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SERVING PATRIOTS AND HEROES: ENSURING HEALTH AND HEALING FOR OUR NATION'S VETERANS

FIELD HEARING

BEFORE THE

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SERVING PATRIOTS AND HEROES: ENSURING HEALTH AND HEALING FOR OUR NATION'S VETERANS

TUESDAY, JULY 3, 2007

U.S. SENATE,
SPECIAL COMMITTEE ON AGING,
Portland, OR

The Committee met, pursuant to notice, at 2 p.m., in the auditorium of the Veterans Administration Hospital, 3710 S.W. U.S. Veterans Hospital Road, Portland, OR (Hon. Gordon H. Smith, Ranking Member of the Committee) presiding.

Present: Senators Smith and Wyden.

OPENING STATEMENT OF SENATOR GORDON H. SMITH, RANKING MEMBER

Senator SMITH. Good afternoon, ladies and gentlemen. On behalf of the U.S. Senate Special Committee on Aging, we welcome you to this official hearing that we have entitled, "Serving Patriots and Heroes: Ensuring Health and Healing for our Nation's Veterans."

I would say that Ron and I come here as Oregon Senators, but we also come with a common concern, as a Republican and as a Democrat, for our Nation's veterans, particularly as it relates to issues of mental health, issues that both his family and mine have been touched by. So mental health is a cause of the heart for both of us.

I think because it is also the eve of the Fourth of July, we feel to wish you all a happy Fourth and a happy birthday to our Country. I am reminded of the noble words of Abraham Lincoln in his second inaugural address, when he spoke to the ongoing need that our Nation would have to "bind up the wounds of him who shall have borne the battle and of his widow and his orphan." That is the spirit we come here in today.

Now, I have a prepared statement that I need to deliver to you. I hope you find it just spellbinding. [Laughter.]

But it is important because it needs to be on the record of the U.S. Senate. Then I will turn the time to my esteemed colleague.

Ensuring proper physical and mental health care for our Nation's veterans, both old and young, is essential. In addition to the work we will do here today, I will also be meeting with facility and community mental health professionals as well as veterans' advocates at the V.A. facility in White City on Thursday.

I will use the information we gather here today and Thursday to hold a follow-up hearing in Washington, DC, later this summer so

that my colleagues in Congress can also benefit from the expertise and the many recommendations I have already heard today but which we will hear again from our witnesses that come from these events we are conducting.

While we hear many news reports on the mental state of new veterans returning from Iraq and Afghanistan, which I believe our Government must do a better job in addressing, we cannot forget the mental health care needs of our aging veterans.

What we now refer to as post-traumatic stress disorder was once described as "soldier's heart" in the Civil War, "shell shock" in World War I, and "combat fatigue" in World War II. Whatever the name, they are serious mental illnesses and deserve equal attention and care as a physical wound.

In recent reports, we have heard that 20 to 40 service men and women are evacuated each month from Iraq due to mental health problems. In addition to those who are identified, there are many more who will return home after their service to face readjustment challenges. Some will need appropriate mental health care to help them adjust back to normal life, while others will need medical assistance to heal more serious PTSD issues. Yet others will need help to mentally cope with their physical wounds.

A system must be in place to help our veterans as they adjust back to life with their families and within their communities. For this reason, I have introduced a bill entitled the "Heroes Helping Heroes Act" in the Senate to provide funding for peer support programs so that trained veterans can help returning veterans navigate the sometimes perilous adjustment process.

So many of our veterans from previous conflicts, such as World War II, Korea, and Vietnam, needed similar programs when they returned home, yet I am sorry to say we didn't do enough to help them. With proper and early support systems in place, we can work to prevent more serious and chronic mental health issues that come from a lack of intervention.

I also look forward to working with Senator Wyden on developing legislation to help combat the problems we see plaguing our mental health system for veterans. I look forward to working with the V.A. as well as veterans' service organizations, community groups and, most importantly, the veterans themselves to develop thoughtful legislation that ensures not only new veterans are being served but those who served us in the past are not forgotten.

Recent reports, including a thoughtful and informative series done by The Washington Post, have highlighted ways we can and must improve the current mental health system for our veterans.

Lack of culturally sensitive mental health professionals, inability to reach rural areas, stigma within the military, bureaucratic runarounds, and long waiting times are just a few of the problems that we hear about both in the news and directly from veteran constituents.

These are problems that must be addressed and can only be addressed if we all work together to find solutions.

I am also anxiously awaiting a report from the President's Commission on Care for America's Returning Wounded Warriors, chaired by former Senator and World War II veteran Bob Dole and

former Secretary of the Department of Health and Human Services Donna Shalala.

In March of this year, I sent a letter to the commission asking that they give an equal review of mental health services as they do for physical health services. With the report expected to come out in mid-July, I hope that we can use their recommendations for thoughtful improvement.

I hope that the commission recognizes that we cannot afford another generation of soldiers who lack appropriate support for health and healing of their physical and mental wounds.

The Senate Special Committee on Aging has a long and distinguished history of leading the Senate on issues of great importance to our aging population. We have an opportunity today to focus on the ongoing and critical needs of our new and aging veterans and their mental health needs.

As our Country faces new waves of veterans with mental health illnesses, many of whose issues arise from combat stress, we must ensure that we learn from the lessons of the past. We must ensure that they are cared for, and we must not leave behind those who fought for our Nation in previous generations.

With that, I thank you for your attention, and turn the mike to my friend, my colleague, Ron Wyden.

OPENING STATEMENT OF SENATOR RON WYDEN

Senator WYDEN. I thank you, Senator Smith. You said it very well. I know time is short, and I think what I will do, Madam Recorder, is I will make my especially profound prepared statement part of your hearing transcript.

I thought Senator Smith said it very well. Let me make just a couple of points by way of supplementing his remarks.

Back in April and May, I essentially went to all of the major veteran facilities in our State, systematically went through the State from La Grande, Bend, the valley, here, and the message I got was pretty consistent all across the State. The message that I got is that care is very, very good—if our veterans can get it.

It really comes down to a question of funding to a great extent, in Oregon; that there are scores of dedicated doctors and hospitals and nurses doing an incredible job, but still we have a lot of folks falling between the cracks. I see some of you who give the care nodding in the audience.

So I have supported "The Independent Budget," which is the budget proposed by all the veterans groups, and I have supported what is called mandatory funding, so that we can get veterans funding off this roller coaster. It shouldn't be subject to the whims of the annual budget cycle. There ought to be mandatory funding so that we say if you are serious about taking care of the needs of our veterans, that the funding should be mandatory.

The reason I feel so strongly about that is that ultimately much of the decisionmaking in the U.S. Senate—and we do ours in a bipartisan way—comes down to choices, and it comes down to priorities.

This Congress, for example, has been willing to allow more than $10 billion in subsidies to major oil companies—not the small companies, not the independent companies, but the major companies.

When you make cutbacks in that area—and the President of the United States, to his credit, says oil companies don't need subsidies when the price of oil is over $50 a barrel—you make cuts there, and it directly relates to having additional funding available to cut the wait times, to cut the lines for mental health services, and all the areas that Gordon has laid out very well.

I will tell you that getting this funding is not an abstract issue. Much of what I saw on this tour just struck me as unconscionable. For example, in central Oregon, in 2007, we have our veterans sleeping in the woods. That is what the veterans told me.

There are a couple of them who run a terrific outreach program. We have got one of them right here in the front row.

Just think about that. In a Country as good and rich and strong as ours, for veterans who serve our Country with such valor and distinction, our friend in the front row has to run a program to reach out to veterans in central Oregon who certainly are in need of mental health services and a variety of others in order to try and get them decent health care.

That is not acceptable to anybody. That is not a Democratic issue. That is not a Republican issue. That is a question of our values and our choices.

So we anxiously await your testimony and your input.

Gordon, I look forward to working with you on this.

Senator SMITH. Thank you, Senator Wyden.

We appreciate our witnesses, one of whom has come a long, long way to be here, all the way over the Oregon Trail from Washington, DC., Dr. Antonette Zeiss, who is the deputy chief consultant, the Office of Mental Health Services within the Veterans Administration. She is going to tell us the work they are doing to try to meet this great challenge.

Then Mr. Jack Heims, who is our second witness, he works at the V.A. center here in Portland. He is the administrative director of the Mental Health and Neuroscience Division. I know that our facility here in Portland has a number of innovative programs, and we look forward to hearing about your approaches to these issues.

So, Dr. Zeiss, why don't we start with you?

STATEMENT OF ANTONETTE ZEISS, DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, VETERANS ADMINISTRATION, WASHINGTON, DC

Dr. ZEISS. Thank you. Very glad to be here.

Is the microphone on?

Senator SMITH. Can you hear? Yes. Just talk close to it.

Dr. ZEISS. Good afternoon, Mr. Chairman and members of the committee. I am pleased to be here today to discuss how the Department of Veterans Affairs is addressing the mental health care needs of our Nation's veterans.

V.A. provides mental health services to veterans in all our patient care centers. General and geriatric mental health services are being integrated into primary care clinics, V.A. nursing homes, and residential care facilities where many veterans receive mental health care.

Veterans with a serious mental health illness are seen in specialized programs, such as mental health intensive case management, day centers, work programs, and social rehabilitation.

V.A. 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 care for mental health services for veterans.

We have seen returning veterans from prior eras through to the current Operation Enduring Freedom and Operation Iraqi Freedom conflict who have injuries of the mind and spirit as well as the body.

From these veterans we have learned that mental disorders can increase the risk for certain physical illnesses and vice versa. Our goal is to treat a veteran as a whole patient, to treat a patient's physical illnesses as well as any mental disorders he or she may be facing.

Post-traumatic stress disorder, PTSD, has been the focus of national interest as it relates to not only veterans of past combat service but also our current returning veterans. V.A. provides a full range of services related to PTSD as well as other military-related readjustment problems, along with the treatment of the physical wounds of war, in its continuum of health care programs.

Our mental health services are provided in all V.A. medical facilities. This may include in-patient and outpatient services and related services in the area of substance abuse.

Moreover, V.A.'s Vet Centers provide counseling and readjustment services to returning combat veterans and, in some cases, their family members in the community setting. Vet Centers provide an alternative to traditional access for veterans who may be reluctant to come to medical centers and clinics.

V.A. plans to expand its Vet Center program. We will open 15 new Vet Centers and eight new Vet Center outstations at locations throughout the Nation by the end of 2008, and seven of them will open this year, in 2007.

In addition, V.A. provides services for homeless veterans, the ones living out in the woods, including transitional housing, paired with services to address social, vocational, and mental health problems associated with homelessness.

Care for OEF/OIF veterans is among the highest priorities in our mental health care system. Since the start of combat, 686,306 service members have been discharged and become eligible for V.A. care, and of those 33 percent have sought V.A. care.

Among those returning veterans, mental health problems are the second most commonly reported health concerns, with almost 37 percent reporting symptoms suggesting a possible mental health diagnosis. That is almost 84,000 veterans to date.

The diagnosis of PTSD topped the list for possible mental health diagnoses, but close behind were problem drinking and use of drugs without addiction and oppressive disorders. So it is not just PTSD; we need to respond to the whole array of mental health problems.

V.A. data show that the proportion of new veterans, newly returning veterans, who are seeking V.A. care and who have a pos-

sible mental health problem has been increasing over the past 2 years. For example, the proportion with possible mental health problems at the end of fiscal year 2005 was 31 percent, and now, in the most recent report in April 2007, it had risen to 37 percent. PTSD diagnoses during this same timeframe went from 13 percent to 17 percent.

There are many possible explanations of this increase: extended deployments, more difficult combat circumstances, but also effective screening and outreach efforts and the positive impact of efforts to destigmatize seeking mental health services.

Whatever the reasons for the increase, we need to follow closely that there is an increase and devote increased resources to serve these mental health needs.

Funding resources are currently available for a V.A. Mental Health Initiative that supports implementation of our comprehensive mental health strategic plan based on the President's New Freedom Commission on Mental Health.

The plan recognizes that the ongoing war effort necessitates special attention to the needs of returning veterans, and we have improved capacity and access using our funding. We have hired over 3,000 new mental health professionals to date, since the spring of 2005, and there are more in the pipeline to be hired.

Senator SMITH. Are you hiring them from outside? Current mental health professionals, you are hiring them into the V.A. system?

Dr. ZEISS. Yes. Yes.

Senator SMITH. What are you doing to get them to remain?

Dr. ZEISS. We have not had a problem with people leaving V.A. once they have been hired. There have been some problems within the Department of Defense, but we actually have a good retention record.

We have recently gone through the conversion of psychology and some of the other professions to hybrid Title 38, which I think is also having some positive impact on retention. There has been the Physician's Pay Bill, which has increased pay for physicians.

So Congress has served us well in passing legislation that has helped with retention of staff in V.A. We have been quite successful in recruiting such a large number of new staff in the last 2 years. We have an extensive recruitment and retention program.

Those 3,000 professionals have funded a wide variety of programs: community-based outpatient clinics, so that we can get on-site staffing out to more rural areas. We are expanding tele-mental-health services to reach more rural veterans.

We have enhanced PTSD, homelessness, and substance abuse care and programs that recognize the common co-occurrence of these problems. We are fostering integration of mental health and primary care in medical facility clinics and in the care of homebound veterans served by V.A.'s home-based primary care program.

We have mental health staff well-integrated into the polytrauma care sites, and we have increased the number of staff in our Vet Centers, establishing outreach counselors, many of whom are global war on terror veterans themselves.

Very importantly, focusing on concerns about suicide in veterans, we have funded a suicide prevention coordinator in every V.A. medical facility. A national hotline for suicide prevention will soon be

available. V.A. staff are being educated about this valuable tool and how veterans will be able to access it.

In addition, V.A. sponsored its first Suicide Prevention Awareness Day, which included every V.A. facility, and this is going to be an annual event with, again, a national push and planned local activities.

We continue to promote early recognition of mental health problems, with a goal of making evidence-based treatments available early. Veterans are routinely screened in primary care for PTSD, depression, substance abuse, traumatic brain injury, and military sexual trauma.

When there is a positive screen, patients are further evaluated and, when indicated, they are referred to a mental health provider for follow-up.

Screening for this broad array of mental health problems helps support effective identification of veterans needing mental health services, and it promotes our suicide-prevention efforts, a major priority for V.A.

Our goal is to make the point that in V.A., suicide prevention is everyone's business, not just that of our mental health providers. Everyone who comes into contact with our veterans and their families plays an important part.

I think that covers my comments, and I want to thank you again——

Senator SMITH. Thank you, Doctor.

Dr. ZEISS.—for having me here.

[The prepared statement of Dr. Zeiss follows:]

STATEMENT OF
ANTONETTE ZEISS, PH.D.
DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SENATE AGING COMMITTEE

JULY 3, 2007

Good afternoon Mr. Chairman and members of the committee, I am pleased to be here today to discuss how the Department of Veterans Affairs (VA) is addressing the mental health care needs of our Nation's veterans.

VA provides mental health services to veterans in all our patient care settings. General and geriatric mental health services are being integrated into primary care clinics, VA nursing homes, and residential care facilities where many veterans receive mental health care. Veterans with a serious mental illness are seen in specialized programs, such as mental health intensive case management, day centers, work programs and social rehabilitation. VA employs full and part time psychiatrists and full and part time psychologists who work in collaboration with social workers, mental health nurses, counselors, rehabilitation specialists, and other clinicians to provide a full continuum of care for mental health services for veterans.

We have seen returning veterans, from prior eras to the current Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) conflict, who have injuries of the mind and spirit as well as the body. From these veterans, we have learned that mental disorders can increase the risk for certain physical illnesses, and vice versa. Our goal is to treat a veteran as a whole patient—to treat a patient's physical illnesses as well as any mental disorders he or she may also be facing.

Post Traumatic Stress Disorder (PTSD) has been the focus of national interest as it relates to not only veterans of past combat service but also OEF/OIF veterans. VA provides a full range of services related to PTSD as well as other military-related readjustment problems, along with the treatment of the physical wounds of war in its continuum of health care programs. Our mental health services are provided at all VA medical facilities. This may include both inpatient and outpatient services and related services in the area of substance abuse.

Moreover, VA's Vet Centers also provide counseling and readjustment services to returning war veterans and, in some cases, their family members, in the community setting. These Vet Centers provide an alternative to traditional access for some veterans who may be reluctant to come to our medical centers and clinics. VA plans to expand its Vet Center Program. We will open 15 new Vet Centers and eight new Vet Center outstations at locations throughout the Nation by the end of 2008. Seven of the 23 new centers will open this Calendar Year 2007.

In addition, VA provides services for homeless veterans, including transitional housing paired with services to address social, vocational, and mental health problems associated with homelessness. Care for OEF/OIF veterans is among the highest priorities in VA's mental health care system. Since the start of OEF/OIF combat, 686,306 service members have been discharged and have become eligible for VA care. Of those, 229,015 (33 percent) have sought VA medical care. Among those returning veterans, mental health problems are the second most commonly reported health concerns, with almost 37 percent (83,889) reporting symptoms suggesting a possible mental health diagnosis. The diagnosis of PTSD topped the list for possible mental health diagnoses along with problem drinking, use of drugs without addiction and, and Depressive Disorders.

VA's data show that the proportion of new veterans seeking VA care who have a possible mental health problem has increased slightly over the past two years. For example, the proportion with possible mental health problems at the end of FY 2005 was 31 percent, compared to 37 percent in the most recent report, released in April, 2007. PTSD diagnoses during this same time frame went from 13 percent to 17

percent. Possible explanations of this increase include extended deployments, more difficult combat circumstances, effective screening and outreach efforts, and the positive impact of efforts to destigmatize seeking mental health services. VA follows this closely and is devoting increased resources to serve these mental health needs.

Funding resources are currently available for a VA Mental Health Initiative that supports implementation of our comprehensive Mental Health Strategic Plan that is based on the President's New Freedom Commission on Mental Health. The plan recognizes, as part of its broad vision for enhancement of mental health care, that the ongoing war efforts necessitate special attention to the needs of OEF/OIF veterans. Using Mental Health Initiative funding, we have improved capacity and access. These funds have resulted in the hiring of over 3,000 new mental health professionals to date. We have expanded mental health services in Community Based Outpatient Clinics (CBOC), with on-site staffing or by telemental health.

We have enhanced PTSD, homelessness, and substance abuse specialty care services, and programs that recognize the common co-occurrence of these problems. We are fostering integration of mental health and primary care in medical facility clinics and in the care of home-bound veterans served by VA's Home Based Primary Care program. We have mental health staff well integrated in polytrauma care sites. At Secretary Nicholson's direction, we have increased the number of staff in our Vet Centers by establishing outreach counselors, many of whom are Global War on Terror veterans, themselves. We are also expanding the number of Vet Centers over the next two years.

Very importantly, focusing on concerns about suicide in veterans, we have funded a Suicide Prevention coordinator in every VA medical facility. A national hotline for suicide prevention will soon be available. VA staff has been educated about this valuable tool and how veterans can access it. In addition VA sponsored its first Suicide Prevention Awareness Day, which included every VA facility. This is to be an annual event.

VA continues to promote early recognition of mental health problems, with the goal of making evidence-based treatments available early. Veterans are routinely screened in Primary Care for PTSD, depression, substance abuse, Traumatic Brain Injury, and Military Sexual Trauma. When there is a positive screen, patients are further evaluated and, when indicated, referred to a mental health provider for follow-up. Screening for this array of mental health problems helps support effective identification of veterans needing mental health services, and it promotes our suicide prevention efforts, a major priority for VA. Our goal is to make the point that in VA, suicide prevention is everyone's business—not just that of our mental health providers—everyone who comes into contact with our veterans and their families plays an important part.

VA will continue to monitor and address the mental health needs of our Nation's veterans through progressive, state-of-the-art programs. VA is approaching the mental health needs of veterans with an orientation that is designed to promote an optimal level of social and occupational function and participation in family and community life for our veterans.

Thank you again Mr. Chairman for having me here today. I will answer any questions that you or other members may have.

Senator SMITH. Very excellent.

You heard me in my opening statement refer to this Washington Post article.

Dr. ZEISS. Yes.

Senator SMITH. Have you read that?

Dr. ZEISS. I have.

Senator SMITH. It certainly represented that there was a serious backlog related to mental health issues. Would you dispute that?

Dr. ZEISS. The backlog that was described I would argue was very much about the Veterans Benefits Administration side of the house.

Senator SMITH. Not the mental health aspect?

Dr. ZEISS. Not the direct provision of mental health care and access.

One of the things that I felt really moved by in the story of the woman veteran—not everyone got to the end of the story. The last sentence was, "V.A. saved my life." She talked about how meaningful the in-patient program they had was, even though she had complained about some aspects of it being boring. She said it was the right thing and offered the right program.

Then she got to a specialized women's program with the latest evidence-based care for PTSD for women, and it has turned her life around.

Senator SMITH. If you had two or three suggestions that Senator Wyden and I could achieve for you in Congress, what you need, what would they be?

Dr. ZEISS. Well, we have been really encouraged by the tremendous support for mental health. I have never in my professional life, of many years now, seen a time when there was so much bipartisan support for really caring about the mental health of our veterans.

We need this to remain a priority throughout the conflict and to recognize that many veterans will not begin to have significant mental health problems until several years after the end of the conflict. So we need to build a system that can be sustained.

Senator SMITH. OK. You have participated in the roundtable I had before this.

Dr. ZEISS. Yes.

Senator SMITH. You heard over and over again that in the—not the Guard and Reserve, but in the professional military, there is a machismo as part of the warrior ethic that is taught. The comment was made that that is necessary to do what they have to do, apparently.

But I wonder, when they go through that and they come home and they are suffering psychological setbacks from what they have had to do, I am wondering if there is not, with that warrior ethic, a stigma against people admitting that they have serious issues and that that is somehow professionally held against them.

Are you familiar with that? Do you believe that is true? What can we, as lawmakers, do to remedy that?

Dr. ZEISS. Well, I won't speak for what happens in DOD. I have certainly seen some evidence of that. But, you know, the speaker was talking particularly about the Department of Defense.

I think there are two things that are really important. One is continuing to really make the distinction between Department of Defense and the Department of Veterans Affairs, and that when people come to seek care at V.A., it is not going back to any command structure, it is not having any impact on their military career, including if they seek care between deployments when they are Reserve and Guard.

We need to really protect that and help people feel confident that their care in V.A. will respond to——

Senator SMITH. Are there any impediments to your protecting that confidentiality?

Dr. ZEISS. I don't know that it is an impediment. There is much, much enthusiasm for a bidirectional, single medical record between V.A. and the Department of Defense. While there are many, many benefits to such a bidirectional record, in our Office of Mental Health Services—and the Under Secretary for Health has been supportive—we want to recognize that if a Guard or Reserve member comes to V.A. for mental health care during a time between deployments, that it is not automatically the case that it would be bidirectional; that all that information would go back. It would be treated differently in the Department of Defense than it would in V.A.

If we have informed consent from that Guard or Reserve member, of course we would send the information. But we want to ensure the kind of confidentiality that you were hearing in the roundtable is so important to to these folks.

Then the other thing is a national push for destigmatization of mental health problems, just as you are doing. We need total support with you.

Senator SMITH. I don't want to get in the way of military ethics to do their job, but I also want to say to our military professionals, end the stigma. Understand there are all kinds of wounds that come from war, and they should not be professional deterrents to healing.

Dr. ZEISS. The other thing that we have tried to do, is more than V.A. has traditionally done for families, and of course we stay within our congressional authority in doing that, but we have funded—there wasn't time in the written testimony—but have funded family psychoeducation programs around mental health, family to-family training that is offered by the National Association for the Mentally Ill, and has been offered to some extent in V.A.

We are looking at possible expansion of that. We are encouraging families to come in and be part of the evaluation and treatment planning process for returning veterans, again, within our congressional mandates. But we believe, as you heard in the roundtable, that reaching out and including families is very important for veterans' care.

Senator WYDEN. Mrs. Zeiss, thank you.

I have a number of questions.

Now, you state in your written testimony that the V.A. has plans to expand the Vet Center program and is going to open 15 new Vet Centers and eight new Vet Center outstations by the end of 2008.

Now, in our State, we don't have a Vet Center east of the Cascades. Can you lay out on the record the criteria and process the V.A. uses in determining where to open a new Vet Center?

Dr. ZEISS. I can tell you who does lay out the process. The Vet Centers are not run through our office, the Office of Mental Health Services. They are a separate program of the Readjustment Counsel Services.

Dr. Al Batres is the head of that, and he is currently guiding the process for making decisions about where those Vet Centers will be placed. I would be happy to get you in touch with him.

Senator WYDEN. So your office, with respect to looking at Vet Center and Vet Centers needs, does what, if anything?

Dr. ZEISS. At this point we don't have things that our office does with Vet Centers.

We have in planning the possibility of placing tele-mental-health equipment in the Vet Centers so that they can link to the medical facilities and receive more specialized mental health care from providers.

The Vet Centers have traditionally offered counseling and supportive services, and this is an opportunity—again, if there are Vet Centers in some more rural areas—to get more partnership between the medical facilities and the Vet Centers.

But our office really works with the medical facilities and the community-based outpatient clinics.

Senator WYDEN. That really was my second area. So would you all have the authority, for example, to get into the community-based outpatient clinics on tele-mental services?

Essentially a fancy way of saying we are going to use modern technology, we are going to use computers, we are going to use phone networks in order to make it easier to compensate for distance.

Do you have the authority to get into that?

Dr. ZEISS. We not only have the authority, we are doing it. We have placed tele-mental-health equipment in many of the CBOCs, with planned rollout with anticipated fiscal year 2008 funding. To the rest, we have, then, in the medical facilities the tele-mental-health equipment. We have staff who are prepared to offer specialized mental health services.

We also have placed mental health providers directly in the community-based outpatient clinics, but they are generalists, and when there is specialty care needed, we believe that tele-mental-health care is going to be——

Senator WYDEN. What do we need to do to convince you to expand services, particularly in central and eastern Oregon? I gather, from of your last answer, we would be talking about both the tele-mental services and practitioners? What we have in our State is a lot of veterans who simply cannot physically get to Portland——

Dr. ZEISS. Yes.

Senator WYDEN [continuing]. Who find it hard to get to Walla Walla. I mean, we have just got scores of veterans falling between the cracks, and I don't think we meet our obligation, particularly to older veterans, to let you walk out the door today without getting a commitment to expanding those services.

Dr. ZEISS. Absolutely. I am very willing to go back. I brought with me a listing—I can provide to you, I have given to Senator Smith already—of what we have funded here in Oregon. I know that we have funded community-based outpatient clinic enhancement in Bend, in Salem, in Eugene, in Bandon and Brookings. I may be missing a couple.

But that is not the whole State by a long shot. I lived in Oregon for 4 years. I went to graduate school here, and I know the State a bit.

Senator SMITH. Are you a Duck or a Beaver? [Laughter.]

Dr. ZEISS. A Duck. A Duck. Yes.

There is much more to be done. There is a call for more community-based outpatient clinics to be developed.

Again, our office supports the mental health component once the site is approved, but there is a broader approval because it needs to provide the whole spectrum of primary care services as well as mental health services.

I am happy to work with you to try to ensure that Oregon services are considered, and I think there is a need. I certainly can make a commitment that if there are new community-based outpatient clinics approved, our office will find out about the staffing as well as tele-mental health.

Senator WYDEN. What can we do so that over, say, the next 90 days we can get you to specifically look at expanding services in Oregon and tell us whether or not you can do it? Certainly if not, why not?

Because I can tell you, the need is just extraordinary out there. I know you mean well, and my constituents very much want to see, in the area of mental health services, particularly in rural Oregon, a commitment to expanding those services.

So question one: Can you tell us over the next 90 days whether you will review those services, particularly in community-based outpatient clinics, which you do have jurisdiction over?

Dr. ZEISS. Yes, I do.

Senator WYDEN. Give us an assessment of whether or not you think expanded services are needed, in terms of practitioners and the technology, and whether or not you can deliver those services? Can you get that to us in the next 90 days?

Dr. ZEISS. I can't speak beyond the Mental Health Office.

Senator WYDEN. That is what I am talking about.

Dr. ZEISS. But I can certainly do it for the Mental Health Office.

I can also say we are in the process of beginning to spend and making plans for rapidly spending the congressional supplemental budget, which is no year money, as you know, but we want to spend it as quickly as we can.

One of the things we are looking at is purchasing or leasing more Government vehicles so that we could have circuit riders, so that people can go out more to provide services more broadly. I can commit to looking at what are we funding in Oregon in terms of the opportunities to get our current V.A. providers out into the communities more.

I also can commit—one of our programs is the mental health intensive case management for veterans with serious mental illness, and we are currently piloting a rural model. It was originally devel-

oped for more areas that had higher concentration of veterans with serious mental illness, but we are piloting a rural model.

I can go back and look at exactly what is under planning for Oregon and what ways we could expand the possibility of the mental health intensive case management for the rural areas.

Senator WYDEN. That is constructive, and to have the assessment within 90 days so we can get a sense of what you make of the current situation, because I can tell you, our veterans consider it just very dire whether or not you can then expand services both with actual practitioners and with technology.

It is also our job to make sure that you have adequate resources. But we are going to first need to get your specific assessment. I appreciate that commitment today, and I think the veterans all over our State do as well.

One last question with respect to what steps the V.A. is taking to help veterans who have trouble physically traveling to V.A. facilities. In other words, one of the reasons I think veterans are falling between the cracks is that they simply cannot get to facilities. We are going to need help there.

Mr. Chairman, I just realized I have one additional question.

Senator SMITH. Go ahead.

Senator WYDEN. Time is tight.

Let's get your views on help for veterans who are having difficulty traveling, physically traveling to V.A. facilities, and what additional steps the V.A. can take to help them.

Dr. ZEISS. There are many reasons why they would have trouble, physically.

I am going to start with the home-based primary care teams. I think this is a wonderful V.A. program. It provides medical care, nursing care, social services care to veterans who are homebound because of physical or mental health problems.

The whole team will go out, one at a time, not en masse, to serve those veterans. There are programs all over the Country, there are programs here in Oregon. As I said in my written testimony, we have recently ensured that every single one of those teams has a mental health provider as well.

But those are based in—you know, there are not going to be services that will be accessible to folks in eastern Oregon because the team is not out there.

One of the things that we are trying to develop is a program called the Home Health Buddies, which are electronic devices that can be actually in the veteran's home so they don't have to travel. They can interact directly with their mental health care providers, and there is a parallel program for other physical health care.

It has been deployed for many of the physical health care needs. I can't speak to how broadly and how much there is in Oregon. We are trying to develop tools so that it could provide safe, effective care for mental health problems. We don't want to place it in a home and promise care before we are confident that it really would meet the need and make that service available.

Senator WYDEN. Make that part of your 90-day assessment as well, this question of what do you think the present system offers veterans who are having trouble getting assistance to physically

travel to the V.A. facilities and what else you can do about it. Because that is also very much on the minds of veterans in our State.

One last question that comes from, again, the visits I made in April and May. I get the sense that there is still a lot of confusion with respect to the record systems at V.A., the record systems of the DOD, particularly trying to integrate the computer systems and trying to make sure that information is exchanged quickly.

In fact, up in Walla Walla, where there is a very talented administrator who came in and just started. The administrator talked about wanting to change the records. She said there was going to be a special effort made in that area.

What do you think the implications are for mental health services, of veterans falling between the cracks, between the computers at V.A. and the computers at DOD? Do you think that is a problem?

Dr. ZEISS. Well, I think the V.A. electronic medical record system is absolutely world-class. It has been recognized by the Harvard Business School as—received an award for excellence in government, has received many other awards.

So I think the V.A. has a splendid record system in which mental health records are fully integrated to the overall——

Senator WYDEN. My question is something else. My question is: Do you think that there is a problem coordinating the system at V.A. and the system in DOD? If you do, what do you think ought to be done?

Dr. ZEISS. Well, I think I spoke to that a bit earlier. I think that it is true that they are not fully coordinated and bidirectional. I would like the initial push to be on ensuring that the DOD records can be made available to V.A. when someone is leaving the military and coming to V.A. I think that would increase our capacity to serve veterans. I would like to see there be continued effort to ensure that.

I do have some concern about the concept that it should be completely bidirectional without the consent of the person who comes to us in a civilian capacity but then might return to the military.

Senator WYDEN. I would like to follow that up with you, because I think you touched on a couple of the key areas of change. Certainly it ought to ensure that the patients control their records. When you think about veterans' health care, if ever there was a group in this Country that deserved to control their records——

Dr. ZEISS. Yes.

Senator WYDEN [continuing]. It is our courageous veterans and those who serve their Country. But we have got to do a better job of sharing information between the V.A. and the DOD. Call up that new administrator in Walla Walla, because I am telling you, I think she is going to go gangbusters on this.

Dr. ZEISS. Yes.

Senator SMITH. I think she is here.

Dr. ZEISS. I met her.

Senator WYDEN. Great. There she is.

Just talk to her after you are done testifying, because she has got it. She is on it.

Senator SMITH. Jack Heims. Thank you.

STATEMENT OF JACK HEIMS, ADMINISTRATIVE DIRECTOR, MENTAL HEALTH AND NEUROSCIENCE DIVISION, VETERANS ADMINISTRATION, PORTLAND, OR

Mr. HEIMS. Good afternoon, Mr. Chairman and Senator Wyden. Thank you for this opportunity to share in this strong work of our employees to improve mental health services to our veterans. We know of your strong support and interest in mental health issues.

My comments will focus on efforts of the catchment areas of the Portland V.A. Medical Center and on behalf of Operation Enduring Freedom and Operation Iraqi Freedom, returning veterans who have served primarily in the National Guard.

We play a significant role in co-leading Oregon's post-deployment integration effort with the National Guard. We worked cooperatively in compiling and keeping current a comprehensive resource directory Website to orient them to our services and to our materials.

Semiannually we have co-led summits of 85 leaders of various agencies and community agencies to help in all aspects of veterans' re-entry into civilian and community life. This model, I am proud to say, has received national recognition from both the V.A. and the National Guard.

We have held training conferences that highlight community integration processes with family organizations and with veterans themselves.

Portland Medical Center also participates in the 90-day post-deployment health reassessment sessions. At Canby conference grounds, we have held two family weekend retreats, complete with child care, focusing specifically on the impact of combat veteran service as it relates to family issues.

Military sexual trauma program is coordinated with our primary care service, and we have presented training on this and other reintegration issues for 200 community mental health and primary care providers.

Most of our previous knowledge on traumatic brain injury care has been gained from sports injuries and auto accidents. Now, however, we are learning more as we treat injuries received because of blast events in combat. These issues may be coupled with other traumatic injuries. To deal with these specialized injuries, we have added an additional neuropsychologist to our staff.

We have been meeting the mental health needs of rural veterans for more than 10 years through our services at outpatient clinics in Salem, Bend, and Warrenton. We have added a part-time therapist at Warm Springs Indian Reservation.

I might add the Walla Walla facility is opening a CBOC, community-based outpatient clinic, in La Grande, as far east in eastern Oregon as you can get. It is little, and it is mandated.

Senator SMITH. You can actually get to Ontario. [Laughter.]

Mr. HEIMS. Actually, Ontario has served as a——

Senator SMITH. Idaho?

Mr. HEIMS [continuing]. Understood—as a Boise traveling road show.

In addition, a new initiative involving tele-psychiatry will provide our outlying clinics with the ability to pull in subspecialty expertise such as substance abuse and PTSD in these locations.

We are pleased to share that the VISN has received funding for 100 home-based v-tel setups, video-teleconferencing, so patients who live in rural areas or are incapacitated, as Senator Wyden indicated, can video-conference with their provider and obtain mental health care.

Suicide has always been a major concern of Portland V.A. Medical Center due to the demographic of our veterans. Suicide risk increases with age. Our veteran population continues to age. We know that increased awareness of the possibility of suicide will lead not only to better identification of those who are at risk, but also improve our ability to implement appropriate suicide prevention treatments.

We have five geriatric psychiatrists on staff for the aging population. This year, as Dr. Zeiss indicated, we have hired a full-time suicide prevention coordinator. With great pride, we can say our suicide screening program has been implemented at many sites nationally in the V.A.

V.A. has mandated ready access to mental health treatment for our veterans. Portland Medical Center has 24-hours, 7-days-a-week, emergency coverage, a phone triage system, an acute interim care provision, immediate OEF/OIF access, and an evening clinic. We are restructuring to provide full diagnostic, evaluation, and treatment for all patients requesting or referred for mental health or substance abuse treatment.

Portland Medical Center has been a national leader for the recovery model for our shizophrenic and bipolar patients. Our veterans have recovered from what they were told would be a chronic and debilitating mental illness. As a result of treatment received at the Portland V.A., these veterans go on to become productive members of society, living the life of their choosing.

The recovery model sends a message of hope. One veteran recently said, "I am going on a date"—and I think he was a shizophrenic patient—"for the first time in 18 years." Awareness, training, and access to appropriate mental health care continues to be our major components of our multi-faceted approach to reaching out and helping veterans while we continue to refine our treatment strategies.

Thank you again, Mr. Chairman, for inviting me today. I will be pleased to answer any questions you or Senator Wyden may have.

[The prepared statement of Mr. Heims follows:]

STATEMENT OF
JACK HEIMS
ADMINISTRATIVE DIRECTOR OF MENTAL HEALTH AND NEUROSCIENCE DIVISION
DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
SENATE AGING COMMITTEE
July 3, 2007

Thank you for this opportunity to share the strong work of our employees to improve Mental Health services for our veterans. My comments will focus on efforts in the catchments area of Portland VA Medical Center (Portland VAMC) and on behalf of our Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) returning veterans who have served in the National Guard.

OEF/OIF

Partnering with the National Guard

Portland VAMC plays a significant role in co-leading Oregon's Post Deployment Reintegration effort with the Oregon National Guard. We worked cooperatively with the Oregon National Guard to compile a comprehensive resource directory website and to orient them to our services and materials.

Semi-annually, we have co-led Summits for 85 leaders of various agencies and organizations to help in all aspects our veterans' reentry into civilian community life. This model has received national recognition in both VA and the Oregon National Guard.

Moreover, we will have a physician provider at the Anderson Readiness Center in Salem to provide needed services more readily.

Providing Training for Families and Professionals

Here at the Portland VAMC, we've held training conferences that highlight community reintegration processes with family organizations and with veterans themselves.

Portland VAMC also shares in 90 day Post Deployment Health Reassessment sessions. Specifically, at a conference center in Canby, we've held 2 family weekend retreats, complete with child care, focusing specifically on the impact of combat service as it relates to family issues. This includes the impact in multiple aspects --spouse, parent or child.

The Military Sexual Trauma program here in the Portland VAMC is coordinated through our Primary Care Service and is led by our Psychiatric Nurse

Practitioner. We have presented training on this and other reintegration issues for 200 community Mental Health and Primary Care providers.

Traumatic Brain Injury Care
Most of our knowledge on this subject has been gained from sports injuries and auto accidents. Now, however, we're learning more as we treat injuries received in concussive blast events in combat. These injuries may be coupled with other traumatic injuries. To deal with these specialized injuries, Portland VAMC has added an additional Neuro-Psychologist on staff. The clinical identification and management of these cases are challenging and something that we are continuing to explore.

Rural Mental Health Care
Portland VAMC has been meeting the mental health needs of rural veterans for more than ten years through our services at Outpatient Clinics in Salem, Bend, and Warrenton. We have recently added a part time therapist at the Warm Springs CBOC. In addition, a new initiative involving telepsychiatry will provide our outlying clinics with the ability to pull in subspecialty expertise for Substance Abuse and Post Traumatic Stress Disorder in these locations.

We are pleased to share that the VISN has received funding for 100 home based video -teleconferencing set-ups so patients who either live in rural areas or are incapacitated, can video conference with their provider and obtain mental health care.

Suicide
Suicide has always been a major concern of the Portland VAMC due to the demographic of our veterans. Suicide increases with age and our veterans average age is 55 years old. We know that increased awareness of the possibility of suicide will lead to better identification of those who are at risk and improve our ability to implement appropriate suicide prevention treatments.

We have five geriatric-psychiatrists on staff. This year, we hired a full time Suicide Prevention Coordinator. With great pride, we can say our suicide screening program has been implemented nationally in the VA.

Access
VA has mandated ready access to mental health treatment for our veterans. Portland VAMC has 24 hours, seven days a week emergency coverage, a phone triage system, an acute interim care provision, immediate OEF/OIF access, and an evening clinic. We are restructuring to meet the Department's mandate to provide full diagnostic and evaluation and treatment for all patients requesting or referred for mental health or Substance Abuse treatment.

Hope for Veterans with Bi-polar Disease and Schizophrenia

For the last four years, Portland VAMC has been a national leader in the Recovery model. Our veterans have recovered from what they were told would be a chronic and debilitating mental illness. As a result of treatment received at the Portland VAMC, these veterans go on to become productive members of society, living the life of their choosing. The Recovery model sends a message of hope. Our Veterans are no longer hiding in their homes. They are employed and active. One veteran recently said, "I am going on a date for the first time in 18 years."

The Portland VAMC has a large task ahead. Awareness, training, and access to appropriate mental health care continues to be the major components of our multi-facted approach to reaching out and helping veterans while we continue to refine our treatment strategies.

Thank you again Mr. Chairman for inviting me today. At this time, I will be pleased to answer any questions you or other members may have.

Senator SMITH. Thank you very much, Jack.

We spoke a little bit about this earlier, but for the record, I want to talk to you about what we read about, whether it is true or not, in terms of the high rates of turnover and burnout among mental health professionals in the V.A. and the time it takes to fill them.

You are not experiencing that; is that correct?

Mr. HEIMS. We have had no difficulty in turnover. Our turnover rates are one of the lowest in our V.A. as a division. Our recruitment has been excellent, particularly for social workers, psychologists, and nurse practitioners. It is a little tougher for psychiatrists.

Senator SMITH. You know, with conflicts in Afghanistan and Iraq, there are tremendous amounts of traumatic brain injuries because of the kinds of weapons used against our soldiers, and we are finding that PTSD can even mask itself in terms of mental health disorders. Whether it is irritability, an inability to concentrate, all of these kinds of things are also signs of depression and other mental illnesses.

Can you talk to us about the modeling you do to help a vet identify what it is they have and how you then put them on the right kind of therapy to get them to recovery?

Mr. HEIMS. As you say, it is a tough issue, and I would add to our list of others that mask: substance abuse. Frequently we have veterans who have traumatic brain injury, PTSD, and they are self-medicating with substance abuse, and how to decipher those diseases is very difficult.

As I said, we have two neuropsychologists on staff. We have a group that meets twice a month to review patients with traumatic brain injury. We have a screening mechanism for all patients coming through primary care who are OEF and OIF and with mental health. So I think we have a way to not only isolate these patients, but also decipher——

Senator SMITH. What it is they have.

Mr. HEIMS [continuing]. What it is they have and what the treatment plan needs to be.

Senator SMITH. You have heard Senator Wyden's concern—I share it—as it relates to rural Oregon. I live in rural Oregon, and there are a lot of vets in Pendleton and many other surrounding communities, and I am wondering what you think of our outreach to mental health issues to rural Oregonians who are veterans.

Mr. HEIMS. I feel very proud of Portland's outreach. Not only do we have an outreach van that goes to, oh, probably a 200-mile radius of Portland and also to the homeless areas, areas such as Longview or The Dalles or these kind of areas, but we also through Dr. Sardo's, mentioned earlier, PTSD team has been sending our experts out to the small family groups in the rural areas talking about what they are to expect, how to cope with the returning vets.

Plus, again, as I mentioned, our wonderful relationship with the National Guard. They have four reintegration—happen to be purple hearts—scattered throughout the area.

Our main contact in eastern Oregon is Luke Wilson, an amputee in Hermiston, and we have worked with him in cooperation with his outreach to eastern Oregon. Plus, our Bend unit also does some work activities.

Senator SMITH. Senator Wyden.

Senator WYDEN. Just a couple.

Doctor, in May, Thomas Insel, the director of the National Institute of Mental Health, testified that only 23 to 40 percent of the veterans experiencing mental health problems actually seek mental health services. So his appraisal was well under half of the veterans in the United States who need these mental health services actually seek them. At some points, it is a quarter.

What is your estimate here in Oregon? What percentage do you think, of the veterans who need mental health services, actually come forward? I recognize that this is an inexact science for you.

Mr. HEIMS. It is an inexact science. As we heard in the roundtable, there are—for instance, pro bono counselors see people, and they are very hidden. People who seek help through their churches or synagogues also are hidden.

I think this can also, sadly, be said for the entire population, those who need to seek help and those who actually do.

Our experience is that 35 percent first 6 months coming back from OEF/OIF seek mental health care, and that is paralleled in the V.A. and that is paralleled——

Senator WYDEN. That is the overall. What I think Dr. Insel was saying is that between 23 and 40 percent of veterans experiencing mental health problems—these are people who actually had problems—came forward. I am trying to get you to give me a sense of what it is in Oregon.

Mr. HEIMS. I would say for our area, it runs about 30 percent.

Senator WYDEN. About 30 percent of the veterans in Oregon who are experiencing mental health problems are coming forward?

Mr. HEIMS. Correct. May I——

Senator WYDEN. Yes.

Mr. HEIMS. As we all know, particularly with substance abuse, which is considered mental health issues, you get into such denial, and with PTSD, it is hard—the old saying is you can lead a horse to water, but you can't make them drink. It is hard to make them thirsty.

Senator WYDEN. Tell us how you tailor your outreach for that population. In other words, my sense is—and both of us have been involved in mental health services—that you have the general outreach in terms of mental health services, but here you have got a situation where you said, of veterans experiencing mental health problems, about 30 percent are coming forward.

How do you tailor your outreach to try to get those folks to get service?

Mr. HEIMS. We saw it a little earlier today with Senator Smith, and that is using vets who are in recovery to show the way to those who want recovery. That is particularly true for our patients with serious mental illness, like shizophrenia, bipolar, and major depression.

Senator WYDEN. Just tell us for the record, because I have heard the story so many different ways and would appreciate your setting it out on record, what, if any, is the waiting list for mental health services in Oregon?

I have heard it two different ways. So you can perhaps just work your way through it; that with the additional hirings, that some

have said that has pretty much cleared out the waiting list, and I have heard others say that is not the case.

It would be helpful for you to set out on the record, what is the situation today with respect to the waiting list, if any?

Mr. HEIMS. Senator, I can't respond for the other two facilities in the State, but I can respond for Portland.

Our waiting list is, again, triaged. So as a person presents, we determine their acuity, and obviously if they are in high acuity, they are either admitted or seen that minute, that hour. For those who are OEF/OIF with service connected, we are seeing them within a week or two. Those who are less than that, we are seeing them within the 30 days.

We have a couple exceptions, depending on matching people. Somebody wants, for instance, a female counselor, a female psychiatrist, that may throw some things a little. We are in the process of doing all of this hiring. We aren't at 100 percent yet in hiring.

Senator WYDEN. I thank you. We are also pleased that Oregon is out in front in the recovery model.

Mr. HEIMS. Thank you.

Senator WYDEN. I think that is really important news, because people who can be in the vanguard of figuring out how to lead this Country to cure bipolar disorder and shizophrenia, that is the kind of leadership we want in Oregon.

Mr. HEIMS. Our leader, Dr. Mark Ward, has been doing this for at least 4 years, and we are very proud of his work.

Senator WYDEN. Thank you both.

Senator SMITH. We are proud of both of you, and we thank you both, as our first panel, for sacrificing the time you have made to be with us.

Our second panel is equally as important. Since we know that more than three-quarters of our veterans do not receive health care through the V.A., we also have invited a number of community representatives to discuss how they serve veterans and help them find the care that they need.

So we call up Dr. Nathalie Huguet with Portland State University; Mr. Ed Blackburn with Central City Concern—he is here to talk about the great work they are doing in Portland—Mr. Kevin Campbell from The Dalles, OR, who is the coordinator of the Eastern Oregon Human Services Consortium; Mr. Joseph Reiley is here from Lane County, veterans service coordinator; and Mr. Stuart Steinberg from the Crooked River Ranch near Bend.

We thank you all.

I would note that Mr. Steinberg is a Vietnam war veteran who was diagnosed with PTSD and received mental health services through V.A.

So, we are anxious to hear of your experiences, Stuart. Thank you for being here.

Why don't we start with Nathalie, and we will just work our way down.

STATEMENT OF NATHALIE HUGUET, RESEARCH ASSOCIATE, PORTLAND STATE UNIVERSITY CENTER FOR PUBLIC HEALTH STUDIES, PORTLAND, OR

Dr. HUGUET. Good afternoon. My name is Dr. Nathalie Huguet, and I am honored to present testimony today on behalf of my colleagues at Portland State University and Oregon Health and Science University.

Today I will address the results of a collaborative project that focused on suicide risk among veterans in the general population. The National Institute of Mental Health funded the study. I am a research associate at Portland State University Center for Public Health Studies.

Dr. Mark Kaplan, professor of community health at Portland State, is the lead author and principal investigator on this study and is unavailable to attend this hearing today. Accompanying me is Dr. Jason Newsom, an associate professor at the Institute on Aging. He is also a co-author on this study.

Suicide is a major cause of death in the United States. Approximately 30,000 people per year complete suicide, and nearly 650,000 people are seen in emergency departments after they attempted suicide. The suicide rate for men is four times that for women. Veterans may have an even greater risk of suicide than the general population.

Previous studies conducted among veterans have focused on samples derived from patient populations in the Department of Veterans Affairs system. Equally important, much of the earlier suicide research has been based exclusively on Vietnam-era veterans.

According to the literature, suicide risk factors common in the V.A. patients include male gender, older age, diminished social support, substance dependence, combat-related trauma, medical and psychiatric conditions associated with suicide, and the availability and knowledge of firearms.

The reliance on V.A. clinical samples is a limitation on other studies because, according to the final report from the 2001 National Survey of Veterans, three-quarters of veterans do not receive health care through the V.A. facilities. Consequently, little is known at this time about suicide risk factors among veterans in the general U.S. population. Estimates of suicide risk may be inaccurate because the characteristics of veteran who use the V.A. system may differ from those of the larger population of veterans.

Therefore, the purpose of our study was to examine suicide risk factors among veterans in the general population. In pursuing this goal, we used a large, nationally representative, prospective data base to: (1), assess the relative risk of suicide for male veterans in the general population (2) compare male veteran suicide decedents with those who died of natural and external causes and (3) examine the effects of baseline sociodemographic circumstances and health status on the subsequent risk of suicide.

We used data from the 1986 through 1994 National Health Interview Survey, which was conducted by the National Center for Health Statistics. The NHIS data file was linked to the Multiple Cause of Death file through the National Death Index. The total sample of male veterans for the pooled NHIS data used in our analysis was over 100,000 cases. We identified 508 male suicide

cases using the International Classification of Disease, ninth revision; 197 of these were veterans.

Respondents were identified as veterans if they answered in the affirmative to the question: Did you ever serve on active duty in the Armed Forces of the United States? Veterans represented 16 percent of the NHIS sample, but accounted for 31 percent of the suicide decedents.

The findings show that over time veterans were twice as likely to die of suicide compared to male non-veterans in the general population. Conversely, the risk of death from natural causes or external causes, accidents or homicides did not differ significantly between the veterans and the non veterans.

At baseline, veteran suicide decedents were significantly more likely than the non veteran decedents to be older, white, high school graduates, and less likely to be never married. Our results also show that activity limitation was an important suicide risk factor among veterans.

Health care providers are well-positioned to intervene with veteran patients who have physical or mental disabilities. Primary care physicians, as the gatekeeper of the health care system, along with other specialists, have important roles to play in the assessment and management of depression and suicidality among veterans in clinical settings.

Another important finding was the higher probability of firearms use among veteran suicide decedents. Supplementary analyses with data from the National Mortality Followback Survey showed that veteran suicide decedents were 58 percent more likely than non veterans to use firearms than other suicide methods.

Furthermore, an analysis of veteran suicide decedents in the NMFS revealed that those who owned guns were 21 times more likely to use firearms than those who did not own guns. According to the recent data from the 2003 Behavioral Risk Factors Surveillance System, veterans are substantially more likely to own guns than are individuals in the general population.

Although there is a debate among the suicidologists and policymakers about the association between availability of firearms and the risk of suicide, the preponderance of the evidence from other studies suggests that a gun in the house, even if unloaded, increases the risk of suicide in adults. Case-control studies on the prevalence of guns and suicide risk have shown significant increases in suicide in homes with guns, even when adjustments were made for other factors, such as education, arrest, or drug abuse.

Because veterans are familiar with and have greater access to firearms, health care providers need to be more attentive to the critical role that firearms play in suicidal behaviors among veterans. Unfortunately, some physicians find it difficult to ask directly about firearms. Previous research by Dr. Kaplan and colleagues found that only half of the primary care physicians who identified patients as suicidal would inquire about their access to firearms.

In conclusion, the results have potential clinical and public health implications. Clinicians outside the V.A. system need to be alert for signs of suicidal intent among veterans as well as their

access to firearms. Similarly, health care providers who serve veterans outside the V.A. system should also recognize the elevated risk of suicide in this population.

With a projected rise of functional impairment and psychiatric mobility among veterans from the conflicts of Afghanistan and Iraq, clinical and community intervention directed toward patients in both V.A. and non-V.A. health care facilities will be needed.

Thank you again for the opportunity to appear today. I will be happy to answer any of your questions.

[The prepared statement of Dr. Huguet follows:]

Suicide Risk Among Veterans in the General Population

Written Testimony to the
Senate Special Committee on Aging

July 3, 2007
Portland VA Medical Center
Portland, OR

Nathalie Huguet, PhD
Research Associate

Mark S. Kaplan DrPH*
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Good afternoon. My name is Nathalie Huguet, Ph.D., and I am honored to present testimony today on behalf of my colleagues at Portland State University and the Oregon Health and Science University. Today, I will address the results of a collaborative project that focused on suicide risk among veterans in the general population. The National Institute of Mental Health funded the study. I am Research Associate at Portland State University Center for Public Health Studies. Dr. Mark Kaplan, Professor of Community Health at Portland State, is the lead author and principal investigator on this study.

Suicide is a major cause of death in the United States; approximately 30,000 people per year complete suicide; and nearly 650,000 people are seen in emergency departments after they attempted suicide. Suicide rate for men is four times that for women. Veterans may have an even greater risk of suicide than the general population.

Previous studies conducted among veterans have focused on samples derived from patient populations in the Department of Veterans Affairs (VA) system. Equally important, much of the earlier suicide research has been based exclusively on Vietnam-era veterans. According to the literature, suicide risk factors common in VA patients include male gender, older age, diminished social support, substance dependence, combat-related trauma, medical and psychiatric conditions associated with suicide, and the availability and knowledge of firearms.

The reliance on VA clinical samples is particularly limiting from a population-based perspective because three quarters of veterans do not receive health care through VA facilities. Consequently, little is known about suicide risk factors among veterans in the general U.S. population. Estimates of suicide risk may be inaccurate

because the characteristics of veterans who use the VA system differ from those of the larger population of veterans. In light of the high incidence of physical and mental disabilities among veterans of Iraq and Afghanistan, it is important to examine the risk of suicide among veterans in the general population.

Therefore, the purpose of our study was to examine suicide risk factors among veterans in the general population. In pursuing this goal, we used a large, nationally representative, prospective database to: (1) assess the relative risk of suicide for male veterans in the general population, (2) compare male veteran suicide decedents with those who died of natural and external causes, and (3) examine the effects of baseline sociodemographic circumstances and health status on the subsequent risk of suicide.

We used data from the 1986 through 1994 National Health Interview Survey (NHIS). In the NHIS, which was conducted by the National Center for Health Statistics (NCHS), noninstitutionalized people from the 50 states and the District of Columbia were sampled. The total sample of male veterans for the pooled NHIS data used in the analyses was 104,026. The demographic profile for the NHIS veteran sample closely matched that of other surveys, including the 2001 National Survey of Veterans and the Current Population Survey for September 1989.

The NHIS 1986–1994 data file was linked to the Multiple Cause of Death file (1986–1997) through the National Death Index (NDI) in order to ascertain the cause of death of veteran and nonveteran decedents. NHIS participants aged 18 and older were matched from the date of interview through December 1997 using the following criteria: social security number, first and last name, middle initial, race, sex, marital status, birth date (day, month, and year), and state of birth and residence. We used the recommended NCHS scoring cutoff, which corresponds to an estimate of 97% correctly

classified deaths

Suicide cases were identified using the International Classification of Diseases, ninth revision, Clinical Modification (ICD-9 E950-E959). Respondents were identified as veterans if they answered in the affirmative to the question, "Did you ever serve on active duty in the Armed Forces of the United States?" We explored the potential effects of age (18–44, 45–64, or 65+), marital status (married, widow/divorced/separated, or single), living arrangement (alone or with others), race (white or nonwhite), education (less than 12 years or 12 years or more), employment status (employed, unemployed, or not in the labor force - i.e., retired, disabled, or not looking for a job), region of residence (Northeast, Midwest, South, or West), place of residence (rural or urban), body mass index (BMI), number of chronic non-psychiatric medical conditions (ICD-9 001 to 289 and 320 to 779), number of psychiatric conditions (ICD-9 290 to 316), self-rated health, and activity limitations. Activity limitations was assessed with the following question: "Does any health problem now keep you from working at a job or business, keeping house, going to school, or something else?" with the reply options: (1) "Unable to perform major activities," (2) "limited in kind/amount of major activities," (3) "limited in other activities," and (4) "not limited." The first three categories were collapsed and henceforth are referred to as "limited."

The Cox proportional hazards model (also known as survival analysis) was used to estimate the relative risk of suicide adjusting for demographic characteristics, socioeconomic factors, and health. The comparison group consisted of individuals who died of other causes (i.e., non-suicides) or those who survived through the entire period (through December 1997). In addition, we compared the relative risk of suicide to other causes of death among veterans relevant to nonveterans. A statistical program called

SUDAAN (Release 9.0.1; Research Triangle Institute, Research Triangle Park, N.C.) was used to adjust for complex sample design of the NHIS and ensure accurate estimates of the broader population. Because there were too few female veterans in the sample who completed suicide (6 cases), we did not include women in the analyses.

Veterans represented 16% of the NHIS sample but accounted for 31% of the suicide decedents. The findings showed that over time veterans were twice as likely (adjusted hazard ratio or relative risk 2.13, $p < .05$) to die of suicide compared to male nonveterans in the general population. Conversely, the risk of death from "natural" causes (diseases) and the risk of death from "external" causes (accidents and homicides) did not differ between the veterans and the nonveterans after we adjusted for confounding factors.

At the baseline, veteran suicide decedents were significantly ($p < 0.05$) more likely than were nonveteran decedents to be older, white, high school graduates and less likely to be never married. Veteran suicide decedents had more activity limitations at baseline than nonveteran decedents. Furthermore, at the time of death, veterans were more likely to have completed suicide using a firearm than were their nonveteran counterparts.

An examination of only veterans over time showed that whites, those with 12 years or more of education, and those with activity limitations (after adjusting for medical and psychiatric morbidity) were at a greater risk for suicide completions. An interesting result was that relative to those with normal weight (BMI, 20.0 to 24.9 Kg/m2), overweight (BMI, 25.0 to 29.9 Kg/m2) male veterans were at lower risk of completing suicide.

In summary, using prospective population-based health and mortality data, we

examined suicide risk among male veterans of military service. The results revealed that male veterans are at elevated risk of suicide relative to nonveterans.

The results of this study are especially noteworthy because they were derived from a sample representative of all veterans in the U.S. general population, whether or not they sought care in the VA system. Conversely, nearly all previous studies examined suicide in VA-based samples and such studies may over- or underestimate suicide risk because the VA serves only a minority of veterans.

Our results also showed that activity limitation is an important suicide risk factor among veterans compared to nonveterans in the general population. Health care providers are well positioned to intervene with at-risk veteran patients who have physical and/or mental disabilities. Primary care physicians, as the gatekeepers of the health care system, along with other specialists, have important roles to play in the assessment and management of depression and suicidality among veterans in clinical settings.

Another important finding was the higher probability that veterans used firearms as a mode of suicide compared with nonveterans. Supplementary analyses with data from the National Mortality Followback Survey (NMFS) showed that veteran suicide decedents were 58% more likely than nonveterans to use firearms than other suicide methods, after adjusting for potential confounding factors, including sex, age, marital status, race, education, region, metropolitan status, psychiatric visit in the last year of life, number of half-days in bed for illness or injury in the last year of life, and alcohol use. Furthermore, an analysis of veteran suicide decedents in the NMFS revealed that those who owned guns were 21.1 times more likely to use firearms than were those who did not own guns after adjusting for sex, age, marital status, race, education,

region, and metropolitan status. Other data show that active duty military personnel are more likely to own and use firearms to complete suicide than the nonmilitary population. According to recent data from the Behavioral Risk Factor Surveillance System, veterans are substantially more likely to own guns than are individuals in the general population (46% versus 32%).

Although there is a debate among suicidologists and policymakers about the association between the availability of firearms and risk of suicide, the preponderance of the evidence suggests that a gun in the house, even if unloaded, increases the risk for suicide in adults. Case-control studies on the prevalence of guns and suicide risk have shown significant increases in suicide in homes with guns, even when adjustments were made for other factors, such as education, arrests, and drug abuse.

Because veterans are familiar with and have greater access to firearms, health care providers need to be more attentive to the critical role that firearms play in suicidal behavior among veterans. Unfortunately, some physicians find it difficult to ask directly about suicide. Previous research by Dr. Kaplan and colleagues found that only half of the primary care physicians who identified patients as suicidal would inquire about their access to firearms.

There are several potential limitations to this study. The first limitation concerns the reliability of suicide data derived from death certificates. Second, a further constraint of the NHIS-NDI design was the absence of time-varying covariates. However, most suicides occurred shortly after the interview (i.e., 75% died within 3 years) so there was a limited opportunity for baseline measures to change (such as marital status). Third, data were unavailable on important measures such as suicide attempts, source of health care coverage, or combat experience--all of which are related to suicide risk.

Fourth, psychiatric conditions are critical risk factors in suicide. One would expect over 90% of suicide decedents to have psychiatric illness. However, little information about baseline psychiatric morbidity was available in the NHIS. Therefore, we were unable to examine the role of well-established risk factors such as major depressive disorders (MDD) or post-traumatic stress disorder (PTSD) because of the small number of suicide decedents and because MDD and PTSD were not available as a separate psychiatric conditions in the NHIS-NDI dataset. Finally, we could not address cohort and period effects associated with suicide rates. For example, there have been major developments in suicide prevention since the NHIS was conducted, particularly the enormous change in the last 10 years in rates of antidepressant prescriptions and reduced suicide rates.

In spite of these limitations, the results have substantial clinical and public health implications. Clinicians outside the VA system need to be alert for signs of suicidal intent among veterans, as well as their access to firearms. Similarly, health care facilities that serve veterans outside the VA system should also recognize the elevated risk of suicide in this population. With the projected rise in functional impairments and psychiatric morbidity among veterans from the conflicts in Afghanistan and Iraq, clinical and community interventions directed toward patients in both VA and non-VA health care facilities will be needed.

Thank you again for coming to Portland and for the opportunity to appear today. I am happy to answer any questions you may have. We look forward to continuing to work with you to address veteran mental health issues.

Senator SMITH. Thank you very much, Nathalie. We will probably have some questions for you. We will just go down each witness, and then we will go back to you.

Ed Blackburn.

STATEMENT OF ED BLACKBURN, DEPUTY DIRECTOR, CENTRAL CITY CONCERN, PORTLAND, OR

Dr. BLACKBURN. Senators Smith and Wyden, thank you for the opportunity to be here. I hope I do our veterans and staff that work with them justice in this testimony.

Senator Smith, your comments about peer support are right on. Without the peer support from veterans, we cannot be successful as we should be, particularly with the population I am about to speak of, and that is homeless vets. I think with all vets, a corps of veterans in recovery would be a big help.

Senator Wyden, your observations about the housing issue, not in just central Oregon but here in Portland, OR, is critical. Peer support, supportive housing, supportive employment, these things are the foundation of any kind of recovery, particularly for the homeless population.

I am Ed Blackburn. I am the deputy director of Central City Concern, which has operated in Portland for almost 30 years. We provide services to about 15,000 homeless people per year, and amongst those 15,000 are quite a few veterans. We estimate that there are about 17,000 homeless people in the metropolitan area annually, and 4,000 and 7,000 of these people are veterans.

What do they face? Poverty, addictions, mental health issues, including PTSD, physical disabilities, poor health, in some cases criminal backgrounds, poor employment or rental histories, disaffiliation with service systems and social support network—and that is why the peer support is so important—post-traumatic stress disorder, traumatic brain injury. Some people have all these things.

I want to talk about three programs that produce success for homeless veterans. One is called the Community Engagement Program. I am going to tell just a brief story.

"W" is a veteran who had been homeless for approximately 5 years with a substance abuse disorder. He was referred to the Community Engagement Program by the V.A. Medical Center and received housing and intensive case management through Central City Concern, including support from an employment specialist.

He was connected to vocational rehab services, substance abuse treatment, which was successful in his case. He obtained his GED and his commercial driver's license and recently has been accepted into the truck drivers' union and has obtained a job with a local trucking company.

The Community Engagement Program was funded through the Interagency Council on Homelessness, which the Veterans Administration is part of, and also Department of Labor and Department of Human Services. It targets chronically homeless adults in the Portland area and uses a multi-disciplinary team, including psychiatric, substance abuse, peer case managers, and primary care. It is out in the community, and it does outreach on that basis. It provides immediate access to housing, primary health care, and employment support.

This program, over the last 3 or 4 years, has served about 250 clients. That is, 250 chronic homeless clients with their average homelessness of about 8 years have been placed in a house. About 60 of those are veterans. The major barrier to serving more veterans is the discharge status of the veterans and the relationship of their injury to military service.

So how do we fund services for those people? We find other ways of doing that, but that needs to be looked at, the rules around that, and whether exceptions can be made under certain circumstances.

Next I want to talk about the Homeless Veterans Reintegration Project.

"R" was unemployed for 3 years, homeless for 2, addicted to heroin and alcohol. He had a history of mental health issues and domestic violence and debt. He was honorably discharged from the Navy after 6 years of active duty.

Through the Veterans Reintegration Project, he attended employment classes and moved in supportive housing. He used V.A. Medical for primary care, dental, mental health, substance abuse, and work training services. The V.A.'s Compensated Work Therapy program enrolled him in entrance-level custodial work, and the V.A. Medical Center later offered him full-time employment as a Federal employee with a starting salary of $26 an hour.

The Veterans Reintegration Project is funded by the Department of Labor, and it expedites reintegration of homeless individuals into the labor force, provides job training, placement assistance, and initial case management.

Through this program in Central City Concern, we have enrolled 2,300 veterans. 814 obtained employment, with an average wage of $11.20 an hour, and over 1,600 of those veterans obtained housing through this program. During the last fiscal year, 67 percent of the HVRP participants were placed into employment.

So that is another success story about what works.

The Veterans Grant and Per Diem program. "D" had a criminal background and history of drug use and no legal I.D. except for documentation of his U.S. Army veteran status of 6 years military service and honorable discharge. He had failed in most local service channels and had no income, no food sources, and was sleeping in a flower bed.

After entering the program, he moved into housing, obtained employment at a local service station, and soon gained certification as an auto technician. He is now fully employed, employed full-time as a supervising mechanic at a wage of $25 an hour.

The Veterans Grant and Per Diem program is funded through the V.A. and offers transitional housing and case management for servicemen with an honorable discharge. Since its inception—it is 2 years old there are about 112 veterans that have been housed, 60 have been employed, and about 12 of those have received a V.A. pension and been able to work the system because they had housing. Without the housing, they would be on the streets, would not have obtained their benefits.

That program has a 4-month waiting list now. In other words, there is a 4-months wait for a veteran to be able to get housing through that program.

These are the three programs that we know work at Central City Concern. We provide other services in our alcohol and drug treatment program and our detox center and other housing opportunities for veterans. But these are the things that work.

So my recommendation to you is, particularly when it comes to homeless vets, the peer support is essential. We ought to find a way of the various community-based programs with Veterans Affairs to fund more veterans and employment services.

We have found that when we hire recovering people, formerly homeless, they bring people in. They are able to connect people to services, kind of break down the cynicism and the disaffiliation that has occurred, and encourage them to move forward with the recovery. They are living examples of what can happen when people are in the recovery process.

Housing, there is an absolute shortage of housing, affordable housing, for veterans. It is the key to ending their homelessness and allows the mental health and clinical primary care services to be successful. You cannot be successful with these people who are homeless unless housing is available, and appropriate housing.

There are rules that I would be glad to talk to your staff about around how that—the Per Diem program, for example, is financed, that make it difficult, probably unnecessarily so, both for Veterans Affairs and for us that we need to look at.

What do we mean by "recovery"? Recovery means re-establishing the right relationship with oneself, right relationship with others that you need to live with, and right relationship spiritually or ethically to find a greater meaning in life. These people have been wronged, and what we are about is making a wrong right.

I wish you all luck in moving forward on these issues.

[The prepared statement of Mr. Blackburn follows:]

Homeless Veterans
Service barriers, innovations and recommendations

By
Ed Blackburn
Deputy Director, Central City Concern

My name is Ed Blackburn; I'm the Deputy Director of Central City Concern, an agency that has been working with homeless adults and families in the Portland metro area for almost 30 years. I'm here today to talk about my agency's experience, and the challenges we face dealing with homeless veterans. I want to start by saying that many of our most successful programs serving homeless veterans, and the general homeless population, have been started with or sustained by federal funding, so I want to thank you for your commitment to vulnerable populations, and for inviting us here to share our knowledge.

Homelessness is disproportionately represented among veterans. Nationally, veterans account for an estimated 23% of all homeless people in America.[1] Locally, the Veterans Administration (VA) estimates that between 12 to 30% of the Portland area homeless population is comprised of veterans. It is difficult to obtain hard census data around a transient demographic that exists outside of mainstream service channels. However results from a "point-in-time" One Night Shelter Count provide insight.[2] Such data is often used to estimate the total number of homeless in Multnomah County, currently estimated to be 17,000 people annually.[3] Based on these numbers, an estimated 4,000 to 5,000 veterans are likely homeless in Portland each year, although some place the number as high as 7,000.[4]

What sorts of issues lead to homelessness in this population? Homeless veterans face the same interconnected barriers and challenges as the general homeless population: poverty, addictions, mental health issues, physical disabilities, poor health, criminal backgrounds, poor employment and rental histories, and disaffiliation with service systems and social support networks. These barriers, however, are often intensified due to the presence of Post Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI). These two factors, while not limited to the veteran population, are clearly elevated due to the likelihood of past combat experiences. The impact of PTSD and TBI cannot be overstated as both a cause of homelessness for veterans, and as barriers to ending homelessness.

Despite these significant hurdles facing veterans, their past military service can work in their favor in two very important ways. First, there is the distinct possibility that the personal discipline inherent in military life is advantageous as they seek to rebuild their lives after the trauma of homelessness. Second, there are services available to veterans – provided primarily by the federal government – that not available to civilians. The ability to enroll in any veteran care

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[1] National Survey of Homeless Assistance Providers and Clients, U.S. Interagency Council on Homelessness and the Urban Institute, 1999
[2] One Night Shelter Count, Multnomah County Dept. of County Human Services
[3] Home Again: A 10-Year Plan to End Homelessness in Portland and Multnomah County, 12/04
[4] National Coalition for Homeless Veterans; www.nchv.org

program ultimately enhances their utilization of all veteran benefits and dramatically increases the probability of achieving success across other life domains.

At Central City Concern (CCC), we provide a continuum of affordable housing options integrated with primary and behavioral healthcare services, drug and alcohol addictions treatment and recovery support, and employment services. An estimated 15,000 people access these services each year. As you can imagine, a significant number are veterans. While most of the housing and programs available to adults are also available to veterans, I want to focus on three specific programs that directly serve – or serve a high percentage of – veterans: the Community Engagement Program, the Homeless Veterans Reintegration Project, and the Veterans Grant and Per Diem program. And I will preface each discussion of the program with a story about a client that it serves.

The Community Engagement Program (CEP): a success story
W. is a 44 year old veteran who had been homeless for approximately five years and had a substance abuse disorder. After living in the woods for 18 months, he developed a serious infection and sought shelter during a snowstorm in December 2003. After stays at a local shelter and engagement in a detox program, he was connected to medical services at the VA and from there, was referred to CCC's Community Engagement Program. He received housing and intensive case management, including support from a CEP employment specialist. W. was connected to vocational rehabilitation services and was assisted with obtaining his GED and then his Commercial Drivers License. Recently W. was accepted into the truck-drivers union and has obtained a job with a local trucking company. He is saving money to buy his own truck, which will assure him long-haul driving jobs. W. also receives Social Security benefits.

The Community Engagement Program (CEP) was created in 2004 to bring outreach and assertive engagement to the chronically homeless. Federal grant funding from agencies participating in the Interagency Council on Homelessness (ICH), including the VA, allowed the program to expand capacity and include critical housing and healthcare treatment components. CEP targets chronically homeless adults dually diagnosed with mental and/or physical disabilities and addictive disorders – some of the hardest to serve individuals in the community. The program, based on the Assertive Community Treatment model, relies on multidisciplinary teams to provide intensive case management and immediate access to supportive housing. The CEP approach also utilizes access to primary and behavioral healthcare and, when appropriate, employment support. There are currently three teams serving approximately 250 clients. Due to the ICH funding and the strong VA influence, CEP has a significant focus on chronically homeless veterans. CEP Team II includes a VA case manager assigned to eligible CEP clients and able to connect them to VA medical services. Please refer to *Figure 1.* below for usage statistics related to CEP, the number of veterans served, and outcomes achieved.

Figure1: Community Engagement Program Veteran Statistics, July 2004 - June 2007

Total Clients Served by CEP		
	Total	Percentage
CEP clients	250	
CEP clients who are veterans	60	24%

Figure1 (continued:. Community Engagement Program Veteran Statistics, July 2004 - June 2007

CEP Client Veterans – demographics (for 60 clients)		
	Total	Percentage
Ineligible for VA services	14	23%
Eligible for VA services	40	66%
Unknown eligibility	6	10%
Receiving VA NSC pension	5	8%
Receiving SC pension < 50%	1	1%
Receiving SC pension > 50%	1	1%
Eligible veterans refusing/not accessing VA services	5	8%
Experiencing A&D only	11	18%
Experiencing mental health only	2	3%
Dual diagnosis	44	73%
Physical disability only	3	5%
Avg. length of homelessness	5.94 years	
Range of length of homelessness:	1 – 17 years	
Approx. cumulative years of homelessness	350	

CEP Client Veterans – Outcomes		
While with CEP, clients were:	Total	% (of total)
Employed (fulltime)	5	8%
Employed (part time/ temporary)	7	11%
Receiving VocRehab services	4	6%
Volunteering at Client Center	9	15%
Volunteering at other locations	6	10%

The Homeless Veterans Reintegration Project: a success story

R., unemployed for three years, homeless for two, came to WorkSource in August 2004. He was divorced, had a history of mental health issues including anger and domestic violence. Deeply in debt, R. was a ten year user of heroin and alcohol and – despite strong labor skills – had poor social abilities. His only reported source of monthly "income" was food stamps ($141.00).

A Navy veteran of six years active duty, R. was honorably discharged in 1983. He stated that he was seeking employment assistance and enrolled with the Homeless Veterans Reintegration Project (HVRP). The program became his navigator into reintegration and he began attending employment classes and successfully followed the guidance of case mangers.

Due to his success in the program, six months later (February 2005), R. became the first veteran to be admitted into the new Veterans Grant Per Diem Program. He ended 30 months of homelessness when he moved into CCC's Henry building, though for the first several weeks, hesecured every lock on his door and placed a chair against it for added security. This fear slowly subsided as did his intense and escalated expressions of anger. Through the Per Diem program, R. began to trust and utilize VA Medical for primary care, dental, mental health,

substance abuse and work training services. VA's Compensated Work Therapy (CWT) enrolled him in entrance level custodial work, a platform from which he could demonstrate his skills and renewed reliability. VA Medical soon offered him full time employment as a federal employee with a starting salary of $26.00 an hour.

R. has been in recovery since joining the program, helping to establish an AA group that meets in the Henry building. While in the program, he also repaired broken family relationships. R. graduated from the program in October 2006 and currently resides in permanent housing in SW Portland as a veteran in recovery and federal employee.

R.'s story illustrates the great success the Homeless Veterans Reintegration Program (HVRP) has had with this population. The HVRP is operated out of Central City Concern's WorkSource job resource center, a common portal for individuals accessing other services within the continuum. Because of the important role WorkSource plays in all agency veterans' services, a brief discussion of the program follows.

WorkSource is the employment arm of CCC's service continuum. Benefits focus on pre-employment support, employment retention, career advancement training, vocational training, enhancing computer skills, writing effective resumes, and developing interview skills, among others. WorkSource provides general services to the public, and specialized services to individuals facing barriers to employment, including many veterans. Please refer to *Figure 2.* below for usage statistics related to WorkSource, the number of veterans served, and the outcomes achieved. (Note: the significant increase in the percentage of veterans employed in 2006-07 reflects changing priorities from the Department of Labor requiring a more aggressive screening for clients considered most likely to achieve employment stability.)

Figure 2. WorkSource Veteran Statistics, July 2004 - June 2007[5]

		2004-05		2005-06		2006-07	
		Clients	% of total	Clients	%'s	Clients	%'s
WPOS Enrollment	Total	2,555		1,904		1,414	
	Homeless	1,554	60.8%	1,180	62.0%	912	64.5%
Veteran Enrollment		351	22.6% (total homeless)	287	24.3% (total homeless)	136	14.9% (total homeless)
Veteran Employment		192	54.7% (total vets enrolled)	173	60.3% (total vets enrolled)	105	77.2% (total vets enrolled)
Veteran Housing		295	84% of total vets enrolled	269	93.7% of total vets enrolled	125	91.9% of total vets enrolled
Addictions among Veterans		348		266		104	
Veteran Welfare Recipient		333 (95%)		273 (95%)		129 (95%)	
Veteran Ex Offender		296		266		99	
Homeless Veterans		351		287		136	

[5] Notes to Figure 2:
1. Stats for 2006-2007 are through the date of June 18, 2007.
2. DOL directives to HVRP to place primary enrollment focus on employment, rather than general reintegration services, have led to an obvious reduction in enrollment numbers for HVRP in the 2006-07 year.

All veterans enrolled in veteran-specific services (including HVRP and the Veterans grant Per Diem Program) are also co-enrolled in other WorkSource programs for resource leveraging and service maximization. WorkSource has developed an ever expanding network of support on behalf of veterans with local, state and national employment and veteran services agencies, and with justice and prison systems.

The Homeless Veterans Reintegration Project (HVRP) is funded by the Department of Labor (first awarded to CCC in 1998) to expedite the reintegration of homeless veterans into the labor force. The program provides homeless veterans with job training and placement assistance as well as initial case management. Veterans come to HVRP for guidance and assistance in reintegration tasks in job search, employment, housing, personal hygiene, and transportation, as well as how to reshape their lives as self-sufficient community members. HVRP staff seeks to enhance the reintegration of veterans by encouraging the veteran's participation in existing continuum of support services, employment and housing. The Disabled American Veterans Charitable Service Trust has funded dental and vision services for homeless veterans for three years now, helping HVRP staff employment readiness services.

Since inception, HVRP has

- Enrolled over 2,294 veterans;
- Assisted 814 in obtaining employment with an average wage of $11.20/hr; and,
- Assisted 1,664 veterans in gaining various types of housing.

During the last fiscal year, 67% of HVRP participants were placed into employment.

The Veterans Grant and Per Diem program: a success story

D. came to WorkSource in April of 2005 seeking assistance for employment, housing, and simple basic life needs. He had a criminal background, a history of drug use and no legal identification except for documentation of his US Army veteran status – six years military service and honorable discharge in 1983. He had failed in most local service programs and had no income, no food resources, and no place to live; he was sleeping in a flower bed when he first connected with WorkSource. He had multiple unpaid driving fines across several states, court issues, and drug addiction issues. He also had considerable natural skills as an auto technician.

D. entered the Homeless Veterans Reintegration Program, and then the Per Diem program, moving into the Henry Building and ending four years of homelessness. Over the next two years, D. started work in a day labor job, enrolled in the VA Voc Rehab which led him to Compensated Work Therapy (CWT) employment at a local service station. He soon gained certification at several advanced levels as an auto technician and is now employed full time as the Supervising Mechanic at a wage of $25.00 an hour.

In terms of mental health and addictions issues, D. is currently undergoing methadone treatment. VA Medical is treating him for depression and other mental health challenges and he has enrolled in the Substance Abuse Treatment Program at VA Medical and maintains active enrollment as a patient. For his legal issues, D. has cleared all legal issues creating barriers for obtaining a driver's license. He has also developed a personal tool inventory for professional

work, recently purchased a motorcycle for personal transportation, and saved over $2,400.00 in the Per Diem Move Out Account (to be used securing permanent housing in the community). Related to housing, D. has completed Ready to Rent Classes at the Better People program, upon graduation from the Per Diem program moved into a Single Room Occupancy on VA Medical campus in Vancouver, and continues to maintain eligibility on HAP lists.

The Veterans Grant and Per Diem Program (VGPDP) operates out of the WorkSource job center. It was funded by a grant from the Department of Veterans Affairs awarded in 05/2004. The program offers transitional housing for 50 veterans, with honorable discharge, for up to 24 months of enrollment. The length of stay in this program allows for long term case management. VGPDP participants are required to be enrolled in VA Medical at every point of benefit that applies to them. Participant goals include obtaining better housing, increasing income, and achieving better self-determination and self-sufficiency. One year follow up is offered to each graduate. VGPDP veterans participate in weekly resident advisory council meetings and work closely with case managers of WPOS and VA.

Participants are referred through the HVRP (detailed above). After a rigorous assessment and intake process, veterans are moved off the street and into stable housing at the Henry Building, a 153 unit downtown apartment building owned by CCC. Program capacity has been at 100% since implementation (02/05). Staff from CCC's WorkSource job resource center provides case management to ensure that participants are making progress. Participating veterans develop an employment and/or self-sufficiency plan that includes transitioning into permanent housing and work with staff to develop individual action plans that maximize client access to a range of services available through CCC, the local VA and a broad array of community partners.

Since inception, VGPDP has served 112 clients. Of those:

- Approximately 60 participants (54%) have been employed while in the program
- Approximately 39 participants (34%) have disabilities that prohibit or restrict employment
- 25 of 62 former graduates (40%) receive VA pension
    - 12 Service Connect Disability
    - 13 Non Service Connect Pension
- 12 of the 50 current participants (24%) receive VA pensions
    - 5 Service Connect Disability
    - 7 Non Service Connect Pension
- Approximately 43 of the 62 program graduates (69%) have secured housing upon discharge

As clearly evidenced by the strong outcomes of these three programs, Central City Concern has a tremendous amount of experience dealing with homeless veterans. By identifying gaps in existing services and leveraging the strengths and funding commitments of other stakeholders, the agency has been able to create innovative programs and housing options able to best meet the needs of this underserved demographic.

Some of the gaps and challenges we have currently identified in this area include:

- Lack of access to services: Many homeless veterans are not connected to needed services and remain living on the streets and in need of primary and behavioral healthcare as well as addictions treatment
- Service barriers related to discharge status: Due to constraints imposed by funders, many of the veterans services offered by Central City Concern and other providers are not available to veterans with anything other than an honorable discharge. The VGPDP, for example, is only available to veteran with an honorable discharge; this is a funding requirement and outside of the agency's control. Similarly, VA medical services are only available to veterans who have been honorably discharged from military service.
- Lack of housing options: Without housing – supportive housing in particular – homelessness in general and in this specific subgroup cannot be ended.

Based on our experience and success in meeting the distinct needs of homeless veterans, I would also like to make a few recommendations that I think will be key in best serving this population:

- Increased outreach: Only by engaging clients "where they are" (on the streets, in homeless camps, etc.) can we ever hope to connect them to needed services.
- Reformed/revised funding parameters: In order to provide the most effective and comprehensive services, it is imperative that service access not be tied to discharge status.
- Mental Health/A&D services: To best serve them, veterans must have low-barrier access to behavioral healthcare and addictions treatment. Without such access, there can be no permanent intervention in homelessness.
- Streamlined benefits acquisition process: The current process for connecting to entitled benefits is simply too challenging for individuals impacted by homelessness and mental health issues. Streamlining the process will help veterans connect more quickly to benefits and allow them to engage in needed services.
- Employment: Employment support is critical for homeless veterans. With initial support and case management, we have seen tremendous success in connecting clients to long term jobs. Not only does this address self-sufficiency issues for clients, it removes strain on safety net resources and opens service slots for homeless veterans with no resources and/or in need of initial support.
- Increased housing capacity: Federal funding should be set aside to drive development of affordable, supportive housing in all communities.

* * *

As I stated before, these and other successful agency programs rely on federal funding commitments. To best serve veterans, and to best serve the most disenfranchised in our communities, this continued support will be critical. We have been actively involved in meeting the many and unique needs of veterans and will continue working in this area to influence policy reform and to provide the most effective services to veterans impacted by homelessness, addictions and mental health issues.

Thank you for providing us with this opportunity to talk to you today.

Appendix A: About Central City Concern

Central City Concern (CCC) is a 501(c)(3) nonprofit agency serving single adults and families in the Portland metro area who are impacted by homelessness, poverty and addictions. Founded in 1979, the agency has developed a comprehensive continuum of affordable housing options integrated with direct social services including healthcare, recovery and employment. CCC currently has a staff of 450, an annual operating budget of $28 million dollars and serves an estimated 15,000 individuals annually. The mission statement of CCC is "*to provide pathways to self sufficiency through active intervention in poverty and homelessness.*"

Current agency activities

HOUSING

Access to affordable housing is the cornerstone of CCC's mission. The agency currently owns or manages 20 buildings with 1,309 units of transitional and permanent affordable housing. New projects will add over 300 units by 2009. Seventy percent of CCC housing is alcohol and drug free, and 93 units are devoted to family housing. The agency also maintains needs-appropriate residential facilities for people living with HIV/AIDS, for those suffering from mental illness and for individuals on parole or probation.

HEALTH AND RECOVERY SERVICES

CCC maintains the following Health and Recovery services, integrated with agency housing, to meet the primary and behavioral healthcare and drug and alcohol treatment and recovery needs of low income or chronically homeless clients:

- The Community Engagement Program (CEP) is a multidisciplinary healthcare, recovery and housing model designed to meet the unique needs of chronically homeless individuals with co-occurring mental and physical disabilities, addictive disorders and/or medical issues. The program was recognized by the U.S. Department of Health & Human Services as one of six exemplary programs in the country serving mentally ill homeless individuals in 2003.
  - The Family Latino Outreach and Addictions Treatment (FLOAT) program (a CEP program) provides linguistically and culturally appropriate treatment services for Spanish-speaking families and individuals who are homeless or are at risk of homelessness and are struggling with substance abuse and/or mental health disorders.
  - Housing Rapid Response (a CEP program) works with the Portland Police and Project ACCESS to engage high utilizers of public resources (jails, hospitals, etc.) in housing and supportive services.
- The Hooper Detox Center provides drug and alcohol treatment services – including outreach, sobering and subacute medical detoxification – to over 10,000 clients each year, and is a common referral point for clients to access other agency services.
- The Old Town Clinic (OTC) is a medical, surgical and psychiatric healthcare clinic for a patient base of homeless individuals. The clinic is a Federally Qualified Health Center and member of the Coalition of Community Health Clinics.
  - The Recuperation Care Program (an OTC program) is a collaborative project between CCC and a number of local hospital systems to provide housing, case management and recuperative healthcare services care for low-income/homeless patients post-hospitalization.

- The Letty Owings Center is a residential drug and alcohol treatment program for poverty level, chemically dependent women who are pregnant or newly parenting. Since inception (1989), 1,092 families have received services and 190 babies have been born there drug free.
- The CCC Recovery Center (CCCRC) is an outpatient drug and alcohol treatment program serving primarily homeless and low-income clients. In 2002, the Center was recognized by the National Healthcare for the Homeless Council as one of the top six "exemplary Substance Abuse Treatment programs for people experiencing homelessness" in the United States.
  - The Recovery Mentor Program (a CCCRC program) utilizes the experience and knowledge of mentors in recovery from chemical dependency to assist, support and offer guidance to those new to the recovery process and has been shown to greatly improvement engagement and completion rates.
- Supportive Housing Services, maintained through CCC's Housing Department, provides support services to clients so that they are better maintain housing stability and engage in other aspects of agency programming.

EMPLOYMENT

CCC's WorkSource is a job resource center with specialized programs able to assist homeless individuals, or those at risk of becoming homeless, achieve self-sufficiency by identifying and teaching the vocational and social skills they need to find and sustain full-time employment. The program was identified by the U.S. Department of Labor as a national best practices homeless program in 2004. Along with core employment services and over a dozen on-site partners, WorkSource also maintains a variety of specialized programs including:

- Access to Building Trades & Customer Service Occupations
- Dislocated Workers Program
- Portland Prisoner Re-Entry Initiative
- Workforce Investment Act

CCC is one of the largest employers of formerly homeless individuals in the Portland metro area and operates five Business Enterprises to teach on-the-job skills and impart work experience to individuals who might otherwise face barriers to employment. These businesses include:

- Downtown Clean & Safe – a public sanitation and safety service.
- Central City Janitorial – a professional cleaning service.
- Central City Maintenance – a general contractor service.
- Central City Painting – a certified lead-abatement interior and exterior painting contractor.
- Second Chance – a resale furniture and furnishings store.

RECENT AGENCY AWARDS

- The Northwest Regional Primary Care Association's Award of Excellence for the Social Medicine Curriculum – collaboration between CCC and Oregon Health & Sciences University (OHSU) (2007).
- First place in the Donald Terner Prize for Innovation and Leadership in Affordable Housing, awarded to CCC's 8NW8th building by the Center for Community Innovation at the University of California, Berkeley (2007).
- Second place in the Supportive Housing Award was given to CCC's Chez Ami residential project in the MetLife Foundation's Awards for Excellence in Affordable Housing (2006).
- The National Innovators Award, given to CCC's Executive Director Richard L. Harris at the National Homeless Summit hosted by the U.S. Interagency Council on Homelessness (2006).

- The Award of Excellence for Hotel Alder, given by the Oregon Downtown Development Association and the Oregon Housing & Community Services Department (2006).
- The Urban Pioneer Award, given to CCC by Portland State University's College of Urban and Public Affairs in recognition of public service and community engagement (2005).

Senator SMITH. Thank you, Ed. Those were terrific suggestions. I am grateful for your time here.

Joseph Reiley.

STATEMENT OF JOSEPH REILEY, VETERANS SERVICE COORDINATOR, LANE COUNTY, OR

Mr. Reiley. Thank you, Mr. Chairman, Senator Wyden.

Senator SMITH. Speak right up in that machine there.

Mr. Reiley. Thank you for inviting me today, and thank you you for your interest in these issues.

I am the Lane County Veteran Services Officer, and as you know, Lane County service officers and all veteran service officers are really dedicated to ensuring that the veterans and their surviving spouses and their dependents, who have the eligibility for V.A. benefits, obtain the maximum benefit that they are entitled to under the law.

For the most part, we help veterans and claimants with VBA, Veterans Benefits Administration, claims for service connected compensation and non-service connected pension claims. We also help facilitate enrollment in V.A. health care.

I took the job with Lane County Veteran Services in June of 2003, and at that time, and still today, the majority of our clients are World War II veterans filing re-evaluations on old service-connected conditions, sometimes filing new claims for service connection even; also, though, accessing the non-service-connected pension a needs-based benefit based on their income and medical expenses.

Also, Korean-era veterans, similar situations, and Vietnam-era veterans. Many of those filing initial claims for service connection, 20, 30 years after their service, they are coming to realize that the conditions which they didn't think were a big deal during their service really are impacting their health to a great degree, and they are hoping to get help with those conditions.

During that summer of 2003 there was—there is an organization, very informal, called the Lane County Vet Net. It is veterans service providers. They are staff from the V.A, and some of the congressional veterans staffers come to these meetings. We meet once a month. At that time we are mostly focused on planning the Eugene Stand Down, an event to try to integrate homeless veterans into the V.A. system, reach out to them, get those folks benefits. It was also a Veteran Appreciation Day, so all veterans were, of course, welcome.

Day to day, my work really wasn't impacted by the wars in Iraq and Afghanistan. Maybe once a month we would have a veteran out of Afghanistan that we would help enroll in V.A. health care or file an initial claim for service connection. But it wasn't really a big issue, frankly.

Then in October 2003 it became a very big issue for Lane County. At that time the 2–162nd National Guard infantry unit was called up. They trained for 6 months here in the States and then deployed to Iraq for a year. That unit consisted of 700 to 900 individuals, the vast majority of whom lived in Lane County. The unit is based out of Cottage Grove, but their main armory is the Eugene armory.

The Vet Net organization realized that we needed to help in reaching out to their families who were left behind and to prepare for their return. We sent out word to nontraditional veteran service providers, folks that don't focus solely on serving veterans. We held a Vet Net summit in the spring of 2004 where 30 to 40 organizations sent representatives.

We all got together in one room at the Lane County Mental Health building and talked about this Title 10 call-up of the 2–162nd and also discussed our various organizations so that the barriers between V.A. and veteran service providers and traditional community providers could start to be whittled down.

I am happy to say that many of those organizations have continued in the Vet Net process, and so we continue to meet with them monthly.

Out of that came a realization that, while there are concerns about the V.A.'s ability to serve these veterans, services for the family members really wasn't going to be available through the V.A. There are some services available for family members in the mental health realm, and I refer to them in my written materials, but for the most part, without the veteran being actively engaged in treatment, there is really nothing available for the family members.

Of course while an individual is on deployment in Iraq, they are obviously not engaged in V.A. treatment. So Lane County Mental Health and LaneCare reached out to the providers to see if any were interested in trying to fill that gap.

Lane County Mental Health and LaneCare organized a combat post-traumatic stress disorder treatment program and a reintegration treatment program to bring those issues to providers who typically treat PTSD from other stressors.

We are fortunate at Lane County Mental Health to have on staff Dr. Michael Reaves, who worked for a long time here at the Portland V.A. Medical Center in PTSD treatment of veterans. He brought in some of his former colleagues, and they provided specific training for the local providers to address veterans' issues.

That program is still in place, and veterans or their family members are able to access that through LaneCare. These providers are available on a short notice and with a sliding fee.

I, frankly, have kind of a skewed perspective, I think, from being in Lane County and not just because I am in Eugene. I don't think we do anything any better or any different than anywhere else in Oregon, but we are really blessed in the fortuitous coincidences that we have had.

When the 2–162nd was mobilized, family support coordinators, in my perspective, seemed to be a fairly new thing for the National Guard and for the military in general. That might just be my inexperience with the system, but that is how it seemed from an outsider's perspective.

We were very fortunate in the quality of the family support coordinators who were based out of the Eugene armory. Darcy Woodke and Laura Boggs went on to win national awards for their services to the family members of the 2–162nd.

Additionally, within VHA, Veterans Health Administration, in Eugene at the Community Reintegration Service Center, there is

an individual who retired out of the Oregon National Guard, and so he was able to make sure that he and other Roseburg VHA employees were at the demobilizations of the 2–162nd. So all of those individuals had 1010EZ forms completed during their demobilization, and that is the application for VHA health enrollment. So we were able to get all of these individuals enrolled in V.A. health care, right on their demobilization.

Senator SMITH. So none of them have fallen through the cracks?

Mr. Reiley. Well, they were enrolled, but not all of them went to their initial appointments. Not all have followed up with that initial enrollment and eligibility.

Senator SMITH. But what a good idea.

Mr. Reiley. Again, not just Lane County, but the Oregon National Guard, the 2–162nd, they weren't the first major unit to be deployed from Oregon, but really seemed to wake up the V.A. providers, the National Guard command, the county veteran service officers, the Oregon Department of Veterans Affairs, that we are getting a lot of nontraditional veterans created.

Ones that are called up under Title 10 and complete their call-up, they are eligible for all of the V.A. benefits that regular Army, regular Marines were historically eligible for. Traditionally, National Guardsmen aren't entitled to those benefits without a Title 10 call-up.

Senator SMITH. So what you did is not traditional.

Mr. Reiley. Well, we are not in a traditional period of history.

Senator SMITH. Maybe it should be traditional.

Mr. Reiley. The reintegration summits, which Dr. Heims mentioned, the Oregon National Guard, and Oregon Department of Veterans Affairs has really worked together to try to be at these demobilizations so that we can get these folks right at that point.

There is some tension there because, you know, oftentimes it is somebody like me standing in front of these folks trying to tell them what their benefits are; on the other side of the door is their family that they haven't seen in a long time. So we have concerns about how much is being heard.

Senator WYDEN. They characterize that, that part of their experience, as the biggest recycling program in history, because what happens is people get those materials that you all have diligently tried to put together, but their loved ones are right there, so they want to see their loved ones, and off go those printed materials in the recycling bins.

Senator SMITH. As nice it is to see you, I imagine they want to see their loved ones more.

Mr. Reiley. I imagine so, Senator.

Senator SMITH. But maybe there is a better time. Maybe on the plane back or some point before they get here there ought to be a requirement.

Mr. Reiley. This is definitely a work in progress.

Senator SMITH. You have given us a good idea.

Mr. Reiley. Some differences to be aware of: National Guard, Army Reserve called up under Title 10, demobilized, there is kind of a cooling-off period or an untouchable period for 90 days, when they don't have to attend drills, they don't have to go to the armor-

ies. They are allowed to, but the command cannot require them to attend.

Marine Corps Reserve does it a little differently. I am not sure if it is 60 or 90 days, but upon their return home, they are kept on active duty, and so they have that period to kind of decompress, still while drawing active-duty pay and still where the command can say, you know, "You have been home for 3 weeks. Come on back in. We are going to have a presentation about your V.A. benefits."

So there are pluses and minuses to each procedure, but that is one thing that the Marine Corps does a little differently, which seems to allow them to get information out at perhaps better times.

If I could take a moment to address some of the broader concerns. VBA, Veterans Benefits Administration, VHA, Veterans Health Administration, are in a period of prioritizing OEF and OIF veterans, and that is simply something which, again, has many pluses. If we can address these most recent veterans' concerns immediately, perhaps those concerns won't become the long-term problems that we have seen in other-era veterans.

The problem is we establish priorities within a group that really is equal and within which there are no distinctions based on when one is served, in the sense of a period being better than another. So within VHA, Congress has authorized additional funds, additional positions are being created and filled to reach out to those veterans specifically. But we are not reaching out to, if we presume that 30 percent of those with a mental health condition seek treatment, those 70 percent from Vietnam, from the Korean era, from World War II.

So it is a difficult issue, but it does seem to be one that can be fixed with additional funds. It is not one of those problems which isn't going to be helped by money being thrown at it; getting more staff within VHA, getting more outreach coordinators within the Vet Centers. There are ones dedicated to global war on terrorism veterans, but no other-era veterans. Getting more of those folks on board with VHA I think really could make a difference, getting these folks in.

The eligibility criteria which we discussed, those returning from combat, one eligible for 2 years of VHA treatment from their date of separation, that is only for veterans who served in combat theater after 1998. So we have the Vietnam-era veteran who loses their job, the V.A. looks back to their income to the previous calendar year.

Oftentimes I have to tell them, "It is February. I understand you are having difficulties. But next year we will probably be able to make you eligible for V.A. health care because we will look back for this year, but right now you don't have eligibility."

So, some type of emergency period of eligibility for all veterans, whether it is 2 years or 5 years, that they can access at any point in their life might be something to consider.

The last point I would like to bring to your attention or issue to address is the confidentiality of VHA records. Dr. Zeiss's testimony, I think the key word there was "automatically" be shared with DOD. Also at the roundtable we were at earlier, you heard mention that the Oregon National Guard commander has stated that he

will not request VHA treatment records. Well, he had to state that because he has that ability to get those records.

It is my understanding that if DOD commanders believe that VHA treatment records are necessary to review to determine their mission readiness, whether in general or for a particular soldier, that they have the ability to get those treatment records.

In Oregon, where nearly 7,000 of our 8,000 National Guardsmen have been called up since September 11th and are being called up again and again and are scheduled in 2009 to go back to Iraq, this is a great concern, whether those records are going to be shared. I am sure it is a law which allows that.

Senator WYDEN. I want to make sure I understand that point. When I asked Dr. Zeiss about that, the central question was right now there seems to be a lot of confusion about the records with respect to the computers at V.A. and the computers at DOD. She said, yes, that was the case. They were working on policy, but that it was the intent, at least of their program, that the patient should own the records, which is something I feel very strongly about.

What you are saying is here is another program where it doesn't look like the patient's interests are paramount. Is that right?

Mr. Reiley. That is my understanding, Senator.

Senator WYDEN. So we are going to have to sort out, as we try to coordinate how to make sure that the V.A., and the DOD are working together, we are going to have to coordinate different policies with respect to how records are handled. Is that right?

Mr. Reiley. I would appreciate that, Senator.

Senator WYDEN. Very good.

Mr. Reiley. I think the key is that it has to be requested by DOD, and that is why I believe the doctor mentioned that the records would not automatically be provided. From an outsider's perspective, this does not seem to be something that VHA is, frankly, thrilled about, but it seems to be something that they have to deal with.

Senator WYDEN. It ought to be that if ever there was a group in America that ought to control its records, it is the veterans. That is a part of my Healthy Americans Act, for example, is to make sure that as we go forward and set up electronic medical records, that the patient owns it. Certainly those who have worn the uniform of the United States deserve to own their medical records.

So you have now highlighted the fact that there may even be different policies with differing programs, and we are going to have to sort through it. We will be consulting with you on it.

Mr. Reiley. Thank you, Senator. Thank you very much.

[The prepared statement of Mr. Reiley follows:]

Field Hearing on Mental Health Treatment Issues for Veterans

Written Testimony to the

Senate Special Committee on Aging
Senator Herb Kohl, Chairman
Senator Gordon Smith, Ranking Member

July 3, 2007

Portland, OR

Joseph J. Reiley

Lane County Veteran Services Officer

Accredited VA Claims Representative by Oregon Department of Veteran Affairs

Good Afternoon, Senators. Thank you for this opportunity to discuss the mental health treatment needs of our Veterans, and thank you for your interest in this issue.

I have been the Lane County Veteran Services Officer since June, 2003. As you know, the mission of County Veteran Services Officers – and all Service Officers – is to help insure that a VA claimant obtains the maximum benefit to which they are entitled under the law. Having helped thousands of Veterans file claims and being familiar with VA rules, regulations and procedures, we guide the Veteran or surviving spouse through the process and help them obtain and present their evidence to the VA.

When I first stared with the Veteran Services Office, our clients were mostly Vietnam Era Veterans, and World War II and Korean War Veterans. The Veterans from those eras still make up the majority of our clients, but they obviously have been joined by Veterans of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) in seeking our services to obtain VA benefits and access to VA health care.

Background – Veteran Demographics

Oregon Veterans

According to the VA demographic estimates and projections contained in Vet Pop 2004 v. 01 (available at: http://www1.va.gov/vetdate/page.cfm?pg=2 (last accessed 6/20/2007)). As of September 30, 2006 there were 357,319 Veterans in Oregon. Of these, nearly 75% are considered Wartime Era Veterans. By 2017, the total number of Veteran in Oregon is projected to be just under 300,000.

It is not surprising to note that while the overall number of Oregon Veterans decreases over the next ten years, the number of our oldest Veterans increases. Below are the age breakdowns for Lane County Veterans:

Age	2006	2017
17 – 44	6,443	5,348
45 – 64	15,225	9,183
65 – 84	12,100	14,286
85+	1,891	2,185
Total Lane County Veterans	35,659	31,002

"Non-Traditional Veterans"

The VA continues to work on its demographic estimation and projection formula and appears to more accurately capture the number of service members who now qualify as Veterans based on their Title 10 call-ups from the National Guard and Reserves. Of Oregon's nearly 8,000 National Guard personnel, over 6,650 have been called up and deployed to either Iraq or Afghanistan since September 11, 2001. Many of these individuals either resided in Lane County

prior to their mobilizations or have since moved here to attend school. These "non-traditional" Veterans make up the majority of the OIF/OEF Veterans whom Lane County Veteran Services assists.

VHA in Lane County

Care for Veterans

Lane County Veterans access Veterans Health Administration (VHA) through the Roseburg VA Health Care System (RVAHCS). Although the VA Medical Center is based in Roseburg, 53% of the patients in the RVAHCS reside in Lane County. Typically, Lane County Veterans will have their primary care provider at the Eugene CBOC, and this clinic serves around 9,000 unique patients per year. The Eugene Clinic provides outpatient medical care and mental health counseling. Currently, appointments for new enrollees are being made within the required 30-day period.

Recent data indicates that 750 OEF/OIF Veterans are enrolled in RVAHCS. The majority of these Veterans most likely reside in Lane County – again based on pre-mobilization homes of record and post-mobilization educational opportunities. Currently, RVAHCS is hiring new staff which was made possible by the additional funds Congress authorized to address the specific mental health and medical needs of OEF/OIF Veterans. These positions will include a suicide prevention specialist and an outreach coordinator dedicated to insuring that OEF/OIF Veterans are getting the care they need – abilities which will even include facilitating transportation for the Veteran to attend VHA appointments.

OEF/OIF Veterans typically begin their enrollment within VHA pursuant to their automatic eligibility within the first two years of their separation from military service. This is an excellent and much needed benefit – especially for National Guard and Reservists. Often times, their deployment to Iraq or Afghanistan will negatively affect their employment and they may demobilize to unemployment and lack of health insurance. Automatic eligibility for VHA care allows them to create a baseline health record to possibly support later claims for service-connected benefits, gives them time to transition back to work and thus obtain traditional private health care coverage, and gives them time to establish eligibility for VHA through other criteria (e.g., successful adjudication of a claim for service-connection by VA). Furthermore, VHA has greater expertise than the private sector in treating combat-related PTSD and other conditions associated with military service. Finally, treatment of OEF/OIF veterans within a single health care system will allow us to determine if there are trends concerning the health issues of these Veterans and more appropriately treat and care for those specific issues.

However, limiting these combat theater Veterans to two years of automatic eligibility is often inadequate. If the Veteran does not avail him or herself of this benefit soon after separation, it may not be there when they need it. Oregon has done an amazing job ensuring that National Guard members enroll in VHA upon their demobilization – we are fortunate to have a number of VHA employees who have strong ties, or have retired from, the Oregon National Guard. I imagine this is not the case for other state's National Guards, and many service members separating from traditional active duty service are unaware of this two year period

when I first meet with them. Accordingly, I would like to bring your attention to H.R. 612 which recently passed the House and was received by the Senate. This legislation is identical to S. 383 and would increase the period of automatic eligibility for combat theater Veterans from two to five years.

Additional mental health counseling is available for Veterans who served in a combat theater at the Eugene Vet Center. Since 2002, this facility has seen 776 clients, of whom 139 were GWOT Veterans. Furthermore, the Vet Centers have hired specialists dedicated to outreach to GWOT (Global War on Terrorism) Veterans. The Eugene Vet Center GWOT Outreach Coordinator had one of the highest number of contacts with GWOT Veterans in 2005. This is a testament to not only this individuals exemplary efforts, but also to the number of Veterans in Oregon who have served in OEF/OIF – many of whom were left jobs, businesses and families under Title 10 mobilization orders.

Care for Family Members of Veterans

Obviously, VHA's primary mission is to care for Veterans. However, there is some limited possibility for the family members of Veterans to receive care – typically in the mental health realm. The Vet Centers may see family members of deployed soldiers for assessments and short term care. Additionally, these family members are eligible for bereavement counseling at Vet Centers if necessary.

Otherwise, in order for family members to obtain counseling services, the Veteran must also be engaged in treatment. The Vet Center, as well as the Eugene CBOC, offers some couples counseling, but many of the VA counselors take on this treatment in their own time – coming in on weekends or staying late to see these folks. The Eugene Vet Center has a group session for Spouses of Veterans with PTSD. This group is dedicated to the spouses, but the Veteran must be engaged in treatment somewhere, as well. Finally, some VA facilities have dedicated family therapists on staff, but there are none within the RVAHCS.

Community Response

In October, 2003, the 2/162nd Infantry Battalion of the Oregon National Guard, based in Cottage Grove and Eugene was mobilized to Iraq. With this call-up, nearly 700 families, many of whom had ties to Lane County, were affected. This was a crystallizing event for service providers in Lane County.

Prior to this call-up, a small group of Veteran service providers would attend a monthly meeting of the Lane County Vet Net. This group would typically include 5 to 10 individuals who worked for VA, the County Veteran Service Officer or were Congressional staffers. Once our local infantry Guard unit was activated, this group reached out to community service providers as we realized that we would need help to address the needs of the family members of these soldiers and also help in reintegrating the soldiers upon their return. Once the word got out, this group swelled to the nearly 30 who continue to meet regularly.

In the Spring, 2004, we held a Vet Net Summit in which Veteran and community service providers came together and shared information about their programs and their services. From this, and the involvement of Lane County Mental Health and LaneCare, grew a combat PTSD/post-deployment adjustment training program for community mental health counselors. Organized by LaneCare, a group of their contract therapists was trained by VA mental health providers and agreed to be available on short notice to either Veterans or the family members who were seeking mental health care. These providers agreed to treat such referral on sliding fee scales or to accept Tricare Health Insurance. LaneCare worked closely with the 2/162nd's Family Support Team in order to get the word out to the families and soldiers about these services.

In addition to the direct services made available by community providers, other community members were interested in learning more about the post-deployment adjustment issues which these Veterans may face. Specifically, both the University of Oregon and Lane community College invited Veteran service providers onto campus to discuss some of the issues their students may have upon their return from combat. Furthermore, both the UO and LCC now have Veteran organizations on campus.

Additionally, the Eugene Vet Center Team Leader, Gary Hunter, reached out to local law enforcement. He briefed teams from both Eugene and Springfield Police on the nature of the service of those who served in Iraq with the 2/162nd and on some of the issues they were having upon their return. This was instigated by a couple of encounters with law enforcement soon after their return – none of which escalated very high but in which there was great potential for tragedy. This program to train law enforcement on post-deployment adjustment issues and combat PTSD is now being rolled out to the State Police Academy in Monmouth, Oregon so all law enforcement personnel who receive training there will be made aware of these issues.

Although not directly related to the mobilization of the 2/162nd, another community resource came on board during this period. St. Vincent de Paul applied for, and was awarded, a VA grant to create a program to provide housing and case management services for homeless, dual diagnosed Veterans. As part of their efforts they coordinate with VA medical and mental health care providers and co-case manage with the Veterans VA caseworker. St. Vincent de Paul purchased and renovated an apartment building in Eugene and provides housing for 13 Veterans – some of whom have families. St. Vincent de Paul continues to seek funding to expand the program and has qualified for 12 grant-per-diem beds by the VA and is also in the process of renovating another eight apartments.

Concerns and Conclusions

Over the past couple of years, Congress and the American public have become aware of some of the deficiencies in the VA system. Finding anything less than the best for our Veterans unacceptable, Congress authorized additional expenditures so that VA can fill gaps in its ability to care for our most recent Veterans. While this is greatly appreciated, many have concerns that these gaps will still exists for the rest of our Veterans. As the VA benefit adjudicators prioritize the claims of OEF/OIF Veterans, those claims from other Veterans continue to languish. As special outreach workers are hired to insure that health care services are adequately and timely provided to some Veterans, others still face lengthy delays and difficulty in traveling the great

distances sometimes necessary to access VHA care. This is especially true in the more rural areas of Oregon and true for our older Veterans who often have the least means. As Ronald Reagan observed, "A rising tide lifts all boats." Only through adequate funding for VA in general can we insure that all Veterans obtain the care and benefits which they earned through their sacrifices for our Nation.

Thank you very much for your consideration and for allowing me this opportunity to share with you the experiences we have had in Lane County and for listening to some of my concerns.

Senator SMITH. Thank you, Joe.
Kevin. Kevin Campbell.

STATEMENT OF KEVIN CAMPBELL, COORDINATOR, EASTERN OREGON HUMAN SERVICES CONSORTIUM, THE DALLES, OR

Mr. CAMPBELL. Good afternoon. Thank you, Senator Smith and Senator Wyden, for coming out here for this very important matter. It is a privilege to be with you this afternoon.

My name is Kevin Campbell, for the record. I am the coordinator of the Eastern Oregon Human Services Consortium. The consortium was established in the 1980's to represent the mental health needs of 13 rural Oregon counties.

In essence, counties got into this business on a Federal initiative. We had support from the State services, then moved and migrated because of lack of money, and the mental health directors of eastern Oregon decided very early in the system development that the only way we were going to be able to provide services to our citizens is by banding together.

I looked on the Web to see how many vets reside in our counties, and there are about 23,000 vets living in the EOHSC catchment area. So about 23,000 vets scattered over about 45,000 square miles. That is about two square miles per vet. Some of them would think that is just about right. [Laughter.]

If you get to counties the size of Grant County, which has about 800 vets, they have five and a half square miles per vet. For Harney County, you are dealing with about 10 square miles per vet.

The reason I go into this is what we discovered very early was you don't bring people to the services and you don't build facilities to treat people; you bring the services to the people. You do it based upon community strengths, and you do it based upon sensitivity to culture.

In our part of the State, I would dare to say we are pretty independent, and I would say that people don't very quickly ask for help. If they do ask for help, they generally talk to a friend, a family member, or a neighbor or a clergy member, not somebody that is new to them or not somebody from an agency program that is necessarily there to help them.

Our vets I think are tremendous volunteers, and it is their spirit of volunteerism that oftentimes made them veterans in the first place. When they come back to their communities, they deserve the dignity and the opportunity to continue being volunteers to the communities that they are from. Because of the way things are working together today, that is very, very difficult.

A number of our folks in the current conflicts served in the National Guard. Many of them are nearly my age. To be disrupted from paying a mortgage and moving from a job to a period of active duty puts tremendous pressure on a family to just make ends meet.

When that individual comes back from the conflict, regardless of whether there are mental health symptoms or not, there is going to be more stress than that individual and their family have ever had to deal with in their lives.

All of us are very happy and very proud when vets come home. However, we need to be sensitive to the issues that are placed on them, not only by the conflicts overseas, but just the financial pres-

sure of trying to reintegrate in the community when they come back.

If I had one thing to say, it is very important that we recognize that the Federal Government has some ownership in the health and future of our veterans, and that if the Federal Government steps up and takes some ownership in that health and future, I think the dividends paid will be tremendous.

I truly appreciate your idea of peer support networks. We in eastern Oregon are strong advocates of recovery from mental illness, and as in recovery from any other malady, early intervention is the key to it. The sooner we can get to people, the sooner we can work with people, and the less stigma we attach to needing help, then the better our outcomes are going to be.

The publicly funded community mental health centers of eastern Oregon are there to serve all the residents of the county. Our primary funding source at this point in time is Medicaid. It is ironic that the numbers of people who are on Medicaid are very similar to the numbers of vets in our counties: approximately 7,000 in Umatilla County on both vets and Medicaid numbers.

Now, some of those are going to be duplicated, but it seems to me that we can get economy of scale if we can leverage some Federal dollars to serve veterans in local community health programs and also use the Medicaid money that is serving the Medicaid population to serve that population. So maybe for $1.50 we can get $2 worth bigger out of the investment, if we think of it in that way.

The primary thing that we have to deal with today is, in rural Oregon, we strongly embrace the managed care concept. We took responsibility for the long-term care of our folks, primarily with Medicaid. We created systems of care within the community. We did not rely upon expensive acute care in hospitalization. We have among the lowest hospitalization rates in the State.

I believe that we are leading the State and the Country in recovery from mental illness in places like Wallowa County, Harney County, Malheur County, and now indeed in Umatilla County as well.

The challenges in doing that are that you have to have some money to absorb risk, and you have to have a payoff. If you are willing to take the risk, you can't just be managed down to the dollar of what you spent last year, because 1 bad year could wipe you out.

The Deficit Reduction Act is really moving us back to a fee-for-service type of system rather than a managed care system.

If we are going to provide services to our vets in the future, then I would encourage you to think about the role of the community and the fact that the VFW, the American Legion, the veteran service officers, and the local mental health clinic and indeed county government all have a role in helping people through times of need. If we can invest only a few dollars in the bottom of the system, I think it will pay huge dividends to the top of the system.

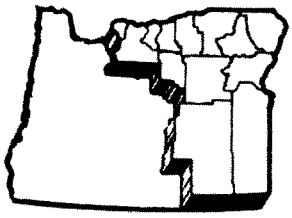
I was sitting next to a gentleman from Pendleton, who I just met. It turns out he has known my family for a hundred years, kind of an eastern Oregon thing. But Mr. Cook, I was talking to him about VFW in Grant County, and he told me that they were in danger of losing their post down there because there are so few members

and people are so busy and it is very difficult to make a living and don't have time to volunteer.

That has a real impact to me because in that county, that is one of the few natural supports that we have out there for vets, both new vets and vets that have been around for a while. I think that it is really important that we recognize the value of those organizations and buildupon their strength and their volunteerism rather than just trying to squeeze services into silos, if you will, or squeeze veterans into cars or buses to access best-of care.

Thank you very much.

[The prepared statement of Mr. Campbell follows:]



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Statement of Kevin M. Campbell

Coordinator
EOHSC: Eastern Oregon Human Services Consortium

"Portland field hearing on veterans' mental health issues"

Senate Special Committee on Aging

Senator Herb Kohl, Chairman
Portland, Oregon
July 3, 2007

Providing Assistance to the Community Mental Health Programs of Baker, Gilliam, Grant, Harney, Hood River, Malheur, Morrow, Sherman, Umatilla, Union, Wallowa, Wasco and Wheeler Counties

Good Afternoon,

I am pleased to be here today to talk with you about the mental health needs of our veterans living in rural Oregon. Oregon is a large state with approximately 100,000 square miles. The EOHSC Region encompasses nearly half the landmass of Oregon and contains only 8% of its population. While we pride ourselves in the provision of excellent mental health services, access to those services is often times difficult. There is very little public transportation available in the region. Our population tends to be older and poorer than the statewide average. Our response to these challenges has been to bring the services to the people, rather than waiting in the clinic for people to access the services. While this effort has struggled with a statewide shortage of funds, it has had a marked impact on making our part of the state a place where people enjoy an excellent chance for recovery from debilitating mental illness.

Many of our citizens have answered the call to serve in the military and are finding it ever more difficult to access mental health services upon their return home. A disproportionate number of Oregon Soldiers fighting in Iraq and Afghanistan are members of the National Guard. Many of these soldiers have families, jobs, mortgages and other ongoing expenses that they left behind when deployed. But, due to their decreased earnings, while in active duty, find they are much deeper in debt than they ever imagined when they return home. Because of these financial obligations, pressures on the families of soldiers have never been greater.

A high number of soldiers returning home from the military are suffering from PTSD and/or Depression, problems which are new to them and their families. Without treatment, family problems escalate and the overall rate of divorce and other social consequences increases. Although many veterans are deeply in debt they are not currently eligible for the Oregon Health Plan (Medicaid) and often times find themselves confused about their eligibility for Veterans Benefits. Public mental Health Clinics in the region are reporting that Guardsmen home on leave are experiencing extreme difficulty accessing follow up to crisis services locally. For them, the lack of availability of timely follow up services can mean no services prior to their return to duty.

Once veterans are determined to be eligible for benefits, services are often times many miles away, access is commonly delayed by a preauthorization process, and many providers no longer accept Tri-Care Insurance due to difficulty being paid for their services. Payment rates are often so low that

private practitioners are unable to provide services because the payment does not cover the cost of the needed services.

Without adequate treatment for their mental health conditions, a growing number of our veterans are turning to alcohol and drugs to deal with the challenges of their lives. Unfortunately, the consequences of "self medicating" have increased exponentially because the drug of choice in many of our communities is now methamphetamine. This relatively inexpensive and highly addictive drug can have devastating long-term impacts on those who turn to its use. We are currently experiencing a growing number of Vietnam War Veterans who are presenting in crisis due to untreated PTSD and years of substance abuse. All too often, veterans with significant addictions are ending up in our jails and prisons rather than in community based treatment. This is a trend that we can ill afford to allow to continue with our currently returning veterans.

Public Alcohol and Drug Treatment and Mental Health Clinics are not currently funded at a level which allows timely access to treatment for many of our returning veterans and their families. While Oregon has chosen to embrace a system of Managed Care for provision of such services, Federal initiatives such as the Deficit Reduction Act have dramatically reduced access to Medicaid Funding. Rates for Medicaid Capitation Payments are now entirely based on experience from previous rate setting periods, actuarially adjusted for cost trends. When the system of the future is directly tied to cost experience of a system that was inadequately funded in the past, it is impossible to meet increased demand for services in the future. Fee for Service reimbursement systems have never proven to be cost effective in the long run, in that volume of services is rewarded more than outcomes of those services, but that is what we are being driven back to at the present time.

Now is the time to invest in the future of our veterans and their families. Supporting Public Alcohol and Drug Treatment and Mental Health Clinics can do this. By assisting us in our efforts to bring the services to the clients, rather than waiting for the clients to come to us, we can meet the needs of veterans earlier and avoid much of the stigma associated with accessing mental health services at clinics in rural communities. Finally, I would encourage you to rethink decisions imbedded in the Deficit Reduction Act and move back to a system that rewards outcomes. Systemic savings should be reinvested into enhanced services at the community level which benefit the veterans and other targeted populations

rather than a system which rewards efficiency with reduced rates in the future.

Thank you very much for coming to Oregon. We appreciate your focus on this important issue and stand ready to provide assistance in meeting this very important challenge. Our communities are very proud of our veterans and their families. With adequate resources we will be better prepared to provide them the assistance necessary to continue living in our part of the state for many generations to come.

Senator SMITH. Thank you, Kevin. Those were really excellent words. We appreciate it so much.

Stuart, you are going to bat clean-up here.

STATEMENT OF STUART STEINBERG, EXECUTIVE DIRECTOR, CENTRAL OREGON VETERANS OUTREACH, CROOKED RIVER RANCH, OR

Mr. STEINBERG. OK. Before I actually start my formal testimony, I was very interested in hearing about this concept of peer support, and I want to just kind of briefly mention our organization.

I am the executive director of Central Oregon Veterans Outreach, and we are a peer support organization. Eight of our board members and staff are combat vets: seven from Vietnam, one from World War II. Six of us are diagnosed with post-traumatic stress disorder.

I am a Vietnam veteran who has had to deal with this issue for many years and have a personal perspective that allows me to discuss this problem in detail. In addition, I have been a national service officer for Vietnam Veterans of America since 1978, and in that position have assisted hundreds of veterans in claims for benefits from the Department of Veterans Affairs, but often involved mental health issues, particularly claims for combat-related post-traumatic stress disorder.

Finally, directly related to veterans' mental health issues is the problem of alcoholism and substance abuse that is often secondary to the primary mental health diagnosis.

I served in the U.S. Army from 1966 until 1971 and was in Vietnam from August 1968 until March 1970. I was an explosive ordnance disposal specialist; that is bomb squad, for those of you who aren't familiar with military language. I saw a lot of combat. I was wounded twice and decorated for heroism in ground combat.

I was first diagnosed with post-traumatic stress disorder in 1993 by the V.A. after many years of dealing with things I didn't understand.

I want to say that many people believe that everyone diagnosed with this disorder is incapable of functioning, and this is simply not true. It is unfortunate that this is a myth foisted upon the American public by media reports of a few sensational cases that leave people with the impression that this is the way it is with all of us diagnosed with PTSD.

In my own case, despite my symptoms—startle response, hypervigilance, a sleep disorder, intrusive thoughts about the war, substance abuse and alcoholism, two failed marriages, and anger management issues—I managed to get a college degree, a law degree, and an advanced law degree. I was a graduate teaching fellow at the Georgetown University Law Center, a successful criminal defense attorney, and then an equally successful capital defense investigator for the Oregon Capital Defenders.

In 2002, my PTSD symptoms finally got to a point where I was almost unable to function, either in the workplace or in social settings, and I had to give up a job that I loved.

I am now rated by the V.A. as being totally disabled by PTSD and several physical problems related to being wounded and being

exposed to herbicides. I was 55 when this happened, and I have learned that I am not alone in this regard.

Because of my involvement in a PTSD group at the Bend's V.A. community-based outpatient clinic, I learned that a number of older veterans, most of whom served in Vietnam, found themselves finally having to deal with their issues related to the war late in life. I cannot tell you precisely why this is, but in my own case it was as simple as approaching the age of 60 and not wanting to live the rest of my life having this illness interfere with virtually everything, every day.

I, and many of the veterans I know, also have had to deal with alcohol and substance abuse issues that were directly related to our mental health problems. It was a way that we self-medicated so that we didn't have to deal with the primary problem. If it had not been for the group I was able to get into at the clinic—and that is a key phrase right there, "able to get into"—I really don't know what I would be doing now, but I can assure you I would not be sitting here today talking to you.

The issue of veterans' mental health problems, especially among older veterans, is a serious and growing situation in the V.A. system. This has become particularly true since the additional burdens on the V.A. mental health system caused by the return of soldiers from the wars in Iraq and Afghanistan. Let's not forget that in addition there were combat veterans also being seen from the first Gulf War, the Balkans conflict, the Sinai, and now the Horn of Africa.

The inability of the V.A. to adequately provide services for all who need them when they need them is not their fault. It is one of simple numbers. They do not have the funds to care for those who need treatment, and this is the direct result of the Government refusing to recognize the depth of the problem and failing to seek enough funding for the V.A. in their budget requests.

This has been going on for years, and claims about how much the V.A. budget has been increased in recent years are disingenuous since the increases do not reflect inflation or the rapidly expanding costs of health care.

Moreover, even the current Congress, while seeking greater funding, is still not asking for enough to care for all of those who need care now or those who will need care in the future, when they need it.

The care we get at our clinic is absolutely top-notch—that is, for those of us lucky enough to be getting treated. The mental health staff is professional and extremely knowledgeable about PTSD, and they have helped hundreds of us over the years. The problem is that there are so many veterans in need of mental health services—and this is a nationwide problem—that the staff is overwhelmed.

I am going to depart a little bit here. We have one psychiatrist who essentially is writing all of the prescriptions for psychotropic medication. We have one clinical social worker, and we have one clinical psychologist who, unfortunately, was recently diagnosed with a disease that he is probably not going to recover from. So he is out of the picture.

I don't know how long it is going to take for them to replace this man who has helped so many of us, but however long it is, it is going to be too long, I can guarantee you, and the men and women he is treating are completely freaking out about this possibility.

OK. So what it boils down to is there are too few mental health professionals and too many clients. I don't know where these 3,000 mental health professionals I heard Dr. Zeiss—where they are, but they are not in Bend.

Senator WYDEN. We are going to try and change that.

Mr. STEINBERG. I hope so, Senator.

Those who are being seen are typically being seen once a month individually, even if they should be seen weekly because of acute problems. As far as the groups go, there are waiting lists to get into them because the staff can only see so many in this setting.

In fact, I have a client, as a service officer, who it is clear to me has post-traumatic stress disorder. He is a Vietnam veteran who served for 18 months as a helicopter door gunner. He flew more than 500 hours of combat flight time, has 21 air medals, one for valor, the Bronze Star, and the Army Commendation Medal. He is on a waiting list at our clinic for his initial mental health assessment, and that means that he is months away from actually getting into treatment, despite his acute symptoms.

As far as my organization is concerned, this is immoral and it should be criminal. In our world, we were taught during our military service that you never, never leave a man or woman behind, yet that is precisely what happens to veterans in this Country every day due to a lack of adequate funding.

This problem is not only affecting us older veterans, but it is also having an impact on the younger men and women returning from the current wars.

There is no question that as time passes, more of the younger veterans will seek treatment for mental health problems directly related to their combat experiences, just as we Vietnam veterans have. If adequate funding is not available, you will see the results in failed marriages, lost jobs, anger management problems, and addiction problems.

In terms of the addictions issue—and this is something I have personal experience in—the V.A. has totally failed in this regard. They have closed down numerous in-patient programs throughout the Country, and the number of beds have been cut to the point of near extinction.

At a recent meeting between Senator Wyden, regional V.A. medical people, and local veterans, I asked about this problem. Incredulously, I was informed that the V.A. was shifting to outpatient care—and this is a quote—"because everyone knows it works better."

In the words of one my colleagues, this is a giant load. Anyone who knows anything about long-term alcohol and drug abuse knows that in-patient treatment, the famous 21 days, is critical to successful recovery before outpatient care can begin.

I want to say to the new director who is here from Walla Walla that I did their in-patient program, and it is an incredible program. Now I hear there is talk about shutting it down and turning it into a giant outpatient clinic, and this is just wrong.

Senator WYDEN. Well, I will oppose that, too.

Mr. STEINBERG. I hope so.

The V.A. is apparently the only provider of alcohol and drug rehab treatment that believes that in-patient care is less efficacious in successful recovery than outpatient care.

Again, there is simply no question that the real reason for loss of in-patient care is money. Once again, the cause is lack of funding for critically needed V.A. programs.

My program has referred more than a dozen veterans to in-patient programs in Walla Walla and Boise, and all of them who have had multiple outpatient failures are still sober and now in a successful after-care program.

By the way, if you expect to successfully deal with PTSD and other mental health problems when there is a co-existing substance abuse problem that is being inadequately treated, the likelihood of success in the mental health area is virtually impossible.

The addition of the addictions therapists at the local clinic—and we just got one in Bend in the year 2007—is a good start, but it cannot replace in-patient care in the first instance.

I could go on about these issues for hours, but I think I have said what I wanted to say. I appreciate the opportunity to have been able to speak about this important and serious issue, and hope that you were able to use all of the data you gathered today to help bring about long-overdue change in the way the V.A. has been so woefully and inadequately funded.

When a man or woman goes off to war and defends their Country, they should not have to come home to continue to be at war with their Government over adequate medical and mental health treatment.

Thank you.

[The prepared statement of Mr. Steinberg follows:]

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Training Service

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June 27, 2007

Gordon H. Smith
United States Senator
Special Committee on Aging
Washington, D.C. 20510-6400

RE: Veterans Mental Health Issues.

Dear Senator Smith:

I am pleased to provide testimony for the Special Committee on Aging hearing on veterans' mental health issues. I am a Vietnam veteran who has had to deal with this issue for many years and have a personal perspective that allows me to discuss this problem in detail. In addition, I have been a national service officer for Vietnam Veterans of America since 1978 and in that position have assisted hundreds of veterans in claims for benefits from the Department of Veterans Affairs that often involve mental health issues, particularly claims for combat-related post-traumatic stress disorder. Finally, directly related to veterans' mental health issues is the problem of alcoholism and substance abuse that is often secondary to the primary mental illness diagnosis.

I served in the US Army from 1966 until 1971 and was in Vietnam from August 29, 1968, until March 23, 1970. I was an Explosive Ordnance Disposal Specialist—the bomb squad—and saw a lot of combat. I was wounded twice and decorated for heroism in ground combat. I was first diagnosed with post-traumatic stress disorder in 1993 by the VA after many years of dealing with things I didn't understand. I want to say that many people believe that everyone diagnosed with this disorder is incapable of functioning and this is simply not true. It is unfortunate that this is a myth foisted upon the American public by media reports of a few sensational cases that leave people with the impression that this is the way it is with all of us diagnosed with PTSD. In my own case, despite my symptoms—startle response, hypervigilance, a sleep disorder, intrusive thoughts about the war, substance abuse and alcoholism, two failed marriages, anger issues—I managed to get a college degree, a law degree and an advanced law degree. I was a graduate teaching fellow at the Georgetown University Law Center, a successful criminal defense attorney and then an equally successful capital defense investigator for the Oregon Capital Defenders.

In 2002, my PTSD symptoms finally got to a point where I was almost unable to function, either in the workplace or in social settings and I had to give up a job that I loved. I am now rated by the VA as being totally disabled by PTSD and several physical problems related to being wounded and being exposed to herbicides. I was 55 when this happened and I have learned that I am not alone in this regard. Because of my involvement in a PTSD group at the VA's Bend Community-Based Outpatient Clinic I learned that a number of older veterans—most of whom served in Vietnam—found themselves finally having to deal with their issues related to the war late in life. I cannot tell you precisely why this is, but in my own case it was as simple as approaching the age of 60 and not wanting to live the rest of my life having this illness interfere with virtually

everything, everyday. I, and many of the veterans I know, also have had to deal with alcohol and substance abuse issues that were directly related to our mental health problems. It was a way that we self-medicated so that we didn't have to deal with the primary problem. If it had not been for the group I was able to get into at the Clinic, I really don't know what I'd be doing now, but I can assure you I would not be here talking to you.

The issue of veterans' mental health problems, especially among older veterans, is a serious and growing situation in the VA system. This has become particularly true since the additional burden on the VA mental health system caused by the return of soldiers from the wars in Iraq and Afghanistan. In addition, there are combat veterans also being seen from the first Gulf War, the Balkans conflict, the Sinai, and now the Horn of Africa. The inability of the VA to adequately provide services to all those who need them is not their fault. It is one of simple numbers: they do not have the funds to care for those who need treatment. This is the direct result of the current administration refusing to recognize the depth of the problem and failing to seek enough funding for the VA in their budget request. This has been going on for the past six years and claims about how much the VA budget has been increased are disingenuous since the increases do not reflect inflation or the rapidly expanding costs of healthcare. Moreover, even the current Congress, while seeking greater funding, is still not asking for enough to care for all of those who need care now, or those who will need care in the future.

The care we get at our clinic is absolutely top-notch. That is, for those of us lucky enough to be getting treated. The mental health staff is professional and extremely knowledgeable about PTSD and they have helped hundreds of us over the years. The problem is that there are so many veterans in need of mental health services—and this is a nationwide problem—that the staff is overwhelmed. There are too few mental health professionals and too many clients. Those who are being seen are typically being seen once a month individually, even if they should be seen weekly because of acute problems. And as far as the groups go, there are waiting lists to get into them because the staff can only see so many in this setting. In fact, I have a client who it is clear to me has PTSD. He is a Vietnam veteran who served for eighteen months as a helicopter door gunner. He flew more than 500 hours of combat flight time, has 21 Air Medals, one for Valor, the Bronze Star and the Army Commendation Medal. He is on a waiting list at our clinic for a mental health assessment, despite his acute symptoms. As far as my organization is concerned, this is immoral and it should be criminal. In our world, we were taught during our military service that you never—never—leave a man or woman behind, yet, that is precisely what happens to veterans in this country every day due to a lack of adequate funding. This problem is not only affecting us older veterans, but it is also having an impact on the younger men and women returning from the current wars. There is no question that as time passes, more of the younger veterans will seek treatment for mental health problems directly related to their combat experiences—just as we Vietnam veterans have—and if adequate funding is not available, you will see the results in failed marriages, lost jobs, anger management problems and addictions problems.

In terms of the addictions issues, the VA has totally failed in this regard. They have closed down numerous inpatient programs throughout the country and the number of beds has been cut to the point of near extinction. At a recent meeting between Senator Wyden, regional VA medical people and local veterans, I asked about this problem. Incredulously, I was informed that the VA was shifting to outpatient care "because everyone knows it works better." In the words of one of my colleagues, this is a giant load. Anyone who knows anything about long-term alcohol and drug abuse knows that inpatient treatment—the famous "21-days"—is critical to successful recovery before outpatient care can begin. The VA is apparently the only provider of alcohol and drug rehab treatment who believes that inpatient care is less efficacious in successful recovery than outpatient care. Again, there is simply no question that the real reason for the loss of inpatient care is money and once again the cause is lack of funding for critically needed VA programs. My program has referred more than a dozen veterans to inpatient programs in Walla Walla and Boise and all of them—who have multiple outpatient failures—are still sober and now in a successful aftercare program. And, by the way. If you expect to successfully deal with PTSD and other mental health problems when there is a co-existing substance abuse problem that is being inadequately treated, the likelihood of success in the mental health area is virtually impossible. The addition of addictions therapists at the local clinics—which just got in 2007—is a good start, but it cannot replace inpatient care in the first instance.

I could go on about these issues for hours, but I think I've said what I wanted to say. I appreciate the opportunity to have been able to speak about this important and serious issue and hope that you are able to use all of the data you gather today to help bring about long overdue change in the way the VA has been so woefully and inadequately funded. When a man or woman goes off to war and defends their country, they should not have to come home to continue to be at war with their government over adequate medical and mental health treatment.

Senator SMITH. Thank you, Stuart, so very much, for your service to our Country and the Vietnam conflict and for your courage in sharing your story and then serving other veterans.

Senator Wyden has a few questions. I am going to submit my questions for the record, because if I don't get home for the Fourth of July activities my wife has planned in Pendleton, she is going to have an anger management issue with me. [Laughter.]

So, Senator Wyden.

Senator WYDEN. I thank you, Senator Smith, and I thank you for the chance to work with you on this. I am going to ask a couple of quick questions.

Joe, Governor Kulongoski and I were told in late spring that an Oregon Guard member or Reservist can be holding a gun in Afghanistan and then 12 days later be holding their child, say, in Portland or Ontario or anywhere else in Oregon.

What are the implications of such a rapid transition for mental health services, and what do you think ought to be done?

Mr. Reiley. Well, Senator, I am not a mental health professional, so I would defer to their judgment on how best to transition one from that setting to the other.

In my perspective, when a client comes to my office, they are already either aware that there may be something available for them or aware that there is something there. Sometimes we have folks come in just to say, "I am a veteran. I served during this period. What could I be eligible for?"

So part of the need is to get that information out to those folks during that 12-day period so that they know, when they are home with their family, that if they feel something going awry, if they have some concerns, that there are folks that are able and willing to help them.

Also, during the deployments we meet with the family members. At the Eugene armory we will typically do a couple of meetings with family members while troops are deployed. Representatives from the V.A. and myself are typically there and talk about the benefits.

I think in the roundtable this came up, oftentimes the referrals for post-traumatic stress disorder issues come from spouses. They are often the first to recognize that something is different with this individual.

But the best way to transition from one setting to the other, I cannot answer that.

Senator WYDEN. Senator Smith is on a tight timeline. I am going to ask all of you to answer that on the record because it just strikes me, given everything we are seeing about the nature of the conflict in Iraq and Afghanistan, that is not going to work. In a 12-day transition period from literally holding a gun to holding your child, something like that, we are going to have to look at this. So I will ask you do that in writing.

One question for you, because I have been asking a lot of questions about rural areas: What do you think is the biggest barrier in the metropolitan area for vets getting services?

Dr. BLACKBURN. I think the biggest barrier is the disaffiliation from the system and the reluctance to get involved in highly bu-

reaucratic systems. For those with special needs, navigating those systems is particularly difficult.

So I think for people that are suffering from some of the conditions we are talking about, I think peer advocacy is probably the most important thing we can do right away for vets coming, is that they are connected to peer advocates who can help them make that transition, kind of warn them what to expect over the next few weeks, and kind of stick with them if they have these special needs or state a desire to have that kind of service.

Senator WYDEN. You all have been an excellent panel.

Mr. Steinberg, let me thank you again——

Mr. STEINBERG. Thank you.

Senator WYDEN [continuing]. Both for your service and your advocacy. As I listen to you, I think, frankly, mandatory funding would go a long way to handling a number of the issues you describe.

Mr. STEINBERG. Absolutely.

Senator WYDEN. But one of the reasons I did ask Dr. Zeiss to get us that 90-day assessment, we can get an assessment of what is actually going on in this State with respect to mental health services and then have a debate about where to get the money, because I share your view. I think a lot of people are falling between the cracks, and we definitely, both of us, feel if one veteran falls between the cracks, that is one darn too many.

Mr. STEINBERG. Can I say something here?

Senator WYDEN. Of course. Sure.

Mr. STEINBERG. Let me tell you the biggest reason, or at least the most cogent example of why mandatory funding is so necessary. I have mentioned this to Mike on Senator Smith's staff.

A couple of years ago it was discovered that the V.A. was taking money from programs and spending it—I swear I am not making this up—on outsourcing studies, outsourcing V.A. jobs to some other country.

Now, Vietnam Veterans of America, as far as I know, is the only organization that filed a formal complaint with the Department of Justice. It was my understanding at the time that this act may have, in fact, been criminal.

There has been no response from either the V.A. or the Department of Justice about this situation. That is the first thing.

The second thing, you know, you talk about these kids coming back from Iraq and Afghanistan, 12 days. Imagine what it was like when we flew back from Vietnam and went from, literally in my case, from being in a firefight to being in Oakland, California, in less than 24 hours, a little over 24 hours.

I don't know what the answer is, but when you talk about the stigma, right now I have seen probably six or seven OEF and OIF vets, and all of them have come to me because they have post-traumatic stress disorder. As I think it was Kevin said, they come to me through their families. In fact, I just got one where the mother-in-law was so concerned.

Every one of these cases I get these kids' records, and I look at their post-deployment questionnaire, where it goes right down the list of post-traumatic stress disorder symptoms: startle response,

hypervigilance, intrusive thoughts, and on and on and on. Yes or no? No. No. No. No. No. No.

Then it gets to the question: Is your health, including mental health, as good as, better than, or worse than it was before you deployed? Every single one of them checks off "it is as good as" or "it is better than."

Every single one of these kids, when I asked them, "Are you going to sit here and tell me you didn't have any of these problems when you came back?" "Oh, no, I had them all." "Well, then why did you check no, no, no, no?" "Because I knew that my career would be crap if I checked yes and asked for help." Now, that is what the guys that I have seen said.

Senator WYDEN. Well, thank you all for being advocates for vets every day. We are grateful.

Senator SMITH. Let me join my colleague's commendation to each of you. I want you to know your time here is well-spent. It certainly has been for me. I know it has, I suspect, for Senator Wyden as well.

You have added immeasurably to the record of the U.S. Senate. You have given us a laundry list of things to work on. We take on this issue with genuine concern and desire to fix it where we can and bind up the wounds and care for those who have borne the battle for our Country's sake.

So we are grateful for your time and your attention. We thank all who have traveled a long way or short way for being here.

With that, we are adjourned.

[Whereupon, at 4:05 p.m., the Committee was adjourned.]

APPENDIX

PREPARED STATEMENT OF SENATOR ROBERT P. CASEY

I want to thank my colleague, Senator Gordon Smith, for chairing this important hearing to address mental health care for aging veterans. I look forward to working with him through this committee to meet the needs of our aging veterans.

This hearing could not come at a more important time for veterans' health care in this country. In the coming months and years, the Veterans Administration faces the challenge of caring for the veterans from the wars in Iraq and Afghanistan that will return home in increasing numbers. Tragically, as the war in Iraq continues to escalate with no sign of improvement, we can only expect more casualties, and most will be survivors who return home to cope with devastating physical and mental injuries and illnesses as a result of their combat service.

At the same time, in our efforts to expand our health care system to accommodate these young men and women, we must not forget or neglect our duty to our older veterans who have served America valiantly in previous wars. Combat veterans from World War II and the Korean War are now senior citizens. Many of those who served in Vietnam have retired, adding thousands of senior citizens to the VA's health care rolls. Men and women who fought in the Gulf War of 1991 have unique physical and mental health care concerns, the evidence of which has appeared in the years following the end of that war. We cannot allow our older veterans to suffer in our rush to devote health care resources to our returning Operation Enduring Freedom and Operation Iraqi Freedom soldiers and Marines.

Addressing mental health care quality and access is particularly crucial to the VA's plans for the future. The high incidence of mental illness—including depression and Post-Traumatic Stress Disorder (PTSD)—among OEF/OIF veterans has been well-documented in recent months. Sadly, patients are not the only victims of these terrible diseases—their families suffer as well, particularly children. The emotion impact upon children of PTSD suffered by their parent veterans has received very little attention and it must be addressed. Many veterans resist admitting their problems and seeking treatment. Mental and emotional illnesses are often not diagnosed for months or even years. The VA must prepare for the immediate influx of veterans needing treatment, but also for the decades ahead during which post-combat trauma in veterans can be identified and treated expediently by qualified, well-trained psychiatrists and other medical professionals. Again, as we address the specific needs of OEF/OIF veterans, we must not forget our older veterans, the sacrifices they made, and the challenges they encounter as they age.

Pennsylvania shares many of the geographic and demographic characteristics of Oregon that can challenge access to and quality of mental health care for aging veterans. Like Oregon, Pennsylvania has a high rural population—thousands of citizens are spread throughout a large territory, and many have to travel for hours to access quality health care. Our state is home to 1.9 million citizens over the age of 65, the third largest number of senior citizens per capita of any state in the country.

In fiscal year 2006, the VA reported that nearly 1.1 million veterans reside in Pennsylvania. Over 480,000 were 65 or older. In 2004, the VA spent $2.5 billion on health care for veterans in Pennsylvania, and that number continues to increase year by year.

I am grateful to Senator Smith for calling attention to these critical issues and I look forward to the testimony of our witnesses. We must do whatever is necessary to meet the physical, psychological and emotional needs of our veterans and fulfill this nation's promise to our returning heroes of every age.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM JACK HEIMS

Question. Since Portland is an urban environment and a vibrant city, I would imagine that some of these issues may be lessened at this facility, but is this something that you experience?

How do you attract and retain qualified professionals?

Answer. Our post training programs remain the major source of hires. We host post graduate programs in psychiatry (residency and fellows), psychology (intern and post doc), social work, art therapy, nurse practitioner, occupational therapy and nursing.

Others are attracted to the rare environment where clinical missions are shared with the missions of education and research. Many like that the business end of medicine is taken out of their job description so they can focus on patient care. An increasing number are attracted to the concept of serving our Veterans. Also, on an increasing basis, a benefits package for Federal Employees becomes a beacon for recruitment.

Typically, we advertise in various websites and national professional journals. Word of mouth by our own employees is our best advertiser.

Retention is high for all of the aforementioned reasons. More often than not, when we lose someone it is to another VA Medical Center. Another factor is the lengths we go to to provide ongoing education programs through hosting conferences, grand rounds, brown bag seminars and et cetera.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM NATHALIE HUGUET

In your testimony you mention that primary care physicians have an important role to play in the assessment and management of depression and suicide prevention for veterans.

Question. What do you think is the most effective way to encourage physicians to do this?

Answer. Primary care physician assessment and management of depression and suicide prevention for veterans could be encouraged by expanding reimbursement so that primary care providers can implement and sustain evidence-based procedures aimed at detection and treatment of veterans with major depressive disorder. Federally funded research projects over the past twenty years have shown that primary care providers can do an excellent job at detecting and treating people with major depressive disorder. The key to success is inclusion in primary care practices of "care managers" who have expertise in mental health. Care managers are nurses or couselors (usually with masters degrees such as social workers) who follow protocols for detection and treatment of people with depression. Primary care providers facilitate treatment by prescribing medication as needed. This care management approach has been well studied and shown to be effective. Unfortunately, this model has rarely been sustained owing to lack of reimbursement. Primary care providers nowadays are not infrequently in financial difficulty and are unable to sustain evidence-based practices such as care management. Congress should direct the Department of Veterans Affairs to provide reimbursement for primary care depression detection and management for veterans unable to be served within the Veterans Affairs system.

Do you think that there is more that could be done in their general training to prepare them to identify possible mental illness along with physical illnesses.

Answer. Primary care training could be expanded to provide education about the care management model and to facilitate educational experiences within a care management system. Again, lack of reimbursement is the chief obstacle. Academic health centers are not able to finance care managers. Congress should direct the Department of Veterans Affairs to provide funding for academic health centers offering care management services to veterans unable to be served within the Veterans Affairs system.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM MR. BLACKBURN

In your testimony you mention that there is a lack of supportive housing options that ensure stability of chronically homeless veterans. I am a cosponsor of a bill in the Senate that would provide services for permanent supportive housing programs because I understand how important and effective supportive housing is for this hard-to stabilize population.

Question. How many units of supportive housing do you think we would need to better serve our homeless veterans here in Portland?

Answer. Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) is an annual survey of VA and local community and government agencies serving homeless veterans. The survey assesses the needs of homeless vets and rates the coordination of services with the various local partners.

According to this CHALENG survey, collected in the summer/fall of 2006, there are 1856 homeless veterans in Portland, including 587 chronically homeless vets. The survey is a self-administered questionnaire completed by the local VA homeless veteran coordinator in collaboration with federal, state, county, city, nonprofit and for profit agency representatives, as well as local VA staff and homeless veterans. The need for permanent supportive housing ranks high as an unmet need. Given that the definition of chronically homeless includes 4 or more episodes of homelessness in the last 3 years of 1 continuous year of homelessness and one or more disabilities, we feel comfortable recommending that all 587 of the chronically homeless vets could benefit from supportive housing. Supportive housing for this population would need to include both housing subsidy and the supportive case management services needed to stabilize these individuals and help them access the benefits and entitlements for which they may qualify. The level of supportive services can range from minimal, with a check in only once per month, to frequent, with case managers needing to see someone several times a week ongoing for multiple years. Our experience working with chronically homeless individuals is that they typically need very intensive services over multiple years with step down occurring for short periods of time throughout.

The remaining 1,269 episodically homeless veterans may benefit from limited rent assistance needed to acquire their own housing units. One program currently funded through the Housing Authority of Portland provides up to 3 months worth of rent and covers security deposits so that recipients can stabilize and secure employment. This resource has proven quite effective, with 70 percent of individuals served still housed one year after they last received rent assistance.

In Central City Concern's experience, a high number of homeless veterans experience alcohol or drug addiction. These veterans have a need for transitional Alcohol and Drug Free Community clean and sober supportive housing, provided in conjunction with alcohol and drug treatment. We recommend creating 20–30 units of this type of housing for homeless veterans.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM MR. REILEY

In your testimony you state that claims for care from veterans returning from Iraq and Afghanistan have caused claims from other veterans to languish.

Question. How long are older veterans waiting for services?

Answer. There are a number of points within the VA system where veterans must wait. The three major bottlenecks are: 1) obtaining an initial appointment within Veterans Health Administration (VHA); 2) obtaining an appointment with one's VHA Primary Care Provider (PCP); and 3) having one's claim processed by a Regional Office (RO) of the Veterans Benefits Administration (VBA).

1) Locally, the Roseburg VA Health Care System (RVAHCS) is usually close to the VA's mandate to enroll veterans within 30 days of receiving their application. Enrollment consists of not only processing the application, but scheduling the veteran's "Introduction Clinic" and initial appointment with their assigned PCP. Recently however, Roseburg has lost one of their enrollment staffers due to retirement and initial appointments now are taking approximately 6 weeks to obtain. This is understandable, but I am concerned that RVAHCS has had to go through a formal process to justify rehiring this position. The results of this process were not known as of August 2, 2007. Until this process has been successfully navigated, the position cannot be filled and thus I am concerned that the backlog will increase.

2) Although RVAHCS typically does a good job scheduling initial appointments within or close to the goal of 30 days, there are problems accessing follow-up care. Often times veterans must wait upwards of four months in order to obtain an appointment with their medical PCP. Locally, the Eugene VA Clinic has moved to a "same day appointment" system within their mental health clinic. There was some discussion about expanding this type of system to the medical side, but I am unaware of any progress towards that end.

3) Perhaps the most frustrating aspect of seeking services from the VA is the period of time it takes for VBA to adjudicate a claim for service-connected compensation. On the positive side, the Portland Regional Office has developed a program called "Ready to Rate." If a veteran can submit a claim—typically a claim for Non-service-Connected Pension with Aid and Attendance—which needs no development the Portland R.O. will rate that claim within, typically, 14 days. A claim needs no

development if there is a complete application, proper proof of service, and evidence which satisfies each element of the benefit for which the veteran is applying. In the case of pension claims, that often entails a medical statement of disability and need for care and proof of long-term care expenses.

However, the majority of claims filed are for service-connected compensation and rarely are these able to be filed as "Ready to Rate." The barrier to accessing expedited processing for these types of claims is the requirement for VBA to obtain the veteran's service medical records (SMRs) and to determine the nexus, if any, between those conditions detailed in the SMRs and those conditions with which the veteran is currently diagnosed. Accordingly, claims for service connected compensation typically take from 9 to 12 months in Oregon.

Some cases can take significantly longer than the average. Often time, claims for service connection for Post-Traumatic Stress Disorder (PTSD) take some of the longest periods to obtain a decision from VBA. It appears the problem is the time it takes for VBA to verify the military stressor which the veteran experienced which has lead to the development of PTSD. If the veteran does not have documentation of a military stressor, or an award which allows VBA to concede the stressor, the Regional Office must request verification from JSRCC (formerly USACURR). The local RO submits a request for verification and then will calendar the file for review every 60 days. Unfortunately, this part of the process alone can take a year. Furthermore, only upon stressor verification will the RO further develop the claim which will include a request for a mental health evaluation to determine if the veteran has PTSD and upon completion of the development may the claim be adjudicated.

Question. How would you describe the impact from the backlog on older veterans?

Answer. The impact on the VBA claims backlog is significant and manifold. Many older veterans must first be recognized to have a compensable service connected condition before they are eligible for VA health care. Thus the delays in claims adjudication results in a delay in their ability to receive health care.

Also, many veterans try to be self-sufficient for as long as possible and so only file a claim for service connection when a condition becomes unbearable. This often also coincides with when the condition negatively impacts their employment abilities and thus they may be suffering financial hardship when they initiate a claim. Waiting many months for a determination of eligibility can thus lead to the loss of one's home or other severe financial ramifications.

Finally, there are many ramification of a less tangible nature. The long delays inherent in the claims process are seen by many veterans as based on an underlying lack of commitment by our government to assist those that served our country in times when they are in need. This leads to the often heard, yet still upsetting comments from veterans that, "The VA is just waiting until I die so they don't have to help me."

Veterans in rural areas have the added burden of having to travel great distances to receive care at a veterans' facility. This is a challenge for all rural veterans, particularly elderly veterans.

Question. How prevalent are the transportation issues for the veterans you work within Lane County?

Answer. The transportation issues for veterans in Lane County are there, but not to the degree of other counties that have no VA facilities. Lane County veterans often face difficulty if they must travel to Roseburg or Portland for specialty care. Also, west Lane County residents sometimes have difficulty traveling to Eugene for primary care appointments. While those in Eugene-Springfield have access to the DAV van which runs up and down the I–95 corridor connecting VA facilities. Those outside the Williamette Valley are left to their own devices.

Question. How is your agency preparing for the expected increase in the number of older veterans as the baby-boom generation ages?

Answer. Lane County Veteran Services certainly recognizes the average age of veterans is increasing—please see my previously submitted written materials for demographic details of Lane County veterans over the next 10 years.

As for preparing for the increases in older veterans, we have systems currently in place which will serve such veterans well, but there are concerns about our ability to continue these services. In January, 2006, additional State funds were transferred to Oregon counties in "expand and enhance" veteran services. These new funds, coupled with traditional support from Lane County, and the Cities of Eugene and Springfield, allowed us to increase our staffing levels and markedly increase our outreach efforts. Lane County Veteran Service Counselors now travel to Florence on a weekly basis and travel to Cottage Grove, Oakridge, Junction City, and Blue River once per month. The veterans seen during these outreach efforts are typically older and less able to either physically of financially afford to travel to our office. While

in these local communities, our counselors will also conduct home visits or visits to veterans in long-term care facilities. Furthermore, once per week a counselor will also conduct local outreach to housebound or facility-resident veterans in the Eugene-Springfield area.

But these services are in jeopardy. Lane County is facing a shortfall of up to 30 percent of its discretionary General Fund due to the possible loss of federal funding provided through the Secure Rural Schools and Community Self-Determination Act (SRS) (PL 106–393 and its recent extension of 2007). If federal funding is not made available under this or some similar program which recognizes the inability of Lane County to tax the large tracts of federal lands within its borders, the county will face financial crisis. If such a situation were to come to pass, the county would likely focus on its primary and mandated services—public safety. Under a recent potential budget which was premised on the loss of the SRS funding, the Lane County Veteran Service Office was reduced to only one staff person. Such a situation would obviously wreak havoc on the office's ability to serve Lane County's 35,000+ veterans.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM KEVIN CAMPBELL

In your testimony you state that bringing mental health services to those in need is the best response for serving rural populations.

Question. Can you explain how you do that—are you essentially talking about house calls from mental health providers?

What sort of outreach have you seen with the VA to the rural areas to help soldiers identify and access care?

Answer. No, I was not implying that mental health providers should be required to make house calls. What I am referring to is making services available to veterans in their home communities rather than forcing them to travel up to a hundred miles to access services in the nearest mental health clinic or well over a hundred miles to access services from a VA Clinic. Our efforts to bring services to veterans rather than force veterans to travel to services can best be summed up by three strategies:

Better use of technology. We are utilizing two way video, tele-health, technology throughout Eastern Oregon at the present time. This technology allows access to specialized services with high quality resolution.

Better use of natural supports such as peers who live in the community. Establishing peer support networks in smaller communities which assist veterans and their families in meeting challenges as they arise. Peer to Peer Support is often times the timeliest and effective treatment to conditions as they arise and it needs to be supported.

Better use of Case Management for veterans and their families. Case Management is a valuable service which connects the veterans and their family to service providers who can best meet a variety of needs. Case Management services can often be provided by the telephone.

In your testimony, you also mention that there has been a drop in the number of physicians willing to accept Tri-Care Insurance due to low reimbursement payments.

Question. Are low VA and Tri-Care reimbursement rates resulting in access issues for military families?

What type of incentives do you think are necessary for attracting and keeping mental health professionals and physicians in rural areas?

Answer. My written testimony included the following; "Once veterans are determined to be eligible for benefits, services are often times many miles away, access is commonly delayed by a preauthorization process, and many providers no longer accept Tri-Care Insurance due to difficulty being paid for their services. Payment rates are often so low that private practitioners are unable to provide services because the payment does not cover the cost of the needed services."

In using the term, "private practitioners", I did not imply that only physicians were concerned about payment rates. When mental health practitioners do not see people with insurance, these individuals come to the public mental health system for service. Low reimbursement rates lead to cost shifting or dependence on state and local funds to continue to support the service. By mirroring Medicare rates, Tri-Care has a disproportionate impact on rural practitioners. Increased numbers of veterans has stressed the system.

Oregon recently passed a law to give tax credits to physicians who accept Tricare. Under the new law, physicians can claim a $2,500 tax credit the first year they accept patients under the federal Tricare health system and $1,000 for each following year.

Continuation of programs such as the National Health Service Corps is essential to recruiting Mental Health Professionals in Rural areas. Reimbursement Rates must be adequate to maintain these professionals in rural areas. While housing is often times less expensive, gas and food are significantly more expensive in rural areas and it is not cheaper to live in a rural community than in the city.

RESPONSES TO SENATOR SMITH'S QUESTIONS FROM STU STEINBERG

Unfortunately, the stigma associated with mental illness deters many soldiers and veterans from seeking help.

Question. What do you think the Department of Defense and VA could and should do to help overcome the stigma associated with mental illness?

Answer. The DOD must insure that all soldiers can seek mental health care without fear for their career. To the extent that the military denies this is occurring, it is simply a lie. One only need listen to the NPR story about soldiers at Ft. Carson, CO, to verify that this is occurring. Moreover, I have several recent returnee clients who have told me the same thing. They check "no" to every question asked about PTSD symptoms on their post-deployment questionnaire because it has been made very clear to them that their career will be negatively impacted if they say they have PTSD or other mental health symptoms. It has now been established that since the beginning of the two recent wars, the military is doing everything it can to discharge soldiers with personality disorders in order to deny them medical boards and retirement benefits or severance pay—the number is approximately 22,000 soldiers. We saw this happen over and over again during Vietnam. I have a case now where an Iraq veteran was treated in Iraq for PTSD at the Combat Stress Facility, then transferred to Germany for further treatment. There, he was diagnosed with a Bipolar disorder which mysteriously existed prior to his enlistment more than four years earlier. Needless to say, you aren't Bipolar one day and then not have symptoms for more than four years and suddenly you have it again. Even if he did have it prior to enlistment, it is clear that what he had in Iraq was PTSD. Because it is now an EPTE thing, he gets no VA benefits because he had less than 24 months on active duty.

As far as the VA is concerned, I see no Stigma issue on that front.

The importance of addressing mental health problems in a timely manner cannot be overstated. If ignored, they can result in much more severe problems for the veterans and their loved ones.

Answer. The VA is where the problem is, here. There are too few programs, not enough staff and there are waiting lists for initial intake and referral for individual and group treatment. This is particularly a problem at the CBOCs where the need is greatest and clients have to wait for treatment, sometimes for many months. The VA needs to stop building new facilities and use their funds for hiring more staff and treatment. It is just that simple. Every medical center and CBOC should have a PTSD/mental health program and every medical center should have an inpatient program. As far as I know, the Portland/Vancouver facility does not have an inpatient PTSD programs. In addition, since substance abuse and alcoholism are often symptomatic of PTSD, it is criminal in my opinion that every medical center does not have an inpatient program and that every CBOC does not have an addictions therapist. Someone from the VA at the hearing stated that outpatient treatment works better. This is the most incredible load I have heard recently since any addictions thereapist or counselor will tell you that long-term addictions problems *always* require inpatient care before outpatient care is a possibility. Furthermore, without addictions therapists at the CBOCs, aftercare does not occur, thus, creating a situation where relapse is probable.

Question. Based on your experience, how long do some veterans wait for the care they need?

Answer. Months and in some cases I have seen it take as long as a year for admission to a PTSD group. Moreover, it is simply not useful to have individual therapy occurring on a monthly or even a lesser occasion. Every veteran with a mental health diagnosis should have the benefit of weekly therapy, bi-weekly at the outside. No veteran who wants group therapy should have to wait longer than a month. Claims by the CA that they are providing adequate mental health care are belied by reports of veteran after veteran of having to wait inordinate lengths of time, or not receiving adequate care. They can't all be liars.

Question. What other barriers to access and services do you see?

Answer. Lack of funding, lack of funding, lack of funding.

Question. What would help bring down these barriers?

Answer. More funding, more funding, more funding.

One of my priorities is to ensure that veterans of all ages and eras have access to quality mental health services and receive treatment in a timely manner.

Question. How have you seen the delivery of services for older veterans impacted in the past few years when soldiers began returning from Iraq and Afghanistan?

Answer. I really haven't seen this problem occur at the Bend CBOC. Veterans from all conflicts face the same problem of too few staff and not enough funds to make mental health and addictions care meaningful.

Question. What specific improvements would have the biggest impact on improving mental health services for veterans in Oregon?

Answer. More funding and, therefore, more staff. I hate to keep harping on the same issue over and over, but that's the simple truth. Maybe if the Army wasn't funding professional auto racing teams, such as their Top Fuel Dragster and Pro Stock Motorcycle teams in the National Hod Rod Association, the VA could put that money to better use. This is costing the American taxpayer millions of dollars each year.