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**OVERSIGHT HEARING ON SYSTEMIC INDIFFERENCE
TO INVISIBLE WOUNDS**

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS

UNITED STATES SENATE

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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JUNE 4, 2008
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OVERSIGHT HEARING ON SYSTEMIC INDIFFERENCE TO INVISIBLE WOUNDS

WEDNESDAY, JUNE 4, 2008

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9.30 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Tester, Sanders, and Burr.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The hearing of the U.S. Senate Committee of Veterans Affairs on Systemic Indifference to Invisible Wounds will come to order.

Before we begin, I want to share with you what happened yesterday. I want all of you to look up over the door and see what is there. I want to describe a ceremony that took place yesterday in our newly-renovated hearing room.

The room received a traditional Hawaiian blessing. I know you—our guests and witnesses and specifically Dr. Kussman—would have an idea about this.

You may notice the green lei that is draped over the top of the room's entrance. It is called *maile*, and in Hawaii that is a sacred lei that is made of a vine that is very symbolic because it is used by what we call the *ali'i*, or the people that are there in charge, and it connects the things that are separated; so, the symbolism there is good.

This is a lei we tied and untied at entry through the door during the blessing, and traditionally after the lei is used in the ceremony, it remains hung along the door's outline as you see it.

When the room was blessed, I was reminded of the Hawaiian concept of *Kuleana*, or responsibility. While many come to this room with different perspectives, all of us enter with the same *Kuleana*, and that is to honor veterans. And we want to do the best we can to honor veterans.

It is my hope that we will be mindful of *Kuleana* to the veterans of this Nation, and our Nation as a whole.

This morning we meet to discuss VA's commitment to PTSD, both in terms of treatment and compensation.

Recent events at the Temple VA Medical Center have raised concerns about the Department's dedication to the mental health needs of our returning servicemembers.

I stress, however, that this hearing is not simply about one facility or one clinician. This hearing is a part of the Committee's ongoing oversight of VA activities including VA mental health care.

Last month we learned that a VA official sent an email that appeared to deliberately conceal data on suicides. Now, we have another VA employee who appears to have linked the increase in veterans seeking compensation for PTSD with a desire to assign a lesser diagnosis of adjustment disorder—an action that alarmed many veterans and others.

One question that was raised repeatedly about this email was, and I quote, "why would a clinician be so concerned about the compensation rolls?" Unquote.

We must know whether the actions of these VA employees point to a systemic indifference to invisible wounds.

The Committee must understand how VA is dealing with PTSD and other mental health concerns relating to war-zone service.

We must ensure that veterans receive compensation for conditions related to their military service, and we must ensure they are getting appropriate care.

From the testimony submitted for today's hearing, it appears that VA takes the position that adjustment disorder is a rational differential diagnosis to give to a veteran while clinicians take the time to determine if PTSD is involved.

VA indicates that at Temple, whether a veteran has PTSD or not, the treatment is the same. This suggests to me that the diagnosis is meaningless if everyone gets the same treatment. It is my understanding that the reason a clinician makes a diagnosis is to inform treatment.

To the extent that there are issues or problems that exist regarding PTSD or other psychological issues related to service, the Committee must know what it can do to help ensure that veterans receive accurate diagnosis from VA, proper care and appropriate benefits.

The number of troops suffering from PTSD continues to mount. The numbers are staggering. With so many troops returning from multiple tours with various mental health issues, VA must have the credibility, resources and commitment to ensure that veterans are properly treated and appropriately compensated.

If anyone here is puzzled about the reason for this hearing, let me answer by using a letter I received yesterday from the brother of a young man with PTSD who committed suicide last year.

The brother writes, "For PTSD the stigma of the label must be removed starting prior to a veteran's discharge from the armed services and confidence in the Veterans Health Administration's ability to adequately treat the condition must be restored." This is why we are holding this hearing today.

Veterans and their families must be assured when they turn to VA, the Department is capable of caring for the veteran.

I am working with the Inspector General as his investigation related to Temple progresses; and we expect something formal in the

next couple of months. In the meantime, it is imperative that the Committee understand what is occurring.

In closing, I note that last night the Senate passed critical legislation on mental health care named for yet another young veteran who died tragically after returning home from service. His name was Justin Bailey.

Senator Burr and I worked to make this bill as focused as possible on PTSD and substance abuse. I look forward to seeing this bill through to the President's desk.

Again, I want to thank the witnesses for being here today and look forward to your testimony.

Now I would like to call on the Ranking Member, Senator Burr, for his statement.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Aloha, Mr. Chairman.

As I look up and see the Hawaiian decorations that appeared late yesterday and the ceremony—which I had the opportunity to meet your son and to know a little bit about the impact of that ceremony in this beautiful room where some of the most important work of this Congress is done—I want to thank you and your family for the personal commitment you have to make sure that we are blessed in more ways than we can imagine, and guided, as I was told last night, by the ceremony and what it will do.

Mr. Chairman, you called this oversight hearing today to address potential mental health issues in the VA. Last month we learned about the email that was sent at the Temple, Texas, VA Medical Center that caught the attention of the media and the attention of this Committee.

The email message contained references to, quote, “compensation-seeking veterans” and suggested to five other VA clinicians that they, quote, “refrain from giving a diagnosis of PTSD straight out.”

We will have an opportunity to understand that email from its author and I think that that will be helpful and informative to all of us.

Dr. Kussman is here. Admiral Dunne is here. They will have an opportunity to explain, as well, if there is a larger problem within the VA health care system and the benefits system.

Last month I joined with you, Mr. Chairman, in asking the Inspector General to look into this matter. We asked the IG to look into whether the email is evidence of a bigger problem with PTSD examinations at the Temple facility and whether any disability compensation claims were affected by those examinations.

My preference, to be totally honest, would have been to wait until the Inspector General completed his investigation before holding this hearing. I dare say that we do not hold a hearing that mental health is not a part of the hearing. But the decision was made and I am prepared to join you, Mr. Chairman, and other Committee Members to address any findings in the IG's report once it is completed.

We are moving toward today, quite frankly, without having all the facts. The title of today's hearing, Systemic Indifference to In-

visible Wounds suggests that some have already reached a conclusion. Based on the title, it appears they are prepared to use this email and maybe other emails, rightly or wrongly, as a springboard to launch into attacks on the system of VA care, as a whole.

There may be some areas of legitimate criticism, but I do hope that we can avoid impugning the professionalism of the entire cadre of VA health care workers to score any political points.

Let us be careful about damaging the confidence veterans have in our VA health care to the point that they stop seeking treatment. We ought to be encouraging veterans to seek mental health care.

Treatment is so important to me that I introduced a bill that would pay for their living expenses while participating in an effective program. So let us not destroy the progress we are hoping to make with the use of headline-seeking rhetoric.

If, however, it is the judgment of my colleagues that there is systemic indifference in how VA cares for veterans, then be prepared to give those veterans an option for their care. Let them go wherever they want for their care. It would not make much sense to continue funding a system that was indifferent to their needs. No amount of money can cure indifference.

Mr. Chairman, political headlines will not solve problems inside the VA. The Chair will decide whether policy or politics wins and drives this Committee.

Mr. Chairman, I will stay engaged regardless of the direction the Committee Members choose, focused on our veterans, thinking outside the box for solutions to complex health care issues, confident that a promise that we made in this country trumps any political agenda.

Mr. Chairman, our troops ignored party affiliations when they chose to serve. I believe that we have a responsibility to display a similar courage in how we approach the policies that fulfill that promise.

I thank the Chair. I yield the floor.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray.

**STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Thank you very much, Chairman Akaka and Senator Burr, for holding today's hearing to talk about the Department of Veterans Affairs' efforts to address the critical mental health care needs of our veterans.

Today's hearing, as we all know, is going to explore whether a recent email sent by a VA manager, directing staff to refrain from diagnosing PTSD in veterans, is an isolated case or whether it is representative of greater problems within the VA mental health care system.

Now, I know Secretary Peake has strongly condemned this email and said that it was an isolated case by a single practitioner in a single location, and I sincerely hope that this email is the only one of its kind. But I just have to tell this Committee I have reason to be skeptical.

It was just a few months ago that we learned about an email that was sent by Dr. Ira Katz, the VA's top mental health official, that started off by saying, "shhh," and indicated that the VA had downplayed the number of suicides and suicide attempts by veterans in the past several years.

It was not that long ago that Secretary Nicholson sent a letter to Congress saying that the VA had all the resources it needed, only to tell us just a short time later that, indeed, they were \$3 billion short. So, with all due respect to the witnesses, I have to take the VA's explanations with a grain of salt.

Now, one of the most frustrating things about this latest episode is that it furthers the perception, the perception that the VA is shortchanging our veterans. Citing, quote, "compensation-seeking veterans," the email in question encourages VA practitioners to avoid diagnosing veterans with PTSD in order to save time and money.

After years of trying to get the VA and the Administration to be honest about the cost of caring for our veterans, it is very frustrating to read this email and see that it clearly indicates that resources are an issue in getting our veterans both the proper diagnosis and the care they need.

So, to me this email is really a sad reminder that this Administration's attempt to play down the cost of war or the cost of taking care of our veterans has begun to actually affect the way that VA employees view their own work. VA officials should be more focused on providing a lifeline to our veterans than on meeting a bottom line that this Administration has put above all else.

And so, today it is our responsibility to find out what else needs to be done to ensure that our veterans are not being shortchanged due to a lack of resources. And we, on this Committee, know the stakes have never been higher. According to the RAND Corporation, one in five troops who have returned from Iraq and Afghanistan have PTSD or severe depression.

Last week, the Pentagon released a report showing that PTSD cases increased by 50 percent in 2007, and just a few days ago the Army reported that the number of soldiers who committed suicide in 2007 is the highest it has been in decades. It is well past time that every VA official, particularly those setting policy for their employees, take the psychological wounds of war just as seriously as the physical injuries.

Now, despite my grave concerns about the candor of senior VA officials and the shortcomings of the President's budget, I continue to believe that the VA is the best and most appropriate place for veterans to receive health care. The VA, unlike any other health care organization in this country, is uniquely prepared to care for the distinct wounds of war.

VA staff across this country work their hearts out to get our veterans the care they need and deserve every day. They have a very hard job.

The stigma in our society surrounding mental health care deters a great number of veterans from seeking help. That is why we need to be doing everything we can to encourage veterans with psychological wounds to go to the VA to get the care they need and that they have earned; but time and again we have seen the VA under-

mine its own employees and make their jobs harder, and the email from Dr. Perez is only the latest example, but it is a striking one.

So, Mr. Chairman, it is appropriate that we take a look at this today to find out the extent of the problem, to make sure that the VA truly, from the top to the very bottom, is seeking these veterans, getting them the help they need, and not just saying we do not have the resources, we cannot take care of it.

It is our job, as Members of Congress, to make sure they have the resources they need. Without the accurate information, we are just incapable of doing that.

So thank you very much for holding this important hearing, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.
Senator Brown.

**STATEMENT OF HON. SHERROD BROWN,
U.S. SENATOR FROM OHIO**

Senator BROWN. Thank you, Mr. Chairman. Senator Burr, thank you and Senator Murray for your comments always.

Dr. Kussman, thank you for your meeting with and talking about mental health issues with the Dayton Development Coalition. I appreciate that some time ago.

When President Bush was inaugurated, he pledged our Nation this goal. He said, "When we see that wounded traveler in the road to Jericho, we will not pass on the other side."

This hearing should be about how we are going to care for those men and women who have traveled to the other side of the world for us and back. We should be working together to openly start filling the gaps, closing loopholes, improving the benefits and services available to vets. Yet here we are again, hearing testimony from an Administration on the defense. Instead of following the example of the Good Samaritan, the Bush Administration has been too often passing to the other side of the road.

One news story after another has documented the proposed scheme, as Senator Murray said, to obscure the true numbers of soldiers with Post Traumatic Stress Disorder.

The *Cleveland Plain Dealer* writer, Elizabeth Sullivan, in reaction to this discovery, wrote, "The VA should not be limiting care and tightening hatches on information leaks. It should be adding to services for weary and traumatized veterans." Ms. Sullivan was married for many years to a Vietnam veteran, who is since deceased.

It is shameful the Administration would treat injured veterans in such a cavalier manner. It is also incredibly shortsighted. The men and women who serve in our military—as we all know and we all talk about here, and you all talk about—have proven themselves time and again. They enrich our workforce when they return. They strengthen our communities when they are back State-side.

When we ignore veterans' injuries or deny a veteran care or do not take care of veterans who want to go to school, we are not only shortchanging them, we are shortchanging our economy and our society.

Look at the flip side: what happened after World War II when we really did take care of veterans in terms of health care and education the way that we should.

In the last 15 months, I have held some 100 round tables around my State—gatherings of 15 and 20 people whom I just listen to talk about their concerns in some 60-plus counties in my State—and I have heard from many veterans many of these same concerns that we talk about ad nauseam on this Committee.

The answer is not for the VA to fail and then privatize the VA. We have seen that in part with Medicare. We have seen it as part of a political philosophy in town. The answer is to make the VA work, to fund it as we should and to make it work. There is simply no reason we cannot do that, and I look forward to working with all of you.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Brown.

Senator TESTER.

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Chairman Akaka, Ranking Member Burr. It is a pleasure to be here. Unfortunately, I wish we were talking about something more pleasant.

It would be the easiest thing in the world for me or my colleagues to sit up here and talk about how outrageous some of the emails are that have come out of the VA recently. I will just tell you, it is a baseline set of information without honesty, without honesty of diagnosis, without honesty of care, without honesty of a realization that there is a problem, a systematic problem in the VA right now that is apparent to me. I do not know that the VA culture will change.

There is a lack of urgency among many of the bureaucrats and a continued unwillingness to let the needs of our veterans drive the VA budget. Instead budgets have been bean counted and seem to come before the actual needs of our veterans. I think that is very unfortunate.

Even after we have renewed the focus on the plight of the wounded warriors caused by the Walter Reed scandal, even after 18 months of what I think is some greater oversight by this Committee, even after a much needed change in leadership at the top of the VA, the problems still exist.

And to be blunt, I am frustrated by the fact that whether I am asking about veterans suicides or construction of new clinics, the answer from the middle layers of the VA bureaucracy seems to be the same, we will deal with it when we can; it is not a big deal. Well, it is a big deal. The good news is when I talk to the Secretary himself, I get a much better response and that is good news.

But, it should not have to be that we have to work this hard to make the system work. It should not be a matter whether the Congress is trying to get some information about how we are going to help our veterans or whether an individual veteran is trying to get the benefits that he or she has earned. So, we need some answers today.

The witnesses, myself, and other Members of this Committee are in this business for a reason. That reason is that we all believe that getting benefits and better health care for our veterans is not something we do to feel good about ourselves. It is not something we do to spend taxpayers' money. It is something we do because our Nation has made a promise to the fighting folks in this country: that after they served our country, our country will serve them. And the VA is the organization that bears responsibility for the entire country for a follow-through on that promise.

In many cases it is happening and good jobs are being done, but it is not happening in a lot of cases, and I regret to say that in the cases where it did not happen, everyone is falling short of doing their job; and as a result, our country is falling short of doing its job. And when we fail a single veteran, it is unacceptable.

I, too, have spent a lot of time with doctors and nurses and right on down the line to the maintenance staff in VA facilities in the State of Montana. Almost every person out these hundreds of employees understand this concept. But when it comes to the managers, I am not sure that they understand it.

So, I hope that the witnesses are prepared and are able to talk a little bit about what each of them is doing to make sure the VA culture is changing from "business as usual." I would very much like to hear your thoughts on this and I have a number of other questions that we can do during the questioning rounds.

You folks are here for a reason. You are the easiest folks for us to talk to and you will get the brunt, and that is good, but the truth is that I have talked to veterans, I have talked to staff, and things need to change.

Now, I do not know if it is because we do not have enough veterans working in the VA. Maybe that is the problem. Or if it is because people do not understand the urgency, the special urgency with what is going on with returning soldiers from Iraq and Afghanistan. But I will tell you this, it has to change and I have a tremendous amount of respect for Secretary Peake. I think he is a good man, but he cannot do it alone. Things have to change. And I can give you example after example where I have talked to people within the VA and have not been told the whole story; I have been told part of the story.

I will tell you guys the same thing I told the head of the VA in Montana, I am not here to fight you. I am here to help you. I am here to help you to make sure the promises we made to our veterans become a reality, and that is it. That is all I want to do.

So with that, thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.
Senator Sanders.

**STATEMENT OF HON. BERNARD SANDERS,
U.S. SENATOR FROM VERMONT**

Senator SANDERS. Thank you, Mr. Chairman. I apologize for being here late. And thank you, guests, very much for being here. Thank you for calling this important hearing.

Very clearly, I think there is a reality taking place today that is a new reality. I think, generally speaking, we understand from an historical perspective that when soldiers have been wounded in a

conventional military sense, gunshot wounds or amputation needs, the VA has done an extraordinarily good job.

But, I think, increasingly, what we also understand is that we have what we call invisible wounds. Maybe it was Gulf War syndrome that I worked on very hard when I was in the House. Maybe it is Post Traumatic Stress Disorder, maybe it is Traumatic Brain Injury—something where somebody has not lost an arm or a leg.

It appears that the VA has not been as effective as it might, and I think it has something to do with the culture, perhaps, of the military where if you lose an arm or you lose a leg, you are wounded. But if you come home with PTSD or TBI and you are walking or talking, well, maybe. Are you really wounded or maybe you are a little bit wimpy, or whatever the case may be.

And I think the thrust of what you are hearing and have been hearing for a number of months is that the evidence is overwhelming: that what we are seeing today in terms of PTSD, what we are seeing in terms of TBI—which is what is called the signature injury of this war—is that tens and tens and tens of thousands of our soldiers are being impacted. And we need a culture now within the VA that begins to understand and address that reality.

In my State and in every State in this country, men and women are coming home who are not getting their lives together. They are drinking too much. They cannot do their jobs. They are getting fired from their work. They are turning to drugs. Their marriages are falling apart. And that is absolutely as important as other types of injuries; and we need a culture in the VA which appreciates that. We also understand that issues like TBI are very difficult to diagnose as being issues separate from PTSD. Often they go together, and how to pull them apart is something that is not so easy and that requires a lot of work.

But I think the most important thing that we need from the VA is an absolute commitment to understand that these so-called invisible injuries are wrecking havoc on tens of thousands not only of soldiers, but of their families and of their children. And we consider it as important an injury as any other. So, we need a culture and an approach that effectively addresses those issues.

I should mention, Mr. Chairman, that in my own State of Vermont, one of the things that we did is recognize that no matter what kind of treatment the VA may have, it is not going to do anybody any good unless our families and our soldiers get to that treatment, which speaks to the need for an effective outreach program.

And then when you are dealing with outreach, you understand that PTSD is a different type of injury. It is not something—by definition, it is not an injury where some guy is going to stand up and you say, “I am in pain. I am drinking too much. I am on drugs. My marriage is falling apart. Help me.” That is not necessarily what happens.

So you have got to figure out a way to connect with those men and women and bring them into the system. Then you have to figure out a way to create the kind of support systems that they need and provide the individual treatment; none of which is easy. A lot has been thrown on you. This war, among many other things, has

given you hundreds and hundreds of thousands of soldiers from all walks of life who need help.

I come from a rural State. That means a lot of our guys are coming home from the National Guard. They are living in small towns. They do not have the infrastructure of the U.S. Army. How do you address that? We need help on that as well.

But I think, Mr. Chairman, clearly we need a culture in the VA that recognizes that these problems are quite as significant in people's lives as other problems and we want the VA to step up to the plate and address them.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

I want to welcome today's panel of witnesses from VA.

First, I will welcome Dr. Norma Perez, Mental Health Integration Specialist, Austin Outpatient Clinic and former PTSD Clinical Team Coordinator at the Temple, Texas VA Medical Center.

Next, I will welcome Dr. Michael Kussman, Under Secretary for Health. He is accompanied by Dr. Ira Katz, Deputy Chief Patient Care Services Officer for Mental Health.

Finally, I welcome Admiral Patrick Dunne, Acting Under Secretary for Benefits and Assistant Secretary for Policy and Planning. He is accompanied by Mr. Brad Mayes, Director of Compensation and Pension Service.

I thank all of you for being here today. Your full statements will appear in the record of the Committee.

Dr. Perez, will you please begin with your statement.

STATEMENT OF NORMA J. PEREZ, Ph.D., MENTAL HEALTH INTEGRATION PSYCHOLOGIST, AND FORMER COORDINATOR, PTSD CLINICAL TEAM, TEMPLE, TEXAS VA MEDICAL CENTER

Ms. PEREZ. Good morning, Mr. Chairman and Members of the Committee. Thank you for inviting me here to discuss the quality of mental health care Central Texas veterans are receiving in the Temple PTSD Clinic.

As the daughter, niece, sister, and cousin of Army, Navy and Marine veterans, I have a personal commitment to my work, and I have been blessed with the gift of trust from many East Coast and Central Texas veterans. They instill the passion for my work.

I started working for the Central Texas Veterans Health Care System in June 2007 as a psychologist and program coordinator of the Post Traumatic Stress Disorder Clinical Team.

I came to VA after completing a National Cancer Institute Research Fellowship at the University of Texas, Health Science Center at Houston, School of Public Health.

Prior to that, I completed a clinical postdoctoral fellowship at Brown University. I earned my Ph.D. in clinical psychology from the University of Rhode Island, and I completed a clinical internship at the Edith Nourse VA Medical Center in Bedford, Massachusetts.

I realize the Committee is interested in learning more about an email I sent to my team on March 20th so I will provide some context for that message and explain its purpose.

My written statement, which I asked to be submitted for the record, discusses the approaches and treatment provided by the Temple PTSD clinical team.

The Central Texas Veterans Health Care System offers specialized mental health care through the Temple PTSD Clinical Team, or the PCT. Although we are a PTSD clinic, we have been able to offer treatment to any veteran displaying any symptoms of combat stress.

Combat stress is a normal reaction to abnormal events. It can occur immediately following an event or many years later, but in either situation, we stand ready to assist the veteran.

Combat stress can manifest itself in different clinical conditions, including PTSD and Adjustment Disorder. We know we can improve the lives of veterans by teaching them coping strategies and other skills to reduce their level of distress and improve their quality-of-life, and this is exactly what we do in Central Texas.

All of our clinicians are trained to use the guidelines published within the Diagnostic Standards Manual-IV for clinical diagnosis of mental health conditions, including PTSD.

Individual providers develop a rapport and trust with each patient and it is through this that the veteran is able to safely convey their experiences and symptoms.

Although PTSD is sometimes recognizable as early as the first few sessions, veterans often need more time to fully disclose their trauma and its impact on their lives.

Several veterans expressed to my staff their frustration after receiving a diagnosis of PTSD from a team member during an initial intake when they had not received that diagnosis during their compensation and pension examination. This situation was made all the more confusing and stressful when a team psychiatrist correctly told them, they were displaying symptoms of combat stress but did not meet criteria for the diagnosis of PTSD.

Because veterans were receiving conflicting messages from the team, I thought it was necessary to provide further guidance. As an extension of ongoing discussions and to address the frustrations of veterans, I sent an email to my staff on March 20th emphasizing careful evaluation of a patient's symptoms to ensure consistent and accurate diagnosis.

The Temple PCT fully supports the compensation process and the Department's policy of erring in the best interest of the veteran whenever there is any doubt.

In retrospect, I realize I did not adequately convey my message appropriately, but my only intent was to improve the quality of care our veterans received.

I would like to conclude by discussing what a diagnosis of Adjustment Disorder with rule out for PTSD means.

When a clinician makes a diagnosis, he or she is considering the patient's symptoms and conditions that would explain them. Many conditions look very similar to one another and sometimes it is important to identify the likely diagnosis while noting in the patient's record to test for possible alternatives.

For example, a patient with chest pains could have indigestion or could be experiencing the early effects of a heart attack. Based on initial information, a clinician would determine the most likely

diagnosis, heartburn, but note in the record the need to rule out a heart attack and proceed with further assessment. In clinical shorthand, that diagnosis would be indigestion, rule out heart attack, which would prompt further testing.

The diagnostic note actually means, “do not forget this diagnosis” and serves as a reminder for further investigation into multiple possible conditions.

In the context of mental health and my email, I believed that it was important to remind the team clinicians of the diagnosis of Adjustment Disorder, which is a clinically sound diagnosis and will result in the appropriate treatment while continuing the assessment process for a possible PTSD diagnosis.

Mr. Chairman, I am happy to report Central Texas veterans are receiving the care that honors our pledge to care for those who have sacrificed in service to this Nation.

This concludes my prepared statement and I am ready to address the Committee’s questions.

[The prepared statement of Ms. Perez follows.]

PREPARED STATEMENT OF DR. NORMA PEREZ, MENTAL HEALTH INTEGRATION
PSYCHOLOGIST, CENTRAL TEXAS VETERANS HEALTH CARE SYSTEM

Good morning, Mr. Chairman and Members of the Committee. On behalf of Bruce Gordon, Director of the Central Texas Veterans Health Care System, and Timothy Shea, Director of the VA Heart of Texas Health Care Network (VISN 17), thank you for inviting me here to discuss the quality of mental health care Central Texas veterans are receiving in the Temple PTSD Clinic. As the daughter, niece, sister, and cousin of Army, Navy, and Marine veterans, I have a personal commitment to my work, and I have been blessed with the gift of trust from many East Coast and Central Texas veterans—they instill my passion for my work.

I started working for the Central Texas Veterans Health Care System in June 2007 as a psychologist and program coordinator of the Post Traumatic Stress Disorder (PTSD) Clinical Team. I came to VA after completing a National Cancer Institute Research Fellowship at the University of Texas Health Science Center at Houston, School of Public Health. Prior to that, I completed a clinical postdoctoral fellowship at Brown University. I earned my Ph.D. in clinical psychology from the University of Rhode Island and completed a clinical internship at the Edith Nourse VA Medical Center in Bedford, Massachusetts.

The Central Texas Veterans Health Care system offers specialized mental health care through the Temple PTSD Clinical Team (PCT). This Clinical Team provides treatment only. Although we are a PTSD Clinic, we have been able to offer everyone treatment who displays any symptoms of combat stress. Combat stress is a normal reaction to abnormal events. It can occur immediately following an event or many years later, but in either situation, we stand ready to assist the veteran. Combat stress can manifest itself in different clinical conditions, including PTSD and Adjustment Disorder. Simply reporting combat-related stress is insufficient for an accurate diagnosis, in the same way that chest pain would be inadequate for determining whether a patient was suffering from heartburn or a heart attack. Regardless of how combat stress appears, our staff can make an initial diagnosis of a combat-stress related disorder and begin treatment immediately. We know we can improve the lives of veterans by teaching them coping strategies and other skills to reduce their level of distress and improve their quality-of-life, and this is exactly what we have been doing for the last year in Temple.

Many individuals with symptoms of combat stress are not ready to discuss the details of their experiences, but they can describe their symptoms and their levels of distress. An accurate diagnosis of PTSD, however, would require a veteran fully disclose the details and feelings associated with a traumatic event, and in my clinical experience, many have been unwilling to do this without a strong sense of safety and trust, which can only be developed over time. Rather than deter veterans from seeking treatment by requiring them to provide more information than they feel comfortable, we believe it is essential to begin providing care and support immediately. The Temple PCT Team invites individuals into treatment if they exhibit any symptoms of combat stress and works with them to develop skills and strategies to

reduce or eliminate those symptoms. Based on follow up data, this approach has proven effective in reducing the distress levels of veterans.

Our phases of treatment are generally the same for all veterans, regardless of their specific condition. We begin by teaching veterans skills and strategies they can use to address the specific combat stress symptoms they describe. This process usually lasts 8–9 sessions, although we continue to measure the veteran’s self-reported level of distress throughout the course of treatment and we often notice improvement after only a few appointments. The second phase of treatment, for those willing to pursue it, involves exposure therapy. In this phase, we explore the most distressing trauma and work with the veteran through any of several different approaches to allow them to reprocess the trauma. This helps our patients cope with their feelings and memories in a safe and therapeutic environment. The final phase of treatment is available to all veterans and involves episodic follow up at the veteran’s request. While the strategies and therapy we teach veterans work very well for the initial trauma, future stressful situations, such as the loss of a job or a family member, may trigger additional anxiety and re-aggravate the veteran’s condition. Our staff is available to veterans any time they need it to help them cope with these new problems.

All of our clinicians are trained to use the guidelines established within the Diagnostic Standards Manual IV for clinical diagnosis of mental health conditions, including PTSD. I sent an email to my staff on March 20 to stress the importance of an accurate diagnosis. Many of the veterans we treat in Temple have already undergone an examination for Compensation and Pension benefits, and our sole mission at the Temple PCT is to provide treatment to veterans in need. Although our clinic is a treatment clinic, we all fully support the compensation process and the Department’s policy of erring in the best interest of the veteran whenever there is any doubt.

Several veterans expressed to my staff their frustration after receiving a diagnosis of PTSD from a team member at Temple when they had not received that diagnosis during their Compensation and Pension examination. This situation was made all the more confusing and stressful when a team psychiatrist correctly told them they were displaying symptoms of combat stress, but did not meet criteria for the diagnosis of PTSD. Veterans were receiving conflicting messages from the team and I believed it was important to resolve this situation by providing further guidance while not blaming any specific clinical approach. In retrospect, I realize I did not adequately convey my message appropriately, but my intent was unequivocally to improve the quality of care our veterans received.

In conclusion, Mr. Chairman, I am happy to report Central Texas Veterans are receiving care that honors our pledge to care for those who have sacrificed in service to this Nation. This concludes my prepared statement and I am ready to address questions from the Committee.

Chairman AKAKA. Thank you very much, Dr. Perez.
Dr. Kussman.

**STATEMENT OF THE HONORABLE MICHAEL J. KUSSMAN, M.D.,
UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VET-
ERANS AFFAIRS; ACCOMPANIED BY IRA KATZ, M.D., DEPUTY
CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL
HEALTH**

Dr. KUSSMAN. Mahalo, Mr. Chairman, and Members of the Committee. Good morning.

Thank you for mentioning earlier my time in Hawaii and my appreciation of the blessing of this room. And I hope the blessing allows all of us together to do what we are here for, which is to provide the best service for all of our veterans.

Thank you for the opportunity to discuss the VA’s mental health services with you today.

I realize that you are concerned by an email sent from the program coordinator of the Post Traumatic Stress Disorder clinical team in Temple, Dr. Perez.

The email, as characterized by others, does not reflect the policies or conduct of our health care system.

Let me be very clear. Any suggestion that we would not diagnose a condition, any condition, is unacceptable and I, as a veteran and a retiree, would not tolerate such a position for personal and professional reasons.

I will further state for the record that not only was there no systemic effort to deny diagnosis, but there was not even an individual effort to that end.

However, the perception remains. So, we welcomed the opportunity to appear before you today to explain the VA's commitment to an honest and accurate diagnoses for every veteran for every diagnosis. That this perception continues is very unfortunate and how it has unfairly damaged the reputation of VA's dedicated health care employees.

I was going to mention that with me is Dr. Perez, but obviously that has already taken place.

I am grateful to the Committee for giving her the opportunity to speak for herself and I will, therefore, not say anything further about her email or about the specific situation in Temple.

Delivering world class mental health care to enrolled veterans is a requirement that the VA and VHA take extremely serious. VA plans to spend more than \$3.5 billion for mental health services in fiscal year 2008 and project \$3.9 billion in fiscal year 2009.

We are proud of our accomplishments in this area. Many health care professionals have recognized the VA's leadership in this area and I firmly believe no one receives better mental health care in this Nation than veterans enrolled in the VA for care.

This is particularly true for veterans with Post Traumatic Stress Disorder, an area in which the VA is nationally and internationally recognized, both for its research work and its ability to deliver outstanding care.

Although the quality of VA health care has been found equal to and often superior to that furnished anywhere, "best care anywhere" has been mentioned in numerous publications, the popular perception of the quality of VA care is something less than favorable. It is unfortunate and undeserved.

Some continue to believe that health care services furnished by a government system can never be as good as those delivered by the private sector. In many cases we have not done enough to educate the public about VA's many achievements and outstanding programs and we could do more to ensure our own health care employees are informed about the Department's recognized awards and achievements outside their own area of expertise.

VA and this country have much to be proud of in terms of the health care provided to veterans by the very skilled and talented cadre of VA clinicians—not to mention our researchers—who continue to improve the clinical care veterans receive.

Improving VA's mental health services has been an active pursuit of the Department for many years.

In 2004 we developed a mental health strategic plan that was both unprecedented and widely acclaimed within the mental health community. Through that effort we began to address gaps in the mental health services provided at the local level and to initiate programs at the national level.

This plan was intended to serve as a guide for 4 or 5 years. During that time we have continually reassessed our progress and amended the strategic plan based on new information particularly concerning new evidence-based standards of care and improvements in the delivery and mental health services. We continue to periodically re-access the plan as appropriate.

As I alluded to earlier, the strategic plan was designed to incorporate evidence-based treatments wherever possible, encourage system redesigned activities and move our system to a recovery-based model as required by the President's New Freedom Commission for Mental Health.

For these significant changes to be successful, they must be accompanied by a major educational effort appropriately targeted at our staff and clinicians and patients. I now believe, in retrospect, that we have not done as good a job as we should have to educate veterans and our staff.

As we have initiated new programs that emphasize recovery models for our newest veterans, we have, in some places, not adequately responded to the needs of those who use and have benefited from our existing programs such as group therapy sessions for combat theater Vietnam era veterans.

In addition, some of our own providers have not thoroughly understood our new approach, unfortunately compounding the confusion experienced by veterans at those sites.

In response, we have developed an aggressive communication and education plan for both clinicians and veterans which will be launched shortly. Be assured that despite these inadvertent but significant educational or communication lapses, our commitment to our veterans and to improving their health status is unwavering. Their well being and their continued improvement to fully functional status has always been the objective of the strategic plan.

We will work even harder to ensure that all understand the needs of different groups of veterans and will keep them apprised of further changes based on newer evidence.

As we have always sought to do, we will do the right thing for every veteran who has entrusted us with his or her care—one veteran at a time. We will do more to make sure our decisionmaking process for these clinical policy determinations is open and transparent to veterans.

Moreover, we will work with Members of this Committee, with other mental health professionals and with veterans themselves to ensure veterans continue to receive the highest quality care available.

In summary, Mr. Chairman, I am very proud of what the VA does in the area of mental health. More than 200,000 people are fully committed to helping veterans receive the health care benefits they have earned through their service and their sacrifices.

I hope we can continue to move forward from this episode and help veterans and their families, Congress and the news media, and others to better understand what the VA has done and is doing to fulfill our Nation's commitment to those who have worn the uniform of our armed services.

Mahalo nui loa.

[The prepared statement of Dr. Kussman follows.]

PREPARED STATEMENT OF MICHAEL J. KUSSMAN, MD, UNDER SECRETARY FOR
HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee, good morning. Thank you for the opportunity to discuss VHA's mental health services with you today. I am aware that today's hearing had its origins in the situation that recently arose in our Temple, Texas facility. On March 20, 2008, a VA psychologist and program coordinator for the Post Traumatic Disorder (PTSD) sent an internal email to the PTSD Clinical Treatment Team. The email, as characterized by others, does not reflect the policies or conduct of our health care system. The email has been taken out of context, though we certainly agree that it could have been more artfully drafted. This is an unfortunate situation, which has also unfairly damaged the reputations of VA's dedicated and committed health care employees. The erroneous characterization may also hurt veterans and their families, as some of them may call into question the quality of VA's health care. As a result, those individuals may not seek needed medical care from the Department, leaving their health care needs unaddressed.

At the witness table with me is Dr. Norma Perez, who wrote the email in question. As I have stated, Dr. Perez' motives and actions have been unfairly characterized by others. I am grateful to the Committee for giving her the opportunity to speak for herself, and I will therefore not say anything further about her email or about the specific situation at Temple.

VA has been, and remains, absolutely committed to delivering world-class mental health care to enrolled veterans. We are very proud of our accomplishments in this area. VA will spend more than \$3.5 billion for mental health services in Fiscal Year 2008, and we are very proud of our accomplishments in this area. Indeed, many mental health professionals and organizations outside the Department have recognized VA's leadership in this area, and I firmly believe that no one receives better mental health care in this Nation than veterans enrolled in VA's health care system. This is particularly true for veterans with Post Traumatic Stress Disorder (PTSD). VA is nationally recognized for its outstanding PTSD treatment and research programs. Although the quality of VA health care has been found equal to, and often superior to, that furnished elsewhere, the popular perception of the quality of VA care is sometimes less favorable. This is unfortunate and undeserved. Some continue to believe that health care services furnished by a government system can never be as good as those delivered by the private sector. In many cases, we have not done enough to educate the public about VA's many achievements and outstanding programs. And we could do more to ensure our own health care employees are informed about the Department's recognized awards and achievements outside their own areas of expertise. VA and this country have much to be proud of in terms of the health care provided to veterans by the very skilled and talented cadre of VA clinicians, not to mention our researchers who continue to improve the clinical care veterans receive.

Improving VA's mental health services has been an active pursuit of the Department for many years. In 2004, we developed a Mental Health Strategic Plan that was both unprecedented and widely acclaimed within the Mental Health Community. Through that effort, we began to address gaps in the mental health services provided at the local level, and to initiate programs at the national level. This plan was intended to serve as a guide for four to five years. During that time, we have continually reassessed our progress and amended the strategic plan based on new information, particularly concerning new evidence-based standards of care and improvements in the delivery of mental health services. We continue to periodically reassess the plan, as appropriate.

As alluded to earlier, the strategic plan was designed to incorporate evidence-based treatments wherever possible; encourage system redesign activities; and move our system to a recovery-based model as required by the President's New Freedom Commission for Mental Health. For these significant changes to be successful, they must be accompanied by a major educational effort appropriately targeted at our staff and clinicians. I now believe, in retrospect, that we have not done as good a job as we should have to educate veterans and our staff.

As we have initiated new programs that emphasize recovery models for our newest veterans, we have, in some places, not adequately responded to the needs of those who use, and have benefited from, our existing programs, such as group therapy sessions for combat-theater Vietnam era veterans. In addition, some of our own providers have not fully understood our new approach, unfortunately compounding the confusion experienced by veterans at those sites. In response, we have developed an aggressive communication and education plan for both clinicians and veterans, which will be launched in the coming weeks.

Be assured that despite these inadvertent, but significant, educational and communication lapses on our part, our commitment to our veterans and to improving their health status is unwavering. Their well-being and their continued improvement to fully functional status has always been the objective of the strategic plan. We will work even harder to ensure we are fully sensitive to veterans' needs from this point forward and will keep them apprised of further changes based on newer evidence.

As we have always sought to do, we will do the right thing for every veteran who has entrusted us with his or her care—one veteran at a time. We will do more to make sure our decisionmaking process for these clinical policy determinations is open and transparent to veterans. Moreover, we will work with Members of this Committee, with other mental health professionals, and with veterans themselves to ensure veterans continue to receive the highest quality care available.

At this time, Mr. Chairman, let me talk more generally about the status of mental health care in our Department. VA strongly believes that fully addressing the physical and mental health needs of veterans is essential to their successful re-integration into civilian life. As evidence of that commitment, we plan to spend more than \$3.5 billion in Fiscal Year (FY) 2008 for mental health services and the President's Budget has allocated \$3.9 billion for that purpose in FY 2009.

Mental health care is being integrated into primary care clinics, Community Based Outpatient Clinics, VA nursing homes, and residential care facilities. Placing mental health providers in the context of primary care for the veteran is essential; it recognizes the interrelationships of mental and physical health, and also provides mental health care at the most convenient and desirable location for the veteran.

In contrast to the private sector, whenever a veteran is seen by a VA provider, he or she is screened for PTSD, military sexual trauma, depression, and problem drinking. Screening gives us an early opportunity to assess and treat the veteran for any identified problem. Our clinicians act on positive screens, and we will continue to monitor their compliance with our national screening directives.

VA employs full and part time psychiatrists and psychologists who work in collaboration with social workers, mental health nurses, counselors, rehabilitation specialists, and other clinicians to provide a full continuum of mental health services for veterans. We have steadily increased the number of these mental health professionals over the last 3 years. We have hired more than 3,800 new mental health staff in that time period, for a total mental health staff of over 16,500. VA will continue expanding our mental health staff and also will continue to expand hours of operation for mental health clinics beyond normal business hours.

We have reduced wait times throughout our system. At Temple, for example, 99.58 percent of all mental health appointments are within 30 days of the desired appointment date. Nationwide, the percentage is 99.34 percent—and for veterans with PTSD, the percentage rises to 99.66 percent. We've also set standards for timeliness in our Compensation and Pension Examinations. Nationally, our average in March is 28 days to process these exams; Network 17, in which Temple is located, processed exams in 22 days.

Our Department will continue to aggressively follow up on patients in mental health and substance abuse programs who miss appointments to ensure they do not miss needed, additional care. VA will also continue to monitor the standards the Veterans Health Administration has set for itself: to provide initial evaluations of all patients with mental health issues within 24 hours, to provide urgent care immediately when that evaluation indicates it is needed, and to complete a full evaluation and initiate a treatment plan within 14 days for those not needing immediate crisis care. At present, 93.4 percent of all veterans seeking mental health care receive full evaluations within 14 days. VISN 17 has a percentage exactly equal to the national average.

On May 1, VA began contacting nearly 570,000 combat veterans of the Global War on Terror to ensure they know about VA medical services and other benefits. The Department will reach out to every veteran of the war to let them know we are here for them. Last month, we completed calls to more than 15,000 veterans who were sick or injured while serving in Iraq or Afghanistan. If any of these 15,000 veterans do not now have a care manager to work with them to ensure they receive appropriate health care, VA offered to appoint one for them.

While the numbers of veterans seeking VA care for PTSD is increasing, VA is monitoring parameters (such as time to first appointment for new and established veterans of all service eras) to ensure they receive prompt and efficient services for PTSD and other mental disorders. In FY 2009, funding enhancements will close gaps in services and allow us to implement a more comprehensive and uniform package of clinical services for PTSD and other disorders.

The Mental Health Initiative provides for the implementation of the Veterans Health Administration's Comprehensive Mental Health Strategic Plan (MHSP). Funding has been allocated for the Comprehensive MHSP each year since FY 2005 and has been committed through FY 2008.

Funds were specifically allocated last year to promote dissemination and delivery of exposure-based psychotherapies for PTSD. In addition, we are providing training and dissemination of evidence-based psychotherapies for other mental disorders. VA has allocated additional funds to implement evidence-based programs integrating mental health with primary care, with particular emphasis on depression. That program will be further expanded in FY 2008 and FY 2009.

Since the implementation of the Mental Health Strategic Plan, VHA has dedicated more than \$458 million to improve access and quality of care for veterans who present with substance use disorder treatment needs. We have authorized the establishment of 510 new substance use counselor positions and plan to continue expanding our services throughout FY 2008 and FY 2009. In FY 2008, for example, our mental health enhancement budget includes over \$37.5 million for expanded services.

VA is developing plans to allocate medical care funds from the FY 2008 funding to hire even more new mental health professionals, develop new programs, expand existing services, and create an appropriate physical environment for care by upgrading the safety and physical structure of inpatient psychiatry wards, as well as domiciliary and residential rehabilitation programs.

Further, VA is taking significant steps to prevent suicide among veterans. We have provided training to all VA employees to underscore that even strong and normally resilient people can develop mental health conditions making them susceptible to suicide; care for those conditions is readily available and should be immediately provided; and treatment typically works.

VA's suicide prevention program includes two centers that conduct research and provide technical assistance in this area to all locations of care. One is the Mental Health Center of Excellence in Canandaigua, New York, which focuses on developing and testing clinical and public health intervention related to suicide risk and prevention. The other is the VISN 19 Mental Illness Research Education and Clinical Center in Denver, which focuses on research in the clinical and neurobiological sciences with special emphasis on issues related to suicide risk.

VA has opened a unique suicide prevention call center in Canandaigua focused entirely on veterans. Suicide prevention coordinators are located at each of VA's 153 hospitals. Altogether, VA has more than 200 mental health providers whose jobs are specifically devoted to preventing suicide among veterans.

In developing the suicide prevention call center, the Department has partnered with the Lifeline Program of the Substance Abuse and Mental Health Services Administration. Those who call 1-800-273-TALK are asked to press "1" if they are a veteran, or are calling about a veteran.

From its beginnings in July 2007 through the end of April, 16,414 calls have come to the hotline from veterans and 2,125 family members or friends have called on behalf of a loved one. These calls have led to 3,464 referrals to suicide prevention coordinators and 885 rescues involving emergency services. Of note, 493 active duty servicemembers have also called our suicide hotline.

Unlike other such hotlines, VA's hotline is staffed solely by mental health professionals—24 hours a day, 7 days a week. Our hotline staff is trained in both crisis intervention strategies, and in issues relating specifically to veterans, such as Traumatic Brain Injury and Post Traumatic Stress Disorder. In emergencies, the hotline staff contacts local emergency resources, such as police or ambulance services, to ensure an immediate response.

If the veteran is a VA patient and willing to identify him or herself, the hotline staff is able to access the veteran's electronic medical record during the call. These records provide information that is invaluable during a crisis, including information on medications; the patient's treatment plan; and names and numbers of persons to contact during this emergency. VA hotline staff can also talk directly to the facility that is treating the veteran. They can place consults in the patient's medical record. For veterans not under VA care, staff can refer them to an individual VA Medical Center or Community Based Outpatient Clinic as appropriate, and see to all of the necessary administrative requirements.

And our hotline staff follows up on these referrals. They also check patients' records to see if consultations were completed and to ensure follow-up actions were taken or are ongoing. If the record does not show this information, the suicide prevention coordinator at the VA facility is called and tasked with following up on the case to ensure that no referral is lost in the process.

In addition to the care offered in Medical Centers and Community Based Outpatient Clinics, VA's Vet Centers provide outreach and readjustment counseling services to returning combat-theater veterans of all eras. It is well-established that rehabilitation for war-related PTSD, substance use disorder, and other military-related readjustment problems, along with the treatment of the physical wounds of war, is central to VA's continuum of health care programs specific to the needs of combat-theater veterans.

The Vet Centers' mission is to provide readjustment and related mental health services, through a holistic mix of services designed to treat the veteran as a whole person in his/her community setting. Vet Centers provide an alternative to traditional mental health care that helps many combat-theater veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses and social workers, many of whom are veteran peers.

Vet Centers provide professional readjustment counseling for war-related psychological readjustment problems, including PTSD. Other readjustment problems may include family relationship problems, lack of adequate employment, lack of educational achievement, social alienation and lack of career goals, homelessness and lack of adequate resources, and other psychological problems such as depression and/or substance use disorder. Vet Centers also provide military-related sexual trauma counseling, bereavement counseling, employment counseling and job referrals, preventive health care information, and referrals to other VA and non-VA medical and benefits facilities.

VA is currently expanding the number of its Vet Centers. In February 2007, VA announced plans to establish 23 new Vet Centers increasing the number nationally from 209 to 232. This expansion began in 2007 and is planned for completion in 2008. Eighteen of the new Vet Centers have hired staff and are fully open. Five other Vet Centers have hired staff and are providing client services, but are operating out of temporary space while they finalize their lease contracts. They will all be open by the end of the Fiscal Year.

To enhance access to care for veterans in underserved areas, some Vet Centers have established telehealth linkages with VA medical centers that extend VA mental health service delivery to remote areas to underserved veteran populations, including Native Americans on reservations at some sites. Vet Centers also offer telehealth services to expand the reach to an even broader audience. Vet Centers address veterans' psychological and social readjustment problems in convenient, easy-to-access community-based locations and generally support ongoing enhancements under the VA Mental Health Strategic Plan.

In summary, Mr. Chairman, I am very proud of what VHA does in the area of mental health care. More than 200,000 people are fully committed to helping veterans receive the health care benefits they have earned through their service and sacrifices. I hope we can continue to move forward from this episode, and help veterans and their families; Congress; the news media and others to better understand what VA has done, and is doing, to fulfill our Nation's commitment to those who have worn the uniform of our Armed Services.

RESPONSE TO WRITTEN QUESTIONS FROM HON. BERNARD SANDERS TO MICHAEL J. KUSSMAN, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 3(a). Under Secretary Kussman, a recent Rand report estimates that the costs of treating brain injuries in 2007 ranged from \$26,000 for mild cases to \$409,000 for severe ones. The report estimates that the costs for treating Post Traumatic Stress Disorder and depression in the first 2 years after deployment could be as high as \$6 billion. And that is only the cost for TBI and PTSD. It does not include the cost of prosthetics, eye injuries, or other medical or mental health care. An Associated Press (article attached below) recently reported on VA documents it had obtained that said the government expects to be spending \$59 billion a year to compensate injured servicemembers over the next 25 years, up from today's \$29 billion. The AP story noted that some at the VA believe these are conservative estimates. Given these high costs, and the increased demand and use of VA services, I would like the VA to provide me with the long-term, 40 year, trend for the number of veterans that VA expects to serve and the amount the VA expects to expend for:

- Inpatient medical care
- Outpatient medical care
- Vet Center readjustment counseling

Response. The Veterans Health Administration (VHA) develops projections for 20 years to support strategic and capital planning activities. Our estimates are revised annually to reflect the most recent enrollment, demographic, and economic data available. Through the VA enrollment health care model, VHA makes assumptions regarding potential changes in health care practice, new technologies, medical advances, and new generations of drugs such as biologics. Given the dynamic nature of health care, VHA would have concerns projecting health care and readjustment counseling demand 40 years into the future.

Question 3(b). Please provide this number both as an aggregate number for all of the benefits/services and broken down by each type.

Response. The following table is from page 1C-20 of the FY 2009 Budget Submission for medical program and information technology programs.

Outlay Reconciliation					
Medical Care					
(Dollars in Thousands)					
Description	2007 Actual	2008		2009 Estimate	Increase/ Decrease
		Budget Estimate	Current Estimate		
Obligations.....	\$35,232,474	\$36,789,140	\$40,478,018	\$41,448,363	\$970,345
Obligated Balance (SOY).....	\$4,951,997	\$5,706,273	\$6,532,990	\$8,368,581	\$1,835,591
Obligated Balance (EOY).....	(\$6,532,990)	(\$6,446,216)	(\$8,368,581)	(\$9,049,151)	(\$680,570)
Adjustments in Expired Accts.....	(\$146,764)	\$0	\$0	\$0	\$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Unexp.).....	(\$11,924)	\$0	\$0	\$0	\$0
Chg. Uncoll. Cust. Pay. Fed. Sources (Exp.).....	\$12,507	\$0	\$0	\$0	\$0
Outlays, Gross.....	\$33,505,300	\$36,049,197	\$38,642,427	\$40,767,793	\$2,125,366
Offsetting Collections.....	(\$222,723)	(\$235,000)	(\$235,000)	(\$245,000)	(\$10,000)
PY Recoveries.....	(\$14,000)	\$0	\$0	\$0	\$0
Net Outlays.....	<u>\$33,268,577</u>	<u>\$35,814,197</u>	<u>\$38,407,427</u>	<u>\$40,522,793</u>	<u>\$2,115,366</u>

Question 3(c). Given these high costs, and the increased demand and use of VA services, does the VA have a long term plan which includes expanded facilities, staffing, and other relevant matters that will meet the needs of this new generation of veterans as well as our existing veterans?

Response. We are constantly planning and implementing new initiatives to address the needs of all veterans, including the new generation of veterans through the following initiatives:

- VA recognizes that delivering health care closer to the veteran's place of residence is one way to better achieve our mission of being a patient-centered integrated health care organization. VHA continues to seek opportunities in the coming fiscal years to deploy community based outpatient clinics (CBOC) in areas where they will improve veterans' access to health care, particularly in underserved and rural areas.
- VA recognizes the need for expanded mental health care and is now providing mental health services in all VA medical centers and a majority of CBOCs across the country.
- VA recognizes the need to address the fact that many of the injured OEF/OIF veterans return with multiple injuries. To meet their needs, VA established four polytrauma centers across the country (Palo Alto, California; Tampa, Florida; Richmond, Virginia; and, Minneapolis, Minnesota), and will soon open a fifth center in San Antonio, Texas.
- To meet the needs of veterans, VA is developing, monitoring, tracking, and trending performance measures in various administrative and clinical categories. These include: quality management, clinic waiting times, financial and human resource management, employee and patient satisfaction, workload production, capital and planning, and special populations/clinical cohorts.
- To address the needs of this new, younger generation of veterans, VA is changing the culture of care at its nursing homes, now known as community living centers.
- Primary care/specialty care hours of operations are being extended and made available in many medical centers and CBOCs nationwide.

- VA continues its efforts to outreach to veterans by conducting multiple and diverse activities through, for example, dedication ceremonies, educational programs, clinical care, health fairs, town hall meetings, news releases, and other publications, special event programming, speeches, and homeless stand downs.

- VHA has opened CBOCs to make services more readily accessible to veterans, especially in rural areas. Videoconferencing technologies and diagnostic equipment mean specialists from major hospital centers can review veteran patients in a CBOC close to home thus avoiding travel and offering easier access to specialist care. Veterans with chronic diseases such as diabetes, heart failure and chronic pulmonary disease can be monitored at home using home telehealth technologies. This prevents or delays an elderly veteran needing to leave their home and move into long-term institutional care unnecessarily.

- With the addition of the 23 Vet Centers initiated in 2007, the Readjustment Counseling Service's (RCS) will administer 232 Vet Centers across the country by the end of FY 2008. Vet Centers are unique in VA providing community-based services that go beyond medical care, and professional readjustment counseling for war-related psychological trauma, including Post Traumatic Stress Disorder (PTSD), to returning combat veterans of all eras. Vet Centers are staffed by interdisciplinary teams, including psychologists, nurses, and social workers, many of whom are veterans themselves.

Question 4. Dr. Katz and Under Secretary Kussman, can you tell me what the VA is doing system-wide to coordinate the medications that our veterans are taking, particularly our OEF/OIF veterans? This Committee has heard a number of stories about veterans in VA care that are being over-medicated and medicated with different drugs that when taken together can have drastic consequences including increasing the risk of suicide. What kind of a tracking system does the VA have in place and does this include tracking prescriptions a veteran may be taking outside of the VA, such as those prescribed by another physician or those prescribed while a veteran was in a military hospital?

Response. VA has upgraded capabilities in its computerized patient record system (CPRS) to ensure the prescribing of medications is coordinated. Using VA's award-winning electronic health record, the veterans health information system technology architecture (VistA) and CPRS, providers are notified automatically regarding any potential conflicts with other medications the patient is taking, as well as any possible allergies a patient may have. CPRS gives the provider the ability to document medications a patient is taking from outside the VA system. The automatic notification occurs with non-VA medications as well as with medications provided by the VA.

In addition, VA has upgraded its systems to include remote data interoperability, which provides medication and allergy order checks between VA facilities. VA and the Department of Defense (DOD) have created a bidirectional health information exchange system and clinical health data repository, which makes available to DOD and VA providers real time information on medications and allergies for shared patients.

VA has placed a high priority on medication reconciliation. Medication reconciliation is a Joint Commission National Patient Safety Goal and is the process for comparing the patient's current medications with those new medications ordered for the patient; communicating this information to the next provider of service, and providing a comprehensive written list to the patient. As part of this process, VA staff engages the patient as an active partner in developing the list with every admission and discharge from an inpatient stay or outpatient appointment.

RESPONSE TO WRITTEN QUESTIONS FROM HON. ROGER F. WICKER TO MICHAEL J. KUSSMAN, M.D., UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Modern medicine has made such significant progress on healing the physical wounds and saving lives on the battlefield, but the impact of mental wounds is becoming increasingly apparent. Traumatic Brain Injury is one of the signature injuries of the war on terror. Under Secretary Kussman, please provide me with an overview of the changes the Veterans' Administration has made in screening for TBI over the last decade. How does VA currently diagnose brain injury?

Response. Beginning in April 2007, VA has had a policy to screen all OEF/OIF veterans who come to VA for possible Traumatic Brain Injury (TBI). VA established a task force to develop a TBI screening procedure in December 2006; the task force completed its charge by developing a TBI screening instrument and evaluation protocol. An automated TBI clinical reminder was established in the clinical patient

record system, policy was established (VHA Directive 2007–013), and national training was completed for over 50,000 VA practitioners. The national clinical reminder TBI screening was implemented on April 14, 2007. Those who screen positive are offered a comprehensive evaluation to confirm a diagnosis and be provided treatment for symptoms associated with their TBI.

VA's approach to diagnosing TBI is consistent with the American Congress of Rehabilitation's Diagnostic Criteria for mild TBI, which is the "occurrence of a traumatically induced physiologic disruption of brain function as indicated by one of the following:

- Any period of loss of consciousness,
- Any loss of memory for events immediately before or after the accident,
- Any alteration in mental state at the time of the accident,
- Focal neurologic deficits that may or may not be transient."

For those who screen positive for possible TBI, VA's standardized evaluation protocol includes the origin or etiology of the patient's injury, assessment for neurobehavioral symptoms (via the 22 question neurobehavioral symptom inventory), a targeted physical examination, and a follow-up treatment plan. When any symptom is positive, the protocol provides recommendations on physical examination, diagnostic testing, and recommendations for initial treatment interventions and referral pathways for persistent symptoms.

Question 2. With the large number of servicemembers that have served in combat and, in particular, those returning with injuries from mortar, grenade, RPG, or IED attacks, does the VA have the capacity to properly evaluate them for brain injury? Does VA currently employ, or is VA investigating the use of, diagnostic software that can help identify brain injury?

Response. VA is sufficiently resourced to respond to the needs of OEF/OIF veterans with TBI. VA provided health care to 5.5 million veterans in FY 2007. Since April 2007, VA has screened approximately 185,000 OEF/OIF veterans for possible TBI. Of those who have screened positive for possible TBI and completed the second level evaluation, 7,561 have received a definitive diagnosis of TBI. Additionally, there have been about 550 OEF/OIF active duty servicemembers and veterans who have been treated in VA polytrauma rehabilitation centers for severe TBI since March 2003.

VA is actively pursuing initiatives, both clinically and through research, to investigate use of various diagnostic tools that can help identify brain injury. Currently, several diagnostic tests are being used to diagnose mild TBI: magnetic resonance imaging (MRI), single photon emission computed tomography (SPECT) scans, positron emission tomography (PET) scans, evoked response potentials, and a variety of neuropsychological test batteries. Many of these procedures are sensitive to any type of brain dysfunction such as trauma, congenital disease (for example, multiple sclerosis or Alzheimer's disease), and depending upon the procedure, may be affected by conditions such as mood, mental state, fatigue, medication, and patient participation in the test. While these tests are sensitive to any trauma of the head, body or even vigorous physical activity, none is specific to mild TBI. Currently, no diagnostic test, software or other, has been demonstrated to differentiate and identify mild TBI from numerous other potential causative conditions. Definitive diagnosis of mild TBI requires evaluation that includes documenting the injury, status immediately following the event, cognitive screening, neurobehavioral assessment, and medical evaluation.

Question 3. Secretary Kussman, is there any coordination between the VA and the Department of Defense to assess servicemembers prior to deployment to determine a cognitive baseline that can later be tested against to diagnosis a brain injury?

Response. We would refer you to DOD for further explanation of any mandatory TBI tests conducted for members of the Armed Services, the National Guard, or the Reserve prior to deployment.

Question 4. Dr. Kussman, are there any mandatory TBI tests for soldiers returning from a combat zone or separating from the military? If so, please describe them.

Response. DOD has added questions to its post-deployment health assessment and post-deployment health reassessment to screen for Traumatic Brain Injury. When a veteran enrolls in the VA health care system, DOD shares that information with VA clinicians as part of an effort to facilitate the continuity of care for the veteran or servicemember.

Since April 2007, any OEF/OIF veteran seen by a VA health care provider is automatically screened for possible TBI. Veterans are asked four sequential questions regarding events that may increase the risk of TBI, immediate symptoms following the event, new or worsening symptoms following the event, and current symptoms. If a person responds negatively to any of the sets of questions, the screen is negative

and the remainder is completed. If the patient responds positively to one or more possible answers in all four sections, the screen is positive and the veteran is referred for further evaluation or the veteran's refusal is documented. Not all patients who screen positive have TBI; it is possible to respond positively to all four sections due to the presence of other conditions such as PTSD, cervicocranial injury with headaches, or inner ear injury. Therefore, it is critical that patients not be labeled with the diagnosis of TBI on the basis of a positive screening test. Patients need to be referred for a comprehensive evaluation by a specialized team to substantiate the diagnosis. Since April 2007, VA has screened approximately 185,000 OEF/OIF veterans for possible TBI. Of those who have screened positive for possible TBI and completed the second level evaluation, 7,561 have received a definitive diagnosis of TBI.

For severely injured veterans and servicemembers, VA's polytrauma system of care provides specialized rehabilitation and treatment and develops an individualized recovery plan tailored to the specific needs of the veteran or servicemember.

Chairman AKAKA. Thank you very much, Dr. Kussman, for your statement.

Admiral Dunne.

STATEMENT OF PATRICK W. DUNNE, ACTING UNDER SECRETARY FOR BENEFITS AND ASSISTANT SECRETARY FOR POLICY AND PLANNING, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY BRAD MAYES, DIRECTOR OF COMPENSATION AND PENSION SERVICE

Mr. DUNNE. Good morning, Mr. Chairman and Members of the Committee.

Thank you for the opportunity to discuss the important issue of Post Traumatic Stress Disorder. I am pleased to be accompanied by Mr. Brad Mayes, the Veteran Benefits Administration's Director of the Compensation and Pension Service.

We all share the goal of preventing and minimizing the impact of this disability on our veterans and providing those who suffer from it with just compensation for their service.

Today I will review how VBA processes claims for service connection of PTSD and the relationship between VBA and the Veterans Health Administration.

The number of veterans submitting claims for PTSD has grown dramatically. From fiscal year 1999 through May 2008, the number of veterans receiving disability compensation who are service-connected for PTSD increased from 120,000 to nearly 329,000.

24,087 of these veterans served in World War II; 12,229 in the Korean Conflict; 222,191 in the Vietnam Era; 11,220 during peace time; 59,196 in the Gulf War Era. The Gulf War Era number includes 37,460 OEF and OIF veterans.

Service connection for PTSD requires medical evidence diagnosing the condition, medical evidence of a link between current symptoms and an in-service stressor, and credible supporting evidence that the in-service stressor occurred.

VA regulations established three categories of in-service stressors: first, combat or prisoner of war; second, personal assault; and third, non-combat.

Combat status may be established through the receipt of certain recognized military citations and other supportive evidence. If the evidence establishes that a veteran engaged in combat or was a POW and the stressor relates to that experience, the veteran's lay testimony alone may establish an in-service stressor for purpose of service-connecting PTSD.

If the stressful event is not linked to combat or POW status, VA requests that the veteran submit information to help substantiate that the incident occurred. Reasonable doubt is always resolved in favor of the veteran.

A VA examination is requested once credible supporting evidence establishes that the claimed in-service stressor occurred. The VHA medical examination for PTSD or an equivalent contract examination essentially serves three purposes.

First, it serves to establish whether the veteran has PTSD.

Second, it provides an opinion as to the existence of a link between the current symptoms and the in-service stressor. It is important to note that this is a medical determination performed by the examining psychiatrist or psychologist, not by the rating specialist.

Third, it serves to provide an assessment of the current level of disability resulting from the veteran's symptoms so that VA can provide a rating for the extent of that disability.

Although a veteran may have received a diagnosis of PTSD from a private mental health provider before submitting a claim to VBA, the VHA examination is still necessary to confirm the diagnosis in accordance with the DSM-IV, and to provide the proper diagnostic criteria and level of disability assessment needed for rating purposes.

To ensure that a qualified professional is responsible for the examination, VA requires the initial examination be conducted or supervised by a board-certified psychiatrist or licensed doctorate-level psychologist.

Additionally, all potential examiners now must undergo specific training and become certified prior to performing PTSD exams.

Ratings are based on the rating schedule for mental disorders. VBA rating personnel must evaluate the examination report and any other relevant evidence to determine the most appropriate level of disability. The examination report must be carefully reviewed to match the examiner's description of the veteran's symptoms with the disability percentage most closely representing the severity of those symptoms.

This is a complex process that involves an element of judgment. However, when a conflict arises as to what level of evaluation should be assigned, reasonable doubt is resolved in favor of the veteran.

It is critical that our employees receive the essential guidance, materials and tools to meet the increasingly complex demands of their decisionmaking responsibilities. To accomplish this goal, VBA has developed new training tools and centralized training programs that support more accurate and consistent decisionmaking. New employees receive comprehensive training through the national centralized training program called "Challenge."

VBA has developed job aids and training sessions to provide employees the skills and tools essential to render fair and timely decisions on PTSD claims. All veteran service representatives and rating veteran service representatives are required to receive training on the proper development and analysis of PTSD claims. The training materials include medical and military references and

prerecorded video broadcasts pertaining to PTSD development and records research.

Mr. Chairman, this completes my statement. I will be happy to answer any questions.

[The prepared statement of Mr. Dunne follows.]

PREPARED STATEMENT OF REAR ADMIRAL PATRICK W. DUNNE, USN (RET.), ACTING UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman and Members of the Committee: Thank you for providing me the opportunity to appear before you today to testify on the important issue of Post Traumatic Stress Disorder (PTSD). I am pleased to be accompanied by Mr. Brad Mayes, the Veterans Benefit Administration's (VBA) Director of Compensation and Pension Service. We all share the goal of preventing and minimizing the impact of this disability on our veterans and providing those who suffer from it with just compensation for their service to our country. Today I will explain how VBA processes claims for service connection of PTSD and the relationship between VBA and the Veterans Health Administration (VHA) in processing these claims.

The number of veterans submitting claims for PTSD has grown dramatically. From FY 1999 through May 2008, the number of veterans receiving disability compensation who are service-connected for PTSD increased from 120,000 to nearly 329,000 (328,923). These veterans represent veterans of World War II (24,087), the Korean Conflict (12,229), the Vietnam Era (222,191), Peacetime (11,220), and the Gulf War Era (59,196). The Gulf War Era number includes 37,460 OEF/OIF veterans.

When a VBA regional office receives an initial claim for service connection of PTSD, a series of steps are followed which include: (1) providing the veteran with notice of what evidence is required to substantiate the claim, commonly referred to as a Veterans Claims Assistance Act or VCAA notice, and providing assistance with gathering that evidence; (2) researching the evidence needed to support the claimed in-service stressor; (3) providing the veteran with a PTSD examination; and (4) assigning a disability rating percentage for compensation purposes. These steps will be explained in detail.

PROVIDING THE VETERAN WITH NOTICE OF EVIDENCE REQUIRED TO SUBSTANTIATE THE CLAIM AND ASSISTANCE WITH GATHERING THAT EVIDENCE

When an initial claim for PTSD is received, the regional office will respond to the veteran with a letter outlining the information and evidence needed to substantiate the claim and the actions VBA will take to assist the veteran with developing for that evidence and the veteran's responsibility for providing evidence. VBA will then obtain the veteran's service medical and personnel records and any post-service medical or hospital records identified by the veteran. These procedures are the same for all claims, regardless of the disability. However, in PTSD claims, the veteran will generally be asked to provide a description of the in-service stressor that has caused the current PTSD symptoms.

RESEARCHING FOR EVIDENCE TO SUPPORT THE CLAIMED STRESSOR

The processing of PTSD claims is governed by our regulation at 38 CFR § 3.304(f). This regulation states that, in order for service connection to be granted, there must be medical evidence diagnosing the condition, there must be medical evidence establishing a link between current symptoms and an in-service stressor, and there must be credible supporting evidence that the claimed in-service stressor occurred. The first two requirements involve medical assessments, while the third requirement generally involves investigation by VBA personnel into the nature of the stressor.

The steps required to establish service connection for PTSD can be affected by the specific circumstances in the claim.

In cases where PTSD is diagnosed in service and the nature of the stressful event is not apparent, VA will request that the examiner detail the circumstances surrounding the development of PTSD. If those circumstances are consistent with military service, evidence of the stressful event will be accepted without further development.

Even if PTSD is not diagnosed in service, under certain conditions established by sections 3.304(f)(1) and (2), the veteran's lay testimony alone can establish the occurrence of the stressor. When sufficient evidence shows that the veteran engaged in combat with the enemy or was a prisoner of war (POW) and the claimed stressor

is related to that combat or POW status, the veteran's statement describing the stressor will allow the claim to go forward without corroborating evidence. VBA will accept certain military awards received by the veteran that designate participation in combat, such as a Combat Infantryman Badge, Combat Action Ribbon, Purple Heart Medal, etc., as evidence of exposure to combat-related stressors.

When evidence for combat status is not readily apparent or where the claimed stressor is not directly related to combat, VBA is obligated to search for evidence to corroborate the combat status or the non-combat stressor before the claim can go forward. Such evidence can come from additional military records, from the "buddy statements" of individuals who served with the veteran, or from on-line documents available at official military or government Web sites. In addition, VBA personnel have access to thousands of declassified military unit reports and histories from all periods of war on the Compensation and Pension Service Intranet Web site. These reports and histories document unit combat actions and can serve to corroborate a stressor when the veteran's records show assignment to a particular unit at the time covered in the report or history.

When VBA personnel cannot find sufficient credible evidence to support a claimed stressor, the stressor information is forwarded to the Army's Joint Services Records Research Center (JSRRC). This DOD activity with full time researchers has access to multiple sources of military documents, not readily available to VBA personnel. If JSRRC is able to find evidence supporting the claimed stressor, it will be provided to VBA. In all cases where there is an approximate balance of evidence for and against occurrence of the stressor, the veteran will be given the benefit of doubt and VA will find that the stressor occurred.

Where PTSD is due to military sexual trauma and evidence of the trauma is not of record, VA has developed processes to develop this extremely sensitive issue. These include a search for potential "markers" of sexual assault such as sudden degradation in performance, seeking duty station changes, visits to clinics for sexually transmitted disease testing, provost marshal records, and seeking out of medical or spiritual assistance.

In general, VBA procedures require that a claimed stressor must be corroborated by credible supporting evidence before an initial PTSD examination is scheduled with VHA. Generally, neither the examination report as such nor the examiner's opinion can serve as credible evidence to support occurrence of the stressor. However, under section 3.304(f)(3), when an in-service personal assault is involved, evidence that can corroborate the veteran's account of the stressor includes records from rape crisis centers and mental health counseling services. A VHA examination may be scheduled before there is sufficient evidence to corroborate the assault, and the examiner may be asked for an opinion as to whether the assault occurred based on the available evidence and the examination results. Also, where the veteran was diagnosed with PTSD in service, there is an assumption that the diagnosis was made by a competent military medical authority with a factual basis for recognizing the stressor. Therefore, VBA need not seek further credible evidence for the causative stressor. In these cases, a VHA examination can be scheduled immediately to evaluate the level of disability.

PROVIDING THE VETERAN WITH A PTSD EXAMINATION

The VHA medical examination for PTSD, or an equivalent contract examination, essentially serves three purposes. First, it serves to establish whether the veteran has PTSD, or some other mental disorder for the veteran's presenting symptoms. Second, it provides an opinion as to the existence of a link between the current symptoms and the in-service stressor. Third, it serves to provide an assessment of the current level of disability resulting from the veteran's symptoms so that VA can provide a rating for the extent of the disability.

VBA and VHA have jointly developed a project to improve the delivery and oversight of medical examinations used for VBA disability rating purposes, referred to as the Compensation and Pension Examination Program (CPEP). This project involves monitoring the accuracy of the examination requests sent from VBA to VHA, as well as the quality of the examinations conducted by VHA examiners. Quality in this sense refers to the sufficiency of the examination report for VBA disability rating purposes. Examination worksheets have been developed to assist the VHA examiners with providing medical information that fits the disability criteria described in 38 CFR, Part 4, Schedule for Rating Disabilities. Specific information about these criteria is necessary for VBA adjudicators to provide accurate and fair disability rating evaluations for compensation purposes. Oversight efforts similar to those of CPEP are also in place to monitor the quality of contract examinations.

PTSD examinations are subject to the requirements of 38 CFR § 4.125(a), which provides that the diagnosis must conform to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (DSM-IV), published by the American Psychiatric Association and must be supported by the findings on the examination report. Although a veteran may have received a diagnosis of PTSD from a private mental health provider before submitting a claim to VBA, the VHA examination is still necessary to confirm the diagnosis in accordance with the DSM-IV and to provide the proper diagnostic criteria and level-of-disability assessment needed for rating purposes. To ensure that a qualified professional is responsible for the examination, VBA requires that the initial examination be conducted or supervised by a board-certified psychiatrist or licensed doctorate-level psychologist. Additionally, all potential examiners must now undergo specific training and become certified prior to performing PTSD examinations.

ASSIGNING A DISABILITY RATING PERCENTAGE FOR COMPENSATION PURPOSES

VBA personnel evaluate the examination reports and assign the veteran a percentage disability rating when the evidence supports initial service connection for PTSD. Rating personnel also evaluate PTSD reexamination reports for service-connected veterans who are claiming an increase in compensation due to a worsened condition. Ratings are based on the rating schedule for mental disorders found at 38 CFR § 4.130. The schedule is a general rating formula for all mental disorders except eating disorders based on the level of occupational and social impairment caused by the veteran's mental disorder. It provides for disability percentages of 10, 30, 50, 70, and 100, with a description of symptoms associated with each percentage level. VBA rating personnel must evaluate the examination report, and any other relevant evidence, to determine the most appropriate level of disability. The examination report must be carefully reviewed to match the examiner's description of the veteran's symptoms with a disability percentage most closely representing the severity of those symptoms. This is a complex process that involves an element of judgment. However, when a reasonable doubt arises as to which of two possible percentages to assign, 38 CFR § 4.3 dictates that reasonable doubt will be resolved in favor of the veteran and the higher of the 2 percentages will be assigned.

In response to recommendations of the Veterans' Disability Benefits Commission and the Institute of Medicine, VBA is reviewing the mental disorders rating schedule with a particular focus on possibly providing specific criteria for rating PTSD based on the symptoms described in the DSM-IV.

PTSD TRAINING

As more veterans returning from Iraq and Afghanistan are turning to VA for benefits and medical care, including care for PTSD, it is critical that our employees receive the essential guidance, materials, and tools to meet the increasingly complex demands of their decisionmaking responsibilities. To accomplish this goal, VBA has deployed new training tools and centralized training programs that support accurate and consistent decisionmaking. New employees receive comprehensive training through the national centralized training program called "Challenge." The current curriculum consists of full lesson plans, handouts, student guides, instructor guides, and slides for classroom instruction. Recognizing the importance of continuing education, all Veterans Service Center employees are required to complete a mandatory cycle of training, consisting of 80 hours of annual coursework.

VBA has developed job aids and training sessions to provide employees the skills and tools essential to render fair and timely decisions on PTSD claims. All Veteran Service Representatives (VSRs) and Rating Veteran Service Representatives (RVSRs) are required to receive training on the proper development and analysis of PTSD claims. The training materials include medical and military references and pre-recorded video broadcasts pertaining to PTSD development and records research. VBA published PTSD guidance includes "Handling PTSD Claims Based on Stressors Experienced During Service in the Marine Corps" dated June 2005, "Military Sexual Trauma Training Letter" dated November 2005, and "JSRRC Stressor Verification Guide" dated January 2006. Additionally, VBA introduced the PTSD Training and Performance Support System (TPSS) module for VSRs and RVSRs in 2006. The TPSS module is an interactive learning tool in which employees complete self-guided lessons on PTSD development and verification of in-service stressors. Due to the success of the TPSS learning system, a second PTSD module titled, "Rate a Claim for PTSD" was released in July 2007.

The foregoing description of the PTSD claims process is a general outline of the procedures followed by VBA. I would be happy to answer any specific questions the Committee Members may have.

RESPONSE TO WRITTEN QUESTIONS FROM HON. BERNARD SANDERS TO REAR ADMIRAL PATRICK W. DUNNE, USN (RET.), ACTING UNDER SECRETARY FOR BENEFITS, VETERANS BENEFITS ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Under Secretary Dunne, can you 1) tell me the current backlog of claims for OEF/OIF veterans, 2) the average time to process their claims, and 3) the average waiting time OEF/OIF veterans experience when having these claims processed? In addition, please provide a breakdown of the data requested in items #2 and #3 into percentages, i.e., 25% of OEF/OIF claims take 5 months to process, 15% take 4 months, etc). Can you also provide these same numbers for OEF/OIF veterans only from Vermont?

Response. Our inventory of pending claims from Operation Enduring Freedom/ Operation Iraqi Freedom (OEF/OIF) veterans is 50,528 as of May 31, 2008. Of those, 42,944 are original claims and 7,584 are reopened claims. This fiscal year through May 2008, we completed 102,318 OEF/OIF cases with an average processing time of 154 days. Our White River Junction Regional Office's inventory of OEF/OIF cases is 116 as of the end of May. Through May, White River Junction completed 218 OEF/OIF cases in an average of 170 days.

The table below summarizes completed OEF/OIF claims for the Nation and Vermont.

FY 2008 Thru 5/31/08	USA		Vermont	
	Cases	%	Cases	%
Total	102,318	-	218	-
0-30 Days	8,897	8.7%	11	5.0%
31-60 Days	10,294	10.1%	35	16.1%
61-90 Days	12,103	10.1%	16	16.1%
91-120 Days	13,466	13.2%	32	14.7%
121-180 Days	23,999	23.5%	36	16.5%
181-365 Days	28,894	28.2%	71	32.6%
Over 1 year	4,665	4.6%	17	7.8%

Question 2(a). Under Secretary Dunne, a recent Rand report estimates that the costs of treating brain injuries in 2007 ranged from \$26,000 for mild cases to \$409,000 for severe ones. The report estimates that the costs for treating Post Traumatic Stress Disorder and depression in the first 2 years after deployment could be as high as \$6 billion. And that is only the cost for TBI and PTSD. It does not include the cost of prosthetics, eye injuries, or other medical or mental health care. An Associated Press article (attached below) recently reported on VA documents it had obtained that said the government expects to be spending \$59 billion a year to compensate injured servicemembers over the next 25 years, up from today's \$29 billion. The AP story noted that some at the VA believe these are conservative estimates. Can you provide me with the documents that are referenced in the Associated Press article included below?

Response. The Associated Press article written by Jennifer Kerr reported that the government expects to be spending \$59 billion a year to compensate injured servicemembers over the next 25 years. This figure was obtained from the Veterans Benefit Administration's (VBA) contingent liability model, prepared by PricewaterhouseCoopers, used to estimate VA's total liabilities on the Consolidated Financial Statement Balance Sheet. The liability for future compensation payments is reported on the balance sheet as the net present value of expected future payments. Various assumptions in the actuarial model, such as the number of veterans and dependents receiving payments, discount rates, cost of living adjustments, and life expectancy, impact the amount of the liability. Although the liability model forecasts future beneficiaries of the compensation program, including some members of the current active duty military who may receive benefits, it does not project new military enlistments. This model is not used to estimate future budgetary needs because not all future payments are captured.

Ms. Kerr obtained the *Annual Benefits Reports for 1999 to 2006* from the Department of Veterans Affairs' (VA) Web site (<http://www.vba.va.gov/reports/index.htm>). Ms. Kerr contacted VA to obtain data on benefits dating back to 1950. Since VBA does not have benefits reports prior to 1999, we provided her with copies of the VA Annual Reports from 1918 to 1998, which contain some benefits information, on CDs. We are providing a copy of these CDs for your reference.

The following documents were also provided and are attached.

1. Compensation and pension programs—estimate of liability as of September 30, 2007, prepared by PricewaterhouseCoopers
2. Estimated values underlying the estimate of veterans compensation liability as of September 30, 2007, prepared by PricewaterhouseCoopers
3. Statistics on Global War on Terror (GWOT) veterans

Question 2(b). What yearly funding does the VA estimate will be needed to compensate injured servicemembers over the next 25 years? Given these high costs, and the increased demand and use of VA services, I would like the VA to provide me with the long-term, 40 year trend for the number of veterans that VA expects to serve and the amount the VA expects to expend for:

- Compensation
- Pension
- Home loan guaranty, including defaults (foreclosures and sales)
- Vocational rehabilitation
- Life insurance (for deaths), and Traumatic Insurance (for major injuries)
- Educational benefits
- Burial benefits
- Adaptive automobile and home benefits.

Please provide this number both as an aggregate number for all of the benefits/services and broken down by each type.

Response. VBA's budgetary needs are projected using budget models specific to each benefit program. For example, the compensation and pensions budget estimation model forecasts both the number of disability compensation beneficiaries as well as the average benefit payment for veterans and survivors using a complex combination of historical data, current experience, workload and performance projections and assumptions.

The budget models forecast obligations and outlays for 10 years. VBA does not forecast benefit payments beyond the 10-year projection. Projecting future demand is extremely difficult, as caseload and average payment assumptions may be impacted by military operations and separation rates, legislative and regulatory changes, court decisions, changing demographics of the population, outreach efforts, future application trends, and trends in benefits usage, as well as economic factors.

Shown below are the fiscal year (FY) 2009 and 2018 estimated caseload and obligations for VBA mandatory programs from the 2009 President's Budget submission.

**Veterans Benefits Administration
2009 Congressional Submission
(Obligations in millions)**

	2009 Estimate		2018 Estimate	
	Cases	Obligations	Cases	Obligations
Mandatory:				
Compensation (Veterans and Survivors)	3,356,343	\$39,866	4,196,539	\$66,666
Pensions	517,736	4,033	477,789	6,123
Burial	168,543	193	197,591	209
Education	575,374	3,122	610,324	4,016
Vocational Rehabilitation	70,374	660	78,499	1,108
Adaptive, Automobile and Housing Grants	8,650	98	8,650	162
Housing	186,777	181	187,696	236
Insurance	7,087,725	2,600	5,798,582	2,020
Total VBA Mandatory		\$50,753		\$80,540

Notes:

Cases can not be summed as a beneficiary may be in receipt of more than one benefit at a time.

Burial cases reflect the number of plot and burial allowances awarded.

Vocational Rehabilitation cases reflect the number of cases receiving payment.

Housing cases reflect the number of loans provided.

Insurance cases reflect the number of policies in force.

Question 2(c). Given these high costs, and the increased demand and use of VA services, does the VA have a long term plan which includes expanded facilities, staffing, and other relevant matters that will meet the needs of this new generation of veterans as well as our existing veterans?

Response. We are aggressively working to meet the increased demand and improve benefits delivery by employing enhanced technologies that will support claims processing in a “paperless” environment. Our strategy is to move to a business model less reliant on paper documents. Enhanced workflow capabilities, rules-based engines, enterprise content management, and correspondence services are important elements of our strategic vision for meeting the needs of this new generation as well as those of our existing veterans. We are also working to incorporate the use of portal technology and identity management/user authentication to provide veterans the capability for online self service. The integration of these new technologies will significantly increase our flexibility to expand and electronically move work to where we have the supporting infrastructure and resources. We have already consolidated the processing of all benefits delivery at discharge (BDD) claims to two sites and are implementing paperless processing at these sites. Our plans call for all BDD claims to be processed using imaging technology by the end of this fiscal year. We are also developing a strategy for expanding the types of claims to be processed in a paperless environment.

ATTACHMENT 1 IN SUPPORT OF RESPONSE TO QUESTION 2(a) ABOVE

DEPARTMENT OF VETERANS AFFAIRS
 COMPENSATION AND PENSION PROGRAMS
 ESTIMATE OF LIABILITY AS OF SEPTEMBER 30, 2007
 TABLE 2 – BASE CASE
 Undiscounted Estimated Cash Flows (Total Benefits/Obligations)

Fiscal Year	Compensation Veterans	Compensation Survivors	Pensions Veterans	Pensions Survivors	Burial
2008	\$ 31,619,212,732	\$ 5,040,641,237	\$ 2,889,358,463	\$ 882,520,442	\$ 172,213,558
2009	\$ 33,765,924,104	\$ 5,200,700,719	\$ 2,996,011,624	\$ 906,353,710	\$ 175,865,420
2010	\$ 35,772,005,859	\$ 5,368,763,104	\$ 3,027,153,256	\$ 930,586,407	\$ 179,307,066
2011	\$ 37,579,920,431	\$ 5,538,294,967	\$ 3,045,796,238	\$ 953,493,914	\$ 182,206,956
2012	\$ 39,400,362,396	\$ 5,723,687,936	\$ 3,058,067,940	\$ 975,260,570	\$ 184,751,499
2013	\$ 41,084,003,238	\$ 5,912,551,852	\$ 3,062,133,804	\$ 995,925,721	\$ 186,958,597
2014	\$ 42,665,282,840	\$ 6,104,135,797	\$ 3,059,993,038	\$ 1,015,541,852	\$ 188,856,568
2015	\$ 44,182,578,208	\$ 6,298,186,997	\$ 3,056,459,900	\$ 1,034,135,409	\$ 190,481,538
2016	\$ 45,639,256,938	\$ 6,494,636,662	\$ 3,052,480,381	\$ 1,051,909,103	\$ 191,868,909
2017	\$ 47,036,515,085	\$ 6,693,838,184	\$ 3,044,390,694	\$ 1,069,157,372	\$ 193,049,692
2018	\$ 48,372,497,516	\$ 6,896,090,181	\$ 3,033,424,337	\$ 1,086,158,238	\$ 194,063,246
2019	\$ 49,649,274,520	\$ 7,101,816,868	\$ 3,022,843,428	\$ 1,103,226,798	\$ 194,943,389
2020	\$ 50,861,062,795	\$ 7,311,716,681	\$ 3,013,063,668	\$ 1,120,810,531	\$ 195,719,416
2021	\$ 52,008,711,305	\$ 7,525,442,903	\$ 3,002,855,823	\$ 1,139,062,293	\$ 196,418,740
2022	\$ 53,083,835,177	\$ 7,743,875,785	\$ 2,991,080,589	\$ 1,158,452,517	\$ 197,064,763
2023	\$ 54,080,961,404	\$ 7,967,500,214	\$ 2,978,332,590	\$ 1,179,195,232	\$ 197,666,566
2024	\$ 54,996,323,521	\$ 8,196,785,439	\$ 2,966,571,230	\$ 1,201,447,732	\$ 198,225,818
2025	\$ 55,826,679,667	\$ 8,431,916,554	\$ 2,956,358,911	\$ 1,225,170,565	\$ 198,739,851
2026	\$ 56,570,334,666	\$ 8,673,218,294	\$ 2,946,921,888	\$ 1,250,457,142	\$ 199,210,252
2027	\$ 57,225,082,699	\$ 8,920,672,994	\$ 2,936,723,592	\$ 1,277,296,053	\$ 199,643,639
2028	\$ 57,788,758,051	\$ 9,174,542,831	\$ 2,924,831,162	\$ 1,305,628,338	\$ 200,020,472
2029	\$ 58,256,888,214	\$ 9,434,911,294	\$ 2,911,373,147	\$ 1,335,334,402	\$ 200,316,294
2030	\$ 58,622,384,909	\$ 9,701,933,648	\$ 2,896,223,754	\$ 1,366,227,717	\$ 200,521,443
2031	\$ 58,882,164,934	\$ 9,975,192,122	\$ 2,879,068,585	\$ 1,398,027,770	\$ 200,615,310
2032	\$ 59,028,774,969	\$ 10,254,583,339	\$ 2,861,122,050	\$ 1,430,451,978	\$ 200,578,220
2033	\$ 59,059,031,869	\$ 10,531,613,611	\$ 2,840,240,827	\$ 1,462,734,409	\$ 200,382,649
2034	\$ 58,970,547,210	\$ 10,801,481,904	\$ 2,816,337,845	\$ 1,494,312,961	\$ 199,997,368
2035	\$ 58,763,113,759	\$ 11,067,032,912	\$ 2,786,281,529	\$ 1,524,508,549	\$ 199,388,221
2036	\$ 58,449,751,154	\$ 11,327,109,129	\$ 2,753,087,685	\$ 1,552,806,246	\$ 198,536,871
2037	\$ 58,038,886,630	\$ 11,580,503,030	\$ 2,714,690,610	\$ 1,578,740,557	\$ 197,418,528
2038	\$ 57,540,342,397	\$ 11,826,202,695	\$ 2,671,081,531	\$ 1,601,771,978	\$ 196,019,295
2039	\$ 56,959,576,800	\$ 12,063,084,586	\$ 2,623,300,844	\$ 1,621,532,295	\$ 194,337,922
2040	\$ 56,298,890,486	\$ 12,290,452,207	\$ 2,572,719,209	\$ 1,637,684,274	\$ 192,407,427
2041	\$ 55,562,034,049	\$ 12,507,705,173	\$ 2,516,860,139	\$ 1,650,026,573	\$ 190,259,112
2042	\$ 54,756,242,906	\$ 12,714,620,620	\$ 2,455,455,617	\$ 1,658,408,501	\$ 187,922,342
2043	\$ 53,889,336,041	\$ 12,911,055,880	\$ 2,387,741,400	\$ 1,662,652,473	\$ 185,424,840
2044	\$ 52,965,186,639	\$ 13,096,781,106	\$ 2,315,677,848	\$ 1,662,751,228	\$ 182,806,818
2045	\$ 51,985,292,072	\$ 13,272,746,900	\$ 2,237,014,601	\$ 1,658,762,849	\$ 180,114,788
2046	\$ 50,943,132,321	\$ 13,439,336,985	\$ 2,151,910,508	\$ 1,650,567,399	\$ 177,379,878
2047	\$ 49,841,485,902	\$ 13,597,375,130	\$ 2,061,583,020	\$ 1,638,266,577	\$ 174,623,986
2048	\$ 48,679,457,644	\$ 13,746,392,293	\$ 1,976,960,606	\$ 1,622,217,734	\$ 171,875,469
2049	\$ 47,462,866,863	\$ 13,888,133,593	\$ 1,902,389,719	\$ 1,603,252,326	\$ 169,187,077
2050	\$ 46,193,693,081	\$ 14,022,774,074	\$ 1,838,241,201	\$ 1,582,528,826	\$ 166,565,251
2051	\$ 44,872,478,489	\$ 14,151,172,382	\$ 1,783,655,075	\$ 1,561,031,148	\$ 163,990,470
2052	\$ 43,506,351,035	\$ 14,273,451,817	\$ 1,736,518,582	\$ 1,539,478,593	\$ 161,414,885
2053	\$ 42,097,912,484	\$ 14,389,793,875	\$ 1,695,562,825	\$ 1,518,394,824	\$ 158,790,175
2054	\$ 40,650,133,852	\$ 14,499,957,001	\$ 1,659,248,783	\$ 1,498,073,812	\$ 156,071,188
2055	\$ 39,165,424,331	\$ 14,603,806,354	\$ 1,625,581,721	\$ 1,478,712,416	\$ 153,218,709
2056	\$ 37,649,277,538	\$ 14,700,809,535	\$ 1,590,543,117	\$ 1,460,240,974	\$ 150,194,309
2057	\$ 36,106,999,136	\$ 14,790,546,526	\$ 1,550,582,111	\$ 1,442,438,016	\$ 146,979,343
2058	\$ 34,542,348,158	\$ 14,851,995,590	\$ 1,506,088,934	\$ 1,431,470,168	\$ 143,569,663

DEPARTMENT OF VETERANS AFFAIRS
 COMPENSATION AND PENSION PROGRAMS
 ESTIMATE OF LIABILITY AS OF SEPTEMBER 30, 2007
 TABLE 2 – BASE CASE
 Undiscounted Estimated Cash Flows (Total Benefits/Obligations)

Fiscal Year	Compensation Veterans	Compensation Survivors	Pensions Veterans	Pensions Survivors	Burial
2059	\$ 32,964,095,712	\$ 14,881,294,293	\$ 1,465,089,867	\$ 1,427,375,678	\$ 139,969,853
2060	\$ 31,380,732,736	\$ 14,894,757,652	\$ 1,426,607,550	\$ 1,421,759,191	\$ 136,184,606
2061	\$ 29,797,211,411	\$ 14,892,024,217	\$ 1,382,883,765	\$ 1,414,590,749	\$ 132,219,625
2062	\$ 28,219,055,163	\$ 14,872,420,973	\$ 1,336,634,465	\$ 1,405,373,811	\$ 128,098,172
2063	\$ 26,649,446,610	\$ 14,835,449,773	\$ 1,289,410,663	\$ 1,393,944,116	\$ 123,942,832
2064	\$ 25,093,324,798	\$ 14,781,224,374	\$ 1,243,220,070	\$ 1,380,337,703	\$ 119,475,627
2065	\$ 23,555,403,240	\$ 14,709,316,685	\$ 1,197,737,181	\$ 1,364,575,153	\$ 115,015,802
2066	\$ 22,036,804,202	\$ 14,618,922,827	\$ 1,151,440,037	\$ 1,347,178,479	\$ 110,478,432
2067	\$ 20,540,550,949	\$ 14,511,543,701	\$ 1,104,831,794	\$ 1,327,411,452	\$ 105,872,028
2068	\$ 19,068,704,538	\$ 14,386,238,051	\$ 1,059,224,052	\$ 1,305,807,726	\$ 101,197,223
2069	\$ 17,624,629,587	\$ 14,242,808,651	\$ 1,014,601,663	\$ 1,282,494,957	\$ 96,454,521
2070	\$ 16,214,401,472	\$ 14,081,343,160	\$ 971,589,118	\$ 1,257,730,995	\$ 91,641,785
2071	\$ 14,846,647,448	\$ 13,901,812,759	\$ 930,929,908	\$ 1,231,937,882	\$ 86,762,820
2072	\$ 13,528,866,910	\$ 13,704,006,858	\$ 894,426,345	\$ 1,204,975,489	\$ 81,832,927
2073	\$ 12,268,060,494	\$ 13,487,989,216	\$ 865,679,867	\$ 1,177,755,964	\$ 76,873,995
2074	\$ 11,068,999,505	\$ 13,253,451,859	\$ 837,772,673	\$ 1,150,325,301	\$ 71,894,248
2075	\$ 9,937,440,330	\$ 13,000,913,727	\$ 811,413,164	\$ 1,123,094,619	\$ 66,906,491
2076	\$ 8,877,050,380	\$ 12,730,524,445	\$ 783,324,689	\$ 1,095,984,503	\$ 61,928,048
2077	\$ 7,892,422,189	\$ 12,442,710,774	\$ 748,779,479	\$ 1,068,610,675	\$ 56,981,841
2078	\$ 6,986,394,133	\$ 12,138,565,797	\$ 711,739,088	\$ 1,040,691,691	\$ 52,099,759
2079	\$ 6,158,084,975	\$ 11,818,582,714	\$ 675,276,655	\$ 1,012,236,600	\$ 47,321,551
2080	\$ 5,406,230,031	\$ 11,484,118,627	\$ 636,242,137	\$ 983,303,414	\$ 42,683,507
2081	\$ 4,729,247,786	\$ 11,135,974,169	\$ 595,888,139	\$ 953,773,440	\$ 38,226,579
2082	\$ 4,125,238,974	\$ 10,775,937,683	\$ 555,980,543	\$ 923,599,297	\$ 33,989,262
Total Benefits (including Retro Awards)	\$ 2,917,916,632,400	\$ 852,213,504,495	\$ 155,072,718,893	\$ 98,480,066,396	\$ 11,536,137,340

ATTACHMENT 2 IN SUPPORT OF RESPONSE TO QUESTION 2(a) ABOVE

**DEPARTMENT OF VETERANS AFFAIRS
ESTIMATED VALUES UNDERLYING THE ESTIMATE OF
VETERANS COMPENSATION LIABILITY AS OF SEPTEMBER 30, 2007**

<u>Fiscal Year</u>	<u>End of Year Number of Beneficiaries</u>	<u>Undiscounted Benefit Amount including COLAs</u>	<u>Undiscounted Benefit Amount excluding COLAs</u>	<u>Present Value of Benefit Amount including COLAs</u>
2007	2,844,488			
2008	2,953,496	\$ 31,619,212,732	\$ 31,043,592,967	\$ 30,944,003,262
2009	3,037,985	\$ 33,765,924,104	\$ 32,427,315,572	\$ 31,782,726,771
2010	3,099,666	\$ 35,772,005,859	\$ 33,575,472,987	\$ 32,407,194,203
2011	3,139,990	\$ 37,579,920,431	\$ 34,493,341,201	\$ 32,663,972,930
2012	3,162,972	\$ 39,400,362,396	\$ 35,371,284,742	\$ 32,714,443,425
2013	3,170,061	\$ 41,084,003,238	\$ 36,072,356,330	\$ 32,546,377,332
2014	3,170,240	\$ 42,665,282,840	\$ 36,636,130,589	\$ 32,233,226,173
2015	3,164,366	\$ 44,182,578,208	\$ 37,102,425,886	\$ 31,763,654,772
2016	3,153,165	\$ 45,639,256,938	\$ 37,479,123,555	\$ 31,147,739,809
2017	3,137,214	\$ 47,036,515,085	\$ 37,771,937,790	\$ 30,415,638,404
2018	3,116,967	\$ 48,372,497,516	\$ 37,983,919,696	\$ 29,691,897,504
2019	3,092,769	\$ 49,649,274,520	\$ 38,121,339,915	\$ 29,013,348,150
2020	3,064,855	\$ 50,861,062,795	\$ 38,184,038,304	\$ 28,281,401,745
2021	3,033,369	\$ 52,008,711,305	\$ 38,176,950,796	\$ 27,504,723,740
2022	2,998,405	\$ 53,083,835,177	\$ 38,098,174,968	\$ 26,686,670,736
2023	2,960,032	\$ 54,080,961,404	\$ 37,948,217,501	\$ 25,832,278,590
2024	2,918,304	\$ 54,996,323,521	\$ 37,729,199,026	\$ 24,947,300,202
2025	2,873,252	\$ 55,826,679,667	\$ 37,443,358,603	\$ 24,037,468,717
2026	2,824,932	\$ 56,570,334,666	\$ 37,093,952,037	\$ 23,108,845,810
2027	2,773,384	\$ 57,225,082,699	\$ 36,683,813,235	\$ 22,166,857,213
2028	2,718,623	\$ 57,788,758,051	\$ 36,215,741,110	\$ 21,302,745,625
2029	2,660,701	\$ 58,255,888,214	\$ 35,690,668,855	\$ 20,521,536,956
2030	2,599,782	\$ 58,622,384,909	\$ 35,110,279,834	\$ 19,739,661,810
2031	2,536,103	\$ 58,882,164,934	\$ 34,475,138,631	\$ 18,958,087,629
2032	2,469,961	\$ 59,028,774,969	\$ 33,785,739,299	\$ 18,177,637,980
2033	2,401,698	\$ 59,059,031,669	\$ 33,044,527,307	\$ 17,400,083,943

NOTES:

(1) These estimated values represent benefit amounts (excluding associated administrative expenses and benefit payments for survivors) for military service through September 30, 2007. In other words, it excludes estimated benefits for disabilities incurred after that date. Thus, it underestimates the total amounts expected to be paid under the Compensation program for veterans, with the level of underestimation increasing over time.

(2) Number of beneficiaries is at September 30 of the fiscal year and benefit amounts are payments during the fiscal year.

**Department of Veterans Affairs
Statistics on GWOT Veterans****Purpose**

This data summarizes participation in VA benefits programs by veterans identified by the Department of Defense as having been deployed overseas in support of the Global War on Terror (GWOT). It is important to understand that because many GWOT veterans had earlier periods of service, the benefits activity identified in this data could have occurred either prior to or subsequent to their GWOT deployment (or both).

The update provides data on VA program participation for 754,911 GWOT veterans separated from military service through May 2007. Disability compensation statistics pertain to claims in the system as of the end of September 2007.

Summary of GWOT Data

- Deployed Servicemembers = **1,552,408** (May 2007)
- Total GWOT Veterans = **754,911** (May 2007)
- Total GWOT Veterans Filing Disability Claims = **223,564** (September 2007)
- Total GWOT Veterans with Claims Decisions = **198,522** (September 2007)
- Pending from First-Time Claimants = **25,042** (September 2007)
- Veterans Awarded Service-Connection = **181,151** (September 2007)

Background

VBA's computer systems do not contain any data that would allow us to attribute veterans' disabilities to a specific period of service or deployment. We are therefore only able to identify GWOT veterans who filed a disability compensation claim at some point either prior to or following their GWOT deployment. We are not able to identify which of these veterans filed a claim for disabilities incurred during their actual overseas GWOT deployment.

"Veterans Awarded Service-Connection" are those veterans who have at least one condition that meets eligibility requirements for service connection under VA statutes and regulations. For veterans who filed a claim for more than one condition, this category contains veterans with a full grant of all conditions as well as veterans with a combination of disabilities granted and denied.

GWOT Veterans Awarded Service-Connection by Combined Degree

Disabilities are evaluated according to VA regulations, and the extent of the disability is expressed as a percentage from zero percent to 100 percent disabling, in increments of 10 percent. Veterans with more than one service-connected disability receive a combined disability rating. The chart below includes GWOT veterans awarded combined service-connected disability ratings from zero percent to 100 percent.

GWOT Veterans Awarded Service-Connection (by Combined Degree of Disability)

Combined Degree	Total
0%	26,453
10%	39,014
20%	25,980
30%	23,782
40%	20,935
50%	12,062
60%	13,050
70%	8,072
80%	5,503
90%	2,236
100%	4,064
Total	181,151

Ten Most Frequent Service-Connected Disabilities for GWOT Veterans

Diagnostic Code	Diagnosis Description	Count
6260	Tinnitus	57,589
5237	Lumbosacral or cervical strain	50,699
6100	Defective hearing	46,761
9411	Post-Traumatic Stress Disorder	31,465
5260	Limitation of flexion of leg	26,563
5271	Limited motion of the ankle	25,548
5299	Generalized, Elbow and Forearm, Wrist, Multiple Fingers, Hip and Thigh, Knee and Leg, Ankle, Foot, Spine, Skull, Ribs, Coccyx	21,817
5242	Degenerative arthritis of the spine	19,588
7101	Hypertensive vascular disease (essential arterial hypertension)	18,654
5201	Limitation of motion of the arm	17,448

Chairman AKAKA. Thank you very much, Admiral.

Dr. Kussman, you mentioned the word “perception” and for me this is part of the reason we are having this hearing and that is to deal with the perceptions of our veterans about the Veterans’ Administration and its service.

We know that the quality of service is good. Accessibility and problems that we have always had, but we are trying to correct the perception if there is a wrong perception here. I share your concern about veterans not seeking treatment because of the public perception that VA may not be sympathetic toward their needs.

My question to you is what are your thoughts on how VA can better assure veterans that they are welcome and will receive needed care? You mentioned some of that in your statement.

As Chairman of this Committee I can tell that even before the story broke about this email, veterans were quite vocal with their concerns about how their mental health care needs are regarded. Indeed, many of the stories about the email expressed the view that it was only the latest example of how VA regards PTSD, and that was the perception.

So what I am asking for is your thoughts on how VA can better show veterans that they are welcome and will receive needed care.

Dr. KUSSMAN. Thank you, Mr. Chairman, for the question, and obviously that type of thing is on my mind almost on an hourly basis.

We are a large organization, 230,000 people, and I would be the first person to say we are not perfect in what we do. When we know about areas where this clearly is not being communicated, we put a great deal of effort into that.

But sometimes as I alluded to in my written statement is that a lot of times in our effort to meet the needs of the veterans, sometimes we do not do what they want. I mean our effort is to be sure that they get the right care and get a firm and appropriate assessment. Sometimes they do not like what the assessment is, and so there is a constant concern about whether they perceive that they did not get what they want rather than that the appropriate and an honest evaluation was done.

But we have gone to a large degree. We have hired more than 3800 mental health people over the last year and one-half to provide services and expand services. We are trying to put those services as far forward into our CBOCs as well as our clinics, increase the number of Vet Centers to provide services. So we are doing everything we can to provide services that make it convenient and easier for the veteran to come in.

As we talked about, and it was mentioned in opening statements, patients do not come to say, oh, I think I have PTSD. They usually come—and we know this from the 300,000 or so OEF/OIF veterans who have already come to us—is that they generally come for some other thing. They may come for a musculoskeletal thing.

As you know, we screen everybody for PTSD in an effort to determine whether there is any possibility of a diagnosis of PTSD. Then we realize also that people are reluctant to go to a mental health clinic because there is stigma, again, related to that. That is a societal thing. It may be more so in the group of patients that we take care of.

And I speak from 35 years of experience in that. Perhaps some people think I should have gone to the mental health clinic. I do not know.

But the important point here, not to make light of it, is that what we have done is had an innovative process of putting mental health in the primary care clinic, putting mental health people there, partnering with the primary care people so that as much as possible we can provide mental health services in a more friendly and less stigmatizing environment for patients, because we are concerned that people will not follow up if we send them to a mental health clinic. And that has been eminently successful with our primary care and mental health people and Dr. Katz.

The other thing that we are doing, as you know, is waiting for people to come to us. We have seen about one-third or 35–37 percent of the total number of people who have served in the theater. And so, at least we have an opportunity to interact with PTSD, or any other thing for that group.

But what about the other 60 plus percent who have not come to us? With the Secretary's leadership, we have embarked upon a very aggressive campaign of calling all the people that we have contact numbers on—over 500,000 who have not come to us—but who already have received two letters from the Secretary saying we are here for you, and for whatever reason have chosen not to use us. Maybe they have their own health care insurance or maybe they do not need any health care. However, that is not the issue.

The issue is to try to get in touch with them, particularly offering them mental health services and other things because we know people are reluctant to come.

We have been suggesting and we are working now—you know, we have talked about the 24-hour suicide hotline, and I think you have been briefed on that previously—to develop a different type of 24-hour hotline, really an extension of rehabilitation services that Dr. Adonis Al-Botros gives to Vet Centers.

So not only will we have the Vet Centers themselves that people can go to, but they would be staffed by people hired by Dr. Al-Botros in the Vet Centers to be eligible to take calls 24/7, to talk to people because, as you know, many of these combat veterans appreciate talking to someone who has walked in their shoes.

They have done a great job, as you know, over 25 years, and we would like to extend that into a virtual clinic that would be open so that people do not even have to go look or try to get to a Vet Center or a facility. They would have the ability to call and get counseling.

This is not meant to replace any other 800 number but rather specifically talk about some of the readjustment issues, PTSD and other things; not suicide. If suicide came up in the context of this, they would be referred to the suicide hotline because you do not want dueling hotlines.

So, these are some of the things that we are doing to aggressively assist people. But it is a challenge, as mentioned. Particularly mental health, people are reluctant to come. And what we are trying to do is make it easy for them to come. Again, not to belabor the word, but to de-stigmatize it and make sure people feel comfortable

about what we can do. We cannot impact if they do not come and see us.

Chairman AKAKA. Thank you, Dr. Kussman.

Dr. Perez, I do not feel as if this issue has been adequately addressed. The first line of your email notes that there are, and I am quoting, "more and more compensation seeking veterans," unquote.

What exactly did you mean by this? It appears to me and many others that you were linking diagnosis of PTSD and potential compensation together and thereby either intentionally or unintentionally raising concerns about the cost to VA.

Can you please clarify what you meant by this?

Ms. PEREZ. Yes, sir. What I was stating there was the fact that there were those individuals—it is even more critical to be sensitive to what they have already gone through with a C&P interview and knowing that they have had another evaluation—so we have to really be very very accurate in our diagnosis.

All of our clinicians strive to give the accurate diagnosis. But when you have somebody who may have already seen a professional, then you want to really make sure that you are going to be consistent and accurate with your diagnosis so that you do not add to any distress levels.

Chairman AKAKA. I have other questions here. I am going to defer to our Ranking Member for his questions at this time.

Senator BURR. Thank you, Mr. Chairman.

Dr. Kussman, I had the opportunity with the opening of a CBOC in Hickory, North Carolina, to see the changes that you are making relative to mental health that makes a tremendous amount of sense.

Mr. Chairman, I would ask unanimous consent to enter three letters into the record. Two to General Peake and one to Dr. Kussman.

The first one is from the University of Pittsburgh Medical Center, Western Psychiatric Institute Clinic where within the body of that letter it states, "I am writing on behalf of the president-elect of the American Psychiatric Association to support the VA in their efforts to care for veterans. A substantial amount of effort has gone into revitalizing the system." So that was to Secretary Peake.

The second one, Mr. Chairman, is from the Association of VA Psychologist Leaders, and I will also read from the body.

"We are very appreciative of the enormous efforts by all of you at the VA and especially the Office of Mental Health Services in supporting the efforts of those in the field to provide the best quality mental health care possible to our veterans." That was to Dr. Kussman.

The last one is from the American Society for Suicide Prevention on an email that went to Secretary Peake. And I will also read from the body.

"Dr. Ira Katz is an outstanding leader for this work. He is uniquely qualified to organize the best programs based on the latest psychiatric research."

I would ask that they all be in the record.

Chairman AKAKA. Without objection.

[The three letters follow:]

ASSOCIATION OF VA PSYCHOLOGIST LEADERS,
May 1, 2008.

MICHAEL KUSSMAN, M.D.,
*Under Secretary for Health,
 Department of Veterans Affairs,
 Washington, DC.*

DEAR DR. KUSSMAN, This last March you were very generous in spending time with the Executive Committee of the Association of VA Psychologist Leaders (AVAPL) during our recent trip to Washington, DC. It was very useful to hear about the large array of policy issues that have to be dealt with in order to provide resources to those of us in the field.

AVAPL is an independent organization of VA psychologists in leadership positions or psychologists aspiring to leadership positions. As such, our membership directly benefits from the resources provided by VHA and, more specifically, the Office of Mental Health Services. In the past several years, we have experienced a very large and beneficial increase in resources available to us to help meet the mental health needs of veterans. Many new positions have been created and filled and this has substantially increased the number of psychologists within VA. It has allowed for the creation of new and innovative programs for the treatment of traumatic brain Injury and Polytrauma, integrating mental health and primary care services, expanding treatment options in areas such as PTSD and substance abuse and residential treatment for homelessness. The recent placement of Suicide Prevention Coordinators at facilities and the creation of a national VA suicide hotline have greatly enhanced our ability to assess for and respond to these emergent mental health issues. We are very appreciative of the enormous efforts by all of you in VHA and especially the Office of Mental Health Services in supporting the efforts of those of us in the Field to provide the best quality mental health care possible to our veterans. AVAPL as an organization also remains dedicated to promoting this same goal.

Sincerely,

STEVEN LOVETT, PH.D.,
*President,
 Association of VA Psychologist Leaders.*

AMERICAN FOUNDATION FOR SUICIDE PREVENTION (AFSP),
New York, NY, May 04, 2008.

JAMES B. PEAKE, M.D.,
*Secretary
 Department of Veterans Affairs*

DEAR DR. PEAKE, As Medical Director of the AFSP I strongly encourage the administration to continue to support the valiant efforts of the current VA leadership. They face an enormous task because the frequency of PTSD with depression and suicide is high and a suicide outcome is very common. Their Hotline and hiring of suicide prevention coordinators are the first steps in dealing with this unprecedented problem. Many other things must follow, but this is a very appropriate beginning. Dr. Ira Katz is an outstanding leader for this work. He is uniquely qualified to organize the best program based on the latest psychiatric research. Please don't do anything to interfere with the progression of care that must be instituted.

Sincerely,

PAULA J. CLAYTON, M.D.,
Medical Director.

Cc: Clayton Paula

UNIVERSITY OF PITTSBURGH MEDICAL CENTER,
 WESTERN PSYCHIATRIC INSTITUTE AND CLINIC,
Pittsburgh, PA, May 5, 2008.

Dr. JAMES B. PEAKE,
*Secretary of Veterans Affairs,
 Office of Mental Health Services
 Washington, DC.*

DEAR DR. PEAKE: Serving the health care needs of our veterans is one of the greatest honors a clinician can experience. The current war, and the political attention to the war, has brought the health care of our veterans to a national forum. We are fortunate that mental health care has been recognized as a vital part of the

health care system. Indeed, the Department of Veteran Affairs may be the largest mental health group in the country. I am writing on behalf of the President-elect of the American Psychiatric Association to support the VA in their efforts to care for veterans. A substantial amount of effort has gone into revitalizing the system. These efforts should not go unnoticed. In the last year alone, the VA has developed a suicide hotline and placed a suicide prevention coordinator in every facility. The system has accomplished true integration of behavioral health into primary care. Moreover, the VA has established a minimum set of requirement for all programs to follow in an effort to bring new evidence based treatments to every facility and every veteran. These efforts are unprecedented in our society. While there is more work to be done, I want to applaud the Office of Mental Health Services for the dedication and innovation that they have shown during the last two years. I am committed to continue working with VA leadership in accomplishing the goals of developing a truly national mental health system for veterans.

Sincerely,

CHARLES F. REYNOLDS III, M.D.,
*UPMC Endowed Professor of Geriatric Psychiatry,
 Director, Advanced Center for Interventions and
 Services Research for Late-Life Mood Disorders and
 John A. Hartford Center of Excellence in Geriatric Psychiatry.*

Senator BURR. What we see, and I say this to all our witnesses, we have an oversight responsibility that cannot be ignored. And when issues are raised, whether they are internal or external—these happen to be external—it is appropriate for this Committee to begin to look. Do we know the full breadth of the problem? Is there a problem? If there is not, is there a reasonable explanation?

Hopefully, at some point in the process we also remember to ask whether we are making progress. Are we positively affecting the lives of more veterans? Are we learning? Are we, as I read from the piece on Dr. Katz, are we using the latest of what we have learned to incorporate in the delivery of care for patients?

It is certainly my hope that we are doing that and I have every reason to believe that there is every effort made at every level of the VA to incorporate that into a field that is very difficult, and I think Dr. Perez has alluded to that.

Let me just ask two very pointed questions because they were raised in opening statements.

Dr. Kussman, Senator Murray said that we did not have enough resources to treat mental health. Do you have the resources needed to provide mental health services to our veterans?

Dr. KUSSMAN. Mr. Ranking Member, yes. Again, if you talk to any of our mental health people I believe you will be told that frequently when we are challenged about providing services in some geographic area, it is not the resources themselves but the ability to buy those resources or provide those resources.

And so, I believe that there are adequate resources. As he said, almost \$4 billion, significant amounts targeted directly to PTSD; 3800 new employees.

Actually we have been so successful that there was an article in a mental health journal that sort of in a backhand way criticized the VA for having scooped up so many mental health people in the country that we are hurting the delivery of care in the civil community. And I know my friends south of the river at the Pentagon who we have been challenged to hire more mental health people are a little frustrated with us because we got ahead of them, and they are having challenges hiring people because there is a shortage of

mental health services, psychiatrist and Ph.D. psychologist nationally.

Senator BURR. We see that in North Carolina.

Is there a culture in the VA that ignores or devalues mental health needs?

Dr. KUSSMAN. I do not believe that to be the case. If I was aware of any kind of culture, I would be at the forefront of trying to change that culture. I think that our people understand the mission that we have and they are committed to doing that.

I will respond to Senator Tester, if I might, where he had talked about the culture. I do not think it was the culture, I hope he was not mentioning the culture of not providing services but responding to needs and things related to that.

Senator TESTER. It was the response I am talking about, the response to the needs.

Dr. KUSSMAN. Of issues coming up with whether it was the construction or hiring more people or whatever it was. This is a huge organization. We are well aware of that. The Secretary and I are working very hard to inculcate changes.

I have four primary things that I am pushing at. One is patient care and the second one is leadership. We are working hard to develop the appropriate leadership and the understanding of everyone in the system to expeditiously look at the problems that we have. If we cannot fix something, admit it. Be transparent. Communicate with the congressional people and the VSOs. We have a good new story to talk about. And when it gets clouded by the perception or the reality of people not responding, shame on us.

Senator BURR. Dr. Perez, two quick questions and really going to what the Chairman raised and that was in your email, compensation-seeking veterans specifically. What relationship does your clinic have with the disability compensation process?

Ms. PEREZ. No relationship whatsoever.

Senator BURR. Were there veterans looking to your clinic to improve their health through treatment or to provide diagnosis of PTSD that could be used to substantiate their disability claims that drove that phrase?

Ms. PEREZ. No, not at all. Our clinic is just a treatment clinic. That is it. We are pretty clear with all our veterans that this is why we are here, to offer the treatment.

Senator BURR. So, given the nature of your treatment facility—even though I agree with you that this could have been worded differently in your email—it cannot imply that veterans were only there to try to enhance their disability claims because you had no connection to disability process and you are there not to do anything other than treat for mental health illness?

Ms. PEREZ. Exactly. It is just a treatment clinic.

Senator BURR. I thank you for that.

I thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator Murray.

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

Like a lot of my colleagues, I am very concerned not only with the content of Dr. Perez's March 20th email but also with its potential implications.

A lot of our veterans perceive the VA as an obstacle rather than an ally today. I know everyone is working in an effort to make that better. I am greatly concerned that this incident only adds to that impression. I think that is part of why we really need to get good strong answers from all of you.

I do have a lot of questions but I want to begin by asking Dr. Perez today if her testimony was reviewed by the OMB today before you gave it?

Ms. PEREZ. Pardon me. I am real new to the VA and unfamiliar with the initials.

Senator MURRAY. With the Office of Management and Budget.

Ms. PEREZ. No, no, no. The reason I was so grateful to be invited here was that I was given the opportunity to give my entire story.

Senator MURRAY. Good. So you wrote it yourself.

Ms. PEREZ. Yes.

Senator MURRAY. It did not go to any other agency or get reviewed by anybody before it came?

Ms. PEREZ. Correct.

Senator MURRAY. Great. OK.

Dr. Perez, your email raises a serious question about whether or not veterans are receiving inadequate evaluations for their mental health issues because the VA lacks the staff or the money that they need.

Can you tell us how much time you think is needed to properly evaluate a veteran to accurately diagnose PTSD?

Ms. PEREZ. It really is on an individual case basis, because in order to diagnose anyone with PTSD, they have to be at the point where they are ready to share their most traumatic experience, and that takes time. So in order to compassionately do that, it has to be at the veteran's own pace and on their time table.

Senator MURRAY. So it may take some time to do that?

Ms. PEREZ. Right. It is very different for each one.

Senator MURRAY. How much time did VA staff spend with veterans when they were evaluated for PTSD at Temple VA Medical Center where you work?

Ms. PEREZ. When we do our intakes, they can range usually anywhere from half an hour to an hour. It kind of depends on the veteran and what time they get there and what materials they have already answered for us. But usually at the intake our goal really is to kind of gather information that will help us identify the most significant symptoms that bring them there that day and what are the strengths and the limitations that they have in treatment so we can develop a treatment strategy.

Senator MURRAY. So it is a very complex process.

Ms. PEREZ. It is very complex, yes.

Senator MURRAY. You are on the ground. Do you think that the VA has enough staff to properly evaluate the veterans you are seeing with mental health care issues?

Ms. PEREZ. Well, I know in my clinic we did have an opening. So, I think that they are, from what I see, intensely, actively recruiting to try to get those positions filled, specifically, in Central Texas.

Senator MURRAY. OK. I understand they are trying to be filled. But do you think you have enough staff to evaluate everybody in the complex procedures that you just talked about a minute ago?

Ms. PEREZ. Like I said, for those that we have there and the numbers that are coming in at this current time, we do have that staff. But at any given day you really do not know the numbers that are going to walk through the door.

Senator MURRAY. I think at least why I am confused is because the actual language of your email is “we really do not have time to do the extensive testing that should be done to determine PTSD.”

Ms. PEREZ. Right. If we were going to require—in our clinic we would accept anybody with even one single combat stress symptom. If we were to require a diagnosis of PTSD in order to admit them into treatment, then you are going to want to get that answer initially, right off the bat, and you really should do the extensive testing because you do not have the gift of time to let them go at their own pace. You have to kind of push the issue and give them more assessments and kind of push them to share their story before they are ready.

Dr. KUSSMAN. Could I just add a comment, Senator? Is that OK? Senator MURRAY. Yes.

Dr. KUSSMAN. I think what Dr. Perez was also talking about is that they have a clinic that has no wait times. People can walk in.

Senator MURRAY. I understand.

Dr. KUSSMAN. If I could just finish please. So, most people who are involved in the treatment of PTSD acknowledge that the best way to evaluate and treat is developing a relationship with a provider over time as this evolves.

Senator MURRAY. My question is do you have enough staff to do that? Because your email implies that you do not have the time to do that kind of extensive testing. I am asking you because it is our responsibility to make sure we have enough people out there that have the time, which should not be the factor that stops people from being treated.

So, your email says we do not have enough time to evaluate everybody. Does that mean you do not have enough people to do that evaluation, or you do not have—

Ms. PEREZ. That was more at the initial 1-hour or half-to-1-hour intake; that they were scheduled for that amount of time in the initial intake. If we were going to require that, then we would have to have scheduled probably a 3-hour window for the intake.

Senator MURRAY. Right. OK. Let me ask Dr. Katz and Dr. Perez a question. In the email that we have, Dr. Perez, you suggest that they “consider a diagnosis of Adjustment Disorder, rule out PTSD.” That was meant I understand to suggest that the initial diagnosis would be Adjustment Disorder while the clinician took the time to determine if a diagnosis of PTSD was warranted.

Here is my question. It is my understanding that the guidelines, the Adjustment Disorder guidelines, indicate that an Adjustment Disorder diagnosis should be limited to a period of 6 months after the event or stressor.

Now I suspect that most of our VA facilities do not see very many veterans within the 6 months of their having actually had

that stressor or left a war zone. So, is Adjustment Disorder the correct diagnosis to give to a veteran who presents with serious behavioral or emotional symptoms?

Ms. PEREZ. Well, we actually are getting quite a few veterans, that have not even completely discharged from DOD. So we do get some active duty. As part of the out-processing, they will sometimes come see us when they are still actually active duty. Also we are doing redeployment counseling because we did have quite a few veterans who were—

Senator MURRAY. In your email you suggest a diagnosis that suggests that it is an Adjustment Disorder. But from what I am looking at, that should be done within 6 months. So it is curious to me that you suggest that diagnosis when it is obvious that you are outside the 6-month timeframe.

Ms. PEREZ. Well, that is why it is just a suggestion because each clinician needs to really look at the criteria of what the veteran is presenting with—what symptoms are they presenting with—and do an assessment based on that, on whatever they are willing to—

Senator MURRAY. Dr. Katz, is that concurrent with what you believe should be done in the field?

Dr. KATZ. Thank you for asking. About the Adjustment Disorder diagnosis, my read is actually close to yours. I would disagree respectfully with my colleague about the diagnosis of an Adjustment Disorder a year after an event relating it to the event. I would have concerns about it.

There are questions, in general, about whether a diagnosis matters and whether the specific diagnosis matters. And the answer is probably, yes and no.

One thing that really does matter is making a diagnosis of PTSD versus something else. PTSD versus depression, for example. The best treatment—behavioral and cognitive—for PTSD is trauma-focused, going back to the event. But, the best treatment for depression is present-focused, dealing with current problem-solving, beliefs and thoughts. So, diagnosis matters to help someone plan treatment.

In another sense, however, diagnosis does not really matter that much. There are a certain number of symptoms required for PTSD. Many people have subclinical PTSD or partial PTSD where they may be one symptom short of the number required for a formal diagnosis. And my read is that the best treatment for subclinical, subsyndromal partial PTSD is the same treatment as PTSD.

So, if someone does not quite make the diagnosis for PTSD, I would think if they are suffering, they should get exposure-based treatments just like if they have PTSD.

Senator MURRAY. Thank you for your honesty on that which goes really to my real concern, and our responsibility is that this is a difficult diagnosis. Our job is to make sure that we do have enough people on the ground who are capable of doing that in a timely fashion and that we do not have a VA or a system or anywhere isolated or not to say, “do not make this diagnosis because we do not have the resources.” It rather should be we need the resources so we can make the proper diagnosis.

And I have a number of other questions but I know my time is out so, Mr. Chairman, I will wait until the second round. Thank you.

Chairman AKAKA. Thank you, Senator Murray.

Senator SANDERS.

Senator SANDERS. Thank you, Mr. Chairman.

Let me begin with Dr. Katz. Dr. Katz, I am looking at the email that you exchanged with Ev Chasen, Chief Communications Director. In it you respond to Mr. Chasen and you say, “Shhh. Our suicide prevention coordinators are identifying about 1000 suicide attempts per month among the veterans we see in our medical facilities. Is this something we should carefully address ourselves in some sort of release before someone stumbles on it?”

Media reports tell us the Army just reported that at least 115 soldiers killed themselves in 2007. Is this an epidemic? A thousand attempted suicides—that sounds like a very large number.

Dr. KATZ. The “is it an epidemic question” comes up again and again. Is a thousand a month too many? Of course, it is too many. Are there too many suicides among veterans? Of course, there are too many suicides among veterans.

Senator SANDERS. That was not my question. One suicide attempt, no matter where, is one too many; but 1000 a month sounds like an extraordinary number. What is going on where 1000 guys who were in the military—people who were trained, tough guys—are attempting suicide? Can you give me something?

Dr. KATZ. Yes. Could I comment on the “Shhh” email first for just a minute? I was very excited when I learned about this finding and I wrote to a friend on the eighth floor, Mr. Chasen, asking what should we do with this new knowledge? Should we send it out to the field or should we use it to improve care first? I was writing to someone who gets about 400 emails a day so I wanted to get his attention right away and I was far too dramatic in trying to do that.

Senator SANDERS. I am not here to talk—I just want to know the numbers. Go back to this issue. Is it true that a thousand soldiers a month are attempting suicide? Is that true?

Dr. KATZ. Well, we still have to validate that number. We expect so. We know from NIH data that the ratio of suicide attempts to deaths from suicide is between 8- and 25-to-1.

Senator SANDERS. Excuse me. I am just asking one simple question. All right, to a lay person, the fact that you have a thousand active-duty soldiers, a thousand soldiers—

Dr. KATZ. A thousand veterans.

Senator SANDERS. A thousand veterans—I am sorry—a month. That sounds like a very high number. Is that not the case?

Dr. KATZ. It is a thousand attempts. We do not yet know how many multiple attempts there are. It is within the expected range but it is too much.

Senator SANDERS. OK. What about—

Dr. KATZ. It does suggest something, through, if I may. We know that the group at highest risk for suicide is those who have previously attempted suicide. So this knowledge is an important window into prevention.

Senator SANDERS. What about 115 soldiers having killed themselves in 2007 within the Army?

Dr. KATZ. I have read that in the paper and in the Pentagon report just as you have. That is very separate from the VA.

Dr. KUSSMAN. Sir, if I could just add to that question.

Senator SANDERS. Yes.

Dr. KUSSMAN. I am obviously aware, and as Dr. Katz just mentioned, that is the Department of Defense, not us. But as far as my understanding of that number, even though it has gone up, if you look at an age-adjusted population of the group that are in the uniform that commit suicide, it is a lower rate than it is in the civilian community for an age-adjusted population.

It is not to say that it is not going up, but suicide is a great problem in our society, particularly in young people who tend to be somewhat impulsive. So I think that the military is well aware of that and so are we. And the question is why do they do it? And we are looking at research and everything to try to determine what etiologies would lend somebody to be more susceptible to suicide than others.

Senator SANDERS. 115 soldiers in the Army in 2007 killed themselves. Again to a layman this seems like a very high number. Is that not, in your judgment, a very high number?

Dr. KUSSMAN. I am saying it is much higher than we would like to see.

Senator SANDERS. That goes without saying.

Dr. KUSSMAN. But if you put it in perspective and I am not trying to minimize it in any way, shape or form. But it is my understanding that if you look at the same age group of people who never put on a uniform, the amount of suicides per 100,000 is higher.

Senator SANDERS. If I could ask Mr. Dunne a question.

Mr. Dunne, the AP recently reported on VA documents it had obtained that said that the government expects to be spending \$59 billion a year to compensate injured servicemembers of the next 25 years, up from today's \$29 billion. The AP story noted that some at the VA believe that these are conservative estimates.

Overall there are some people who think that the end result of this war might be as high as some \$3 trillion, and that one of the reasons is that there will be a huge amount of money spent over the lifetime of soldiers who served dealing with their wounds, mental and physical.

What is your estimate in terms of how much we will be spending per year to compensate injured servicemembers?

Mr. DUNNE. Senator, I do not have numbers with me with that calculation. I can make a projection and get back to you afterwards.

Senator SANDERS. I would appreciate that.

If the number is really what the AP says it is, \$59 billion a year, I mean that is for the next 25 years. That is just an extraordinary sum of money. And I would like to know if that is accurate. And it gets to the issue of what the cost of war is. When we go to war, it is not just the guns and tanks of today; it is the cost years into the future.

Last, if I could, Mr. Dunne, as I understand it, there are some 400,000 outstanding claims for our veterans. I know that this Committee and the Congress has put a lot more money into the VA in recent years not only for health care but to accelerate the processing of these claims.

Are we making any progress?

Mr. DUNNE. Senator, I think we are making progress. We are not happy with where we are right now. We are striving to do better. As of the first of this month, we had an inventory of 390,034 claims which we were still working on. We have made progress on our hiring initiative. We have hired since January 2007—2650 approximately of the 3100 that we intend to hire by the end of this fiscal year.

They take about 2 years to become journeyman status when they are most effective at handling claims, but probably within the first year that they are onboard and complete their training they can begin to have an impact.

We think that we are starting to see an impact on that but we are continuing to look at other initiatives such as a paperless environment. This week we have just instituted electronic signatures for original applications for claims and education and VR&E.

Senator SANDERS. This is an issue that interests me very much. I look forward to talking with you more in the future.

Thank you very much, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Sanders.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman.

I want to thank you all for your service. I appreciate your testimony today. I want to echo the Chairman's remarks. This email is not why I am here exclusively. You hear a lot of things on the ground that are going on from veterans and I think this email contributes to that because it reaffirms what you hear on the ground.

I am going to bring up two cases that reflect back to what you said earlier. This has nothing to do with mental health. It has to do with a clinic that is to be built in Billings where Secretary Peake and I thought it was to be done, yet the people down below had a different idea. We found out in the paper that it was not going to be built until 2009, and that is what I am talking about. That is what I am talking about being laid back. We will get to it when we get to it attitude. That is unacceptable.

The other thing that is unacceptable is when I was also told by a veteran that when he talks to me, he was threatened with his disability being reduced. That is unacceptable.

And I got in a bit of trouble through the papers because I said I thought the person who did that, and I did not know who it was, should be fired on the spot. But that is the way it goes.

Senator Murray talks about getting through the door. Getting through the door is proper diagnosis.

I have some questions for your, Dr. Perez. You are at the Central Texas PTSD clinic. How long have you been in that position?

Ms. PEREZ. Since June 10, 2007.

Senator TESTER. June 10, 2007. So you are coming on a year?

Ms. PEREZ. Yes, sir.

Senator TESTER. All right. Have you seen the PTSD diagnoses going up over your tenure there or is it pretty static?

Ms. PEREZ. It is pretty static.

Senator TESTER. OK. The diagnosis between Adjustment Disorder and PTSD, are there different factors involved that diagnosis?

Ms. PEREZ. Yes.

Senator TESTER. They are clear?

Ms. PEREZ. They are clear.

Senator TESTER. OK. Can you tell me, folks that come in with, that are diagnosed with Adjustment Disorder, do they stay at that level or is there a percentage that are moved up to PTSD later on; or once they are diagnosed with Adjustment Disorder, they are there for a while? What is the process?

Ms. PEREZ. No, no. Immediately a treatment plan is developed and they are entered into treatment. And as their provider works with them, again at their own pace of disclosure, then that is adjusted by the provider that is working with them.

Senator TESTER. Adjusted to PTSD diagnosis?

Ms. PEREZ. It depends on whatever their symptoms are.

Senator TESTER. Can you tell me what percentage of veterans that are diagnosed with Adjustment Disorder are moved to a PTSD category?

Ms. PEREZ. I do not have that information

Senator TESTER. Can you get it for me?

Ms. PEREZ. I can take that for the record, yes, sir.

[The Department of Veterans Affairs was unable to provide this information within the Committee's timeframe for printing.]

Senator TESTER. That would be great. Can you tell me what percentage of claims where you make the diagnosis for PTSD and you find out that that diagnosis was a mistake?

Ms. PEREZ. I am not sure I understand the question.

Senator TESTER. A veteran comes in. A diagnosis is made that they have PTSD. You find out later or you do not think they have PTSD. What percentage of those that you diagnosis with PTSD do you feel that the diagnosis was inadequate or the person did not have PTSD?

Ms. PEREZ. There have actually been two cases where—because we do not require a DD-214, we do not require them to tell us, you know, everything at the initial interview—so there has been twice where I have been told that.

Senator TESTER. Out of how many cases?

Ms. PEREZ. That I do not know.

Senator TESTER. Out of a hundred?

Ms. PEREZ. More than that.

Senator TESTER. A thousand.

Ms. PEREZ. Well, probably close to a thousand.

Senator TESTER. In your facility.

Ms. PEREZ. I am thinking just from what I have seen, my own patients that I have evaluated.

Senator TESTER. In the whole system?

Ms. PEREZ. I have no idea of the whole system.

Senator TESTER. OK. I want to go to your email, because I think it is quite instructive, and you know what it says because you

wrote it. It says that “given that we are having more and more compensation seeking veterans, I would like to suggest that you refrain from giving the diagnosis of PTSD straight out.”

So what that implies to me is that the diagnoses for PTSD that were given—for you to send something like that out—either they were not accurate at diagnosis or you want to deny benefits. Tell me what it says if that does not say one of those two things.

Ms. PEREZ. Again it was really to stress the accuracy of diagnoses.

Senator TESTER. But there is only two that have been diagnosed wrong.

Ms. PEREZ. Right. But that was in my personal experience with my patients. That email was triggered out of two other ones who had become distressed and had verbalized that distress with a psychiatrist. And so, that email was a result of trying to remind everybody to be accurate in your diagnoses.

Senator TESTER. But that is not what it says. It does not say you need to be accurate in your PTSD diagnosis. It says refrain from giving a diagnosis of PTSD.

Ms. PEREZ. Well, again, that email was written specifically to my clinical staff there.

Senator TESTER. There has to be a reason for this. So what is the reason that you send this email out? I do not mean to put you on the spot.

Ms. PEREZ. No, no. I understand. But I mean it was a real significant issue when you have got two veterans that are coming to you very distressed.

Senator TESTER. Yes.

Ms. PEREZ. And it led to some—

Senator TESTER. So what you are saying is those veterans were diagnosed with Adjustment Disorder and they really had PTSD?

Ms. PEREZ. Well, what I was told from the psychiatrist was that they were given a diagnosis of Adjustment Disorder when they had their compensation and pension examination. At intake a clinician gave them a diagnosis of PTSD. They went for their psychiatric consult, and that psychiatrist evaluated them and showed, OK, you do have symptoms of combat stress but you do not meet criteria for PTSD. At that time, in both instances the veterans became very distressed, and in one case they charged the psychiatrist, and so it became a safety issue.

Senator TESTER. I am trying to track you here. What you are saying is they were diagnosed with PTSD and then they came in and they back off that diagnosis?

Ms. PEREZ. No, no.

Senator TESTER. So you are saying they were diagnosed with Adjustment Disorder and they went in they were kept at Adjustment Disorder?

Ms. PEREZ. No, no, no.

Senator TESTER. So the only third option left is they came in with Adjustment Disorder and they were diagnosed with PTSD.

Ms. PEREZ. Right. Then another team member, a psychiatrist—when they went to go have an evaluation to see if they needed any kind of medication—

Senator TESTER. Yes.

Ms. PEREZ [continuing]. Then that second team member stated no, no, no, you do not have that. You do not meet criteria but you do have combat trauma symptoms.

It is not unusual for someone to come in and have a different rapport with a different provider so they may share different information.

Dr. KUSSMAN. Senator.

Senator TESTER. Go ahead.

Dr. KUSSMAN. I do not want to belabor it. I apologize. But as Senator Murray mentioned, this is complex stuff sometimes with things. I think what we are doing here is that the individual may have been in the system before and may have submitted a claim for PTSD.

Senator TESTER. Sure.

Dr. KUSSMAN. That went through the process, and on occasion they do not get their diagnosis. Most people do, by the statistics, but some do not.

Senator TESTER. Yes.

Dr. KUSSMAN. The person may then still have symptoms.

Senator TESTER. Yes.

Dr. KUSSMAN. No question. They are enrolled with us and then they come to a treatment clinic like Dr. Perez is working in. It has nothing to do with compensation. But they are still pretty upset that they did not sometimes get a diagnosis of PTSD when they went through the VBA process. So they come in, and again, in the intake on the cases that I think Dr. Perez was talking about somebody said I think you have PTSD—

Senator SANDERS. What you are saying is you have two docs that have a different opinion on what is going on, right?

Dr. KUSSMAN. Right.

Senator TESTER. OK. I know this is complicated stuff. I know we are on grounds where we have got, what, 30 percent of the folks coming back. There is a claim that there is PTSD involved. I know that this is new ground. I know you are hiring, what, 3800 new psychiatrists, psychologists. I know you are doing this stuff.

But I can tell you what the veterans think because I just talked to a bunch of them last week. They think that they are given this Adjustment Disorder diagnosis so that it takes away the government's liability in paying for anything that may be more than that. That is what the veterans think. That is what the people who put their lives on the line for this country think that the VA is doing to them. That is what they think. Perception is reality.

What I have to say is just I am not a doc. You guys are far more educated than I am, probably. We have got to have definite criteria for PTSD and you have got to have definite criteria for Adjustment Disorder so that, quite frankly, you can sit down and explain to the person why. That is what is really important.

The other thing is that I am going to go back to the very first statement. Make sure that people below you are doing what you want them to do. That is critically important because you can have the best, the best intentions, and if the folks on the ground that are working with the vets are not doing what needs to be done, you guys end up in front of a hearing, in front of the VA Committee in Washington, DC.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Tester.

Dr. Perez, in your testimony you make two points about the best way to provide a diagnosis for PTSD. One, that a differential diagnosis is good medicine; and two, that trust must be established before PTSD can be identified. I agree with both of these points.

I am concerned, however, with how you appear to have made these points in your email to your colleagues, your suggestion to them. When you were preparing your email, did you believe that the other clinicians of the PTSD treatment team, some of whom have many years of experience with PTSD, whether they were not aware of the treatment approach you set forth in your testimony?

For example, did they know about providing a differential diagnosis even one that Dr. Katz said was probably not the best one?

Ms. PEREZ. Yes, they do know that. They are very familiar with that and very—my thoughts are that they are probably very accurate in that.

Chairman AKAKA. Dr. Katz, you said that Adjustment Disorder is probably not a good suggested diagnosis. What are you doing to ensure that your providers understand your position on this?

Dr. KATZ. Well, specifically after that 6 months or so period, as Mrs. Murray mentioned, I would have concerns about it. I think the issue comes to how doctors say, “I do not know” or “I do not know yet,” and I think this is the issue that Dr. Perez was probably addressing.

Sometimes after one-half hour or an hour or an hour and one-half with the patient, you do not know enough to make a diagnosis. We have to allow coding for that in an appropriate way to be able to get credit for the visit but not to commit ourselves prematurely to the presence or absence of any diagnosis.

Chairman AKAKA. Dr. Kussman and Admiral Dunne, do you agree that there may be confusion for both veterans and clinicians when a particular clinician may act as both care provider and evaluator? Does this suggest that C and P exams, that is, compensation and pension, should be conducted by non-VA physicians; or at a minimum, that no VA physician who provides direct care should be tasked to conduct a C and P exam?

Dr. KUSSMAN. OK. I win. First of all, Mr. Chairman, there are two ways that the exam is done, as you know, either through the VHA personnel or under contract with QTC. And the evaluation is very proscribed. There are templates and other guidance that have to be followed.

We have set standards for that saying that only psychiatrists and Ph.D. psychologists should do that. Although the IOM did not put that level of proscription, we wanted to be sure that that took place.

If you are asking specifically about whether a psychologist or psychiatrist who was taking care of somebody in a clinical setting be the one that does their Comp and Pen, I would have to think about that. But, the fact that somebody is in a clinic and does a Comp and Pen exam would not preclude them from doing it, because we have lots of people who maybe Monday and Wednesday they are in the treatment clinic, and maybe Tuesday afternoon they are doing Comp and Pen exams.

So, I do not think they are mutually exclusive. But if, you know, we want to separate the clinical treatment from the assessment of how much compensation a person gets I think I would—and again I do not know if anybody has done it on their own patient—but that would, I think, not be the best way to do it.

Do you have any comments?

Chairman AKAKA. Admiral Dunne.

Mr. DUNNE. Senator, I would agree that, as people have said this morning, the process is very complex and what I have learned over the past 2 months is a review of the template that is used to conduct that examination, which is a very very extensive and complex template. I have confidence in that. I have confidence in the VA doctors to execute that template and to provide us with a valid, medically correct evaluation of every veteran who comes to see them.

Chairman AKAKA. Thank you very much.

Senator Burr.

Senator BURR. Thank you, Mr. Chairman.

Admiral Dunne, your testimony noted that there has been 150 percent increase in the number of veterans receiving disability compensation since 1999. In 2004, the Inspector General found that veterans PTSD rating levels, and I quote, “typically increase over time indicating the veterans’ PTSD condition had worsened. Generally, once a PTSD rating was assigned, it was increased over time until the veteran was paid at the 100 percent rate.”

Does your information square with the IG’s findings—that veterans with PTSD get worse over time?

Mr. DUNNE. Senator, I do not have that information but perhaps Mr. Mayes does.

Mr. MAYES. Yes, sir. What we know is that—or I guess what the IG found was that—once veterans were service-connected for PTSD that it was rare that service connection was stopped or that the evaluations were reduced. So what we have done is, we have begun to look at PTSD. We are looking at evaluations across States and we are evaluating that as part of our quality assurance program.

So, we are taking a look at that. That was also one of the things that the Institute for Defense Analysis also recommended, that you take a look at any possible variants and, you know, any underlying causes for that.

So we are taking a look at it. But I cannot, other than that—I guess the question was does it square with the IG report. That is what we found. That’s what the IG found.

Senator BURR. Let me go to the clinician if I can. The 2007 Institute of Medicine report found insufficient evidence to support the effectiveness of most PTSD treatment therapies with the exception of exposure therapy.

If, in fact, we see this trend of increasing PTSD claims, a worsening of the disability over time, is that not a suggestion to us that we either need to implement total exposure therapies because it is the only one that has the evidence of success; or, two, that we need to look outside of the therapies that we are currently using to try to find something to turn this trend around. Or would this Committee accept the fact that from the standpoint of mental health

treatment there is no cure, that we are managing a continual progress of getting sicker? Somebody help you with that.

Dr. KATZ. I like to think about an analogy, and the medical advance that came out of World War II was penicillin. It was known that penicillin existed in a laboratory and could kill bacteria there beforehand. But it was during the war that it was translated into a drug that helps people.

There was information about exposure-based treatments before but in the past year or year and one-half, the VA has trained almost 1200 people—existing staff members—to deliver cognitive processing therapy for PTSD.

That is a huge number—enough to make a public health difference. We have similar programs underway for prolonged exposure therapy. So, we are very seriously working to disseminate these treatments. I hope these treatments can be the “penicillin” that comes out of this war.

Senator BURR. Dr. Katz, is the intent to try to cure, to try to delay any further disability?

Dr. KATZ. I want to respond to that and then talk about medications and research.

PTSD is probably like asthma. We want to treat events. We want to treat exacerbations and deal with symptoms. But once someone has had PTSD, I am afraid they may be increasingly vulnerable throughout their lives to retraumatization or stress-induced traumatic reactions.

So we hope the treatment does both to deal with the event, to deal with the episode and to decrease the probability that another one would occur with retraumatization.

Going back to other forms of treatment, the Food and Drug Administration views certain anti-depressants as safe and effective for the treatment of PTSD. So, they differ in some ways with the Institute of Medicine.

What this calls for is a need for more knowledge; a need for research. And VA has been and continues to be a real leader in research.

Senator BURR. Dr. Kussman keeps us up-to-date on the progress.

Dr. KUSSMAN. Yes, sir. If I could add to it, I think that it is clear that you want to aggressively try to intervene early in the diagnosis because sometimes the long-term effects of PTSD are not really PTSD itself. It is the second- or third-level effects where people will try to treat themselves with substances or get depressed.

They frequently are the more severe things, longitudinally, rather than the PTSD itself. So that is why it is so important to try to get people in early, get them to feel comfortable so you can prevent or attenuate some of those long-term issues.

What the IOM said, I think, sir, is that when they looked academically, critically at the literature that was available, what they said was the only treatment—the exposure treatment—was the only one that they could say unequivocally had effect on the basis of the search that was available.

But they did not say that other therapies like medication and psychotherapy and things were not effective. They just did not think there was evidence to show it was as effective as the—

Senator BURR. Yes. The key word is “evidence.” Let me just summarize by making a statement, and I think this might express why there are so many questions about this from this Committee.

Since the year 2001, the mental health budget at the Veterans’ Administration has doubled. Staffing has increased 73 percent over the last 3 years and we are not where we are targeting yet, but we have got an aggressive goal as to how we are going to get there.

Yet, people are still asking for an explanation about why our veterans are getting worse versus better, as it relates to mental health services.

I am not going to take up my colleagues’ time asking for an answer. I am not sure that there is an answer. But I think that is the focus of where we need to be.

If all agree that the resources are there, that the plan to hire the people and to train the people, which was a very important part of the statements that you need, and that we understand to some degree, to quote Dr. Perez, how we need to peel the onion back before we begin to realize the true problem or the depth of the problem.

At some point I hope you will share with us what it is we should use to gauge success versus a continued worsening of the health of our veterans; an increase in their disability ratings, which is an indication to me that the therapies that we are using are not working. And my hope is that that will turn around.

I thank the Chair.

Chairman AKAKA. Thank you very much, Senator Burr.

Senator MURRAY.

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

I would hope that the gauge of our success is that after a very complex, difficult war—10, 15, 20 years from now—we do not have men and women who served in that war who came home and who were not treated.

I guess, really, the bottom line here is Post Traumatic Stress Disorder is not a new issue from just this war. It has been from every war. In World War I and World War II, many of our veterans came home and suffered from mental health issues and may or may not have been treated.

Certainly, the ones that I know better—the Vietnam War veterans—came home and because of a culture that was not ready to accept them, many of them never tried to get treatment, and did not get treatment. We did not have the term PTSD in our vocabulary at the time. And as a result, decades later those men and women are suffering.

I think what we want is to make sure that in this conflict that our generation is responsible to make sure that we do not have veterans 20 years from now who were not given treatment.

Hence, Dr. Perez, our deep concern with an email that indicates that because of cost, because of time, because of whatever reason, we are not going to give you a diagnosis. That is the genesis of the concern that many of us have.

It is difficult, but we need to make sure that any veteran who seeks care is not under the perception at anytime that they will not get that care, that the VA or this country does not have the time for them, or the resources to help them.

We have to make every effort to do that, and every message coming from the VA has to be that—that if you are a veteran and you need care, this country will be there for you. Period.

So, Dr. Kussman and Secretary Dunne, I want to ask you. The Chief of Staff at Temple apologized to the veterans and to the advocates about Dr. Perez's email. Both Secretary Peake and Deputy Secretary Mansfield have repudiated the email and that was good. It needed to be done. The message had to be clear.

I was sort of struck by both of your testimonies today, that they did not appear to have any remorse, and I wondered if you could explain that, both of you.

Dr. KUSSMAN. Senator, I think I said that any perception or real that we were not approaching veterans in an appropriate way and gave any perception that we would not make the diagnosis is something that I cannot accept.

There were some, as we discussed, some interpretation of what took place in the email and I think that we have adequately discussed this here. But I have just as much concern about all the things that you mentioned.

But I think a lot of it is communication; and we do need to be able to be sure that we are explaining what we are doing and things do not get taken out of context.

Mr. DUNNE. Senator, I would agree that the email was poorly worded, and it is an unfortunate instance but it only makes me want to work harder to ensure that veterans understand that we are here for them, whether it be for PTSD compensation or for education or for loans, VR&E, whatever it is; we are working hard to make sure that they know we are here and we want to hear from them when they need something.

Senator MURRAY. Let me just say I am confused about something. Deputy Secretary Mansfield said that Dr. Perez's suggestion should be disregarded. That came from Secretary Mansfield.

And that the people working there had been instructed this was not what we are going to do. We are going to follow Secretary Peake's direction, which is to put out the full and accurate word and make sure that we stick with that.

Yet your testimony does not in any way backpedal from Dr. Perez's suggestion even though Dr. Katz said that he would not agree with that.

Dr. Kussman, Secretary Dunne, can you tell us—inartfully worded is one thing—can you tell us what direction is from the VA in terms of the diagnosis on someone coming in, whether it should be as was stated in an email, that it should be considered a diagnosis of Adjustment Disorder or not?

Dr. KUSSMAN. As we have discussed, I think on any given case do not make the diagnosis of Adjustment Disorder if you think that is inappropriate or that it should be PTSD. And do not make any diagnosis that you think is inappropriate for anything other than the true clinical assessment of what you think.

It should have nothing to do with time or money or anything else. It should just be an appropriate diagnosis. As I said, I would agree with the Secretary and Deputy that we would repudiate any suggestion that somebody would make a diagnosis of Adjustment

Disorder in lieu of PTSD if there was any suggestion that that is not an appropriate thing to do.

Now you mentioned that Dr. Katz has mentioned that after 6 months or whatever, and I think that that is something that has to be determined on a clinical basis.

Senator MURRAY. Would you agree that most vets do not come in and see you within 6 months of when they were in the field?

Dr. KUSSMAN. Most do not. Some do, and it depends on the timing. So, if it is beyond the 6 months, I think that maybe something else would be as combat stressful, rule out PTSD. I do not know what the appropriate thing is, but the message is, I think, that just like any diagnosis: be careful when you make the diagnosis; do a thorough assessment of people.

Senator MURRAY. Do you agree with Deputy Secretary Mansfield that said Dr. Perez's suggestion should be disregarded?

Dr. KUSSMAN. If you again did not have the opportunity to discuss exactly what was going on, I would agree that it should be disregarded if it was intended in any way to be that you should not make the diagnosis.

Senator MURRAY. Admiral Dunne.

Mr. DUNNE. Senator, I have no disagreement with the Deputy Secretary, and as I mentioned before, the templates that are used for a claims evaluation examination are very specific. They are very detailed. They would require the doctor to answer a number of questions, many of them to respond to the DSM-IV criteria so that the rating representative could make a valid understanding and evaluation of the disability.

If that template is not filled out correctly or completely, the rating representative is trained to reject that and return it until it is sufficient medical evidence so that all the questions are answered, all the information is available.

Senator MURRAY. Secretary Dunne, I appreciate the complexity of the answer that you just gave. But to a country that is listening to the VA, to a soldier that has come home from a very challenging war, can you please give us in plain English what you would say to someone who is seeking help from a very difficult diagnosis of mental health?

Mr. DUNNE. Yes, Senator. I would say that if they were aware and had read about that email, that it did not reflect the guidance of VA and that they should feel confident and come see us both for treatment and compensation.

Senator MURRAY. Thank you very much.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Murray.

Senator TESTER.

Senator TESTER. Yes. Thank you, Mr. Chairman.

Dr. Kussman, either in your opening remarks or the questions you mentioned stigma surrounding mental health issues, and it is a point that I appreciate and it is a good one, and I appreciate your interest to address it from a societal standpoint.

It has been a difficult problem in Montana—the perception issue around mental illness—but the National Guard has done a great job in Montana and I do not anticipate that you've been in contact with them so let me ask this question as kind of a comment, and

that is, are you coordinating VA's efforts with State guard units around the Nation?

Dr. KUSSMAN. Yes, sir. I have not personally spoken to anybody in Montana but we have an office of seamless transition and DOD/VA coordination, and there are individuals who do nothing else but work the Guard and Reserve issues.

Senator TESTER. Good.

Dr. KUSSMAN. We have tried to learn from some of the States that have done a good job and tried to encourage States that maybe are not as engaged as others to do things.

But, my sense is that since this war has been different than any war we have had since World War II—with the use of the National Guard and Reserve—this has presented us with challenges that we have not dealt with for 60 years. And I can just tell you that we are committed to doing everything we can to do that.

Senator TESTER. I appreciate that.

Going to Senator Murray's question, I think, Dr. Kussman, what I heard you say was spot on, and that is, if somebody comes in, diagnose them properly. Do not diagnose them on additional workload or anything like that.

I just want to say that because I appreciate that, because what Admiral Dunne said in a previous question—that the template for PTSD was solid. That's good to know. Hopefully, the template for Adjustment Disorder is solid or whatever disorder they may have either below or above what a PTSD diagnosis would be.

I appreciate Dr. Katz's point about proper treatment depends upon proper diagnosis, dealing with past events or current events.

This question is for both Dr. Kussman and Patrick Dunne because you both had a part in why I am asking this question.

Admiral Dunne had said reasonable doubt goes to the veteran. And in my previous round of questions, Dr. Kussman said that there was a difference of opinion that really causes this problem.

One guy diagnoses it. One guy come in and says, or gal, says, no, this is not correct and there it becomes a difference of opinion. So if the tie goes to the runner, the tie goes to the veteran, why does not the tie go to the veteran? Or do you see it as an issue?

Dr. KUSSMAN. No. First of all, it is rare that that actually happens because most people will come to a consensus of what the individual has. I agree wholeheartedly using the baseball analogy; the tie goes to the runner.

Our job is to provide services, the full gamut of health care benefits, and not try to find ways of not doing it, and so whenever it is an appropriate clinical thing, we should err on the side of the veteran unequivocally.

Dr. KATZ. Could I?

Senator TESTER. I will get to you, Dr. Katz. Admiral Dunne first. Then you.

Mr. DUNNE. Senator, I would agree in that we do the same thing within our process. Once we get a medical evaluation in, we then have to take it into the rating table and decide on a percentage disability.

When the information in the medical exam would cause the rating specialist to have a concern as to whether it is one disability

percentage or another, then the higher disability would be assigned.

Senator TESTER. So, the rating happens after the diagnosis and not before.

Mr. DUNNE. Yes, sir, that is correct.

Senator TESTER. That is good to know.

Dr. Katz.

Dr. KATZ. When we are talking about treatment rather than compensation, the whole issue of the tie going to one side or the other does not count. The patient needs the most accurate diagnosis to allow the most precise and predictive treatment planning.

Sometimes you do not get it right the first time. Someone may be treated for what looks like depression, and during the course of treatment for depression, symptoms of PTSD may emerge and we should then change the treatment.

Senator TESTER. Right. That is why that template that Admiral Dunne talked about is so critically important. If that template is as good as we think it is it will help your treatment be solid from the get-go. Now, I am not saying mistakes cannot be made and there are not things that happened, but ultimately, in the end, what we need is diagnosis of a proper problem when that problem exists and not putting folks off.

Thank you, Mr. Chairman.

Thank you folks, too.

Chairman AKAKA. Thank you very much, Senator Tester.

Do you have any more questions?

Senator MURRAY. No, Mr. Chairman.

Chairman AKAKA. I have more questions that I will submit for the record.

In closing I again thank all of our witnesses for appearing before the Committee today. We really appreciate hearing your views on these important issues. Your testimony today will hopefully ensure that we will be able to better serve those who are suffering with invisible wounds.

While it is apparent that VA is trying to do all that it can to help, there is still much room for improvement. Issues of veterans' suicide and PTSD are topics that cannot be taken lightly.

We all must be careful about what we say, and, of course, how we say it. You are all representatives of VA both to veterans and to the public as a whole. And when it is discovered that emails such as these have been written, it reflects not just on an individual but on the Department as a whole.

VA, without question, has a very very important mission. When charged with such a heavy mission, it is imperative that VA remains the best health care system in the Nation for veterans.

We must not lose focus on that and that mission. VA is here to serve those who served us. I look forward to continuing to work with you to improve services and care for veterans and their families.

This hearing is now adjourned.

[Whereupon, at 11:41 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. BARACK OBAMA, U.S. SENATOR FROM ILLINOIS

Chairman Akaka, I want to thank you for holding this important hearing today. We are a nation at war and every day our brave men and women return home from battle with wounds both visible and unseen, and tragically these wounds can often end in death. We must do everything we can to prevent these tragedies, but unfortunately, we have been forced to battle the Veterans Administration over the past seven years to ensure that our veterans receive the best care possible.

I don't deny that the Veterans Administration can provide some of the highest quality health care in this country. Many veterans have been pleased with the care they have received at the VA. But recent events indicate a practice and a culture at the VA that seems intent on denying full care for our veterans. We have seen the deputy chief of patient care services imply that the actual rates of suicide among veterans be suppressed. We have a mental health care therapist suggesting to her colleagues that veterans with PTSD be underdiagnosed. It is too easy to suppress and ignore the invisible wounds of PTSD and mental health problems, and we cannot allow that.

When I first heard of Ms. Perez's email to her colleagues recommending an underdiagnosis of PTSD cases, I immediately called on Secretary Peake to investigate these efforts to provide fraudulent diagnosis in an effort to save money. To Secretary Peake's credit, I received the swiftest response from any Federal agency—he responded within the day—but I demanded answers to specific questions regarding the quality of mental health care provided our veterans and I expect those answers to be forthcoming.

I hear every day from Illinois veterans who are frustrated—frustrated with the bureaucracy at the Veterans Administration, frustrated with the denial of claims, frustrated with an apparent indifference to their needs. Too many veterans see the Veterans Administration as a bureaucracy with the sole goal of denying their benefits. Mr. Chairman, I know you agree that this is unacceptable and I look forward to working with you and my colleagues on the Committee to ensure that the Veterans Administration lives up to its mission—"to care for him who shall have borne the battle."

