987

The table below list represents funds not allocated to medical centers by type of mental health services for FY 2006. The reason for funds not allocated is due in part to delayed implementation of three new COEs, and to the unanticipated length of time required for refining the processes for implementation of the integration of mental health with primary care after responses to the request for proposals were received.

Type of Mental Health Service	Planned Amount Not Allocated	Revised Amount Not Allocated
<i>Related to legislation</i>		
Centers of Excellence	\$4,500,000	\$4,500,000
Domiciliary expansion	\$490,459	\$8,804
<i>Not directly related to legislation</i>		
Psychosocial and recovery-oriented services	\$21,500,000	\$5,652,638
PTSD and OEF/OIF	\$11,370,699	\$10,690,920
Telemental health	\$3,977,601	\$3,936,013
Community-based outpatient clinic mental health	\$3,525,808	\$194,266
Substance abuse	\$3,188,708	\$3,112,450
Mental health program review	\$1,000,000	\$1,000,000
Mental health intensive case management teams	\$963,016	\$539,419
Inpatient mental health services at two VA facilities in Tennessee	\$778,603	\$773,503
Stand-downs	\$400,000	\$0
Development of educational programs	\$300,000	\$0
Reserved for emerging needs	\$11,900,000	\$11,900,000
Total	\$63,904,287	\$42,308,013

To ensure that funds available for FY 2007 are used effectively and efficiently, procedures for allocated funds have been revised. The processes of allocated funds has been streamlined by emphasizing the need to fill gaps in care and to use available opportunities, rather than responses to requests for proposals; notices of funding are being distributed earlier in the year; and monitoring of the use of funds and the implementation of programs has been enhanced, both to increase accountability and to allow targeting of technical assistance. It should be noted VA is still under a continuing resolution and this may hamper full execution of the Strategic Mental Health Plan in FY 2007.

Question 7: The Administration's FY 2007 budget identifies \$306,110,000 for the mental health initiatives to implement the Comprehensive Strategic Mental Health Plan.

Question 7(a) Does VA plan to reallocate additional funding in FY 2008 to continue new mental health initiatives started in FY 2005 through FY 2007?

Response: Yes, VA intends to provide recurring funding in FY 2008 for initiatives started in FY 2005 through 2007.

Question 7(b) Please provide the Subcommittee with a detailed breakdown of how VA currently plans to allocate and spend the \$306,110,000 in FY 2007.

Response: The breakdown is shown in the following table.

FY 2007 Proposed Budget	2007 Estimate (\$000)
Primary Care/Mental Health.....	\$31,500
Suicide Prevention Counselors.....	\$6,400
Other	\$2,000
Psychosocial Rehabilitation (PSR):	
Staff members for PSR development.....	\$165
Facility & VISN Recovery Coordinators ((160 facilities + 21 VISNs)x\$120,000 roughly).....	\$16,290
Funding from unfunded FY06 RFP proposals after further development.....	\$7,500
Mental Health Intensive Case Management (MHICM): Rural, multiple teams, etc.....	\$825
MHICM Educational/Training staff.....	\$100
Homeless.....	\$15,000
Residential Augmentation.....	\$3,000
Substance Use Disorders:	
Buprenorphine Expansion.....	\$3,375
Other Expansion.....	\$2,250
Mental Health in CBOCs.....	\$15,000
OEF/OIF Outreach.....	\$2,083
PTSD, including Dual Diagnosis.....	\$9,000
Telemental Health.....	\$8,333
Evidence Based Psychotherapy Training Centers (CBT, IPT, MI, PE, PSR approaches, etc.)....	\$4,500
Care Coordination:	
Personnel.....	\$840
Equipment.....	\$1,050
Employee Education Service (EES) Training.....	\$600
Centers of Excellence.....	\$4,500
Gulf Coast Market Survey.....	\$300
Psychogeriatrics.....	\$750
Chaplaincy Initiatives.....	\$338
Recurring Commitments.....	\$170,411
2007 Estimate Total.....	\$306,110

CBT = Cognitive Behavioral Therapy; IPT = Interpersonal Therapy; MI = Motivational Interviewing;
PE = Prolonged Exposure.

Question 7(c) Please identify any monies that VA anticipates will be unspent in FY 2007.

Response: VA does not anticipate any unspent funds in FY 2007, at this time.

Question 7(d) Please identify any monies that will be distributed through VERA.

Response: Mental health initiative funds will not be distributed through VERA in FY 2007.

Question 8: During the hearing, Dr. Cross stated that VA had not planned to use the Defense-VA Brain Injury Center (DVBIC) screen for mild traumatic brain injury (TBI) because of concerns that the screen may not be valid for veterans and that VA would be conducting research to test the DVBIC developed screen with the VA patient population.

Question 8(a) When will VA begin and complete the research to test the validity of the DVBIC developed screen on the VA OIF/OEF patient population?

Response: Screening for TBI is currently in the evidence building stage. Research on TBI screening is a major focus for the Polytrauma/Blast Related Injury Quality Enhancement Research Initiative (QUERI) for the 2007 Fiscal Year. A literature review has been completed and a workgroup has been charged to develop a clinical reminder for the screening of OEF/OIF veterans for possible TBI. This group will identify appropriate follow-up for potential positive screens, and ensure the ability to tabulate statistics at the facility, Network, and national levels on use of the screen, any referrals that result, and outcomes, as appropriate. The group recommendations are due to VHA in spring 2007.

Question 8(b) Until such research is completed, how will VA ensure that OIF/OEF veterans receive routine and standardized screening for mild TBI?

Response: The Under Secretary for Health's Information Letter, Screening And Clinical Management Of Traumatic Brain Injury, provides guidance to VHA primary care clinicians on how to identify and initiate clinical management of TBI in veterans and eligible active duty service members.

To ensure that all VHA health care providers are educated on brain injury sequelae, clinical management, and treatment approaches, completion of a four-hour continuing education course on TBI has been mandated.

Question 8(c) Since FY 2002, how many OIF/OEF veterans were screened for mild TBI? Of these veterans, how many were referred for a follow-up evaluation after screening positive for mild TBI?

Response: VHA's database does not have the capability to differentiate severity of brain injury or a specific screening procedure.

Question 8(d) How many OIF/OEF veterans have received treatment for mild TBI?

Response: VHA does not routinely aggregate this information at a national level, VHA is unable to do so because there is no medical code that allows VA to definitively identify veterans who may have received treatment for a mild TBI. The diagnosis code for concussion (International Classification of Disease (ICD)9. 850.0-850.9) may be associated with a mild brain injury. From October 2001 through June 2006, approximately 326 OEF/OIF veterans with diagnosis codes associated with concussion have been identified as having been treated for a

condition possibly related to TBI. However, there is no direct correlation between the diagnostic code and mild TBI symptoms.

TBI is a wide reaching reference to what is actually numerous codes depicting locations in the brain, involvement skull fractures, and extent of injury. This is not one code with varying degree of complexity—e.g. mild, moderate, and severe.

The ICD-9-CM codes are overseen by a Coordination and Maintenance committee comprised of four cooperating parties that include the American Hospital Association, Centers for Medicare and Medicaid Services, National Center for Health Statistics and the American Health Information Management Association. Proposed changes are submitted to this committee in April for the October annual release. VA will draft a written request for submission to the ICD-9-CM Coordination and Maintenance committee to develop a new code or series of codes to more accurately reflect traumatic brain injury severity.

Question 9: The testimony from the Blinded Veterans Association and the Iraq and Afghanistan Veterans of America raises concerns expressed by families about their frustrations in accessing adequate care for veterans with traumatic brain injury (TBI) once they leave the VA polytrauma centers. How does VA plan to improve coordination of care for veterans with TBI who have left the polytrauma centers?

Response: VA developed the polytrauma system of care (PSC) to improve access to specialized rehabilitation services for TBI and polytrauma to facilitate delivery of care closer to home, and to provide life long case management services for OEF/OIF veterans and active duty service members.

VA facilities participating in the PSC are distributed geographically throughout the country so as to facilitate access to specialized care closer to the home, and to help veterans and their families to transition back into their home communities. Interdisciplinary teams of professionals have been designated at these facilities to work together to develop an integrated plan of medical and rehabilitation treatment for each veteran. In some cases, polytrauma may cause long-term impairments and functional disabilities. VA is committed to provide services and coordinate the lifelong care needs of these individuals.

The four components of the PSC include:

- Polytrauma Rehabilitation Centers (PRCs) – These four regional centers (Richmond, Virginia; Tampa, Florida; Palo Alto; California, Minneapolis, Minnesota) are fully operational. They provide acute comprehensive medical and rehabilitation care for complex and severe injuries and serve as resources for other facilities in the PSC.
- Polytrauma Network Sites (PNSs) – These 21 sites, one in each of the VISNs are also fully operational. Their role is to manage the post-acute effects of TBI and polytrauma and to coordinate life-long rehabilitation services for patients within their VISN.
- Polytrauma Support Clinic Teams (PSCTs) – These teams are currently under development. They include local providers of rehabilitation services who have the expertise to deliver follow up services in consultation with regional and network specialists.
- Polytrauma Points of Contact (PPOCs) – All other facilities will provide local PPOCs. These are smaller facilities without the expertise or resources to meet the rehabilitation and prosthetic needs of the polytrauma patients. Each of these facilities ensures that at least one person is identified to serve as PPOC for consultation and referral of polytrauma patients to a facility capable of providing the level of services required.

Case management has a crucial role in ensuring lifelong coordination of services for patients with polytrauma and TBI, and is an integral part of the system at each polytrauma care site. The PSC uses a proactive case management model, which requires maintaining routine contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the case manager at the referring facility is responsible for a "warm hand off" of care to the case manager at the receiving facility closer to the veteran's home. The assigned case manager handles the continuum of care and care coordination, acts as the PPOC for emerging medical, psychosocial, or rehabilitation problems, and provides patient and family advocacy.

Question 10: Please describe the successes and challenges for expanding telemental health to help rural veterans access specialized mental health care.

Response: Telemental health in VHA involves the use of health information and telecommunications systems to enable delivery of care when veteran patient and clinician are separated by geographical distance. The advantages of telemental health are that it: improves access to mental health services; reduces the need for travel by patients; and is associated with preliminary evidence that it reduces the "no show" rate in clinics.

All levels of mental health providers deliver mental health services using telemental health. Telemental health encounters encompass the spectrum of services from new assessments, medication management, individual, family and group therapies. Telemental health is also being used for specialized programs such as smoking cessation sessions, behavioral interventions, and pain management. Telemental health consultations may involve expert mental health evaluations, screening to a specialty program, performing a VA compensation and pension examination, or administering a diagnostic or psychological test remotely.

VHA has demonstrated a sustained success in expanding access to mental health services for veterans via telemental health. Implementation of care coordination/ general telehealth services that involve real videoconferencing between VAMCs and clinics grew from 290 sites in FY 2004 to 311 sites in FY 2005 (data for FY 2006 is pending). The number of patients in VHA treated via telemental health has grown from 9,750 in FY 2004, to 15,051 in FY 2005 to 19,628 in FY 2006.

In FY 2007 an expansion of telemental health services is anticipated to a further 245 CBOCs. This expansion is expected to provide care to a further 30,040 veterans with mental health conditions. Of these sites for telemental health expansion in VHA 213 (87 percent) are in medically underserved areas. VHA has completed a telemental health training course to support the education of clinicians that is necessary to accompany this expansion by creating a telemental health competent workforce.

VHA has implemented care coordination/home telehealth (CCHT) to support the care of veteran patients with chronic mental health conditions in their homes/local communities. Currently 703 patients are being supported with 50 percent being cared for depression, 7 percent for substance abuse and 21 percent for PTSD. In VISN 1 there are 13 patients and in VISN 19, 199 patients receiving care via CCHT – these are predominantly patients in rural areas.

The main challenges in developing telemental health services is in ensuring that the necessary clinical, technical and business processes are in place so that the services that VHA develops are robust and sustainable. VHA is providing increasing levels of care to veterans in rural areas via telemental health by having the necessary processes in place to ensure the robustness and sustainability of its telehealth services.

**Department of
Veterans Affairs**

Memorandum

Date: February 3, 2004

From: Chief Officer, Readjustment Counseling Service (15)

Subj: Vet Center Outreach to veterans returning from the Global War on Terrorism

To: Under Secretary for Health (15/10)

THRU: Deputy Under Secretary for Health (10A) *1/4*

The purpose of this memorandum is to request approval for authorizing Department of Veterans Affairs (VA) Vet Centers to provide outreach services specifically geared to locate, inform, and engage veterans returning from the Global War on Terrorism.

Provisions in Current Law: Authority for this initiative is found in title 38, United States Code, Section 1712A as amended by Public Law 104-262 in October 1996. The latter legislation extended eligibility for Vet Center services to any veteran who served in the active military in any war, or in any area during a period of armed hostilities.

Background:

Legislative Response to Gulf War One: In 1991, on the day the ground war began in the Persian Gulf, the Secretary of Veterans Affairs requested and the Chairman of the Senate Committee on Veterans Affairs introduced legislation to extend eligibility for readjustment counseling at VA Vet Centers to veterans of the Gulf War. The Secretary's legislative request included \$1.4 million additional dollars for fiscal year 1991 and another \$4.4 million to be spread out over the next five years. Public Law 102-25 was passed into law in April 1991 extending Vet Center program eligibility to all post-Vietnam era veterans who served in an area of armed hostilities. Public Law 102-27, the Dire Emergency Supplemental Appropriations for Consequences of Operation Desert Shield/Desert Storm.... Act of 1991, was also passed in April 1991. The latter contained a \$25 million supplemental appropriation for unbudgeted VA medical expenses resulting from the Gulf War. Of that amount, \$1.4 million were earmarked for readjustment counseling through the Vet Center program.

Vet Center Program Utilization of Supplemental Appropriation: Utilizing emergency funds supplied by Congress, RCS hired 84 temporary counselors in fiscal year 1991, primarily to provide outreach and counseling to the new veterans returning from the Gulf War. The additional staff was instrumental in enabling the Vet Center program to provide timely outreach, education and other services to the new veterans and family members, thereby freeing up regular staff to serve the increasing numbers of re-traumatized older veterans responding to the news about the war.

Outcome Indicator: The final report of The Presidential Advisory Committee on Gulf War Illnesses, March 7, 1997, cited the Vet Centers as providing exemplary outreach services to contact and inform over 100,000 Gulf War veterans. The Committee recommended that other VHA services and programs adopt Vet Center strategies for outreach on behalf of improving services to Gulf War veterans.

Readjustment Counseling GWOT Outreach Services

Pursuant to the provisions of 38 U.S.C., Section 1712A, the Secretary of Veterans Affairs has approved extension of eligibility for readjustment counseling at Vet Centers to veterans who served in the Global War on Terrorism (1) in Afghanistan in Operation Enduring Freedom and (2) in Iraq in Operation Iraqi Freedom. To date the Vet Centers have seen approximately 4,000 GWOT veterans.

Pursuant to the provisions in 38 U.S.C., Sections 1712A, 1782 and 1783, the Secretary of Veterans Affairs authorized the Vet Centers to provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. The Vet Centers are now actively providing bereavement counseling to military family members whose loved ones were killed on active duty in Afghanistan and Iraq.

As reported in the May/June edition of the Vanguard, Vet Centers across the nation reported an increase in visits from veterans and family members during the onset of Operation Iraqi Freedom. Vet Centers reported a 9 percent increase in visits by veterans and a 12 percent increase in family visits for March 2003, as compared to the same period in 2002.

In April 2003, the Chief Readjustment Counseling Officer directed the Vet Centers system-wide to commence outreach operations specifically geared to locate, inform and engage veterans returning from the Global War on Terrorism. Such outreach included visits to military installations with particular attention to National Guard and Reserve personnel returning to their home communities following deployment to Afghanistan or Iraq. Vet Center outreach to military installations also included coordination with local military family assistance centers. The Vet Centers were also directed to initiate early services to veterans returning from the Global War on Terrorism to include the following specific guidelines:

- Any family members of soldiers killed in action in OEF or OIF can be provided readjustment counseling.

- Any OEF or OIF soldier wounded in action, and their family members, can be provided with readjustment counseling services once separated from the military.
- All family members of military personnel deployed in OEF and OIF can receive outreach services, educational information, preventive care, and case management and referral services.
- Vet Centers have provided services to over 4,000 GWOT returning servicemen/women. Additionally, they have provided information and supportive services to many families across the country.

The provision of outreach services to GWOT returning service men/women is consistent with the mission of VA "To care for him who shall have borne the battle, and for his widow, and his orphan." This initiative is also consistent with the spirit of VA's strategic goals as specified in the Secretary's Strategic Plan for Employee's for 2001-2006. The four strategic goals are particularly relevant in this regard:

- **Restore the Capability of Disabled Veterans to the Greatest Extent Possible and Improve their Quality of Life and That of Their Families.**
- **Ensure a Smooth Transition for Veterans from Active Military Service to Civilian Life.**
- **Honor and Serve Veterans in Life and Memorialize Them in Death for Their Sacrifices on Behalf of the Nation.**
- **Contribute to the Public Health, Socioeconomic Well Being, and History of the Nation.**

The spirit of all four of these strategic goals is well served through provision of care to returning soldiers and their families who have been put in harms way in serving their country in a combat theatre of operations.

Client Target Population

The population of veteran clients for this service initiative includes any veteran or active military member who has served in-country as a part of the Global War on Terrorism and their families. Based upon data provided by the Department of Defense's (DOD) Manpower Data Center in California, the total number of active duty personnel deployed to Operation Iraqi Freedom (OIF) is 483,000. Of that total 336,000 are active military and 102,000 are Reserve and National Guard personnel combined. DOD has also provided information indicating that approximately 89,000 veterans returning from OIF have separated from the military and who are thereby eligible for veterans'

benefits. DOD has additionally indicated recently that there will be an influx of more veterans returning from OIF in the near future. They also report that the volume of soldiers returning will present challenges in meeting all of their perceived needs. Based upon 24 years of experience providing outreach and readjustment counseling to returning war veterans, the Vet Center program has a well informed organizational history of providing services for the psychological and social readjustment needs to other returning troops like those returning from the Gulf War of 1991, and other post-Vietnam era war veterans such as those returning from Somalia and the former Republic of Yugoslavia. For every war and armed conflict since Vietnam, the Vet Center program has functioned as VA's first line of contact for troops returning from the combat theater. VA's extension of timely outreach and counseling services to these most recent combatants will help to prevent possible development of more chronic and delayed forms of war-related trauma.

Recommendation

Specifically this recommendation is to augment Vet Centers with temporary positions to provide outreach to Global War on Terrorism Veterans modeled after the initiative for Gulf veterans. We recommend 50 national temporary positions (at 3.8m per year) to be added to the RCS specific purpose account. These positions are to be located on or near military out processing stations and reserve and National Guard facilities. Given the two year time window of VA eligibility for reserve and National Guard servicemen/women, the positions would be needed for at least three years to provide these outreach services to returning troops. These veteran temporary employees would augment Vet Center services in providing briefing services at active military, reserve, and national-guard stations to transitioning servicemen/women regarding the spectrum of VA services available to them and their families. They would also organize local community activities to provide information and education about VA, DOD, and other community support systems. Special attention would be paid to localities where there are military bases where veterans are being discharged, as well as more rural Reserve and National Guard locations. The outreach effort would focus on military related readjustment issues impacting on those who have served in the GWOT.

A. Batres
Alfonso R. Batres, Ph.D.

Approved ✓ However, TEMPORARY EMPLOYEES SHOULD
have SERVICE IN OIF/OEF
WHENEVER POSSIBLE. THIS
WILL ASSURE THEIR ABILITY
TO QUICKLY REACT TO
RETURNING VETERANS WHO
ARE IN THIS "PEAK"
GROUP.

Disapproved

J. Roswell
Robert H. Roswell

**Department of
Veterans Affairs****Memorandum**

Date: November 23, 2004

From: Chief Officer, Readjustment Counseling Service, 15

Subj: Nashville, TN Vet Center

To: Under Secretary for Health, 10

1. This memorandum is written to request approval to establish a new Vet Center in Nashville, Tennessee. The Nashville Vet Center would be supported by the Tennessee Valley Health Care System – Nashville Campus (VAMC 626) within the VA Mid South Healthcare Network (VISN 9).
2. The establishment of a Vet Center in Nashville would address the mental health and readjustment needs of underserved veterans in central and northwestern Tennessee and is consistent with the needs identified by VISN 9 senior management.
3. The proposed Nashville Vet Center would be located in Davidson County (Tennessee 5th Congressional District) and serve veterans and their families living in Williamson, Rutherford, Wilson, Trousdale, Sumner, Robertson, Cheatham, Montgomery, Stewart, Houston, Dickson, Humphreys, Hickman, Maury, Marshall, Bedford, Henry, Carroll, Benton, Perry, Lewis, Henderson, Decatur, Hardin, Wayne, Lawrence, Giles, Lincoln, Cannon, De Kalb, Smith, Macon, Clay, Jackson, Overton and Putnam Counties (Tennessee 4th, 6th, 7th, & 8th Congressional Districts). In addition, the Nashville Vet Center would provide services to out processing veterans from Fort Campbell, home of the 101st Airborne Division (Air Assault).
4. The proposed catchment area contains 193,358 veterans. All of these veterans currently reside at least 65 miles, with many over 150 miles, from the nearest existing Vet Center.
5. There are currently four Vet Centers in Tennessee, all located between 100 and 250 miles from Nashville {Chattanooga Vet Center, 109 miles, Knoxville Vet Center, 161 miles, Memphis Vet Center, 173 miles, and Johnson City Vet Center, 247 miles}. Access to Vet Center services for all veterans and family members living in the counties identified in the proposed catchment area would be improved by establishing a Vet Center in Nashville.

6. The staffing of the proposed Vet Center would consist of one (1) Vet Center Team Leader (GS-12), three (3) Vet Center Counselors (GS-11), and one (1) Vet Center Office Manager (GS-6). The estimated staffing costs (5 Recurring FTEE) would be as follows:

Position	Grade	Base	Benefits	Total
Team Leader	GS-12/5	\$66,486	\$19,946	\$ 86,432
Counselor	GS-11/5	\$55,472	\$16,642	\$ 72,114
Counselor	GS-11/5	\$55,472	\$16,642	\$ 72,114
Counselor	GS-11/5	\$55,472	\$16,642	\$ 72,114
Office Manager	GS-6/5	\$33,731	\$10,119	\$ 43,850
Grand Total				\$346,623

7. The establishment of the proposed Vet Center would require 3000 square feet of leased office space within the local community. This would be consistent with the RCS mission and legislative mandate of providing services to combat veterans in a non-medical setting in or near their community. The estimated recurring lease costs would be \$31.200 (3000 square feet @ \$10.40 per square foot per annum). In addition, \$15,000 in recurring operating funds (GSA vehicle, telephone, supplies, etc.) would be needed.
8. The request to establish a Vet Center in Nashville, Tennessee would require \$392.823 in recurring costs and 5 FTEE. Thank you for your consideration in this matter.

ALFONSO R. BATRES, Ph.D., M.S.S.W.
Chief Officer, Readjustment Counseling Service, 15

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Acting Deputy Under Secretary for Health, 10A

Approve Disapprove

DEC 02 2004

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Acting Under Secretary for Health, 10

**Department of
Veterans Affairs****Memorandum**

Date: March 28, 2005

From: Chief Officer, Readjustment Counseling Service, 15

Subj: Vet Center Outreach to Veterans Returning from Global War on Terrorism

To: Under Secretary for Health, 10

THRU: Deputy Under Secretary for Health *10A myk*

1. The purpose of this memorandum is to recommend approval to further augment the Department of Veterans Affairs (VA) Vet Centers with an additional 50 employees hired from the ranks of veteran returnees from the Global War on Terrorism (GWOT). As with the program's original 50 GWOT employees, these veterans will also be used specifically to provide timely outreach services specifically geared to locate, inform, and engage veterans returning from Afghanistan and Iraq. The February 3, 2003 memorandum requesting the original 50 GWOT employees is attached for background (Attachment 1).

Readjustment Counseling Service GWOT Outreach Services

2. Pursuant to the provisions of 38 U.S.C., Section 1712A, the Secretary of Veterans Affairs has approved extension of eligibility for readjustment counseling at Vet Centers to veterans who served in the Global War on Terrorism (1) in Afghanistan in Operation Enduring Freedom and (2) in Iraq in Operation Iraqi Freedom. To date the Vet Centers have had substantive contact with approximately 16,000 GWOT veterans, with over half of these veterans and their family members receiving ongoing readjustment services in the Vet Center.

Pursuant to the provisions in 38 U.S.C., Sections 1712A, 1782 and 1783, the Secretary of Veterans Affairs authorized the Vet Centers to provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. The Vet Centers are now actively providing bereavement counseling to military family members whose loved ones were killed on active duty in Afghanistan and Iraq. To date over 300 families (over 450 family members) have received assistance from Vet Center counselors.

3. As instituted in April 2003 by the Chief Readjustment Counseling Officer, the Vet Center program is actively conducting outreach operations specifically geared to locate, inform and engage veterans returning from the Global War on Terrorism. Such outreach includes visits to military installations with particular attention to National Guard and Reserve personnel returning to their home communities following deployment to

Afghanistan or Iraq. Vet Center outreach to military installations also includes coordination with local military family assistance centers. The Vet Centers are also initiating early readjustment counseling services to facilitate a seamless transition for veterans returning from the Global War on Terrorism to include the following:

- Family members of soldiers killed in action in OEF or OIF are provided readjustment and/or bereavement counseling.
 - All OEF or OIF soldiers wounded in action, and their family members, are eligible for provision of readjustment counseling services once separated from the military.
 - All family members of military personnel deployed in OEF and OIF can receive outreach services, educational information, preventive care, and case management and referral services.
4. As reported above, Vet Centers have provided substantive services to over 16,000 GWOT returning servicemen/women. This number, however, does not represent a major proportion of the overall veterans contacted nation-wide via outreach activities conducted by the Vet Centers. A significant amount of outreach activity is not recorded because the encounters do not include sufficient substantive one-on-one interaction with Vet Center staff to enable collecting veterans' demographic data. To more accurately account for the outcome of the GWOT veteran outreach initiative, the Chief Readjustment Counseling Officer directed a monthly report from each RCS Regional Manager's Office of the number of outreach activities and the number of veterans and/or family members contacted for each Vet Center in the region and aggregated regional totals. These reports will also give particular attention to the activities of the GWOT veteran outreach counselors. This report is specifically designed to capture productivity for those outreach activities that are primarily educational and that do not result in sufficient one-on-one contact with individual veterans for collection of demographic information.
5. As an example of the types of outreach activities currently provided by the Vet Centers to facilitate services to returning GWOT veterans, the following is a recent collaborative initiative organized by the RCS Northeast Region Vet Centers and the New Hampshire National Guard. This event provided outreach, education and assessment for 800 National Guard troops returning from the combat theaters of OEF/OIF. This initiative was spearheaded by the Team Leader and the GWOT outreach worker of the Manchester, NH, Vet Center. From January through March 2005, VA collaborated with the New Hampshire National Guard to provide educational briefings and clinical assessments to over 800 National Guard personnel returning from OEF/OIF. During this time period, seven distinct groups of approximately 150 returning soldiers each rotated through the outreach and educational sessions. The sessions took place at the National Guard Armory and the Manchester VAMC. The VA was represented by Vet Center clinicians, VA medical center staff, and VBA representatives from the VA Regional Office. The seven sessions combined totaled 15 working days and over 900 individual counseling hours. Services provided were an organized forum of VHA and VBA briefing information. The Vet Center contribution was unique in including, along with educational briefings about Vet Center services, a one-on-one hour long clinical assessment for symptoms of acute stress and other military-related problems for each returning soldier. Fifty percent of the 800 veterans screened requested a 30 day follow-up appointment at their local Vet Center. The initiative included 27 Vet Center service providers from 16 Vet Centers in New England. Congressional representatives in other

New England states have requested similar sessions for returning soldiers in their respective states.

6. Based upon 25 years of experience providing outreach and readjustment counseling to returning war veterans, the Vet Center program has a well informed organizational history of providing services for the psychological and social readjustment needs to other returning troops like those returning from the Gulf War of 1991, and other post-Vietnam era war veterans such as those returning from Somalia and the former Republic of Yugoslavia. For every war and armed conflict since Vietnam, the Vet Center program has functioned as VA's first line of contact for troops returning from the combat theater. VA's extension of timely outreach and counseling services to these most recent combatants will help to prevent possible development of more chronic and delayed forms of war-related trauma.
7. Community outreach and other accommodations to improve access to care for veterans are essential to veterans' readjustment and successful transition to civilian life. This is true both from the standpoint of ensuring timely provision of services for new eras of veterans returning from combat and peace-keeping missions, as well as, for overcoming psychological and cultural barriers to care associated with the avoidance tendencies of traumatic war-time experiences. Traumatized war veterans frequently present with stigmas about accessing services. In this regard, Vet Center counselors are especially effective in forging alliances with local veterans through outreach contacts in the community, helping veterans relax negative attitudes via a safe and accepting environment and in initiating more formal individual and/or group counseling at the Vet Center. Outreach conducted by fellow veterans of the same era with similar war-time experiences generates immediate rapport and accelerates the process of engaging the veteran in a meaningful therapeutic relationship.

Client Target Population

8. Authority for readjustment counseling is found in Title 38, United States Code, Section 1712A as amended by Public Law 104-262 in October 1996. The latter legislation extended eligibility for Vet Center services to any veteran who served in the active military in any war, or in any area during a period of armed hostilities. Therefore, the population of veteran clients eligible for this extended service initiative includes any veteran or active military member who has served in-country as a part of the Global War on Terrorism and their family members. VHA reports that as of January 14, 2005, 244,054 veterans have returned from the combat theaters in Afghanistan and Iraq, and that approximately 45 percent of these are National Guard and Reserve component personnel. Difficulties related to obtaining reliable estimates of total troop strength for OEF and OIF from the Department of Defense precludes the practicality of attempting to estimate the baseline population for the purpose of this request. However, there is no reason to assume a reduction in returning veterans for the foreseeable future. Of note in this regard is VHA's institutionalization of the activities of its Seamless Transition Task Force into a permanent Seamless Transition Program Office.

Recommendation

9. Specifically this request consists of two recommendations as follows:

- I. It is recommended that VHA augment the Vet Center program by an additional 50 three-year term temporary positions to provide outreach to Global War on Terrorism veterans, and to be located in each of the fifty states near military out processing stations and Reserve and National Guard facilities. Existing nonrecurring personal service funding will cover the additional costs of any new hires for FY 2005. \$1 million add on will be required for FY 2006 and \$1.3 million for FY 2007. To facilitate the implementation of these additional hires, it is recommended that VHA senior management take steps as necessary to promote this initiative to VA Human Resources Service to ensure timely selections for these vital positions. This includes guidance to field stations regarding use of appointing authorities such as Veteran's Recruitment Appointments (VRA).

- II. It is recommended that VHA take the necessary measures to convert the original existing 50 term positions authorized in February 2004 to career/career conditional status with recurring personal service funding of \$2.4 million per year beginning in FY 2006. This initiative would be of value to VA as an effective means of recruiting new full time veteran employees. A pool of motivated and skilled veteran service providers is a sound investment in VA's future and long term commitment to serving this generation of veterans.

Cost Projections

10. Given that current GWOT funding level remains constant:

FY 05	No cost (given the lateness into the fiscal year and RCS efficiencies, RCS can effect with no funding for FY05)
FY 06	\$1.1 million
FY 07	\$1.3 million
FY08	\$1.5 million

Alfonso R. Bates
Alfonso R. Bates, Ph.D., M.S.S.W.

Concur / Non-Concur

Michael J. Kussman
Michael J. Kussman, M.D., M.S., MACP

Approved: ✓

Disapproved: _____ Date: 3-30-05

Jonathan B. Perlin
Jonathan B. Perlin, M.D., Ph.D., MSHA, FAACP

Attachments

**Department of
Veterans Affairs****Memorandum**

Date: April 18, 2006

From: Chief Readjustment Counseling Officer (15)

Subj: RCS Program Augmentation 2006

To: Under Secretary for Health (10)

Through: Principal Deputy Under Secretary for Health (10A) *[initials]*

1. The purpose of this memorandum is to recommend approval to augment the Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS-15) with 2 additional Vet Centers, 11 additional FTEE to augment staff at existing Vet Centers, and conversion of the second 50 Global War on Terrorism {GWOT} Outreach Specialists from term to career status. The augmentation will address increased demand for readjustment counseling services over the last several years.

Readjustment Counseling Service (RCS)

2. The RCS Vet Center program is a special VHA program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theater of operations. VA's Vet Center program consists of 207 community-based Vet Centers located outside the larger medical facilities, in easily accessible, consumer friendly facilities. The Vet Center program's service mission is beyond medical care featuring a holistic mix of professional readjustment counseling for war trauma and other social readjustment problems, family readjustment counseling, and multiple community-based services to include outreach, education, extensive case-management and referral. Authorizing legislation is found in Public Law 96-22, all associated House and Senate Reports, and subsequent amendments where it is outlined that, "Within the context of readjustment counseling, each vet center is tasked with three major functions: outreach, direct service delivery, and referral. A readjustment problem does not usually amount to a definable psychiatric illness requiring extended professional services but could become such an illness in the absence of early detection and counseling and follow up care where necessary. Thus, in the sensitive field of readjustment counseling, it is essential that services be available and accessible on an outpatient basis, and that all unnecessary barriers to help be removed. Most importantly, the veteran must understand that seeking readjustment counseling does not imply or result in a diagnosis of mental illness."
3. Each Vet Center is staffed by a small multidisciplinary team and nationally the Vet Centers maintain a majority of combat theater veterans as direct service providers. Current law defines eligibility for readjustment counseling to include any veteran who

served in the active military in a theater of combat operations during any period of war, or in any other area during a period in which hostilities occurred in such area

4. In FY 2005 the Vet Centers provided 1,046,628 (including 23,476 documented outreach contacts) visits to 132,853 veterans and their families. This represents an increase of 9,477 veterans and 14,863 veteran visits from the previous fiscal year. Each Vet Center readjustment counseling service provider averaged 6.7 veteran visits per day.
5. In meeting the readjustment counseling mandate to veterans as defined by the authorizing legislation, Vet Centers provide both social and psychological services to veterans and their families. According to a GAO audit in 1996 (GAO/HEHS-96-113), Vet Centers and medical centers generally serve different clients and missions. In contrast to VA medical facilities, Vet Centers do not provide inpatient care or medical prescriptions, but do provide services that medical facilities cannot or do not provide. Such services include community-based outreach; social, economic, and family readjustment counseling; and bereavement services for surviving military family members. As originally documented in their 1996 audit, GAO found that from 30 to 40 percent of Vet Center unique clients are not seen in any other VA facility. As consistently documented in succeeding years, these veterans constitute a core group of frequent users who access Vet Center care primarily for psychological war trauma and other social readjustment problems. Most of the visits provided by the Vet Centers are devoted to this core group of veteran users. In FY 2005, 47,860 of all veterans served were not seen at any other VHA facility. This core group of RCS clients represents over 36% of veterans receiving services in the Vet Centers and is an increase of 29.2% from FY 2004's core group.
6. Pursuant to the provisions of 38 U.S.C., Section 1712A, the Secretary of Veterans Affairs approved extension of eligibility for readjustment counseling at Vet Centers to veterans who served in Operation Enduring Freedom (OEF) in April 2003 and Operation Iraqi Freedom (OIF) in June 2003. An indication of the Vet Centers emphasis on outreach to OEF/OIF veterans is the rate of market penetration. From 1991 through 2005 RCS provided services to 10% of the 603,820 veterans who served in Operation Desert Shield/Storm (ODS). RCS initiated service provision and outreach efforts to OEF/OIF veterans in late 2003, and by the end of February 2006 has already provided readjustment counseling to 41,838 separated veterans and outreach services to 76,973 OEF/OIF veterans. This represents services to 118,811 of the 547,218 (21.7%) veterans separated. RCS has reached a much higher market penetration with the newest cohort of combat veterans in 3 years, over twice the level that took 14 years to accomplish with the previous cohort of combat veterans.
7. The final report of The Presidential Advisory Committee on Gulf War Veterans' Illnesses, March 7, 1997, cited Vet Centers as providing exemplary outreach services to contact and inform Gulf War veterans of VA services. The committee recommended that other VHA services and programs adopt Vet Center strategies for outreach to improve services to combat veterans. The Vet Center ODS outreach served as the model for outreach to OEF/OIF veterans and drove the hiring of 50 GWOT Outreach Specialists

beginning in February 2004 and an additional 50 Specialists beginning in March of 2005. The hiring of GWOT Outreach Specialists, all of which are themselves OEF/OIF veterans directly supports the VA Secretary's "Fulfilling the Commitment - Coming Home to Work" initiative. RCS GWOT Outreach Specialists are now averaging over 13,000 outreach contacts each month with newly returning OEF/OIF veterans and their families. If current trends continue as anticipated this will annualize to over 156,000 contacts for FY 2006.

8. Pursuant to the provisions of 38 U.S.C., Section 1712A, 1782 & 1783, the Secretary of Veterans Affairs authorized the Vet Centers to provide bereavement counseling services to surviving family members of Armed Forces personnel who died while on active duty in service to our country. Through March 2006 the families of 632 fallen Service Members (983 family members) have received assistance from Vet Center counselors.

Recommendation

9. Specifically this request consists of the following recommendations:
 - a. Establish 2 New Vet Centers in high demand areas.
 - b. Staff Augmentation of 11 Existing Vet Centers.
 - c. Conversion of 50 GWOT Outreach Specialists to Career/Career Conditional.

Cost Projection

10. The cost projections (see attached spreadsheet) for each recommendation are:

- a. **\$800,000** (2 Vet Centers, 8 FTEE)
- b. **\$700,000** (11 FTEE)
- c. **\$3,000,000** (50 FTEE)
\$2.5 million currently funded for FY 2006 & FY 2007 (Non-Recurring). Request conversion of existing \$2.5 million to Recurring, plus an additional \$500,000.

TOTAL REQUEST: \$4,500,000 {Recurring}

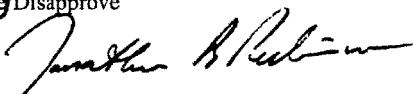
ALFONSO R. BATRES, Ph.D., M.S.S.W.
Chief Officer, Readjustment Counseling Service, 15

Concur/Non-Concur



MICHAEL KUSSMAN, MD, MS, MACP
Principal Deputy Under Secretary for Health, 10A

Approve/Disapprove



JONATHAN B. PERLIN, MD, PhD, MSHA, FACP
Under Secretary for Health, 10

Based upon an agreement between the Chief Readjustment Counseling Officer and the Chief Financial Officer, recurring VHA funding for the RCS Program Augmentation will begin in fiscal year 2007. No additional funding for the remainder of FY 2006 is required.

A. New Vet Centers – High Demand Areas (2 Vet Centers)

1. Atlanta, GA

Criteria:

- a. Total Population of the catchment area – 1,178,566
- b. Veteran population – 468,005
- c. FY 2005 Market Penetration = 0.369 RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 9.1 RANKING – FAIR (7.7 -12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.735: RANKING – **TOP** (2,300 and above Visits)
- f. OVERALL STATISTICAL RANKING – 1st of 206
- g. Targeted outreach and service provision to African American veterans (62 % in Atlanta city limits, 31.8% in Atlanta Metropolitan Statistical Area (MSA)).
- h. Collaboration with the Atlanta VA Medical Center and the Atlanta Midtown CBOC.
- i. Area growth rate of since 1990 census: 5.8%
- j. Georgia Army National Guard maintains 90 armories, and is present in 73 communities - State Area Command, 78th Troop Command, 48th Infantry Brigade (Mechanized), 265th Engineer Group, 1st Aviation Group, 122nd Regiment (RTI)

2. Phoenix, AZ

Criteria:

- a. Total Population of the catchment area – 2,111,705
- b. Veteran population – 315,323
- c. FY 2005 Market Penetration = 0.392: RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 8.1: RANKING – FAIR (7.7 -12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 1.426: RANKING – FAIR (1,200 – 1,799 Visits)
- f. Phoenix is the largest metropolitan area in the country served by only one existing Vet Center (sixth largest metropolitan area in the United States).
- g. Diverse city with high number of Native American, Hispanic and African American veterans
- h. Collaboration with Carl T. Hayden VA Medical Center, Southeast Health Care Extension Clinic, the Northwest Health Care Extension Clinic, Buckeye Health Care Extension Clinic, and the Show Low Health Care Extension Clinic.
- i. Area growth rate of since 1990 census: 20.3%
- j. Arizona Army National Guard maintains 45 armories, and is present in 22 communities - State Area Command, 98th Troop Command, 385th Aviation Regiment, 153rd Field Artillery Brigade 158th Regiment (RTI), 91st WMD CST, The Western Army National Guard Aviation Training Site, (WAATS) Silverbell

- Army Heliport Marana, Arizona. Co-located at the heliport is the 385th Attack Regiment, 1st Battalion, 285th Aviation Brigade
- k. Marine Corps Reserve: Bulk Fuel Company C, 6th Engineer Support Battalion, 4th FSSG Detachment 7, Engineer Support Company, 6th Engineer Support Battalion, 4th FSSG

B. Staff Augmentation – High Demand Areas (11 FTEE – 1 per Site)

1. Little Rock, AR

Criteria:

- a. 246,446 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 0.284: RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 8.95: RANKING – FAIR (7.7-12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.506: Ranking – **TOP** (2,300 and above)
- f. OVERALL STATISTICAL RANKING – 2nd of 206
- g. The Arkansas Army National Guard maintains 75 armories, and is present in 74 communities. State Area Command, 87th Troop Command, 39th Infantry Brigade (Light) (Separate), 142nd Field Artillery Brigade, 233rd Regiment (RTI), 61st WMD CST

2. Ft. Wayne, IN

Criteria:

- a. 250,693 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 0.4855: RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 5.52: RANKING – **GOOD** (4 - 7.7 Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 1,404: Ranking – FAIR (1,200 -1,799 Visits)
- f. OVERALL STATISTICAL RANKING – 5th of 206
- g. The Indiana Army National Guard maintains 79 armories, and is present in 69 communities. State Area Command, 81st Troop Command, 38th Infantry Division, 76th Infantry Brigade (Separate), 138th Regiment (RTI)

3. Columbus, OH

Criteria:

- a. 211,457 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.8
- c. FY 2005 Market Penetration = 0.3414: RANKING – **TOP** (0.5 or below)

- d. FY 2005 Visits per Client = 11.98: RANKING – FAIR (7.7 -12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 1.913: Ranking – **GOOD** (1.800 – 2.299)
- f. OVERALL STATISTICAL RANKING – 6th of 206
- g. The Ohio Army National Guard maintains 54 armories, and is present in 51 communities. – State Area Command, 73rd Troop Command, 37th Armored Brigade, 16th Engineer Brigade, 145th Regiment (RTI), 52nd WMD CST
- h. Marine Corps Reserve: Lima Company, 3rd Battalion, 25th Marines, 4th Marine Division

4. East St. Louis, IL

Criteria:

- a. 137,359 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 1.5
- c. FY 2005 Market Penetration = 0.4183: RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 9.3: RANKING – FAIR (7.7 -12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 1.829: Ranking – **GOOD** (1.800 – 2.299)
- f. OVERALL STATISTICAL RANKING – 9th of 206
- g. Illinois Army National Guard maintains 59 armories, and is present in 50 communities – State Area Command, 65th Troop Command, 33rd Area Support Group, 66th Infantry Brigade, 129th Regiment (RTI), 5th WMD CST - Bartonville

5. Johnson City, TN

Criteria:

- a. 146,122 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 1.5
- c. FY 2005 Market Penetration = 0.4122: RANKING – **TOP** (0.5 or below)
- d. FY 2005 Visits per Client = 8.65: RANKING – FAIR (7.7 -12 Visits per Client)
- e. FY 2005 annual Visits per Direct Service FTEE = 1.954: Ranking – **GOOD** (1.800 – 2.299)
- f. OVERALL STATISTICAL RANKING – 10th of 206
- g. Tennessee Army National Guard maintains 109 armories, and is present in 91 communities. State Area Command, 30th Troop Command, 194th Engineer Brigade, 196th Field Artillery Brigade, 230th Area Support Group, 278th Armored Cavalry Regiment, 117th Regiment (RTI)

6. Orlando, FL

Criteria:

- a. 303,647 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 0.6204: RANKING – **GOOD** (0.5 to .944)
- d. FY 2005 Visits per Client = 4.75: RANKING – **GOOD** (4 – 7.734 Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.009: Ranking – **GOOD** (1,800 – 2,299)
- f. OVERALL STATISTICAL RANKING – 11th of 206
- g. Florida Army/Air National Guard maintains 72 armories, and is present in 63 communities. State Area Command, 83rd Troop Command, 53rd Infantry Brigade (Sep) (Light), 50th Area Support Group, 32nd Army Air & Missile Defense - Detachment 1, 211th Regiment (RTI)
- h. Marine Corps Reserve: 4th Air Naval Gunfire Liaison Company (4th ANGLICO), MARFORRES

7. Savannah, GA

Criteria:

- a. 207,294 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 0.6421: RANKING – **GOOD** (0.5 to .944)
- d. FY 2005 Visits per Client = 5.43: RANKING – **GOOD** (4 – 7.734 Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 1.906: Ranking – **GOOD** (1,800 – 2,299)
- f. OVERALL STATISTICAL RANKING – 12th of 206
- g. Georgia Army National Guard maintains 90 armories, and is present in 73 communities - State Area Command, 78th Troop Command, 48th Infantry Brigade (Mechanized), 265th Engineer Group, 1st Aviation Group, 122nd Regiment (RTI)

8. Raleigh, NC

Criteria:

- a. 91,041 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 0.8419: RANKING – **GOOD** (0.5 to .944)
- d. FY 2005 Visits per Client = 11.5: RANKING – FAIR (7.734 - 12 Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.589: Ranking – **TOP** (2,300 or above)
- f. OVERALL STATISTICAL RANKING – 16th of 206

- g. North Carolina Army/Air National Guard: State Area Command, 60th Troop Command, 30th Heavy Separate Brigade, 30th Engineer Brigade, 113th Field Artillery Brigade, 449th Aviation Group (lift), 139th Regiment - Fort Bragg, 42nd WMD CST

9. Columbia, SC

Criteria:

- a. 127,942 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.0
- c. FY 2005 Market Penetration = 1.0192: RANKING – FAIR (.945 – 1.5)
- d. FY 2005 Visits per Client = 5.5: RANKING – **GOOD** (4 – 7.734 Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.380: Ranking – **TOP** (2.300 or above)
- f. OVERALL STATISTICAL RANKING – 22nd of 206
- g. South Carolina Army National Guard maintains 86 armories, and is present in 80 communities - State Area Command, 59th Troop Command, 151st FA Brigade, 218th Infantry Brigade, 228th Signal Brigade, 263rd ADA Brigade, 218th Regiment (Ldr), 43rd WMD CST - Eastover

10. Fayetteville, NC

Criteria:

- a. 133,502 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.5
- c. FY 2005 Market Penetration = 3.7095: RANKING – Poor (Above 1.5)
- d. FY 2005 Visits per Client = 2.1: RANKING – **TOP** (3.99 or below Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 2.961: Ranking – **TOP** (2.300 or above)
- f. OVERALL STATISTICAL RANKING – 23rd of 206
- g. Market penetration is high due to extensive outreach at Ft. Bragg with many separating Service Members who leave the area.
- h. Ft. Bragg, NC
 - i. Post population – 43,000 Service Members
 - ii. Power Projection Platform 253 Units, 48,236 Service members
 - iii. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Bragg – 5,600 (calendar year 2005)
 - iv. Active Duty Service Members deployed from / redeployed to Ft. Bragg – 9,300 (calendar year 2005)
 - v. Major Units: XVIII Airborne Corps, 16th Military Police Brigade, 18th Aviation Brigade Corps (Airborne), 18th Corps Soldiers Support Group, 18th Personnel Group, 20th Engineer Brigade (Airborne), 35th Signal Brigade, 44th Medical Brigade, 82nd Replacement Detachment, 525th Military Intelligence Brigade, 1112th Signal Battalion, 1st Brigade / 82nd

Airborne Division, 2nd Brigade / 82nd Airborne Division, 3rd Brigade / 82nd Airborne Division, Dragon Brigade, USA JFK Special Warfare Center, USA Special Operation Command

- i. North Carolina Army/Air National Guard: State Area Command, 60th Troop Command, 30th Heavy Separate Brigade, 30th Engineer Brigade, 113th Field Artillery Brigade, 449th Aviation Group (Lift), 139th Regiment - Fort Bragg, 42nd WMD CST

11. Sioux Fall, SD

Criteria:

- a. 48,577 Veterans in catchment area
- b. FY 2005 Direct Service FTEE = 2.0
- c. FY 2005 Market Penetration = 4.020: RANKING – Poor (Above 1.5)
- d. FY 2005 Visits per Client = 3.2: RANKING – **TOP** (3.99 or below Visits)
- e. FY 2005 annual Visits per Direct Service FTEE = 3.111: Ranking – **TOP** (2.300 or above)
- f. OVERALL STATISTICAL RANKING – 24th of 206
- g. The South Dakota Army National Guard maintains 32 armories, and is present in 31 communities. State Area Command, 88th Troop Command, 147th Field Artillery Brigade, 109th Engineer Group, 196th Regiment (RTI) - Ft Meade, 1st Battalion (GS), 82nd WMD CST.

C. Conversion of 50 GWOT Outreach Positions

Request current non-recurring funding of \$2,500,000 for FY 2006 & FY 2007 is converted to recurring funding. Request an additional \$500,000 in recurring funding. Request totals \$3,000,000 in recurring funding to convert the 50 GWOT outreach positions to career/career conditional and provide space, equipment, and operating expenses for these positions.

Criteria:

- a. Through February 2006 Vet Centers have provided services to 118,811 separated OEF/OIF Service Members. 41,838 Service Members receiving readjustment counseling in the Vet Centers and 76,973 receiving outreach services at demobilization sites and military facilities.
- b. The program is now averaging over 13,000 outreach contacts per month.

Overall Ranking	Support Facility	VISN	Vet Center	Market Penetration	.9440 National Avg.	Visits/Client	7.7 National Avg.	Visits/FTEE	1800 National Avg.
1	304	7 0304	Atlanta, GA	0.3689	TOP	9.1	FAIR	2735	TOP
2	713	16 0713	Little Rock, AR	0.4586	TOP	9.0	FAIR	2506	TOP
3	205	10 0205	CLEVELAND-EAST, OH	0.4272	TOP	2.8	TOP	727	POOR
4	228	5 0228	ALEXANDRIA, VA	0.4948	TOP	3.2	TOP	863	POOR
5	409	11 0409	Ft. Wayne, IN	0.4855	TOP	5.5	GOOD	1404	FAIR
6	221	10 0221	COLUMBUS, OH	0.3414	TOP	12.0	FAIR	1913	GOOD
7	305	8 0305	Jacksonville , FL	0.3522	TOP	9.3	FAIR	2288	GOOD
8	413	11 0413	Indianapolis, in	0.4570	TOP	11.3	FAIR	1803	GOOD
9	422	15 0422	East St. Louis, IL	0.4183	TOP	9.3	FAIR	1829	GOOD
10	701	9 0701	Johnson City, TN	0.4122	TOP	8.6	FAIR	1955	GOOD
11	314	8 0314	Orlando, FL	0.6204	GOOD	4.7	GOOD	2009	GOOD
12	323	7 0323	Savannah, GA	0.6421	GOOD	5.4	GOOD	1906	GOOD
13	508	20 0508	Tacoma, WA	0.8138	GOOD	5.4	GOOD	2078	GOOD
14	719	9 0719	Memphis, TN	0.7753	GOOD	6.5	GOOD	1955	GOOD
15	217	6 0217	RICHMOND, VA	0.8187	GOOD	7.8	FAIR	2421	TOP
16	328	6 0328	Raleigh, NC	0.8419	GOOD	11.5	FAIR	2590	TOP
17	418	15 0418	Evansville, IL	0.7966	GOOD	10.9	FAIR	2680	TOP
18	507	20 0507	Seattle, WA	0.5352	GOOD	10.0	FAIR	2462	TOP
19	602	21 0602	Concord, CA	0.8949	GOOD	9.9	FAIR	2955	TOP
20	638	21 0638	Sacramento, CA	0.8636	GOOD	7.8	FAIR	3026	TOP
21	131	2 0131	Syracuse, NY	1.2909	FAIR	6.3	GOOD	2371	TOP
22	324	7 0324	Columbia, SC	1.0192	FAIR	5.3	GOOD	2381	TOP
23	315	6 0315	Fayetteville, NC	3.7095	POOR	2.1	TOP	2961	TOP
24	425	23 0425	Sioux Falls , SD	7.4301	POOR	3.2	TOP	3111	TOP
25	611	22 0611	Corona, CA	2.7118	POOR	3.8	TOP	2930	TOP
26	642	22 0642	Vista, CA	0.3190	TOP	2.9	TOP	2462	TOP
27	201	5 0201	Baltimore, MD	0.4020	TOP	7.3	GOOD	912	POOR
28	414	15 0414	St. Louis, MO	0.3487	TOP	4.9	GOOD	1127	POOR
29	431	23 0431	Cedar Rapids, IA	0.3789	TOP	6.4	GOOD	873	POOR
30	114	3 0114	Trenton, NJ	0.4850	TOP	9.4	FAIR	1523	FAIR
31	202	9 0202	LOUISVILLE, KY	0.4179	TOP	10.2	FAIR	1579	FAIR
32	219	4 0219	PHILADELPHIA, PA	0.3450	TOP	11.5	FAIR	1686	FAIR
33	325	8 0325	Tallahassee, FL	0.3848	TOP	11.4	FAIR	1594	FAIR
34	327	6 0327	Greensboro, NC	0.4388	TOP	8.6	FAIR	1598	FAIR
35	415	12 0415	Milwaukee, WI	0.2736	TOP	10.5	FAIR	1617	FAIR
36	504	19 0504	Denver, CO	0.4265	TOP	12.0	FAIR	1726	FAIR
37	505	22 0505	Las Vegas, NV	0.4595	TOP	10.4	FAIR	1544	FAIR
38	517	18 0517	Phoenix, AZ	0.3915	TOP	8.2	FAIR	1426	FAIR
39	318	8 0318	Tampa, FL	0.3718	TOP	13.4	POOR	2241	GOOD
40	320	8 0320	Sarasota, FL	0.4666	TOP	13.9	POOR	1890	GOOD
41	403	11 0403	Grand Rapids, MI	0.1872	TOP	18.4	POOR	2258	GOOD
42	711	16 0711	Houston, TX	0.2560	TOP	16.1	POOR	1896	GOOD
43	416	23 0416	St. Paul, MN	0.6133	TOP	3.4	TOP	814	POOR
44	104	1 0104	Brockton, MA	0.9199	TOP	7.7	GOOD	1428	FAIR
45	213	5 0213	SILVER SPRING, MD	0.9089	TOP	6.1	GOOD	1323	FAIR
46	302	7 0302	Birmingham, AL	0.6731	TOP	4.8	GOOD	1765	FAIR
47	303	7 0303	Charleston, SC	0.7842	TOP	6.5	GOOD	1642	FAIR
48	424	23 0424	Omaha, NE	0.7649	TOP	7.0	GOOD	1272	FAIR
49	426	15 0426	Wichita, KS	0.5100	TOP	6.9	GOOD	1481	FAIR
50	514	19 0514	Salt Lake City, UT	0.7960	TOP	5.4	GOOD	1233	FAIR

Proposed FTEE	*Estimated Salary Cost per FTEE	Estimated Total Salary Costs	Physical Plant & Equipment + Operating Expenses	Totals	NOTES
New Vet Centers					
Atlanta, GA	4	\$ 68,750	\$ 275,000	\$ 125,000	\$ 400,000
Phoenix, AZ	4	\$ 68,750	\$ 275,000	\$ 125,000	\$ 400,000
*based on one GS-12 Team Leader, 2 GS-11 Counselors, one GS-6 Office Manager					
Proposed FTEE	Salary Cost per FTEE	Total Salary Costs	Estimated Additional Space/Equipment	Estimated Total Additional Space/Equipment	Totals
Augmentation	1.1	\$ 76,192	\$ 838,112	\$ 11,750	\$ 129,250 \$ 987,362
** based on actual RCS average cost per GS-11 Counselor FTEE (includes all benefits)					
Conversion	50	\$ 48,216	\$ 2,410,750	\$ 11,750	\$ 587,500 \$ 2,988,250
*** based on actual RCS average cost per GWOT FTEE (includes all benefits)					
GRAND TOTAL					\$ 4,765,612 RCS will absorb the additional \$265,612 needed

JUN 15 2004

Vet Center Proposed Augmentations

<u>Current FTEE</u>	<u>Proposed Expansion</u>	<u>City</u>	<u>State</u>	<u>Notes</u>	<u>New Total</u>
4	1	Mobile	AL		5
3	1	Wasilla	AK		4
6	4	Phoenix	AZ	*two teams	10
1	3	Ft. Meyers	FL		4
6	4	Miami	FL	*two teams & one outstation	10
2	2	Agana	Guam		4
3	1	Hilo	HI		4
3	1	Kauai	HI		4
3	1	Kona	HI		4
3	1	Maui	HI		4
3	1	Sioux City	IA		4
3	1	East St. Louis	IL		4
5	3	Moline (1)	IL	*Cedar Rapids (2)	8
3	1	Lowell	MA		4
3	1	New Bedford	MA		4
3	1	Caribou	ME		4
6	1	Elkton	MD	*Cambridge (1)	7
3	1	Minot	ND		4
3	1	Lincoln	NE		4
4	1	Ventnor	NJ		5
0	3	Las Cruces	NM		3
3	1	Santa Fe	NM		4
3	1	Staten Island	NY		4
4	1	Syracuse	NY		5
3	1	Grants Pass	OR		4
3	1	Columbia	SC		4
3	1	Johnson City	TN		4
4	1	Knoxville	TN		5
4	1	Corpus Christie	TX		5
4	1	EI Paso	TX		5
4	1	McAllen	TX		5
2	1	Provo	UT		3
4	1	Norfolk	VA		5
3	1	Beckley	WV		4
3	1	Princeton	WV		4
3	1	Wheeling	WV		4
120	49	TOTAL			169

Department of Veterans Affairs (VA)

Fact Sheet for Dr. Kussman

Regarding Enhancement of Vet Center Services

Issue: Program enhancement of RCS to meet the need of OEF/OIF returning veterans.

Discussion: The Vet Center Program has experienced increased demand for readjustment counseling services over the last two years. The number of unique veterans in the program increased approximately 10% (125,737 in FY04 to 137,037 in FY05). If adjusted for the new Vet Center GWOT employee outreach work in FY05, the workload increased to 190,053 unique veterans, an increase over 50% during the same time period.

In FY2003, 1,857 OEF/OIF (GWOT) were seen, in FY04, 9,597, and in FY05, 33,463 were provided services. Similarly, the visits in FY04 were 18,819 and in FY05, 61,859 visits were recorded. There was a 154% increase in bereavement referrals from DOD and VA in FY05 compared to FY04.

The Vet Center Program averaged 6.8 visits per day per counselor in FY05. The increase in new clients will exceed our capacity to provide quality services. In order to meet the demand, the following enhancements are proposed.

- Five new Vet Centers near major military facilities (20 FTE)
- Seven new Vet Centers in underserved areas (27 FTE)
- Staff augmentation in 17 existing Vet Centers (17 FTE)
- Conversion of the 50 GWOTS from temporary to career status
- Family therapist for bereavement services (8 FTE)
- Sexual trauma counselors (2 FTE)

The approximate cost for all of these enhanced services is 11.5 million dollars. With your concurrence, request that RCS be considered in the VHA 100 million dollar allotment for mental health in the coming fiscal year. 100% of every dollar spent will be directly applied to veteran care.

Alfonso R. Bates
Chief Officer, Readjustment Counseling Service
Veterans Health Administration
October 20, 2005

NEW VET CENTERS (Major Military Facilities) (20 FTEE)

<u>FTEE</u>	<u>Location</u>	GWOT Outreach Specialist at each
4	Columbus, GA (Ft. Benning) (186 K)	
4	Kileen, TX (Ft. Hood) (87 K)	
4	Manhattan, KS (Ft. Riley) (45 K)	
4	Pueblo, CO (Ft. Carson) (102 K)	
4	San Antonio, TX (Lackland, Kelly, Randolph & Brooks AFBs, Ft. Sam Houston) (1.15 M)	

NEW VET CENTERS (Increased Demand/Underserved Area) (27 FTEE)

<u>FTEE</u>	<u>Location</u>
4	Phoenix, AZ (1.32 M)
4	Miami, FL (450 K)
4	Kansas City, MO (588 K)
4	Las Cruces, NM (74 K)
4	Springfield, MO (152 K)
4	Modesto/Stockton, CA (189 K/244 K)
3	Ft. Meyers, FL (Outstation to Full Team) (104 K)

STAFF AUGMENTATION (17 FTEE)**FAMILY / BEREAVEMENT (8 FTEE)**

<u>FTEE</u>	<u>Location</u>	<u>FTEE</u>	<u>Location</u>
1	Sioux City, IA	1	Los Angeles, CA
1	Lincoln, NE	1	Washington, DC
1	Santa Fe, NM	1	Fayetteville, NC
1	East St. Louis, IL	1	Columbus, OH
1	Staten Island, NY	1	Syracuse, NY
1	Tucson, AZ	1	West Palm Beach, FL
1	Philadelphia, PA	1	Columbus, GA
1	El Paso, TX	1	San Antonio, TX
1	Grants, Pass, OR		
1	Norfolk, VA		
1	Princeton, WV		
1	Honolulu, HI	<u>FTEE</u>	<u>Location</u>
1	Hilo, HI		
1	Missoula, MT	1	San Antonio, TX
1	Hopi Reservation, AZ	1	Wichita, KS
1	Navajo Reservation, AZ		
1	Martin, SD (Sioux/Rosebud)		

SEXUAL TRAUMA (2 FTEE)

1A Northeast Region (2 FTEE)

- 1 Staten Island, NY – FTEE Augmentation (Augment to 4 FTEE)
- 1 Syracuse, NY – Bereavement/Family Therapist

1B Mid-Atlantic Region (5 FTEE)

- 1 Philadelphia, PA – FTEE Augmentation (+ GWOT) – Major Military Installation (Ft. Dix)
- 1 Norfolk, VA – FTEE Augmentation – Major Military Installation (Norfolk Naval Shipyard)
- 1 Princeton, WV – FTEE Augmentation (Augment to 4 FTEE)
- 1 Washington, DC – Bereavement/Family Therapist (*Malogne House*)
- 1 Columbus, OH – Bereavement/Family Therapist

2 Central Region (17 FTEE)

- 4 Manhattan, KS (45 K) – New Vet Center (+ GWOT) - Major Military Installation (Ft. Riley)
- 4 Kansas City, MO (588 K) – New Vet Center (2nd – Eastern KS Coverage)
- 4 Springfield, MO (152 K) – New Vet Center (Southern MO/Northern AR Coverage)
- 1 Sioux City, IA – FTEE Augmentation (Augment to 4 FTEE)
- 1 Lincoln, NE – FTEE Augmentation (Augment to 4 FTEE)
- 1 East St. Louis, IL – FTEE Augmentation - (Augment to 4 FTEE) Minority Services/Outreach
- 1 Martin, SD – FTEE Augmentation – Native American Services/Outreach (Sioux/Rosebud)
- 1 Wichita, KS – Sexual Trauma Counselor

3A Southeast Region (14 FTEE)

- 5 Columbus, GA (186 K) New Vet Center (+ GWOT) - Major Military Installation (Ft. Benning)
include Bereavement/Family Therapist
- 4 Miami, FL (450 K) – New Vet Center (2nd)
- 3 Ft. Meyers, FL (104 K) FTEE Augmentation (Augment to 4 FTEE)
- 1 Fayetteville, NC - Bereavement/Family Therapist
- 1 West Palm Beach, FL - Bereavement/Family Therapist

3B South-Central Region (10 FTEE)

- 6 San Antonio, TX (1.15 M) New Vet Center (2nd) - Major Military Installations (Lackland, Kelly, Randolph & Brooks AFBs, Ft. Sam Houston) *include Bereavement/Family Therapist, include Sexual Trauma Therapist*
- 4 Kileen, TX (87 K) - New Vet Center (+ GWOT) - Major Military Installation (Ft. Hood)

4A Western Mountain Region (17 FTEE)

- 4 Pueblo, CO (102 K) - New Vet Center (+ GWOT) - Major Military Installation (Ft. Carson)
- 4 Phoenix, AZ (1.32 M) - New Vet Center (2nd)
- 4 Las Cruces, NM (74 K) - New Vet Center (Southern NM Coverage)
- 1 Santa Fe, NM - FTEE Augmentation (Augment to 4 FTEE)
- 1 Tucson, AZ - FTEE Augmentation
- 1 Missoula, MT - FTEE Augmentation
- 1 Hopi Reservation, AZ - FTEE Augmentation – Native American Services/Outreach
- 1 Navajo Reservation, AZ - FTEE Augmentation – Native American Services/Outreach

4B Pacific Western Region (8 FTEE)

- 4 Modesto/Stockton, CA - New Vet Center (Central Valley Coverage) (189 K/244 K)
- 1 Grants, Pass, OR - FTEE Augmentation (Augment to 4 FTEE)
- 1 Honolulu, HI - FTEE Augmentation
- 1 Hilo, HI - FTEE Augmentation (Augment to 4 FTEE)
- 1 Los Angeles, CA - Bereavement/Family Therapist (*Spanish Speaking*)

**Department of
Veterans Affairs****Memorandum**

Date: November 15, 2005

From: Chief Readjustment Counseling Officer (15)

Subj: RCS Program Enhancement 2006

To: Under Secretary for Health (10)

Through: Deputy Under Secretary for Health (10A)

1. The purpose of this memorandum is to recommend approval to augment the Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS-15) with 12 additional Vet Centers, 26 additional FTEE to augment staff at existing Vet Centers (to include bilingual staff, family therapists and bereavement specialists), and conversion of the second 50 Global War on Terrorism (GWOT) Outreach Specialists from term to career status. The Vet Center program has experienced increased demand for readjustment counseling services over the last several years.

Readjustment Counseling Service (RCS)

2. The RCS Vet Center program is a special VHA program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theater of operations. VA's Vet Center program consists of 207 community-based Vet Centers located outside the larger medical facilities, in easily accessible, consumer friendly facilities. The Vet Center program's service mission is beyond medical care featuring a holistic mix of professional readjustment counseling for war trauma and other social readjustment problems, family readjustment counseling, and multiple community-based services to include outreach, education, extensive case-management and referral. Each Vet Center is staffed by a small multidisciplinary team and nationally the Vet Centers maintain over 50 percent or higher combat theater veterans as direct service providers. Current law defines eligibility for readjustment counseling to include any veteran who served in the active military in a theater of combat operations during any period of war, or in any other area during a period in which hostilities occurred in such area
3. In FY 2005 the Vet Centers provided 1,046,628 visits to 132,853 veterans and their families. Compared to the previous year this is a 1.4% increase in the visits provided and a 5.7% increase in the number of veterans and families served. Each Vet Center readjustment counseling service provider, including Team Leaders who maintain significant additional administrative and supervisory duties, averaged 5.7 veteran visits per day. When Team Leader administration time is factored in, the average becomes 6.7

veteran visits per day for each service provider.

4. In meeting the readjustment counseling mandate to veterans as defined by the authorizing legislation, Vet Centers provide both social and psychological services to veterans and their families. According to a GAO audit in 1996 (GAO/HEHS-96-113), Vet Centers and medical centers generally serve different clients and missions. In contrast to VA medical facilities, Vet Centers do not provide inpatient care or medical prescriptions, but do provide services that medical facilities cannot or do not provide. Such services include community-based outreach; social, economic, and family readjustment counseling; and bereavement services for surviving military family members. As originally documented in their 1996 audit, GAO found that from 30 to 40 percent of Vet Center unique clients are not seen in any other VA facility. As consistently documented in succeeding years, these veterans constitute a core group of frequent users who access Vet Center care primarily for psychological war trauma and other social readjustment problems. Most of the visits provided by the Vet Centers are devoted to this core group of veteran users. In FY 2005, 47,860 of all veterans served were not seen at any other VHA facility. This core group of RCS clients represents over 36% of veterans receiving services in the Vet Centers and is an increase of 29.2% from FY 2004's core group.
5. Pursuant to the provisions of 38 U.S.C., Section 1712A, the Secretary of Veterans Affairs approved extension of eligibility for readjustment counseling at Vet Centers to veterans who served in Operation Enduring Freedom {OEF} in April 2003 and Operation Iraqi Freedom {OIF} in June 2003. From April 2003 through the end of Fiscal Year 2005, the Vet Centers have had substantive contact with 44,917 OEF/OIF veterans and their families. This represents 10.3% of the 435,193 OEF/OIF veterans that have separated. By comparison, from January 1991 through the end of fiscal year 2005, the Vet Centers have provided services to 68,846 (11.4%) of the 603,820 veterans deployed to Operation Desert Shield/Storm (ODS). Based upon this information it is clear that the percentage of combat veterans from OEF/OIF who accessed Vet Center services in less than three years, is approximately the same as the percentage of ODS veterans who accessed care at a Vet Center in fifteen years. This data clearly documents an accelerated utilization rate for OEF/OIF veteran returnees.
6. The final report of The Presidential Advisory Committee on Gulf War Veterans' Illnesses, March 7, 1997, cited Vet Centers as providing exemplary outreach services to contact and inform Gulf War veterans of VA services. The committee recommended that other VHA services and programs adopt Vet Center strategies for outreach to improve services to combat veterans. The Vet Center ODS outreach served as the model for outreach to OEF/OIF veterans and drove the hiring of 50 GWOT Outreach Specialists beginning in February 2004 and an additional 50 Specialists beginning in March of 2005. The hiring of GWOT Outreach Specialists, all of which are they themselves OEF/OIF veterans directly supports the VA Secretary's "*Fulfilling the Commitment – Coming Home to Work*" initiative. RCS GWOT Outreach Specialists are now averaging over 6,500 outreach contacts each month (26,239 over a four month period) with newly returning OEF/OIF veterans and their families. If current trends continue as anticipated

this will annualize to over 78,000 contacts for FY 2006.

7. Pursuant to the provisions of 38 U.S.C., Section 1712A, 1782 & 1783, the Secretary of Veterans Affairs authorized the Vet Centers to provide bereavement counseling services to surviving family members of Armed Forces personnel who died while on active duty in service to our country. To date 527 families (809 family members) have received assistance from Vet Center counselors. This represents a 154% increase from FY 2004 to FY 2005.

Recommendation

8. Specifically this request consists of the following recommendations. The rationale for each recommendation is contained in Attachments A-D:
 - A. Establish 5 New Vet Centers Near Military Installations
 - B. Establish 7 New Vet Centers In Underserved Areas
 - C. Staff Augmentation of 26 Existing Vet Centers.
 - D. Conversion of 50 GWOT Outreach Specialists to Career/Career Conditional

Cost Projection

9. The cost projections for each recommendation are:

- A. 2.5 million dollars (5 Vet Centers)
- B. 3.5 million dollars (7 Vet Centers)
- C. 2.0 million dollars (26 FTEE)
- D. 2.5 million dollars (currently non-recurring FY2006 & FY2007)

TOTAL: 11.5 million dollars

ALFONSO R. BATRES, Ph.D., M.S.S.W.
Chief Officer, Readjustment Counseling Service, 15

Recommendation A

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation B

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation C

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation D

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

A. NEW VET CENTERS - Near Major Military Facilities (5)

1. **Columbus, Georgia** (Ft. Benning) - Total Population of Catchment Area = 1,094,121
Veterans = 185,218 (RCS Eligible Veterans ~ 75,732)

Separated GWOT Veterans = 5,114

Nearest Vet Centers = Atlanta, GA (108 miles), Birmingham, AL (178 miles)

Overall population in the area has grown 3.7% since 1990 Census.

Columbus, Georgia is located over 100 miles from the nearest Vet Center and maintains a very large veteran population to include a large population of separating GWOT veterans. The proximity to Ft. Benning would significantly enhance the seamless transition of separating Service Members and their families. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services in southwestern Georgia and southeastern Alabama where current services are located a great distance away. Many separating Service Members and their families integrate into the local community during their military service and remain there following separation.

2. **San Antonio, TX** (Lackland AFB, Kelly AFB, Randolph AFB, Ft. Sam Houston) - Total Population of Catchment Area = 1,110,954

Veterans = 208,037 (RCS Eligible Veterans ~ 87,605)

Separated GWOT Veterans = 4,019

2nd Vet Center for metropolitan area

Overall population in the area has grown 20.3% since 1990 Census.

The existing San Antonio Vet Center provided services to 1,153 Veterans in FY 2004 and to 1,358 Veterans in FY 2005 (17.8% increase). Veteran visits increased from 8,065 in FY 2004 to 8,257 in FY 2005 (2.4% increase). GWOT services have increased from 120 GWOT Veterans provided 136 visits in FY 2004 to 518 GWOT Veterans provided 605 visits in FY 2005. The proximity to several large military installations, the large veteran population, and the increasing workload of the existing Vet Center warrants consideration of a second Vet Center for the San Antonio metropolitan area.

3. **Killeen, Texas** (Ft. Hood) – Total Population of Catchment Area = 302,404

Veterans = 66,242 (RCS Eligible Veterans ~ 24,511)

Separated GWOT Veterans = 3,983

Nearest Vet Centers = Austin, TX (75 miles), Ft. Worth, TX (146 miles)

Overall population in the area has grown 46.1% since 1990 Census.

Killeen, Texas, home of Ft. Hood and the Third Infantry Division has been one of the military's largest deployment sites for Operations Iraqi and Enduring Freedom. The significant population growth and large veteran population demonstrates that separating Service Members and their families are choosing to remain in the community following separation. The nearest Vet Center is

currently 75 miles from Killeen. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services in central Texas.

4. **Manhattan, Kansas** (Ft. Riley) - Total Population of Catchment Area = 243,748
Veterans = 42,698 (RCS Eligible Veterans ~ 21,175)
Separated GWOT Veterans = 2,019
Nearest Vet Centers = Kansas City, MO (120 miles), Lincoln, NE (135 miles)
Overall population in the area has grown 3.1% since 1990 Census.

Manhattan, Kansas is located over 120 from the two nearest Vet Centers and would be able to provide services to veterans in northern and western Kansas. This rural outreach and service provision would target a veteran population that has significant geographical barriers to access for VA services. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services. The proximity to Ft. Riley will enhance the seamless transition of Service Members and their families.

5. **Pueblo, Colorado** (Ft. Carson) - Total Population of Catchment Area = 171,836
Veterans = 32,351 (RCS Eligible Veterans ~ 15,832)
Separated GWOT Veterans = 231
Nearest Vet Centers = Colorado Springs, CO (44 miles), Denver, CO (115 miles)
Overall population in the area has grown 4.6% since 1990 Census.

Pueblo, Colorado would maintain the primary outreach mission for Ft. Carson, Colorado and also veterans located in southern and western Colorado. This rural outreach would improve access to VA services for veterans currently located a large distance from an existing Vet Center. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services.

B. NEW VET CENTERS - Underserved Areas (7)

6. **Phoenix, AZ** - Population of Catchment Area = 2,111,705

Veterans = 346,997 (RCS Eligible Veterans ~ 168,823)

Separated GWOT Veterans = 3,840 (55.5% National Guard/Reserve)

2nd Vet Center for metropolitan area

Overall population in the area has grown 20.3% since 1990 Census.

The existing Phoenix Vet Center provided 6,419 visits to 805 Veterans in FY 2005 (7.97 visits per Veteran). On average, each counseling staff member provides 152.8 visits to 19.2 unique Veterans each month. This translates to over 6 visits per day for each for each counseling staff member member. The large veteran population in a rapidly growing area coupled with the current workload levels for the existing Vet Center warrants consideration of a second Vet Center for the Phoenix metropolitan area.

7. **Kansas City, MO** - Population of Catchment Area = 2,076, 287

Veterans = 353,346 (RCS Eligible Veterans ~ 163,950)

Separated GWOT Veterans = 3,173 (74.8% National Guard/Reserve)

2nd Vet Center for metropolitan area

Overall population in the area has grown 1.8% since 1990 Census.

The existing Kansas City Vet Center provided services to 1,163 Veterans in FY 2004 and to 1,649 Veterans in FY 2005 (41.8% increase). GWOT services have increased from 11 GWOT Veterans provided 27 visits in FY 2004 to 648 GWOT Veterans provided 749 visits in FY 2005. The large separating National Guard and Reserve population and the increased workload of the existing Vet Center warrants consideration of a second Vet Center in the Kansas City metropolitan area. A second Vet Center would provide the opportunity for extended outreach and services to veterans in eastern Kansas currently geographically isolated from Vet Center and VA services

8. **Miami, FL** - Population of Catchment Area = 1,655,214

Veterans = 104,090 (RCS Eligible Veterans ~ 86,964)

Separated GWOT Veterans = 1,700 (59.4% National Guard/Reserve)

2nd Vet Center for metropolitan area

Overall population in the area has grown 4.7% since 1990 Census.

The existing Miami Vet Center provided services to 805 Veterans in FY 2004 and to 2,614 Veterans in FY 2005 (224% increase). Veteran visits increased from 6,755 in FY 2004 to 8,005 in FY 2005 (18.5% increase). GWOT services have increased from 304 GWOT Veterans provided 763 visits in FY 2004 to 2,111 GWOT Veterans provided 2,960 visits in FY 2005. The significant increases in workload coupled with a large veteran population warrant consideration of a second Vet Center in the Miami metropolitan area.

9. **Springfield, MO** - Population of Catchment Area = 936,021
Veterans = 170,668 (RCS Eligible Veterans ~ 84,192)
Separated GWOT Veterans = 1,681 (74.2% National Guard/Reserve)
Nearest Vet Centers = Tulsa, OK (182 miles), Kansas City, MO (171 miles)
Overall population in the area has grown 6.8% since 1990 Census.

Springfield, Missouri is located over 170 miles from the nearest two Vet Centers. The catchment area maintains a large eligible veteran population including a large number of separated National Guard and Reserve OEF/OIF veterans. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services in southern Missouri and northern Arkansas where current services are located a great distance away. Springfield is also 68 miles from Ft. Leonard Wood and would be able to enhance seamless transition of separating Service Members and their families.

10. **Modesto, CA** - Population of Catchment Area = 740,534
Veterans = 97,375 (RCS Eligible Veterans ~ 46,334)
Separated GWOT Veterans = 1,010 (48.9% National Guard/Reserve)
Nearest Vet Centers = San Jose, CA (85 miles), Fresno, CA (95 miles)
Overall population in the area has grown 23.0% since 1990 Census.

Modesto, California is located 85 miles from the nearest Vet Center with this distance compounded by significant traffic congestion. There is a large eligible veteran population and the area is experiencing sizeable growth. Modesto would be able to offer outreach and services to all of central-eastern California. There is a sizeable Hispanic veteran population in this area and a bi-lingual (Spanish) counselor would be targeted.

11. **Ft. Myers, FL** - Population of Catchment Area = 574,119
Veterans = 134,732 (RCS Eligible Veterans ~ 86,464)
Separated GWOT Veterans = 895 (46.5% National Guard/Reserve)
Nearest Vet Center = Sarasota, FL (77 miles)
Overall population in the area has grown 52.2% since 1990 Census.

Ft. Myers, Florida is located 77 miles from the nearest Vet Center and maintains a very large eligible veteran population, to include a large number of retirees. The area is experiencing very significant growth. Current out stationed staff (1 FTEE-donated space) is reporting robust demand for services. At least one of the counselors hired would be a family therapist / bereavement counseling specialist to increase capacity for these RCS specific services.

12. Las Cruces, NM - Population of Catchment Area = 298,934

Veterans = 32,351 (RCS Eligible Veterans ~ 15,832)

Separated GWOT Veterans = 655 (31.1% National Guard/Reserve)

Nearest Vet Centers = El Paso, TX (44 miles), Albuquerque, NM (223 miles)

Overall population in the area has grown 23.2% since 1990 Census.

Las Cruces, New Mexico would provide outreach and services to all of southern New Mexico freeing the El Paso Vet Center to concentrate on western Texas. At least one of the counselors hired would be a bi-lingual (Spanish) family therapist / bereavement counseling specialist to increase capacity for these RCS specific services for veterans with language barriers. Targeted rural outreach would bring services to veterans who are currently have limited access to VA services.

C. Staff Augmentation at 26 Existing Vet Centers (26 FTEE)

i. **American Indian Outreach / IHS Collaboration**

1. **Chinle, AZ (Navajo)** - (*From 2 FTEE to 3 FTEE*) – 12,272 Veterans (includes Hopi) in catchment area. Increase access to care for high risk minority veterans in a rural setting. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices. *Targeted recruitment for a Navajo counselor who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166)*
2. **Keams Canyon, AZ (Hopi)** - (*From 2 FTEE to 3 FTEE*) – 12,272 Veterans (includes Navajo) in catchment area. Increase access to care for high risk minority veterans in a rural setting. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices. *Targeted recruitment for a Hopi counselor who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166)*.
3. **Martin, SD (Sioux)** - (*From 1 FTEE to 2 FTEE*) – 5,616 Veterans in catchment area. Increase access to care for high risk minority veterans in a rural setting. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices. *Targeted recruitment for a Sioux counselor who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166).*

ii. **Specialized Services/ Large Veteran Populations / Increased Demand**

4. **West Palm Beach, FL** - (*From 4 FTEE to 5 FTEE*) – 199,717 Veterans in catchment area (~149,897 Vet Center eligible). In FY2005 Vet Center provided 4,712 visits to 482 unique Veterans (including services to 91 GWOT veterans). This averages to 5.95 visits per day for each counseling staff member. *Targeted recruitment for a family therapist / bereavement counseling specialist. At this Vet Center over 11% of all visits have a family member participate. This Vet Center has six active bereavement counseling cases and has provided over 185 bereavement counseling visits. Over 12% of all visits at this Vet Center have a family member participate.*
5. **Fayetteville, NC** - (*From 4 FTEE to 5 FTEE*) – 143,612 Veterans in catchment area (~112,265 Vet Center eligible). In FY2005 Vet Center provided 7,402 visits to 3,628 unique Veterans (including services to 3,254 GWOT veterans). This averages to 5.05 visits per day for each counseling staff member. *Targeted recruitment for a family therapist / bereavement counseling specialist. A large number of separating GWOT veterans and their families in this community which includes Ft. Bragg. This is the most active Vet Center in the nation in the provision of services to GWOT veterans.*

6. **Los Angeles, CA** - (*From 4 FTEE to 5 FTEE*) – 102,142 Veterans in catchment area (~50,235 Vet Center eligible). In FY2005 Vet Center provided 6,133 visits to 560 unique Veterans (including services to 136 GWOT veterans). This averages to 7.74 visits per day for each counseling staff member. ***Targeted recruitment for a bi-lingual (Spanish) family therapist / bereavement counseling specialist. Central metropolitan location (cover the entire Los Angeles basin) insures access to services for persons with limited English proficiency (Executive Order 13166). Over 5.4% of all visits have a family member present.***
7. **Columbus, OH** - (*From 4 FTEE to 5 FTEE*) – 211,457 Veterans in catchment area (~177,618 Vet Center eligible). In FY2005 Vet Center provided 4,003 visits to 949 unique Veterans (including services to 405 GWOT veterans). This averages to 9.35 visits per day for each counseling staff member. ***Targeted recruitment for a family therapist / bereavement counseling specialist. At this Vet Center over 8.4% of all visits have a family member participate. This Vet Center has eighteen active bereavement counseling cases and has provided over 172 bereavement counseling visits.***
8. **Syracuse, NY** - (*From 4 FTEE to 5 FTEE*) – 186,415 Veterans in catchment area (~66,611 Vet Center eligible). In FY2005 Vet Center provided 5,477 visits to 1,057 unique Veterans (including services to 855 GWOT veterans). This averages to 6.92 visits per day for each counseling staff member. ***Targeted recruitment for a family therapist / bereavement counseling specialist. At this Vet Center over 8.4% of all visits have a family member participate. Would offer bereavement counseling and family services for a large geographical area to include Ft. Drum.***
9. **Washington, DC** - (*From 4 FTEE to 5 FTEE*) – 67,990 Veterans in catchment area (~56,818 Vet Center eligible). In FY2005 Vet Center provided 2,426 visits to 305 unique Veterans (including services to 123 GWOT veterans). This averages to 3.06 visits per day for each counseling staff member. ***Targeted recruitment for a family therapist / bereavement counseling specialist. Outreach to be provided at the Mologne House and Fisher House for soon to be discharged wounded veterans and their families. This will facilitate referrals to local Vet Centers and VHA facilities in their communities and promote seamless care for wounded veterans and their families.***
10. **San Antonio, TX** - (*From 4 FTEE to 6 FTEE*) – 208,037 Veterans in catchment area (~87,605 Vet Center eligible). In FY2005 Vet Center provided 8,257 visits to 1,358 unique Veterans (including services to 518 GWOT veterans). This averages to 6.26 visits per day for each counseling staff member. ***Targeted recruitment for a bi-lingual (Spanish) family therapist / bereavement counseling specialist and bi-lingual (Spanish) sexual trauma counselor. The San Antonio Vet Center currently has 9 active bereavement cases and has***

provided over 362 family visits and over 1,324 (17% of all visits) military sexual trauma visits.

11. **Wichita, KS** - (*From 4 FTEE to 5 FTEE*) – 241,300 Veterans in catchment area (~187,500 Vet Center eligible). In FY2005 Vet Center provided 5,183 visits to 757 unique Veterans (including services to 437 GWOT veterans). This averages to 6.54 visits per day for each counseling staff member. ***Targeted recruitment for a sexual trauma counselor. Over 5% of the visits at this Vet Center are for military sexual trauma to include very active group therapy.***
12. **Tucson, AZ** - (*From 4 FTEE to 5 FTEE*) – 119,080 Veterans in catchment area (~58,276 Vet Center eligible). In FY2005 the Vet Center provided 4,330 visits to 356 unique Veterans (including services to 719 GWOT veterans). This averages to 4.29 visits per day for each counseling staff member. ***Targeted recruitment for a bi-lingual (Spanish) counselor. Targeted recruitment for a counselor who speaks Spanish to improve access to services for persons with limited English proficiency (Executive Order 13166).***
13. **Philadelphia, PA** - (*From 4 FTEE to 5 FTEE*) – 219,226 Veterans in catchment area (~191,744 Vet Center eligible). In FY2005 the Vet Center provided 3,398 visits to 859 unique Veterans. This averages to 5.69 visits per day for each counseling staff member.
14. **El Paso, TX** - (*From 4 FTEE to 5 FTEE*) – 93,330 Veterans in catchment area (~75,445 Vet Center eligible). In FY2005 the Vet Center provided 4,658 visits to 586 unique Veterans (including services to 138 GWOT veterans). This averages to 5.88 visits per day for each counseling staff member. ***Targeted recruitment for a bi-lingual (Spanish) counselor. Targeted recruitment for a counselor who speaks Spanish to improve access to services for persons with limited English proficiency (Executive Order 13166).***
15. **Norfolk, VA** - (*From 4 FTEE to 5 FTEE*) – 226,121 Veterans in catchment area (~189,603 Vet Center eligible). In FY2005 the Vet Center provided 4,003 visits to 949 unique Veterans (including services to 405 GWOT veterans). This averages to 5.05 visits per day for each counseling staff member.
16. **Honolulu, HI** - (*From 4 FTEE to 5 FTEE*) – 88,177 Veterans in catchment area (~38,621 Vet Center eligible). In FY2005 the Vet Center provided 5,236 visits to 595 unique Veterans. This averages to 6.61 visits per day for each counseling staff member. ***Targeted recruitment for a native Hawaiian counselor.***

iii. **Small/Rural Teams**

17. **Missoula, MT** - (*From 4 FTEE to 5 FTEE*) – 66,911 Veterans in catchment area (~35,203 Vet Center eligible). In FY2005 Vet Center provided 2,991 visits to 429 unique Veterans. This averages to 3.78 visits per day for each counseling staff member.
18. **Princeton, WV** - (*From 3 FTEE to 4 FTEE*) – 24,991 Veterans in catchment area (~22,186 Vet Center eligible). In FY2005 the Vet Center provided 14,605 visits to 760 unique Veterans.
19. **Sioux City, IA** – (*From 3 FTEE to 4 FTEE*) – 43,277 Veterans in catchment area (~20,347 Vet Center eligible). In FY2005 the Vet Center provided 2,869 visits to 735 unique Veterans (including services to 51 GWOT veterans). This averages to 5.63 visits per day for each counseling staff member.
20. **Lincoln, NE** - (*From 3 FTEE to 4 FTEE*) – 68,345 Veterans in catchment area (~54,626 Vet Center eligible). In FY2005 the Vet Center provided 3,011 visits to 698 unique Veterans (including services to 174 GWOT veterans). This averages to 5.70 visits per day for each counseling staff member.
21. **Santa Fe, NM** (*From 3 FTEE to 4 FTEE*) – 50,372 Veterans in catchment area (~24,728 Vet Center eligible). In FY2005 the Vet Center provided 3,002 visits to 859 unique Veterans (including services to 92 GWOT veterans). This averages to 5.69 visits per day for each counseling staff member.
22. **East St. Louis, IL** (*From 3 FTEE to 4 FTEE*) – 63,238 Veterans in catchment area (~56,104 Vet Center eligible). In FY2005 the Vet Center provided 2,744 visits to 300 unique Veterans. This averages to 5.63 visits per day for each counseling staff member.
23. **Staten Island, NY** - (*From 3 FTEE to 4 FTEE*) – 32,477 Veterans in catchment area (~22,000 Vet Center eligible). In FY2005 the Vet Center provided 2,493 visits to 100 unique Veterans. This averages to 6.92 visits per day for each counseling staff member.
24. **Grants Pass, OR** (*From 3 FTEE to 4 FTEE*) – 56,736 Veterans in catchment area (~29,850 Vet Center eligible). In FY2005 the Vet Center provided 3,167 visits to 463 unique Veterans. This averages to 6.00 visits per day for each counseling staff member.
25. **Hilo, HI** - (*From 3 FTEE to 4 FTEE*) – 9,532 Veterans in catchment area (~4,594 Vet Center eligible). In FY2005 the Vet Center provided 2,884 visits to 454 unique Veterans (including services to 81 GWOT veterans). This averages to 5.46 visits per day for each counseling staff member.

D. Conversion of second 50 GWOT Outreach Specialists

Does not require new funding only the conversion of existing funding from non-recurring to recurring. The current funding is for 2.5 million dollars for FY 2006 & FY 2007.

**Department of
Veterans Affairs****Memorandum**

Date: December 13, 2005

From: Chief Readjustment Counseling Officer (15)

Subj: RCS Program Enhancement 2006

To: Under Secretary for Health (10)

Through: Deputy Under Secretary for Health (10A)

1. The purpose of this memorandum is to recommend approval to augment the Department of Veterans Affairs (VA) Readjustment Counseling Service (RCS-15) with 12 additional Vet Centers, 23 additional FTEE to augment staff at existing Vet Centers (to include bilingual staff, family therapists and bereavement specialists), and conversion of the second 50 Global War on Terrorism {GWOT} Outreach Specialists from term to career status. The Vet Center program has experienced increased demand for readjustment counseling services over the last several years.

Readjustment Counseling Service (RCS)

2. The RCS Vet Center program is a special VHA program designed to provide readjustment counseling to veterans exposed to the uniquely stressful rigors of military service in a combat theater of operations. VA's Vet Center program consists of 207 community-based Vet Centers located outside the larger medical facilities, in easily accessible, consumer friendly facilities. The Vet Center program's service mission is beyond medical care featuring a holistic mix of professional readjustment counseling for war trauma and other social readjustment problems, family readjustment counseling, and multiple community-based services to include outreach, education, extensive case-management and referral. Each Vet Center is staffed by a small multidisciplinary team and nationally the Vet Centers maintain a majority of combat theater veterans as direct service providers. Current law defines eligibility for readjustment counseling to include any veteran who served in the active military in a theater of combat operations during any period of war, or in any other area during a period in which hostilities occurred in such area
3. In FY 2005 the Vet Centers provided 1,046,628 visits to 132,853 veterans and their families. Compared to the previous year this is a 1.4% increase in the visits provided and a 5.7% increase in the number of veterans and families served. Each Vet Center readjustment counseling service provider averaged 6.7 veteran visits per day.
4. In meeting the readjustment counseling mandate to veterans as defined by the authorizing

legislation, Vet Centers provide both social and psychological services to veterans and their families. According to a GAO audit in 1996 (GAO/HEHS-96-113), Vet Centers and medical centers generally serve different clients and missions. In contrast to VA medical facilities, Vet Centers do not provide inpatient care or medical prescriptions, but do provide services that medical facilities cannot or do not provide. Such services include community-based outreach; social, economic, and family readjustment counseling; and bereavement services for surviving military family members. As originally documented in their 1996 audit, GAO found that from 30 to 40 percent of Vet Center unique clients are not seen in any other VA facility. As consistently documented in succeeding years, these veterans constitute a core group of frequent users who access Vet Center care primarily for psychological war trauma and other social readjustment problems. Most of the visits provided by the Vet Centers are devoted to this core group of veteran users. In FY 2005, 47,860 of all veterans served were not seen at any other VHA facility. This core group of RCS clients represents over 36% of veterans receiving services in the Vet Centers and is an increase of 29.2% from FY 2004's core group.

5. Pursuant to the provisions of 38 U.S.C., Section 1712A, the Secretary of Veterans Affairs approved extension of eligibility for readjustment counseling at Vet Centers to veterans who served in Operation Enduring Freedom {OEF} in April 2003 and Operation Iraqi Freedom {OIF} in June 2003. From April 2003 through the end of Fiscal Year 2005, the Vet Centers have had substantive contact with 44,917 OEF/OIF veterans and their families. An indication of the Vet Centers emphasis on outreach to OEF/OIF veterans is the rate of market penetration. From 1991 through 2005 RCS saw 10% of the 603,820 veterans who served in Operation Desert Shield/Storm (ODS). RCS initiated outreach efforts to OEF/OIF veterans in late 2003, and by the end of 2005, had already seen 10% of veterans deployed. RCS has reached the same market penetration with the newest cohort of combat veterans in 2 ½ years, a level that took 14 years to accomplish with the last cohort of combat veterans.
6. The final report of The Presidential Advisory Committee on Gulf War Veterans' Illnesses, March 7, 1997, cited Vet Centers as providing exemplary outreach services to contact and inform Gulf War veterans of VA services. The committee recommended that other VHA services and programs adopt Vet Center strategies for outreach to improve services to combat veterans. The Vet Center ODS outreach served as the model for outreach to OEF/OIF veterans and drove the hiring of 50 GWOT Outreach Specialists beginning in February 2004 and an additional 50 Specialists beginning in March of 2005. The hiring of GWOT Outreach Specialists, all of which are themselves OEF/OIF veterans directly supports the VA Secretary's "*Fulfilling the Commitment – Coming Home to Work*" initiative. RCS GWOT Outreach Specialists are now averaging over 6,500 outreach contacts each month (26,239 over a four month period) with newly returning OEF/OIF veterans and their families. If current trends continue as anticipated this will annualize to over 78,000 contacts for FY 2006. .
7. Pursuant to the provisions of 38 U.S.C., Section 1712A, 1782 & 1783, the Secretary of Veterans Affairs authorized the Vet Centers to provide bereavement counseling services

to surviving family members of Armed Forces personnel who died while on active duty in service to our country. Through the end of Fiscal Year 2005, 542 families (833 family members) have received assistance from Vet Center counselors. This represents a 154% increase from FY 2004 to FY 2005.

Recommendation

8. Specifically this request consists of the following recommendations. The rationale for each recommendation is contained in Attachments A-D:
 - A. Establish 4 New Vet Centers near Military Installations
 - B. Establish 8 New Vet Centers in Underserved Areas
 - C. Staff Augmentation of 23 Existing Vet Centers.
 - D. Conversion of 50 GWOT Outreach Specialists to Career/Career Conditional

Cost Projection

9. The cost projections for each recommendation are:
 - A. 2.0 million dollars (4 Vet Centers)
 - B. 4.0 million dollars (8 Vet Centers)
 - C. 2.0 million dollars (23 FTEE)
 - D. 2.5 million dollars (currently non-recurring FY2006 & FY2007)

TOTAL: 11.5 million dollars

ALFONSO R. BATRES, Ph.D., M.S.S.W.
Chief Officer, Readjustment Counseling Service, 15

Recommendation A

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation B

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation C

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

Recommendation D

Concur / Non Concur

MICHAEL KUSSMAN, MD, MS, MACP
Deputy Under Secretary for Health, 10A

Approve / Disapprove

JONATHAN B. PERLIN, MD, Ph.D., MSHA, FACP
Under Secretary for Health, 10

A. New Vet Centers – Near Major Military Facilities (4)

1. Ft. Benning, GA

Criteria:

- a. Post population – 91,900 active duty and family members
- b. Major Units: 3 Brigade, 3rd Infantry Division, 1/15th Infantry, 1/30th Infantry, 11th Infantry Regiment, 29th Infantry Regiment, 1/10th Field Artillery, 75th Infantry (Ranger) Regiment, 5th Ranger Battalion, 2d Battalion, 69th Armor, 36th Engineer Group, 317th Engineer Battalion, 608th Ordnance Company, 498th Medical Company, 690th Medical Company, Basic Training Brigade, Infantry Training Brigade, Ranger Training Brigade, 598th Maintenance Company, 13th S & S Battalion, School of the Americas
- c. Power Projection Platform – 59 Units / 11,061 Service Members
- d. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Benning – 4,900 (calendar year 2005)
- e. Active Duty Service Members deployed from /redeployed to Ft. Benning – 4,300 (calendar year 2005)
- f. Total population of catchment area – 1,094,121
- g. Separated GWOT veterans living in area – 5,114
- h. Veteran population in catchment area – 190,332
- i. Nearest VA / RCS Facility – Atlanta, GA (108 miles)
- j. Area growth rate since 1990 Census: 3.7%
- k. BRAC recommendations indicate that Ft. Benning will be growing in the future.
- l. Nearest Vet Center providing outreach is Birmingham, AL (178 miles)

Enhancements:

- a. Local VA services to a major military base
- b. Access to separating combat veterans at a Power Projection Platform
- c. Readjustment Counseling Services to 190,332 local veterans
- d. Liaison with military family assistance programs
- e. Promoting seamless transition services for veterans and families
- f. Establishing early intervention and prevention services to enhance normalization of the transition process
- g. Provide VA healthcare and benefits information
- h. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- i. Enhance outreach and services to veterans and their families in southwestern Georgia and southeastern Alabama where currently readjustment counseling services are a great distance away
- j. Promote access to quality VA healthcare services
- k. Collaboration with Columbus CBOC

2. Ft. Hood, TX

Criteria:

- a. Post population – 71,000 active duty and family members
- b. Major Units: III US Corps, 13th Corps Support Command, 1st Cavalry Division, 4th Infantry Division, 3rd Signal Brigade, 21st Cavalry Brigade (Air Combat), 504th Military Intelligence Brigade, 89th Military Police Brigade, Army Operational Test Command (AOTC) 13th Finance Group, 3rd Personnel Group, 4003rd Garrison Support Unit (Army Reserve), Hood Army Airfield
- c. Power Projection Platform – 289 Units / 74,326 Service Members
- d. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Hood 13,000 (calendar year 2005)
- e. Active Duty Service Members deployed from / redeployed to Ft. Hood – 36,000 (calendar year 2005)
- f. Total population of catchment area – 302,404
- g. Separated GWOT veterans living in area – 2,983
- h. Veteran population in catchment area – 69,225
- i. Nearest VA / RCS Facility – Austin, TX (75 miles)
- j. Area growth rate since 1990 Census: 46.1%

Enhancements:

- a. Local VA services to a major military base
- b. Access to separating combat veterans
- c. Readjustment Counseling Services to 69,225 local veterans
- d. Liaison with military family assistance programs
- e. Promoting seamless transition services for veterans and families
- f. Establishing early intervention and prevention services to enhance normalization of the transition process
- g. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- h. Promote access to quality VA healthcare services
- i. Collaboration with Waco VA Medical Center and Austin Outpatient Clinic

3. Ft. Riley, KS

Criteria:

- a. Post population – 23,500 active duty and family members
- b. Major Units: 24th Infantry Division, 1st Brigade/1st Infantry Division (Mechanized), 3rd Brigade, 1st Armor Division, 3rd Brigade, 75th Division (TS), 937th Engineer Group, 1st Battalion, 13th Armor, 1st Battalion, 16th Infantry, 1st Battalion, 34th Armor, 1st Battalion, 41st Infantry, 1st Battalion, 5th Field Artillery, 1st Brigade, 1st Infantry Division, 1st Engineer Battalion, 1st Finance Battalion, 1st Maintenance Company, 1st Personnel Service Battalion, 2nd Battalion, 34th Armor, 2nd Battalion,

70th Armor, 2d FA Battalion, 495th FA Brigade, 4th Battalion, 1st Field Artillery, 70th Engineer Battalion, 101st Support Battalion, 125th Support Battalion, 541st Maintenance Battalion, 24th Transportation Company, 55th Engineer Company, 82nd Medical Company, 568th Engineer Company (CSE), 596th Signal Company, 172nd Chemical Company, 300th MP Company, 331st Signal Company, 977th MP Company, 482nd Engineer Fire Fighting Platoon, C Battery, 4/3 Air Defense, 48th Medical Detachment, 95th Maintenance (TMDE), 95th Maintenance Detachment, 523rd MP Team, 774th Ordnance Detachment, 6025th Garrison Unit, Detachment 1, Air Force, 10th ASOS

- c. Power Projection Platform – 152 Units / 33,585 Service Members
- d. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Riley – 8,500 (calendar year 2005)
- e. Active Duty Service Members deployed from /redeployed to Ft. Riley – 8,000 (calendar year 2005)
- f. Total population of catchment area – 243,748
- g. Separated GWOT veterans living in area – 2,019
- h. Veteran population in catchment area – 44,717
- i. Nearest VA / RCS Facility – Kansas City, MO (120 miles)
- j. BRAC recommendations indicate that Ft. Riley will be gaining personnel in the future.
- k. Area growth rate since 1990 Census: 3.1%

Enhancements:

- a. Local VA services to a major military base
- b. Access to separating combat veterans
- c. Readjustment Counseling Services to 44,717 local veterans
- d. Liaison with military family assistance programs
- e. Promoting seamless transition services for veterans and families
- f. Establishing early intervention and prevention services to enhance normalization of the transition process
- g. Provide VA healthcare and benefits information
- h. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- i. Promote access to quality VA healthcare services
- j. Collaboration with Topeka VA Medical Center and Salina CBOC

4. Ft. Carson, CO

Criteria:

- a. Post population – 27,000 active duty and family members (additional 6,073 at Peterson AFB, 2,589 at Schriever AFB and 3,991 at the Air Force Academy)
- b. Major Units: 2nd Brigade, 2nd Infantry Division, 1/12th Infantry, 1/3rd ACR, 1/68th Armor, 1/8th Infantry, 10th CSH, 10th Special Forces Group (Airborne), 10th Special Forces Group (Airborne) 2nd Battalion, 10th Special Forces Group (Airborne) 3rd

Battalion, 2/3rd ACR, 3/29th Field Artillery, 3/3rd ACR, 32nd Transportation, 360th Transportation, 3rd ACR, 3rd Brigade Headquarters, 4/3rd ACR, 43rd Area Support Group, 4th Engineers, 4th PSB, 52nd Engineer Battalion, 60th Ordnance Company, 64th Support Battalion, 68th Corps Support Battalion, 759th MP, 764th EOD, K/CO, 158th AVN

- c. Power Projection Platform – 93 Units / 21,178 Service Members
- d. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Carson – 5,000 (calendar year 2005)
- e. Active Duty Service Members deployed from /redeployed to Ft. Carson – 14,000 (calendar year 2005)
- f. Total population of catchment area – 171,836
- g. Separated GWOT veterans living in area – 231
- h. Veteran population in catchment area – 32,582
- i. Nearest VA / RCS Facility – Colorado Springs, CO (44 miles)
- j. Area growth rate since 1990 Census: 4.6%

Enhancements:

- a. Local VA services to a major military base
- b. Access to separating combat veterans
- c. Readjustment Counseling Services to 44,717 local veterans
- d. Liaison with military family assistance programs
- e. Promoting seamless transition services for veterans and families
- f. Establishing early intervention and prevention services to enhance normalization of the transition process
- g. Provide VA healthcare and benefits information
- h. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- i. Promote access to quality VA healthcare services
- j. Collaboration with Colorado Springs CBOC and Pueblo CBOC.

B. New Vet Centers – Underserved Areas (8)

1. Phoenix, AZ

Criteria:

- a. Total Population of the catchment area – 2,111,705
- b. Veteran population – 346,997
- c. Separated GWOT veterans living in the area – 3,840
- d. Phoenix is the largest metropolitan area in the country served by only one existing Vet Center (sixth largest metropolitan area in the United States).
- e. Diverse city with high number of Native American, Hispanic and African American veterans
- f. Productivity FY 2005 – 787 Veterans provided 6,419 visits
- g. Area growth rate of since 1990 census: 20.3%

- h. Arizona Army National Guard maintains 45 armories, and is present in 22 communities - State Area Command, 98th Troop Command, 385th Aviation Regiment, 153rd Field Artillery Brigade 158th Regiment (RTI), 91st WMD CST. The Western Army National Guard Aviation Training Site, (WAATS) Silverbell Army Heliport Marana, Arizona. Co-located at the heliport is the 385th Attack Regiment, 1st Battalion, 285th Aviation Brigade
- i. Marine Corps Reserve: Bulk Fuel Company C, 6th Engineer Support Battalion, 4th FSSG Detachment 7, Engineer Support Company, 6th Engineer Support Battalion, 4th FSSG

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population.
- b. Enhance liaison with National Guard / Reserves
- c. Provide access to services by area American Indian veterans (Salt River Indian Reservation, Gila River Indian Reservation, Ak-Chin Indian Reservation, Ft. McDowell Indian Reservation, San Carlos Indian Reservation)
- d. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166)
- e. Provide VA healthcare and benefits information
- f. Increase capacity to provide services to clinically complex readjustment cases
- g. Collaboration with Phoenix VA Medical Center and Mesa CBOC

2. San Antonio, TX

Criteria:

- a. Total Population of the catchment area – 1,110,954
- b. Veteran population – 212,056
- c. Separated GWOT veterans living in the area – 4,019
- d. Diverse city with high number of Native American, Hispanic and African American veterans
- e. Productivity FY 2005 – 1,329 Veterans provided 8,257 visits
- f. Area growth rate of since 1990 census: 20.3%
- g. Active Military: Fort Sam Houston is the home of the HQ U.S. 5th Army, U.S. Army 5th Recruiting Brigade, Brooke Army Medical Center, Institute of Surgical Research, U.S. Army Medical Department Center and School, U.S. Army Center Brigade, and U.S. Army Medical Command (6,950 Active Duty Officers & Enlisted). Lackland Air Force Base is home to the 37th Training Wing, 149th Fighter Wing and the 59th Medical Wing.
- h. Army Reserve: 90th Regional Support Group headquartered at Fort Sam Houston, commands approximately 5,300 soldiers and 280 fulltime personnel in 47 units including the 694th Maintenance Battalion.

- i. Marine Corps Reserve: Headquarters 4th Reconnaissance Battalion, Headquarters and Service Company, 4th Reconnaissance Battalion, and Companies A & C, 4th Reconnaissance Battalion, 4th Marine Division
- j. Texas Army/Air National Guard maintains 117 armories, and is present in 102 communities.
- k. San Antonio is the 8th largest city in the United States and is currently served by only one Vet Center.

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population by establishing a second Vet Center for the metropolitan area.
- b. Enhance liaison with National Guard / Reserves
- c. Establishing early intervention and prevention services to enhance normalization of the transition process.
- d. Readjustment Counseling services for 212, 056 local veterans.
- e. Provide access to services by area Native American veterans
- f. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166)
- g. Increase capacity to provide services to clinically complex readjustment cases
- h. Collaboration with South Texas Veterans Health Care System, San Antonio VAMC and San Antonio CBOC

3. Miami, FL

Criteria:

- a. Total Population of the catchment area – 1,655,214
- b. Veteran population – 105,790
- c. Separated GWOT veterans living in the area – 1,700
- d. Productivity FY 2005 – 1,547 Veterans provided 8,005 visits
- e. Area growth rate of since 1990 census: 4.7%
- f. Florida Army/Air National Guard maintains 72 armories, and is present in 63 communities - State Area Command, 83rd Troop Command, 53rd Infantry Brigade (Sep) (Light), 50th Area Support Group, 32nd Army Air & Missile Defense - Detachment 1, 211th Regiment (RTI)
- g. Increase capacity to provide services to clinically complex readjustment cases

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population by establishing a second Vet Center for the metropolitan area.
- b. Enhance liaison with National Guard / Reserves
- c. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166)
- d. Increase capacity to provide services to clinically complex readjustment cases

- e. Collaboration with Miami VA Medical Center
- f. Collaboration with Florida Department of Veterans Affairs

4. Kansas City, MO

Criteria:

- a. Total Population of the catchment area – 2,076,287
- b. Veteran population – 356,519
- c. Separated GWOT veterans living in the area – 3,173
- d. Diverse city with high number of Hispanic and African American veterans
- e. Productivity FY 2005 – 1,013 Veterans provided 8,969 visits
- f. Area growth rate of since 1990 census: 1.8%
- g. Marine Corps Reserve: Marine Forces Reserve, 4th Force Service Support Group - Headquarters and Service Battalion, 4th Maintenance Battalion, 6th Motor Transport Battalion, 4th Supply Battalion, 6th Communications Battalion, 4th Landing Support Battalion, 6th Engineer Support Battalion, 6th Motor Transport Battalion, 4th Medical Battalion, 4th Dental Battalion, Headquarters Company, 24th Marines, 4th Marine Division, Direct Support Team 2, Headquarters, 4th Marine Division, Headquarters, Marine Corps Mobilization Command .
- h. Missouri Army/Air National Guard maintains 65 armories, and is present in 64 communities - State Area Command, 70th Troop Command, 35th Division Support Command, 35th Engineer Brigade, 35th Aviation Brigade, 135th Field Artillery Brigade, 140th Regiment, 7th WMD CST

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population by establishing a second Vet Center for the metropolitan area.
- b. Enhance liaison with National Guard / Reserves
- c. Increase capacity to provide services to clinically complex readjustment cases
- d. Collaboration with Kansas City VA Medical Center

5. Springfield, MO

Criteria:

- a. Total Population of the catchment area – 936,021
- b. Veteran population – 170,668
- c. Separated GWOT veterans living in the area – 1,681
- d. Area growth rate of since 1990 census: 6.8%
- e. Ft. Leonard Wood, MO (68 miles)
 - i. Post population – 13,361 Service Members
 - ii. Power Support Platform
 - iii. Major Units: 169th Engineer Battalion, 1st Engineer Brigade, 35th Engineer Battalion, 399th Army Band, 3rd Training Brigade, 43rd Adjutant General,

- 554th Engineer Battalion, 577th Engineer Battalion, 58th Transportation Battalion, 5th Engineer Battalion, Libby NCO Academy, Drill Sergeant School, Law Enforcement Command, M.P. A Company (Permanent Party), M.P. B Company (Officer Basic), M.P. C Company (Officer Advanced), U.S. Army Chemical School
- f. Missouri Army/Air National Guard maintains 65 armories, and is present in 64 communities - State Area Command, 70th Troop Command, 35th Division Support Command, 35th Engineer Brigade, 35th Aviation Brigade, 135th Field Artillery Brigade, 140th Regiment, 7th WMD CST
 - g. Marine Corps Reserve: Weapons Company, 3rd Battalion, 24th Marines, 4th Marine Division
 - h. Nearest VA / RCS Facility – Tulsa, OK (182 miles)

Enhancements:

- a. Readjustment Counseling Services to 170,668 local veterans
- b. Access to separating combat veterans at a Power Support Platform
- c. Liaison with military family assistance programs
- d. Promoting seamless transition services for veterans and families
- e. Establishing early intervention and prevention services to enhance normalization of the transition process
- f. Provide VA healthcare and benefits information
- g. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- h. Improve access to readjustment counseling in southern Missouri and northern Arkansas for rural veterans and their families.
- i. Enhance liaison with National Guard / Reserves
- j. Increase capacity to provide services to clinically complex readjustment cases
- k. Collaboration with Kansas City VA Medical Center and Ft. Leonard Wood CBOC

6. Las Cruces, NM

Criteria:

- a. Ft. Bliss, TX (90% in New Mexico)
 - i. Post population – 8,264 Service Members
 - ii. Power Projection Platform 45 Units, 11,138 Service Members
 - iii. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Bliss – 15,218 (calendar year 2005)
 - iv. Active Duty Service Members deployed from / redeployed to Ft. Bliss – 377 (calendar year 2005)
 - v. Major Units: 32nd Army Air and Missile Defense Command, 6th Air Defense Artillery Brigade 11th Air Defense Artillery Brigade, 31st Air Defense Artillery Brigade, 35th Air Defense Artillery Brigade, 108th Air Defense Artillery Brigade, 204th MI Battalion, Joint Task Force Six, USACAS

McGregor Range, Oscura Range, Red Rio Bombing Range, White Sands Missile Range, Holloman Air Force Base

- b. Total Population of the catchment area – 298,934
- c. Veteran population – 32,351
- d. Separated GWOT veterans living in the area – 655
- e. Diverse city with high number of Native American and Hispanic veterans
- f. Area growth rate of since 1990 census: 23.2%
- g. New Mexico Army/Air National Guard: 93rd Troop Command, 111th ADA Brigade, 515th Regiment (RTI), 64th WMD CST

Enhancements:

- a. Readjustment Counseling Services to 32,351 local veterans
- b. Access to separating combat veterans at a Power Support Platform
- c. Liaison with military family assistance programs
- d. Promoting seamless transition services for veterans and families
- e. Establishing early intervention and prevention services to enhance normalization of the transition process
- f. Provide VA healthcare and benefits information
- g. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- h. Provide access to readjustment services for area Native American veterans
- i. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166)
- j. Increase capacity to provide services to clinically complex readjustment cases
- k. Collaboration with Las Cruces CBOC, Truth or Consequences CBOC and Silver City CBOC

7. Modesto, CA

Criteria:

- a. Total Population of the catchment area – 740,534
- b. Veteran population – 97,375
- c. Separated GWOT veterans living in the area – 1,010
- d. Diverse area with high number of Hispanic and African American veterans
- e. Area growth rate of since 1990 census: 23.0%
- f. National Guard / Reserve Units: State Area Command, 49th Combat Support Command, 100th Troop Command, 40th Infantry Division, 115th Area Support Group, 223rd Infantry Regiment (CA), 1106th AVCRAD, 9th WMD CST, 95th WMD CST
- g. Nearest VA / RCS Facility – San Jose, CA (85 miles) – significant traffic congestion

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population.
- b. Enhance liaison with National Guard / Reserves
- c. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166)
- d. Increase capacity to provide services to clinically complex readjustment cases
- e. Enhance outreach and readjustment services to all of central-eastern California.
- f. Collaboration with Central California Health Care System, Modesto Out Patient Clinic and Stockton Out Patient Clinic
- g. Collaboration with California Department of Veterans Affairs.
- h. Promote access to quality VA healthcare services

8. Ft. Meyers, FL*Criteria:*

- a. Total Population of the catchment area – 574,119
- b. Veteran population – 134,732
- c. Separated GWOT veterans living in the area – 895
- d. Area growth rate of since 1990 census: 52.2%
- e. National Guard / Reserve Units: The Florida Army National Guard maintains 72 armories, and is present in 63 communities. State Area Command, 83rd Troop Command, 53rd Infantry Brigade (Sep) (Light), 50th Area Support Group, 32nd Army Air & Missile Defense - Detachment 1, 211th Regiment (RTI)

Enhancements:

- a. Provide quality Readjustment Counseling to a large underserved diverse veteran population.
- b. Enhance liaison with National Guard / Reserves
- c. Bi-lingual Spanish speaking counselor to enhance services for Limited English Proficiency (LEP) veterans and family members.
- d. Increase capacity to provide services to clinically complex readjustment cases
- e. Collaboration with Ft. Myers Out Patient Clinic, Port Charlotte CBOC and Naples CBOC
- f. Collaboration with Florida Department of Veterans Affairs

C. Staff Augmentation (24 FTEE)**American Indian Services****1. Chinle, AZ (Navajo)***Criteria:*

- a. The Navajo Reservation has a population of 173,987 (149,423 American Indian), making it the most populated Reservation in the United States.
- b. The Navajo Reservation encompasses over 24,000 square miles, making it the geographically largest Reservation in the United States.
- c. Veteran Population – 12,272 (includes Hopi)

Enhancements:

- a. Increase access to care for high risk minority veterans in a rural setting.
- b. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices.
- c. Targeted recruitment for a Navajo counselor who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166)

2. Keams Canyon, AZ (Hopi / Ft. Apache)*Criteria:*

- a. The Hopi Reservation has a population of 6,815 (6,442 American Indian) – 2,450 square miles
- b. The Ft. Apache Reservation has a population of 12,429 (11,702 American Indian) making it the third most populated Reservation in the United States – 2,600 square miles
- c. Veteran Population – 12,272 (includes Navajo)

Enhancements:

- a. Increase access to care for high risk minority veterans in a rural setting.
- b. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices.
- c. Targeted recruitment for a Apache counselor (Hopi Counselor currently on staff) who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166)

3. Martin, SD (Lakota Sioux: Pine Ridge / Rosebud)*Criteria:*

- a. The Pine Ridge Reservation has a population of 14,068 (12,985 American Indian), making it the second most populated Reservation in the United States. (*Additional 1,439 American Indians on Off-Reservation Trust Land*)
- b. The Rosebud Reservation has a population of 9,050 (7,747 American Indian). (*Additional 1,419 American Indians on Off-Reservation Trust Land*)
- c. Veteran Population – 5,616

Enhancements:

- a. Increase access to care for high risk minority veterans in a rural setting.
- b. Vet Center services on reservation lands maintain sensitivity to the local culture and collaborate with native healing philosophies and practices.
- c. Targeted recruitment for a Lakota counselor who speaks the language to improve access to services for persons with limited English proficiency (Executive Order 13166)

Underserved Areas

4. Fayetteville, NC

Criteria:

- a. North Carolina - Active Duty Military: 91,855, Reserve Component: 39,918
- b. Ft. Bragg, NC
 - i. Post population – 43,000 Service Members
 - ii. Power Projection Platform 253 Units, 48,236 Service members
 - iii. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Bragg – 5,600 (calendar year 2005)
 - iv. Active Duty Service Members deployed from /redeployed to Ft. Bragg – 9,300 (calendar year 2005)
 - v. Major Units: XVIII Airborne Corps, 16th Military Police Brigade, 18th Aviation Brigade Corps (Airborne), 18th Corps Soldiers Support Group, 18th Personnel Group, 20th Engineer Brigade (Airborne), 35th Signal Brigade, 44th Medical Brigade, 82nd Replacement Detachment, 525th Military Intelligence Brigade, 1112th Signal Battalion, 1st Brigade / 82nd Airborne Division, 2nd Brigade / 82nd Airborne Division, 3rd Brigade / 82nd Airborne Division, Dragon Brigade, USA JFK Special Warfare Center, USA Special Operation Command
- c. North Carolina Army/Air National Guard: State Arca Command, 60th Troop Command, 30th Heavy Separate Brigade, 30th Engineer Brigade, 113th Field Artillery Brigade, 449th Aviation Group (Lift), 139th Regiment - Fort Bragg, 42nd WMD CST
- d. Veteran Population – 143,612
- e. Productivity FY 2005 – 3,482 Veterans (3,254 GWOT) provided 7,402 visits

Enhancements:

- a. Readjustment Counseling Services to 143,612 local veterans
- b. Access to separating combat veterans at a Power Support Platform
- c. Liaison with military family assistance programs
- d. Promoting seamless transition services for veterans and families
- e. Establishing early intervention and prevention services to enhance normalization of the transition process
- f. Provide VA healthcare and benefits information
- g. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- h. Enhance outreach and readjustment services to southeastern North Carolina and northeastern South Carolina.
- d. Enhance capacity to provide family services and bereavement counseling.
- e. Collaboration with Fayetteville VA Medical Center.

5. Syracuse, NY*Criteria:*

- a. New York - Active Duty Military: 18,853, Reserve Component: 56,774
- b. Ft. Drum, NY
 - i. Post population – 12,123 Service Members
 - ii. Power Projection Platform 253 Units, 48,236 Service members.
 - iii. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Drum – 12,000 (calendar year 2005)
 - iv. Active Duty Service Members deployed from /redeployed to Ft. Drum – 15,000 (calendar year 2005)
 - v. Fort Drum is a major training center for reserve component forces. Offers planning and support for the mobilization and training of almost 80,000 troops annually
- b. New York Army National Guard maintains 82 armories, and is present in 72 communities - State Area Command, Latham, 53rd Troop Command, 42nd Infantry Division (Mechanized), 27th Infantry Brigade (Enhanced) (Separate), 106th Regiment (RTI), 2nd WMD CST – Scotia
- c. Marine Corps Reserve: Detachment 3, Headquarters and Service Company, 8th Tank Battalion, 4th Marine Division, Company B, 8th Tank Battalion, 4th Marine Division
- d. Veteran Population – 186,415
- d. Productivity FY 2005 – 1,126 Veterans provided 7,113 visits

Enhancements:

- a. Readjustment Counseling Services to 186,415 local veterans
- b. Access to separating combat veterans at a Power Support Platform
- c. Liaison with military family assistance programs
- d. Promoting seamless transition services for veterans and families

- e. Establishing early intervention and prevention services to enhance normalization of the transition process
- f. Provide VA healthcare and benefits information
- g. Liaison with casualty assistance program to enhance referral process for bereavement counseling
- h. Enhance the capacity to provide family services and bereavement counseling.
- i. Collaboration with Syracuse VA Medical Center.

6. El Paso, TX

Criteria:

- a. Texas - Active Duty Military: 110,956, Reserve Component 93,162.
- b. Ft. Bliss, TX
 - i. Post population – 8,264 Service Members
 - ii. Power Projection Platform 45 Units, 11,138 Service Members
 - iii. National Guard / Reserve GWOT's mobilized/demobilized at Ft. Bliss – 15,218 (calendar year 2005)
 - iv. Active Duty Service Members deployed from /redeployed to Ft. Bliss – 377 (calendar year 2005)
 - v. Major Units: 32nd Army Air and Missile Defense Command, 6th Air Defense Artillery Brigade 11th Air Defense Artillery Brigade, 31st Air Defense Artillery Brigade, 35th Air Defense Artillery Brigade, 108th Air Defense Artillery Brigade, 204th MI Battalion, Joint Task Force Six, USACAS McGregor Range, Oscura Range, Red Rio Bombing Range, White Sands Missile Range, Holloman Air Force Base
- c. Marine Corps Reserve: Battery D, 2nd Battalion, 14th Marines, 4th Marine Division
- d. Texas Army/Air National Guard maintains 117 armories, and is present in 102 communities
- e. Veteran Population – 93,330
- f. Productivity FY 2005 – 831 Veterans provided 5,644 visits

Enhancements:

- a. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166).
- b. Readjustment Counseling Services to 32,351 local veterans
- c. Access to separating combat veterans at a Power Support Platform
- d. Liaison with military family assistance programs
- e. Promoting seamless transition services for veterans and families
- f. Establishing early intervention and prevention services to enhance normalization of the transition process
- g. Provide VA healthcare and benefits information
- h. Liaison with casualty assistance program to enhance referral process for bereavement counseling

7. Los Angeles, CA

Criteria:

- a. California - Active Duty Military: 121,971, Reserve Component: 103,711
- b. Marine Corps Reserve: (Encino) - 2nd Battalion, 23rd Marines, 4th Marine Division, Headquarters and Service Company, 2nd Battalion, 23rd Marines, 4th Marine Division. (Long Beach) - 3rd Air Naval Gunfire Liaison Company (3rd ANGLICO), MARFORRES. (Pasadena) - Headquarters, 4th Low Altitude Air Defense Battalion, Marine Air Control Group 48, 4th MAW, Headquarters and Service Battery (-), 4th Low Altitude Air Defense Battalion, Marine Air Control Group 48, 4th MAW, Battery A, 4th Low Altitude Air Defense Battalion, Marine Air Control Group 48, 4th MAW, (Riverside) - Detachment 4, 4th Tank Battalion, 4th Marine Division, Company D, 4th Tank Battalion, 4th Marine Division
- c. California Army/Air National Guard: State Area Command, 49th Combat Support Command, 100th Troop Command, 40th Infantry Division, 115th Area Support Group, 223rd Infantry Regiment (CA), 1106th AVC RAD, 9th WMD CST, 95th WMD CST
- d. Veteran Population – 102,142
- e. Productivity FY 2005 – 716 Veterans (136 GWOT) provided 6,133 visits

Enhancements:

- a. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166).
- b. Enhance outreach and readjustment services to National Guard and Marine Reserve Service Members and their families.
- c. Enhance capacity to provide family services and bereavement counseling in the entire Los Angeles basin.
- d. Collaboration with Desert Pacific Healthcare Network (VISN 22), Greater Los Angeles Health Care System, Los Angeles and West Los Angeles Ambulatory Care Centers, and the East Los Angeles and Gardena CBOCs.
- e. Enhance targeted outreach to Hispanic and African American veterans and their families.

8. Columbus, OH

Criteria:

- a. Ohio - Active Duty Military: 8,174, Reserve Component 48,523
- b. Veteran Population – 211,457
- c. Ohio Army/Air National Guard maintains a presence in 54 of the state's 88 counties. Ohio's Air Guard units are dispersed in seven geographic locations-Columbus, Toledo, Springfield, Cincinnati, Mansfield, Zanesville and Port Clinton -- and the state's Army Guard units occupy several training sites and 51 armories statewide - State Area Command, 73rd Troop Command, 37th Armored Brigade, 16th Engineer Brigade, 145th Regiment (RTI), 52nd WMD CST

- d. Marine Corps Reserve: Lima Company, 3rd Battalion, 25th Marines, 4th Marine Division
- e. Productivity FY 2005 – 447 Veterans provided 5,357 visits
- f. Eighteen active bereavement counseling cases have generated over 172 bereavement counseling visits.

Enhancements:

- a. Readjustment Counseling services to 211,457 local veterans.
- b. Enhance capacity to provide family services and bereavement counseling.
- c. Enhance outreach and readjustment services to National Guard and Marine Reserve Service Members and their families.
- d. Liaison with Casualty Assistance office to facilitate bereavement counseling referral process.
- e. Collaboration with Chalmers P. Wylie Outpatient Clinic (Columbus).

9. Washington, DC

Criteria:

- a. Marine Corps Reserve: (Washington DC) Detachment 1, Supply Company, 4th Supply Battalion, 4th FSSG, Rations Company, 4th Supply Battalion, 4th FSSG, Surgical Company B (-), 4th Medical Battalior, 4th FSSG, 4th Civil Affairs Group, MARFORRES, 10th Counter Intelligence Team, MARFORRES, 12th Counter Intelligence Team, MARFORRES, (Quantico) Detachment 3, Headquarters and Service Company, 4th Light Armored Reconnaissance Battalion, 4th Marine Division, Company D, 4th Light Armored Reconnaissance Battalion, 4th Marine Division
- b. Washington DC National Guard - 74th Troop Command, 260th Regiment RTI, 33rd WMD CST, 104th Maintenance Company, 121st Medevac Air Ambulance, 140th Transportation Company, 260th MP Command, 715th Public Affairs Team, 547th Transportation Company Light-Medium Truck, 257th AG Bnd Army, Detachment 4 OSAC, RAID Washington, HQ District Area Command
- c. Veteran Population – 67,990
- d. Productivity FY 2005 – 300 Veterans provided 2,426 visits

Enhancements:

- a. Enhance outreach and services to Service Members and their families utilizing Walter Reed Army Medical Center, Malogne House and Fisher House ensuring seamless transition.
- b. Readjustment Counseling services for 67,990 local veterans.
- c. Enhanced outreach and services to Marine Reserve and National Guard Service Members and their families.
- d. Collaboration with the Washington DC VA Medical Center.

10. Wichita, KS

Criteria:

- a. Kansas - Active Duty Military: 16,659, Reserve Component: 17,749
- b. Army Reserves: 89th Regional Readiness Command – Command for all Army Reserve Units in Kansas, Nebraska, Iowa, and Missouri - 326th Area Support Group, 648th Area Support Group, 649th Area Support Group, 8th Legal Support Organization, 139th Medical Group, 331st Medical Group, 372nd Engineer Group, 561st Corps Support Group, 917th Corps Support Group, 166th Aviation Brigade, 89th Ordnance Battalion, 89th Transportation Battalion, 243rd Quartermaster Battalion, 312th Army Band, 317th Quartermaster Battalion (S&S), 320th Ordnance Battalion, 325th Quartermaster Battalion (PS), 329th Supply and Services Battalion, 368th Finance Battalion, 387th Replacement Battalion, 388th Medical Battalion, 389th Engineer Battalion, 394th Corps Support Battalion, 450th Transportation Battalion, 530th Military Police Battalion, 620th Corps Support Battalion, 809th Quartermaster Battalion, 821st Transportation Battalion
- c. Marine Corps Reserve: Detachment, Engineer Maintenance Company, 4th Maintenance Battalion, 4th FSSG and Electronic Maintenance Company, 4th Maintenance Battalion, 4th FSSG (USMC Reserves)
- d. Kansas Army/Air National Guard maintains 76 armories, and is present in 57 communities - State Area Command, 69th Troop Command, 35th Infantry Division (Mechanized), 130th Field Artillery Brigade, 235th Regiment (RTI). Smoky Hill Air National Guard (ANG) Range.
- e. Veteran Population – 241,300
- f. Productivity FY 2005 – 748 Veterans provided 5,183 visits

Enhancements:

- a. Readjustment Counseling services to 241,300 local veterans.
- b. Enhance outreach and readjustment services to Army Reserve, Marine Reserve, and National Guard Service Members and their families.
- c. Targeted recruitment for a military sexual trauma counseling specialist.
- c. Enhance outreach and readjustment services for rural veterans in western Kansas.
- d. Collaboration with Robert J. Dole Department of Veterans Affairs Medical and Regional Office Center.

11. Tucson, AZ

Criteria:

- a. Arizona - Active Duty Military: 22,297, Reserve Component: 20,613
- b. Arizona Army National Guard maintains 45 armories, and is present in 22 communities - State Area Command, 98th Troop Command, 385th Aviation Regiment, 153rd Field Artillery Brigade 158th Regiment (RTI), 91st WMD CST. The Western Army National Guard Aviation Training Site, (WAATS) Silverbell Army Heliport

Marana, Arizona. Co-located at the heliport is the 1st /285th Apache Helicopter Attack Battalion.

- c. Veteran Population – 119,080
- d. Productivity FY 2005 – 1,123 Veterans provided 5,360 visits
- e. Tohono O'odham Nation –tribal members 20,640 (Tohono O'odham Reservation - population 10,787 - total land area 4,450 square miles).

Enhancements:

- a. Readjustment Counseling services to 119,080 local veterans
- b. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166).
- c. Enhance access to VA services for American Indian veterans and their families.
- d. Enhance outreach and readjustment services to Arizona Army & Air National Guard Service Members and their families.
- e. Enhance outreach and readjustment counseling for rural veterans and their families in southeastern Arizona.
- f. Collaboration with Southern Arizona VA Health Care System, Green Valley CBOC,

12. Philadelphia, PA

Criteria:

- a. Pennsylvania - Active Duty Military: 3,566. Reserve Component: 57,393
- a. Naval Air Station JRB Willow Grove - Patrol Squadron Six Four, Patrol Squadron Six Six, Fleet Logistic Support Squadron Five Two, Helicopter Anti-Submarine Squadron HSL-94, Marine Aircraft Group Forty Nine , 913th Airlift Wing, 111th Fighter Wing. US Navy: Defense Distribution Center, Naval Inventory Control Point (NAVICP), Naval Supply Systems Command (NAVSUP), Navy Fleet Material Support Office (FMSO), Defense Depot Susquehanna, PA (DDSP), Naval Sea Logistics Center (NAVSEALOGCEN), Defense Enterprise Computing Center (DECC MECH), Naval Ammunition Logistics Center (NALC or NAVAMMOLOGCEN), Document Automation and Production Service Headquarters (DAPS-HQ), Document Automation and Production Service (DAPS), Defense Reutilization and Marketing Service (DRMS)
- b. Pennsylvania Army National Guard maintains 129 armories, and is present in 96 communities - State Area Command, 28th Infantry Division (Mechanized), 213th Area Support Group, 166th Regiment, 3rd WMD CST - Annville
- c. Marine Corps Reserve: 3rd Battalion, 14th Marines, 4th Marine Division, Headquarters Battery, 3rd Battalion, 14th Marines, 4th Marine Division, 14th Dental Company, 4th Dental Battalion, 4th FSSG
- d. Veteran Population – 219,226
- e. Productivity FY 2005 – 368 Veterans provided 4,215 visits

Enhancements:

- a. Readjustment Counseling services to 219,226 local veterans.
- b. Enhance the bereavement referral process through collaboration with the VA National Cemetery Service Philadelphia Memorial Network.
- c. Enhance outreach and readjustment services to Active Duty Navy, Marine Reserve, and National Guard Service Members and their families as they separate from service.
- d. Collaboration with Philadelphia VA Medical Center and Philadelphia CBOC.

13. Norfolk, VA

Criteria:

- a. Virginia - Active Duty Military: 84,463, Reserve Component 42,835
- b. Hampton Roads is the world's largest naval base (Norfolk) - NAVSTA Norfolk, NAS Norfolk, CINCLANTFLT Compound, Craney Island, St. Juliens Creek Annex, Deperming Crib, Golf Anchorages, (Little Creek) - NAVPHIBASE Little Creek, NAS Oceana, FCTC LANT Dam Neck, Fentress Field, Lynnhaven anchorages, NAVMASSO, NAVSECGRUACT Northwest, (Portsmouth) - NAVSHIPYD Norfolk, NAVHOSP Portsmouth, RADTRANSFAC Driver Norfolk, Shipyards at Brambleton, Berkley and Metro, ANA Shipyard, (Newport News) - SUPSHIP Newport News, MARCORESCEN Newport News, (Yorktown) - WPNSTA Yorktown, Cheatham Annex, York River anchorages
- c. Marine Corps Reserve: (Norfolk) Detachment 1, Headquarters and Service Company, 4th Assault Amphibian Battalion, 4th Mar Div, Company A (-), 4th Assault Amphibian Battalion, 4th Marine Division, Detachment, Marine Air Logistics Squadron 42, Marine Aircraft Group 42, 4th MAW, Marine Heavy Helicopter Squadron 774 (HMM-774), Marine Aircraft Group 42, 4th MAW, (Newport News) Detachment 8, Headquarters Company, Headquarters and Service Battalion, 4th FSSG, Headquarters, 4th Supply Battalion, 4th FSSG, Headquarters and Service Company (-), 4th Supply Battalion, 4th FSSG, Medical Logistics Company (-), 4th Supply Battalion, 4th FSSG, Detachment, Surgical Company B (-), 4th Medical Battalion, 4th FSSG
- d. Virginia Army National Guard maintains 61 armories, and is present in 50 communities – State Area Command - Ft Pickett, 91st Troop Command, 29th Infantry Division (Light), Engineer Brigade, 28th ID, 54th Field Artillery Brigade, 183rd Regiment (RTI)
- e. Veteran Population – 226,121
- f. Productivity FY 2005 – 949 Veterans provided 4,450 visits

Enhancements:

- a. Readjustment Counseling services to 226,121 local veterans.
- b. Enhance outreach and readjustment services to Active Duty Navy, Marine Reserve, and National Guard Service Members and their families as they separate from service.
- c. Enhance outreach and readjustment services to rural veterans and their families in southern Virginia and northeastern North Carolina.

14. Honolulu, HI

Criteria:

- a. Hawaii - Active Duty Military: 34,826, Reserve Component: 10,449
- b. U.S. Army Hawaii-Garrison Hawaii Army Education Centers, Island of Oahu, Hawaii, serves over 17,000 active duty Army soldiers: 25th MP Battalion, Fort Shafter MP Battalion, 25th Infantry Division, 2nd Brigade "Warriors", 3rd Brigade "Bronco", Aviation Brigade, 1-62nd Air Defense Artillery, DISCOM, 45th Corps Support Group, 45th Sustainment Brigade, 65th Engineer Battalion, 125th MI Battalion "Eyes of Lightning", 125th SIG Battalion "Voice of Lightning", 556th Personnel Service Battalion
- b. Army Reserve: 9th Regional Readiness Command - HHC, 9th RSC, 4960th Multifunction Training Brigade, 100th Battalion, 442nd Infantry, 322nd Civil Affairs Brigade, 411th Engineer Battalion, 657th Area Support Group, 8th State Military Office, 305th Public Affairs Detachment, 368th Military Police Company, 368th Military Intelligence Company, 456th Replacement Detachment, 548th Transportation Detachment, 1984th US Army Hospital, 804th Signal Company, US Forces Korea Support Unit, US Army Japan Support Unit, Hawaii Garrison Support Unit, Alaska Garrison Support Unit, Guam Garrison Support Unit
- b. Marine Corps Reserve: 4th Force Reconnaissance Company (-), Headquarters, 4th Marine Division
- c. The Hawaii Army National Guard maintains 21 armories, and is present in 17 communities - State Area Command, 103rd Troop Command, 29th Infantry Brigade (Separate), 298th Regiment (Regional Training Institute), 93rd WMD CST - Honolulu
- d. Veteran Population - 88,177
- e. Productivity FY 2005 - 561 Veterans provided 5,236 visits

Enhancements:

- a. Readjustment Counseling services for 88,177 local veterans.
- b. Enhance targeted outreach to Asian American / Pacific Islander veterans and their families.
- c. Collaboration with the Honolulu VA Medical and Regional Office Center.
- d. Collaboration with the Hawaii Office of Veteran Services.

15. West Palm Beach, FL

Criteria:

- a. Florida - Active Duty Military: 57,426, Reserve Component 59,805
- b. Veteran Population - 199,717
- c. Productivity FY 2005 - 480 Veterans (91 CWOT) provided 4,712 visits
- d. Six active bereavement counseling cases have generated over 185 bereavement counseling visits.

- d. Florida Army/Air National Guard maintains 72 armories, and is present in 63 communities. State Area Command, 83rd Troop Command, 53rd Infantry Brigade (Sep) (Light), 50th Area Support Group, 32nd Army Air & Missile Defense - Detachment 1, 211th Regiment (RTI)
- e. Marine Corps Reserve: 4th Air Naval Gunfire Liaison Company (4th ANGLICO), MARFORRES

Enhancements:

- a. Enhance capacity to provide family services and bereavement counseling.
- b. Enhance liaison and outreach to National Guard and Reserve units.
- c. Enhance outreach and readjustment services in south-central and southeastern Florida.
- d. Collaboration with West Palm Beach VA Medical Center, Ft. Pierce CBOC and Vero Beach CBOC

Rural / Small Teams

16. Missoula, MT

Criteria:

- a. Veteran Population – 66,911
- b. Montana Army/Air National Guard - State Area Command, 95th Troop Command 1-163rd Infantry Battalion, 1-190th Field Artillery Battalion, 1-112 AVN (LUH) (UH-1), 495th Transportation Battalion, 208th Regiment (RTI), 631st Chemical CO (RECON/DECON), 83rd WMD CST
- c. Flathead Indian Reservation (Confederated Salish and Kootenai Tribes) – population 26,172 (6,999 American Indian)
- d. Blackfeet Indian Reservation – population 10,100 (8,507 American Indian)
- e. Productivity FY 2005 – 477 Veterans provided 4,639 visits
- f. Existing Staff – 4 FTEE (3 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 66,911 local veterans
- b. Enhance ongoing outreach and services to American Indians
- c. Enhance outreach and services to a large geographical area with widely dispersed rural veterans and their families.
- d. Collaboration with Montana Health Care System, Missoula CBOC, Anaconda CBOC and Kalispell CBOC.
- e. Collaboration with Montana Veterans Affairs Division

17. Princeton, WV

Criteria:

- a. Veteran Population – 24,991
- b. West Virginia Army National Guard maintains 36 armories, and is present in 34 communities – State Area Command, 77th Troop Command, 2-19 Special Forces Group, 1-150th Armor (M1A1), 1-201st Field Artillery, 111th Engineer Group, 1092nd ENG Battalion (CBT) (C), 197th Regiment (RT!), Aviation Support Element, 35th WMD CST - St. Albans
- c. Productivity FY 2005 – 752 Veterans provided 14,605 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 24,991 local veterans.
- b. Enhance ongoing outreach and services to rural veterans and their families in southern West Virginia and southwestern Virginia.
- c. Collaboration with Beckley VA Medical Center
- d. Collaboration with West Virginia Division of Veterans Affairs

18. Sioux City, IA

Criteria:

- a. Veteran Population – 43,277
- b. Iowa Army National Guard maintains 56 armories, and is present in 53 communities – State Area Command, 67th Troop Command, 671st Troop Command, 2nd Brigade, 34th Infantry Division, 185th Regiment (RT!)
- c. Productivity FY 2005 – 736 Veterans provided 2,998 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 43,277 local veterans.
- b. Enhance ongoing outreach and services to veterans and their families in western Iowa, southwestern South Dakota and northwestern Nebraska.
- c. Collaboration with Sioux City CBOC and G. Dodge CBOC

19. Lincoln, NE

Criteria:

- a. Veteran Population – 68,345
- b. Nebraska Army National Guard maintains 31 armories, and is present in 31 communities – State Area Command, 92nd Troop Command, 67th Area Support

Group, 72nd WMD CST, 209th Training Regiment, Detachment 43, Operational Support Airlift

- c. Productivity FY 2005 – 701 Veterans provided 3,099 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 68.3% local veterans.
- b. Enhance ongoing outreach and services to veterans and their families in a large geographical area (majority of Nebraska).
- c. Collaboration with Lincoln Division – VA Nebraska Western Iowa Health Care System, Lincoln Regional Office

20. Santa Fe, NM

Criteria:

- a. Veteran Population - 50,372
- b. New Mexico Army/Air National Guard: 53rd Troop Command, 111th ADA Brigade, 515th Regiment (RTI), 64th WMD CST
- c. Productivity FY 2005 – 848 Veterans provided 3,050 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 50.27% local veterans.
- b. Bi-lingual Spanish speaking counselor to improve access to services for persons with limited English proficiency (Executive Order 13166).
- c. Enhance ongoing outreach and services to veterans and their families in northern New Mexico.
- d. Collaboration with Santa Fe CBOC

21. East St. Louis, IL

Criteria:

- a. Veteran Population – 63,238
- b. Illinois Army National Guard maintains 53 territories, and is present in 50 communities – State Area Command, 65th Troop Command, 33rd Area Support Group, 66th Infantry Brigade, 129th Regiment (RTI), 5th WMD CST - Bartonville
- c. Productivity FY 2005 – 295 Veterans provided 2,744 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services to 63,23% local veterans.

- b. Enhance outreach and services to a large African American veteran population (97% African America in East St. Louis city limits).
- c. Collaboration with St. Louis VA Medical Center Jefferson Barracks & John Cochran Divisions.

22. Staten Island, NY

Criteria:

- a. Veteran Population – 32,477
- b. New York Army National Guard maintains 32 armories, and is present in 72 communities - State Area Command, Laham, 53rd Troop Command, 42nd Infantry Division (Mechanized), 27th Infantry Brigade (Enhanced) (Separate), 106th Regiment (RTI), 2nd WMD CST – Scotia
- c. Productivity FY 2005 – 100 Veterans provided 2,493 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling for 32,477 local veterans.
- b. Enhance ongoing outreach and services to urban veterans in a densely populated area with significant traffic congestion and transportation issues.
- c. Collaboration with Staten Island CBOC

23. Grants Pass, OR

Criteria:

- a. Veteran Population – 56,736
- b. The Oregon Army National Guard maintains 45 armories, and is present in 37 communities – State Area Command, 82nd Troop Command, 41st Infantry Brigade (Light) (Separate), 249th Regiment (RTI) - Molalla, 1st Battalion (GS), 102nd WMD CST (RAID) - Salem
- c. Productivity FY 2005 – 497 Veterans provided 3,724 visits
- d. Existing Staff – 3 FTEE (2 Direct Service providers)

Enhancements:

- a. Readjustment counseling services for 56,736 local veterans.
- b. Enhance ongoing outreach and services to veterans and their families in southern Oregon and northern California.
- c. Collaboration with White City VA Domiciliary and VA Roseburg Health Care System

D. Conversion of Second 50 GWOT Outreach Specialists

Does not require new funding only the conversion of existing funding from non-recurring to recurring. The current funding is for 2.5 million dollars for FY 2006 & FY 2007.

Proposed Vet Center	Population of Catchment Area	Post Population	Mobilized & Demobilized NG/Reserve	Deployed/ Redeployed SM's	Veteran Population	Separated GWOT Veterans	Nearest Vet Center	Distance to Nearest Vet Center	Proposed FTE	FY05 Veterans	FY05 Visits
1 Ft. Benning, GA	1,084,121	91,900	4,900	4,300	190,332	5,114	Atlanta (108 m)	5			
2 Ft. Hood, TX	302,404	71,000	13,000	36,000	69,225	2,983	Austin (75 m)	5			
3 Ft. Riley, KS	243,748	23,500	8,500	44,717		2,019	Kansas City (120 m)	5			
4 Ft. Carson, CO	171,836	27,000	5,000	14,000	32,582	231	Colorado Springs (44 m)	4			
6 Phoenix, AZ	2,111,705				346,997	3,840			5	787	6,419
5 Kansas City, MO	2,076,287				353,346	3,173			5	1,608	6,155
7 San Antonio, TX	1,110,954				208,037	4,019			5	1,329	8,257
8 Miami, FL	1,655,214				104,090	1,700			5	1,574	8,005
9 Springfield, MO	936,021				170,668	1,681	Tulsa (182 m)	5			
10 Ft. Myers, FL	574,119				134,732	895	Sarasota (77 m)	4			
11 Modesto, CA	740,534				97,375	1,010	San Jose (85 m)	5			
12 Las Cruces, NM	298,934				32,351	655	El Paso (44 m)	4			

	Location	Veteran Population	Existing FTEE	GWOT FTEE	2005 Veterans	2005 Visits	Notes:
1	Chinle, AZ	12,272*	2.0				Hopi
2	Keams Canyon, AZ	12,272*	2.0				Navajo & Apache
3	Martin, SD	5,616	1.0				Lakota Sioux & Rosebud
4	Fayetteville, NC	143,612	4.0	1.0	3,482	7,402	Family / Bereavement Specialist
5	Syracuse, NY	186,415	4.0	1.0	1,126	7,113	Family / Bereavement Specialist
6	El Paso, TX	93,330	4.0	1.0	831	5,644	LEP Family / Bereavement Specialist
7	Los Angeles, CA	102,142	4.5		716	6,133	LEP Family / Bereavement Specialist
8	Columbus, OH	211,457	4.0		447	5,357	Family / Bereavement Specialist
9	Washington, DC	67,990	4.0	1.0	300	2,426	Malogne House / Fisher House
10	Wichita, KS	241,300	4.0	1.0	748	5,183	Military Sexual Trauma Specialist
11	Tucson, AZ	119,080	4.0	1.0	1,123	5,360	LEP Family / Bereavement Specialist
12	Philadelphia, PA	219,226	4.0		368	4,215	Family / Bereavement Specialist
13	Norfolk, VA	226,121	4.0	1.0	949	4,450	Family / Bereavement Specialist
14	Honolulu, HI	88,177	4.3	1.0	561	5,236	Family / Bereavement Specialist
15	West Palm Beach, FL	199,717	4.0		480	4,712	Family / Bereavement Specialist
16	Missoula, MT	66,911	4.0	1.0	477	4,639	Rural / American Indian Veteran Outreach/Services
17	Princeton, WV	24,991	3.0		752	14,605	Rural Veteran Outreach/Services
18	Sioux City, IA	43,277	3.0		736	2,998	Rural Veteran Outreach/Services
19	Lincoln, NE	68,345	3.0		701	3,099	Rural Veteran Outreach/Services
20	Sante Fe, NM	50,372	3.0		848	3,050	Rural/American Indian/Hispanic Veteran Outreach/Services
21	East St. Louis, IL	63,238	3.0		295	2,744	African American Veteran Outreach/Services
22	Staten Island, NY	32,477	3.0		100	2,493	Urban Veteran Outreach/Services
23	Grants Pass, OR	56,736	3.0		497	3,724	Rural Veteran Outreach/Services

*Overlapping Catchment Areas

**Department of
Veterans Affairs****Memorandum**

Date: November 15, 2006

From: Chief Readjustment Counseling Officer (15)

Subj: Vet Center Program Augmentation 2007

To: Acting Under Secretary for Health (10)

Through: Acting Principal Deputy Under Secretary for Health (10A)

1. Purpose:

The purpose of this memorandum is to request approval for additional recurring resources to support the recent increase in new veterans and family members at Vet Centers nationwide. The vigorous outreach effort to the OEF-OIF veterans has significantly and directly increased the numbers receiving outreach and seeking readjustment services in RCS Vet Centers. The effort to meet the increasing volume will be facilitated by establishment of (a number to be established) new Vet Centers in currently underserved areas based on list of recently discharged new veterans and augment the staff FTEE at (a number to be established) existing Vet Centers. Rural sites will be part of the augmentation to better serve geographically challenged areas. Also included are requests for non-recurring funds to purchase outreach vehicles to cover more rural sites. The additional resources will enhance the Vet Center program's capacity to provide quality readjustment services to increasing demands for care from returning OEF/OIF veterans and address the growing demand for military related problems with family members and to augment services to families of severely wounded warriors located in areas distant from DOD and VA treatment facilities.

2. Vet Center Program Description:

The Vet Center program is a unique VHA program designed to overcome unnecessary barriers to care and to provide outreach and readjustment counseling to veterans returning from military service in a combat theater of operations. The Vet Center program consists of 209 community-based Vet Centers located outside the larger VA medical facilities in easily accessible, consumer friendly settings. The Vet Centers are located in all 50 states, Puerto Rico, the Virgin Islands, the District of Columbia and Guam.

Vet Centers are staffed by small multidisciplinary teams, the prototype being from four to five team members consisting of a Team Leader, an Office Manager, and two or three Counselors. Every Vet Center team has at least one VHA qualified mental health professional on staff. Nationally the Vet Centers maintain higher than 60 percent veteran staffing, the majority of whom served in a combat theater of operations.

VA's authority to provide readjustment counseling is located in a special section of 38 U.S.C. (1712A). Current law authorizes the Vet Centers to provide readjustment counseling to any veteran who served in any war or in an area during a period of armed hostility. This eligibility is lifetime for the veteran and includes the veteran's family members to the extent this is required for the veteran's successful readjustment.

3. Vet Center Service Mission:

The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the veteran as a whole person. Services include professional counseling for war trauma and other military-related social readjustment problems, military sexual trauma counseling, family counseling when needed for the readjustment of the veteran, employment counseling, community outreach and education, preventive health care services, and case management and brokering services. Since 2003 the Vet Centers also provide bereavement services to surviving family members of service men and women killed while serving on active duty. The Vet Center strategy is to intervene early to facilitate a successful post-war readjustment in a safe and confidential setting to negate stigma and other barriers to care. This is exemplified in the new Army Battle Mind training which stresses recovery and early intervention.

The Vet Center mission is unique within VA. Resulting from a comprehensive analysis of Vet Center workload in its 1996 audit, GAO found that approximately 40 percent of Vet Center unique clients are not seen in any other VHA facility. From this finding GAO concluded that these veterans constitute a core group of frequent users who access care specifically for psychological war trauma to include war-related PTSD, and that most Vet Center visits are devoted to this core group of veterans. GAO further concluded that Vet Centers and VA medical centers serve different clients and have different missions. These findings have been consistently documented annually through to the present.

4. VA, VHA, RCS, and President's New Freedom Commission Report on Mental Health Integration:

The Readjustment Counseling Service Strategic Plan is fully integrated within the VHA and overall VA Strategic Plans. Vet Centers are specifically tasked with ensuring a smooth transition for veterans from active military service to civilian life (VA Strategic Objective 2) which states that "*Veterans will be fully reintegrated into their communities with a minimum disruption to their lives through outreach, transitional health care, readjustment counseling, and employment services, including vocational rehabilitation and educational assistance.*"

VA Mission Statement	VHA Mission Statement	RCS Mission Statement
To fulfill President Lincoln's promise - "To care for him who shall have borne the battle, and for his widow, and his orphan" – by serving and honoring the men and women who are America's veterans.	Honor America's veterans by providing exceptional health care that improves their health and well being.	We are the people in VA who welcome home war Veterans with honor by providing readjustment counseling in a caring manner. Vet Centers understand and appreciate Veterans' war experiences while assisting them and their family members toward a successful post-war adjustment in or near their community.
VA Vision Statement	VHA Vision Statement	RCS Vision Statement
To provide veterans the world-class benefits and services they have earned – and to do so by adhering to the highest standards of compassion, commitment, excellence, integrity, accountability, and good stewardship.	To be a patient centered integrated health care organization for veterans providing excellence in healthcare, research, and education; an organization where people choose to work; an active community partner and a back-up for National emergencies.	Vet Centers serve veterans and their families by providing a continuum of quality care that adds value for veterans, families, and communities. Care includes professional readjustment, counseling, community education, outreach to special populations, the brokering of services with community agencies, and provides a key access link between the veteran and other services in the United States Department of Veterans Affairs.
VA Values	VHA Values	RCS Values
<ul style="list-style-type: none"> • Compassion • Commitment • Excellence • Professionalism • Accountability • Integrity • Stewardship 	<ul style="list-style-type: none"> • Trust • Respect • Excellence • Compassion • Commitment 	<ul style="list-style-type: none"> • Veteran focused services • Quality care • Community-based care • Delivery of cost effective services • Health, wellness and preventive services • Diverse composition and experiences of the Veterans we serve

VA	VHA	RCS
<p>1. Restore the capability of veterans with disabilities to the greatest extent possible and improve the quality of their lives and that of their families</p> <p>2. Ensure a smooth transition for veterans from active military service to civilian life.</p> <p>3. Honor and serve veterans in life, and memorialize them in death for their sacrifices on behalf of the Nation.</p> <p>4. Contribute to the public health, emergency management, socioeconomic well-being, and history of the Nation.</p> <p>5. Deliver world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.</p>	<p>1. Maximize the physical, mental, and social functioning of veterans with disabilities and be recognized as a leader in the provision of specialized health care services.</p> <p>2. Ease the reentry of new veterans into civilian life by increasing awareness of, access to, and use of VA health care, benefits, and services.</p> <p>3. Provide high quality, reliable, accessible, timely, and efficient health care that maximizes the health and functional status for all enrolled veterans, with special focus on veterans with service-connected conditions, those unable to defray the cost, and those statutorily eligible for care.</p> <p>4. Advance VA medical research and development programs that address veterans' needs, with an emphasis on service-connected injuries and illnesses, and contribute to the Nation's knowledge of disease and disability.</p> <p>5. Sustain partnerships with the academic community that enhance the quality of care to veterans and provide high quality education and experiences for health care.</p> <p>6. Improve the Nation's preparedness for response to war, terrorism, national emergencies, and natural disasters by developing plans and taking actions to ensure continued service to veterans as well as support to national, state, and local emergency management and homeland security efforts.</p> <p>7. Deliver world-class service to veterans and their families through effective communication and management of people, technology, business processes, and financial resources.</p>	<p>1. Extend Vet Center capacity to provide quality readjustment counseling services to eligible veterans and their families in or near their respective communities.</p> <p>2. Optimize outreach to transitioning military and all eligible veterans.</p> <p>3. Promote veteran health care information, education, and access to care via electronic means.</p> <p>4. Continuously improve Vet Center services that go beyond medical care by optimizing the availability and efficient use of resources and services.</p> <p>5. Maintain and augment collaborative relationships with VA and beyond VA agencies and organizations to ensure optimal and holistic services for veterans and their families.</p> <p>6. Enhance outreach and delivery of services by maintaining and promoting a diverse work force that reflects the local veteran community and their respective needs for service.</p> <p>8. Improve the overall governance and performance of VA by applying sound business principles, ensuring accountability, and enhancing our management of resources through improved capital asset management; acquisition and competitive sourcing; and linking strategic planning, budgeting, and performance planning.</p>

5. Vet Center Outreach Functions:

Another unique feature of the Vet Center program is community outreach. Outreach to provide veterans and family members with educational information about services is one of the legislatively mandated missions of the Vet Center program. In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to welcome home and educate returning service members at military demobilization and National Guard and Reserve sites. Through its community outreach and brokering efforts, the Vet Center program also provides many veterans the means of access to other VHA and VBA programs. To augment this effort the Vet Center program recruited and hired 100 OEF/OIF veterans to provide the bulk of this outreach to their fellow veterans. To improve the quality of its outreach services, in June 2005 the Vet Centers began documenting every OEF/OIF veteran provided with outreach services. The program's focus on aggressive outreach activities has resulted in the provision of timely Vet Center services to significant numbers of OEF/OIF veterans and family members. Since the beginnings of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 177,000 OEF/OIF veterans, of which over 134,000 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites. A similar outreach program conducted during the first Gulf War received the commendation of the President's Advisory Committee on Gulf War Veterans' Illnesses. In its final report of March 1997, the Committee cited the Vet Centers for providing exemplary outreach to contact and inform this veteran cohort about VA services. The utilization pattern for war veterans from other eras indicates that these veterans will require sustained services and will increase in numbers over time.

6. Current Caseload:

In FY 2006 the Vet Centers saw 228,612 total veterans. 110,045 were provided direct, one to one significant, readjustment counseling services. Vietnam and other combat era veterans seen were 88,214. This represents a small increase in the number of war veterans of all eras provided one to one direct services exclusive of the OEF/OIF caseload. In addition to this normal caseload, 21,831 additional OEF/OIF veterans were added, which is a significant increase.

According to data provided to VA by DOD as of May 2006, 588,923 veterans have been released from active duty following deployment to OEF/OIF and are now eligible for VA services. The total number of OEF/OIF veterans provided outreach services in Fiscal Year 2006 was 118,567 veterans, a highly significant increase testifying to the efficiency of our GWOT Outreach Program. The Vet Center program has contacted approximately 30% of the discharged OEF/OIF veteran population either through outreach events at demobilization sites or through provision of direct services at the Vet Center. This represents a significant level of market penetration for this new veteran group. DOD's demographic information indicates that 56% of these veteran returnees are National Guard and Reserve components. The Reserve and National Guard represent a significant increase of warriors who are married which indicates an increased need for family counseling resources for those with military related problems.

The majority all returning combat veterans will not have PTSD, but most would benefit from the early intervention, education, employment, screening, and other types of readjustment services to help them stabilize and normalize their life re-entry and successful adjustment to civilian life following their military experience.

Given the results of the Army Land Combat Studies conducted by Col. Charles W. Hoge et al, of the WRAIR, the rate of psychological and social problems among this new group of returning war veterans is documented. Dr. Hoge's initial study published in The New England Journal of Medicine in July 2004 reported elevated levels of depression, anxiety and PTSD for Army and Marine cohorts following deployment in Iraq. The post-deployment level of PTSD was 18% in the Army Study Group and 19.9% in the Marine Study Group. This study also documented high levels of combat exposure for both the Army and the Marines. Hoge's findings also document increased incidences of marital problems, physical aggression and substance use following combat deployment to Afghanistan and Iraq. The Hoge studies also show the need for service providers to consider the stigma and fears associated with the veteran's screening positive for PTSD or other war-related mental health problem as a major barrier to care for combat veteran populations. The unique confidentiality offered at Vet Centers tends to mitigate these concerns, some of which are salient and pertain to continued military service, readiness and employability.

A subsequent study published by Hoge et al in JAMA in March 2006 analyzed responses to the Post Deployment Health Re-Assessment (PDHRA) administered by DOD to screen returning service members from OEF/OIF. A major finding was that 19% of soldiers and Marines returning from OIF and 11% of the soldiers and Marines returning from OEF met the risk criteria for mental health problems. Another important finding was the high rate of mental health service utilization for OEF (48%) and OIF (56%) returnees during their first year post-deployment following a PDHRA referral.

An October 2006 study by Grieger, et al, published in the American Journal of Psychiatry, documents the delayed onset of elevated levels PTSD and depression in a cohort of severely wounded combat soldiers from OEF/OIF. The researchers followed a group of 243 soldiers wounded in battle in Afghanistan and Iraq, and assessed them for PTSD and/or depression at 1, 4 and 7 months post-injury. At 1 month, 4.2% of soldiers met the criteria for PTSD and 4.4% met the criteria for depression. At 7 months, 12% met the criteria for PTSD and 9.3% met the criteria for depression. 78.8% of those with a positive result for PTSD or depression at 7 months had had a negative result for both conditions at the initial assessment. Physical injury severity was a major predictor for the onset of PTSD and/or depression at 7 months. The researchers concluded that physical wounds sustained in combat contribute significantly to physical and psychological burdens in veterans' post-war lives.

7. Methodology:

Analysis of actuarial data is the main driver of the needs assessment component. These areas assessment criteria variables will include: Geographical area of responsibility veteran population (by county) as defined by the U.S. Census Bureau, number of those veterans already served by Vet Centers to assess market penetration, actual DOD figures on the number of discharged OEF/OIF veterans and reported home of record (by zip code) as a measure to project where they will reside, and prior actuarial data collected last year by the VHA office of Policy and Planning (Art Klein). Prevalence projections were utilized from previous epidemiological research as well as studies done by DOD.

The variables considered included current case load at Vet Centers coupled with projected OEF/OIF discharges by county and zip code. The current FTE staff was used as a baseline to calculate veterans per direct service FTE and visits by direct service FTE on current number of veterans being treated and number of visits done by that particular Vet Center. The outreach number of OEF/OIF in FY05 were contrasted with FY06 to determine what per cent of veterans were subsequently seen at Vet Centers, the outcome was that approximately 18% came in later. If projections are actualized, over 20,000 new OEF/OIF veterans will be accessing one to one services at Vet Centers in the coming year. The Vet Centers are reporting an increased demand for provision of family services to deploying and returning warriors. We used the number of married warriors to project an estimate of the increase for family counselors. In addition, the Vet Center has provided bereavement services to families of warriors killed while on active duty totaling over 800 cases to date.

Proposed new Vet Centers were vetted by looking at the Census veteran population and analysis of the discharged list provided by DOD by county and zip code as well as distance from other VA facilities and existing VA/RCS FTE.

The original list was proposed by the seven RCS Regional Offices and vetted through the criteria listed above. Special consideration was given to rural sites where geographical variables were considered (e.g., geographical distance from any VA services, geographical terrain and cultural barriers etc.).

Recommendation

1. Specifically this request consists of the following recommendations:
 - a. Establish 19 New Vet Centers in high demand areas.
 - b. Staff Augmentation of 91 Existing Vet Centers.
 - c. Outreach travel funding
 - d. Non-recurring expenditures to improve access/outreach.

Cost Projection

2. The cost projections for each recommendation are:

- a. **\$7,600,000** (19 Vet Centers, 75 FTEE)
- b. **\$7,544,000** (91 FTEE)
- c. **\$250,000** Outreach Travel
- d. **\$1,730,000** Non-Recurring

TOTAL REQUEST: \$15,394,000 {Recurring}
\$1,730,000 {Non-Recurring}

ALFONSO R. BATRES, Ph.D., M.S.S.W.
Chief Officer, Readjustment Counseling Service, 15

Concur / Non Concur

GERALD CROSS, MD
Acting Principal Deputy Under Secretary for Health, 10A

Approve / Disapprove

MICHAEL KUSSMAN, MD, MS, MACP
Acting Under Secretary for Health, 10

ATTACHMENT A***RECOMMENDATIONS SUBMITTED BY REGIONAL OFFICES (subject to vetting through actuarial data)***

1. New Vet Centers: 19 sites @ \$400,000 = \$7,600,000

Northeast Region (1A)

Berlin, NH (4.0 FTEE)
Binghamton, NY (4.0 FTEE)
Watertown, NY (3.0 FTEE)
East Long Island, NY (4.0 FTEE)
Keene, NH (4.0 FTEE)
Poughkeepsie, NY (4.0 FTEE)
Cape Cod, MA (4.0 FTEE)
Jamestown, NY (4.0 FTEE)

Southeast Region (3A)

Montgomery, AL (4.0 FTEE)
Ft. Meyers, FL (4.0 FTEE)
Gainesville, FL (4.0 FTEE)
Augusta, GA (4.0 FTEE)
Macon, GA (4.0 FTEE)
Wilmington, NC (4.0 FTEE)

Mid-Atlantic Region (1B)

Dover, DE (4.0 FTEE)
Vineland, NJ (4.0 FTEE)
Toledo, OH (4.0 FTEE)
Du Bois, PA (4.0 FTEE)

South-Central Region (3B)

Baton Rouge, LA (4.0 FTEE)

Western Mountain Region (4A)

Grand Junction, CO (4.0 FTEE)
Las Cruses, NM (4.0 FTEE)
Everett, WA (4 FTEE)

Pacific Western Region (4B)

Modesto, CA (4.0 FTEE)

2. ***Staff augmentation*** of existing Vet Centers as submitted by the Regional Offices: 51 FTEE @ \$82,000 = \$4,182,000 subject to review based on actuarial variables

Northeast Region (1A)

Springfield, MA
Brockton, MA
Manchester, NH
Queens, NY
Providence, RI
Trenton, NJ
New Haven, CT
Caribou, ME
Bangor, ME,
Rochester, NY
Lowell, MA
Worcester, MA
Norwich, CT
New Bedford, MA
Sanford, ME

Southeast Region (3A)

St. Petersburg, FL
Miami, Fl
Ft. Lauderdale, FL
Mobile, AL
Charlotte, NC
Tampa, FL
Greenville, NC
Pensacola, FL
Tallahassee, FL
Palm Beach, FL
Greensboro, NC
Raleigh, NC

Mid-Atlantic Region (1B)

Harrisburg, PA
Beckley, WV
Princeton WV
Wheeling, WV

South-Central Region (3B)

Austin, TX
New Orleans, LA

Central Region (2)

Madison, WI
Rapid City, SD
Lincoln, NE
Sioux City, IA

Western Mountain Region (4A)

Boise, ID
Tacoma, WA
Albuquerque, NM
Farmington, NM
Provo, UT

Pacific Western Region (4B)

Concord, CA
Corona, CA
San Jose, CA
Fresno, CA
Maui, HI
San Bernardino, CA
Santa Cruz, CA
Vista, CA

3. Staff augmentation of Family Therapists at existing Vet Centers as submitted by Regional Offices: 41 FTEE @ \$82,000 = \$3,362,000 subject to review based on actuarial variables

Northeast Region (1A)

Springfield, MA
Bangor, ME
Norwich, CT
Sanford, ME

South-Central Region (3B)

Austin, TX
Shreveport, LA
El Paso, TX
Oklahoma City, OK
San Antonio, TX

Mid-Atlantic Region (1B)

Baltimore, MD
Elkton, MD
Columbus, OH
Beckley, WV
Princeton WV
Wheeling, WV

Western Mountain Region (4A)

Tacoma, WA
Spokane, WA
Albuquerque, NM
Boulder, CO

Southeast Region (3A)

St. Petersburg, FL
San Juan, PR
Arecibo, PR
Miami, FL
Ft. Lauderdale, FL
Mobile, AL
Charlotte, NC
Tampa, FL
Greenville, NC
Sarasota, FL
Pensacola, FL
Tallahassee, FL
Palm Beach, FL
Greensboro, NC
Raleigh, NC

Pacific Western Region (4B)

Los Angeles, CA
Honolulu, HI
Portland, OR
San Diego, CA
Anaheim, CA
Sacramento, CA
Ventura, CA

3. Non-recurring expenditures (\$1,730,000)

a. **Emergency Response Vehicles/Outreach Vehicles (\$1,120,000)**

4 EA Emergency Response Vehicles @ \$250,000 = \$1,000,000

Mid-Atlantic Region
Southeastern Region
South-Central Region

Pacific Western Region

4 EA 12 Passenger Van @ \$30,000 = \$120,000

Northeast Region

b. Outreach Displays / Materials (\$25,000)

Northeast Region \$14,500
Southeast Region \$10,500

c. Build-outs (\$505,000)

Mid-Atlantic Region \$200,000
Western Mountain Region \$250,000
Pacific Western Region \$55,000

ATTACHMENT B

Example of data collection that will be utilized for final site selections.

ATTACHMENT 10

3.a. Research VA is conducting on the mental health needs of OIF/OEF veterans who have not sought care at VA			
Program Title/Research Objective	Primary Investigator	FY08 Allocation*	Projected Conclusion Date
Program Title: Comprehensive Needs Assessment for OIF/OEF Veterans Research Objective: To assess needs of OEF/OIF veterans to develop & implement clinical services, policies & research for veterans post-deployment	Straits-Trotter, K	\$46,000	Dec-07
Program Title: National Center for PTSD Research Objective: To provide details about needs of OEF/OIF veterans, as well as other populations	Multiple	\$18 Million+	Ongoing
Program Title: Does PTSD Service Connection Affect Disease Course and Functioning? Research Objective: To look at outcomes associated with receiving or not receiving VA disability benefits			
Program Title: Prospective Study of Functional Status in Veterans at Risk for Unexplained Illnesses Research Objective: To examine unexplained illnesses in veterans at risk	Quigley, Karen S.	\$241,344	Dec-09
Program Title: Physical and Sexual Assault in Deployed Women: Risks, Outcomes and Services Research Objective: To examine the incidents of sexual and physical assault among deployed women	Sadler, Anne G.	\$57,339	Jun-09
Program Title: Barriers and Facilitators to PTSD Treatment Seeking Research Objective: To examine barriers to and facilitators of PTSD treatment-seeking among veterans	Sayer, Nina A.	\$148,900	Dec-07
Program Title: Prospective Assessment of Neurocognition in Future Gulf-deployed and Gulf nondeployed Military Personnel Research Objective: To assess neurocognitive & emotional changes occurring between pre- /post-deployment timeframes	Vasterling, Jennifer J.	\$182,119	Jan-07

*Funding allocations may vary over fiscal years.

ATTACHMENT 10

Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Comprehensive Needs Assessment for OIF/OEF Veterans Research Objective: To assess needs of OEF/OIF veterans to develop/implement clinical services, policies & research for veterans post-deployment	Straits-Trostier, K	\$46,000	Dec-07
Program Title: National Center for PTSD Research Objective: To provide details about needs of OEF/OIF veterans & other populations	Multiple	\$18 Million+	Ongoing
Program Title: Health Risk Behaviors and Quality of Life Among Oif/Oef Veterans and Implications for VA Healthcare Research Objective: To examine prevalence of health risk behaviors (smoking, alcohol use), quality of life, access to health care & satisfaction with VA health care during 2003-2005	Straits-Trostier, K	VA resources	Jan-07
Program Title: OEF/OIF Study Registry Research Objective: To screen participants for mental health status, substance use disorders, depression, TBI & bank blood samples for assessment of neurotransmitters & genetic markers of mental illness	Morey, Rajendra	\$214,000	Ongoing

ATTACHMENT 10

Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Barriers and Facilitators to PTSD Treatment Seeking Research Objective: To examine barriers to & facilitators of PTSD treatment-seeking among veterans	Sayer, Nina A.	\$148,900	Dec-07
Program Title: Prospective Assessment of Neurocognition in Future Gulf-deployed and Gulf-nondeployed Military Personnel Research Objective: To assess neurocognitive & emotional changes occurring between pre- /post-deployment timeframes	Vasterling, Jennifer J.	\$182,119	Jan-07

*Funding allocations may vary over fiscal years.

ATTACHMENT 10

Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Comprehensive Needs Assessment for OIF/OEF Veterans Research Objective: To assess needs of OEF/OIF veterans to develop & implement clinical services, policies & research for veterans post-deployment.	Straus-Troster, K	\$46,000	Dec-07
Program Title: National Center for PTSD Research Objective: To provide details about needs of OEF/OIF veterans, & others	Multiple	\$ 18 Million+	Ongoing
Program Title: Health Risk Behaviors and Quality of Life Among OIF/OEF Veterans and Implications for VA Healthcare Research Objective: To examine prevalence of health risk behaviors (smoking, alcohol use), quality of life, access to health care & satisfaction with VA health care during 2003-2005	Straus-Troster, K	VA resources	Jan-07
Program Title: OEF/OIF Study Registry Research Objective: To screen participants for mental health status, substance use disorders, depression, TBI & brain blood samples for assessment of neurotransmitters & genetic markers of mental illness	Morey, Rajendra	\$214,000	Ongoing
Program Title: Neuroactive Steroids and Nicotine Dependence Research Objective: Study of neuroactive steroids that might have relevance to nicotine dependence	Marx, Christine	\$35,000	Nov-07
Program Title: Optimizing Smoking Cessation Interventions in Posttraumatic Stress Disorder Research Objective: To study which cessation strategies might be best in veterans with PTSD & nicotine dependence	Beckham, Jean	\$250,000	Sep-09
Program Title: Telephone Quit Line Tobacco Cessation for Veterans or Military Service in OIF/OEF Research Objective: To determine whether telephone-based counselling is effective in reducing smoking in OEF/OIF veterans	Beckham, Jean	\$75,000	Dec-07
Program Title: The Effect of Smoking on Startle and Prepulse Inhibition in PTSD Research Objective: To examine the relationship between smoking and stress using startle and prepulse inhibition	Beckham, Jean	\$100,000	Dec-08
Program Title: Pregnenolone Augmentation Targeting Cognitive Symptoms in Veterans with PTSD Research Objective: To study impact of pregnenolone augmentation in persistently symptomatic veterans with PTSD on cognitive symptoms, resulting in improved quality of life & overall functioning in these patients	Marx, Christine	\$50,000	May-07
Program Title: Guided Imagery for Military Sexual Trauma Research Objective: Randomized controlled trial of self-administered guided imagery intervention for PTSD related to MST, to assess PTSD symptoms & potential biomarkers of PTSD	Straus, Jennifer	\$15,000	Jan-08

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3.c Research VA is conducting on the evaluation and comparison of treatment interventions for PTSD					
Program Title/Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date		
Program Title: Evaluating the Clinical and Neurobiological Effects of Guided Imagery for PTSD in Women Veterans Research Objective: To assess the effects of guided imagery on PTSD symptoms, brain function associated with processing stress, and biological markers of stress	Straus, Jennifer	\$175,000	Jan-08		
Program Title: Secondary Prevention with Paroxetine vs Placebo in Subthreshold PTSD Research Objective: To evaluate a secondary prevention strategy using the selective serotonin reuptake inhibitor paroxetine which might be effective in OEF/OIF veterans with early manifestations of PTSD symptoms	Marx, Christine	\$45,000	Dec-08		
Program Title: TBI/PTSD Collaborative Multi-site Study Research Objective: To characterize traumatic brain injury and post traumatic stress disorder co-occurrence	Tupler, Larry	\$88,000	Ongoing		
Program Title: QUERI Center: PT-BRI Research Objective: To promote rehabilitation, psychological adjustment, & community re-integration of individuals who have experienced polytrauma & blast-related injuries	Sayer, Nina	\$350,000	Dec-08		
Program Title: Cerebrospinal Fluid (CSF) and Plasma Pro-Inflammatory Cytokines: Relationship to Combat Exposure, PTSD and Health Status Research Objective: To investigate the role of cytokines in health outcomes related to PTSD	Baker, Dewleen G.	\$206,200	Dec-07		
Program Title: Serotonin and Dopamine Transporter Genetics: A Factor in PTSD Risk? Research Objective: To use serial CSF sampling techniques in twenty-four hour circadian studies to measure CSF and plasma cytokines and key neurohormones in male combat veterans with and without PTSD and in male non-combat healthy controls.	Baker, Dewleen G.	\$140,912	Dec-08		
Program Title: Ad Lib Smoking in PTSD: A Naturalistic Study Research Objective: To examine the relationship between smoking and stress, as well as to evaluate an electronic diary method that will be used to obtain study information	Beckham, Jean C.	\$105,180	Sep-07		
Program Title: Evaluation of Stress Response Systems in Gulf War Veterans with CMI Research Objective: To evaluate how veterans with chronic multi-symptom illness respond to stress	Blanchard, Melvin	\$4,000	Sep-06		
Program Title: Neural Correlates of PTSD Prevention with MBSR in Iraq Veterans Research Objective: To conduct a trial of MBSR to determine effectiveness in preventing PTSD	Bremner, J. D.	\$174,877	Sep-06		
Program Title: Integrated Cognitive Behavioral Therapy (CBT) for Substance Use and Depressive Disorders Research Objective: To determine the effectiveness of psychotherapy in dually diagnosed patients	Brown, Sandra A.	\$144,365	Sep-08		

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3.c. Research VA is conducting on the evaluation and comparison of treatment interventions for PTSD				
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date	
Program Title: A Placebo Controlled Trial of Adjunctive Quetiapine for Refractory PTSD Research Objective: To conduct a clinical trial to determine effectiveness of a pharmacotherapy adjunct in PTSD	Davis, Lori	\$47,500	Sep-06	
Program Title: Integrating Smoking Cessation into Mental Health Care for Veterans with PTSD Research Objective: To conduct a large, multi-site clinical trial to determine the effectiveness of incorporating smoking cessation treatment into the care provided to patients with PTSD	McFall, Miles E.	\$1,576,680	Sep-09	
Program Title: Telemedicine and Anger Management Groups for PTSD Veterans in the Hawaiian Islands Research Objective: To assess clinical effectiveness of conducting an anger management therapy group treatment intervention with veterans who have PTSD & reside in remote locations, using a video-teleconferencing modality as compared to traditional in-person modality	Morland, Leslie	\$267,348	Mar-09	
Program Title: Does PTSD Service Connection Affect Disease Course and Family? Research Objective: To examine the disease course trajectory of PTSD and to what extent receipt of VA disability improves or worsens veterans' disease course	Murdoch, Maureen	\$266,900	Sep-06	
Program Title: Efficacy of an Integrated Cognitive Behavioral Therapy Approach to Treating Chronic Pain and PTSD Research Objective: To conduct a pilot test of CBT in PTSD	Ots, John D.	\$241,716	Aug-08	
Program Title: Adrenergic Mechanisms and Treatment for PTSD and Secondary Drug Abuse Research Objective: To determine the underlying pathways which would respond to treatment for PTSD co-morbid with substance abuse	Raskind, Murray	\$369,849	Sep-10	
Program Title: Prazosin Treatment for Combat Trauma PTSD Nightmares and Sleep Disturbance Research Objective: To conduct a small randomized clinical trial to test the effectiveness of a pharmacological treatment to relieve nightmares and sleep disturbances in combat-related PTSD	Raskind, Murray	\$145,400	Mar-07	
Program Title: Cognitive - Behavioral Treatments for PTSD Sleep Disturbance Research Objective: To explore a CBT approach for treatment of sleep disturbances in PTSD	Ross, Richard J.	\$144,200	Dec-07	
Program Title: The Performance-Perception Test (PPT) as a Counseling Tool Research Objective: To determine if the use of PPT and simple counseling can be used to align perceived and measured ability	Saunders, Gabrielle	\$145,850	Sep-07	

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3.c. Research VA is conducting on the evaluation and comparison of treatment interventions for PTSD			
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women Research Objective: To evaluate the efficacy of exposure therapy for treating PTSD and associated problems in female veterans and active duty military personnel!	Schnurr, Paula P.	\$660,594	Mar-07
Program Title: Treatment and Costs of Blast Related Injuries in VA Research Objective: To characterize the diagnoses, treatments, and clinical complication associated with initial VA hospitalization for persons with blast injuries; using data from FY01-06; investigate health care use & costs associated with inpatient & outpatient services for individuals with blast-related complications for the first 18 months after presenting to VAMC. Describe healthcare experience from the patient's perspective, including access, timeliness, appropriateness, & overall quality of care	Siddharthan, Kris	\$54,080	Apr-08
Program Title: Testosterone Replacement Therapy in Opioid Induced Hypogonadal Wasting Research Objective: To test the effects of TRT on indices of physical function, muscle strength, and pain control	Siegel, David	\$115,860	Apr-09
Program Title: Prospective Assessment of Neurocognition in Future Gulf-deployed and Gulf nondeployed Military Personnel Research Objective: To assess neurocognitive & emotional changes occurring between pre-/post-deployment timeframes	Vasterling, Jennifer J.	\$182,119	Jan-07

*Funding allocations may vary over fiscal years.

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3 d Research VA is conducting on whether access to care is impacting rural OIF/OEF veterans with mental health concerns.				
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date	
Program Title: Comprehensive Needs Assessment for OIF/OEF Veterans Research Objective: To assess needs of OEF/OIF veterans to develop & implement clinical services, policies & research for veterans post-deployment.	Straits-Troster, K	\$46,000	Dec-07	
Program Title: National Center for PTSD Research Objective: To provide details about needs of OEF/OIF veterans, as well as other populations	Multiple	\$18 Million+	Ongoing	
Program Title: Health Risk Behaviors and Quality of Life Among OIF/OEF Veterans and Implications for VA Healthcare Research Objective: To examine prevalence of health risk behaviors (smoking, alcohol use), quality of life, access to health care & satisfaction with VA health care during 2003-2005	Straits-Troster, K	VA resources	Jan-07	
Program Title: OEF/OIF Study Registry Research Objective: Screen participants for mental health status, substance use disorders, depression, TBI & bank blood samples for assessment of neurotransmitters & genetic markers of mental illness	Morey, Rajendra	\$214,000	Ongoing	
Program Title: Telephone Quit Line Tobacco Cessation for Veterans of Military Service in OIF/OEF Research Objective: To determine whether telephone-based counseling is effective in reducing smoking in OEF/OIF veterans	Beckham, Jean	\$75,000	Dec-07	
Program Title: Cerebrospinal Fluid (CSF) and Plasma Pro-Inflammatory Cytokines: Relationship to Combat Exposure, PTSD and Health Status Research Objective: To investigate the role of cytokines in health outcomes related to PTSD	Baker, Dawleen G.	\$206,200	Dec-07	

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3.d. Research VA is conducting on whether access to care is impacting rural OIF/OEF veterans with mental health concerns.			
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Serotonin and Dopamine Transporter Genetics: A Factor in PTSD Risk? Research Objective: To use serial CSF sampling techniques in twenty-four hour circadian studies to measure CSF and plasma cytokines and key neurohormones in male combat veterans with and without PTSD and in male non-combat healthy controls.	Baker, Dewleen G.	\$140,912	Dec-08
Program Title: Telemedicine and Anger Management Groups for PTSD Veterans in the Hawaiian Islands Research Objective: To assess clinical effectiveness of conducting an anger management therapy group treatment intervention with veterans who have PTSD & reside in remote locations, using a video-teleconferencing modality as compared to traditional in-person modality	Morland, Leslie	\$267,348	Mar-09
Program Title: Telephone Case Monitoring for Veterans with PTSD Research Objective: Randomized controlled trial to assess whether adding telephone monitoring to usual care reduces PTSD symptoms & hospitalization	Rosen, Craig S.	\$113,300	Mar 2011

**Funding allocations may vary over fiscal years.*

ATTACHMENT 10

3.e Research VA is conducting on the implementation of VA's screening, referral and treatment programs for OIF/OEF veterans with mental health concerns.	Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Comprehensive Needs Assessment for OIF/OEF Veterans	Straits-Troster, K	\$46,000	Dec-07	
Research Objective: To assess needs of OEF/OIF veterans to develop & implement clinical services, policies & research for veterans post-deployment				
Program Title: National Center for PTSD	Multiple	\$ 18 Million+	Ongoing	
Research Objective: To provide details about needs of OEF/OIF veterans, as well as other populations	Straits-Troster, K	VA resources	Jan-07	
Program Title: Health Risk Behaviors and Quality of Life Among OIF/OEF Veterans and Implications for VA Healthcare				
Research Objective: To examine prevalence of health risk behaviors (smoking, alcohol use), quality of life, access to health care & satisfaction with VA health care during 2003-2005	Morey, Rajendra	\$214,000	Ongoing	
Program Title: OEF/OIF Study Registry				
Research Objective: Screen participants for mental health status, substance use disorders, depression, TBI & bank blood samples for assessment of neurotransmitters & genetic markers of mental illness	Morey, Rajendra			
Program Title: TBI/PTSD Collaborative Multi-site Study	Tupler, Larry	\$88,000	Ongoing	
Research Objective: To characterize traumatic brain injury and post traumatic stress disorder co-occurrence				
Program Title: Olfactory Sensory Processing in PTSD and TBI	Morey, Rajendra	\$26,000	FY 2010	
Research Objective: Using 8-channel MRI compatible olfactometer, to precisely time presentation of odors during functional MRI studies in veterans				

ATTACHMENT 10

3.e. Research VA is conducting on the implementation of VA's screening, referral and treatment programs for OIF/DEF veterans with mental health concerns.				
Program Title/Research Objective	Primary Investigator	Allotment*	Projected Conclusion Date	
Program Title: <i>Rapid Needs Assessment of VA Polytrauma Rehabilitation Centers</i>	Freidemann-Sanchez	\$44,420	Sep-06	
Research Objective: To investigate health care needs via survey				
Program Title: <i>Evaluation of Stress Response Systems in Gulf War Veterans with CMI</i>	Blanchard, Melvin	\$4,000	Sep-06	
Research Objective: To evaluate how veterans with chronic multi-symptom illness respond to stress				
Program Title: <i>Improving the Treatment of Chronic Pain in Primary Care</i>	Dobscha, Steven	\$299,880	Nov-09	
Research Objective: The primary objective of this study is to determine to what extent a multifaceted, collaborative intervention improves patient outcomes and adherence to guidelines for treatment of chronic pain in a VA primary care setting. We will also determine to what extent the intervention improves treatment of comorbid depression, and if treatment of depression is associated with improvements in pain and pain-related function				
Program Title: <i>Pathways to Vocational Rehabilitation: Enhancing Entry and Retention</i>	Drebinger, Charles	\$253,000	Sep-07	
Research Objective: To evaluate the effectiveness of a brief motivational interviewing intervention				
Program Title: <i>Integrating Smoking Cessation into Mental Health Care for Veterans with PTSD</i>	McFall, Miles E.	\$1,576,680	Sep-09	
Research Objective: To conduct a large, multi-site clinical trial to determine the effectiveness of incorporating smoking cessation treatment into the care provided to patients with PTSD				

ATTACHMENT 10

3.e. Research VA is conducting on the implementation of VA's screening, referral and treatment programs for OIF/OEF veterans with mental health concerns.			
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Does PTSD Service Connection Affect Disease Course and Family?	Murdoch, Maureen	\$266,900	Sep-06
Research Objective: To examine the disease course trajectory of PTSD and to what extend receipt of VA disability improves or worsens veterans' disease course			
Program Title: Physical and Sexual Assault in Deployed Women: Risks, Outcomes and Services	Sadler, Anne G.	\$57,339	Jun-09
Research Objective: To examine use of DVA services & barriers to their use for Reserve & National Guard military women previously deployed to OEF or OIF. This cross-sectional observational study will use telephone survey methods to identify organizational, situational and individual risk factors for assault, explore associations between physical and sexual assault and health status and health risk behaviors, and identify current and potential VA use			
Program Title: Effectiveness of Screening and Treatment for PTSD in Substance Use Disorder Patients	Trafton, Jodie	\$109,050	Dec 2011
Research Objective: To identify feasible & inexpensive methods to detect & treat co-morbid PTSD among VA SUD patients, to improve treatment outcomes			

*Funding allocations may vary over fiscal years.

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3.1. Research VA is conducting on the mental health concerns of OIF/OEF veterans			
Program Title/ Research Objective	Primary Investigator	FY'06 Allocation*	Projected Conclusion Date
Program Title: <i>Comprehensive Needs Assessment for OIF/OEF Veterans</i> Research Objective: To assess needs of OEF/OIF veterans to develop & implement clinical services, policies & research for veterans post-deployment	Straits-Trostier, K	\$46,000	Dec-07
Program Title: <i>National Center for PTSD</i> Research Objective: To provide details about needs of OIF/OEF veterans, as well as other populations	Multiple	\$18 Million+ [†]	Ongoing
Program Title: <i>Health Risk Behaviors and Quality of Life Among OIF/OEF Veterans and Implications for VA Healthcare</i> Research Objective: To examine prevalence of health risk behaviors (smoking, alcohol use), quality of life, access to health care & satisfaction with VA health care during 2003-2005	Straits-Trostier, K	VA resources	Jan-07
Program Title: <i>OEF/OIF Study Registry</i> Research Objective: Screen participants for mental health status, substance use disorders, depression, TBI & bank blood samples for assessment of neurotransmitters & genetic markers of mental illness	Morey, Rajenda	\$214,000	Ongoing
Program Title: <i>Neuractive Steroids and Nicotine Dependence</i> Research Objective: Study on neuroactive steroids that might have relevance to nicotine dependence	Marx, Christine	\$35,000	Nov-07
Program Title: <i>Optimizing Smoking Cessation Interventions in Posttraumatic Stress Disorder</i> Research Objective: To study which cessation strategies might be best in veterans with PTSD & nicotine dependence	Beckham, Jean	\$250,000	Sep-09
Program Title: <i>Telephone Quit Line Tobacco Cessation for Veterans of Military Service in OIF/OEF</i> Research Objective: To determine whether telephone-based counseling is effective in reducing smoking in OEF/OIF veterans	Beckham, Jean	\$75,000	Dec-07
Program Title: <i>The Effect of Smoking on Startle and Prepulse Inhibition in PTSD</i> Research Objective: To examine the relationship between smoking and stress using startle and prepulse inhibition	Beckham, Jean	\$100,000	Dec-08
Program Title: <i>Pregnenolone Augmentation Targeting Cognitive Symptoms in Veterans with PTSD</i> Research Objective: To study impact of pregnenolone augmentation in persistently symptomatic veterans with PTSD on cognitive symptoms, resulting in improved quality of life & overall functioning in these patients	Marx, Christine	\$50,000	May-07
Program Title: <i>Guided Imagery for Military Sexual Trauma</i> Research Objective: Randomized controlled trial of self-administered guided imagery intervention for PTSD related to MST, to assess PTSD symptoms & potential biomarkers of PTSD	Strauss, Jennifer	\$15,000	Jan-08
Program Title: <i>Evaluating the Clinical and Neurobiological Effects of Guided Imagery for PTSD in Women Veterans</i> Research Objective: To assess the effects of guided imagery on PTSD symptoms, brain function associated with processing stress, and biological markers of stress	Strauss, Jennifer	\$175,000	Jan-08

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3. Research VA is conducting on the mental health concerns of OEF/OIF veterans	Program Title/Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Secondary Prevention with Paroxetine vs Placebo in Subimposthoushold PTSD Research Objective: To evaluate secondary prevention strategy using selective serotonin reuptake inhibitor paroxetine which might be effective in OEF/OIF veterans with early manifestations of PTSD symptoms	Marx, Christine	\$45,000	Dec-08	
Program Title: TBI/PTSD Collaborative Multi-site Study Research Objective: To characterize traumatic brain injury and post traumatic stress disorder co-occurrence	Tupler, Larry	\$88,000	Ongoing	
Program Title: QI/ER Center: PT-BRI Research Objective: To promote rehabilitation, psychological adjustment, & community re-integration of individuals who have experienced polytrauma & blast-related injuries	Sayer, Nina	\$350,000	Dec-08	
Program Title: Olfactory Sensory Processing in PTSD and TBI Research Objective: Using 8-channel, MRI compatible olfactometer, to precisely time presentation of odors during functional MRI studies in veterans	Morey, Rajendra	\$26,000	FY 2010	
Program Title: Neuroactive Steroid Alterations as Candidate Biomarkers of Suicidality Risk in OEF/OIF Veterans Research Objective: To investigate relationships of steroids and risk for suicide	Marx, Christine	\$35,000	May-07	
Program Title: Veterans Causes of Death from an Eleven-Year Consecutive Outpatient PTSD Clinical Sample Research Objective: To determine cause of death from a small sample of veterans with PTSD	Beckham, Jean	MIRECC	Sep-07	
Program Title: Imaging of Brain Structure and Function Research Objective: To characterize brain function through imaging	Morey, Rajendra	MIRECC	Ongoing	
Program Title: Rapid Needs Assessment of VA Polytrauma Rehabilitation Centers Research Objective: To investigate health care needs via survey	Freidemann-Sanchez	\$44,420	Sep-06	
Program Title: Pain Transmitter Regulation in Sensory Neurons Research Objective: To determine pathophysiology underlying neuropathic pain	Adler, Joshua E.	\$135,400	Sep-06	
Program Title: Mechanisms Underlying Pain Behavior Post Lamieectomy Research Objective: To understand the underlying changes in back pain from compression, inflammation and scarring	Akeson, Wayne H.	\$122,100	Sep-08	
Program Title: Cerebrospinal Fluid (CSF) and Plasma Pro-Inflammatory Cytokines: Relationship to Combat Exposure, PTSD and Health Status Research Objective: To investigate the role of cytokines in health outcomes related to PTSD	Baker, Dewleen G.	\$206,200	Dec-07	
Program Title: Serotonin and Dopamine Transporter Genes: A Factor in PTSD Risk? Research Objective: To use serial CSF sampling techniques in twenty-four hour circadian studies to measure CSF and plasma cytokines and key neurohormones in male combat veterans with and without PTSD and in male non-combat healthy controls.	Baker, Dewleen G.	\$140,912	Dec-08	
Program Title: Role of Adaptive Processes in Mediating the Effects of Drugs on Mood Research Objective: Understanding the relationship between psychological symptoms of withdrawal, pharmacodynamic tolerance and dependence	Barrett, Robert J.	\$195,968	Mar-08	

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Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: <i>Intracellular Signaling in Response to Adenosine in Basal Forebrain</i> Research Objective: To understand the molecular mechanisms underlying the long term effects of sleep deprivation	Basheer, Radhika	\$53,785	Sep-05
Program Title: <i>Ovarian Hormone Regulation of Behavior Following Traumatic Stress</i> Research Objective: To understand how stress affects female psychological processes and neurobiology	Beck, Kevin	\$113,300	Sep-08
Program Title: <i>Ad Lib Smoking in PTSD - A Naturalistic Study</i> Research Objective: To examine the relationship between smoking and stress, as well as to evaluate an electronic diary method that will be used to obtain study information	Beckham, Jean C.	\$105,180	Sep-07
Program Title: <i>Evaluation of Stress Response Systems in Gulf War Veterans with CMI</i> Research Objective: To evaluate how veterans with chronic multi-symptom illness respond to stress	Blanchard, Melvin	\$4,000	Sep-06
Program Title: <i>Neural Correlates of PTSD Prevention with MBSS in Iraqi Veterans</i> Research Objective: To conduct a trial of MBSS to determine effectiveness in preventing PTSD	Bremner, J. D.	\$174,877	Sep-06
Program Title: <i>Pro-Inflammatory Cytokines, and Coping Behavior</i> Research Objective: To characterize the relationship between cytokines and stress	Brennan, Francis X.	\$115,847	Sep-05
Program Title: <i>Integrated Cognitive Behavioral Therapy (CBT) for Substance Use and Depressive Disorders</i> Research Objective: To determine the effectiveness of psychotherapy in dually diagnosed patients	Brown, Sandra A.	\$144,365	Sep-08
Program Title: <i>Facilitation of Functional Recovery Following Acute Spinal Cord Injury</i> Research Objective: To test combined treatments to facilitate functional recovery of the injured spinal cord in a pre-clinical model	Chakkalakal, Dennis A.	\$20,833	Apr-07
Program Title: <i>Neuropsychology of Retrograde Amnesia</i> Research Objective: These studies should inform us on the nature of the neurobiology of human memory impairment	Clark, Robert E.	\$156,836	Mar-06
Program Title: <i>Suppression of PTSD-Related Information-Processing Biases</i> Research Objective: To determine how information may be processed differently in subjects with PTSD	Constans, Joseph I.	\$70,525	Dec-06
Program Title: <i>The Role of APOE in Recovery After Brain Injury</i> Research Objective: To determine how APOE might play a role in the recovery from traumatic injury to the brain	Crawford, Fiona	\$136,900	Sep-06
Program Title: <i>A Placebo Controlled Trial of Adjunctive Quetiapine for Refractory PTSD</i> Research Objective: To conduct a clinical trial to determine effectiveness of a pharmacotherapy adjunct in PTSD	Davis, Lori	\$47,500	Sep-06
Program Title: <i>Effects of Stress on Memory: Brain Circuits, Mechanisms and Therapeutics</i> Research Objective: To investigate the neural underpinnings of stress in a pre-clinical model	Diamond, David M.	\$273,053	Mar-09

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3.1. Research VA is conducting on the mental health concerns of OIF/OEF veterans				
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date	
Program Title: <i>Improving the Treatment of Chronic Pain in Primary Care</i> Research Objective: The primary objective of this study is to determine to what extent a multifaceted, collaborative intervention improves patient outcomes and adherence to guidelines for treatment of chronic pain in a VA primary care setting. We will also determine to what extent the intervention improves treatment of comorbid depression, and if treatment of depression is associated with improvements in pain and pain-related function.	Dobscha, Steven	\$299,880	Nov-09	
Program Title: <i>The Role of the Serotonin 2C Receptor mRNA Editing and Alternative Splicing in Suicidal Behavior</i> Research Objective: To further understand the neurobiological factors that may underlie suicide	Dracheva, Stelia	\$104,225	Dec-07	
Program Title: <i>Pathways to Vocational Rehabilitation: Enhancing Entry and Retention</i> Research Objective: To evaluate the effectiveness of a brief motivational interviewing intervention	Drebig, Charles	\$253,000	Sep-07	
Program Title: <i>Rehabilitation Outcomes Research Center for Veterans with Central/Nervous System Damage</i> Research Objective: Central nervous system damage (CNS) as the result of a stroke. Evaluating the structure, process, quality, access, outcomes and cost of rehabilitation services; using quantitative and qualitative methodologies to develop new and more precise measures across the continuum of care. Evaluating innovative systems and processes of care through the continuum: Recruiting, training, and retaining highly qualified and productive health services and rehabilitation outcomes researchers and building capacity for rehabilitation outcomes research	Duncan, Pamela W.	\$679,798	Sep-07	
Program Title: <i>A Human Neuronal Cell Line for Treatment of Chronic Pain After Spinal Cord Injury</i> Research Objective: To determine the potential of GABA cell therapy to attenuate chronic as well as acute, neuropathic pain	Eaton, Mary J.	\$9,242	Oct-05	
Program Title: <i>Reversibly Immortalized Chromaffin Cells for Chronic Pain After Spinal Cord Injury</i> Research Objective: To determine if chronic pain can be reversed by a chromaffin-sensitive mechanism	Eaton, Mary J.	\$94,650	Dec-06	
Program Title: <i>Effectiveness of Chronic Pain Management in Rehabilitation Medicine</i> Research Objective: To evaluate treatment strategies for patients who have both CLBP and either major depressive disorder (MDD) or dysthymia	Fann, Alice V.	\$49,750	Dec-05	
Program Title: <i>Emotional Stress and Cardiac Myocyte Dysfunction</i> Research Objective: To characterize how stress may affect cardiac changes	Finkel, Mitchell S.	\$150,000	Mar-09	
Program Title: <i>Mechanisms of Action of Transcranial Magnetic Stimulation (TMS)-Induced Performance Enhancement</i> Research Objective: To study the mechanisms of action by which transcranial magnetic stimulation (TMS) enhances human performance	Fox, Peter T.	\$36,275	Jun-10	

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Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: Context and the Hippocampus in Unmitigating PTSD Research Objective: To use MRI brain imaging, employing methods for determining hippocampal, amygdala, and total brain volume differences in PTSD.	Gilbertson, Mark	\$147,700	Mar-09
Program Title: Validation of the Activewatch as a Pain Treatment Outcome Measure Research Objective: To determine whether activewatch may be beneficial in treatment chronic pain	Gironda, Ronald J.	\$111,275	Sep-07
Program Title: Hypothalamic-pituitary-adrenal Axis Alterations in PTSD: A Comparison of Gulf War and Vietnam Veterans Research Objective: To comprehensively examine the hypothalamic pituitary adrenals (HPA) axis in Gulf War veterans and Vietnam veterans with PTSD in order to clarify the mode or models of HPA axis dysfunction that may account for the neuroendocrine alterations described in these populations.	Goller, Julia	\$111,350	Sep-06
Program Title: Adenosine S' Role in Sleep and Arousal Research Objective: To induce a local decrease in A1R expression in the cholinergic basal forebrain area and to examining the effect on total sleep and sleep homeostasis	Greene, Robert W.	\$125,000	Sep-09
Program Title: Cellular Function and Regulation of 5-HT7 Serotonin Receptor Isoforms Research Objective: To induce a local decrease in A1R expression in the cholinergic basal forebrain area of transgenic mice and to then examine the effect on total sleep and sleep homeostasis	Hamblin, Mark W.	\$125,600	Sep-06
Program Title: Corticotropin-releasing Factor 1 (CRF1) Receptor, G-protein-coupled Receptor Kinases (GRKs), Arrestins, Stress Sensitization and Mood Disorders Research Objective: To determine whether telomeric GRK3 expression may contribute importantly to the pathophysiology of stress-influenced psychiatric disorders by reducing the activation threshold, and increasing the magnitude and duration of CRH-mediated stress response	Hauger, Richard L.	\$135,000	Sep-06
Program Title: Acute Post-Operative Pain Management Using Massage as Adjunctive Therapy Research Objective: To determine if massage, a major non-pharmacologic complementary therapy, can serve as a useful adjunct therapy in the management of acute postoperative incisional pain	Hinshaw, Daniel B.	\$27,875	Nov-05
Program Title: Quantitative Trait Genes Controlling Circadian and Sleep Behaviors Research Objective: To find genes responsible for the normal differences in circadian and sleep behaviors	Hofstetter, John R.	\$202,800	Mar-08
Program Title: Promotion of Functional Recovery Following Spinal Cord Injury Research Objective: Provide novel therapeutic strategies for SCI	Jones, Kathryn J.	\$225,000	Jan-10
Program Title: Antidepressant Mechanisms of Vagus Nerve Stimulation Research Objective: To explore the antidepressant efficacy and therapeutic mechanisms of VNS in two validated animal models of depression	Krahl, Scott E.	\$124,242	Sep-05
Program Title: Proteomics of Neurotoxic Amphetamines Research Objective: To gain a better understanding of the mechanisms by which neurons are damaged by methamphetamine and MDMA	Kuhn, Donald M.	\$192,568	Mar-07

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3.1 Research VA is conducting on the mental health concerns of OIF/OEF veterans				
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date	
Program Title: <i>Electrophysiologic and Anatomic Correlates of Functional Recovery on Traumatic Brain Injury</i> Research Objective: To use cognitive event-related potentials as a tool for understanding cognitive recovery in patients with traumatic brain injury	Lew, Henry L.	\$158,880	Jun-06	
Program Title: <i>Neurobiological Mediators of Symptom Development in Animal Model of PTSD</i> Research Objective: Characterize the specific neurobiological changes, following trauma-exposure, that lead to treatment-resistant symptoms, and test the therapeutic effectiveness of pharmacological compounds designed to reverse these effects	Liberzon, Israel	\$109,400	Sep-09	
Program Title: <i>Regulation of the Gial Response to Neuronal Injury</i> Research Objective: Provide insight into the mechanisms that underlie the heterogeneity of bone cancer pain	Mantyh, Patrick W.	\$209,552	Sep-07	
Program Title: <i>Prefrontal Cortical Function in PTSD: A Proton Magnetic Resonance Spectroscopy Study</i> Research Objective: To answer important questions about regional brain function in combat PTSD with emphasis on underlying neurochemistry	Martis, Brian	\$15,000	Sep-09	
Program Title: <i>Integrating Smoking Cessation into Mental Health Care for Veterans with PTSD</i> Research Objective: To conduct a large, multi-site clinical trial to determine the effectiveness of incorporating smoking cessation treatment into the care provided to patients with PTSD	McFall, Miles E.	\$1,576,680	Sep-09	
Program Title: <i>Adult Neurogenesis: Regulation by Sleep</i> Research Objective: To determine which characteristics of sleep are critical for support of adult neurogenesis - sleep timing within the context of daily circadian-endocrine cycle, sleep continuity, total sleep time, or occurrence of a particular	McGinty, Dennis	\$310,909	Sep-09	
Program Title: <i>Classical Associative Learning in Male and Female Detoxified Veterans</i> Research Objective: To further define the extent of associative learning impairment in alcoholics and begin to uncover the neural substrates responsible for impaired and preserved learning	McGirrhey, Regina	\$126,600	Mar-09	
Program Title: <i>Electroneurograph Asymmetry and Autonomic Response to Threat in PTSD</i> Research Objective: To explore the electrophysiology and psychophysiology within appropriate emotion-eliciting experimental paradigms and the neurobiologic basis of PTSD, particularly motivational states and symptoms related to traumatic fear and threat	Metzger, Linda J.	\$50,000	Sep-10	
Program Title: <i>Noise-Enhanced Galvanic Vestibular Stimulation for Hemispatial Neglect</i> Research Objective: To determine the effectiveness of galvanic vestibular stimulation	Milberg, William P.	\$145,020	Dec-08	

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3.1 Research VA is conducting on the mental health concerns of OIF/OEF veterans				
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date	
Program Title: <i>Telemedicine and Anger Management Groups for PTSD Veterans in the Hawaiian Islands</i> Research Objective: To assess clinical effectiveness of conducting anger management therapy group treatment intervention with veterans who have PTSD & reside in remote locations, using video-teleconferencing modality as compared to traditional in-person modality	Morland, Leslie	\$267,348	Mar-09	
Program Title: <i>Sexual Assault Prevalence among Male PTSD Disabled Gulf War Veterans</i> Research Objective: To replicate, in a larger cross-sectional survey sample of 1,300 male Gulf War era veterans applying for PTSD disability benefits, preliminary findings and precisely define in-service sexual assault prevalence. The study will identify the proportion of sexually assaulted men who have been screened for sexual trauma, been offered or received treatment or perceive need for sexual assault treatment and test the validity of a conceptual model describing these men's sexual assault odds and odds of being screened for sexual trauma	Murdoch, Maureen	\$266,900	Aug-09	
Program Title: <i>Does PTSD Service Connection Affect Disease Course and Family?</i> Research Objective: To examine the disease course trajectory of PTSD and to what extent receipt of VA disability improves or worsens veterans' disease course	Murdoch, Maureen	\$266,900	Sep-06	
Program Title: <i>Safety and Efficacy of Bionic Neural/Muscle Stimulation for Pain Therapy</i> Research Objective: To determine the appropriate human use of Bion Technology	Myers, Robert R.	\$161,600	May-07	
Program Title: <i>A Clinical Trial of Magnetic Stimulation in Depression</i> Research Objective: To conduct a controlled clinical trial to directly test the hypothesis that the effects of prefrontal rTMS on mood are related to both the laterality and the frequency of magnetic stimulation	Nadeau, Stephen E.	\$131,400	Sep-06	
Program Title: <i>ATP Receptors and Mitogen-Activated Protein Kinase Signaling in Traumatic Brain Injury and Gliosis</i> Research Objective: To determine the role of extracellular ATP, P2 purinergic receptors and ERK signaling in the development of gliosis induced by traumatic injury.	Neary, Joseph T.	\$212,931	Mar-08	
Program Title: <i>Predicting Chronic PTSD in Individuals Exposed to Trauma</i> Research Objective: To conduct a longitudinal assessment of psychophysiological reactivity in individuals with ASD and acute PTSD to examine the evolution of this marker as psychiatric symptoms remit or transition into chronic PTSD	Orr, Scott P.	\$239,750	Dec-06	
Program Title: <i>Efficacy of an Integrated Cognitive Behavioral Therapy Approach to Treating Chronic Pain and PTSD</i> Research Objective: To conduct a pilot test of CBT in PTSD	Otis, John D.	\$241,716	Aug-08	
Program Title: <i>A Spinal Cord Injury Vocational Integration Program: Implementation and Outcomes</i> Research Objective: To evaluate whether a vocational rehabilitation program patterned after the VA Community Employment and Support approach improves rehabilitation outcomes compared with vocational rehabilitation practices currently used in most VA MICS	Ottomanelli, Lisa	\$603,779	Jun-10	

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Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
Program Title: <i>Can We Facilitate Consciousness After Severe Traumatic Brain Injury</i> Research Objective: To study the effectiveness of standard medical treatment and standard rehabilitation early after severe TBI and up to 1-year after injury.	Pape, Theresa L. B.	\$94,622	Jun-07
Program Title: <i>Mood-Stabilizing Medications and the Insolit Signaling System</i> Research Objective: Characterize the promoters of human IMPA1 and IMPA2, which are lithium-sensitive and crucially involved in brain insulin's second messenger system.	Parthasarathy, Ranganathan	\$287,900	Sep-09
Program Title: <i>Neural Substrates Underlying Behavioral Organization</i> Research Objective: To conduct state-of-the-art imaging studies to characterize how decision making is processed and how it might be improved with treatment.	Paulius, Martin P.	\$102,301	Jun-09
Program Title: <i>Role of Thyrotropin-Releasing Hormone (TRH) in Antidepressant Treatment</i> Research Objective: To investigate the role of hormones and their action in models of depression	Pekary, Albert Eugene	\$166,300	Dec-07
Program Title: <i>Learned Helplessness Model of Stress</i> Research Objective: Develop an understanding of the neurochemical effects of inescapable stress in creating "learned helplessness," and of antidepressant drugs in normalizing learned helplessness behavior.	Petty, Frederick	\$135,000	Sep-07
Program Title: <i>Perforata Control of Associative Learning</i> Research Objective: Provide new information regarding perforatal mechanisms underlying a range of clinical disorders	Powell, Donald A.	\$395,380	Sep-10
Program Title: <i>Prospective Study of Functional Status in Veterans at Risk for Unexplained Illnesses</i> Research Objective: To prospectively examine (pre- & immediately post-deployment) factors drawn from previous research & theory that are probable risk factors for increased MUS in military personnel after a deployment. Primary outcomes are symptoms, functional status (perceived health & health care use). Will determine if pre-deployment variables like personality (e.g., neuroticism), & exaggerated neuroendocrine reactivity are associated with post-deployment functional status & utilization. Will determine if possible resilience factors like coping styles & social support can mitigate declines in functional status & increased use. Finally, will determine whether immediate post-deployment changes like coping style, social support, & psychological distress predict changes in health care use. This study will provide prospective data on both pre- & early post-deployment factors relating to post-deployment MUS & accompanying functional status and utilization changes in reserve veterans.	Quigley, Karen S.	\$241,344	Dec-09
Program Title: <i>Risk Perception and The Psychological Sequelae of Vaccination</i> Research Objective: To determine: (a) whether a threatening vaccine context or having optimal information in form of a vaccine risk communication influences risk ratings of a vaccine, (b) whether a threatening vaccine context or vaccine-specific communication will increase post-vaccine non-specific bodily symptoms & psychological distress, & reduce vaccine effectiveness, & (c) whether a threatening vaccine context or vaccine-specific symptoms combined with physiological arousal at time of vaccination will increase post-vaccine non-specific bodily symptoms & psychological distress, & reduce vaccine effectiveness.	Quigley, Karen S.	\$137,925	Jun-07

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Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date
3.1. Research VA is conducting on the mental health concerns of OIF/OEF veterans			
Program Title: <i>Adrenergic Mechanisms and Treatment for PTSD and Secondary Drug Abuse</i>			
Research Objective: To determine the underlying pathways which would respond to treatment for PTSD comorbid with substance abuse.	Raskind, Murray	\$369,849	Sep-10
Program Title: <i>Prazosin Treatment for Combat Trauma PTSD Nightmares and Sleep Disturbance</i>	Raskind, Murray	\$145,400	Mar-07
Research Objective: To conduct a small randomized clinical trial to test the effectiveness of a pharmacological treatment to relieve nightmares and sleep disturbances in combat-related PTSD			
Program Title: <i>Attentional Disorders in Patients with Brain Injury</i>			
Research Objective: To better understand differences in performance on visuospatial tasks between patients with unilateral focal lesions and normal controls	Robertson, Lynn C.	\$302,705	Sep-09
Program Title: <i>Telephone Case Monitoring for Veterans with PTSD</i>	Rosen, Craig S.	\$113,300	Mar-11
Research Objective: Randomized controlled trial to assess whether adding telephone monitoring to usual care reduces PTSD symptoms & hospitalization.	Ross, Richard J.	\$144,200	Dec-07
Program Title: <i>Cognitive - Behavioral Treatments for PTSD Sleep Disturbance</i>			
Research Objective: To explore a CBT approach for treatment of sleep disturbances in PTSD			
Program Title: <i>Physical and Sexual Assault in Deployed Women: Risks, Outcomes and Services</i>			
Research Objective: To examine use of DVA services & barriers to their use for Reserve & National Guard military women previously deployed to OEF or OIF. This cross-sectional observational study will use telephone survey method to identify organizational, situational and individual risk factors for assault; explore associations between physical and sexual assault and health risk behaviors, and identify current and potential VA use	Sadtler, Anne G.	\$57,339	Jun-09
Program Title: <i>The Performance-Perception Test (PPT) as a Counseling Tool</i>			
Research Objective: To determine if the use of PPT and simple counseling can be used to align perceived and measured ability	Saunders, Gabrielle	\$145,850	Sep-07
Program Title: <i>BARRIERS AND FACILITATORS TO PTSD TREATMENT SEEKING</i>			
Research Objective: To examine barriers to & facilitators of PTSD treatment-seeking among veterans.	Sayer, Nina A.	\$148,900	Dec-07
Program Title: <i>A Randomized Clinical Trial of Cognitive-Behavioral Treatment for PTSD in Women</i>			
Research Objective: To evaluate the efficacy of exposure therapy for treating PTSD and associated problems in female veterans and active duty military personnel!	Schnurr, Paula P.	\$660,594	Mar-07
Program Title: <i>Neural Substrates of Acute Opioid Dependence and Withdrawal</i>			
Research Objective: To determine information critical for prevention and treatment of opioid dependence and drug dependence in general	Schulteis, Gerhard H.	\$221,096	Sep-08

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3.1 Research VA is conducting on the mental health concerns of OIF/OEF veterans				
Program Title/Research Objective	Primary Investigator	FY'06 Allocation*	Projected Conclusion Date	
Program Title: Cholinergic and Monoaminergic Influences on Sleep Research Objective: To provide clues about the function of sleep.	Shironmani, Priyatham J.	\$44,150	Mar-06	
Program Title: Sleep Neurobiology and Circuitry Research Objective: To explore wake-active neurons in basal forebrain (BF) and posterior hypothalamus and ascending influences on BF neurons, which in turn may inhibit sleep-active neurons	Shironmani, Priyatham J.	\$108,359	Sep-10	
Program Title: Treatment and Costs of Blast Related Injuries in VA Research Objective: To characterize the diagnosis, treatments, and clinical complication associated with initial VA hospitalization for persons with blast injuries, using data from FY01-06. Investigate health care use & costs associated with patient & outpatient services for individuals with blast related complications for the first 18 months after presenting to VAMC. Describe healthcare experience from the patients perspective, including access, timeliness, appropriateness, & overall quality of care	Siddharthan, Kris	\$54,080	Apr-08	
Program Title: Testosterone Replacement Therapy in Opioid Induced Hypogonadal Wasting Research Objective: To test the effects of TRT on indices of physical function, muscle strength, and pain control	Siegel, David	\$115,880	Apr-09	
Program Title: Influence of Nicotine on Affect in Smokers: Vulnerable to Depression Research Objective: To characterize nicotine's effects on both positive and negative affect, and to determine how these effects may be moderated by both a prior history of major depressive disorder as well as by the presence of a current depressive episode	Spring, Bonnie J.	\$187,595	Sep-06	
Program Title: The Neuropsychology of Memory Research Objective: To determine which hippocampal brain structures must be damaged to produce amnesia and whether the amnesia is different from amnesia produced by medial temporal lobe lesions	Squire, Larry R.	\$295,829	Mar-10	
Program Title: Trauma and Severe Psychological Trauma in Women Research Objective: To characterize the neurobiological changes evident in women who have experienced severe trauma through numbing/forgetting	Stein, Murray B.	\$146,756	Sep-10	
Program Title: Adenosine and the Basal Forebrain in the Control of Behavioral State Research Objective: Determine the neural mechanisms of sleep cycle control and relevant neuropharmacology to provide a rational basis for treatment of sleep disorders	Strecker, Robert E.	\$241,554	Sep-08	
Program Title: Frontal Lobe Injury and Executive Control of Cognition and Emotion Research Objective: To study frontal lobe injury and executive control of cognition and emotion	Swick, Diane	\$89,750	Dec-06	
Program Title: Hypothalamic and Basal Forebrain Regulation of Sleep and Arousal Research Objective: To examine the neurophysiology, neuropharmacology, and anatomical distribution of putative POA sleep-regulatory neurons, and characterize their anatomical and functional interactions with monoaminergic neurons in the posterior hypothalamus and brainstem	Szymusiak, Ronald S.	\$282,780	Sep-07	
Program Title: PTSD, Anger, Cognition, and Partner Violence Among Combat Veterans Research Objective: Examining anger dysregulation and the salience of cognitive factors with respect to partner violence perpetration among a sample of veterans	Tarr, Casey T.	\$1,000	Sep-09	

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3.i. Research VA is conducting on the mental health concerns of OIF/OEF veterans					
Program Title/ Research Objective	Primary Investigator	FY06 Allocation*	Projected Conclusion Date		
Program Title: Molecular Mechanisms of Methamphetamine Neurotoxicity Research Objective: To learned about how Methamphetamine causes damage to DA nerve terminals	Thomas, David M.	\$101,100	Sep-08		
Program Title: Effectiveness of Screening and Treatment for PTSD in Substance Use Disorder Patients Research Objective: To identify feasible & inexpensive methods to detect & treat co-morbid PTSD among VA SUD patients to improve treatment outcomes	Trafton, Jodie	\$109,050	Dec 2011		
Program Title: Cross-modal Influence on Attention in Patients with Neglect Research Objective: To determine means of maximizing cross-modal interactions for the development of effective treatments	Van Vleet, Thomas M.	\$131,802	Sep-08		
Program Title: Neuropsychology of Information Processing and Memory Research Objective: To study recognition memory in amnesia and to elucidate the neural basis of familiarity and determine how amnesia's reliance on familiarity can be enhanced, thus leading to improved memory performance	Verfaellie, Mieke	\$263,015	Jun-08		
Program Title: Traumatic Neural Injury: Neuroprotection Research Objective: To investigate the mechanism of neuroprotection that could prevent the development of increased vulnerability from so many different neuronal insults in traumatic injury through the development of a beneficial state	Wallis, Roi Ann	\$149,400	Sep-07		
Program Title: The Importance of acid-sensitive ion channel 1 (ASIC1) in Fear and its Potential For Therapeutic Use Research Objective: To extend our understanding of ASIC1 in brain function and behavior, and to explore the potential therapeutic value of ASIC1 antagonists	Wemmie, John A.	\$212,162	Sep-07		
Program Title: Sarcococca Receptoricity in Gulf War Veterans Research Objective: To determine alterations of the hypothalamic-pituitary-adrenal (HPA) axis in PTSD	Yehuda, Rachel	\$148,722	Sep-07		
Program Title: PTSD, Sleep Disordered Breathing and APOE Genotype: Effects on Cognition Research Objective: To examine whether sleep-disordered breathing, APOE status, increasing age and their interactions will predict rate of cognitive decline in veterans who have PTSD, a population already at risk for cognitive deficits	Yesavage, Jerome A.	\$144,250	Dec-09		
Program Title: Endorphin Protein Precursor and Peptide Actions Research Objective: To identify extended endorphin-containing peptides that could derive from a larger protein precursor	Zadina, James E.	\$205,495	Mar-06		
Program Title: Neurologic Studies of Medial Temporal Lobe Function Research Objective: Help clarify the specific roles played by the perirhinal cortex, and the hippocampus in perception and memory	Zola, Stuart M.	\$235,382	Sep-07		

*Funding allocations may vary over fiscal years.

Questions for the Record
The Honorable Bob Filner
Subcommittee on Health
House Committee on Veterans Affairs
September 28, 2006

Hearing on Post Traumatic Stress Disorder (PTSD) & Traumatic Brain Injury (TBI)

Question 1: VA has consistently claimed that it does not need additional staff to provide veterans and their families with family and marital counseling to help veterans and their families stay strong and resilient in the face of debilitating Post Traumatic Stress Disorder (PTSD) symptoms.

Question 1(a): In FY 2006, please state by each VISN how many veterans received treatment for PTSD.

Response: The number of unique veterans by Veterans Integrated Service Network (VISN) who received treatment for PTSD in fiscal year (FY) 2006 is provided in the chart below. Each veteran is counted only once: there were 345,844 unique veterans treated for PTSD in FY 2006.

VISN 1	19356	VISN 8	23456	VISN 17	18231
VISN 2	8856	VISN 9	16655	VISN 18	17733
VISN 3	12875	VISN 10	10761	VISN 19	12104
VISN 4	16570	VISN 11	10501	VISN 20	19685
VISN 5	7963	VISN 12	12909	VISN 21	17361
VISN 6	23488	VISN 15	12940	VISN 22	17522
VISN 7	27106	VISN 16	28521	VISN 23	11251
				TOTAL	345,844

Question 1 (b): Of the veterans, who received treatment for PTSD in FY 2006, please state how many received marriage or family counseling as part of their treatment for PTSD.

Response: The Veterans Health Administration (VHA) does not have specific information on the number of veterans who received marriage or family counseling as part of their treatment for PTSD in FY 2006. However, families are treated in a number of ways in addition to conjoint therapy. The treatment of families includes involving them as important participants in the care of veterans with PTSD, consistent with the patients' preferences. Examples include the families working with the patient in seeking care; and providing the family information about the nature of symptoms, the associated disability, and the impact on quality of life. Families are involved

with planning treatment and choosing between alternative therapies; evaluating the outcomes of care; and helping to decide when treatments should be modified or augmented. Families are also often involved as partners in psychosocial treatments. For example, family psycho-educational interventions have been demonstrated to be effective in other serious mental illnesses, and they are currently being extended to include patients with PTSD. The treatment of the family also includes involving them as an important part of the management of PTSD in primary care settings in the VHA. As provided in the Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline for Management of PTSD in Primary Care, VHA primary care providers regularly assess family support and knowledge of PTSD and incorporate family skills training into the patient's treatment plan, when indicated. In addition, assessments of family functioning and relationships are routinely conducted in both primary care and mental health specialty settings.

Treating the families by involving them in these and other components of care is within the scope of practice for psychiatrists, psychologists, and social workers who are providing care for the patient. Continuity and coordination of care may be best accomplished when interactions with families are conducted by the same providers that are involved in other elements of care.

Care within our medical centers and clinics extends beyond treatment to alleviate symptoms of PTSD to include rehabilitation to optimize functioning and role performance and promote hope, even in the face of persistent symptoms. With the consent of the veteran, families are involved in the process of rehabilitation, as they are in other forms of treatment. Their input and inclusions are, as a rule, coordinated through the psychiatrists, psychologists, and social workers involved in the planning, monitoring, and delivery of care.

Care provided by our medical centers and clinics is part of a treatment plan directed toward meeting the veterans' needs. In conjunction with care provided in VA medical centers (VAMC) and clinics, care within our Vet Centers is designed to facilitate readjustment to the family as well as the community for veterans affected by combat. Vet Centers are authorized to address and frequently serve the readjustment and related needs of the family as well as the veteran. The services provided by Vet Centers are designed to promote continued strength and resilience of veterans and their families in the face of stress and stress-related illnesses.

VA also notes that recently, Congress, under the Veterans Benefits, Health Care and Information Technology Act of 2006, Section 201, Public Law 109-146 authorizes VA to hire marriage and family therapists and licensed mental health counselors and requires VA to provide Congress with a report on marriage and family therapy workload for the treatment of PTSD. VA is currently working on de-

veloping a methodology for tracking the number of veterans diagnosed with PTSD receiving marriage and family therapy.

Question 2: Screening recent veterans for PTSD is a vital first step towards helping veterans become resilient and recover from the psychological wounds of war. Please provide a detailed breakdown by each VISN of:

- The number of OEF/OIF veterans who were screened for PTSD
- Those screened for PTSD, the number who screened positive
- Those who screened positive, the number who received a follow-up mental health appointment
- Those OEF/OIF veterans who screened positive, the number who completed an initial follow-up mental health appointment.

Response: VA has not tracked the number of Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans who were screened for PTSD. Information from DoD indicates that 32.7 percent of the 14,467 referrals for positive Post Deployment Health Risk Assessment (PDHRA) screens were for mental health reasons (4731 individuals). Not all of these were specifically for PTSD and VA is in the process of sorting out how many of those referred actually came to VA for care. VA does have the number of OEF/OIF veterans who received a provisional diagnosis of PTSD at VAMC, broken out by VISN, between FY 2002 through FY 2006, see chart below. It should be noted that a provisional diagnosis of PTSD simply indicates that the veteran responds positive to three of the four items on the screener for PTSD. It does not mean that the veteran has PTSD. Additional evaluation and testing would be required to render a diagnosis of PTSD. Also the data provided in the chart below have to be interpreted with caution because they **only apply to OIF/OEF veterans who have accessed VHA health care** due to a current health question. These data therefore do not represent all 631,174 OIF/OEF veterans who have become eligible for VA healthcare since FY 2002 or the approximately 1.4 million troops who have served in the two theaters of operation since the beginning of the conflicts in Iraq and Afghanistan.

Program Evaluation

VA's goal is to measure and evaluate the outcome of PTSD screening and treatment methods. VHA currently screens all patients and collects data to identify potential PTSD patients. For patients with the definitive diagnosis of PTSD, symptom data on functional outcomes are collected.

The overall goal of PTSD treatment is based on the individual patient. A patient's progress is measured in relation to the severity of their PTSD symptoms and their functional goals. Examples of these functional goals for patients include but are not limited to employment, increased social ability, reduction of anger responses, and reduction of PTSD symptoms.

VA's ongoing PTSD program evaluation series, The Long Journey

Home, reports symptom and functional outcomes of veterans of all service eras served by specialized PTSD programs. Preliminary data will become available starting in the 3rd quarter of 2007.

OEF/OIF Cohort

When patients screen positive, VA clinicians are instructed to provide follow-up either in primary care or by referral to a mental health provider. At this time, VA is unable to provide the number of OEF/OIF veterans who receive and complete a follow-up mental health appointment. VA will provide the numbers when they become available.

As new programs are developed they are included in the data collection processes. Data for screenings and outcomes for PTSD are routinely reported back to a facility and/or program for quality assurance purposes. Data analysis is performed on a national basis to determine overall outcomes and needs for these patients.

Number of OEF/OIF Veterans with Potential PTSD, using a VAMC FY 2002 - FY 2006

Network	Medical Centers and Clinics	
	Primary ²	Any ¹
VISN 1	1732	2011
VISN 2	911	1011
VISN 3	1255	1412
VISN 4	1402	1643
VISN 5	794	900
VISN 6	1940	2227
VISN 7	2421	2763
VISN 8	1998	2378
VISN 9	1324	1603
VISN 10	922	1048
VISN 11	1029	1290
VISN 12	1034	1236
VISN 15	968	1144
VISN 16	2357	2714
VISN 17	1467	1729
VISN 18	1467	1666
VISN 19	1196	1411
VISN 20	1736	2009
VISN 21	1193	1491

VISN 22	1902	2276
VISN 23	1096	1269
Total Counts ¹	29018	33754

1. The patient counts were generated by matching a cumulative roster of 633,867 unique OIF/OEF veterans, who had been separated from active duty as of August 31, 2006, with VA inpatient (PTF) and outpatient (OPC) databases for FY 2002, 2003, 2004, 2005, and through 4th Qt. FY 2006. The DoD Defense Manpower Data Center identified and provided the identity of these veterans to the VA Environmental Epidemiology Service on September 29, 2006.

2. The number for “Primary” indicates the total number of unique veterans whose primary reason for the inpatient or outpatient visit was for treatment or evaluation of PTSD.

3. The number for “Any” indicates the total number of unique veterans with PTSD, whether or not the primary reasons for the inpatient or outpatient visit was for treatment or evaluation of PTSD.

Question 3: Please identify in detail the systematic barriers VA has identified to veterans receiving services for PTSD, depression, and high risk alcohol use. Please describe VA's current and planned initiatives to overcome these systematic barriers to accessing mental health services.

Response: Through extensive health services research, VA has identified potential barriers to veterans' access to VA services for PTSD, depression and high risk alcohol use to include social stigma and lack of information.

Affordability is a barrier in other care systems but is less so in VA. In fact, veterans are able to receive psychological treatment and medications from VA at little or no out-of-pocket cost. In fact, VA provides cost-free care for combat-theater veterans for the first 2 years after their discharge or release from active military service. Vet Center services are always free for war zone veterans. Many VA mental health programs for returning veterans are adding evening or weekend clinic hours to facilitate care for working veterans.

Other potential barriers to access to VA services are the potential social stigma attached to a diagnosis of mental illness and a lack of information about mental illness. VHA's strategy to overcome these barriers includes campaigns addressing de-stigmatized mental illness and its treatment, public education, and the development of community leaders, primary care providers, chaplains, and others as “gatekeepers” supporting the delivery of mental health care. We are also providing outreach services from VA medical centers and clinics, as well as readjustment counseling centers to provide community-based education about illness, services, and the effectiveness of care to returning veterans.

There are also potential provider-related barriers for veterans seeking access to VA services. Limited expertise in dealing with men-

tal disorders among some health care providers and the necessity to respond to the many other disorders presented by the patients are provider-level barriers to obtaining mental health care. VHA is responding to these barriers by including clinical reminders for annual screening for major depression, PTSD, and problem drinking, and for evaluating symptoms in those with ongoing treatment. To address these barriers at the level of primary care providers, VHA is implementing a major initiative to integrate mental health services with primary care and to provide both care management for common mental illnesses and alcohol-related problems and support for referrals, when needed. To address variability in knowledge, and clinical expertise in delivering, evidence-based psychotherapies, we are planning to fund several centers to provide training, supervision, and certification. Other programs will increase the availability of care for mental health and alcohol-related problems, both within primary care and mental health specialty services, including a national initiative to provide a suicide prevention coordinator (SPC) in each medical center. SPCs will work within the community to promote linkages with other mental health providers.

Finally, there are potential system-related barriers. A significant system-level barrier that research shows often limits the treatment of mental illness in the private sector and other public health settings includes the lack of coordination between mental health and general health services. VHA is unique in its degree of and emphasis on service integration and provider collaboration. VHA's integrated care teams and national electronic record system allow for consistent communication, consultation, and tracking so that veterans with mental illness appropriately receive the initial and follow-up treatment they need. Moreover, VHA is implementing a national initiative to integrate mental health and primary services, to further promote service coordination and reduce potential system-level barriers to care.

Question 4(a): Has VA set a goal to increase the percentage of eligible National Guard members and Reservists who utilize VA health care in FY 2007? If so, what is the percentage, and how does VA plan to achieve that increased utilization goal?

Response: VA's goal is to treat all eligible and enrolled veterans, including eligible National Guard and Reservists. VA has made extensive efforts to ensure that information is available to returning troops about VA services and their eligibility. Ultimately it is each veteran's decision regarding whether or where he or she will seek health care, but VA wants that decision to be based on ample information about VA and its programs for veterans. The following is a summary of efforts to reach out and educate veterans and their families:

- a. The Office of Seamless Transition has partnered with the National Guard Bureau to establish 54 transition assistance advisors (TAA), formerly State benefit advisors. A TAA is located in

- every State and territory. The TAAs are National Guard Bureau staff that work closely with VAMCs and Vet Centers in outreach, education, and referral efforts.
- b. VA is actively reaching out to National Guard and Reserve members to increase their awareness of VA benefits and services. Since May 2005, with the signing of the memorandum of agreement (MOA) with the National Guard, VA now has access to National Guard troops at the unit drills, family programs, reunions and Freedom Salute events. This is a major step in closer collaboration with the National Guard soldiers and airmen. A similar MOA is being developed with the US Army Reserve (USAR) Regional Commands and the US Marine Corps at the national level. The goal for these partnerships is to enhance access to VA services and benefits during the de-mobilization process and when service members return home to increase their education and awareness of VA services and benefits at the state and local level.
 - c. VAMC and Vet Centers are heavily involved in DoDs post deployment health reassessment (PDHRA) program for National Guard and Reserve members. PDHRA is an outreach, education, identification, and referral program. Vet Center staff has participated in over 300 PDHRA screening events with National Guard and Reserve units. These screenings have resulted in over 10,000 service members, as of September 30, 2006, being referred to VA for follow-up care. In addition to providing this follow-up care, VA staff actively enrolls National Guard and Reserve members in health care.
 - d. Recently VA has agreed to assign 22 Army Wounded Warrior (AW2) staff to VAMCs to work with seriously injured soldiers/veterans and their families. AW2 soldiers have all been medically discharged from the Army with 30 percent or greater disability ratings. Over 20 percent of the soldiers/veterans in this program have a PTSD disability. An AW2 staff will be located in each VISN (with two assigned in VISN 7). Seventeen AW2 staff members are currently in place, with five more scheduled to begin their assignments by the end of 3rd Quarter FY 07. The VA/AW2 partnership is a major step in the outreach initiative that will help VAMC and Vet Center staff reach out to seriously injured soldiers/veterans and their families.
 - e. The Office of Seamless Transition is actively working with the Army Reserve and the Marine Corps to develop memorandums of understanding (MOUs) to help promote outreach, education, and transition assistance.
 - f. In response to the growing numbers of veterans returning from combat in OEF/OIF, the Vet Centers initiated an aggressive outreach campaign to educate returning service members of the VA benefits available to them. The Vet Centers hired 100 Global War

on Terrorism (GWOT) veterans to enhance their outreach services to GWOT veterans. Since the beginnings of hostilities in Afghanistan and Iraq, the Vet Centers have seen over 177,000 OEF/OIF veterans, of which over 134,000 were outreach contacts seen primarily at military demobilization and National Guard and Reserve sites, usually in group settings.

- g. Returning veterans outreach, education and clinical (RVOEC) teams (funded and monitored through the Office of Mental Health Services) collaborate with readjustment counseling services and with State veterans affairs offices to provide information about VA services. A primary goal of the RVOEC program is to promote awareness of health issues and health care opportunities and the full spectrum of VA benefits. Some VAMCs began these outreach activities before RVOEC teams were funded as local initiatives, and they continue these services, now using the RVOEC teams as their agents.
- h. The National Center for PTSD has a number of informational pamphlets for returning veterans and their families on their web site (<http://www.ncptsd.va.gov/>). The specific information appears prominently on the Web site:

War in Iraq: Information

This section of the Web site contains the latest fact sheets and literature on the war in Iraq. Important links from the site are:

The Iraq War Clinician Guide, 2nd Edition, and two new guides on Returning from the War Zone: A Guide for Military Personnel and A Guide for Families as well as the VA Operation Enduring Freedom and Iraqi Freedom Seamless Transition Web site.

- i. In addition, VA provides briefings on benefits and healthcare services at town hall meetings, family readiness groups, and during unit drills near the homes of returning Guard/Reservists. Return and deactivation of Reserve/Guard units presents significant challenges to VA because rotation is irregular and the service members spend short periods at military installations prior to release to their Guard or Reserve components. For this reason, VA continues to refine and adapt traditional outreach efforts to meet the needs of those who are currently separating from service by focusing at the local armories or reserve centers in the months following deactivation.
- j. Since May 2005, as part of the Secretary's Letter Writing Outreach Campaign, over 658,000 letters were mailed to veterans informing them of VA's wide range of health care benefits and assistance to aid in their transition from active duty to civilian life.

Question 4(b): Of the 326,862 National Guard members and Re-

servists who have separated or been discharged from service since FY 2002 through the 3rd quarter of FY 2006, how many are no longer eligible for VA health care under the two-year window as a Priority 6 enrollment?

Response: DoD's OEF/OIF separation file shows 631,174 separations through August 31, 2006. Of these separations, 338,879 were National Guard members or Reservists. These data indicate that approximately 147,740 had a deployment* end date of at least September 30, 2004 with 50,054 of these separated members having enrollment status with VA. This results in 97,686 or 66 percent of the 147,740 known separated National Guard members or Reservists reviewed during the cited time frame as being no longer eligible for enhanced combat veteran Priority 6 enrollment. These individuals remain eligible to apply for VA health care benefits though they may be subject to eligibility criteria (e.g., income, service connection, etc.).

It is important to note that those "combat" veterans who enroll with VA during the two-year post-discharge period of coverage remain enrolled at the end of that two-year period of eligibility. VA assesses the enrolled veteran's individual eligibility factors at the end of this two-year post discharge period and places them into the appropriate priority group. This effectively "grandfathers" those combat veterans who are not subject to VA's current enrollment restriction for new Priority 8 applicants.

Those combat veterans, who do not enroll with VA during the two-year post discharge period, may be enrolled based on their individual eligibility factors such as service connection or level of income. They are subject to VA's current enrollment restriction for new Priority 8 applicants.

*Note: The deployment end date for a National Guard and/or Reservist may not be the actual separation date.

Question 5: The 2005 SMI Committee report, sent to the Committee on June 23, 2006, recommends that VA develop an initiative to address the needs of veterans with Traumatic Brain Injury (TBI). "This initiative should consider the development of an educational intervention for practitioners both primary care and mental health, consider the addition of data-driven and appropriate screening questions, establish a multidisciplinary task force, establish pilot programs through Request for Proposals, establish a TBI registry, establish a plan for cooperative relationships with DoD, assess the adequacy of VHA's capacity to provide rehabilitation for both veterans with acute and chronic TBI, develop a population-based projection methodology, and issue RFPs to accelerate research in areas of TBI."

Response: The following is VHA's response to each of the 2005 SMI Committee report recommendations:

Recommendation 1 Develop an educational intervention for practitioners in both primary care and mental health settings to assist

them in the identification of veterans with unrecognized mild, acute and chronic TBI.

VHA has mandated completion of a 4-hour continuing education course, Veterans Health Initiative: Traumatic Brain Injury, for VA clinicians in a position to provide services to eligible beneficiaries with TBI. Health care specialties included are: Physicians, Optometrists, Psychologists, Nurse Practitioners, Physician Assistants, Registered Nurses, Prosthetists, Orthotists, Social Workers, Audiologists, Blind Rehabilitation Coordinators, Speech Pathologists, Visual Impairment Services Team (VIST) Coordinators, Occupational Therapists, Physical Therapists, Kinesiotherapists, Recreation Therapists, and clinicians in Readjustment Counseling Centers. The Office of the Under Secretary for Health has mandated that the training be completed by March 31, 2007. Primary care providers and mental health providers are included in this group. New staffs are required to complete this education within 90 days of employment.

The Office of Patient Care Services (PCS) established a work group to develop a TBI Information Letter (IL) on the cognitive, behavioral and affective disorders following TBI. The work group, co-chaired by the National Program Directors for Neurology and Physical Medicine and Rehabilitation Services (PM&RS) included VA central office and field mental health experts as well as others from the disciplines of rehabilitation, primary care, and neurology. The Defense and Veterans Brain Injury Center (DVBIC) also participated. On January 25, 2006, IL 10-2006-004, Screening and Clinical Management of Traumatic Brain Injury, was released to the field. Following the release of the Under Secretary for Health's IL, the PM&RS National Program Office participated in national conference calls to educate the field about the importance of screening and treatment of individuals with unrecognized brain injuries.

Recommendation 2 Consider the addition of data-driven, appropriate screening questions to the current clinical reminder system that identifies those patients needing further assessment for TBI (i.e., the 1-question screening from DVBIC [Defense-VA Brain Injury Center], Walter Reed).

Screening for TBI is currently in the evidence building stage. Research on TBI screening is a major focus for the Polytrauma/Blast Related Injury Quality Enhancement Research Initiative (QUERI) for fiscal year 2007. A literature review has been completed and a workgroup has been charged to develop a clinical reminder for the screening of OEF/OIF veterans for possible TBI. This group will identify appropriate follow-up for potential positive screens, and ensure the ability to tabulate statistics at the facility, network, and national levels on use of the screen, any referrals that result, and outcomes, as appropriate. The group recommendations are due to VHA in spring 2007.

Recommendation 3 Establish a multi-disciplinary task force to 1. Survey and report on the current evidence-based practices that would be appropriate in treating individuals with TBI, and 2. Create standards of clinical care for the treatment of psychiatric symptoms due to TBI.

A recent State of the Science Review was published in April of 2006 that summarizes the evidence base for treating individuals with TBI (Gordon WA, et al, Traumatic Brain Injury Rehabilitation State of the Science, American Journal of Physical Medicine and Rehabilitation, 85,343-382). This body of work updates the results from a National Institute of Health (NIH) Consensus Development Conference, which were published in 1999. The updated review used a methodologically sound process for evaluating all available research reports published since the NIH conference that met rigorous criteria for inclusion. This document has efficiently met the intent of this recommendation and will serve to provide evidence- based guidance in the development of treatment protocols adopted in VHA TBI rehabilitation programs. The above referenced review also addresses the State of the Science for psychiatric interventions that can contribute to clinical care of persons with TBI.

The Polytrauma/Blast Related Injury QUERI maintains a reference “library” of relevant research articles that can be accessed through the QUERI staff or website. This “library” currently consists of approximately 300 references and is updated quarterly. It will allow ongoing review of evidence-based practice relevant to specific treatment protocols or questions.

Recommendation 4 Establish Pilot Programs (through RFPs) that implement cost-effective means of assessment and treatment trials identified from the task force report.

Findings of the above State of the Science Review will be shared with the Office of Research and Development for potential request for proposals (RFPs).

Recommendation 5 Establish a TBI registry that can be used as a place for study of this condition in order to create a more sophisticated evidence-based, cost effective assessment and treatment strategies.

VHA PM&RS has a mature national database, the Functional Status and Outcomes Database (FSOD), that is used system-wide to track active duty and veterans with TBI receiving rehabilitation services. The database is more comprehensive than a registry and includes information such as demographics, diagnoses, functional clinical outcomes, and cost. VA and non-VA researchers use the FSOD database in conjunction with studies on this population.

The Polytrauma/Blast Related Injury QUERI has developed additional variables that have been embedded in the FSOD software. These enhancements will allow additional data to be generated such as military demographics, mechanism of injuries, severity and com-

plexity of injuries.

Recommendation 6 Establish a plan for cooperative relationships with DoD, VA primary care, and physical medicine/rehabilitation to assure that patients at risk for mild unrecognized TBI are followed for early interventions once symptoms appear.

VA has established an OEF/OIF Clinical Reminder Work Group. This group has a time line that will result in a national clinical reminder ready for implementation by Spring 2007. This clinical reminder will cue primary care mental health and other providers to screen for individuals with mild to moderate TBI that has not as yet been recognized and diagnosed. It will be applied across all VHA facilities and will be mandatory. Clinicians familiar with TBI as well as the development and implementation of clinical reminders are participating on this group. In addition, there is active consultation with DoD clinical experts.

VA is participating on a TBI Task Force commissioned by the Office of the Army Surgeon General to review the processes involved with the prevention, identification, assessment, treatment, rehabilitation, family support and transitions to civilian life, of service members with TBI. A report of the findings and recommendations is due no later than May 17, 2007.

The VA Polytrauma System of Care has established 21 Polytrauma Network Sites (one in each VISN) that have specially trained teams to accept referrals from primary care of individuals with mild TBI. These teams have been charged with outreach to providers in their facilities and VISNs to promote their services.

A joint VA and DoD national conference is scheduled for April 10-12, 2007, "Evolving Paradigms: Providing Health Care to Transitioning Combat Veterans." The target audiences for the conference are primary care providers and there will be sessions on the assessment, treatment and management of TBI. Many of the sessions will be recorded for future continuing education.

Recommendation 7 Assess the adequacy of VHA's capacity to provide rehabilitation for both veterans with acute and chronic TBI and recommend a regional approach to provide such capacity.

VA developed the Polytrauma System of Care (PSC) to improve access to specialized rehabilitation services for polytrauma and TBI patients. PSC will also facilitate delivery of care closer to home, and to provide life-long case management services for OEF/OIF veterans and active duty service members.

VA facilities participating in the PSG are distributed geographically throughout the country so as to facilitate access to specialized care closer to the home, and to help veterans and their families to transition back into their home communities. Interdisciplinary teams of professionals have been designated at these facilities to work together to develop an integrated plan of medical and rehabilitation

treatment for each veteran. In some cases, polytrauma may cause long-term impairments and functional disabilities. VA is committed to providing services and coordinating the lifelong care needs of these individuals.

The four components of the PSC include:

- Rehabilitation Centers (PRCs) - These four regional centers (Richmond, Virginia; Tampa, Florida; Palo Alto, California; Minneapolis, Minnesota) are fully operational. They provide acute comprehensive medical and rehabilitation care for complex and severe injuries and serve as resources for other facilities in the PSC.
- Polytrauma Network Sites (PNSs) - These twenty-one sites including the 4 PRCS, one in each of the VISNs, are also fully operational. Their role is to manage the post-acute effects of TBI and polytrauma and to coordinate life-long rehabilitation services for patients within their VISN.
- Polytrauma Support Clinic Teams (PSCTs) - These teams are currently under development. They include local providers of rehabilitation services who have the expertise to deliver follow up services in consultation with regional and network specialists.
- Polytrauma Points of Contact (PPOCs) - All other facilities will provide local PPOCs. These are smaller facilities without the expertise or resources to meet the rehabilitation and prosthetic needs of the polytrauma patients. Each of these facilities ensures that at least one person is identified to serve as point of contact for consultation and referral of polytrauma patients to a facility capable of providing the level of services required.

VHA is in the development stages of a comprehensive review of patients with TBI. Currently, all severely injured, polytrauma patients are followed for improvement in function overtime in the same manner as all rehabilitation patients. VHA has developed a newly implemented screen to assist in identifying patients with mild to moderate TBI. This screening is used for all OEF/OIF veterans. This has been implemented recently; therefore, no formal reports have been generated at this time. VHA is still in the planning stages of determining the best mechanism to track long term outcomes for patients with TBI.

The goal in FY 08 is to have a measure for mild/moderate TBI of percent screened and of those who screened positive. For those who screen positive, a full evaluation will begin within 30 days.

Recommendation 8 Develop a population-based projection methodology to predict distribution of additional and future needs, given the markedly higher percentage of TBI in the population of veterans returning from OEF/OIF.

The PM&RS National Program Office is collaborating with the Rehabilitation Outcomes and Research Center on a research study,

Geographic Access to VHA Rehabilitation Services for OEF/OIF Veterans [and military personnel]. This study will assist PM&RS in planning for the future needs of veterans with TBI and other impairments sustained in combat. Funding for this study is provided through a Health Services Research & Development (HSR&D) grant.

Recommendation 9 Issue RFPs to accelerate research in the area of traumatic brain injury in order to learn the specific mechanisms of action by which they cause mental illness and to develop new and better treatments for veterans.

Prior to the current conflict in Iraq, the Office of Research and Development (ORD) established and maintained an active research portfolio in the area of brain injury. In response to the needs of our returning soldiers with unique injury patterns and polytrauma, ORD issued Combat Neurotrauma RFP. This research initiative seeks to advance treatment and rehabilitation for veterans who suffer traumas from improvised explosive devices and other blasts, including TBI. The solicitation was written with input from various members of DoD. The solicitation is still active, and investigators are encouraged to submit proposals in this area. Applicants are asked to pay special attention to:

- Cooperative projects in TBI with DoD;
- Co-morbid conditions with TBI such as post-traumatic stress disorder and trauma to extremities;
- Screening and diagnostic tools related to mild TBI, especially field-based; and
- Continuity of TBI care between DOD and VA (i.e., treatment and case management over time)

Col. Geoff Ling, MD, PhD, of the Defense Advanced Research Projects Agency (DARPA), chaired the review panel that included neurosurgeons on staff at the Walter Reed Army Medical Center.

Multidisciplinary members of the TBI scientific peer review panel, including members from VA, DoD, NIH and various academic institutions in the areas of molecular neuroscience, neurosurgery, physical medicine and rehabilitation and neuropsychiatry specializing in TBI, have agreed to return to review resubmissions and to serve as an ad hoc advisory group for ORD. It is expected that advice from the scientific review board will lead to increased submissions in the areas of:

- Approaches to short- and long-term consequences of TBI that affect relationships, employment and reintegration;
- Intervention strategies for care giving and family coping; and
- Vocational Rehabilitation training for persons with mild to severe TBI

Proposals deemed meritorious through scientific peer review and, therefore, slated for funding include but are not limited to:

- The neurobiology of acute and chronic TBI,

- Neuroprotection of TBI and effectiveness of interventions,
- Impact of rehabilitation strategies on neural plasticity following TBI, using imaging, neurobiological, and cognitive approaches,
- Primary and secondary drug trial interventions following TBI,
- Identification of factors influencing metabolic changes after TBI, and
- Treatment trials to enhance cognition and attention and to treat emotional, behavioral, and psychomotor conditions related to TBI

Scientific administrators from several federal funding agencies, including VA, NIH, DoD and the National Science Foundation, have self-assembled to prevent duplication and look for points of convergence and collaboration.

Also, ORD staffs are developing a Service-Directed Research project to explore how to improve methods of chronic care for returning OEF/OIF veterans with TBI or TBI-related injuries. In addition, ORD maintains a broad portfolio of research related to mental health issues that could be expected to inform clinicians about issues related to TBI.

Question 6: For each year from FY 2002 through FY 2006, please provide us with the number of veterans who utilize the VA medical facilities and Vet Centers who a) attempted suicide and b) committed suicide.

Response: VHA cannot provide the definitive quantitative information about rates of suicide, for the following reasons:

1. Not all veteran suicides are documented as suicides. For example, when the cause of death is not immediately obvious to the coroner or medical examiner the death certificate may list another cause of death such as heart attack.
2. Not all veteran suicides are reported to VA. A proportion of the events occur in the community and there is no requirement to report that information to VA.

Nonetheless, VHA is working on creating systems and procedures to obtain more complete information about suicides and suicide attempts in an ongoing manner as part of our efforts to develop an evidence-based approach to prevention, and to target care where it is most needed. Although VA does not have the systems in place at this time that would allow it to provide the requested information, it is working intensively to get more complete data, and to apply information on suicides and attempts in quality improvement, and, on attempts, in targeting care.

As part of VHA's efforts at suicide prevention, we have implemented two important projects. First, to obtain the best available estimates for rates and risk factors for suicide together with their geographic variation, VHA has obtained data from the National Death Index of the cause of death for all veterans who have stopped receiving care in

recent years. This is intended to be a sustained activity, with data obtained each year to allow an evidence-based approach to suicide prevention. Second, VISN 19 has developed a systematic strategy for the identification of enrolled veterans who have attempted suicide. They have identified 170 attempts and 22 completed suicides in the past 2 years. The ratio of attempts to completed suicides, approximately 8 to 1, is within the range cited in an National Institute of Mental Health (NIMH) Fact Sheet (www.nimh.nih.gov/suicideprevention/suifact.cfm), and is consistent with what is expected for a population that is predominantly male and middle aged or older; this is preliminary evidence for the validity of their approach to identifying cases. VISN 19's methods for creating a listing of attempts are currently being replicated in other regions. The goal is to implement it broadly in late FY 2007 as a method for targeting care to those patients who may be at the highest risk for suicide, and those who have already made attempts to harm themselves.

The Vet Center program will be an integral part of VHA's suicide prevention system. Currently, the Vet Center program is also moving in the direction of being more evidence-based and oriented towards prevention. In 2006, the Vet Centers initiated a suicide prevention program in conjunction with the University of Rochester, School of Medicine, based on the U.S. Air Force model. The Vet Center suicide prevention program is now in the second year of training Vet Center staff on a community approach to detecting and intervening in preventing suicides.

Question 7: Please provide us with FY 2004 and FY 2005 suicide rates for each of the following groups of veterans who are enrolled in VA health care: Vietnam era veterans, Persian Gulf War veterans, and OEF/OIF veterans.

Response: While that data is not currently available, VHA's has developed an action plan that is included in the Mental Health Strategic Plan (MHSP) to develop the necessary data collection and policies to address it. As part of that plan, VA has funded a Mental Illness Research Education and Clinical Center in Denver to focus on suicide prevention, and supported it to develop and disseminate methods for maintaining a facility-by-facility "registry" of suicide attempts, and its use for both identifying veteran specific risk factors, and targeting enhanced care. VHA will designate suicide prevention coordinators in each of our medical centers. Their responsibilities will include implementing new policy and procedures developed as part of the MHSP.

Question 8: Please provide a detailed update of VA's efforts to implement the VA's Inspector General's recommendations in the report titled "Health Status and Services for Operation Enduring Freedom/Iraqi Freedom Veterans after Traumatic Brain Injury Rehabilitation," Report Number 05-0181-165, dated July 12, 2006.

Response: The Inspector General's report included four specific recommendations, below is VHA response to each of the recommendations:

Recommended Improvement Action(s) A: The Under Secretary for Health should improve case management for TBI patients to ensure life-long coordination of care.

Case management has a crucial role in ensuring life-long coordination of services for patients with polytrauma and TBI, and is an integral part of the system at each polytrauma care site. PSC uses a proactive case management model, which requires maintaining routine contacts with veterans and their families to coordinate services and to address emerging needs. As an individual moves from one level of care to another, the case manager at the referring facility is responsible for a “warm hand off” of care to the case manager at the receiving facility closer to the veteran’s home. Every combat injured veteran with TBI is assigned a case manager at the polytrauma system of care facility closest to his or her home. The assigned case manager handles the continuum of care and care coordination, acts as the point of contact for emerging medical, psychosocial, or rehabilitation problems, and provides patient and family advocacy.

The Office of Social Work (OSW) revised VHA Directive 2005-017, “Social Work Case Management in VHA” in May 2006 to completely describe the functions expected of Social Worker Case Managers, the requirement for after-hours coverage, and the requirement for transfer of case management functions to a case manager at the facility providing follow-up care. OSW is also collaborating with rehabilitation services in hiring and training social worker case managers at the PRCs and PNSs. Documentation templates for social work case management follow-up have been developed.

Consistent documentation of case management follow-up in the medical record improves communication among professionals involved with the patients’ care.

A Polytrauma Telehealth Network (PTN) that links facilities in the PSC is available to support care coordination and case management. The PTN ensures that polytrauma and TBI expertise are available throughout the PSC and that care is provided at a location and time that is most accessible to the patient. The PTN allows provision of specialized expertise available at the PRCs and PNSs to be delivered at facilities close to the veteran’s home.

Specialized rehabilitation care for patients with polytrauma and TBI requires a continuum of services that may include inpatient and outpatient rehabilitation, long-term care, transitional living and community re-entry programs, and vocational rehabilitation and employment services. The twenty-one PNSs have recently completed inventories of VA and non-VA TBI specific services within their VISNs. These are used to coordinate resources to meet individualized treat-

ment needs of patients closer to home. The case managers dedicated to the PSC are responsible for identifying and coordinating these services for the individual patient as close to home as possible.

During the August 2006 Polytrauma System of Care Conference, polytrauma social work case managers received training on expectations for proactive and continuing case management of active duty personnel and veterans with brain injury and polytrauma. Monthly conference calls are held to mentor and educate the PNS case managers.

The OSW, in collaboration with PM&RS, has established a social work case management work group. This group is developing a new model of social work TBI and polytrauma case management that will address the care coordination, psychosocial and family support issues of this special population across different sites, levels of rehabilitation, and health care service delivery. This group is also identifying training needs and will work with the Employee Education System on a variety of education initiatives. A one-hour training session was held in January 2007 via conference call to educate social workers concerning the signs and symptoms of mild to moderate TBI.

VHA is publishing a new VHA Handbook on Transition Assistance and Case Management of OIF/OEF Veterans. The Handbook requires each VA medical center to appoint a master's prepared nurse or social worker to serve as the OIF/OEF Program Manager to oversee all seamless transition activities, coordination of care for OIF/OEF service members and veterans, and coordination of case management services for severely-injured OIF/OEF service members/veterans, including those with TBI. The Handbook also describes the functions of 100 new Transition Patient Advocates, who will be assigned to severely-injured service members/veterans, including those with TBI, and their families. Recruitment for the new positions is already underway.

The Office of Seamless Transition (OST) implemented a seamless transition performance measure for fiscal year 2007. Severely injured OEF/OIF service members/veterans who are transferred by VA/DoD liaisons at the Military Treatment Facilities (MTFs) must be assigned a VAMC Case Manager prior to transfer. This VA case manager must contact the service member/veteran within 7 calendar days of notification of the transfer. OST developed a tracking system into which the VA/DoD social work liaisons stationed at the MTFs enter the patients transferring to VA. Starting October 10, 2006, the tracking system automatically generates an email to the receiving facility when the VA/DoD Liaison enters a potential transfer date. The receiving facility assigns a case manager in the tracking system and the case manager must contact the patient within seven calendar days of notification of the transfer.

The VA has partnered with the Army Wounded Warrior (AW2)

Program to assign an AW2 Soldier and family management specialist to 22 VA medical centers located in the VISN 21. The AW2 staff will integrate with existing polytrauma teams and will function as case managers for both soldiers and their families. They will work with soldiers, veterans and their families to ensure they are fully linked to VA care and benefits. Seventeen AW2 staff members are currently in place, with five more scheduled to begin their assignments by the end of 3rd Quarter FY 07.

Recommended Improvement Action(s) B: The Under Secretary for Health should work with DoD to establish collaborative policies and procedures to ensure that TBI patients receive necessary continuing care regardless of their active duty status, and that appropriate medical records are transmitted.

The revised DoD/VA MOA entitled, “Department of Veterans Affairs (VA) and Department of Defense Memorandum of Agreement Regarding Referral of Active Duty Military Personnel Who Sustain Spinal Cord Injury, Traumatic Brain Injury, or Blindness to Veterans Affairs Medical Facilities for Health Care and Rehabilitative Services” is currently in the Office of the Assistant Secretary of Defense for Health Affairs. DoD is shifting billing and reimbursement under this MOA from the Military Medical Support Office to the three TRICARE regional offices. There are no changes that impact the transfer of clinical care between the two agencies.

VA and DoD have developed the capability to share electronic medical records bi-directionally to coordinate the care of shared patients. The VA/DoD Bidirectional Health Information Exchange (BHIE) supports the real-time bidirectional exchange of outpatient pharmacy data, allergy information, lab results, and radiology reports between all VA facilities and select DoD host sites receiving large numbers of OEF/OIF combat veterans such as the Walter Reed Army Medical Center (WRAMC), the Bethesda National Naval Medical Center (BNNMC), and the Landstuhl Army Medical Center in Germany. All VA medical centers have the capability to view the DoD BHIE data. In addition to BHIE capability, VA and DoD have made significant progress toward sharing inpatient data. VA and DoD have developed the capability to permit the four VA regional polytrauma centers to view DoD inpatient data stored in DoD’s inpatient clinical information system (CIS). This capability provides unprecedented access to electronic DoD inpatient data by VA clinicians treating patients transferred from DoD and enhances continuity of care between DoD and VA. This past quarter, VA and DoD also conducted successful testing of the bidirectional sharing of inpatient narrative and discharge summaries.

Recommended Improvement Action(s) C: The Under Secretary for Health should develop new initiatives to support families caring for TBI patients, such as those identified by patients and family mem-

bers we interviewed.

The Offices of PM&RS, Social Work, Seamless Transition, Mental Health, Spinal Cord Injury and Geriatrics and WRAMC provided a national satellite broadcast, "Serving our Newest Generation of Veterans" in May 2006. This live broadcast was repeated on multiple dates and times to provide VA staff opportunities for viewing. The continuing education program included presentations on understanding the military culture, providing appropriate care across the lifespan; addressing the needs of families of polytrauma patients through supportive services; educating patients, families and staff about polytrauma rehabilitation (which includes a video about the four PRCs), amputation care, cognitive issues, physical and recreation therapy needs of polytrauma patients; and transforming the rehabilitation environment to better meet the unique needs of young polytrauma patients.

The PM&RS National Program Office identified a subject matter expert in the area of therapeutic support for families dealing with stress and loss. During the August 2006 "Polytrauma System of Care Conference." Pauline Boss, Ph.D. provided an educational session on the impact of trauma on the family, assisting families with coping and strategies for VA providers. VHA is continuing to work with Dr. Boss as a consultant. She presented at a conference for Polytrauma Rehabilitation Center staff and VA leadership December 7, 2006.

The OSW has held four quarterly educational conference calls for VHA social workers on polytrauma and seamless transition. Each call stressed different aspects of assessing and meeting the needs of families of polytrauma and other OEF/OIF patients.

VHA has hired seven clinical staff members who are assigned to the new Center for Intrepid Joint Services Rehabilitation Facility (Center) at Brooke Army Medical Center in San Antonio, Texas. VHA staff will provide clinical services and seamless transition services to active duty service members undergoing rehabilitation at the Center and will offer supportive services for families. A memorandum of agreement for VA's role in the operation of the Center was signed by Secretary Nicholson in September, 2006, and by the Secretary of the Army in January 2007. The Center for the Intrepid was dedicated on January 29, 2007 and will be receiving active duty and veteran patients for rehabilitation shortly.

The VHA PRCs at Minneapolis, Minnesota, and Palo Alto, California, have Fisher Houses to lodge the families of active duty service members and veterans undergoing polytrauma rehabilitation. A Fisher House is under construction at the James A. Haley VA Hospital in Tampa, Florida, with an estimated completion date of April 2007. The Fisher House Foundation will break ground for a new Fisher House at the fourth VHA PRC in Richmond, Virginia, in Spring 2007, with an estimated completion date of Fall 2007.

Each PRC and PNS has established a General Post Fund for family lodging and associated needs. Voluntary Service accepts donations made to the VA Medical Centers for family lodging into the Family Lodging General Post Fund. Social workers access the funds to help families defray the costs of hotel lodging, meals, and local transportation at facilities without Fisher Houses or when the Fisher House is full.

In FY 2006, the OSW helped arrange 48 free airline ticket vouchers through the Fisher House Foundation's Hero Miles Program for the families of polytrauma patients so they could visit the patient at the PRCs. The Hero Miles Program will continue in 2007.

More than 200 VHA Social Workers attended the Uniformed Services Social Work & Seamless Transition Conference in August 2006. The VA hosted conference offered a seamless transition track with workshops on transferring care from DoD to VA facilities, meeting the needs of families, treating combat stress and PTSD, and working with veterans suffering from polytraumatic injuries.

Recommended Improvement Action(s) D: The Under Secretary for Health should work with DoD to ensure that rehabilitation for TBI patients is initiated when clinically indicated.

In April 2006, a DoD - VA TBI Executive Board was established. A TBI Summit was held September 18-20 that brought together non-VA, DoD, and VA subject matter experts to discuss contemporary practice concerning the identification and treatment of individuals with brain injuries. Outcomes of this meeting included identification of priority issues, and building consensus across DoD and VA concerning case management, assessment and treatment.

A VA/DoD Rehabilitation Nurse liaison has been recruited and is currently assigned to WRAMC. This individual will monitor and follow the severely injured, assess readiness for rehabilitation, communicate closely with Rehabilitation Nurse Admission Case Managers at the PRCs, provide updates on medical status, functional status, recovery progress, and nursing care issues. The Rehabilitation Nurse liaison will have close contact with families, providing education concerning impairments, rehabilitation process, and orientation to the VA PRCs.