VET CENTERS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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VET CENTERS

THURSDAY, JULY 19, 2007

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

The Committee met, pursuant to notice, at 2:08 p.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Hare, Snyder.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. The Subcommittee will come to order. I would like to thank everyone for coming today. Mr. Miller will be joining us. He is at another meeting that he can't get out of, but he will be here as soon as he can. I would like to thank Mr. Hare for coming.

Before we begin, I would ask unanimous consent that all written statements be made part of the record. Without objection, so ordered. I also ask unanimous consent that all Members be allowed five legislative days to revise and extend their remarks. Without objection, so ordered.

Today we are here to discuss Vet Centers, the benefits that they have provided to our current population of veterans and the important and growing role they are playing helping out veterans from Afghanistan and Iraq. The Vet Centers program was established in 1979 to help Vietnam era veterans with readjustment challenges. Vet Centers provide an alternative environment outside the regular VA system for a broad range of counseling, outreach and referral services.

Most importantly, Vet Centers provide an environment in which veterans can speak openly to veterans about their experiences. Vet Centers have been a success, and now they have a new mission. In 2003, then-Secretary Principi extended Vet Centers eligibility to Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) and Global War on Terror (GWOT) veterans, as well as bereavement counseling to survivors of military personnel who died while on active duty to include Federal active Guard and Reservists.

Not surprisingly, the workload at Vet Centers continues to increase. This trend will likely continue as OEF/OIF veterans deal with everything from mild readjustment issues to serious mental health challenges. VA currently has 2,009 Vet Centers located throughout the United States, Guam, Puerto Rico and the U.S. Virgin Islands. There are five Vet Centers in the State of Maine as well.

The U.S. Department of Veterans Affairs (VA) has scheduled 23 new Vet Centers to be opened in the next 2 years. There has been an effort to hire GWOT veterans to serve as peer-to-peer counselors. The purpose of this hearing is to determine how Vet Centers can continue to fulfill their unique and critical role within the VA continuum of care.

Each generation of veterans has its own unique needs. It is important that Vet Centers are prepared to meet the needs of our new veterans, while continuing to care for veterans from previous conflicts.

I look forward to hearing our witnesses here today on how we can maintain and improve services provided by Vet Centers, if we have appropriate facilities and staffing, what role can and should other resources within our communities play to help veterans and improve care, and most importantly, what should we do to strengthen invaluable peer-to-peer counseling available through Vet Centers.

And now I would like to recognize Congressman Hare for any opening statement that he might have.

[The prepared statement of Chairman Michaud appears on pg. 1.]

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman. Thank you all for coming today. And thank you for holding the hearing.

I am fortunate to have three outpatient Vet Centers in my district and one just directly across the river in Davenport, Iowa. The clinic in Moline actually is about a block and a half from my district office in Moline. And I have to tell you, the work that is done at the clinic and the support services and the people that work at those clinics do a wonderful job and, and I am a stronger supporter of these Vet Centers. And if anything, I would like to see us expand.

I know today we are going to talk about what we can do to, to hopefully get more and, and what we can do better at these Vet Centers. But I just want to commend the people who work at these facilities and I want to say that from my perspective, Mr. Chairman, I think we should do whatever we can do to expand the programs at these Vet Centers and ensure that we keep the ones that we have and expand and get more Vet Centers to help our returning veterans.

I think the problem is going to be made worse when we get a lot of our vets coming back from Afghanistan and Iraq and I think we have a—I said many times, I believe an obligation to provide the services that we need for our returning veterans from any conflict and from any branch of service.

So I am just honored to be here with you this afternoon and I look forward to the testimony. And again, thank you very much, Mr. Chairman, for calling the hearing.

Mr. MICHAUD. Thank you, Mr. Hare, and thank you for your support of veterans' issues. For those of you who don't know, Congressman Hare actually used to work for a gentleman that I have a great deal of respect for who served on this Committee for many years, former Congressman Lane Evans. And I really appreciate

your picking up the mantle from where Congressman Evans had left off.

On the first panel, I would like to welcome Sue Bergeson who is President of the Depression and Bipolar Support Alliance. Thank you for coming here this afternoon. I look forward to hearing your testimony.

STATEMENT OF SUE BERGESON, PRESIDENT, DEPRESSION AND BIPOLAR SUPPORT ALLIANCE

Ms. BERGESON. Thank you. Chairman Michaud and Members of the Committee, on behalf of the Depression and Bipolar Support Alliance (DBSA), thank you for the opportunity to testify today about the types of mental health services offered to our veterans through Veterans Centers. DBSA further thanks you for your efforts in focusing the Nation's attention on the plight of the men and women of our military forces who are returning from combat with their mental health devastated.

DBSA is the Nation's largest peer-run mental health organization, with more than 1,000 State and local chapters in all 50 States. Over 5 million people ask us for help each year. By peer-directed, we mean that our organization is led by staff and volunteers living with mental illnesses, people like me, people who have experienced the debilitating effects of mental illness first-hand. Our organization focuses on the power of peer support as a key component in our recovery.

DBSA regularly partners with the VA on peer support training for veterans, both nationally and at local facilities. Additionally, DBSA has long been represented on the Consumer Liaisons Council to the VA Committee on the Care of Veterans with Serious Mental Illnesses.

The mental health difficulties of today's returning vets are well-documented. Despite the valiant efforts of the many really dedicated VA service providers, current capacity cannot meet new demand. Long waits for treatment, often with tragic consequences, result from an already overloaded system that cannot reach all who are in need.

In 2006, a Committee of experts declared that the VA cannot meet the ongoing needs of veterans of past deployments while also reaching out to new combat veterans by employing older models of care. We have a new job and we need to do it in new and fresh ways.

Chairman Michaud, today we have the greatest resource to help combat this grim picture right at our fingertips, and that resource is our veterans themselves. Let me illustrate the value of veteran peer support services through the example of a resident of the Chairman's home State of Maine. As you know, Mr. Chairman, Jack Berman is a resident of South Portland, Maine. He is a disabled veteran who has served as Vice President to the Maine Military Coalition and is President of the Military Officers Association of America.

Mr. Berman is a man of many talents, in spite of the adversity he has faced in his life. An entrepreneur, a rehabilitation counselor, a highway planning engineer for the New York Port Authority, these are just a few of Jack's accomplishments.

Seventy-nine-year-old Jack Berman was appointed First Lieutenant during the Korean war and fought on the frontlines. He was awarded five medals, including three bronze stars. Yet while in training, he was hospitalized and diagnosed with bipolar disorder with episodes of severe depression. As an individual living with a mental illness, how did Mr. Berman survive and excel in so many areas? The answer was connecting him with individuals just like himself.

As Mr. Berman tells us, veterans are not often inclined to share their stories about the terrible experiences of war with those who may not be able to understand them. He told DBSA, "These guys are willing to get their medications from a psychiatrist, but they don't want to talk to them. They want to talk to others just like them."

That is why Mr. Berman believes that peer-to-peer support is the ideal solution for our country's veterans. "When a soldier can openly share his feelings with another soldier living with a mental illness, something magical happens," Mr. Berman says. "Talking to my peers was the factor in my recovery."

A proven method to harness the power of peer support and overcome the significant barriers to successful treatment is the Certified Peer Specialist. These individuals are trained to help their peers deal successfully with challenges and move forward with their lives. Peer Specialist outreach in the community, especially in rural or remote areas and through veterans centers makes services more accessible than traditional means alone. And this new role provides opportunities for meaningful work and financial independence for veterans with mental illness who otherwise may have difficulty finding employment.

Peer Specialist services are also significantly cost-effective and have been shown to cost up to five times less than older models of care, with improved clinical outcomes. The VA has already identified these services as a priority in its Mental Health Strategic Plan and has provided very limited funding for implementation at local VA facilities. DBSA is proud to have assisted in many of these efforts.

However, barriers to VA implementation of Peer Specialists remain. There is a critical need for a large scale, coordinated national effort that sets the gold standard for VA Peer Specialist training and delivery of services.

Therefore, we urge the Committee to encourage the VA Office of Mental Health Services to do the following three things. One, identify and allocate a significant increase in funding for a national veterans mental health peer training and employment initiative. Two, establish and fund a VA Technical Assistance Center for Peer Support Services, partnering with an established national organization with demonstrated experience in peer support training. Three, create and pilot national veteran Peer Support Technician training and certification projects in multiple locations throughout the country.

These actions are just a small part of what we can do to provide our veterans with the necessary tools to fight this new battle on their return home.

DBSA stands ready to assist the Committee in its efforts. I thank you for this opportunity to offer our input. Happy to answer any questions.

[The prepared statement of Ms. Bergeson on pg. 27.]

Mr. MICHAUD. Thank you very much for that enlightening testimony. I have just a couple of quick questions. You stated that the greatest resource to help veterans suffering with mental illness is veterans themselves in peer-to-peer support. In your opinion, do you feel that the VA system nationwide is not utilizing enough peer-to-peer support counselors?

Ms. BERGESON. Well, our experience working with VA Veterans Integrated Service Networks (VISNs) across the country is that they really embrace this. It is part of the strategic plan. It is welcomed with open arms. And it has been shown to be very successful with limited funding. We know that this works. The data shows it works. It makes sense to extend this. And we believe there is a great deal of openness to extend this.

But this is in the face of increased demand on the VA as vets return home. So we are really urging an increase of resources be made available to the VA to enhance these services.

Mr. MICHAUD. You also had mentioned that 35 percent of the OEF/OIF veterans treated by the VA have been diagnosed with mental disorders and that the VA does not have the capacity to care for them. Is that true for Vet Centers as well, or do you separate the Vet Centers out? Do Vet Centers have the capacity to deal with the need out there?

Ms. BERGESON. Well, the reality is that the VA and the Vet Centers do a phenomenal job. But we are looking at this tremendous surge of additional people. And no matter how wonderfully talented the VA leadership that I have come in contact is, you can only extend these resources so far. So I believe that in light of increased demand on services, we need to be looking at increased resource allocation.

Mr. MICHAUD. Thank you. Congressman Hare.

Mr. HARE. Thank you very much. I only have one question for you Ms. Bergeson. You stated that even though the screening of returning veterans for symptoms of mental illness is now more widespread, that this screening does not identify many of the affected individuals. I was wondering why you believe this is the case and how the Vet Centers can improve the screening to catch the veterans currently falling through the cracks?

Ms. BERGESON. I think that there are still stigmas surrounding these illnesses and the difficulty with illnesses such as depression, bipolar disorder or post traumatic stress disorder (PTSD) is that many of the symptoms mimic or mirror normal life. Are you a little sad today? Were you unable to sleep? So it is difficult to people—for people to raise their hand and say this is a problem for me.

And I think that the VA centers can do a really excellent job in educating people and also highlighting peers who have raised their hand, who are successful, who are great examples of how this works. And I think that is a unique capability that the Vet Centers have to do that and encourage more people to go in and seek treatment.

Mr. HARE. I think you touched on this, but maybe just for my purposes of jotting a couple more notes down, what kind of investments do you think are needed to the Vet Centers to make sure they are fully equipped to deal with the growing veterans population?

One of my big concerns, as you mentioned, is the number of veterans that we are going to be trying to help. And I am wondering how do we get prepared for that? It is going to be coming sooner, I believe, hopefully. But what do we need to do to make these Vet Centers better and to be able to absorb the number of vets that are coming in so that they are taken care of in a timely fashion?

Ms. BERGESON. I guess that is one of the reasons I think of peer-to-peer counselors, vet-to-vet counseling. Think of them as an AA model where you have a mentor or a coach. When you can hire vets who have gone through it and gone through and been successful and give them really specific tools, not to be therapists, not to be mini-psychiatrists, but to be peers to help vets move forward, then you can deploy a larger workforce that is overseen by clinical staff that can really do the kind of things that vets need to move forward into wellness.

And it is a very economically advantageous way to work and it has the benefit of employment for these vets as well.

Mr. HARE. Mm-hmm.

Ms. BERGESON. I think it is a very exciting model. We have seen it work in States across the country and in different VISNs as well.

Mr. HARE. Thank you very much. I yield back, Mr. Chairman.

Mr. MICHAUD. Thank you. We also will be submitting additional questions. So thank you very much once again for coming. I really appreciate it.

Ms. BERGESON. Thank you.

Mr. MICHAUD. Thank you. I would like to ask the second panel to come forward. We welcome Shannon Middleton, Deputy Director for Health for the American Legion, Adrian Atizado, Assistant National Legislative Director for the Disabled American Veterans (DAV). As you can see, I have improved on the pronunciation of your name. And Dennis Cullinan who is the Director of the National Legislative Service for Veterans of Foreign Wars (VFW). And a special welcome back to Susan Edgerton who is the Senior Health Care Counselor for the Vietnam Veterans of America (VVA) and was a former staffer of the Veterans' Affairs Committee.

So I want to thank all you for coming forward today and look forward to hearing your testimony and we will start with Ms. Middleton and, and work down. Thank you.

STATEMENTS OF SHANNON MIDDLETON, DEPUTY DIRECTOR FOR HEALTH, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; ADRIAN M. ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; DENNIS M. CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES; AND SUSAN C. EDGERTON, SENIOR HEALTH CARE CONSULTANT, VIETNAM VETERANS OF AMERICA

STATEMENT OF SHANNON MIDDLETON

Ms. MIDDLETON. Thank you. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to present the American Legion's views on the current and future services provided by Vet Centers.

Vet Centers provide a necessary service and are an important resource for combat veterans experiencing readjustment issues. The American Legion is proud to have been involved in the Vet Center Program since its inception in 1979—excuse me. During the developmental phase, some of the Vet Centers operated out of American Legion Posts, while searching for permanent storefront locations.

Although we got off to a somewhat rocky start, the readjustment counseling program became a safe haven for thousands of Vietnam veterans suffering from PTSD, family problems and other readjustment issues. As the program has expanded, combat veterans of subsequent wars and their family members have been able to avail themselves of the services available through the readjustment counseling program.

OEF and OIF veterans are now positively benefiting from Vet Centers and their outreach activities in increasing numbers. We have stated on many occasions that we receive fewer complaints and more positive comments on the Vet Center Program than any other program administered by the VA.

This year, the American Legion's annual System Worth Saving Report will focus on select Vet Centers as well as select polytrauma centers. The System Worth Saving Task Force members and National Field Service staff visited 46 Vet Centers that were located near demobilization sites across the country.

Since many of the returning servicemembers would most likely reside near the site of demobilization, the Vet Centers selected had particular significance. In an effort to ascertain the effects of OIF on utilization of services and available services, Task Force and National Field Service staff solicited information on enrollment, fiscal and staffing issues for fiscal year 2003, the year OIF began, and fiscal year 2006. It also included challenges faced by Vet Centers as identified by staff and management.

In general, we found that the Vet Centers visited had extensive outreach plans to reach the many counties within their respective regions. Most had at least one position for a Global War on Terror Technician, or a GWOT Technician. Most participate in National Guard and Reserve demobilization activities to include providing available at post-deployment health reassessment activities and conducting briefings at Vet Center services—about Vet Center services.

Many Vet Centers have community partnerships and participate in their local college work study programs, allowing OIF veterans who are enrolled in college to assist with administrative tasks at the Vet Centers.

The Vet Centers all work with veteran service organizations to provide assistance for veterans in filing claims. Some Vet Centers even reserve space for service officers to make weekly visits. They all illustrate productive referral systems between the Vet Centers and the local medical centers.

Some Vet Centers have tailored their programs to accommodate veterans and families that speak languages other than English as a first language, or those who practice other customs. Some Vet Centers indicate that they need to enhance their services to accommodate culture differences and to target rural, women and minority veterans.

In general, the veterans—sorry. In general, the Vet Centers visited by the American Legion had the same staff composition, usually a four-person team to include a team leader, office manager, social workers and a psychologist or a mental health counselor.

However, a few indicated that limited staffing was an overall challenge, giving an anticipated influx of returning OIF/OEF veterans in the catchment area. Some Vet Centers shared GWOT Technicians and sexual trauma counselors with other Vet Centers, or had part-time staff members.

Some Vet Centers had vacancies because the GWOT Technician, as well as other key staff members, had been or would be soon deployed again to serve in Iraq or Afghanistan.

A few indicated the need for a family therapist or a sexual trauma counselor. Some of the vacancies have been funded but not filled as management was seeking qualified individuals to hire. Yet, other Vet Centers indicated that they just needed staff augmentation to handle existing and anticipated workloads.

The American Legion believes that all Vet Centers need to be fully staffed to ensure that combat veterans seeking care for adjustment—readjustment are afforded the same standard of quality care, no matter which Vet Center they utilize. This includes cross-training staff to speak other languages when necessary, or hiring qualified bilingual staff, and training staff to learn different mental health specialties.

The most important aspect of the Vet Center is that it provides timely accessibility. Since Vet Centers are community-based and veterans are assessed within minutes of their arrival, eligible veterans are not subjected to long times to be seem for—I am sorry—long wait times for disability claims decisions to determine eligibility for enrollment, or long wait times for available appointments. The Vet Center can provide immediate attention to the veteran, either directly or through contract are when necessary.

Combat veterans facing readjustment issues require immediate access to mental health assessment and counseling. Vet Centers make this possible. Making more communities aware of Vet Center services will likely improve the quality of life for many families.

Again, thank you, Mr. Chairman, for giving the American Legion this opportunity to present its views on such an important issue

and we look forward to working with the Committee to address the needs of all veterans.

[The prepared statement of Ms. Middleton on pg. 30.]

Mr. MICHAUD. Thank you. Mr. Atizado.

STATEMENT OF ADRIAN M. ATIZADO

Mr. ATIZADO. Mr. Chairman, Members of the Subcommittee, on behalf of the 1.3 million members of the Disabled American Veterans, I do thank you for the opportunity to testify that this important hearing to examine VA's readjustment counseling service.

Mr. Chairman, Vietnam veterans were called to service mostly by involuntary conscription in a very unpopular and politically charged war. They came home with medical, personal and psychological burdens that the U.S. Government and the VA minimized and largely ignored for years. In fact, Honorable Max Cleland himself, a Vietnam veteran, and who at the time was serving as VA's administrator, brought the healthcare needs of Vietnam veterans before the House and Senate Veterans' Affairs Committees, as well as the Administration.

In response, VA's readjustment counseling service was established, as you had mentioned, in 1979, for which members, our own members in DAV, as well as other disabled veterans, have regained not only their health, but their lives by virtue of the Vet Center Program.

Today, while Vet Centers have grown and matured over the years into highly skilled and specialized psychological and counseling centers, the DAV is concerned that demand is, in fact, exceeding capacity. We note that VA's own estimate for the number of OIF/OEF veterans who will seek VA care in fiscal year 2007 had been exceeded back in April. Moreover, VA's budget request for fiscal year 2008, for its readjustment counseling service reflects a downward trend in obligated spending and workload at a time when actual workload capacity and program policies are expanding.

Providing over 6,500 bereavement counseling visits and outreach efforts averaging more than 13,000 contacts each month, this has increased this program's workload for OIF/OEF veterans from less than 20,000 visits in fiscal year 2004 to well over 200,000 in fiscal year 2006. The DAV is concerned that the resources being provided to the Vet Center Program is not commensurate with its expanding workload and responsibilities even with the success of this program, which makes—I am sorry—which provides over one million counseling visits annually and makes an annual average of 200,000 referrals to the Veterans Health Administration for additional medical care.

Mr. Chairman, this program, in part, contributes to the ready access to VA care that OIF/OEF veterans enjoy today, as well as their high rates of healthcare utilization. Accordingly, when VA announced its intention to establish 23 additional Vet Centers bringing its total to capacity to 232, we question why the bulk of these Vet Centers—we question why the bulk of these Vet Centers openings are being delayed.

Also, as the Subcommittee is aware, a Committee staff report issued in October of 2006 on the capacity of Vet Centers, as well as other newspaper reports, clearly show that VA staffing should

be increased in existing centers to ensure that all veterans, all veterans who help—who need help at Vet Centers can gain that access to these important services.

Mr. Chairman, as I indicated earlier, the Vet Centers were established because Vietnam veterans saw little about the old VA of 35 years ago that appealed to them. The *Independent Budget* for fiscal year 2008 recommends and urges VA and the U.S. Department of Defense (DoD) to adopt their programs to meet the needs of our newest combat veterans rather than require these veterans to adapt their needs to the programs being offered today.

From our contacts today with veterans of both Iraq and Afghanistan wars, we are learning that today's VA, including its readjustment counseling service, may not generally be perceived as an organization that is tailoring its program to meet the emerging needs of our newest combat veterans. We urge this Subcommittee to provide VA the necessary tools for it to continue the program adjusts it has made in a way that provides a more welcoming, age appropriate, culturally sensitive, and responsive service.

The DAV stands ready to work with this Committee, Congress and the Administration to do everything in our power to bring needed resources into place to promote early and intensive interventions which are critical in stemming the development of chronic post traumatic stress disorder and other related health problems. We must ensure that family members and veterans devastated by the consequences of PTSD, adjustment disorders and other injuries have access to appropriate and meaningful VA services. Finally, we want to ensure all this occurs without simultaneously displacing older veterans with chronic mental illness under VA care.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you may have.

[The prepared statement of Mr. Atizado on pg. 32.]

Mr. MICHAUD. Thank you. Mr. Cullinan.

STATEMENT OF DENNIS M. CULLINAN

Mr. CULLINAN. Thank you, Mr. Chairman, Members of the Subcommittee. On behalf of the men and women of the Veterans of Foreign Wars, I want to thank you for inviting us to participate in today's forum.

Vet Centers are an integral part of the Department of Veterans Affairs capacity to care for veterans. They provide readjustment counseling to veterans who were exposed to the rigors of combat, and who may need services to help them cope with the traumas after war.

The program is so essential because its design helps to break down most of the stigma of treatment. Vet Centers, by and large, are accessible and welcoming. Over time, the mission has rightly expanded to provide a number of essential services beyond counseling, and has begun providing services to the families of servicemembers, who often are affected just as much by the difficulties of their loved one's combat service.

Their less formal setting helps to encourage those veterans who need its services to utilize them. Vet Centers aim to eliminate many of the barriers to care and its employees are adept at breaking down those barriers.

The quality and variety of services provided at Vet Centers is excellent. We have heard few complaints about the quality of care and the treatment vets receive in these facilities. Our concern lies with access to these services.

The October 2006 report, "Review of Capacity of Department of Veterans Affairs Readjusting Counseling Service Vet Centers," conducted by the then-minority staff of the Subcommittee on Health, provided many details of the access problems veterans face in these centers.

The Subcommittee found that many Vet Centers have scaled back services. "Forty percent have directed veterans for whom individualized therapy would be appropriate to group therapy. Roughly 27 percent have limited or plan to limit veterans' access to marriage or family therapy. Nearly 17 percent of the workload affected Vet Centers have or plan to establish waiting lists."

These are worrisome trends. But they tell just part of the story.

In conversations, representatives of our national Veterans Service have had with Vet Centers throughout the country, their greatest concern is not with the demands for service today, but with the future. Although the Subcommittee report noted that the number of OEF/OIF veterans accessing care at Vet Centers had doubled, they are still just a portion of the population to be served. As more come back and more start to access the benefits and services provided by VA, we can anticipate even larger demand for these Vet Center services.

This is especially true of mental health service provided at these centers. We are all aware of the difficulties returning servicemembers are having because of the unique stress of this conflict, and there correctly has been an increased emphasis on overall mental health well-being. VA's most recent data, through the first quarter of 2007, shows that around 36 percent of hospitalized OEF/OIF veterans are returning with some degree of mental disorder. If these numbers hold firm, as they have in previous VA reports, it will represent a challenge for those Vet Centers.

We are pleased to see the Secretary's recent decision to add 23 new Vet Centers throughout the country. Expending access is clearly a good thing. Accordingly, we need to see that each center, new and existing, is fully staffed, and that the areas that report exceptionally high demands for service are staffed sufficiently so that these centers can retain one of their characteristics that make them unique and a convenience for veterans. And that is the drop-in aspect.

We urge this Subcommittee to utilize its oversight authority by continuing to monitor the demand for services. As demand rises, funding priorities must adapt.

There are a few other concerns we have. First, these centers must be able to handle the increasing number of women veterans sure to seek treatment and increase treatment options and outreach efforts to them. While all centers are required to have sexual trauma treatment, we must ensure that services are available to address any issues that arise from them—from women serving in a war zone where there is no true frontline.

Second, the original version—vision of Vet Centers was of veterans helping veterans. That is still a worthy goal, but we under-

stand the need for qualified and highly trained counselors and staff members, especially those dealing with the complexities of mental impairments and traumatic brain injury who might not always be veterans. What is important here is that they are caring, compassionate and capable. We must be mindful of drawing on the experience of younger veterans, including OEF and OIF veterans and those who served in the Persian Gulf. VA must do more to educate and train these men and women so that they can play an active role in their fellow veterans' treatment.

Mr. Chairman and Members of the Committee, thank you very much. That concludes my statement.

[The prepared statement of Mr. Cullinan on pg. 35.]

Mr. MICHAUD. Thank you. Ms. Edgerton.

STATEMENT OF SUSAN C. EDGERTON

Ms. EDGERTON. Chairman Michaud and Congressman Hare, first of all, let me say what a pleasure it is to be back here on this side of the dais this afternoon. On behalf of the Vietnam Veterans of America, thank you for providing us the opportunity to present testimony regarding the Vet Center Program. This Committee (and Subcommittee) continues to distinguish itself for the attention it has focused on the important issue of post-deployment mental health and VVA wants to thank you for your continuing efforts.

VVA has always strongly supported the Vet Center Program because of its cost effectiveness, staff commitment and solid leadership, but especially because of the high quality of its services. It is a truly unique resource within the system. Vet Centers offer veterans and their families a haven in which to gather in an atmosphere of trust that relieves them from stigma and shame often associated with care-seeking for mental illness elsewhere.

Happily, there has been much good news for the Vet Centers lately. VVA was pleased to learn that the VA plans to open 23 new Vet Centers nationwide and we are pleased that Congress and even VA are now acknowledging programmatic deficiencies in the mental health programs and that Congress has added much needed funds in the appropriation for VA healthcare and in the supplemental. New centers will obviously help with access. Funding increases are much needed and we hope that Congress will be rigorous in monitoring how these funds are used to augment much needed capacity in all of the mental health programs.

Unhappily, experts note the demand for post-deployment mental healthcare services will continue to grow and many veterans are not receiving the proper screenings, referrals or care. Yet, even with so much unmet demand, Vet Centers are struggling. Visits per veteran dropped from 8.2 in FY 2004 to 7.9 in FY 2005 to 5.1 in FY 2006. New centers will help, but existing centers need staff too.

As Vet Centers hire new employees, VVA is concerned that these mental health professionals have the right veteran-specific experience in dealing with the issues that they will address. To that end, we recommend that Congress fund PTSD scholarships to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. This would create a new stream of Vet Center counselors who have both shared the experiences of

their comrades and received adequate professional training to address their issues.

We have called upon Vet Centers to do a great deal for our veterans and yet, ideally, they would do even more. VVA would like to see more family services, counseling for military sexual trauma available at every Vet Center, and a strong role for Vet Centers in VA's recently announced suicide prevention efforts. We hope that Vet Centers are integral in sharing their experience and expertise with community providers who may be called upon to help with the post-deployment mental health needs of vets.

We would like to see Vet Centers become more accessible, particularly for crisis intervention, ideally offering round-the-clock consultation. We would like to see Vet Centers employ nontraditional hours of operation.

As you know, Mr. Chairman, Vet Centers are just one venue that the VA employs to address post-deployment mental health issues. Vet Centers cannot be effective without accessible VA treatment programs for substance abuse, mental illness, homelessness and post traumatic stress disorder. Access to all VA mental healthcare remains problematic.

Finally, Mr. Chairman, we could not leave any debate related to post-deployment health without urging you and the Committee to support efforts to reinvigorate the National Vietnam Veterans Longitudinal Study. This study is not just important to the veterans of the Vietnam era, but would provide important findings about the long-term consequences of post traumatic stress disorder and other stressors related to deployment to generations of future veterans.

The Senate Appropriations Committee has addressed the issue in its report language accompanying the Military Construction bill and we hope that you will urge your colleagues on the House Committee on Appropriations to accept and even strengthen this language.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you may have.

[The prepared statement of Ms. Edgerton on pg. 37.]

Mr. MICHAUD. Thank you very much, each of you, for your testimony this afternoon.

I will start off with the American Legion. First all of, I want to thank you for your report, "A System Worth Saving," that you come out with each year. I read it and find it very helpful and enlightening. So thank you.

You mentioned that this year's focus is on Vet Centers. Could you tell us if there are any areas of the country, such as rural areas, that are experiencing staffing challenges more than others?

Ms. MIDDLETON. So far I haven't seen any trends. We did only see 46 of the 209 Vet Centers, but I haven't noticed any trends and I am still in the process of editing the reports. But I haven't seen any trends yet. And basically—well, no trends. So in some places the staffing was adequate and management was satisfied, had no complaints. And in other places, there were some issues that did arise.

Mr. MICHAUD. Okay. What about waiting lists?

Ms. MIDDLETON. None of them reported any wait lists. They just, you know, said that the veterans are seen as soon as they come in,

within minutes they are assessed. So no one was waiting for anyone to meet with them and, and give them care.

Mr. MICHAUD. Great. Thank you. Actually, to the VFW, you had talked about military sexual trauma and the fact that we do have an increased number of women veterans out there. Have any of the four organizations at the table been hearing complaints about the lack of military sexual trauma counselors at Vet Centers? We will start off with you, Mr. Cullinan.

Mr. CULLINAN. Yeah, thank you, Chairman Michaud. At this point, the direct contacts our national Veterans Services have with the sexual trauma centers, there haven't been those kind of complaints. However, it is our assessment and in the view of some of the individuals working at these centers that there are other things that have to be considered. It is not just the issue of sexual trauma, but other types of traumas. I mean everything from PTSD to things like traumatic brain injury, to simply the stress of combats affects women differently. And there is a concern that there is not enough attention being placed on that—on those differences.

It is not that there is everything expressly wrong right now, but, you know, we expect, the VFW expects and the people we have talked to expect to have quite an increased number of veterans seeking services and associated with that will be the need to address their specific needs.

Mr. MICHAUD. The other three organizations, have you heard any complaints?

Ms. EDGERTON. I have not heard any specific complaints, Mr. Chairman, but I guess there may be some problems even if women aren't talking about them. In my view, the issue would be if you don't have women counselors and don't have military sexual trauma counseling at every Vet Center, you may have a lot of unmet demand. It is kind of the "if you build it, they will come" sort of phenomenon. If there are services available and women become aware of them, I think they would use them. We are not sure that women veterans who do show more propensity toward PTSD, are making as much use of the Vet Centers as they might.

Mr. MICHAUD. Mm-hmm.

Ms. MIDDLETON. I just have a comment. I haven't heard any complaints. But I just wanted to note that in the 6 years I have been at the American Legion, I have had several calls, not a whole lot of them, but several calls from veterans who had experienced military sexual trauma. And I don't think any of them were women. So I think that—and it was in combat setting also. So it is important when we are thinking about military sexual trauma that we don't just think about women, because there are some men who experience it in theater also.

Mr. MICHAUD. And DAV?

Mr. ATIZADO. Thank you for that question, Mr. Chairman. I think the only thing I can add to what has already been said is the realization from our organization that women who serve in combat who are suffering from post traumatic stress disorder, we are hearing that they actually like to be in the same group as men when it comes to mental health counseling for combat experiences, as opposed to military sexual trauma, either men or women who tend to not be in that kind of a setting.

Mr. MICHAUD. We heard a suggestion from the Vietnam Veterans of America to establish a PTSD scholarship. How do the other three organizations feel about that?

Mr. CULLINAN. Mr. Michaud, I would have to say at this point we would have to look at what that means exactly, scholarship. The devils are the details and so are the angels. And I will look at it in that perspective.

Mr. MICHAUD. Thank you. Same for DAV and American Legion?

Ms. MIDDLETON. Yes, sir.

Mr. MICHAUD. Okay. Great. Thank you.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

I have two questions for the whole panel and I know you touched a little bit on this, so I think it gives us another 5 minutes to sort of talk and flesh out some of these things.

Mr. Atizado, you said that the DAV is concerned that the expanding role of Vet Centers has increased and the workload for OEF and OIF veterans from less than 20,000 in fiscal year 2004 to 242,000 visits in fiscal year 2006; is that——

Mr. ATIAZDO. That is correct.

Mr. HARE. Given that, I would like to know from all of you what can the VA—starting with you, Mr. Atizado, what can the VA do to improve their staffing recruitment and retention at the facilities and is it a matter of just funds or the policies or a combination of both?

And then with regard—we have heard a little bit about funds and I am not asking necessarily for a specific dollar amount, but organizationally, does anybody have an idea of how much money it would take to be able to get these centers the way we need to get them? So I would just throw that open to the panel.

Mr. ATIZADO. I will answer first. Thank you for that question, Mr. Hare. I would like to say first and foremost, that along with the other organizations, we think this is a gem of a program that VA has, and that the burden that it is absorbing in treating our combat veterans is—goes without saying that they are doing a tremendous job. We like the fact that they have hired a hundred new peer counselors as was testified to as far as their effectiveness with regard to the first panel and would like to see more of that come about.

We do have a concern, as was actually mentioned earlier, with the ability for VA to recruit mental health providers, whether they be peer counselors all the way up to psychologists, psychiatrists. There is a workforce shortage in practically every aspects of the medical field and VA is not isolated in that. In fact, it is hampered more, considering the way they are—because there are some shortcomings, not only with statutory authority, but also their funding process.

So they are hampered in that sense. I just—the reason why I had outlined the increase in workload, as well as just as importantly the budget request, which is actually, you know, as we all know, is a signal from leadership as to where they want this program to go, there seems to be some kind of conflict. The very same month that they issued their budget request, which as I had said, is a downtrend in obligations and workload, they in the same month

announce that they are going to increase their capacity, as they say their largest expansion since this program was stood up.

So it is a conflicting message and we urge this Committee to figure out what is going on with this, because as my other colleagues have mentioned, this is one program we cannot lose sight of.

Mr. HARE. Anybody else?

Mr. CULLINAN. I would just associate myself with Mr. Atizado's remarks. We can't help but believe that there is going to be a considerable increase in demand at Vet Centers. And the fact that conflicting signals come out of VA is troubling and as Ms. Edgerton has already pointed out, if we do things right, more women are going to start coming into the system if it is made more hospitable for them. So these are all things that need to be addressed. And it comes to—we don't have a specific dollar figure. But it comes down to the funding, staffing, and statutory authority.

Ms. EDGERTON. I just might add, it is great to have peer counselors. Primarily, as I understand it, their job is outreach and it is nice to have them to bring people into the system, but if you have nothing to bring them into, they have to wait in long lines for services or they don't have access to services at the VA medical centers that are needed, it may not, you know, that may not be an appropriate way to focus VA's resources.

I think that that is one of the reasons VVA is thinking about the PTSD Scholarship Program because we see that these are valuable people in the system. But if they could go on and learn clinical psychology, learn skills in counseling, we see those as being very productive employees in the future.

Mr. HARE. Ms. Edgerton, and hopefully I won't go too far over my time. But I am trying to remember, I don't know who said it or where I read it, the numbers of suicides committed by Vietnam veterans is staggering and I am trying to remember what that number was. It was an incredible amount in terms of where we are at. I am very concerned about this, obviously, in terms of not just for the present wars we are doing now, but for our Vietnam vets.

And I am wondering if you do have that information, if you could get that to me, because I would really like to see if there are figures on it, or if any of you have it. What can we do, do you think, to address this problem in a hurry, because it seems to me we better be doing something yesterday and not today?

Ms. EDGERTON. Well, Mr. Hare, I would certainly be happy to get you that number for the record. And I will definitely let VVA know that you are interested in that. I think one of the things that we see as, as really, really, really important for Congress to pursue is that National Vietnam Veterans Longitudinal Study. And as I said, the Senate has included language to reiterate its concerns about that study being done. It has been bogged down in VA for a number of years now, even though it is mandated by Congress.

So whatever you can do to work with your peers on the Appropriations Committee, we would certainly appreciate that.

[The information was not provided to the Committee.]

Mr. HARE. I would be happy to. Thanks very much. I yield back.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman. I just had one question that I think one of you had touched on earlier, but I wanted to

have you supplement the answer a little bit. The issue from Dr. Batres' statement who is going to be testifying here next, that the "Vet Centers have no waiting lists and veterans may be seen by a counselor the same day they stop by for an assessment." You all are in agreement, I understand, that they don't have waiting lists; is that correct? Or do you agree with that statement?

Mr. CULLINAN. Mr. Snyder, I testified earlier we have had contact direct, our National Veteran Service Representatives have had contact with some of the Vet Centers, certainly not all of them. And what we are hearing is right now there is adequate access to services. They like the care they are getting. They find them welcoming. But there is real concern that they are going to run out of resources soon.

And I can't say that there are no waiting list at all Vet Centers. In fact, you know, given what Mr. Atizado was just talking about with the deficit in funding and resources, it is hard to believe that there aren't any where there is not some problem. But our direct contacts that we have had, not yet, but it is coming.

Ms. MIDDLETON. And from our—excuse me—the American Legion's site visits during the "System Worth Saving," for the "System Worth Saving" report, that was the report we got back from the 46 Vet Centers that we visited also.

Mr. SNYDER. Which was that there is no waiting lists?

Ms. MIDDLETON. Yes, sir.

Mr. SNYDER. So that was inconsistent with what Dr. Batres' written testimony says. The real question—I mean I can probably say that of my congressional offices too. We have no waiting list. If somebody walks in the door, they will see somebody. The question is, I may not be there, which is true most of the time for my Little Rock office because I am here. The staff person that is the expert in the area they want to see may not be there.

I mean so, again, I think we want to define what it means by no waiting lists. And are you all satisfied also from what you have been hearing that they are getting to see the kind of person, the level of counselor they need? I mean that is a pretty high bar to expect a system to say a person will walk in the door and we will have the appropriate level of counselor for them to see that same day. I mean that may well be what is going on, but what are you all hearing, or do you know?

Mr. ATIZADO. If I may, I would be hard-pressed to believe that there isn't a waiting list already. There may be, I don't know. One of my concerns are is the model by which they provide treatment, as you said, even the person that is providing mental health services, and if you need a—if you have a veteran that is going to—that is on the brink between requiring one-on-one intensive care versus one-on-one regular mental healthcare versus group care, then you have, in fact, built in extra capacity to meet the demand. Whether or not the quality is the same or the horizon for them to readjust appropriately in civilian life may be lengthened, I don't know. I don't have this information. In fact, you know, panel three may have that.

Mr. SNYDER. And they may have a real good system of triaging, that someone comes in and what is going on. I need a referral for marital counseling. And obviously not an emergency, but then

somebody comes in who says I think I am going to hurt myself today. And they respond appropriately to emergency care. I mean so I don't have any reason to doubt Dr. Batres' statement and he can flesh that out when he testifies.

I just wanted to—but what you are telling is you are not hearing anything—you don't have any evidence to say that Dr. Batres' statement is inaccurate, that—no?

Mr. ATIZADO. No, sir.

Mr. SNYDER. Great. Thank you. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you very much. And once again, I would like to thank all the panelists for your testimony this afternoon and thank you also for all the work that you are doing to ensure that veterans are getting appropriate healthcare. So thank you.

On the last panel today is Alfonso Batres who is the Chief Readjustment Counseling Officer for Veterans Health Administration. He is accompanied by Greg Harms who is the Program Analyst of the Readjustment Counseling Service within the Department of Veterans Affairs.

I want to thank both of you gentlemen for coming here today. I look forward to hearing your testimony, Doctor, and without further ado, I will turn it over to you.

STATEMENT OF ALFONSO R. BATRES, PH.D., M.S.S.W., CHIEF READJUSTMENT COUNSELING OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GREG HARMS, PROGRAM ANALYST, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. BATRES. Thank you, Mr. Chairman. Thank you, sir. Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the Vet Center Program of the Department of Veterans Affairs and the role it plays in providing care and services to veterans.

This year marks our 28th anniversary of the Vet Center Program. Based on the program's record of success in serving the Nation's veterans, eligibility to Vet Center services have been extended by Congress to currently include all veterans that served in combat during any period of armed hostility.

The Vet Center Program is a unique Veterans Health Administration program designed to provide readjustment counseling services to help combat veterans make a successful transition to civilian life. Through their local Vet Centers, eligible veterans have access to professional readjustment counseling for war-related, social and psychological readjustment problems, family and military-related readjustment services, substance abuse screening and referral, military sexual trauma counseling, bereavement services, employment services and multiple community-based support services such as preventative education, outreach, case management and very importantly, referral services.

VA's Vet Center Program currently consists of 209 community-based Vet Centers located in all 50 States, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Island. Designed to remove all unnecessary barriers to care for veterans, the Vet Centers

are located in convenient settings within the community outside of the larger medical facilities.

With the onset of hostilities in Afghanistan and Iraq, the Vet Centers commenced to actively outreach and extend services to veterans returning from Operation Enduring Freedom and Operation Iraqi Freedom. From early in fiscal year 2003 through the end of the third quarter in fiscal year 2007, the Vet Centers provided readjustment counseling services to over 242,000 veteran returnees from OEF and OIF.

To promote early interventions, the Vet Centers initiated an aggressive outreach campaign to locate and form and professionally engage veterans as they return from the war in Afghanistan and Iraq. Over the 2-year period from fiscal year 2004 through fiscal year 2005, the Vet Center Program hired 100 OEF and OIF veteran returnees to provide outreach services to their fellow combatants.

The Vet Centers also provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. Vet Centers are providing bereavement services to military family members whose loved ones were killed in Afghanistan and Iraq. Since 2003 to the end of the third quarter in FY 2007, 1,045 cases of active military, or active duty military-related deaths have been referred to the Vet Center for bereavement services.

Vet Centers are staffed by small multi-disciplinary teams composed of a mix of mental health professionals, which represents over 50 percent of our treatment staff, counselors from other disciplines and outreach specialists. A majority of Vet Center service providers are themselves veterans, most of whom served in a combat theater of operations.

Having a large number of veterans on staff is a distinguishing characteristic of the Vet Centers and enables the program to maintain a veteran-focused treatment environment that communicates a welcome home attitude and respect for veterans' military service.

Today, the Vet Center Program is undergoing the largest expansion in its history since the days of the program's founding. The planned expansion complements the efforts of the Vet Center outreach initiative by ensuring sufficient staff resources be available to provide the professional readjustment services needed by the new veterans as they return home.

In fiscal year 2006, VA announced plans for establishing two new Vet Centers and augmented staff at 11 existing Vet Centers, bringing the current number of Vet Centers to 209. In February 2007, VA announced plans to increase the number of Vet Centers to 232 and to augment the staff at 61 existing sites. In May of 2007, VA announced that it planned to hire an additional 100 new staff positions to the Vet Center Program in FY 2008.

The Under Secretary of Health has also targeted an additional number of sites that are being assessed in 2009 which will further augment the Vet Centers' ability to address the readjustment needs of war veterans and their family.

The Vet Center Program reports the highest level of veteran satisfaction recorded by any VA program. For the last several years, only 99 percent of veterans using the Vet Centers consistently re-

ported being satisfied with services received and responded in addition to that, that they would recommend the Vet Center to another veteran.

Mr. Chairman, this concludes my oral statement. I am happy to answer any questions that you or other Members of the Subcommittee may have.

[The prepared statement of Dr. Batres on pg. 40.]

Mr. MICHAUD. Thank you very much, Doctor. I really appreciate your testimony. Would you tell the Subcommittee what criteria you use to establish a Vet Center?

Dr. BATRES. Yes, sir. We are using demographic data such as the total veteran population in the Vet Centers veteran service areas, measure of market penetration, i.e. how many veterans have been seen within the area. We also looked at the geographical proximity to the VA medical centers, community-based outreach clinics, in that particular area.

In addition, we included an analysis of information from the DMDC which is the DoD Defense Manpower Data Center, as to the current number of separated OEF/OIF veterans and their reported distribution of home zip code codes of those separated, as well as a number who were married and those who had children. All of the above formed the main criteria for our selections.

In addition, through our reports from our regional structures in Vet Centers, we looked at rural areas where you had large concentration of veterans distributed over large geographical areas and where there were no local medical centers or community based outpatient clinics or other services available as part of our criteria.

Mr. MICHAUD. In that DoD information, does that number also include the National Guard and Reserves?

Dr. BATRES. Yes, sir.

Mr. MICHAUD. Okay. Good. Do you know what the projected cost is for the 23 new Vet Centers and does that include the appropriate funding for staff, appropriate staff?

Dr. BATRES. Yes, sir. The amount for the 23 new Vet Centers was $14 million and that included the 61 augmented sites.

Mr. MICHAUD. Okay. Why are there such few number being activated this year and the bulk next year? Could you speed that up more?

Dr. BATRES. Yes, sir. And we are making every effort. We actually will exceed our target by the end of the fiscal year. We look to have—currently I think we are on target to maybe open seven to ten of those Vet Centers. We projected to have six. It is a long process that involves us working with private sector landlords and the like. Bids have to go out by regulation.

It takes a while to select a site. We are hiring people at these sites. We have a fair number already hired. I expect to be ahead of target by the end of the fiscal year and we are already hiring staff that we had planned to open in 2008. So we are speeding it up, sir.

Mr. MICHAUD. Okay. Have you done long-term projections as far as the workload, say, within the next five to 10 years, and in those projections, are you considering what is happening particularly in Iraq and Afghanistan, assuming that we are there for longer periods of time than is sometimes estimated?

Dr. BATRES. Well, like everybody else, sir, we—I personally did not know, like everyone else, how long the war would go. So it has been very difficult to project those kinds of numbers. However, our Office of Policy and Planning are doing those projections as we speak and we are interfaced with them and we will be the number projected. We are getting numbers from DoD. So we are planning for the 5–10-year plan.

Mr. MICHAUD. And when will you have those numbers back?

Dr. BATRES. I will check and get back to you on that.

[The response is included in the answer to Question 3A in the Questions for the Record provided by Dr. Batres, which appears on pg. 53.]

Mr. MICHAUD. I appreciate that. I would be interested in knowing that assumption because we have heard in the past, when we were dealing with budgets within the VA, that they do not calculate the fact of the war.

My last question is, have the Vet Centers seen an increase in women veterans seeking assistance and what are you doing to make sure that assistance is there—are you providing more contract services relating to female veterans?

Dr. BATRES. Yes, sir. We do have a contract program that has been in existence for 28 years. We have over 200 private-sector contractors that we fund primarily for rural areas. We are seeing an increase in women veterans. As I understand it, they reflect about, depending on the estimates, 12 to 13 percent of all in-country service-members. We currently are seeing female veterans from OEF/OIF at about the 11 percent rate among all of the folks that we are treating. So we also have about 10 percent of our OEF/OIF outreach workers are women also, which helps in terms of doing the kind of sensitive, effective outreach that is needed.

So we are seeing an increase in the number of women veterans who are coming in. And they are reflective of how they serve in the theater.

Mr. MICHAUD. Thank you.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman. Doctor, I was wondering, the current number of Vet Centers that you talked about and the ones that are online to be opened up, and I wasn't sure of the Chairman's question in terms of the number of veterans, but you are still looking at how many additional Vet Centers you would need in the next 5 years, correct?

Dr. BATRES. We are looking at the demand and then based on that demand we would be looking at whether we would augment existing sites if they are going to be coming back, or if needed, to create outstations in other places or new Vet Centers. For example, we just opened up—we are opening another Vet Center, I believe, next week in Phoenix, Arizona. Phoenix only had one Vet Center. It has grown into a very large community. So we would want to fund those.

Mr. HARE. Mm-hmm.

Dr. BATRES. And we are also opening one in Grand Junction, Colorado, which is a more rural area, but it has a high level of veteran population.

Mr. HARE. What challenges, Doctor, have you faced in trying to recruit and to retain staff, appropriate staff that you need for the centers? I am assuming that that is probably a big problem for you.

Dr. BATRES. Well, I have an aging staff up until about 5 years ago when we started to heavily recruit the new veterans. We now have hired over 150 younger OEF/OIF veterans to complement our existing cadre. We were predicated on serving Vietnam veterans and for many, many years that is what we did. We served the Vietnam era veterans. So I guess I am about the average age for my staff and I am close to 60. However, in the last 5 years, the average age of the Vet Center employee has dropped by over 10 years.

Mr. HARE. All right. So——

Dr. BATRES. So we are hiring the newer, younger veteran, encouraging to come in and serve. Over 50 percent of my cadre are VA mental health providers. They are either social workers and/or clinical psychologists. And given our mission which is a non-medical setting, I think that that is a pretty effective balance from where I stand in terms of meeting the need for folks who walk in.

Keep in mind also that in the work that we do, we refer a lot of people. We actually are brokers for the veteran when they come in. We cannot provide all the services. So we make over 250,000 referrals to VA medical centers that are appropriate referrals depending on the individual, and we make many more referrals to the VBA for benefits and those types of services. We don't provide every service that a veteran may walk in for.

As Congressman Snyder alluded to, we triage and we get the people to the right places for that type of service. Sometimes when they are not eligible for VA services, we will broker with the local community resources and get them to those places also. We case manage those cases.

Mr. HARE. I just have two real quick questions for you, quick from my perspective, probably longer for you. But in your estimation, where is the biggest gap in service for the Vet Center in the Vet Center Program? And, you mentioned—I have a lot of rural community in my congressional district, 23 counties, a pretty big one. What are the toughest things trying to meet the readjustment needs for veterans that you found in the rural communities?

Dr. BATRES. Well, thanks to Congressman Michaud, we are initiating surveys of the field. We have historically relied on our side visits to assess need and work with our teams. But by initiating questions directly to the folks out in the field, we have gotten a different perspective. And what really seems to be the field's perspective right now is a need for increased family members with the veteran that are coming back and needing assistance.

And those types of services include everything from brokering them like we do with the bereavement cases. In that population, most of them don't need psychiatric help. They need someone to help them manage the huge transition from being in a supportive active military base community as a dependent and then all of a sudden having to move off the base and then move back into civilian life. So we help them to make those transitions as we provide professional counseling where available to those individuals.

Certainly, I think that family services, especially for the wounded and the caregivers, is an area that we need to look more closely

and also sustaining our services to the growing number of Vietnam veterans who are accessing care at the Vet Centers. Vietnam veterans and families are also a growing number for us. So it is kind of a mix between those two.

Mr. HARE. Okay. Thank you, Doctor.

Dr. BATRES. Yes, sir.

Mr. MICHAUD. Dr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman.

Dr. Batres, I am pursuing a little bit this bereavement counseling. We had a hearing last week on the Armed Services Committee on the presentation by the Commission that was set up on mental health services for active-duty personnel. And one of the things that was brought out by Dr. McDermott, not our fellow member Dr. McDermott of Washington, but a woman doctor who is I think the Co-Chair of the Commission or certainly was one of the members of the Commission, was that TRICARE doesn't cover bereavement counseling and I guess we seem to have been surprised since we have a real problem in our country with health insurance covering mental health issues.

But a lot of us were surprised that the TRICARE, being the healthcare system set up for our men and women in uniform, that it didn't cover bereavement counseling for our military families. Were you aware of that? I noticed that you have, specifically in your opening statement, you all do enough bereavement counseling that you included it in your statement. Were you aware that TRICARE didn't cover bereavement counseling for our active-duty military families?

Dr. BATRES. I was not aware of that, but I would not be surprised. I think that historically, the DoD has done a very good job of treating the next of kin and assisting them through that process. Our services are extended to all family members. That would be the children, significant other, grandparents. The extended family is provided counseling. And it is coordinated through DoD. But I was not aware of the TRICARE situation.

Mr. SNYDER. I suspect, and I don't know this, I suspect that it is not so much an issue for those that are on the basis as you talked about, the military families there. While I think you very appropriately pointed out that abrupt transition that can occur for those families when their loved one is killed, but for our activated and deployed Reserve component troops where the family is not on a military base but is in a community, perhaps a civilian community a long ways away from a military base whose healthcare system has been the same local physician for some time and this issue of coverage for bereavement counseling may be something that we need to look at.

I wanted to just flesh out briefly this issue I brought up with the previous panel on your statement where the Vet Centers have no waiting lists and veterans may be seen by a counselor the same day. From what you have said, I assume that you are not saying—and that counselor that they see is the one that is going to meet their every need. It is more of a triage function; is that correct?

Dr. BATRES. Yes, sir, and that is a very important distinction. I think it is in many ways, how you ask the question and what the person interprets the question to be. What we mean by no waiting

list is that we will see the veteran when they come in, make an assessment, schedule them, and/or refer them. If they come in with co-morbid or other kinds of needs that we cannot provide, we will refer them to the medical center, many times scheduling, helping to schedule their appointments and making sure that they get there.

It also means that if they come in and they are non-emergent, that we will schedule them with the appropriate counselor, he or she, whoever is available. And then they will be seen a week or 2 weeks later. What we found in the field after our survey was that what was taking longer was not the initial visit, but that it was taking some of our counselors longer to see clients. And that is a concern. So we are making steps to make sure that we get the right resources to those Vet Centers.

Mr. SNYDER. So your counselors buildup a caseload and then they go to follow-up appointments and then your triage person calls up Mr. Harms who is going to be the counselor and Mr. Harms says great. I have got my earliest appointment is 6 weeks and that is not—is that the kind of thing you are looking at?

Dr. BATRES. We are, except there is no 6 weeks. We would consider 2 weeks a long time to wait.

Mr. SNYDER. A long time.

Dr. BATRES. Yes, sir.

Mr. SNYDER. What is your—what is the worst thing that has happened in one of your Vet Centers in terms of inappropriate care in the last few months? I mean how—do you hear about incidents where someone came in, was triaged, yeah, we can see you 2 days from now and something terrible happened that night? What is the reporting system that you have so that you all are aware of when things don't go right?

Dr. BATRES. They are required to report immediately any type of negative impact and——

Mr. SNYDER. Report to whom?

Dr. BATRES. They report directly to us, meaning we have a chain of command directly to the regional office, to our office and we monitor that very closely. May I say that in 28 years of existence, 26 of which I spent in the program, we have never had a tort claim. We have never been charged with any type of malpractice or anything like that, to my knowledge. So we get very few, if any, of those types of complaints.

And some of the things that concern me are, we had an unfortunate event where a veteran at a post deployment health reassessment committed suicide after being screened. That concerns me a lot. As soon as I find out about it, I informed the Under Secretary for Health and we had our medical inspector do a review of the case routinely and we look at things for lessons learned and we try to improve from those tragic kinds of events that happen.

The most tragic are those that we can't reach because of either stigma or the veteran not being able to be——

Mr. SNYDER. The ones that don't ever get through your door.

Dr. BATRES. The ones that never come to the door.

Mr. SNYDER. Thank you, Mr. Chairman.

Mr. MICHAUD. Yeah. I would like to actually follow up on one of Dr. Snyder's question about the complaint. You said they go to the

regional office and then you. Why would they report to the regional office?

Dr. BATRES. Because that is their chain of command. Our organizational structure is, and we are a very small organization. We are lean and mean, if you will. Central Office, one regional office, and then all, all the Vet Centers, that is our chain of command.

Mr. MICHAUD. Is that regional office a VISN office?

Dr. BATRES. No.

Mr. MICHAUD. Okay. The regional Vet Center office.

Dr. BATRES. Yes, sir.

Mr. MICHAUD. Oh, okay.

Dr. BATRES. In your area, sir, it would be in New Hampshire.

Mr. MICHAUD. Okay. I thought it was the regional VISN office and I couldn't——

Dr. BATRES. No, sir.

Mr. MICHAUD [continuing]. Figure out why they would report there. Following up on Mr. Hare's question as it deals with hiring appropriate staff, because I do know that in a lot of States there is a shortage of healthcare professionals. Did I understand you correctly saying you do not have a problem hiring the medical staff that you need to work at the Vet Centers?

Dr. BATRES. It is a challenge to hire. We hire social workers, psychologists and psychiatric nurses. We are a non-medical setting. Those are getting harder to recruit. We do hire a lot of retirees from DoD though that are coming out and that is a very nice pool. They are veterans. And again, one of our hallmarks is hiring veterans. We feel that that is a strength in the program and we are tapping that pool.

And we have not had the opportunity in the past with this kind of increase in capacity. We are recruiting and I think we are getting a fairly decent initial group of folks into the centers.

Mr. MICHAUD. Good. To followup on that same line of questioning, I have been seeing at Walter Reed and Bethesda, a definite need for healthcare providers out there because of what is happening in Iraq and Afghanistan. So there is a huge influx of need there.

Ultimately, when the war does end, I think you are going to see Walter Reed and Bethesda not needing the capacity that they are building up currently. But within the VA system, there will probably be a higher need.

So my question is, what is the VA doing to work in conjunction with the DoD to see that the healthcare providers that are currently working at DoD are going to be needed, instead of getting laid off? Are you going to have that—can you visualize or are you working to talk about how can you utilize those healthcare providers versus going out and actually hiring someone outside of the Federal Government?

Dr. BATRES. Well, first of all, I don't think that I have not gotten to that point because we routinely screen and actually outreach the recruiting mental health provider population at DoD consistently for that reason. But your point is well-taken. The hundred GWOTs—by the way we have over 150 GWOT veterans to include the hundred GWOTs. We have over 50 staff that are OEF/OIF veterans as regular counselors.

It is a dilemma. Part of the job of the outreach workers is to go out and encounter these folks and get them resources. After the war ends, there should be a downsizing of those efforts. What is happening with our GWOT staff is that many of them are going to school and getting their degrees and their education. And like many of us who served in the Vet Center Program after the war, we got our degrees and then went to work at VA, they, I think, present a pool for hiring down the road.

But I think it is an excellent idea and I can pursue that and get back with you, because I think the last I heard, DoD was also struggling. But once the war ends, there may be a group of folks there that could present a potential pool, if I am hearing you right, for us to hire.

Mr. MICHAUD. Mr. Hare or Dr. Snyder, any additional questions?

Well, once again, I would be remiss if I did not thank you, Doctor, and the entire Vet Center staff for all that you do for our veterans, as well as for your high approval rating of the services that the Vet Centers give to our veterans nationwide. You are all to be commended for what you are doing in such a highly satisfactory manner as well. So I want to congratulate you and thank you personally, as well as your entire staff, for what you are doing.

And once again, I thank all of the other previous panel members for coming today. The hearing is closed. Thank you.

Dr. BATRES. Thank you, sir.

[Whereupon, at 3:33 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of the Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will come to order. I would like to thank everyone for coming today.

Before we begin, I ask unanimous consent that all written statements be made part of the record. Without objection it is so ordered.

I ask unanimous consent that all Members be allowed five legislative days to revise and extend their remarks. Without objection it is so ordered.

Today we are here to discuss Vet Centers—the benefits that they have provided to our current population of veterans and the important and growing role they will have in helping veterans from Afghanistan and Iraq.

The Vet Center program was established in 1979 to help Vietnam Era veterans with readjustment challenges.

Vet Centers provide an alternative environment outside of the regular VA system for a broad range of counseling, outreach, and referral services.

Most importantly, Vet Centers provide an environment in which veterans can speak openly to veterans about their experiences.

Vet Centers have been a success, and now they have a new mission.

In 2003, then Secretary Principi extended Vet Center eligibility to OEF, OIF, and Global War On Terror veterans as well as bereavement counseling to survivors of military personnel who die while on active duty, to include federally activated Guard and Reservists.

Not surprisingly, workload at Vet Centers continues to increase. This trend will likely continue as OEF/OIF veterans deal with everything from mild readjustment issues to serious mental health challenges.

VA currently has 209 Vet Centers located throughout the United States, Guam, Puerto Rico and the U.S. Virgin Islands.

There are five Vet Centers in Maine that do great work (Bangor, Caribou, Lewiston, Portland, and Sanford).

VA has scheduled 23 new centers to open in the next 2 years. There has also been an effort to hire GWOT veterans to serve as peer-to-peer counselors.

The purpose of this hearing is to determine how Vet Centers can continue to fulfill their unique and critical role within the VA continuum of care.

Each generation of veterans has its own unique needs. It is important that Vet Centers are prepared to meet the needs of our new veterans while still caring for veterans from previous conflicts.

I look forward to hearing from our witnesses on:

- How we can maintain and improve services provided by Vet Centers;
- If we have appropriate facilities and staffing;
- What role can and should other resources within our communities play to help veterans and improve care; and
- Most importantly, what should we do to strengthen the invaluable peer-to-peer counseling available through Vet Centers?

Prepared Statement of Sue Bergeson, President, Depression and Bipolar Support Alliance

Chairman Michaud and members of the Committee:

On behalf of the Depression and Bipolar Support Alliance (or DBSA), thank you for the opportunity to testify today about mental health services offered to and needed by our veterans through the veterans centers of the Veterans Administration. DBSA further thanks you and the other members of the Committee for your efforts

in focusing the attention of the nation on the plight of the men and women of our military forces who are returning from combat with their mental health devastated.

DBSA is the nation's largest peer-run mental health organization, with more than 1,000 state and local affiliates in all 50 states. By peer-run, we mean that our organization is led by staff and volunteers living with mental illnesses—people like me—people who experience the debilitating effects of mental illnesses first-hand. Our organization focuses on the power of peer support as a key component in recovery from mental illnesses.

DBSA regularly partners with the VA on peer support training and technical assistance for veterans, both nationally and at local facilities. Additionally, DBSA has long been represented on the Consumer Liaisons Council to the VA Committee on Care of Veterans with Serious Mental Illness.

One of the most important services DBSA offers—indeed, our cornerstone—is helping people diagnosed with mental illnesses to help each other. We train individuals and establish support groups throughout the country, preparing them to assist their peers on the road to recovery.

Let me first briefly describe our perspective on the need faced by veterans today, a need of which I know this Committee is all too aware, but which helps lay the groundwork for an effective and cost-effective solution.

Recent and continuing conflicts in Afghanistan and Iraq have placed a heavy burden on our country's National Guard and Reserves, in addition to the standing armed forces. Not unexpectedly, these conflicts have taken a toll on the mental health of the men and women serving.

With more than a quarter million individuals returning from active military service in FY2006, many of them coming from postings of extreme danger and stress, there is an overwhelming need for mental health care for veterans. More than 35 percent of Afghanistan and Iraq veterans treated at the VA have been diagnosed with mental disorders.

The Defense Medical Surveillance System, in data reflecting the health self-assessments of service members who had returned from Iraq since June 2005, showed that 50 percent of Army National Guardsmen and approximately 45 percent of Army and Marine reservists reported mental health concerns. Much of the mental health treatment these service members receive is provided by the VA, which estimates that 35 percent of the care provided through its facilities from 2002 to 2006 was related to the diagnosis or treatment of a mental health disorder.

According to a recent article published in the *Archives of Internal Medicine*, veterans ages 18 to 24 returning from Afghanistan and Iraq are nearly three times more likely to be diagnosed with mental health or posttraumatic stress disorders, compared with veterans 40 years or older.

Dr. Karen Seal, a physician at the San Francisco VA Medical Center and lead author of this new research, states, "You have a young population possibly not getting treatment for these conditions, and going on to have chronic mental illness . . . It's potentially a big public health problem."

In answer to calls by veterans and their families, screening of returning veterans for symptoms of mental illness is now more widespread. Yet this screening does not identify many affected individuals. Some veterans do not immediately experience symptoms, which arise much later after their return to civilian life. A high proportion of soldiers misinterprets or ignores symptoms in order to return home more quickly, or in response to the pervasive stigma of mental illness in the military.

At the very time the need for mental health services is the greatest, sadly, the Veterans Administration does not have the capacity to deliver these services to all veterans in need. Despite the valiant efforts of the many dedicated service providers working throughout the VA, current capacity cannot meet demand. News reports continue to document a staggering number of unfilled VA mental health positions. These shortages result in long waits for appointments and care, sometimes with tragic consequences for veterans in need.

Many veterans, distrustful of VA services and mental health professionals, or wanting to put all reminders of military service behind them, never seek available care or seek it only after reaching the crisis point.

In 2006, a committee of VA experts declared that the "VA cannot meet the ongoing needs of veterans of past deployments while also reaching out to new combat veterans . . . and their families by employing older models of care. **We have a new job and we need to do it in a new way.** "

Chairman Michaud, Today we have the greatest resource to help combat these grim statistics right at our fingertips—**and *that resource is our veterans themselves***. The members of our armed forces pledge to leave no comrade behind on the battlefield. When the enemy becomes mental illness, our nation's veterans stand willing to help each other in this new conflict. Such support comes naturally to vet-

erans who have been trained to rely on each other in battle, and who now face the biggest battle of their lives—the struggle to overcome mental illness.

Veterans, who have successfully recovered from mental illnesses, reaching out to other veterans with mental illnesses, are an authentic source of hope for the future. Veteran peer supporters can connect with other veterans at a level no clinical provider, however dedicated, can match.

Let me illustrate the value of veteran peer support services through the example of a resident of the Chairman's home state of Maine. Jack Berman is a resident of South Portland, Maine. He is a disabled veteran who has served as vice president of the Maine Military Coalition, and as president of the Military Officers' Association of America (MOAA).

Seventy-nine-year-old Jack Berman is a man of many talents—in spite of the adversity he has faced in his life. An entrepreneur, a rehabilitation counselor, a highway-planning engineer for the New York Port Authority—these are just a few of his accomplishments.

Mr. Berman was appointed first lieutenant during the Korean war and fought on the front lines. In 1953, he finished his tour of duty and was awarded five medals, including three bronze stars for Korean service, the United Nations medal and the American National Defense medal.

Yet while in training to go overseas, he was hospitalized and diagnosed with bipolar disorder with episodes of severe depression. As an individual living with a mental illness, how did Mr. Berman survive and excel in so many areas? The answer was connecting with individuals just like him.

As Mr. Berman tells us, veterans are not often inclined to share their stories about the terrible experiences of war with those who may not be able to understand or identify with them. As he told DBSA, "These guys are willing to get their medications from a psychiatrist, but they don't want to talk to them. They want to talk to others like them."

That is why Mr. Berman believes that peer-to-peer support is the ideal solution for our country's many veterans who are now experiencing the impact of returning from active duty. "When a soldier is able to openly share his feelings with another soldier like himself, someone else with a mental illness, something magical happens," Mr. Berman says. "Talking to my peers was *the* healing factor in my recovery."

Our country's third President, Thomas Jefferson, said, *"Who then can so softly bind up the wound of another as he who has felt the same wound himself?"*

Peer support in the mental health arena represents a bond between two individuals who share the common experience of a mental illness, and who commit themselves to helping each other achieve lasting recovery. Peer support services have been demonstrated to be an effective supplement to clinical care for mental illnesses.

Solid research shows that peer support is an effective tool in improving mental health, leading to improvement in psychiatric symptoms, decreased hospitalization and decreased lengths of hospital stays, enhanced self-esteem and social functioning of those served, and lower services costs overall.

A proven method to harness the power of peer support and overcome the significant barriers to successful treatment is the **Certified Peer Specialist**. These individuals are trained and certified to help their peers—other people with mental illnesses—deal successfully with their challenges and move forward with their lives. Peer Specialists help those they assist to make informed, independent choices, and to gain information and support to achieve those goals. They demonstrate recovery from mental illness and how to maintain ongoing wellness.

Peer Specialists offer more regular interaction with others than overworked clinical staff can provide. The outreach they provide in the community and through veterans centers makes support accessible to larger numbers of veterans than can be reached through traditional means alone. And this new role provides opportunities for meaningful work and financial independence for veterans with mental illnesses, who otherwise may have difficulty finding employment.

Peer Specialist services are also significantly cost-effective and have been shown to cost up to 5 times less than older models of care, with improved clinical outcomes. The VA has already identified paid Peer Specialist services as a priority in its Mental Health Strategic Plan and has provided very limited funding for implementation at local VA facilities. DBSA is proud to have assisted in many of these efforts.

However, barriers to full VA implementation of Peer Specialists remain. Some voluntary veteran peer support initiatives exist but are not always integrated into care and/or seen as effective by providers. Veterans need quality training to help them work effectively as peers, and VA providers need preparation to help them fully understand and accept this new approach. Many VA facilities are moving to hire vet-

erans as Peer Support Technicians *(the VA's terminology for Peer Specialist)*, but no consistent guidelines and standards exist for training and integrating these positions as a key element of mental health services.

There is a critical need for implementation of a national-level pilot project that sets the gold standard for VA Peer Specialist training and delivery of services. Current and future needs require a large-scale and coordinated national effort to make quality peer support services a reality nationwide through the VA.

Therefore, we urge the committee to encourage the VA Office of Mental Health Services to take these three steps:

- Identify and allocate a significant increase in funding for a national veterans mental health peer training and employment initiative.
- Establish and fund a VA Technical Assistance Center for Peer Support Services, partnering with an established national organization with demonstrated experience in peer support training.
- Create and pilot national veteran Peer Support Technician training and certification projects in multiple locations throughout the country.

These actions are just a small part of what we can do to provide our veterans with the necessary tools to fight this new battle on their return home.

DBSA stands ready to assist the committee in its efforts. I thank you for this opportunity to offer our input and would be happy to answer any questions.

Prepared Statement of Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on the current and future services provided by Vet Centers. Vet Centers provide a necessary service and are an important resource for combat veterans experiencing readjustment issues, especially those who do not live in close proximity to a Department of Veterans Affairs (VA) medical facility.

Current and Future Services Provided by Vet Centers

Vet Centers are a unique, invaluable asset to the VA healthcare system. They were designed to provide services exclusively for veterans who served in theaters of conflict, or experienced military sexual trauma. Because Vet Centers are community based and veterans are assessed the day they seek services, they receive immediate access to care and are not subjected to wait lists. They provide mental health counseling to not just the veteran, but those in his or her support system—like the spouse and children. Services are provided in a non-clinical environment, which may appeal to those who would be reluctant about seeking care in a medical facility. A high percentage of the staff, more than 80 percent, are combat veterans and can relate to the readjustment issues experienced by those seeking services.

Vet Centers assist veterans with enrollment into the VA healthcare system. They provide timely assessments and referrals to the local VA medical centers (VAMCs) to ensure a continuum of care. Furthermore, their services encompass more than mental health issues, providing assistance with applying for VA benefits, providing employment counseling, participating in homeless veteran stand-downs, working non-traditional hours or contracting services for the veteran's convenience. Vet Centers have also expanded their services to accommodate the growing needs of veterans and their families, such as providing bereavement counseling to family members of servicemembers who die in combat.

As a tacit rule, Vet Centers never turn anyone away, providing alcohol and drug assessments, or referrals to other VA or community programs, even for those who are not eligible for care.

Since Vet Centers provide such an important service to combat veterans, The American Legion visited several of them to see how their resources are meeting the increasing demand of returning combat veterans. Mandated by Resolution 206, entitled "Annual State of VA Medical Facilities Report", The American Legion publishes an annual report on VA medical centers and other healthcare facilities. This report is a compilation of information gathered from a series of site visits conducted by appointed System Worth Saving Task Force Members and The American Legion's National Field Service Representatives.

Since the initial report in 2003, each year's report has focused on different facilities. Past reports have covered VA medical centers (VAMCs) and Community Based Outpatient Clinics (CBOCs). The System Worth Saving report is delivered each year

to the President of the United States, the leadership of the Department of Veterans Affairs, members of Congress and to the public.

The 2007 System Worth Saving Report will focus on select Vet Centers and select Polytrauma Centers. Task Force members and National Field Service staff visited several Vet Centers around the nation to see how they were servicing veterans, with emphasis on outreach to veterans who served in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). National Field Service Staff selected 46 Vet Centers that were located near demobilization sites in Arizona, California, Colorado, Florida, Illinois, Indiana, Maryland, Massachusetts, Minnesota, Missouri, Nevada, New York, Ohio, Oregon, Puerto Rico, South Carolina, Texas, Virginia, and Washington State. Since many returning servicemembers would most likely reside near the site of demobilization, the Vet Centers selected had particular significance.

Information collected on the respective Vet Centers include: number of veterans seen within the Vet Center's catchment area; a breakdown by war era of the veterans seen—when possible; budget; staffing; outreach activities; physical plant issues; and, challenges as identified by staff and management. In an effort to ascertain the effects of OIF on utilization of services and available resources, the Task Force and National Field Service Staff solicited information on enrollment, fiscal, and staffing issues for fiscal year (FY) 2003—the year OIF began—and FY 2006.

The Vet Center

The Vet Center site visit reports differ among the Vet Centers visited. In general, they all have extensive outreach plans that reach many counties in their respective regions. Most have at least one position for a GWOT Technician. Most are active in participating in National Guard/Reserve demobilization activities, to include providing availability at post deployment health reassessment activities and conducting briefings about Vet Center services.

Many Vet Centers have community partnerships and participate in their local college work-study programs, allowing OIF/OEF veterans who are enrolled in college to assist with administrative tasks at the Vet Centers.

Although most were satisfied with their facilities, indicating recent upgrades and new furniture, a few indicated space challenges such as being forced to use remote parking due to the location of the leased space, having inadequate office space, and needing a new facility because the owner of the leased building was planning other use for the space.

The Vet Centers all work with Veteran Service Organizations (VSO) to provide assistance for veterans in filing claims; some Vet Centers even reserve space for service officers to make weekly visits. They all illustrated productive referral systems between the Vet Center and the local VAMCs.

Some Vet Centers have tailored their programs to accommodate veterans and families that speak languages other than English as a first language, or those who practice other customs. Some Vet Centers indicated that they needed to enhance their services to accommodate cultural differences and to target rural, women and minority veterans. Since many combat veterans visit Vet Centers because of urging from family members, The American Legion believes that enhancing outreach to target minorities is an important aspect to minority veterans accessing Vet Center services.

Staffing of Vet Centers

In general, the Vet Centers visited by The American Legion had the same staff composition, usually a four-person team to include a team leader, office manager, social worker, and a psychologist or mental health counselor.

However, a few indicated that limited staffing was an overall challenge, given an anticipated influx of returning OIF/OEF veterans in the catchment area. Some Vet Centers shared GWOT Technicians and sexual trauma counselors with other Vet Centers, or had a part time staff member.

Some Vet Centers had vacancies because the GWOT Technician, as well as other key staff members, had been or would be soon deployed again to serve in Iraq or Afghanistan.

A few indicated the need for a family therapist or a military sexual trauma counselor. Some of the vacancies had been funded but not filled as management was seeking qualified individuals to hire.

Still other Vet Centers indicated that they just needed staff augmentation to handle existing and anticipated workloads.

The American Legion believes that all Vet Centers need to be fully staffed to ensure that combat veterans seeking care for readjustment are afforded the same standard of quality care, no matter which Vet Center they utilize, this includes

cross training staff to speak other languages when necessary—or hiring qualified bilingual staff—and training staff to learn different mental health specialties.

VA's 23 New Vet Centers

The most important aspect of the Vet Centers is that it provides timely accessibility. Since Vet Centers are community-based and veterans are assessed within minutes of their arrival, eligible veterans are not subjected to long wait times for disability claims decisions to determine eligibility for enrollment, or long wait times for available appointments. The Vet Center can provide immediate attention to the veteran, either directly or through contracted care when necessary. VA's plan to create 23 new Vet Centers within the next 2 years will bring the number of Vet Centers to 232. This will improve access to readjustment services for many combat veterans and their families, some of which reside in underserved areas. The American Legion believes that VA needs to ensure that future Vet Centers are positioned to reach as many rural veterans as possible.

Although Vet Centers have extensive outreach plans, more outreach is needed to reach other groups of veterans who may not know they are eligible to use Vet Centers or those who may not be familiar with the program in general. Many veterans learn of Vet Centers by word of mouth. Reaching veterans residing in rural areas will be a challenge. Surely, the 100 new Vet Center GWOT outreach coordinators that will be hired will also enhance outreach to eligible veterans.

The American Legion will do all it can to inform, not only veterans and their families, but also all other advocates about the service provided by Vet Centers as well. Combat veterans facing readjustment issues require immediate access to mental health assessment and counseling. Vet Centers make this possible. Making more communities aware of Vet Center services will likely improve the quality of life for many families.

Again, thank you Mr. Chairman for giving The American Legion this opportunity to present its views on such an important issue. We look forward to working with the Subcommittee to address the needs of all veterans.

Prepared Statement of Adrian M. Atizado, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman, Ranking Member Miller and other Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV), an organization of 1.3 million service-disabled veterans devoted to rebuilding the lives of disabled veterans and their families, to testify at this important hearing to examine the Department of Veterans Affairs' (VA) Readjustment Counseling Service provided to veterans by its "Vet Center" program.

Mr. Chairman, we appreciate your decision to hold this hearing, since many years have passed since this Subcommittee has examined the Readjustment Counseling Service of the Veterans Health Administration (VHA). This examination is extremely timely, given the ongoing wars in Iraq and Afghanistan.

PROGRAM HISTORY

Congress in Public Law 96–22 established the Readjustment Counseling Service in 1979. President Jimmy Carter proposed a similar program of readjustment services for veterans in a special Presidential Message sent to Congress October 10, 1978. That Presidential Message recognized a number of unmet health, benefits, employment, financial, and readjustment needs in the population of veterans that had served our Nation during the Vietnam Era.

It should be remembered from that time that Vietnam Era veterans, a group of over 8.7 million individuals who were called to service mostly by involuntary conscription in a very unpopular and politically charged overseas war, came home from that service with medical, personal and psychological burdens that the U.S. Government minimized and largely ignored for years. The Veterans' Administration, which at that time was an Independent Establishment of the federal government rather than a Cabinet Department, was managed by World War II and Korean war veterans, and its patient population consisted primarily of veterans of those same eras. The VA then was steeped in the traditions and cultures of that generation's experience in war and of the post-war boom years.

For a variety of reasons, a wide gulf developed between veteran populations and seemed to become essentially a reflection of a "father-prodigal son" relationship. As a general matter, Vietnam veterans did not seek out traditional VA healthcare and other benefits or services, and in particular, VA mental health services. Additionally, World War II-veteran influenced VA facilities did not reach out to them as a

new generation of combat veterans in need. There was a sense that Vietnam veterans had "lost" the war in Vietnam, and the entire nation and the Veterans' Administration turned its back on them, confusing the war with the warriors. However, because of the leadership of one of those Vietnam veterans—the Honorable Max Cleland, who at that time was serving as Administrator of Veterans Affairs—the specialized and emerging readjustment services, healthcare and other needs of Vietnam veterans were brought to the forefront of concerns of this Committee, its counterpart in the other Body, and the Administration of President Carter.

Max Cleland went on from his VA position to other positions of public trust, including serving as a U.S. Senator from Georgia, but we at DAV believe that former VA Administrator Cleland's greatest personal legacy to Vietnam veterans is the establishment of the VA Readjustment Counseling Service. Hundreds of thousands, and perhaps millions, of DAV members and other disabled veterans have regained their health because of the existence of the Vet Center program. Today, the Readjustment Counseling Service conducts its programs through 209 facilities called "Vet Centers." These facilities have grown and matured over the years since first established as "storefronts" primarily in urban areas, into highly skilled, specialized psychological counseling centers that meet vital needs of multiple generations of veterans and their families.

DEMANDS FOR SERVICES

VA estimated the number of Operations Enduring and Iraqi Freedom (OEF/OIF) veterans it will see in fiscal year (FY) 2007 to be 209,308; however, as of April 2007, VA reported that 229,015 OEF/OIF veterans had actually sought VA healthcare since FY 2002. Of those OEF/OIF veterans that have sought VA care, a total of 83,889 (36.6 percent) received an initial diagnosis of a mental health disorder such as adjustment disorder, anxiety, depression, post-traumatic stress disorder (PTSD) and the effects of substance abuse. Some 39,243 (17.1 percent) unique enrolled OEF/OIF veterans have received a diagnosis of PTSD at VA medical facilities.

The most recent data available to DAV indicates the Vet Centers are providing over 1.17 million counseling visits annually to veterans. However, we are concerned that the expanding role of Vet Centers which now includes providing military casualty assistance functions in coordinating and directly providing bereavement counseling to families of those who have been lost in the current wars; newly energized outreach activities averaging more than 13,000 outreach contacts each month to bring knowledge of VA services to the newest generation of combat veterans; and, other new responsibilities that may be assumed by Vet Center personnel, has increase this program's workload for OEF/OIF veterans from less than 20,000 visits in fiscal year 2004, to about 242,000 visits in fiscal year 2006.

VA has intensified its outreach efforts to OEF/OIF veterans through the Vet Centers. Those centers now make an annual average of 250,000 referrals to the VHA. The department reports relatively high rates of healthcare utilization among this veteran population. Nevertheless, with such ready access to VA healthcare provided without cost for 2 years following separation from service for problems related to combat exposure, it should be noted that roughly two-thirds of separated OEF/OIF veterans have not yet turned to VA for healthcare. Furthermore, with post-deployment positive screening rates for mental health concerns around 32 percent–36 percent and 1.5 million individuals having served in OEF/OIF, a very rough estimate is that there may be 480,000 to 540,000 OEF/OIF veterans who have mental health concerns but VA is only seeing a fraction of them.

STRAINING TO MEET THE NEEDS

In October of 2006, subsequent to the VA Secretary's announcement of the permanent hiring of 100 OIF/OEF combat veterans to serve as peer counselors[1] at Vet Centers and the opening of 2 new Vet Centers[2] for a total of 209, the House Committee on Veterans Affairs issued a staff report on the capacity of the Vet Centers. The report found that in the nine months from October 2005 to June 2006, the number of OEF/OIF veterans turning to Vet Centers for PTSD services had doubled. All of the Vet Centers surveyed reported a significant increase in outreach and services to OEF/OIF veterans. Half of the Vet Centers reported that this increase affected their ability to treat existing workloads.

According to news reports on a subsequent internal Vet Center report, 114 of the 209 Vet Centers need at least one additional psychologist or therapist to help with

[1] VA Press Release April 6, 2005 and confirmed during the House Committee on Veterans' Affairs, Statement of the Honorable R. James Nicholson, Secretary, U.S. Department of Veterans Affairs, Testimony Before the House Committee on Veterans' Affairs, May 9, 2007

[2] VA Press Release June 28, 2006

the influx of new veterans. Twenty-two Vet Centers reported that they couldn't provide family counseling when necessary ("Staffing at Vet Centers Lagging," *USA Today*, April 19, 2007). We at DAV believe that VA staffing should be increased in existing centers to ensure all veterans—including previous generations of combat veterans—who need help at Vet Centers can gain access to these important readjustment services.

Moreover, we are concerned that highly dedicated Vet Center personnel may be nearing their maximum efficiency and ability to maintain their professional effectiveness. We believe the Subcommittee should exercise strong oversight in this area to ensure that Vet Centers are being properly staffed for the expanding functions they are expected to perform. We believe VA has the resources available to increase Vet Center staffing, and should do so at the earliest possible date.

In February of 2007, the Department of Veterans Affairs Fiscal Year 2008 Budget Estimate indicates that VA plans to operate 209 Vet Centers in 2008, and that, "Vet Centers are located in the community, outside of the larger medical facilities, in easily accessible, consumer-oriented facilities highly responsive to the needs of the local veterans. As provided at Vet Centers, VA's readjustment counseling mission features community-based service units emphasizing post-war rehabilitation, a varied mix of social services addressing the social and economic dimensions of post-war readjustment, extensive community outreach and brokering activities, psychological counseling for traumatic military-related experiences to include PTSD, and family counseling when needed for the veteran's readjustment. In carrying out its mission, the Vet Centers prioritize services to high-risk veterans to include high-combat exposed, physically disabled, women, ethnic minority, homeless, and rural veterans."

As shown below, VA states that the increase in requested funding is required to provide readjustment counseling at VA's Vet Centers to veterans who have served in the Global War on Terrorism (GWOT). VA plans to operate 209 Vet Centers in 2008 that are essential for accessing and treating PTSD or other conditions experienced by our veterans. VA also states that it expects an increase in PTSD as veterans return from OEF/OIF after multiple tours of duty.

Readjustment Counseling

	2006	2007	2008
Obligations ($000)	$100,333	$110,300	$114,822
Visits (000)	1,170	1,185	1,200

Concurrent to this budget request, VA announced its intention to establish 23 additional Vet Centers distributed throughout the nation, which would bring its total capacity to 232 service delivery points. According to VA, only three of these centers will be opened this year and the remainder are planned to be activated in 2008. Given growing demand for Vet Center services for chronic and acute PTSD and other adjustment disorders, substance abuse, marital dissolution, and financial problems among active duty, National Guard, and Reserve forces who have been deployed in these wars, and given the availability of significant new Medical Services funding in VA healthcare, we question why the bulk of these Vet Center openings are being delayed.

ADAPTING TO A NEW GENERATION OF VETERANS

Mr. Chairman, in examining the needs of the newest generation of veterans disabled by war, the *Independent Budget* for Fiscal Year 2008recommended and urged that both VA and DoD adapt their programs to the needs being presented by new veterans, rather than require new veterans to adapt their needs to the programs traditionally offered. DAV believes that, particularly in respect to mental healthcare needs, significant VA adaptation is still imperative. As indicated earlier, the Vet Centers were established because Vietnam veterans saw little about the "old' Veterans' Administration of thirty-five years ago that appealed to them. That gulf provided the impetus for the creation of the Vet Center program.

From our contacts today with veterans of the wars in Iraq and Afghanistan, we are learning that today's VA, including its Readjustment Counseling Service, may not generally be perceived as an organization that is tailoring its programs to meet the emerging needs of our newest generation of veterans. Many of these veterans are asking the government to allow them a choice of private care rather than be relegated to care in the VA system. Others wounded in these wars seem to be resisting or delaying a smooth transition to VA healthcare

Rather than react swiftly in authorizing dramatic shifts to private healthcare of uncertain quality and questions in continuity, we urge prudence on the part of the Subcommittee. We hope VA will adjust its programs in a way that provides a more welcoming, age appropriate, culturally sensitive and responsive service to our newest generation of combat veterans, in particular the wounded, whether with "visible" or invisible injuries. We do note that VA's recent announcements of employing outreach specialists with direct OEF/OIF experience, designating case managers and others to assist with OEF/OIF veterans' special needs, and other similar initiatives, are moves in the right direction. We appreciate these initial changes. We hope more of these kinds of initiatives can be sustained and expanded where appropriate, to make VA services more relevant, age appropriate and more effective in meeting these new veterans' needs. We would be pleased to follow up with you and your Committee staff to ensure you gain full understanding of our views on these matters.

CLOSING

Without question, Americans are united in their desire and obligation to care for those who have been severely wounded as a result of military service. This obligation is a continuing cost of national defense. Servicemembers who have suffered catastrophic wounds with multiple amputations, traumatic brain injury, or severe burns draw great public sympathy and admiration for their sacrifices. But a greater challenge exists for those that suffer the devastating effects of PTSD and other injuries with mental health consequences that are not so easily recognizable and can lead to serious health catastrophes, including suicide and other social pathologies, if they are not treated.

We can meet that challenge by doing everything in our power to bring these resources into place to promote early and intensive interventions, which are critical in stemming the development of *chronic* PTSD and other related problems, without simultaneously displacing older veterans with chronic mental illnesses under VA care. Finally, we must also ensure that family members of veterans devastated by the consequences of PTSD, adjustment disorders, and other injuries have access to appropriate and meaningful VA services.

Mr. Chairman, thank you for considering the views of DAV on the status of the Readjustment Counseling Service of the Veterans Health Administration. I will be pleased to address any questions from you or other Members of the Subcommittee. This concludes my testimony.

Prepared Statement of Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States

MR. CHAIRMAN AND MEMBERS OF THIS SUBCOMMITTEE:

Thank you for the opportunity to present the view of the Veterans of Foreign Wars of the U.S. (VFW) on this important subject. Vet Centers are an integral part of the Department of Veterans' Affairs (VA) capacity to care for veterans. They provide readjustment counseling to veterans who were exposed to the rigors of combat, and who may need services to help them cope with the traumas of war. The community-based services provided at Vet Centers are a helping hand, giving these brave men and women assistance in obtaining the benefits and healthcare they are entitled to through VA.

The program began in 1979, when Congress gave VA—then the Veterans Administration—the authority to provide readjustment counseling services to Vietnam Veterans, many of whom were encountering serious problems that interfered with their work, education and personal and family lives. The centers were created as outpatient treatment facilities to increase the ease and availability of services. Over time, the mission has rightly expanded to provide a number of essential services beyond counseling, and has begun providing services to the families of servicemembers, who often are affected just as much by the difficulties of their loved one's combat service.

This program is so essential because its design helps to break down much of the stigma of treatment. Vet Centers, by and large, are accessible and welcoming. The less formal setting helps to encourage those veterans who need its services to utilize them. Vet Centers aim to eliminate many of the barriers to care, and its employees are adept at breaking down these barriers.

The quality and variety of services provided at Vet Centers is excellent. We have heard few complaints about the quality of care, and the treatment vets receive in these facilities.

Our concern lies with the access to these services. The October 2006 report, "Review of Capacity of Department of Veterans Affairs Readjustment Counseling Service Vet Centers," conducted by the then-minority staff of the Subcommittee on Health provided many details of the access problems veterans face at these centers.

The Subcommittee found that many Vet Centers have had to scale back services: "40 percent have directed veterans for whom individualized therapy would be appropriate to group therapy. Roughly 27 percent have limited or plan to limit veterans' access to marriage or family therapy. Nearly 17 percent of the workload affected Vet Centers have or plan to establish waiting lists."

These are worrisome trends. But they tell just a part of the story.

In conversations representatives of our national Veterans Service have had with Vet Centers throughout the country, their greatest concern is not with the demands for service today, but with the future. Although the Subcommittee report noted that the number of OEF/OIF veterans accessing care at Vet Centers had doubled, they are still just a portion of the population served. As more come back, and more start to access the benefits and services provided by VA, we can anticipate an even larger demand for these services.

This is especially true of the mental health services provided at these centers. We are all aware of the difficulties returning servicemembers are having because of the unique stresses of this conflict, and there correctly has been an increased emphasis on their mental well-being. VA's most recent data, through the first quarter of 2007, shows that around 36 percent of hospitalized OEF/OIF veterans are returning with some degree of mental disorder. If these numbers hold form, as they have with previous VA reports, it will represent a challenge for these Vet Centers.

Mental impairments affect veterans in different ways. Some are able to easily adapt. Others have intense and immediate needs. Still others require time and patience to come to terms with what they are feeling, and to make the sometimes difficult decision to accept treatment. That latter group is the one that is going to affect these Vet Centers the most in the future. We must be prepared to handle their growing needs, and the demands they place on the system. While the Subcommittee had reported on the problems of today, it is 5 to 8 years from now that must also be of concern.

To that end, we are pleased to see the Secretary's recent decision to add 23 new Vet Centers throughout the country. Expanding access is clearly a good thing. Accordingly, we need to see that each center, new and existing, is fully staffed, and that areas that report exceptionally high demands for service are staffed sufficiently so that these centers can retain one of the characteristics that make them unique and a convenience for veterans, the drop-in aspect. The informality of not having to make an appointment is one of the things that makes these Vet Centers an attractive option for veterans. With rationed treatments, veterans may be less likely to utilize these essential services.

We would urge this Committee to utilize its oversight authority by continuing to monitor the demand for services. As demands rise, funding priorities must adapt.

There are a few other concerns we have:

First, these centers must be able to handle the increasing number of women veterans sure to seek treatment, and increase treatment options and outreach efforts to them. While all centers are required to have sexual trauma treatment, we must ensure that services are available to address any issues that arise from them serving in a war zone where there is no true frontline.

Second, the original vision of the Vet Center was of veterans helping veterans. That is still a worthy goal, but we understand the need for qualified and highly trained counselors and staff members—especially those dealing with the complexities of mental impairments—who might not always be veterans; what's important is that they are caring, compassionate, and capable. A number of senior Vet Center counselors and staff, though, are Vietnam Veterans and are edging closer toward retirement age. We must be mindful of finding replacements, especially if we can draw on the experiences of the younger veterans, including OEF/OIF veterans and those who served in the Persian Gulf War. VA must do more to educate and train these men and women, so that they can play an active role in their fellow veterans' treatment.

Mr. Chairman, I again thank you for the opportunity to present the VFW's testimony. I would be happy to answer any questions that you or the members of the Subcommittee may have.

Prepared Statement of Susan C. Edgerton, Senior Health Care Consultant, Vietnam Veterans of America

Chairman Michaud and Distinguished Members of the House Subcommittee on Health, on behalf of our officers, Board of Directors and members, thank you for providing the opportunity for Vietnam Veterans of America (VVA) to present testimony regarding the Department of Veterans Affairs' (VA) Readjustment Counseling Services (RCS), or Vet Center program. This Committee is distinguishing itself for the attention it has focused on the important issue of post-deployment mental health and VVA wants to thank you for your continuing efforts.

VVA has always strongly supported the community-based Vet Center program because of its cost effectiveness, staff commitment, and solid leadership, but especially because of the high quality of its services, including individual and group counseling, marital and family counseling, bereavement counseling, employment counseling, military sexual trauma (MST) counseling, substance abuse assessments, medical referrals, assistance in applying for VA benefits, outreach, and community education. It is a truly unique resource within the system. Vet Centers, which operate as a non-medical setting, independent from the Veterans Health Administration main facilities, offer veterans and their families a haven in which to gather in an atmosphere of trust that relieves them from the stigma and societal perceived shame often associated with care-seeking for mental illness elsewhere.

Because of our core belief in the value of the Vet Center services, VVA was very pleased to learn that in 2007 the VA plans to open new Vet Center facilities in Grand Junction, CO; Orlando, FL; Cape Cod, MA; Iron Mountain, MI; Berlin, NH; and Watertown, NY, (with others located in Montgomery, AL; Fayetteville, AR; Modesto, CA; Fort Myers and Gainesville, FL; Macon, GA; Manhattan, KS; Baton Rouge, LA; Saginaw, MI; Las Cruces, NM; Binghamton, Middletown, and Nassau County, NY; Toledo, OH; Du Bois, PA; Killeen, TX; and Everett, WA scheduled for opening in 2008). While we are grateful that new centers will offer access to veterans, it is not just the new centers that require staff. VVA has called on the VA to increase staff at existing centers for the past 3 years.

Vet Centers are asked to do a great deal for our veterans and yet, ideally, they would do even more. VVA would like to see more family services, including bereavement counseling, counseling for military sexual trauma available at every Vet Center, and a strong interface between the Department's recently announced suicide prevention efforts at the VA medical centers. Recent legislation has also called on federal community mental health centers to aid in the identification and treatment of post-traumatic stress and other post-deployment mental health issues. We hope that Vet Centers are integral in sharing their expertise with these community providers and become the hub for strong national networks devoted to this type of care.

As you know, Mr. Chairman, Vet Centers are just one venue the Department of Veterans Affairs system employs to address post-deployment mental health issues. Without a host of *accessible* healthcare options to which it can refer veterans, Vet Centers alone cannot be effective. So while this hearing is assessing the Vet Center program, it is important to acknowledge that Vet Centers cannot be successful without VA's other treatment programs for substance abuse, mental illness, homelessness and post-traumatic stress disorder.

Accessibility to post-deployment mental health programs within VA may diplomatically be referred to as "uneven". Unfortunately, stories of suicides among servicemembers returning from Iraq and Afghanistan with severe and acute mental illness are likely to continue to make the system's accessibility problems all too visible. We understand that VA has conducted a study of the prevalence of suicide among recent veterans and hope that the results are available to guide policymaking in the near future. We are pleased that VA plans to also roll out a national 24-hour hotline and hire suicide prevention counselors at each VA medical center to assist suicidal veterans as recommended by its own Inspector General, but once the crisis passes, VA must have services available to ensure that such veterans receive the care they need. As a point of entry into the system for many veterans, Vet Centers should also have a strong role in suicide prevention. In order to be most effective, Vet Centers require trained personnel and non-traditional hours of operation. Ideally, each Vet Center would be able to provide round-the-clock crisis intervention services.

Access to mental healthcare remains problematic even for veterans currently enrolled. As thousands of troops who have been or are now deployed in operations in Iraq and Afghanistan return home in need of post-deployment mental health services—chiefly, treatment for Post-traumatic Stress Disorder (PTSD), anxiety, depression, and substance abuse—most experts agree access problems will only worsen. One study found that about 17 percent of troops from Iraq were returning with post-

deployment mental health issues that required treatment.[1] A new study has found significantly higher rates of post-deployment mental health and psychosocial conditions (31 percent), particularly among the youngest veterans.[2] Anecdotally, VVA is aware of veterans of earlier combat eras who have increased demand for services because of the effects of aging and exacerbations of existing conditions caused by exposure to the ongoing deployments in Iraq and Afghanistan.

VA estimates it will treat more than a quarter of a million veterans (263,000) of Operation Enduring Freedom and Operation Iraqi Freedom in FY 2008—54,000 more than will have been treated in FY 2007. This may be an underestimate, just as the VA figures have underestimated the demand for services by recent returnees the past 3 years. These veterans are seen for a wide variety of problems and concerns, but more than one-third use some sort of post-deployment mental health services. Experts recognize that the number of those veterans seeking services may grow as veterans readjust to civilian life and they or their loved ones recognize symptoms or signs of PTSD, substance abuse, anxiety or depression that have commonly been associated with combat exposure or long-term deployment.

In FY 2006, the readjustment counseling service estimates it offered 1,170,439 visits to the 228,612 veterans it treated. In FY 2005, it offered 1,046,624 visits to 132,853 veterans. As you might assume, the workload increase is attributable to the almost five-fold increase in OIF/OEF veterans, but these numbers tell a more subtle story. While veterans who use the Vet Centers almost doubled (+72 percent), visits only increased by about 12 percent. Visits per veteran dropped from 8.2 in FY 2004 to 7.9 in FY 2005 to 5.1 in FY 2006. These statistics show a system under duress in which many veterans who had previously been using the system are not getting the same level of services they once did and new users are probably not getting what they need.

Staffing patterns have also evolved somewhat in the Vet Centers with a greater part of the workforce comprised of peer support or outreach counselors—in FY 04 such counselors made up 10.6 of the workforce while in FY 06 they comprised 18.2 percent. Perhaps it is not surprising there has been such an increase in workload—peer counselors primarily assigned to outreach are doing their jobs! Mental health professional staff has comprised about 60 percent of the workforce, but there are now more social workers and fewer psychologists than in years past. VVA is concerned that these mental health professionals have the right veteran-specific experience in dealing with the issues they will address—trauma exposure, sexual trauma, or substance abuse. To that end, we recommend that Congress fund "PTSD scholarships" to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. This would create a new stream of Vet Center counselors who have both shared the experiences of their comrades and received adequate professional training to address their issues.

Vet Center funding also tells us a story. The FY 2007 budget request for VA estimated that its obligations for readjustment counseling centers would be $106 million. A $20 million supplement targeted at the Vet Centers seems generous, but actually represents only a 19 percent increase in funding to address the large increases in workload the centers have faced annually during the OIF/OEF deployment (for example, there was a 72 percent increase in FY 2006).

The story is also incomplete without discussing unmet need. Notwithstanding the swells within the ranks of the Vet Centers, recent studies have also shown that four out of five veterans who may need post-deployment mental healthcare are not properly referred for an evaluation and that many veterans of operations in Iraq and Afghanistan who are using VA facilities have failed to seek care for identified mental and psychosocial conditions.[3] A June 2006 study conducted by the Institute of Medicine recommended that all veterans deployed to a war zone receive a face-to-face screening for PTSD from an experienced health professional, yet to date this has not taken place for servicemembers returning from current deployments.[4]

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[1] Charles W. Hoge, MD, et al. "Combat Duty in Iraq and Afghanistan, Mental Health Problems and Barriers to Care", The New England Journal of Medicine, Vol. 351, No. 1:13–22, July 1, 2004.

[2] Karen H. Seal, MD, MPH, et al. "Bringing the War Back Home: Mental Health Disorders Among 103,788 U.S. Veterans Returning from Iraq and Afghanistan Seen at Department of Veterans Affairs Facilities," Archives of Internal Medicine, Vol. 167, No. 5, March 12, 2007.

[3] Government Accountability Office. "Post-Traumatic Stress Disorder: DOD Needs to Identify the Factors Its Providers Use to Make Mental Health Evaluation Referrals for Servicemembers," GAO–06–397, May 11, 2006.

[4] Subcommittee on Posttraumatic Stress Disorder of the Committee of the Committee on Gulf War and Health, Physiologic, Psychologic, and Psychosocial Effects of Deployment Related Stress. "Posttraumatic Stress Disorder: Diagnosis and Assessment," Institute of Medicine of the National Academy of Sciences, June 16, 2006.

Indeed, if these veterans were seeking care in accordance with their demonstrated need, they would overwhelm VA's current capacity. In recent years, VA's internal champions—the Committee on Care of Seriously Chronically Mentally Ill Veterans and the Special Committee on Post-Traumatic Stress Disorder, for example—have expressed doubts about VA's mental healthcare capacity to serve these veterans of ongoing deployments. Last March, the Under Secretary for Health Policy Coordination told a Presidential commission that mental health services were not available everywhere, and that waiting times often rendered some services "virtually inaccessible."

New Vet Centers will certainly help in dispersing needed expertise and accessibility to services throughout the system. However, as Chairman Michaud well remembers, in the fall of 2006, the Democratic staff of the House Committee on Veterans Affairs surveyed 64 Vet Centers. The subsequent report entitled "Review of Capacity of Department of Veterans Affairs Readjustment Counseling Services Vet Centers" noted that "the Vet Centers have seen a significant increase in outreach and readjustment counseling services to OIF/OEF veterans". The report also stated that ". . . from October 2005 through June 2006, the number of returning veterans from Iraq and Afghanistan who have turned to the Vet Centers for PTSD services and readjustment concerns has doubled. Without an increase in counseling staffing this increase in workload has affected access to quality care. Some Vet Centers have started to limit access."

Other survey findings noted that ". . . one in four Vet Centers has taken or will take some action to manage their increasing workload, including limiting services and establishing waiting lists" and "thirty percent of the Vet Centers explicitly commented that they need more staff." So while additional RCS facilities and the additional funding Congress provided through its supplemental appropriation for the VA will certainly help, VVA remains concerned that Vet Center services may still not be uniformly available throughout the system. Obviously, VVA is also concerned that services needed by Vietnam veterans and other earlier conflicts, who also have valid needs, may be curtailed or delayed so long as to not be useful and therefore effectively denied.

VVA is therefore compelled to ask the following questions—

Because of the ebbs and flows in its funding, VA has often been reluctant to invest funding in new staff (an ongoing commitment) in times it has additional resources. Does the RCS have plans to hire more professional staff for the remainder of FY 2007, given that it has received an additional $20 million in the Supplemental Appropriation for the purpose of hiring more staff? And does the RCS have plans to hire more professional staff in FY 2008, given that the VA will get a $6+ billion increase over FY 2007?

If the RCS is not planning to spend the entire $20 million on adding staff to keep up with the demand for the continually rising demand for services from veterans and their families, what is the RCS plan for how these recently provided funds will be effectively spent?

Does the RCS have plans to hire more peer counselors in FY 2007? And does the RCS have plans to hire more peer counselors in FY 2008 than it currently has on board?

What are the plans to use the $20 million for substance abuse and the $100 million to enhance other mental health services that address post-deployment mental health issues?

VVA hopes that the Committee will require detailed plans from VA that ensure these questions are answered and Congress's goals for the system are implemented.

Finally, Mr. Chairman, we could not leave any debate related to post-deployment health without urging you and the Committee to support efforts to reinvigorate the National Vietnam Veterans Longitudinal Study. This study is not just important to the veterans of the Vietnam era, but would provide important findings about the long-term consequences of post-traumatic stress disorder and other stressors related to deployment to generations of future veterans. As you know, VA has found ways to thwart this study, which is already required by law, for several years, but the Senate Appropriations Committee has addressed it in the report language accompanying the Military Construction bill. We hope that you will urge your counterparts on the House Committee on Appropriations to accept and even strengthen this language.

Mr. Chairman, this concludes my statement. I will be happy to answer any questions you may have.

Prepared Statement of Alfonso R. Batres, Ph.D., M.S.S.W., Chief Readjustment Counseling Officer, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, I appreciate the opportunity to appear before you today to discuss the Vet Center program of the Department of Veterans Affairs (VA) and the role it plays in providing care and services to veterans.

VA's authority to provide readjustment counseling to eligible veterans was established by law in 1979 to alleviate the specific psychological symptoms and social readjustment problems that arose from veterans' traumatic combat experiences in Vietnam. Today, in the anniversary of the program's 28th year, the Vet Center program's eligibility includes veterans that served in combat during any period of war or armed hostility. In 1993, following the legislative authority for VA to provide military-related sexual trauma counseling, Vet Centers were designated as one of the main VHA sites for providing these services to veterans of any era who were sexually assaulted during military service.

SERVICES

The Vet Center program is a unique Veterans Health Administration (VHA) program designed to provide readjustment counseling services to help veterans exposed to the stressful conditions of combat military service make a successful transition to civilian life. In terms of service mission, readjustment counseling consists of a more-than-medical, holistic system of care that provides professional readjustment counseling to help veterans cope with and transcend the psychological traumas and other readjustment problems related to their military experiences in war. Vet Center services also include a number of other community-based services to help veterans improve the whole range of their post-military social, economic and family functioning.

One of the distinguishing features of the Vet Center program is the authority to provide services to veterans' immediate family members as part of the treatment and readjustment of the veteran. Veterans' immediate family members are eligible for care at Vet Centers and are included in the counseling process to the extent necessary to treat the readjustment issues stemming from the veterans' military experience and/or post-deployment homecoming. Vet Centers promote preventive educational services to help veterans and immediate family members stabilize post-deployment family readjustment problems and assist the veteran to a successful post-war readjustment.

VA's Vet Center program currently consists of 209 community-based Vet Centers located in all 50 states, the District of Columbia, Guam, Puerto Rico and the U.S. Virgin Islands and operates in the community outside of the larger medical facilities. Designed to remove all unnecessary barriers to care for veterans, the Vet Centers are located in convenient settings within the community, and services are tailored in every community to meet the specific needs of the local veteran population. To further promote ease of access, veterans are always welcome to stop by their local Vet Center at any time. Vet Center staff members are available to welcome veterans and family members, and to provide useful information about available services. Vet Centers have no waiting lists and veterans may be seen by a counselor the same day they stop by for an assessment. Vet Centers also maintain nontraditional after-hours appointments to accommodate veterans' work schedules.

The Vet Center program is the primary outreach arm of VHA. All Vet Centers engage in extensive community outreach activities to directly contact and inform area veterans of available VA services and maintain active community partnerships with local leaders and service providers to facilitate referrals for veterans. Vet Center community-based outreach and referral services also provide many veterans with a point of contact for access into the larger VA healthcare system and benefits programs. The Vet Centers make over 200,000 veteran referrals annually to VA medical centers and regional offices combined.

With the onset of the hostilities in Afghanistan and Iraq, the Vet Centers commenced to actively outreach and extend services to the new cohort of war veterans returning from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF). From early in fiscal year (FY) 2003 through the end of the third quarter in FY 2007, the Vet Centers provided readjustment services to over 242,000 veteran returnees from OEF and OIF. Of this total, more than 183,500 veterans were provided outreach services often through group settings, and approximately 58,500 were provided substantive clinical readjustment services in Vet Centers.

The Vet Center philosophy is early intervention through outreach and preventive educational services. Research indicates that this may result in the best outcomes

for successful post-war readjustment. To promote early intervention, VA initiated an aggressive outreach campaign to locate, inform, and professionally engage veterans as they return from theaters of combat operation in Afghanistan and Iraq. Over the 2-year period from FY 2004 through FY 2005, the Vet Center program hired 100 OEF and OIF veteran returnees to provide outreach services to their fellow combatants. Since 2004 when the initial OEF and OIF veteran outreach specialists were recruited, the focus of the Vet Center program has been on aggressive outreach at military demobilization and at National Guard and Reserve sites as well as at other community events that feature high concentrations of veterans. These fellow veteran outreach specialists are effective in successfully gaining the immediate trust of returning veterans and help them mitigate the fear and stigma associated with seeking professional counseling services.

The Vet Centers also provide bereavement counseling to surviving family members of Armed Forces personnel who died while on active duty in service to their country. Vet Centers are providing bereavement services to military family members whose loved ones were killed in Afghanistan and Iraq. Since 2003 through the end of the third quarter FY 2007, 1,045 cases of active duty, military-related deaths have been referred to the Vet Centers for bereavement counseling, resulting in services provided to more than 1,570 family members.

STAFFING

Vet Centers staffed by small multidisciplinary teams are highly responsive to the needs of the local veterans. The team comprises a mix of mental health professionals, other professional readjustment counselors, outreach specialists and administrative personnel. In FY 2006, the Vet Center program had 1066 assigned staff positions of which 876 were authorized counseling staff and 159 were outreach specialist positions. Of the total counseling staff, 507, or 58 percent, were VHA qualified licensed mental health professionals, i.e., licensed clinical social workers, doctoral level clinical psychologists with an American Psychological Association approved internship, and psychiatric clinical nurse specialists. Every Vet Center has at least one VHA qualified mental health professional on staff.

A majority of Vet Center service providers are themselves veterans, most of whom served in a combat theater of operations. Having a large cadre of veterans on staff is a distinguishing characteristic of the Vet Centers, and enables the program to maintain a veteran-focused treatment environment that communicates a welcome home attitude and respect for veterans' military service. The high percentage of combat veteran Vet Center service providers facilitates immediate rapport and promotes a sense of camaraderie within the local veteran community. Vet Centers also tailor services delivered to meet the specific cultural and psychological needs of the veteran populations they are serving by promoting representative diversity among the staff.

FUTURE PLANS

Today the Vet Center program is undergoing the largest expansion in its history since the early days of the program's founding. The planned expansion complements the efforts of the Vet Center outreach initiative by ensuring sufficient staff resources are available to provide the professional readjustment services needed by the new veterans as they return home. In FY 2006, VA announced plans for establishing two new Vet Centers in Atlanta, GA and Phoenix, AZ, and augmenting staff at 11 existing Vet Centers, bringing the current number of Vet Centers to 209. In February 2007, VA announced plans to increase the number of Vet Centers to 232. Over the remainder of this and the next fiscal year, VA will establish new Vet Centers in 23 communities and augment the staff at 61 existing Vet Centers. The following communities will be receiving new Vet Centers: Montgomery, Alabama; Fayetteville, Arkansas; Modesto, California; Grand Junction, Colorado; Orlando, Fort Meyers, and Gainesville, Florida; Macon, Georgia; Manhattan, Kansas; Baton Rouge, Louisiana; Cape Cod, Massachusetts; Saginaw and Iron Mountain, Michigan; Berlin, New Hampshire; Las Cruces, New Mexico; Binghamton, Middletown, Nassau County and Watertown, New York; Toledo, Ohio; Du Bois, Pennsylvania; Killeen, Texas; and Everett, Washington.

In May 2007, VA announced that it planned to add 100 new staff positions to the Vet Center program in FY 2008. Together with the 100 OEF and OIF outreach specialists hired in FY 2004 and 2005, these program expansions represent an increase in Vet Center staffing by 369 positions over pre-2004 staffing levels, a 39 percent increase.

The Vet Center program reports the highest level of veteran satisfaction recorded for any VA program. For the last several years, over 99 percent of veterans using

the Vet Centers consistently reported being satisfied with services received and responded that they would recommend the Vet Center to other veterans.

In summary, through their local Vet Centers, eligible veterans have access to professional readjustment counseling for war-related social and psychological readjustment problems, family military related readjustment services, substance-abuse screening and referral, military sexual trauma counseling, bereavement services, employment services, and multiple community-based support services such as preventive education, outreach, case-management and referral services.

To locate their local Vet Center, veterans can consult the yellow pages, as well as the federal government listings. In both places the listing is under "Vet Center." Vet Centers are also listed on the following Web site: www.va.gov/rcs.

Mr. Chairman, this concludes my statement. I am happy to answer any questions that you or other Members of the Committee may have.

Prepared Statement of Hon. Jeff Miller, Ranking Republican Member, Subcommittee on Health, and a Representative in Congress from the State of Florida

Thank you Mr. Chairman.

The Vet Center program was established by Congress more than 25 years ago as a means of providing readjustment counseling to many Vietnam era veterans that were experiencing difficulties readjusting to civilian life after returning home from the war. Vet Centers were specifically designed to be separate from VA hospitals to overcome concerns about stigma and offer easy access in friendly community-based settings.

Over the years, the mission of the Vet Centers has been broadened to provide counseling, outreach and referral services to all veterans who served in a combat zone and to include their family members. On the home front, Vet Centers are increasingly becoming an active support system for a new generation of returning soldiers and their families—a place where they can find other veterans who have experienced combat themselves to help them make a successful readjustment to civilian life.

Last Congress, we enacted Public Law 109–461 that required VA to hire not less than 100 additional OEF/OIF veterans to provide specialized peer-to-peer counseling and outreach to these newly returning veterans from the Global War on Terror. The law also authorized $180 million in funding for the Vet Centers.

About forty-one percent of OEF and OIF veterans come from and return to rural communities. Access to VA services for these veterans is far more challenging than for their fellow comrades who live in urban areas.

It is especially important that rural veterans are provided with the same initial outreach to facilitate subsequent access to all VA services.

I welcome our witnesses and appreciate this opportunity to obtain your guidance on how Vet Centers are being used and staffed, the effectiveness of the services, and ways in which provision of services can be improved.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Sue Bergeson
President,
Depression and Bipolar Support Alliance
730 North Franklin Street, Suite 501
Chicago, IL 60610–7224

Attn: Ariel Brenner

Dear Sue:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would

appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Depression and Bipolar Support Alliance,
Responses for the U.S. House of Representatives,
Committee on Veterans' Affairs,
Subcommittee on Health,
Followup Questions from Sue Bergeson

1. ***Capacity***—You stated that over 35 percent of OEF/OIF veterans treated by VA have been diagnosed with mental disorders and also that VA "does not have the capacity" to deliver mental health services to all veterans in need.

- Is this a statement applicable to VA overall, suggesting that even with the Vet Center program VA does not have the capacity to treat veterans?

Bergeson: I'm referring to the VA overall. Veterans Centers in the community are a critical part of care and they reach veterans who are not receptive to visiting VA facilities or who live far from such facilities. However, VA administrative and clinical personnel have indicated capacity was already stretched before OEF–OIF. We are now facing an onslaught. Peers offer a kind of help that clinicians cannot and can help engage their fellow veterans in needed services. They are not a replacement for clinical care, but a different form of support. They also can serve as a cost-effective means of outreach and encouragement to veterans.

2. ***Treatment***—You cited the Archives of Internal Medicine statistic that veterans who are between the ages of 18–24 and returning from Afghanistan and Iraq are nearly three times more likely to be diagnosed with a mental health disorder, compared with veterans 40 years or older.

- Is this reflected in the composition of veterans visiting Vet Centers today and, in your opinion, how is VA working to address this?

Bergeson: I cannot speak to the composition of veterans visiting Veterans Centers. But I can say that we believe many new veterans have not yet experienced symptoms or have not yet recognized these symptoms as signs of mental illness. In addition, many veterans (OEF/OIF and overall) are resistant to using traditional VA facilities, preferring to access help through Veterans Centers or through non VA-affiliated veterans' service or mental health organizations.

The VA could benefit from using OEF/OIF veterans who have experienced mental illnesses as a resource for serving their peers. Since Veterans from the current war will often respond most readily to their peers, training our newest veterans to serve in this support and outreach role will extend peer support services to the thousands of returning veterans in need of understanding and support.

3. ***Peer Support***—You stated that the greatest resource to help veterans suffering with mental illness is veterans themselves and that peer specialist services cost five times less than older models of care.

- In your opinion, is VA utilizing enough peer support?

Bergeson: As I mentioned earlier, I do not believe the problem is whether the VA is utilizing or even wanting to utilize peer support, but rather providing consistent and effective peer training throughout the VA. Numerous VA facilities are hiring veterans as Peer Support Technicians, but what is needed are consistent preparation, guidelines and standards so that the VA provides the best peer support possible. That's why the creation of a VA Technical Assistance Center for Peer Support Services is a crucial component to stimulating and sustaining an effective VA-wide program.

4. ***Training***—You have offered three suggestions: increase funding for peer training; establishing a technical assistance center; and piloting peer support technician training and certification projects throughout the country. Could you go into more detail on how this would work?

Bergeson: In addition to its own emerging expertise, a great deal of experience in peer support and the use of consumers as service providers already exists outside the VA. It is critical that the VA, as the nation's largest healthcare delivery system, utilize all existing knowledge and lessons learned in order to craft training and jobs that are authentic. This will maximize the use of currently stretched resources.

As to possible scenarios, the VA should utilize outside organizations to serve as a peer support Technical Assistance Center for the VA, as recommended in the VA's own Mental Health Strategic Plan. The VA could use current Peer Support Technician job descriptions along with a survey of actual/potential peer roles to determine the necessary competencies for veteran-consumers working as Peer Support Technicians and in other peer support roles

Based on these competencies, pilot Peer Support Technician training and certification projects with a strong evaluation component could be initiated. The evaluation should measure veteran satisfaction and the relevance of training topics to jobs within the VA.

It should also measure outcomes for veterans served by Peer Support Technicians as compared with outcomes of veterans in traditional services only.

Finally, the VA could initiate pilot distance learning and train-the-trainer projects internally and utilize the results of these programs to create peer training continuing education through its existing Employee Education System. Especially needed in addition to veteran training efforts are training programs that are designed to orient VA providers to the unique role of peer supporters and to allay any concerns about that role in the VA's mental healthcare delivery system. Toward that end, the VA could utilize the current supervisors of Peer Support Technicians as mentors for new supervisors.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Shannon L. Middleton
Deputy Director, Veterans Affairs and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Shannon:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, and our joint Subcommittee hearing on "Issues Facing Women and Minority Veterans" held on July 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Joint Subcommittee Hearing,
Issues Facing Women and Minority Veterans,
Held on
July 12, 2007, 10:00 a. m.
Followup Questions for Shannon L. Middleton

1. In testimony provided, DAV gives 8 recommendations to better serve women veterans from combat theaters. The first recommendation concerns barriers to seeking healthcare through VA.

- **In your estimation, what are the three biggest barriers female veterans encounter when trying to access healthcare through VA?**

The three biggest barriers female veterans encounter when trying to access healthcare through VA are: lack of knowledge about VHA services, not knowing that they may be eligible for healthcare benefits, and the perception that VA only caters to male veterans.

2. Women and minority OEF/OIF veterans returning from theater face, what I believe, are additional challenges than their returning peers, due, in part, to the lack of cultural education, lack of adequate research on meeting their unmet needs and other issues.

- **What has your organization done to help in the outreach efforts?**

The American Legion publishes a booklet entitled Guide for Women Veterans that provides information about VA healthcare, services provided by The American Legion, information about health issues (like breast cancer, PTSD, sexual trauma, heart disease, drug and alcohol addiction) and a list of resources to enable them to find information about various issues. We disseminate them through our department service officers, outreach events, on our website and make them available upon request to the public.

In the past, The American Legion has participated in a homeless female veteran workgroup for the Southeast Veterans Service Center and served on Subcommittees for the 2004 Women Veterans Summit hosted by the Department of Veterans Affairs.

The American Legion is currently planning to collaborate with the Center for Women Veterans to organize a Women Veterans' Forum to be held in conjunction with the organization's mid-winter conference. The American Legion is also participating in the 2008 Women Veteran's Summit. We are constantly seeking new ways to bring information to veterans, all veterans.

- **Does your organization have any recommendations as to how to address the growing need for specialized services for both women and minority veterans?**

One effective way to ascertain the need for specialized services is to find various ways to ask women and minority veterans what needs they have that are not being met by current services. This can be patient survey, or an outreach initiative that includes a survey that VA disseminates by mail or via web. The information gathered would be useful in determining system-wide need for specific programs or services and may be useful in depicting geographical or population trends for needed services.

Once these needs are identified, The American Legion recommends that VA develop and implement policy to address these deficiencies in a timely manner and conduct an extensive outreach campaign to make these special populations—and those who serve them—aware of the enhancements. The organization also recommends that Congress appropriate adequate funding to maintain these enhancements, once they are in place.

Finally, DAV's recommendations that VA and DoD collaborate to conduct surveys of recently discharged active duty women and recently demobilized female Reserve component members to assess the barriers that they perceive or have experienced in seeking healthcare through VA and that VA Medical Centers establish a consumer council that includes veterans' service organizations, family members, and veterans—especially OEF/OIF veterans—would be excellent approaches as well.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Shannon Middleton
Deputy Director for Health
Veterans Affairs and Rehabilitation Commission
The American Legion
1608 K Street, NW
Washington, DC 20006

Dear Shannon:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Subcommittee Hearing
Vet Centers
Held on
July 19, 2007
2:00 p.m.
Follow-Up Questions for Shannon L. Middleton

1. ***Staffing*—The American Legion focused on Vet Center visits this year as part of the System Worth Saving Report that your organization has released since 2003. In your testimony you wrote that there were some Vet Centers that indicated that limited staffing was an overall challenge.**

- **Could you tell us if there were certain areas, such as rural areas, that experienced staffing challenges more than others?**

The site visits did not illustrate any defined areas, like rural areas, that experienced staffing challenges. This may be due to the fact that we only selected Vet Centers that were near demobilization sites and did not select many truly rural areas.

However, some Vet Centers did indicate the need for outstations to reach more veterans. For instance, East St. Louis Vet Center (Illinois) is located on the western boarder of Southern Illinois and has a catchment area extending to the Eastern boarder of Illinois. It covers 35 counties; the location of the Vet Center is an obstacle for some. The Syracuse Vet Center's (New York) staff indicated the need for a satellite office in the Utica/Rome area. Oak Park Vet Center (Illinois) expressed a need for satellite offices in St. Charles and Geneva.

- **During your visits, did you find that any of the Vet Centers were actually maintaining a waiting list for veterans to receive services?**

Fortunately, our visits did not uncover that the Vet Centers were maintaining wait lists for service. We found that veterans were vested—or put in the system—upon arrival. When necessary, the Vet Centers used contracted services, or facilitated coordination of care within the Veterans Health Administration (VHA). We also found that Vet Center staff worked extended hours to accommodate the needs of working veterans.

2. ***Military Sexual Trauma*—In testimony, the VFW stated that they had some concerns with the Vet Centers being able to handle the increasing number of women veterans sure to seek treatment. Additionally, they stated that they would like to see an increase in treatment options and outreach efforts to women.**

- **Has your organization been hearing complaints about the lack of MST counselors at the Vet Centers?**

The American Legion has Departments in every state, as well as in Puerto Rico, Mexico, the District of Columbia, France and the Philippines. There have been no reports or complaints on the lack of MST counselors at Vet Centers from the Departments, or Department Service Officers and none made to our National office. However, several of the Vet Centers have identified this deficiency as an obstacle to providing sexual trauma counseling to veterans.

3. ***Challenges*—In your organization's estimation, what are the top three challenges facing the Vet Center program today?**

In The American Legion's estimation, the top three challenges facing the Vet Center program today are acquiring adequate funding for training, hiring or training

staff who specialize in needed fields (sexual trauma counseling, family counseling, Global War on Terror (GWOT) Outreach), and, for some, obtaining a facility that can provide adequate space.

The Vet Centers that identified funding for training as an obstacle indicated that counselors are receiving between $125–$200 per team member annually for continuing education. This does not cover the mandatory 40-hour education and will not cover travel expenses. After the amount has been depleted, other expenses will have to be paid by the individual. Thus, classes and training events must be local.

Although System Worth Saving Task Force and Field Service Representatives visited about a third of the existing Vet Centers, many of them listed the lack of staff trained in sexual trauma counseling and marital counseling challenges. Some Vet Centers found resourceful ways to mitigate this lack, for instance training an existing staff member to provide these specialties or sharing the sexual trauma counseling, GWOT or marital counselor of a neighboring Vet Center.

Military sexual trauma is not a women veterans' issue and treating it as such will further isolate men, who are very reluctant to seek care. For example, the Portland Vet Center is noticing an influx of men seeking MST counseling. Unfortunately, the facility will be losing its MST counselor.

Because MST victims are both male and female, these veterans require choices when seeking counseling. Some men may not be comfortable with a male sexual trauma counselor for the same reason some women may be uncomfortable with a male counselor: similarity with the assailant. Conversely, some men may not feel comfortable working with a female sexual trauma counselor, for fear of appearing less manly.

A few Vet Centers noted the need for larger facilities, due to an increase in workload, the expansion of additional services and to accommodate the need for group sessions. The workload increase stemmed from multiple sources, from an influx of returning Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans to successful outreach efforts.

3. *Education*—Vietnam Veterans of America recommends that Congress fund "PTSD scholarships" to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. How does your organization feel about this idea?

Retaining highly educated staff is a problem for VA system-wide. Some of the Vet Centers indicated that the private sector offers more attractive salaries, making retention a challenge. Also, it is our understanding that approximately 85 percent of current Vet Center staff are combat veterans. So, providing doctorate level scholarships for peer counselors may not remedy the staffing problem. However, increasing funding available for training so that Vet Center peer counselors and other professional staff members could gain certifications and enhanced training may be more beneficial.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Adrian M. Atizado
Assistant National Legislative Director
Disabled American Veterans
807 Maine Avenue SW
Washington, D.C. 20024

Dear Adrian:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

POST-HEARING QUESTIONS FOR
ADRIAN M. ATIZADO
OF THE
DISABLED AMERICAN VETERAN
FROM THE
COMMITTEE ON VETERANS' AFFAIRS
SUBCOMMITTEE ON HEALTH
UNITED STATES HOUSE OF REPRESENTATIVES
JULY 19, 2007

1. **Staffing**—The American Legion focused on Vet Center visits this year as a part of the System Worth Saving Report that your organization has released since 2003. In your testimony you wrote that there were some Vet Centers that indicated that limited staffing was an overall challenge.

- Could you tell us if there were certain areas, such as rural areas, that experienced staffing challenges more than others?

Response: We at DAV will defer to the American Legion any response in particular to its System Worth Saving initiative. As for our concerns about Vet Center staffing, as a part of the Independent Budget we have expressed our concerns about the apparent flat staffing levels of Vet Centers in the face of dramatic growth in their workloads. However, in consultation with VA program officials we have learned that a large percentage of the growth in Vet Centers over the past few years relates to activity in the outreach arena. Vet Centers are dispatching their peer counselors with direct experience serving in Operations Iraqi and Enduring Freedom (OIF–OEF) to demobilization posts, National Guard armories and Reserve barracks, to be sure that all returning OIF–OEF service personnel are fully aware, not only of potential Vet Center assistance but other VA benefits and services that might help them with their transition needs. We believe, in this regard, that the Vet Centers could use additional personnel. This is particularly true, given the Vet Centers' new work in bereavement counseling to surviving families of those lost in OIF-OEF.

- During your visits, did you find that any of the Vet Centers were actually maintaining a waiting list for veterans to receive services?

Response: To our knowledge the Vet Center program, which like other VA programs, has limited resources, needs to prioritize its workloads. While the Vet Centers do not maintain a formal waiting list, they attempt to deal with crisis first and handle their general caseloads in ways that maximize the resources available.

2. **Military Sexual Trauma**—In testimony, the VFW stated they had some concerns with the Vet Centers being able to handle the increasing number of women veterans sure to seek treatment. Additionally, they stated that they would like to see an increase in treatment options and outreach efforts to women.

- Has your organization been hearing complaints about the lack of MST counselors at the Vet Centers?

Response: We believe that the Vet Centers that care for veterans who raise this issue are primarily referred to the VA military sexual trauma counselors at the nearest VA medical center. We are informed that, following initial counseling by specially trained MST counselors and other mental health professionals, individuals often return to the referring Vet Center for follow up counseling. As far as we know, this arrangement is working well.

3. **Challenges**—In your organization's estimation, what are the top three challenges facing the Vet Center program today?

Response: The Vet Center program is soon to enter its thirtieth year of operations. It is one of the most successful programs functioning within VA, and DAV has been a strong supporter of the concept since its inception. Over the years, the program has been challenged because it is outside the medical model otherwise used within the Veterans Health Administration. The 209 Vet Centers do not employ

physicians but rely instead on counselors, and in particular, trained peer counselors to aid veterans in their transitions from military exposures, to a return to civilian society.

Another challenge to the Vet Center program is resources. All VA resources are limited, but since the Vet Center program is funded outside of VA's medical model, the "Veterans Equitable Resource Allocation" or "VERA" system, the program must present a different justification for annual resources, and these debates, when considered within VA's overall need for funding, have been rigorous.

The third biggest challenge is in keeping the Vet Center program contemporary and attractive to new generations of veterans. Historically, the Vet Center program was designed for Vietnam veterans. As it has matured, it has been challenged to maintain relevance for newer generations of veterans from the Persian Gulf War and the current conflicts. We believe that Dr. Alfonso Batres, the current Readjustment Counseling Service Director, has done an excellent job in maintaining a flow of new counselors with relevant experience, and updating appropriate training programs, so that the Vet Centers of today are very much desired and valued by veterans of OIF-OEF.

4. **Education**—Vietnam Veterans of America recommends that Congress fund "PTSD scholarships" to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. How does your organization feel about this idea?

Response: DAV has no adopted resolution from membership on this particular issue, and prior to the hearing was not aware of the proposal, but would have no objection to it since it is intended to improve clinical care programs for those who may be suffering the effects of PTSD.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Dennis M. Cullinan
National Legislative Director
Veterans of Foreign Wars of the United States
200 Maryland Avenue, NE
Washington, DC 20002

Dear Dennis:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Responses to Post-Hearing Questions by
Dennis M. Cullinan, Director,
National Legislative Service,
Veterans of Foreign Wars of the U.S.

1. Staffing—The American Legion focused on Vet Center visits this year as part of the System Worth Saving Report that their organization has released since 2003. In your testimony, you wrote that there were some Vet Centers that indicated that limited staffing was an overall challenge.

- **Could you tell us if there were certain areas, such as rural areas, that experienced staffing challenges more than others?**

- **During your visits, did you find that any of the Vet Centers were actually maintaining a waiting list for veterans to receive services?**

We have not found any results that differ from the Subcommittee's October 2006 report, "Review of Capacity of Department of Veterans Affairs Readjustment Counseling Service Vet Centers." Certainly, rural areas are going to have a more difficult time finding and hiring qualified counseling professionals, which is a challenge the entire Department faces in all of its operations.

Although our staff have not found any Vet Centers actually maintaining waiting lists, from conversations that our staff has had with many of these centers, they are on the verge of needing to do so. They are barely keeping their head afloat today, and with demand projected to increase, it will create a special challenge in the future.

2. Challenges—In your organization's estimation, what are the top three challenges facing the Vet Center program today?

The largest challenge the system faces is in how it is going to handle the demands of tomorrow, as the number of veterans from OIF/OEF continues to grow, and the number of family members impacted by the conflicts goes up. We are concerned that Vet Centers may not have the dedicated resources to handle the influx that is likely to occur as these former warriors transition into civilian life.

We are also concerned with the staffing levels of these centers, especially in the future as more veterans and families utilize the Vet Centers' terrific array of services. Additionally, a number of the most experienced Vet Center counselors and staff are from the Vietnam era and are nearing retirement age. They have a wealth of experience and training, and losing them would be a blow to the system if there are not capable and experienced replacements waiting in the wings.

A third issue we are concerned with is how these clinics adapt to the unique needs of women veterans. With the current conflict, there are no true frontlines, and everyone in the area is exposed to the rigors and challenges of combat. There must be outreach efforts and sensitivity to any unique needs or challenges women veterans face as a result of conflict. This extends beyond just sexual trauma treatment but to the entire range of mental health services provided at these centers. It is an issue that these centers should strive to stay on top of.

3. Education—Vietnam Veterans of America recommends that Congress fund "PTSD scholarships" to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. How does your organization feel about this idea?

VA has had success with scholarships in other medical fields, such as with the nursing program. Given some of the challenges VA faces in attracting and retaining qualified mental health personnel, we feel that this could be an excellent program that could help fill the staffing needs Vet Centers are sure to face in the coming years.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Susan Edgerton
Senior Health Care Consultant
Vietnam Veterans of America
8605 Cameron Street, Suite 400
Silver Spring, MD 20910

Dear Susan:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
Subcommittee on Health Hearing on "Vet Centers", July 19, 2007
Follow-up Questions for Susan Edgerton

1. Staffing: The American Legion focused on Vet Center visits this year as part of the System Worth Saving Report that your organization has released since 2003. In your testimony you wrote that there were some Vet Centers that indicated that limited staffing was an overall challenge.

a. Could you tell us if there were certain areas, such as rural areas, that experienced staffing challenges more than others?

b. During your visits, did you find that any of the Vet Centers were actually maintaining a waiting list for veterans to receive services?

During the hearing, Dr. Batres stated that Vet Centers were able to provide intake services the same day the veteran requests help. We have no reason to dispute Dr. Batres, although it is unclear that there is equally ready access to requested services. We do note that the Chairman's own Oct. 2006 report on Vet Centers cited staffing challenges and waiting times in many of the 60 sites it reviewed. Since demand has grown since this time, we believe that any waiting times identified at that time have likely been exacerbated.

VVA does not collect waiting time data systematically, anecdotally we have heard that there is pressure on the Vet Centers systemwide. Rural areas are disproportionately represented by servicemembers in current deployments and most return to these areas after their service. It would be likely then that Vet Centers that serve largely rural populations of veterans may be subject to disproportionate demand. Recent press, including an April 29, 2007 article in the Boston Globe, "For Veterans in Rural Areas, Care Hard to Reach" spoke in general of problems severely injured service members have receiving follow up care for chronic illnesses and injuries. Such press suggests that there continues to be real challenges in these areas.

2. Military Sexual Trauma: In testimony, the VFW stated that they had some concerns with the Vet Centers being able to handle the increasing number of women veterans sure to seek treatment. Additionally, they stated that they would like to see an increase in treatment options and outreach efforts to women.

a. Has your organization been hearing complaints about the lack of MST counselors at the Vet Centers?

We are not aware of large numbers of women veterans who have complained about the lack of MST services, but that should not be confused for their lack of demand for services. Studies have identified high rates of sexual trauma among both genders during military service that continue in current deployments so there is clearly still a need for counseling. MST may reflect the experience of the women veterans clinics in that once women veterans knew there were services specifically available for them, they came to use them.

VA is required to provide assessment and referral for MST counseling at each VAMC. This may not be enough. VVA strongly urges the Committee to investigate how many qualified staff VA has recently hired to provide military sexual trauma counseling, how many veterans are being served by these programs, and whether veterans face obstacles accessing appropriate counseling services.

3. Challenges: In your organization's estimation, what are the top three challenges facing the Vet Center program today?

The continuing challenge for the Vet Center program is to provide high-quality, timely services to all eligible veterans. From VVA's perspective this requires not only staff with the right credentials, but also with the right experience. Staff should be bolstered at most Vet Centers to allow visits per veteran to return to pre-OIF/OEF levels. In addition, since the location of Vet Centers now reflects a pattern of need demonstrated by past generations of veterans, additional Vet Centers may be

necessary to meet the needs of veterans returning from current deployments. Since Vet Centers rely upon VA medical centers to provide more specialized medical care, VA mental health services should be bolstered across the board.

4. Education: Vietnam Veterans of America recommends that Congress fund "PTSD scholarships" to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. How does your organization feel about this idea?

VVA supports the concept of PTSD scholarships to fund the education of peer counselors who are prepared to pursue advanced degrees in clinical psychology. VA is already authorized to fund training for "professional, paraprofessional, and lay personnel" in order to provide readjustment counseling and related mental health services under Sec. 1712A of USC 38. Clinical psychology scholarships could follow models already in law in Chapt. 76, health professionals education assistance program which have funded education of other types of VA clinical personnel. Such assistance has included scholarships, scholarships in return for a pre-determined time of VA service, tuition reimbursement, or education debt reduction. The Committee might additionally consider specifically earmarking funding for PTSD training. VA might additionally consider programs for recruiting psychologists and psychiatrists specializing in PTSD who are already in practice.

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
August 2, 2007

Alfonso Batres, Ph.D., M.S.S.W.
Chief Readjustment Counseling Officer
Veterans Health Administration
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Alfonso:

In reference to our Subcommittee on Health hearing on "Vet Centers" held on July 19, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on October 2, 2007.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full and Subcommittee hearings. Therefore, we would appreciate it if you would provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Please provide your response to Cathy Wiblemo. If you have any questions, please call 202–225–9154.

Sincerely,

MICHAEL H. MICHAUD
Chairman

Questions for the Record
The Honorable Michael Michaud, Chairman
Subcommittee on Health
House Committee on Veterans' Affairs
July 19, 2007
Vet Centers

Question 1: Services: In your testimony you stated that in terms of service mission, readjustment counseling consists of a more-than-medical, holistic system of care and that Vet Center services include a number of other community-based services:

Question 1(a): Could you explain in more detail what you mean by "more-than-medical" and also give us some examples of the types of community-based services you work with?

Response: The term "more-than-medical," or more accurately "beyond medical," refers to the Vet Center program's unique role in attending to all of the service needs of the veteran considered as a whole person. Through this role Vet Centers

go beyond clinical counseling to help veterans transcend and cope with war-related traumatic experiences from combat. These services include providing, or coordinating, services for veterans related to family and work readjustment; post-military education and career planning; and other general issues related to the adoption of a satisfying and productive role in the civilian community. The latter serves to help veterans gain a sense of pride and confidence from having served their country through the military. Through outreach activities Vet Centers work to contact and inform veterans and family members of the services they provide. Vet Centers are active throughout the community offering educational sessions to community leaders and service providers about veterans and their service needs. Community-based interventions are necessary for establishing local contacts and building service partnerships that lead to veteran referrals to the Vet Center and VA. Vet Centers use these partnerships to help refer and coordinate services not directly provided by the Vet Center.

Question 2: Vet Center Expansion: In Fiscal Year (FY) 2007 and 2008 VA plans to expand the Vet Centers from the existing 209 locations to 232 locations.

Question 2(a): Would you tell us what the criteria is to establish a Vet Center?

Response: The site selection was based on an evidence-based analysis of demographic data from the U.S. Census Bureau and the Department of Defense (DoD) Defense Manpower Data Center (DMDC) and by input from the seven Readjustment Counseling Service (RCS) regional offices. The main criteria for new Vet Center site selection was the veteran population, area veteran market penetration by Vet Centers, geographical proximity to VA medical centers and community based outreach clinics, in the Vet Center's veterans service area (VSA). This analysis included information from the DMDC as to the current number of separated Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans and the reported distribution of home zip codes of separated OEF/OIF veterans as well as the number who were married and those with children. For some of the new Vet Centers special consideration in site selection was given to relatively under-served veterans residing in rural areas at a distance from other Department of Veterans Affairs (VA) facilities.

Question 2(b): Do you know what the projected cost of establishing these 23 new Vet Centers is?

Response: The projected cost for establishing the 23 new Vet Centers is $8.780 million.

Question 2(c): Does the cost include the appropriate level of staffing at each of the new Vet Centers?

Response: The planned Vet Center expansion calls for 17 new four-person Vet Centers and six new three-person Vet Centers for a total of 86 new staff positions. The projected cost is sufficient to support the planned staffing level, and the planning staffing is anticipated to be sufficient based upon the primarily demographic criteria used for targeting each site.

Question 2(d): Why are only three being activated this year? What is the reason for delay?

Response: While it is true that only three are currently planned to be activated this year, in 2007 the Secretary's February 7, 2007 news release regarding the Vet Center program expansion announced that six new Vet Centers were planned to be opened in fiscal year (FY) 2007. And yet by the end of FY 2007, VA had actually opened 10 of the new Vet Centers.

Question 3: Workload: There is concern that only a fraction of the OEF/OIF veterans that could potentially seek care at VA Vet Centers are actually seeking that care.

Question 3(a): Do you have a sense of your projected workload in the next 5 years?

Response: In terms of actual numbers of veterans served cumulative through the end of the FY 2007, the Vet Centers served a total of 254,784 OEF/OIF veterans. Of the total, 196,966 veterans were provided with outreach services primarily at demobilization sites, and 57,818 were seen in Vet Centers for substantive readjustment services. It is anticipated that the number of OEF/OIF veterans accessing Vet Center services will continue to increase as more veterans return from combat and as more veteran recipients of outreach services come into the Vet Centers for readjustment counseling.

Question 3(b): Have the Vet Centers seen an increase in women veterans seeking services for MST?

Response: No, the number of female veterans accessing services at Vet Centers for military sexual trauma (MST) has remained steady at approximately 2,000 a year for FYs 2005, 2006, and 2007.

Question 3(c): In your estimation, what is the fastest growing population that the Vet Centers are providing services to?

Response: Based upon the workload numbers provided above the OEF/OIF veteran population is the fastest growing veteran population served by Vet Centers. The total number of OEF/OIF veterans served by the Vet Centers more than doubled between FY 2005 and FY 2006, increasing from approximately 30 percent of all veterans served in FY 2005 to approximately 60 percent in FY 2006. These percentages include both OEF/OIF veterans provided with outreach services and those receiving readjustment services in the Vet Centers.

Question 4: Staffing: I believe that most would agree that the quality and satisfaction of services that the Vet Centers provide are very high. To maintain that level, adequate, appropriate staffing is needed.

Question 4(a): What challenges have you faced in trying to recruit and retain appropriate staff for the Vet Center mission?

Response: In general, Readjustment Counseling Service (RCS) recruits for qualified mental health professionals and other master degree counselors. Office managers and outreach specialists are recruited under separate skill sets. The Vet Centers also promote the hiring of veterans and staff diversity representative of the local veteran population. The hiring of staff from among the new OEF/OIF veteran population is a high priority to ensure cultural competence in serving this new veteran population. The Vet Centers have been successful in establishing a new cadre of 100 OEF/OIF veterans charged with the mission of providing outreach services to their fellow returning veterans. In addition to the cadre of OEF/OIF outreach workers, the Vet Centers have hired approximately 50 more OEF/OIF veterans into other Vet Center positions. A significant index to the Vet Centers' success in staff retention is reflected in the program's responses to the VA *All Employee Survey.* Results show Vet Center employees have a significantly higher level of job satisfaction.

Question 5: Gaps in Service: By the end of 2008, there should be 232 active Vet Centers. We know VA is continuously faced with providing care to the rural veteran Community.

Question 5(a): What challenges has the Readjustment Counseling Service faced in trying to meet the readjustment needs of the veteran in the rural community?

Response: The challenges to serving veterans are the same everywhere, to reach small populations of veterans dispersed over large geographic areas. Readjustment Counseling Service (RCS) has responded to the needs of rural veterans by locating several Vet Centers in areas accessible to rural veterans, by establishing Vet Center outstations in rural areas, and expanding outreach services into rural areas. In addition, the Vet Center program used its share of the FY 2007 supplemental funds provided by Congress to purchase mobile vans to be assigned to 50 Vet Centers to extend services into rural areas. Vet Center outreach efforts at National Guard and Reserve demobilization sites also enables Vet Center staff to track veterans to their home communities following their release from the demobilization site.

Question 5(b): In your estimation, where is the biggest gap in service for the Vet Center program?

Response: The Vet Center program expansion referenced above was planned to complement the efforts of the Vet Center OEF/OIF aggressive outreach campaign in effect since FY 2004. The expansion is essential to ensure sufficient staff resources are available to provide the professional readjustment services in Vet Centers needed by the new veterans as they return home from Afghanistan and Iraq. In addition to the 23 new Vet Centers, RCS is augmenting the staff at 61 existing Vet Centers. This entails a total of 150 new staff of which 78 have been hired. In addition, the Vet Centers have been authorized to hire an additional 100 staff each year in FY 2008 and FY 2009, to further augment the Vet Centers ability to address the readjustment needs of war veterans and their families. Collectively, starting from the first 50 OEF/OIF outreach specialists in 2004, the Vet Center program will realize a total of 473 new positions by the end of 2009, or a 50-percent increase over pre-2004 staffing levels.

Question 6: Outreach Efforts: Ensuring that veterans are aware of their benefits and services can be an enormous challenge.

Question 6(a): What efforts have you put forth to ensure that women and minority veterans are aware of services?

Response: Community outreach and education services have been an integral part of the Vet Center service mission for the 27 years of the program's history. Demographic analysis of the local veteran population is the prerequisite for effective outreach. Vet Centers have long maintained and exceeded the standard of serving local veterans in numbers representative in the military and in the local veteran population served by the Vet Center. Vet Centers promote representative diversity in *staff* composition and plan outreach events to target minority and women veterans in the community. Vet Center outreach activities also include veterans' family members to the extent feasible.

Question 6(b): Are Vet Centers experiencing an increase in these *veteran* populations seeking services at your locations?

Response: Vet Center levels of service delivery to these veteran populations consistently increases in proportion to their representation in the military.

In FY 2007, veteran clients served and staffing levels both exceeded levels of veteran representation for all ethnic groups facilitating culturally competent services. The information for each ethnic group is presented in the table below.

Ethnic Group	Clients Served	Staff	All Veterans	U.S. Population
African American	17.0%	19.0%	9.7%	11.3%
Hispanic/Latino	11.7%	9.8%	4.3%	11.0%
Asian American	1.4%	1.4%	1.1%	3.7%
American Indian	1.6%	1.7%	0.7%	0.8%
Hawaiian/Pacific Islander	1.7%	0.9%	0.1%	0.1%

Question 7: Staffing Composition: The American Legion described the four-person staff composition that is standard at Vet Centers.

Question 7(a): Is there a standard composition and can you please give us a brief description of the roles of team leader, office manager, social worker and psychologist?

Response: The four-person Vet Center team is the original prototype for a Vet Center dating back to 1979 when the program was established. Since then, some variability has been developed resulting in some Vet Center teams being established with three-person teams and others with five-person teams. In every case, a Vet Center team is structured with one team leader, one office manager and the remaining one to three positions functioning as Vet Center counselors. Team leaders divide their duties equally between direct service provision to veterans, supervisory and administrative functions. Office managers provide reception and administrative duties. Vet Center counselors spend their time in activities related to providing direct care to veterans and family members. Social workers, psychologists and other masters level counselors provided readjustment counseling tailored to their specific professional competencies.