SUBSTANCE ABUSE/COMORBID DISORDERS: COMPREHENSIVE SOLUTIONS TO A COMPLEX PROBLEM

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SUBSTANCE ABUSE/COMORBID DISORDERS: COMPREHENSIVE SOLUTIONS TO A COMPLEX PROBLEM

TUESDAY, MARCH 11, 2008

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

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Michael H. Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Berkley, Hare, and Salazar.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I call the Subcommittee to order, and ask our first group of panelists to please come to the table.

I would like to welcome everyone to our Subcommittee hearing today. We are here today to talk about treatment for substance abuse and comorbid conditions within the U.S. Department of Veterans Affairs (VA).

Substance use disorders (SUDs) are among the most common diagnoses made by the Veterans Health Administration (VHA). According to the 2007 National Survey on Drug Use and Health, 7.1 percent of veterans met the criteria in the past year for a substance use disorder. And 1.5 percent of veterans had a co-occurring substance use disorder.

Of the approximately 300,000 veterans from Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) who have accessed VA healthcare, nearly 50,000 have been diagnosed with substance use disorder. Additionally, more than 70 percent of homeless veterans suffer from alcohol and drug abuse problems.

Over the past several years, Congress has increased funding for substance use treatment programs within the Department of Veterans Affairs to $428 million in fiscal year 2008. I believe that continuing adequate funding is imperative for the health and well-being of our veterans and their families.

Substance use frequently co-occurs with other mental health conditions. VA needs to continue to dedicate itself to providing services that can address both substance use and other mental health conditions such as post traumatic stress disorder (PTSD) simultaneously.

I also was pleased to learn that Dr. Kussman, VA's Under Secretary for Health, recently released a directive on the management

of substance use disorders. This directive states that, among other things, VA facilities must not deny care to any enrolled veteran because they are using substances. And that all VA medical facilities must provide services to meet the needs of veterans with substance use disorders and PTSD.

I think that this is a step in the right direction. I commend VA for its proactive leadership on this.

Last week, Mr. Miller and I introduced the "Veterans Substance Use Disorder Prevention and Treatment Act of 2008." The Subcommittee realizes that substance use and comorbid conditions are complex issues. But we also recognize that it is important and that this deserves serious thought and consideration.

I look forward to hearing from our panels today about the ways that the VA can effectively address these critical issues.

[The prepared statement of Chairman Michaud appears on p. 42.]

Mr. MICHAUD. And now I would like to recognize Mr. Hare for an opening statement.

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. I will be very brief. Thank you, Mr. Chairman. I want to thank you for holding this hearing and the continuance of hearings that you have organized about veterans mental healthcare.

Substance use disorder and its comorbidity with post traumatic stress disorder are clearly a significant health issue among our returning veterans. And while it is crucial that we must understand what needs our veterans have, I believe that we must act quickly to ensure that the VA is providing the necessary services uniformly and across the Nation.

And, again, Mr. Chairman, I thank you very much for this series of hearings. You do a wonderful job as Chairman of this Subcommittee, and I hope to have an informative hearing this morning. Thank you so much.

Mr. MICHAUD. Thank you very much, Mr. Hare, for your leadership on veterans' issues as well.

Our first panel is comprised of Patricia Greer, who is the President of NAADAC, the Association for Addiction Professionals; and Dr. Richard McCormick, who is a Senior Scholar from the Center for Health Care Policy and Research at Case Western Reserve University in Cleveland, Ohio.

I would like to welcome both of you here this morning. And look forward to hearing your testimony. And we will start with Ms. Greer.

STATEMENTS OF PATRICIA M. GREER, PRESIDENT, NAADAC, THE ASSOCIATION FOR ADDICTION PROFESSIONALS; AND RICHARD A. MCCORMICK, PH.D., SENIOR SCHOLAR, CENTER FOR HEALTH CARE POLICY AND RESEARCH, CASE WESTERN RESERVE UNIVERSITY, CLEVELAND, OH

STATEMENT OF PATRICIA M. GREER

Ms. GREER. Thank you, Mr. Chairman and Members of this Subcommittee, for holding today's hearings.

The multiple challenges to our healthcare system to effectively treat co-occurring substance use disorders are significant. But ex-

perience has proven that there are practical steps, which will improve outcomes for clients and their families.

I represent NAADAC, the Association for Addiction Professionals. We are the national professional association for addiction-focused health professionals and educators. NAADAC has 10,000 members across the United States and partner organizations in 46 States, two territories, and several foreign countries.

I would like to take a minute to note the scope of the problem of substance use disorders and comorbidity. In 2004, Dr. Richard Suchinsky ranked substance use disorders as third in the list of diagnoses made by the VHA.

However, reflecting a similar treatment gap in civilian society, substance use disorders remain under diagnosed and under treated in the VHA. In total, it is estimated that 1.8 million veterans suffered from a diagnosable substance use disorder in 2002 and 2003.

Substance use disorders often co-occur with other physical and mental health conditions. In the case of mental health conditions like PTSD, depression, or bipolar disorder, substance use disorders may develop from attempts to self-medicate.

Some experts estimate that about 40 percent of the veterans who have served in Iraq or Afghanistan will experience mental health problems. And of that number, approximately 60 percent will have a substance use disorder. National Guard forces report even higher rates of psychological distress than do the regular forces. And the stigma against addiction and treatment discourages many people from even seeking help.

The Department of Veterans Affairs and Congress should be commended for having made mental healthcare for veterans a priority over the past several years.

As this hearing's title suggests, co-occurring addiction and mental disorders are best treated comprehensively. Treatment for substance use disorders is most effective when delivered by trained healthcare professionals with either a certification or license in addiction-specific care. Licensure and certification ensures that the practitioner has both the education and the clinical experience in evidence-based practices to provide the best possible care.

The commitment by the VHA to prioritize treatment for co-occurring addiction and mental illness must include a commitment to expand and train its addictions-focused workforce. Reports that the addiction-focused VHA workforce has declined by almost half in the past decade are particularly disturbing.

Simply stated, comprehensive care for co-occurring disorders requires professionals with knowledge of both the areas of addiction and mental health trauma.

Additionally, several steps may be taken to enhance the comprehensiveness of care.

First, early screening and intervention leads to more successful results. Of the veterans in the VHA system with diagnosable substance use disorders, only 19 percent received specialized addiction treatment. Primary care health practitioners must be trained in identifying substance use disorders and their co-occurring mental health conditions. And qualified addiction professionals should be on call to provide interventions when needed.

Second, we believe that the VA should be accountable and transparent in cases where they do deny treatment to a veteran claiming to have combat-related symptoms or substance use disorders and report that information publically.

Third, culturally competent care reflecting familiarity with military culture is essential for effective treatment. Fourth, the current conflicts require a new emphasis on gender-specific treatment strategies. Servicewomen are closer to combat than ever before. Female veterans are more vulnerable to PTSD.

The VHA should invest in studying gender-specific treatment and counseling strategies.

Fifth, with the high rates of Reservists and National Guard forces in combat and extended tours of duty, families are under extreme stress. Post-deployment reintegration is often surprisingly difficult. Family inclusion in treatment programs are recommended whenever possible.

Sixth, access to treatment should be as convenient and client-friendly as possible. Compared with the civilian system, both public and private, substance use disorder-specific care in the VA takes place in hospitals that are densely populated and less geographically dispersed than civilian treatment sites. This problem is particularly pronounced for veterans in rural areas.

We encourage the Department of Veterans Affairs to aggressively pursue partnerships with existing civilian treatment centers. Strategic partnerships that expand the capacity of existing treatment systems in underserved areas would provide veterans and their families with timely care close to home, which is much more successful.

In conclusion, the current conflicts in Iraq and Afghanistan pose many new challenges requiring a comprehensive plan of action.

We would like to commend the Department of Veterans Affairs, this Subcommittee, and other policymakers who have worked to improve veterans' access to healthcare in the past several years.

We look forward to working with other stakeholders to improve the Nation's treatment systems for co-occurring substance use disorders. I thank you for the opportunity to testify today. And I would also like to acknowledge the addictions treatment professionals in the room who are also veterans with us today. And I would be happy to answer any questions.

[The prepared statement of Ms. Greer appears on p. 43.]

Mr. MICHAUD. Thank you very much. Dr. McCormick?

STATEMENT OF RICHARD A. MCCORMICK, PH.D.

Dr. MCCORMICK. Mr. Chairman, Members of the Subcommittee, I will attempt in my limited remarks today to provide an independent, ground-level assessment of the needs of veterans for substance abuse disorder services and the current capability of VA to provide them.

Let me first share the basis for my assessment. I retired a few years ago after 32 years in VA, where I worked clinically, mostly in substance abuse. Ending my career as the Mental Health Care Line Director for Network 10.

I was Co-chair of the VA National Committee on the Care of Severely Mentally Ill Veterans, the mental health representative to

the VA Central Office Task Force overseeing all practice guidelines, and Co-chair of the group drafting the practice guidelines for dually diagnosed veterans.

After I retired, I had the additional opportunity to personally visit 39 VA facilities. First as a Commissioner on the VA Cares Commission, also as a member of a special Secretary's mental health task force, and then as a consultant on mental health and substance issues at a number of facilities.

The last 2 years, I personally had the opportunity to visit 23 military bases and Reserve units across the world as a member of the Department of Defense (DoD) Mental Health Task Force.

On these visits, I talked to literally thousands of servicemembers, families, and providers about substance abuse and mental health issues.

I continue to conduct National Institute on Alcohol Abuse and Alcoholism funded research at the university and am involved in two large Department of Defense follow-up studies on the mental health status of National Guard and Reserve members.

First of all, the scope of the problem. The need for comprehensive substance use disorder services is immense and growing. Multiple studies show high rates of problems for returning War on Terror members.

For example, among reservists who are veterans, weeks within their return, across studies looking at confidential surveys, it ranges from the 25 to 35 percent range on average for alcohol problems. When you look at the subset who have frequent deployments and high combat exposure, it goes as high as 52 percent.

This hearing importantly focuses on comorbidities. Substance abuse is a common comorbidity for mental and social problems. The veteran must be able to access good substance abuse services to deal with other conditions as well. For example, most—all PTSD programs require that someone either concurrently or before they enter PTSD treatment deal with the substance abuse problem, which is a common comorbidity for up to one third of those going into treatment.

There is growing concern with suicidality. A recent VA study of over 8,000 veterans in substance abuse treatment found that the year before they entered treatment, 9 percent had—attempted suicide. The year after, 4 percent. The good news is there was a direct relationship to the amount of substance abuse treatment they got and the decrease in suicidal behavior.

What is the—let me just say that VA's priority medical and mental health programs need a state-of-the-art substance abuse program to provide the care they need to provide.

What is the state right now? VA has been a leader in establishing evidence-based guidelines for substance use disorders. We know what works. In the past decade, VA substance abuse care has greatly eroded. Official VA reports document the decline. Much less is being spent on the care. Two hundred million dollars less than was spent in fiscal year 1996.

Some of that might be attributed to increased efficiency were it not for the fact there has also been a drastic decline in the number of unique veterans getting substance abuse care in VA. Nor is this

due to lack of need. Three networks actually increased the care they provide, while increasing efficiency.

But the result of this decline across the system, is that there is a vast discrepancy in access of a full—to a full continuum of care across the country.

Small improvements can be noted in the past couple of years with new money. But even still, there are examples of medical centers that take expansion money for one thing and continue to reduce substance abuse services.

There are many dedicated staff who provide care. Most VA programs do focus on the more severe, dependent abusers. But the new veteran often needs a new kind of service. He or she may be at the beginning of a long drop, binge drinking, getting caught driving under the influence (DUI), getting DUIs, starting to destroy family relationships.

In the private sector, you will find examples, many examples, of comprehensive brief intervention initial treatment programs for such patients.

Alarmingly, these are rare in VA. There are certainly examples of bright spots where it is happening. But across the system, they just aren't there.

I could go on providing more details. But let me end with a true story. On a visit to a Reserve unit last year, I was approached by a reservist home from his second deployment. He was changed. He knew it. His sergeant knew it. His wife knew it. He was drinking too much. He wasn't the father or husband he always saw himself being. He had had a tough time in deployment, but he didn't want to talk about that. And he was reluctant even to go get some help with his alcohol problem.

But he did want to do something. I directed him to the nearest VA facility nearest where he lived. It was not one I had visited recently. I hope he found ready, immediate access to services that he needed, before he talked himself out of sticking with it. Then and now, I am not sure he would.

[The prepared statement of Mr. McCormick appears on p. 47.]

Mr. MICHAUD. Thank you very much, Dr. McCormick.

As you know, one of the issues that is important to me is access to veterans' healthcare for our veterans, all over the United States, but particularly in rural areas.

What, Dr. McCormick, are some of the challenges in providing substance abuse treatment in rural areas? We heard Ms. Greer mention partnerships are one opportunity. Could you talk about the effectiveness of telephonic—or Internet-based treatment for substance use disorders?

Dr. MCCORMICK. Yes, thank you. One of the great strengths of VA, as you know, I am sure Mr. Chairman, is the establishment of community-based outpatient clinics (CBOCs), which are much more accessible, including especially to rural veterans than our medical centers generally.

It is appropriate to have the most intensive substance abuse services at a medical center to a degree. But at every CBOC, every community-based outpatient clinic, in primary care, there needs to be someone who is expert in providing brief interventions to try to immediately impact, especially on those who are misusing rather

than fully dependent, before they spend years going down that deep drop.

And that isn't true right now. Even 4 years after people are coming back—and they need the services right when they come back to stop the drop. And that is true in rural. My own view is that the only way we will ever really attack the rural issue completely is for VA to contract some of that care in local communities.

I myself believe VA can still be the provider of care and payer for care. But especially if it is an intensive outpatient program or even frequent outpatient visits, the reality is that if a veteran—I hear this many times. If a veteran has to drive 100 miles both ways, with the price of gas today, that is not free care. That is real expensive care. It is true in Ohio. I am sure it is true in other rural areas, Florida as well.

So that, yes, I think VA needs to bolster its programs, its intensive programs at the medical center. Make sure every CBOC can really provide immediate care. And I will say that there was a survey done. I was part of the group in 2004, VA's Health Services Research and Development Service (HSR&D) study, a survey of the leaders of primary care and ambulatory care in VA. The number one barrier they saw through their veterans—and they thought 29 percent of them had alcohol problems. The number one problem they had getting them to have short, brief treatment, was lack of resources.

So VA can direct the care, pay for the care, but they will have to contract in some areas to make it truly accessible and useful.

Mr. MICHAUD. What about Internet-based treatment? Do you think that is effective?

Dr. MCCORMICK. In terms of—you know, I really feel that the jury is out whether it is better to treat the disorders at the same treatment site or in separate treatment programs.

But I would stress that the most important thing is that good care for mental health conditions and for medical conditions—take for example hepatitis C, you can't really—the effective treatments for hepatitis C requires someone—the need to be alcohol free. Likewise, even TBI, traumatic brain injury, one of the cardinal symptoms is disinhibition, often misuse of alcohol.

And in fact, the current DoD advice for TBI patients is to abstain from alcohol. If somebody has TBI and has an alcohol problem, they need to be able to get those services.

I myself think the jury is out whether they have to be done at the same time. We are still at the point of trying to make sure that every place we should have it, we have a robust, full continuum of care. So at least it can be offered concurrently.

Mr. MICHAUD. Ms. Greer, would you want to answer that question about Internet-based treatment?

Ms. GREER. My concern on Internet-based treatment is that one of the hallmarks of addiction is disconnection from your family, your friends, and your support network, your natural support network. So I find it difficult to endorse internet-based treatment for addiction disorders.

Mr. MICHAUD. Ms. Greer you recommend that the VHA should provide resources to its current healthcare workforce to become certified or licensed in addiction-specific treatment.

How many VA health professionals are currently certified or licensed? What is the process you have to go through?

Ms. GREER. Well, actually it varies from State to State at this point. All the armed services actually have a process, I believe, for certifying people that are interested in being certified addictions professionals. But it is not consistent nationally.

Mr. MICHAUD. And with, mental health treatment, involvement of the family members is—I feel is extremely important. How do you both, Ms. Greer and Dr. McCormick, envision what that family involvement should look like? Do you feel that the VA currently promotes family involvement in substance use disorder treatment for our veterans?

Dr. MCCORMICK. Let me try that first. That is an excellent question. The reality is that there is less involvement of family actively in VA substance abuse programs than any comparable programs elsewhere in the community.

Partly this is regulatory or at least staff belief about regulations. The reality is, especially for the new War on Terror veteran coming back, when you talk to National Guardsmen when survey—when we do surveys of them, marital problems are where things start to surface first, especially with repeated deployments.

And yet, most VA medical centers don't make marital counseling readily accessible. It is available at Vet Centers. But, again, I would remind everyone that Vet Centers are much less accessible as an entity than our medical centers. And Vet Centers don't really do substance abuse care. So you are talking about trying to separate two things that should be separated, because the family, the wife—we are losing families.

And because of losing families, we are losing veterans and servicemembers, including to suicide. It is the number one factor. You take these three things together: family problems, or relationship problems, or a "dear John" e-mail, alcohol and access to a weapon. That is what you see happening. That is why you see suicide. And that is why you see it so much.

Mr. MICHAUD. Ms. Greer, do you want to add anything to that?

Ms. GREER. I think that informing family members of the role that they play in post-deployment reintegration would be a key step in helping the adjustment to coming home, especially with marital difficulties.

My concern is that speaking to professionals in Fort Hood, I understand their caseloads are in excess of 300, just with returning veterans themselves. And they are not able to handle the family connections that would go with treating the people they serve.

So I don't know how it is nationally. But I know the local providers in Fort Hood are overwhelmed.

Mr. MICHAUD. Thank you. And my last question, Dr. McCormick, since you formerly worked at the VA, we can provide all the resources that we think is needed in this particular area. But my concern is once that we do that, is to make sure that the resources get to the veterans that need it.

I guess my question is how do you see that we as a Committee can make sure that the resources get where they are needed? What type of oversight do you think we need? Is there any report language that we should require the VA to report back?

And the other issue is if we do not—if the veteran does not get the services that they need, what is that actual cost of that—to society as a whole? How much more expensive would it be since they are not getting the services that they need?

Dr. MCCORMICK. Two very important questions. Let me take the first one. You know, when I first came to VA, it was described to me as a series of fiefdoms. It changed somewhat, but not a lot.

On the other hand, one of the things that has happened that is very good in VA, is the establishment of practice guidelines. Now the substance abuse guidelines need to be expanded with modern services on misuse for new veterans. Once that is done, my own belief is that a report card needs to be done on each and every medical center, comparing each and every medical center as to which parts of the continuum of care in VA's own evidence practice guidelines are readily available and accessible at that site.

That report card should be used for two things. It ought to be made public, because frankly there are VA administrators at the local level who are recalcitrant about substance abuse services. But the light of day of a report like that gets converts that—and nothing else would get.

Number two, it allows the money that you do give to go to the right places, because the bottom line is—as the Member correctly said earlier, the bottom line is to try to get accessible services across the whole system. So that if a veteran living in Ohio, who has a problem, gets the same access as one who lives in Florida. And the one in Ohio is probably depressed, because all the defeats we have had from Florida teams lately but beyond that.

The second question you asked is also, you know, important—very important as well. And that has—but you have to remind me of it, because I am an old man.

Mr. MICHAUD. Well, first of all, you mentioned having that report card.

Dr. MCCORMICK. Right.

Mr. MICHAUD. Would you be willing to help to put together what that report card should look like? I think all too often what happens is once we pass legislation and it becomes law, that is it. There is really not much follow up.

So I would like to make sure that, number one, that we have a report card that is legitimate and would really help us. And second, we can evaluate exactly what the Veterans Integrated Services Networks (VISNs) and VA are doing. So would you be able to help with the Committee staff?

Dr. MCCORMICK. Yeah. And there are many old VA people like myself who are around to do that. I would be glad to.

I am still trying to remember the second important question.

Mr. MICHAUD. The second question is when you look at taking care of our substance abuse, that has a cost to it.

Dr. MCCORMICK. Thank you.

Mr. MICHAUD. But if we do not put that money up front, then there are other social costs that could be more expensive, including, unfortunately, loss of life because of suicide.

Dr. MCCORMICK. Well, yes. So first of all, there is—there are social costs, obviously, to the family and to the veteran himself. There are also medical costs, because untreated—substance abuse

treatment does work, although it is a chronic condition. And the earlier we intervene, the more likely we are to be successful down the road.

The good news is the early interventions are our least expensive. So they save not only the veteran and his family all the psychological and social pain, they actually save money over time if we do them well.

When substance abuse gets to be chronic, as somebody mentioned earlier, you get all kinds of things, including homelessness. Actually the number of patients in our homeless programs is more than 70 percent that have a substance abuse problem.

And also there is a medical cost. Again, as I said earlier, and I just used two examples, I am on—we are doing a very large study on hepatitis C. If you aren't able to address substance abuse, it does really make it impossible to provide some state-of-the-art medical treatments, because alcohol—excessive use of alcohol really keeps you from taking antivirals and many of the drugs that are most effective for that. So there is also a medical cost over time.

Mr. MICHAUD. Thank you. Ms. Greer, did you want to add anything?

Ms. GREER. I just wanted to add, that the Federal Government has studied this issue. I think it was around year 2000, and it indicated that for every dollar we spend on intervention, prevention, early treatment, we save $7 down the road avoiding incarceration, the chronic deterioration by a chronic disease, and all the related societal costs.

Mr. MICHAUD. That is a very good point. It would probably be worthwhile to get an up-to-date cost, since that is 8 years old.

Ms. GREER. Well, I am sure they could help us?

Mr. MICHAUD. Yes. Thank you. Mr. Hare?

Mr. HARE. Thank you, Mr. Chairman. Ms. Greer, from your experience, is the treatment offered for SUD or addictions at the VA similar as far as programmatic aspects to those of the public sector?

Ms. GREER. Unfortunately, I can't address that question. I haven't worked within the VA system. I only have secondhand reports.

Mr. HARE. Okay. Dr. McCormick, would you?

Dr. MCCORMICK. They are for—if we are talking about programs for fully dependent patients, they are actually quite similar. The basis of them is really an intensive outpatient program with a residential option.

A couple of things are different. There are few—there is less availability for methadone maintenance, which is actually—has a very heavy evidence base in VA than it is in the private sector. I also do consulting in the private sector.

And the other one that I would, again, underscore, the—one of the huge differences that perhaps is most pertinent to the War on Terror is that VA programs are much less likely, in my personal experience, to offer early, short, brief interventions for people who are just starting down the slope.

Our programs in VA tend, because of the kinds of patients we have treated over the years, to be kind of the end-of-the-line programs. Now when I go around the Nation and you talk to VA sub-

stance abuse people, they recognize this. They would like to provide short, brief interventions. They just don't have the time. They are already barely floating.

Mr. HARE. Well, Doctor, let me—you know, I know you worked in the VA system, as you mentioned, for several years and traveled all over the country. And let me first of all thank you for your service. It is a wonderful thing to do. But can you tell—maybe tell me how much of an understanding do you think the VHA professionals have about SUD? There seems to be a lot of stigma surrounding SUD and whether it is, you know, the willpower to stop, rather than a medical condition.

And I guess my other part to that question is do you find this a problem in the VHA facilities? And would you agree with Ms. Greer's assessment that more specialized training for SUD need to be integrated into the VHA? It is a long question. I apologize.

Dr. MCCORMICK. No. Let me start. When you start at the ground up, if you talk to primary care doctors, having people come in for a 15, 20, most 30-minute visit, and as I said before, their own people say 29 percent of them have an alcohol problem. They recognize it is a problem. They recognize they have neither the time nor the training to address it.

So they have to rely on the availability of other resources, particularly in the specialized substance abuse programs, which often are not really accessible for them or don't offer the kind of services their patients needed.

As you go up the line, there are certainly many very enlightened VA clinicians and VA managers regarding the importance of substance abuse treatment. But there are many who are not. And this is one of the reasons that you have the undeniable variation. I mean, there is an order of three variation on the number of—the percentage of patients treated completely who get substance abuse care in the VA by network.

So there is no question that that is a reality that, again, has to be overcome through top-down enforcement of a consistent continuum of care across the system.

Mr. HARE. And lastly, I don't want to run out of time here, Mr. Chairman, but I just want to ask Ms. Greer one question. Just to clarify what the difference is, if any, between substance abuse disorder and an addiction?

Ms. GREER. An addiction?

Mr. HARE. Mm-hmm.

Ms. GREER. You can have a substance abuse disorder that progresses to addiction. You may just have somebody that is in a phase of abusing substances. And that would be a substance abuse disorder. And that would be a warning that there is potential for dependency or addiction.

Mr. HARE. I thank you very much. Thank you, Mr. Chairman.

Mr. MICHAUD. Thank you. Ms. Berkley.

Ms. BERKLEY. I thank you, Mr. Chairman. And thank you for holding this very important hearing.

I would like to be able to submit my opening statement for the record, if I may.

Mr. MICHAUD. Without objection.

Ms. BERKLEY. Thank you.

[The prepared statement of Congresswoman Berkley appears on p. 42.]

Ms. BERKLEY. Thank you. Thank you both for being here to discuss with us a very important issue and to help educate us. And we always appreciate that.

A constituent of mine, Lance Corporal Justin Bailey, returned from Iraq with PTSD. He developed a substance abuse disorder. And I know that they go hand in hand. He checked himself—with his family's insistence, checked himself into the LA VA facility in West Los Angeles. After being given five medications on a self-medication policy, Justin Bailey overdosed and died. His family, obviously, are beside themselves. And can't understand how he went in with a substance abuse problem, and was given more medication unsupervised.

I have introduced the "Mental Health Improvements Act," which aims to improve the treatment and services provided by the Department of Veterans Affairs to veterans with PTSD and substance abuse disorders.

And what the legislation does is it expands substance abuse disorder treatment services at VA medical centers. It establishes national centers of excellence on PTSD and substance abuse disorders. It creates a program for enhanced treatment of substance use disorder and PTSD in veterans. It requires a report on residential mental healthcare facilities in the VA, creates a research program on comorbid PTSD and substance abuse disorders, and it expands assistance of mental health services for families of veterans.

I think it is imperative that we provide adequate mental health services for those who have sacrificed for this Nation and those who continue to serve. Oftentimes these problems don't manifest themselves until quite a while after the service. But it is a serious issue. And we are recognizing it now, where I think in past wars, it existed. And we just chose not to recognize it.

I am hoping that my colleagues, and I know there are only two here, will help cosponsor this and move it along. I think it is important and will help.

But, Ms. Greer, I wanted to ask you. I am not sure. I mean, we are putting a lot of burden on our VA. In addition to the healthcare that our veterans require when they come home, and we will have several hundred thousand if not close to a million veterans from the current action and our resources are scarce. Added to the healthcare issues are also the mental health issues.

And I am not sure—as a matter of fact I am quite convinced that we don't have enough people—doctors in the VA to accommodate the—what we are tasking them with, and will continue to task them with, and expand their task.

Ms. Greer, do you think it would be beneficial to allow civilians to provide care to veterans with substance abuse disorders if they are qualified addiction specialists? Because right now our military people have to go through the VA.

If we don't have enough personnel, and enough doctors, and enough addiction specialists to handle the influx of people that need their services, do you think it would be appropriate to reach out or go beyond the VA and certify addiction specialists that are not in the VA system to help treat these people?

Ms. GREER. Well, absolutely. The establishment of professional standards is part of what our association does. So I can wholeheartedly recommend using certified addiction professionals or licensed addiction professionals, because they have got the training and the specific ability to be meaningful in their interventions with clients.

Ms. BERKLEY. Thank you very much.

Mr. MICHAUD. Thank you. Mr. Salazar? Well once again, Ms. Greer and Dr. McCormick, I want to thank you very much for your enlightening testimony. I appreciate you coming here today.

Dr. MCCORMICK. Thank you.

Ms. GREER. Thank you, Mr. Chairman.

Mr. MICHAUD. I now ask the second panel to come forward. Joy Ilem who represents the Disabled American Veterans (DAV); Doctor Thomas Berger who represents the Vietnam Veterans of America (VVA); and Todd Bowers who represents the Iraq and Afghanistan Veterans of America (IAVA).

And I would like to thank the three of you for coming forward today to give your testimonies. And I would start off with Ms. Ilem.

STATEMENTS OF JOY J. ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; THOMAS J. BERGER, PH.D., CHAIR, NATIONAL PTSD AND SUBSTANCE ABUSE COMMITTEE, VIETNAM VETERANS OF AMERICA; AND TODD BOWERS, DIRECTOR OF GOVERNMENT AFFAIRS, IRAQ AND AFGHANISTAN VETERANS OF AMERICA

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Mr. Chairman and Members of the Subcommittee.

Thank you for inviting the Disabled American Veterans to testify at this important hearing on substance use and co-existing mental health disorders in the veteran population.

We owe our Nation's disabled veterans access to timely and appropriate care, including specialized treatment programs for those suffering with post-deployment mental health and substance use disorders.

DAV has a growing concern about the reported psychological effects of combat deployments on veterans who have served in Iraq and Afghanistan. There is converging evidence that substance use among other post-deployment mental health problems is a significant problem challenge for many of these veterans. And that the incidence of this problem will likely continue to rise if not properly addressed.

At one facility, VA researchers examined substance abuse and mental health problems in returning Iraq veterans and concluded that increasing attention is being paid to combat stress disorders but that there was insufficient systemic focus on the substance abuse problems in this population.

Access to substance abuse services for the group studied was very low, only 9 percent, compared with access to other mental health services, reported at 41 percent.

In my written statement, I also cite a number of other studies that illustrate the apparent nature and scope of this problem.

Unfortunately, over the past decade, VA substance abuse rehabilitation services have declined and VA has made little progress in restoring them, even in the face of higher demand from the newest generation of combat veterans.

Although it is well known that many mental health conditions, including PTSD, anxiety disorders and depression are frequently associated with substance misuse, VA is not sufficiently focused on restoring these specialized services, including integrated treatment programs to address these co-existing disorders.

We are also concerned about the market increase in geographic variability of access to comprehensive substance abuse services noted across the VA system, as well as reported inconsistencies in offering inpatient detoxification services.

We hope VA will set in place clear policies to ensure that a comprehensive set of substance abuse disorder services are available and consistently provided to all veterans who need them. These services should include screening in all care locations, particularly in primary care; short-term outpatient counseling, including motivational intervention; ongoing aftercare and outpatient counseling; intensive outpatient treatment; residential care for the most severely addicted; detoxification and stabilization services; ongoing aftercare and relapse prevention; self-help groups; and, opiate substitution therapy and other pharmacological treatments, including access to newer drugs to reduce cravings.

While we applaud VA's efforts to save individuals from the misery of chronic addiction, we note that VA has traditionally limited its program focus on those who have seemingly hit rock bottom. Experts agree that early interventions for substance use are more successful when they have not been allowed to become compounded or chronic.

Therefore, we believe access to a robust array of substance abuse disorder services and an expanded focus on prevention and early intervention is not only warranted, but critical to our newest generation of war veterans suffering with post-deployment readjustment issues.

Lack of access to such services could result in sub-optimal rehabilitation for thousands of veterans, including many with comorbid medical and mental health conditions that require concurrent retreatment of their alcohol and/or substance use disorders.

With these views in mind, DAV recommends the Subcommittee advance legislation that assures a full continuum of substance use disorders care for veterans who need it, along with an annual update to Congress on VA's progress in providing such services.

We also urge authorization of a pilot program, specifically designed to offer web-based options for VA substance use counseling, treatment, and group support targeted at rural veterans.

And finally designated funding for research projects to identify best treatment strategies to collectively address substance use disorders and other comorbid mental health readjustment problems.

Congress and VA must ensure that Federal programs aimed at meeting the unique post-deployment needs of veterans are sufficiently funded and adapted to meet them, while continuing to address the chronic health maintenance needs of previous generations of disabled veterans.

Additionally, Congress should require VA to report on how it is spending the significant new funds that have been added and earmarked for the purpose of meeting post-deployment mental healthcare and physical rehabilitation needs of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans.

In closing, VA needs to have effective programs in place now aimed at prevention and early intervention, outreach and education, as well as training for veterans and their families to close the current gaps that exist.

We deeply appreciate the Subcommittee's interest in these issues. And we want to thank the Chairman and Ranking Member for jointly introducing the "Veterans Substance Use Disorders Prevention and Treatment Act of 2008," a measure that would accomplish many of the goals that we have mentioned today.

Mr. Chairman, that concludes my statement. Thank you.

[The prepared statement of Ms. Ilem appears on p. 50.]

Mr. MICHAUD. Thank you. Doctor.

STATEMENT OF THOMAS J. BERGER, PH.D.

Dr. BERGER. Vietnam Veterans of America thanks you for the opportunity to present our views on substance abuse and comorbid disorders.

As you are well aware, substance abuse and PTSD form one of the pillars for my organization. And after 30 years in existence, still represent a very important component of our legislative agenda.

Foremost VVA thanks you for your leadership in holding this hearing today on a most serious concern within the veterans' community, because each month hundreds of active-duty troops, Reservists and National Guard members return to their families and communities from deployment in Iraq and Afghanistan.

Given the demanding and traumatizing environments of their combat experiences, many veterans experience psychological stresses that are further complicated by substance use and related disorders. In fact, research studies, as we have already heard this morning, indicate that veterans in the general U.S. population are at increased risk of suicide.

I was greatly heartened to hear the Chairman refer to the National Survey on Drug Use and Health Reports. I am not going to spend any time going over those figures, since they have already been mentioned.

But we must remember that those data that the Chairman presented to us today, only those veterans who chose to seek help for their disorders from the VA are the ones that are mentioned.

VVA has no reason to believe that the numbers cited in that report would not be higher if more of our OEF and OIF veterans were to seek VA care.

I should also like to point out that yesterday an article appeared in the "Stars and Stripes," just briefly. It was the results of the Defense Department's health behavior survey, which indicated amongst young sailors, airmen, especially Marines and soldiers, 18.5 percent overall indicated on the questionnaire that they would be put in the category of heavy drinking. The Army's actual rate

was higher, 24.5 percent. So the numbers we heard mentioned by the Chairman earlier, I submit, may be actually higher.

The medical, social, and psychological toll from substance abuse disorders is enormous, both for the military and the civilian sectors. In the face of such overwhelming damage, two questions come to my mind: Why does substance abuse receive relatively little medical and public health attention and support compared with other medical conditions? And what can be done to reduce the harm from substance abuse disorders?

Despite their huge toll, substance abuse disorders remain underappreciated and underfunded. And reasons for this include, in my opinion, stigma, tolerance of personal choices, acceptance of youthful experimentation, pessimism about treatment efficacy, fragmented and weak leadership, powerful tobacco and alcohol industries, underinvestment in research, and difficult patients.

Now I am not going to spend a lot of time going over all of those, but despite those obstacles, VVA believes that a coordinated, workable agenda within both the military and civilian sectors is possible to lessen the impact of substance use disorders.

But this better approaches for treatment. For example, adequate treatment for substance abuse is particularly challenging for America's uninsured. Even for the insured, many policies, including most Medicaid programs, do not cover the time for counseling or the costs of drugs for substance use disorders. Again, as new, effective drugs come on the market, patients must have access to them.

We need to devote more support for research. Increase the percentage of the current National Institutes of Health (NIH) budget to substance abuse research. For example, beyond studying the basic science of addiction and exploring new pharmacologic treatments, research could help us better understand why some people who experiment with substances become addicted while others do not.

There needs to be better education of health professionals. Substance abuse receives minimal notice in undergraduate and graduate medical school curricula, especially board certifying exams, continuing medical school education, standard clinical textbooks, and medical journals.

There needs to be stronger leadership. Greater recognition of substance abuse and substance abuse disorders as a major health program or problem should encourage broader and more diverse leadership.

We also need to provide adequate treatment for community-based and incarcerated people with drug addiction, because it generates social and medical savings, lower crime, lower prison spending, less family dysfunction, and better health.

A RAND report of mandatory minimum sentences for cocaine concluded that dollar for dollar, treatment is fifteen times more effective than incarceration in reducing serious crime.

We also need to reform the criminal justice system for substance abuse. Federal and State legislation imposes mandatory terms for possession of illicit drugs, thereby removing sentencing discretion from the hands of judges. Drug courts are an effective antidote to this.

Substance abuse remains a serious medical, public health, and social problem in both our civilian and military sectors. Yet it lacks champions, is underfunded, and is relatively neglected by clinicians and the medical establishment.

Despite some real progress in the past decade, the United States still lags behind virtually every developed country in measures of health status. Our current national strategy to close that gap involves funding for biomedical research to yield new treatments and improving access to care for everyone, including America's veterans.

That concludes my testimony. Thank you very much.

[The prepared statement of Dr. Berger appears on p. 54.]

Mr. MICHAUD. Thank you, Doctor. Mr. Bowers?

STATEMENT OF TODD BOWERS

Mr. BOWERS. Mr. Chairman, Ranking Member, and distinguished Members of the Subcommittee, on behalf of the Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I thank you for the opportunity to testify this morning regarding veterans' substance abuse.

I would like to make it very clear also that I am here testifying in my civilian capacity as the Director of Government Affairs and my opinions and views today in no way reflect the Marine Corps, which I currently serve as a sergeant in the Reserves.

I would like thank the Committee for recognizing the issue of comorbidity. As the Committee knows, among the hundreds of thousands of troops returning from Iraq and Afghanistan with a mental health injury, a small but significant percentage is turning to alcohol and drugs in an effort to self-medicate. Veterans' substance abuse problems, therefore, cannot and should not be viewed distinct from mental health problems.

According to the VA Special Committee on post traumatic stress disorder, at least 30 to 40 percent of Iraq veterans, or about half a million people, will face a serious psychological injury, including depression, anxiety, or PTSD. Data from the military's own Mental Health Advisory Team shows that multiple tours and inadequate time at home between deployments increase rates of combat stress by approximately 50 percent.

We are already seeing the impact of these untreated mental health problems. Between 2005 and 2006, the Army saw an almost threefold increase in "alcohol-related incidents," according to the DoD Task Force on Mental Health.

The VA has reported diagnosing more than 48,000 Iraq and Afghanistan veterans with a drug abuse problem. That is 16 percent of all Iraq and Afghanistan veteran patients at the VA. These numbers are only the tip of the iceberg. Many veterans do not turn to the VA for help coping with substance abuse, instead relying on private programs or avoiding treatment altogether.

Effective diagnosis and treatment of substance abuse is a key component of IAVA's 2008 legislative agenda. First and foremost, IAVA supports mandatory and confidential mental health screening by a mental health professional for all troops, both before and at least 90 days after a combat tour. Moreover, the VA must be authorized to bolster their mental health workforce in hospitals, clin-

ics, and Vet Centers with adequate psychiatrists, psychologists and social workers to meet the demands of returning Iraq and Afghanistan veterans.

At this point, I am going to separate from my written testimony and try and share with the Committee an experience I had a week before last at my Marine Corps Reserve Center. We all have heard about the post-deployment health reassessment (PDHRA) survey. This is a form that individuals are required to fill out when they return. We filled this out the weekend before last. And I wanted to highlight a few of the questions that are actually on here.

On section 10, question A and B, we have, "In the past month, did you use alcohol more than you meant to? Yes or no. In the past month, have you felt that you wanted to or needed to cut down on your drinking? Yes or no." And at the bottom there is still an element of self diagnosis for whether you would like follow-up treatment, which is, "Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern?"

Now I have to say that filling this form out was incredibly useful for our Reserve Center. It allowed people to fill this out confidentially and then sit down with a counselor that would review the PDHRA and recommend whether individuals needed to go see a mental health professional or a follow-up appointment.

The important aspect of this was that we were allowed a confidential referral notice. When we filled out the paperwork, if we did want a follow-up appointment, it was kept completely confidential. From that point, we moved over and the Veterans Administration was at our Reserve Center to enroll every single person who had just completed the PDHRA or who had deployed for over a 90-day period with the Veterans Administration. They provided us a tremendous amount of pamphlets. I have four here approximately, each stating that they have resources available for substance abuse problems.

At that point we then contact—we were connected with our local Vet Center. We spoke with individuals from Maryland, Washington, DC, and Virginia, because we are stationed here in Washington. And they put us in touch with the right sources.

To sum it up, it was perfect. It is exactly what needs to be done for a seamless transition for individuals in the National Guard, Reserves, and also active duty to transition to the VA.

The problem was, it was one corpsman at my unit who organized this. It is not mandated across the board for individuals to have the same sort of screening process and information sessions on what resources are available and, more importantly, communication for these individuals. It was just our unit being proactive.

So I would like, if anything is taken away from my testimony today, that we see that there needs to be that communication of resources directly with the National Guard units and Reserve units for Iraq and Afghanistan veterans to know what resources are made available.

I have been home from my last deployment to Iraq for almost 3 years now. And we are just now getting it right. They are just now doing it. But it is not across the board. If we do the same type of screening that we have done for my unit, for every Reserve Center, again, we can keep people from falling through the cracks.

And I welcome any questions at this point. Thank you.

[The prepared statement of Mr. Bowers appears on p. 58.]

Mr. MICHAUD. Thank you very much, Mr. Bowers. That was very enlightening. And I really appreciate it, because actually that is where a lot of my questions were going.

As with any behavioral conditions, early interventions for substance abuse disorders, effective screening is extremely important.

I guess I would ask the other two how—you heard Mr. Bowers mention what he thought was very helpful. How would you assess the VA's substance abuse screening protocol, and what suggestions would you have about the VA and the DoD? How can they work together to provide outreach for returning veterans for OEF and OIF or veterans in general?

Dr. BERGER. Mr. Chairman, I will just jump in right here. I think what Mr. Bowers said is very, very appropriate. But as he said, it took him 3 years to get to this point. So what can we do to make sure that it permeates the system for our returning vets?

Mr. MICHAUD. Is there anything that Mr. Bowers did not say or any additional ways that the VA or DoD might be able to further this along?

Dr. BERGER. I would just like to note that I was a Navy corpsman. And I have served as a Navy corpsman with the Marines in Vietnam.

Mr. MICHAUD. Great. Ms. Ilem, do you have any——

Ms. ILEM. I think you mentioned at the opening of the hearing about VA indicating that they are—they have sent out memorandum or whatever making sure that substance abuse services are available throughout—comprehensive services throughout the system. And I think, you know, that will take oversight on their behalf to make sure then, really at the local levels, that that is happening.

I know that the Vet Centers have testified before that they have been actively going out. And certainly their reports reflect that in terms of providing support for these returning troops in the Guard and Reserve.

It would be interesting to, you know, continue to see the number of folks that they are really assisting. And if they are, you know, taking it—doing this type of a program. And making sure that that is consistently available in their Vet Centers throughout the country.

Mr. MICHAUD. Great.

Dr. BERGER. Mr. Chairman, if I might add one thing. I participate in the Transitional Assistance Program in the State of Missouri.

The brochures and handouts that Mr. Bowers mentioned, that would be appropriate to hand out at these kinds of meetings. And I know that our returning troops get exposed to a lot of paperwork and a lot of information at these transition assistance program meetings.

But the fact of the matter is, that the materials on substance abuse and PTSD need to be bumped up toward the top of the list, because that is what is affecting these folks.

Mr. MICHAUD. Mr. Bowers, do you have anything else you want to add to that?

Mr. BOWERS. Just real quickly if I could, Mr. Chairman. One of the things that we have highlighted is that the Vet Centers, though they are an outstanding resource, are extremely understaffed right now. And that is something that when I spoke to individuals at the Vet Centers, they said we are just—we are getting beat up right now. And they do need some help in staffing shortages.

Mr. MICHAUD. Thank you. Doctor, you had mentioned research at NIH, and research is very important. Are there any specific areas of research or research questions relating to substance abuse or comorbid disorders that you think the VA should focus on?

Dr. BERGER. As I hinted at, Mr. Chairman, research questions that focus on helping us understand why people who—some people who experiment with substance become addicted, while others do not.

The area of resiliency—the comparative efficacy, excuse me, of different modes of treatment, because you know there is some conflict in certain circles amongst pharmacological versus psychological treatment or the 12-step program treatments.

The complexities of dual diagnosis, that is the co-occurring mental illnesses and substance abuse, the social context of addiction, as you yourself know from the information you gave us this morning, that individuals who are in lower income areas, that is less than $20,000 on that national drug survey, seemed to be—are at higher risk for substance use disorders. And, obviously, the impact of our various social policies on addiction and the harm it causes.

Those are all questions that could be turned into significant research components in my estimation.

Mr. MICHAUD. Thank you. My last question is it is my understanding from talking to a veteran last week, a member of the Veterans of Foreign Wars (VFW) of the United States, the Deputy Secretary of the VA and the Surgeon General were talking to the VFW and mentioned PTSD–NR. It was the first time I ever heard it, the new classification of PTSD–NR. I assume the NR is probably normal reaction. I am not sure.

Have any of you heard of that new classification?

Have any of your members brought it forward? And I'll ask this of the VA when they come up, what the NR is for.

Dr. BERGER. I will just add, I have not heard about that specifically. But one takeaway I did gather from my Marines this weekend was that they said, if there are no problems with it, why is it still referred to as a disorder. Everybody kept pushing whether it was Army's Battle Mind training or things along those lines saying that, there is nothing wrong with it, but it is still a disorder and until that name change comes, until that national stigma is reduced about mental health issues, which whether it be a combat mental injury, whatever name people decide to give it, we are going to have a really hard time getting folks to step up and get the treatment that they need.

Dr. MCCORMICK. I have not heard of any either, sir.

Mr. MICHAUD. Okay. Thank you. Ms. Berkley?

Ms. BERKLEY. Thank you Mr. Chairman. Thank you all very much for outstanding presentations. Actually all of our presenters have been quite informative.

Just an observation, I guess, and then a question at the end.

I spend a considerable amount of time with my veterans in the Las Vegas Valley in Southern Nevada, and of course we have got the fastest growing veterans population in United States there.

On the 4th of July in addition to other times that I interact with my homeless vets, on 4th of July, I go to the United States Vets Home for the homeless and get on the buffet line and serve our veterans, and it occurs to me, when I am standing there serving, that they are mostly Vietnam Vets, which is my age group and my war, for lack of a better word. I was very comfortably serving at the University of Nevada when these men, mostly, were in Vietnam.

It always strikes me when I sit down and talk with my Vietnam Vets who are homeless, and have some major issues. What I am struck with, is we have normal conversations all the time and they are quite intelligent and if not for the grace of God, go I, but I'm wondering if we have any statistics that you can share with us on the comorbid substance use disorders for Vietnam Vets. Is it particularly prevalent? Is it just that we ignored it at the time? What information can you give me? And I know that with each war we have our own set of issues with our veterans, many similar, but many unique to that particular war. But I know my Vietnam Vets had a very, very tough way to go when they came home. And here we are many years later and they are, you know, still suffering from the experience.

Dr. BERGER. That is a very good question, ma'am. Amongst my generation with everything that was going on at the time. World War II and Korea Vets came home and drank a few beers. It was a good time. We won.

Ms. BERKLEY. Yeah.

Dr. BERGER. Vietnam, there were lots of things going on within our culture, and our drug of choice was marijuana for the most part. And while we are not proud of that, that is what happened.

We were also disenfranchised. And I think particularly when we're talking about my cohort of veterans, all these things came together, unfortunately, and that is why you will occasionally run into vets, as you said, at these festivals or celebrations from Vietnam.

Ms. BERKLEY. Do we have any statistics regarding substance abuse for our Vietnam Vets?

Dr. BERGER. I will have to ask my colleagues from the VA.

Ms. BERKLEY. Okay, just curious about that. And let me ask you, I asked the question to Ms. Greer in the earlier panel, do you feel in the least bit uncomfortable with having civilians that have specialties in addiction services counsel?

Dr. BERGER. I have no problem with it on one hand however; as I mentioned a couple of weeks ago while testifying on mental health related issues, I think it is important when you are talking about the use of nonmilitary trained people, that there is an element of trust.

Ms. BERKLEY. Yes.

Dr. BERGER. Okay. That has to be overcome and I don't care whether we are talking about mental health professionals or substance abuse professionals. Trust is very important when it comes to dealing with our Nation's military when it comes to these particular disorders we are talking about.

So with caveat in mind, no, I do not have a problem with it.

Ms. BERKLEY. Okay. Anybody else care to comment?

I am just concerned about the lack of resources in the VA and personnel that can treat the numbers of people coming back with substance abuse disorders and PTSD. And I know, look my dad is a World War II Vet, he would not go anyplace else for his healthcare than the VA. I mean, there is a camaraderie, there is a comfort level.

And I know that there are thousands of my World War II Vets in Vegas that they could easily go to another place for their healthcare, they want to go to the VA. They like going there. They like seeing their friends. They like the comfort level there, and I don't think that should be denied. But there ought to be some way that we can get civilians that may have served that can relate to our returning veterans that have PTSD and substance abuse problems that aren't necessarily working for the VA.

Dr. BERGER. I think there are ways particularly to take advantage, as was mentioned a couple of weeks ago before this very Committee, to take advantage of peer counseling programs when it comes to substance abuse. I know if that would have been available for Vietnam Veterans there would be a lot fewer Vietnam Veterans with substance abuse issues today.

Ms. BERKLEY. Thank you, very much.

Mr. MICHAUD. Just one last question, doctor. You had mentioned incarceration as I said earlier. If you don't take care of the problem up front, we have a long cost, at the other end.

Dr. BERGER. That's correct.

Mr. MICHAUD. Have there ever been any studies done about veterans who might have been incarcerated for alcoholism or drug abuse, because that actually shifts the burdens on to the State and the county jails and what have you. Do you know if there have ever been any studies done on that?

Dr. BERGER. There have been a couple of studies that many of the folks behind the walls do have substance abuse problems. I wish I could just find it here in all the information I brought along today. I am one of those who tend to bring more ammunition than I actually need.

Mr. MICHAUD. Well, if you could just provide it to the Subcommittee.

Dr. BERGER. Well it is in my testimony, sir, where I hint at it. But it is a problem within the penal system, substance abuse disorders.

Mr. MICHAUD. Because I do know that also, that is not the only cost of keeping someone incarcerated, but also if the county has to take up the cost of providing the healthcare, versus the VA, that's an added cost at the State level that really concerns me.

So I would like to, if there has not been an up-to-date study on that, I would be very interested in making sure we get one because that is a shift that should not occur.

Dr. BERGER. Okay. One thing, if I may mention, sir. Vietnam Veterans of America is very proud of the fact that we have chapters inside the walls at many of our institutions and no other veterans service organization can make that claim.

Mr. MICHAUD. Thank you. Once again I want to thank this panel for your testimony this morning and look forward to working with you as we move forward with this piece of legislation. I thank each of you very much.

Our last panel is Dr. Antonette Zeiss, who is the Deputy Chief Consultant for the Office of Mental Health Services within the VHA, accompanied by Charles Flora, the Associate Director of Readjustment Counseling Service, and Dr. John Paul Allen, the Associate Chief Consultant for Addictive Disorders.

I would like to welcome the doctor, and the other two that are accompanying you today and look forward to hearing your testimony as well.

STATEMENT OF ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CHARLES M. FLORA, ASSOCIATE DIRECTOR, READJUSTMENT COUNSELING SERVICE, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND JOHN PAUL ALLEN, PH.D., ASSOCIATE CHIEF CONSULTANT FOR ADDICTIVE DISORDERS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. ZEISS. Thank you very much for having us here at this very, very important hearing. Like the other panelists we share the sense that this is really tremendously important, and we're very glad to be able to talk about what the VA is doing and to answer your questions.

I am pleased to be here today to discuss those ongoing steps that the VA is taking to treat substance use disorder and comorbid disorders.

I am accompanied by Mr. Charles Flora who is the Associate Director of Readjustment Counseling Service. He is a clinical social worker and Vietnam veteran, and has a lifetime of experience in readjustment counseling at both the Vet Center and national levels.

I am also accompanied by my colleague and my new friend, Dr. John Allen, Associate Chief Consultant for Addictive Disorders in the Office of Mental Health Services.

Dr. Allen is a national expert on substance use disorders and he is a veteran of Operation Iraqi Freedom.

The VA has always taken the problem of substance use disorder very seriously and has demonstrated our commitment to helping our veterans overcome this disease and we welcome Dr. Allen's personal connection to our returning veterans as well as his expertise in this area.

We thank the Committee and you, Chairman Michaud, for your active interest in this topic. Tragically, substance use disorders are common in our society, as you have been hearing daily and are definitely common as they are in many societies. And the incidence of substance use among veterans tends to exceed that of comparable civilian populations. For example one study by Todd Wagner, in 2007, found that veterans are more likely than non-veterans to report driving under the influence of alcohol, smoking daily, and

using marijuana. In another study, Dr. Charles Hoge published in the New England Journal of Medicine in 2004 showing that the number of respondents who admitted to using alcohol more than they intended, increased 7 percent among Army respondents after deployment to Iraq or Afghanistan.

Alcohol and drug misuse are associated with a host of medical, social, mental health, and employment problems. Fortunately, those problems are treatable, and with treatment, the lives of our patients and their loved ones can be enriched.

Since the implementation of the Mental Health Strategic Plan in VA, which began to be rolled out in 2005, the VHA has dedicated more than $458 million to improve the access and quality of care for veterans who present with substance use disorder treatment needs.

We have funded 510 new substance use counselors; that's what my written testimony says, I checked this morning and it is actually about 520, and we plan to continue expanding substance use disorder services throughout fiscal year and next fiscal year.

For example, this year, our mental health enhancement budget includes over $37.5 million for expanded substance use disorder services.

Whenever a veteran is seen by a VA provider for the first time and then at annual retesting afterward, he or she is screened for PTSD, military sexual trauma, depression, and problem drinking. We recognize screening is only valuable if we act upon positive screens and follow-up in a timely manner, and we are committed to doing that.

For those needing additional services when screening and evaluation has occurred our outpatient and inpatient substance use disorder programs are available; there are more than 220 programs in place, with more in development.

We maintain extended care facilities, including 19 inpatient programs designed specifically to treat substance use disorder for 14 to 28 days. There are 44 residential rehabilitation treatment facilities that focus on substance use, 15 compensated work therapy programs with substance use particular emphasis, and 19 domiciliaries that focus on substance use disorder.

Mental healthcare, including attention to substance use disorder, is being integrated into primary care clinics, and we also are integrating mental health services into our community-based outpatient clinics, nursing homes, and our home-based primary care teams.

Placing mental health providers in the context of primary care for the veteran is essential; it recognizes the interrelationships of mental and physical health, as well as providing mental healthcare at the most convenient and desirable location for the veteran.

In addition to the care offered in medical facilities and community-based outpatient clinics, VA's Vet Centers provide outreach and readjustment counseling services to returning war veterans of all eras.

It is well-established that rehabilitation for war-related PTSD, substance use disorder, and other military-related readjustment problems, along with the treatment of the physical wounds of war,

is central to VA's continuum of healthcare programs specific to the needs of war veterans.

The Vet Centers provide an alternative to traditional mental healthcare that helps many combat veterans overcome stigma and the fear related to accessing professional assistance for military-related problems.

Substance use disorder is a real problem, and its manifestation along with other mental health conditions can lead to physical health concerns, difficulty readjusting to civilian life, and a host of other problems.

One of VA's highest priorities is to reduce the impact of substance abuse and provide veterans with the care they need.

Thank you for your time and for the opportunity to discuss this important issue with you. I would like to turn to addressing any questions that you have.

[The prepared statement of Dr. Zeiss appears on p. 59.]

Mr. MICHAUD. Thank you very much doctor. You had mentioned that you established 520 new substance use counselors. It is also my understanding that you downsized a number of years ago, so is this just getting you back to where you should be? But I guess the more important question is, I don't necessarily look at the increases or decreases, what I look at when I look at programs is, are you taking care of the problem?

So how many of those 520 are actually onboard and are they taking care of the problem that we currently see out there today and do you have enough?

Dr. ZEISS. Wonderful question and a very complex question.

First of all let me say, it is absolutely true, there was a period in the history of VA's healthcare when there was a decline in availability of mental health and substance abuse treatment services. And the development of the Mental Health Strategic Plan in 2004 and its implementation beginning in 2005, have just been essential and enormously important. And it has been paired with provision of strong resources, financial and support resources within VA, as well as the financial support we receive from Congress.

So there has been a huge turnaround in the last couple of years, and we know that the mental health staff overall now is well above the levels at the historical high earlier which was around 1996 and 1997.

We are above the earlier staffing for some components of substance use care, but because we also shifted from a primarily inpatient model of care to residential rehabilitation and intensive outpatient, the overall number of staff in substance use disorders would not be higher because there is not that round the clock nursing staff that would have been counted earlier. But in terms of our staffing to be able to cover the problem, I think that we are definitely well along the way, and we intend to continue to expand staff and to expand those services.

You probably know that overall in VA in addition to the substance use positions that I have described, we have, in the last 2 years hired over 3,800 new mental health professionals and support staff. Almost entirely professional staff, but some support staff.

So its really a very different VA than it was in 2004. And maybe with that I can let you say a bit, Dr. Allen, about some of the changes.

Mr. MICHAUD. Are all 520 hired?

Dr. ZEISS. Over 90 percent are.

Mr. MICHAUD. Over 90 percent.

Dr. ZEISS. There's about 50 still in the works.

Mr. MICHAUD. Okay.

Dr. ZEISS. They are in the pipeline. They are coming along to be hired.

Mr. MICHAUD. If Dr. Allen could address this also, we heard Mr. Bowers earlier mention about the Vet Centers, are they all fully staffed and running as well?

Dr. ZEISS. We will turn to Mr. Flora then first.

Mr. FLORA. Well I am happy to tell you that, and I'm sure that you know that we're adding 23 new Vet Centers and adding clinical staff at 61 existing Vet Centers.

And I am happy to report that 20 of those Vet Centers are staffed and seeing clients. Some of them are still in temporary space. They are waiting for the contracting for the lease, for the property to get resolved, and only three of them are left to bring up. They will all be up before the end of this year. And staff are rapidly being hired in those remaining three and they're working diligently on the leasing process.

So we should be up and running with all 23 new Vet Centers before the end of this fiscal year.

Mr. MICHAUD. And what about the existing Vet Centers, are they fully staffed?

Mr. FLORA. Eighty percent done.

Mr. MICHAUD. And what's that twenty percent as far as numbers? And when will they be fully staffed?

Mr. FLORA. Very soon. At the end of this fiscal year.

Mr. MICHAUD. Okay. Thank you. And Dr. Allen?

Dr. ALLEN. I am still relatively new at VA. I suppose coming into this system there are several things that I am impressed with that we are doing a very good job on. One of them is the screening for alcohol problems.

I know of no system in the United States that does the amount of screening for alcohol problems as the Veterans Administration does. Right now we are screening close to 100 percent of individuals who access our system. At the time they access the system and annually thereafter.

As has been brought up by previous panels the importance of doing brief intervention is to try to address alcohol problems in their earlier stages when they are, in fact, more malleable. This is coming along extremely well. Right now we have 98, what we refer to as "primary care mental health service" providers. In many cases, more than one provider is at a facility. But in this arrangement the mental health provider is coordinated directly with the primary healthcare staff. And so the brief intervention is done onsite and if the veteran does not respond to the brief intervention we certainly hope they will and the data are quite favorable then they are referred to specialty care. So I think that's quite good.

Another area that has been developing quite well has been the use of buprenorphine. There was a comment made about that there was not adequate use of methadone. It is true, our numbers for methadone maintenance have remained pretty constant since about 2004. But the number of patients who are now on Buprenorphine has increased by a factor of 4. Buprenorphine can be given in a primary healthcare center. And part of the advantage of that, is to diminish some of the stigma of going to a specific methadone maintenance program.

Another area that I think we are doing extremely well in is in the "clinical practice guideline" arena. The Department of Defense and the Veterans Administration together do clinical practice guidelines, based upon to the extent possible, the best research evidence. And when it is not, when we simply do not have the evidence, then it is based on informed clinical opinion. The new substance use disorder guidelines for DoD and VA are nearly complete. We expect them to be complete within the next 6 years. I'm sorry, the next 6 months.

I have reviewed the draft and it is quite good and I think addresses a number of the concerns about quality. This topic of addiction is actually quite heavily researched. There are now probably close to 300 controlled clinical trials on what works in treatment, and it is because of that the VA is committed to propagating and developing training programs on evidence-based treatments for addressing substance use disorders.

The other topic I would like to address, which has been raised by a number of the other witnesses, has to do with the nexus between PTSD and substance use disorder. These problems do often co-occur. And in fact some of research suggests that when you have an individual, a returning servicemember, who suffers both problems the treatment prognosis is worse for both problems than if you had substance use with another psychiatric problem or if you had "pure" substance use disorder.

So we are trying to address these together. Right now we have in all of our medical treatment facilities a team of providers who are dedicated to PTSD. On 12 of those teams we have a substance use disorder specialist and we have plans of adding this kind of resource to all of the other teams. The important thing, I think, with the treatment of substance use and collateral psychiatric problems is the care needs to be coordinated. Either done in an integrated fashion or else at least coordinated in a sequenced way where you would have a case manager who would assure that both kinds of care are being given. But, in short, my initial impressions of this system have been quite favorable.

Mr. MICHAUD. Well I have several more questions, but I will recognize Ms. Berkley.

Ms. BERKLEY. Thank you, Mr. Chairman.

I work very closely with my VA back home and I know what a challenging job you have, and I thank you for all of your efforts on behalf of our vets. And I know sometimes our veterans have unrealistic expectations of what can be provided, and we've tried to have very frank discussions with veterans that call my office making requests that we can't possible fulfill.

There was a time a few years ago and the head of the VA sat here presenting his budget, which was several billion dollars less than The Independent Budget that the veterans organizations provided to Congress, and we kept questioning the VA secretary of how could he possibly do what needs to be done with the budget he is presenting. And he assured us that the budget was fine. We practically threw an extra billion dollars at him, which he respectfully refused and I think it was going to be through attrition or technology that we would save all these billion of dollars and have plenty of money to take care of our vets. Six months later he was sitting where he was 6 months before asking us for that billion that we had asked him if he needed 6 months earlier that he assured us he did not need. Well, he needed it. And I've sat in hearings with the head of the U.S. Department of Agriculture that assured us that there were no additional funds necessary for inspectors, and then the following week we saw those horrific pictures on television of the down cattle and we are told that they did not have enough inspectors, which one shakes their head and says what. They have a perfect opportunity to be sitting in front of Congress and tell us what the needs are and they chose not to. With billions of dollars of toys that are coming into this country and toothpaste and other products from China, when the head of the consumer products safety commission tells us that she does not need additional inspectors, you have got to think that this woman ought to be fired, or is smoking one of the substances that we are talking about today.

So my question to you is, if we were living in a perfect world, and there were unlimited resources and you can come before a Congressional Subcommittee and tell us what you need from us so that you can do the job that we have tasked you with, what would you tell us you needed?

Dr. ZEISS. Well I would respond first by pointing out that the percentage increase in VA population that we are serving, has been about, I can submit the specific numbers later, has been about 3 percent and the budget increase over the last 3 years has been about 15 percent.

So the budget increases have been running well ahead of the increased work load, and personally as I said earlier, I think that we have appropriately devoted a large amount of that to correcting decline in mental health and substance abuse services that had previously developed. And I will actually point out Dr. Dick McCormick, who was on an earlier panel, when he was with VA was very instrumental in helping to focus and start things on a path that I'm thrilled to be a part of implementing.

At this point I think that what we are actually planning to come forward with is that, the resources that we have been getting have been primarily medical care dollars and we have been using them intensively for very effective hiring and expansion of our mental health workforce, but we have lagged in terms of getting from Congress medical facility dollars.

All those 3,800 new staff need offices. They need places to see veterans. They need renovations, sometimes, in space. So there are a number of needs in terms of medical facility dollars, and we are

actually planning to submit a white paper in relation to some upcoming thoughts about budget.

So I would say for me, that is the really the main thing that would be tremendously helpful to us as we have grown so enormously.

Ms. BERKLEY. Let me ask you another question, and I do not know if anybody can answer this, but I am sure you were in the room when I shared the story of Justin Bailey.

Dr. ZEISS. Yes.

Ms. BERKLEY. How does something like that happen, and what can we do in the future to prevent it? I mean, I have introduced this legislation. Is this the end-all-be-all cure for something like this. I had gotten to know his family very well. His father is a schoolteacher in our school district. This is a solid family and I could feel it. I have two sons and I could just imagine the pain that they feel on daily basis. What went wrong and what can we do to prevent it from happening again, so other families do not experience this horrific loss?

Dr. ZEISS. Thank you for raising it. I wanted to raise it proactively if you had not, because it was clearly a terrible event. I personally went out to the LA Veterans Affairs Hospital along with a team, particularly the leadership of the residential rehabilitation staff. We did a very careful analysis of the what had gone wrong and you are quite correct. There were some issues around medication—not mental health medication, it was pain medication, but it could and should have been handled differently.

We left a number of recommendations that were essentially requirements with that VA, and we also came back and generated resources to get out to them so they could implement those recommendations. And the handbook for the residential rehabilitation treatment programs was rewritten, particularly with even stronger emphasis on a staged model of self-medication, which had already been there, but needed real strengthening. That handbook is going to final concurrence within VA, but in the meantime, even before final concurrence, the staff that guide residential rehabilitation have been implementing this. There has just been, 2 weeks ago, a conference for the leadership of the residential rehabilitation treatment programs and will continue to be similar things.

And I personally went out about 3 weeks ago to Los Angeles again, to follow up and make sure that things were being changed that needed to be changed.

I think the other huge issue there was that, that was a domiciliary-type of residential rehabilitation program, and as part of the mental health strategic plan, the domiciliary switched from, Geriatrics and Extended Care to Mental Health. Even before a Department of Veterans Affairs had existed, there had been a Domiciliary Program. It had been under geriatrics and extended care within Veterans Health Administration and one of the recommendations of the strategic plan was to transfer that to the Office of Mental Health Services. That did happen in 2005.

There had been some sites that have had more difficulty shifting their model of care to one of recognizing that these are really mental health programs. By the way, one of the reasons for that shift is that we had data showing that over 90 percent of the residents

of the domiciliaries had a mental health or substance use disorder diagnosis. So clearly there needed to be a different model of care.

So I assure you we have been reorganizing the reporting mechanisms, the funding mechanisms, the guidance and oversight at those residential rehabilitation facilities because we agree with you that it is just not acceptable for something to happen like what happened to Justin Bailey.

Ms. BERKLEY. Mr. Chairman, before Mr. Hare left he said I could have his five minutes. Could I take two of his five?

Mr. MICHAUD. No problem because I have more questions as well. So feel free. You can take all of his five.

Ms. BERKLEY. I am sure he said that as he walked out.

Mr. MICHAUD. You can take all of his five you would like.

Ms. BERKLEY. I do not think I need to, it depends on their answers.

Let me share with you another gut-wrenching story. When anybody dies from the State of Nevada whether they live in my Congressional district or not, if they lose their life in service to our country I call the families, and offer any help that I could provide and just talk to them, and just sometimes they just—actually most of the people need hotel rooms in Las Vegas because they have got family coming for the memorial service, and we try to help and the hotels have been very accommodating.

One phone call I made was to a grandmother in Pahrump, Nevada, which is a bedroom community about fifty minutes from Las Vegas. She had raised her grandson, so she was the appropriate person to call when he killed himself in Iraq.

This was the story that she shared with me, although I knew it before I called her.

Her grandson had served a tour of duty in Iraq, came home and 3 months later he was advised that he would be shipped back. He was having serious emotional problems, did not want to go back. Begged his grandmother to do something to keep him from going back. He was interviewed by a psychologist or psychiatrist with the DoD who diagnosed him as being depressed and gave him Prozac and sent him back to Iraq.

He was on suicide watch in Iraq. They knew that he had an emotional problem and he was suicidal. After a certain amount of time they took him off of suicide watch and the following day he killed himself.

Now, had he not killed himself, and had completed his tour and come home, he would have been an emotional basket case that needed intervention and help.

I know that our military is very stretched right now. Do you think that we are accepting into our volunteer military and keeping people that should not be there because of emotional problems, just so we have bodies on the ground in Iraq and Afghanistan? And do you see an uptick in those type of cases of people that should never be serving in the first place, so if they can get through their tour and they come home as veterans, they become, and I don't mean to—when I say burden I don't mean this is a negative sense, but I would imagine we have a number of people currently with PTSD and other emotional issues and substance abuse issues, that never should have been in the military in the first place. Are you

seeing any of that? I'm not asking to step out of your role and speak policy, could have, would have, should have, but I am kind of wondering, are you seeing an uptick in this? Are there people that are now coming into the VA as veterans that never should have been in the active military in the first place?

Dr. ZEISS. Well I am going to say I am not going to speak to whether or not they should have been in the military in the first place. Those are decisions for a different department and our job is to take care of people when they return.

I am happy to talk about what we are seeing among veterans who are returning, and what we have put in place and will continue to enhance.

We certainly see a high number of returning folks who do have mental health problems. At this point there are 300,000 returning Iraq/Afghanistan veterans who have sought care from VA, and of those—no that is overall—and of those 40 percent have been potentially diagnosed with a mental health concern. Some of those are rule out diagnosis and will not be final diagnosis, but at least they need careful evaluation because of possible mental health problems.

So that is about 120,000 folks, and of those about half have a possible PTSD diagnoses. The second largest is depression. The third largest is if you put all the substance use disorders together they would make up the third largest category of diagnosis.

So there is no question that VA is seeing a high rate of mental health concerns in those veterans who seek care from VA. We can only speak to those who come and to service us. But we follow those data very carefully. We get quarterly reports on the increased number of veterans that we are seeing Iraq and Afghanistan and what are the major diagnosis that they are coming back with. Not just mental health but overall because it is important to integrate the mental healthcare with the other kinds of physical healthcare that these veterans have.

So I assure you we are very carefully attending to what is the information about the breadth of problems that people return with, and what does that mean we need to be ready to do.

Mr. MICHAUD. Earlier in my opening statement, I talked about reports out there that suggest that up to 70 percent of homeless veterans have a substance use disorder. What specifically is the VA doing to address this disorder among our homeless veterans?

Dr. ZEISS. Well we are doing a number of things. Again I can speak first, and then I will let my colleagues also address this.

We do not have with us Paul Smits, who is the head of our homeless section in the Officer of Mental Health Services. A splendid person who has, I know, testified many times.

We have a large expanding homeless outreach and homeless service program that includes many dimensions of care. It includes the residential rehabilitation programs, domiciliaries, grant and per diem programs. We have a new U.S. Department of Housing and Urban Development—Veterans Affairs Supportive Housing Program that has been funded by Congress that we are in the process of implementing. And they do extensive outreach, along with the outreach that we can let Mr. Flora speak about that the Vets Centers do so splendidly.

We have many programs that are specifically designed to work very particularly with substance use disorder in homeless populations.

I would say—I am sorry Ms. Berkley has left—one of the things that is a strength of the LA VA where Justin Bailey's unfortunate death occurred, is that they take in homeless substance-using veterans who are extremely high risk and where that community has documented several times in newspapers stories other parts of the private healthcare system dumping people back on skid row. The VA has never done that, will never do that, and keeps people who are at very high risk in our treatment programs.

Mr. MICHAUD. You mentioned the grant and per diem problem. I know from talking to the folks that deal with that program, there is also a problem with grants and per diem depending on what region of the country that you live in, as far as their reimbursement rate. Are you working with these organizations as well to make sure that they are adequately reimbursed?

Dr. ZEISS. I know that Paul Smits is working very much on that and I'm not the expert on that, but, yes, it is certainly something that is followed carefully.

The other important thing about the grant and per diem program, I just want to stress that may not come up in those discussions about the reimbursement, is that we fund from our mental health enhancement budget the liaisons that go out to those grant and per diem programs, which are not VA programs per se, to make sure that those homeless veterans get linked into our VA substance use disorder and mental health programs and who function as case managers.

So it is above and beyond just providing the place to live that is reimbursed through the grant and per diem funding that you were mentioning. It is a much more complex program than that.

Mr. MICHAUD. You heard Mr. Bowers talk about this this morning, and you mentioned it several times that you are addressing the needs of those who actually come forward for assistance, however there are a lot out there that do not, and Mr. Bowers said, I think, it took him like 3 years before he actually had the information that he really thought was helpful for a veteran to be able to get the services that they need. And he actually recommended that it be mandatory that they go through that type of coming back home with different programs.

Do you agree with that, that they should be mandatory? I guess it gets back to my earlier statement that I am very pleased that Dr. Kussman actually issued a directive that VA facilities to ensure that no veteran is denied PTSD treatment because of substance use disorder. So it leads me to ask, why did Dr. Kussman give that directive? Is it because they were being denied? And so if you could address that, and whether or not we should mandate that they receive the training that Mr. Bowers had mentioned a little bit earlier.

Dr. ZEISS. Yeah. Well two wonderful questions. The first one, which is about the PDHRA screens, I am happy to ask Mr. Flora to respond to, because the Vet Centers are always there.

Mr. FLORA. The Vet Centers and a representative from the VA Medical Center has been at every PDHRA event that has occurred

over the last couple of years. This is facilitated with the Department of Defense. We have Colonel Terry Washam, who is a VA employee, who is the main point of contact in the seamless transition group that sets these up. But we have been at every one of them. And also since 2003, 2004, the Vet Centers have undertaken a very aggressive outreach program. And I am sure you know we hired the 100th Global War on Terrorism Outreach Specialists and they have been extremely active at demobilization sites providing the kind of information that was talked about. And I was very gratified to hear Mr. Bowers say that he had an excellent relationship with the Vet Centers. I think he said locally, but he got exactly the kind of information that he needed.

And if you would not mind, sir, I'd like to go back to the first question that you asked me, and say, we would be happy to provide you a detailed report about where we are with our new Vet Center resources.

I'm absolutely sure about the new Vet Centers numbers, but we can tell you, where we are augmenting staff and give you a very detailed picture.

[The following was subsequently received:]

In February 2007, VA announced plans to increase the number of Vet Centers from 209 to 232 and to augment the staff at 61 existing Vet Centers by one staff position each. Based upon the criteria of having hired staff and providing services to veteran clients, 20 of the projected 23 new Vet Centers are currently open. All 23 Vet Centers will be open by the end of the fiscal year. Fifteen Vet Centers are fully open with a signed lease and hired staff, and are providing services to veterans in Binghamton, NY; Middletown, NY; Watertown, NY; Hyannis, CT; DuBois, PA; Gainesville, FL; Melbourne, FL; Macon, GA; Manhattan, KS; Escanaba, MI; Saginaw, MI; Grand Junction, CO; Baton Rouge, LA; Killeen, TX; and Las Cruces, NM.

Five Vet Centers have hired staff and are providing client services, but are operating out of temporary space while they finalize their lease contracts. They are located in Toledo, OH; Ft. Myers, FL; Montgomery, AL; Everett, WA; and Modesto, CA.

Three Vet Centers are actively pursuing and/or completing staff recruitment and lease contracting. In Berlin, New Hampshire, the lease has been signed and the Team Leader, Office Manager and one Counselor have been hired. VA has hired a Team Leader in Nassau County, NY, and Fayetteville, AR.

The 61 existing Vet Centers selected for augmentation are Mobile, AL; Tucson, AZ; Anaheim, Concord, Corona, Fresno, Los Angeles, Sacramento, San Bernardino, San Diego, San Jose, Santa Cruz County, Ventura and Vista, CA; Boulder, CO; New Haven and Norwich, CT; Jacksonville, Palm Beach, Pensacola, Sarasota, Tallahassee and Tampa, FL; Honolulu and Maui, HI; Cedar Rapids and Sioux City, IA; Boise, ID; New Orleans and Shreveport, LA; Brockton, New Bedford, Springfield and Worcester, MA; Caribou, ME; Charlotte, Greensboro and Greenville, NC; Lincoln, NE; Trenton, NJ; Albuquerque and Farmington, NM; Rochester, NY; Cleveland and Columbus, OH; Oklahoma City, OK; Portland, OR; Harrisburg, PA; Austin, El Paso and San Antonio, TX; Provo, UT; Alexandria and Norfolk, VA; Spokane and Tacoma, WA; Madison and Milwaukee, WI; and Beckley, Princeton, and Wheeling, WV. Currently 49 (or 80%) of the augmented positions are filled. The remaining 12 positions are under recruitment and will be hired by the end of the fiscal year.

The following chart provides additional information regarding where VA is in the context of rural healthcare.

End of Fiscal Year 2006 Enrollees and Patients *

VA Sites by State and percent rural

	Total EOY06 Enrollee	Urban Enrollee	Rural Enrollee	Highly rural Enrollee	Total EOY06 Patient	Urban Patient	Rural Patient	Highly rural Patient
National	**7,848,282**	**4,879,424**	**2,850,173**	**118,685**	**4,877,733**	**2,919,645**	**1,878,624**	**79,464**
% Total		**62.2%**	**36.3%**	**1.5%**		**59.9%**	**38.5%**	**1.6%**
Alabama	148,220	67,954	80,266	0	90,727	41,007	49,720	0
Alaska	24,695	12,934	3,703	8,058	12,700	6,940	1,745	4,015
Arizona	181,233	116,668	59,704	4,861	110,960	69,146	38,991	2,823
Arkansas	114,753	37,740	77,013	0	80,785	25,990	54,795	0
California	638,769	530,070	106,432	2,267	353,793	287,553	64,841	1,399
Colorado	107,864	74,541	26,974	6,349	63,213	42,444	16,650	4,119
Connecticut	80,575	69,354	11,221	0	51,093	44,258	6,835	0
Delaware	22,531	13,820	8,711	0	12,961	7,974	4,987	0
DC	16,113	16,113	0	0	9,417	9,417	0	0
Florida	637,881	510,316	127,565	0	426,443	337,559	88,884	0
Georgia	223,736	131,388	92,348	0	128,983	71,908	57,075	0
Hawaii	33,478	23,424	10,054	0	18,361	12,302	6,059	0
Idaho	46,439	22,410	18,332	5,697	31,041	14,965	12,277	3,799
Illinois	285,615	193,965	91,650	0	170,266	111,603	58,663	0
Indiana	161,719	89,256	72,463	0	108,147	58,688	49,459	0
Iowa	94,290	30,942	63,348	0	65,769	21,287	44,482	0
Kansas	82,282	32,880	43,947	5,455	57,882	23,189	30,540	4,153

Kentucky	131,155	50,975	80,180	0	89,009	33,783	55,226	0
Louisiana	126,172	66,848	59,324	0	79,488	39,485	40,003	0
Maine	50,610	10,428	39,100	1,082	36,817	7,263	28,763	791
Maryland	126,809	100,329	26,480	0	71,304	55,886	15,418	0
Massachusetts	132,529	120,286	12,243	0	77,558	70,342	7,216	0
Michigan	184,417	108,574	75,223	620	115,772	65,499	49,820	453
Minnesota	129,266	55,016	72,035	2,215	89,836	36,322	52,059	1,455
Mississippi	95,968	26,773	69,163	32	66,915	17,585	49,307	23
Missouri	178,250	82,667	95,583	0	121,713	53,962	67,751	0
Montana	42,131	9,727	19,081	13,323	29,023	6,391	13,437	9,195
Nebraska	60,765	23,746	31,163	5,856	40,838	14,695	21,951	4,192
Nevada	86,337	66,523	12,064	7,750	52,324	39,789	7,735	4,800
New Hampshire	37,107	15,377	21,730	0	24,774	9,963	14,811	0
New Jersey	158,295	147,743	10,552	0	78,629	73,297	5,332	0
New Mexico	67,513	31,260	27,916	8,337	45,149	20,917	18,240	5,992
New York	460,464	334,594	125,682	188	232,308	162,853	69,361	94
North Carolina	245,773	112,961	132,812	0	160,503	72,354	88,149	0
North Dakota	25,201	8,811	10,518	5,872	16,549	5,723	6,811	4,015
Ohio	304,456	194,686	109,770	0	186,240	117,788	68,452	0
Oklahoma	120,601	47,267	72,347	987	78,603	29,498	48,480	625
Oregon	115,387	52,163	58,358	4,866	76,514	33,288	39,896	3,330
Pennsylvania	361,114	230,399	130,715	0	228,985	144,361	84,624	0
Rhode Island	27,957	25,378	2,579	0	19,650	17,902	1,748	0

End of Fiscal Year 2006 Enrollees and Patients*—Continued

VA Sites by State and percent rural

	Total EOY06 Enrollee	Urban Enrollee	Rural Enrollee	Highly rural Enrollee	Total EOY06 Patient	Urban Patient	Rural Patient	Highly rural Patient
South Carolina	144,972	75,369	69,603	0	93,181	47,064	46,117	0
South Dakota	38,675	10,046	17,440	11,189	28,529	7,309	12,724	8,496
Tennessee	169,858	88,391	81,467	0	111,087	56,943	54,144	0
Texas	570,121	364,420	198,450	7,251	361,386	224,353	132,167	4,866
Utah	45,924	34,605	6,809	4,510	28,570	21,679	4,171	2,720
Vermont	20,779	2,282	18,497	0	14,185	1,535	12,650	0
Virginia	193,291	119,645	73,572	74	109,106	62,586	46,464	56
Washington	158,147	111,232	45,375	1,540	86,285	60,340	24,960	985
West Virginia	84,795	24,758	60,037	0	56,834	16,131	40,703	0
Wisconsin	145,105	66,367	78,738	0	100,087	44,689	55,398	0
Wyoming	23,892	7,173	6,413	10,306	16,462	4,890	4,504	7,068
Puerto Rico	84,253	78,830	5,423	0	60,979	56,950	4,029	0

*Excludes non-enrolled non-Veterans and Priority 8e, 8g.

Mr. MICHAUD. Yeah, I appreciate that very much.

Dr. ZEISS. In terms of the directive, we feel passionately about it and so I'm glad that you recognize it. And it does not just say that treatment for PTSD cannot be denied—it is any mental health problem. And the reason that it was released is because we knew not only of anecdotal reports of some people being refused treatments, but also that there were some programs who had policies that if someone was using substances they would not be eligible. That is reasonable and I'll ask Dr. Allen to speak more to that. But it is not reasonable to say, therefore no care will be provided. That is absolutely unreasonable. The appropriate level of care needs to be provided.

Dr. ALLEN. It is almost a patient "bill of rights", if you will, which says that substance use problems are always to be addressed, but they are to be addressed appropriately. For example, if you have a veteran that is in one of the residential rehabilitation treatment programs and the individual is actively using substances, that person may be transferred out of that facility because of the risk that he or she would present to other patients, but they are still treated. And in fact, if the veteran is approached on the need for care, and refuses, they are still called to see if things have changed.

One other thing I would like to mention, the PDHRA event that was alluded to earlier, occurs 90 to 180 days post deployment. These events are set up by the Department of Defense, and, in fact, the PDHRA is mandatory for redeploying servicemembers. It is more difficult sometimes if it is a National Guard unit that is in a more remote site, or a Reserve unit, than if it is an active-duty unit, but they are mandatory. I went through it myself, in fact. But the VA is always there and the Vet Centers are always there with a representative.

So we tried to tighten up that linkage. I do agree it does not always happen. It should not have been 3 years. It should have been 90 days to 180 days after return. That is a problem in that unit.

Mr. MICHAUD. You mentioned Guard and Reserve is more difficult, but yet when you look at the war in Iraq and Afghanistan with the number of redeployments and the length of redeployments and the fact that there are so many Guard and Reserves over there, how do you close that gap so that the Guard and Reserves are not hit and miss?

Dr. ALLEN. There is supposed to be a dwell time, and I am sorry I do not know the DoD policy on that, but typically the redeploying servicemember is home at least as long as he or she was deployed previously. And I think, and again it is simply what the newspapers were indicating, yet there may be a requirement that it is twice as long as they were in the country. But there is a dwell time that the individual must be here.

Mr. MICHAUD. Earlier, actually, I believe Dr. McCormick mentioned that there were gaps in services. But also if you look at what is happening nationwide, one facility might be doing a very good job, another facility is not doing a very good job, and hopefully we will come up with a report card on each facility. Do you see that variation between facilities as far as the actual services that they might be receiving or not receiving?

Dr. ALLEN. At this point there is variability, but I can say that every VA Medical Center has a substance abuse treatment program. They differ in terms of the availability of residential rehabilitation programs and intensive outpatient programs.

We have a staffing model for the intensive outpatient programs that looks at the number of veterans in an area, the percent that are dual diagnoses and helps us decide if it is warranted to set up an entire program there. If it is not, the services can be contracted out, and they can be contracted out to community agencies, and that would likely be the case in more remote parts of the country where you simply don't have enough veterans for this to be under our roof. But there is a strong movement toward standardization of services.

Apparently, at one time, the Veterans Administration became highly decentralized and so you have a tremendous amount of discretion at the regional levels. There is an effort now to look at better standardization of services and opportunities so that there will be certain treatment opportunities that must be made available to all veterans regardless of where they live, although the mechanism for providing them may well be a contract. It might be telemedicine or if there are enough people there it would be under our own roof but we are concerned about the problem.

Mr. MICHAUD. When you contract out, how do you know, it there a witness test that you make sure that wherever you are contracting out? Because one of the things that we heard a few meetings ago is to make sure that we have qualified providers out there, and how do you determine that?

Dr. ALLEN. Toni, Do you want to address that?

Dr. ZEISS. Those decisions are made at the local level, so we can gather more information for you if you would like, but our role at central office is to indicate what are the kinds of services that need to be provided and to work with the local folks to determine what is the best way to provide it.

The range of possibilities, I think, just to pull them all together, you've heard about them in a more scattered way, is first certainly for veterans to come to a VA Medical Facility where there will be the most complex and breadth of services.

Second, to go to a community based outpatient clinic, where there are now mental health staff at most clinics, and get services there. There is telemental health, and you have been asking about some other more high-tech ways of delivering service, and we have been working on various fronts with that. But telemental health is a way to really link people to more specialized care at the medical facility who are out getting their care from community based outpatient clinics. And then ultimately, if someone is really too far away even from a community based outpatient clinic, there is the possibility to contract care. And the requirement is that the local facilities develop memorandums of understanding that clearly lay out what are the kinds of services and who are the providers. But we don't require that those be approved at the national level.

Something else, but let me stop there and see what questions that raises.

Mr. MICHAUD. Yes, back in, I believe, 2006, the VA did a PTSD Report. When is the next report due out? Do you have another report? The special Committee?

Dr. ZEISS. If you mean the report of the special committee, it is annual, and I think that the current one, if it has not been released to Congress, it is in its final review prior to that release.

Mr. MICHAUD. Okay.

Dr. ZEISS. Is it still in review. Yeah. Okay. So it is forthcoming.

Mr. MICHAUD. You heard my questions earlier about the Surgeon General and the Deputy Undersecretary when they were talking to the VFW and it was brought to my attention from a veterans service organization, that they have this new classification or it is at least the first time I ever heard of it, PTSD–NR. What is PTSD–NR?

Dr. ZEISS. It was the first we had heard of it, too, and I suspect they were referring to the Diagnostic and Statistical Manual of Mental Disorders (DSM) IV, revised version. We use the most recent version of DSM IV for making PTSD diagnoses.

I don't think that is NR, it is DSM IV R. But that may have snuck in. But I believe that is probably what they were talking about. I will go back and check.

We use the diagnostic and statistical manual of the American Psychiatric Association as the absolute basis for the PTSD diagnosis.

[After researching the term, the VA was unable to find out the origination or definition of the term, PTSD–NR.]

Mr. MICHAUD. Right. And just the last few questions.

As you know treatment of comorbid substance use disorder and other mental health conditions are very challenging, how does the VA ensure that they have the mental health professionals that are competent to treat these comorbid conditions and what research is VA doing on comorbid conditions?

Dr. ZEISS. Do you want to start with this?

Dr. ALLEN. Certainly.

Well I think this is probably a question we should have for the record.

The comorbidity thing is a difficult issue. I know that for our clinical psychologists, and we have increased the number of those people a lot, they have to be extremely well qualified. They must be licensed in the State. They must have taken their doctorate in a program that is approved by the American Psychological Association (APA), and their internship must be in a program approved by the American Psychological Association.

So I think our standards are extremely high for our professional staff. Does that guarantee that they could treat comorbid conditions? I think so. If they are at that level that is what they have been licensed to do, and it is a challenging area. We obviously need to get smarter and better always.

Dr. ZEISS. Let me just, for the record, fine-tune just a bit what Dr. Allen has said.

For psychology and social work where professionals are not licensable until 1 to 2 years after they have completed their internship, VA can hire unlicensed psychologist and social work staff, but they must be professionally supervised during the period while

they are completing licensing. And they must complete licensing within a short period of time if they are going to be able to maintain VA employment.

So I think I would echo strongly what Dr. Allen is saying about the high credentials of our staff and especially the requirement that people have all their training from APA credited programs.

The other thing I would say, is we know, again focusing specifically on psychology, that of recent hires in the last year to 2 years, of new psychology staff, over 75 percent of them have had training in VA before they were hired. And so they were getting at least part of their training, exactly with veterans who have a high rate of comorbid problems, and these trainees then enter our staff already with supervised experience in working with the nature of the problems that veterans present. And we happen to have that specific number for psychology. It is true for other professions, as well, because of the large training program that VA has.

Mr. MICHAUD. What do you do in a situation since that standard is very high, and if a veteran that lives in a rural area might need that type of assistance, it is going to be very difficult because you might not have a provider that you would be able to contract out. So how do you close that gap in those particular situations? Do you have a handle on exactly how big that gap is?

Dr. ZEISS. Well, we have an Office of Rural Health and we can take, for the record, specific questions. I have looked recently at their data and we know that the highly rural veteran population, which is defined by the number of folks per square mile or per acre—is 1.6 percent of the veteran population. But there are States where it is a much higher proportion and we are really looking to the Office of Rural Health to help guide us. And in fact I think they have recently submitted a plan for mental health and geriatric care to Congress based on their extensive analysis and collaboration with us.

As I mentioned, the range of possibilities includes to expanding telemental health. I think the question you have asked earlier, is Internet-based therapy useful or not, and we would re-construe that question as what aspects of care can be provided effectively on an Internet basis. We have My Health*e*Vet, which is a web based set of rich information and screening information that veterans can access from their home computer. And it allows them to get some educational information about mental health and substance problems and to do some self screening.

We are also working to develop the interactive capacities between My Health*e*Vet and medical facilities.

So there could be secure messaging between providers and veterans. But we are not completely there yet, so that is being currently tested in the primary care context.

So we think there are lots of avenues we need to pursue as we have been pursuing, to keep pushing the window and being able to do a better and better job with these rural veterans, who clearly face the most difficult obstacles in terms of getting care from VA, but also as you say, many of these communities do not have rich other resources for mental health and substance use care.

Mr. MICHAUD. I want to thank you very much Dr. Zeiss, and Dr. Allen and Mr. Flora for your testimony today. I look forward to

working with you and I know we will have some more follow up questions. This is a very important issue to Members of this Committee and it is one that we hopefully will be able to get a better handle on as we move forward to make sure that our veterans do receive the services that they need in a timely manner and that they have access to those services as well.

So once again, thank you very much for your testimony today, I appreciate it.

Dr. ZEISS. Thank you.

Dr. ALLEN. Thank you.

Mr. FLORA. Thank you.

Mr. MICHAUD. No further questions. The hearing is adjourned.

[Whereupon, the Subcommittee was adjourned at 12:00 noon.]

A P P E N D I X

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

I would like to welcome everyone to our Subcommittee hearing. We are here today to talk about treatment for substance abuse and comorbid conditions in the Department of Veterans Affairs.

Substance use disorders are among the most common diagnoses made by the Veterans Health Administration. According to the 2007 National Survey on Drug Use and Health, 7.1% of veterans met the criteria in the past year for a substance use disorder and 1.5% of veterans had a co-occurring substance use disorder. Of the approximately 300,000 veterans from Operations Enduring and Iraqi Freedom who have accessed VA healthcare, nearly 50,000 have been diagnosed with a substance use disorder.

Additionally, more than 70% of homeless veterans suffer from alcohol and other drug abuse problems.

Over the past several years, Congress has increased funding for substance use treatment programs within the Department of Veterans Affairs to $428 million in Fiscal Year 2008. I believe that continued adequate funding is imperative for the health and well-being of our veterans and their families.

Substance use frequently co-occurs with other mental health conditions. VA needs to continue to dedicate itself to providing services that can address both substance use and other mental health conditions such as PTSD simultaneously.

I also was pleased to learn that Dr. Kussman, VA's Undersecretary for Health recently released a directive on the management of substance use disorders. This directive states, among other things, that VA facilities must not deny care to any enrolled veteran because they are using substances and that all VA medical facilities must provide services to meet the needs of veterans with substance use disorders and PTSD. I think that this is a step in the right direction and I commend VA for it's proactive leadership on this issue.

Last week, Mr. Miller and I introduced the Veterans Substance Use Disorder Prevention and Treatment Act of 2008. This legislation will require the VA to provide the full continuum of care for substance use disorders, and it will require this full spectrum of care to be available at every VA medical center. This legislation also directs the VA to conduct a pilot program for Internet-based substance use disorder treatment for veterans of Operations Enduring Freedom and Iraqi Freedom. This will enable our newest generation of veterans to overcome the stigma associated with seeking treatment and receive the necessary care in a comfortable and secure setting.

The Committee realizes that substance use and comorbid conditions are complex issues. But we also recognize that it is an important one that deserves serious thought and consideration. I look forward to hearing from our panels today about ways that VA can effectively address these critical issues.

Prepared Statement of Hon. Shelley Berkley, a Representative in Congress from the State of Nevada

Mr. Chairman,

Thank you for holding this hearing on this important issue of substance abuse and comorbid conditions.

Nationally, one in five veterans returning from Iraq and Afghanistan suffers from PTSD. Twenty-three percent of members of the Armed Forces on active duty acknowledge a significant problem with alcohol use. It is vital that our veterans receive the help they need to deal with these conditions.

The effects of substance abuse are wide ranging, including significantly increased risk of suicide, exacerbation of mental and physical health disorders, breakdown of

family support, and increased risk of unemployment and homelessness. Veterans suffering from a mental health issue are at an increased risk for developing a substance abuse disorder.

A constituent of mine, Lance Corporal Justin Bailey, returned from Iraq with PTSD. He developed a substance abuse disorder and checked himself into a VA facility in West Los Angeles. After being given 5 medications on a self-medication policy, Justin overdosed and died.

I have introduced the Mental Health Improvements Act, which aims to improve the treatment and services provided by the Department of Veterans Affairs to veterans with PTSD and substance use disorders by:

- Expanding substance use disorder treatment services at the VA Medical Centers.
- Establishing national centers of excellence on PTSD and substance use disorders.
- Creating a program for enhanced treatment of substance use disorders and PTSD in veterans.
- Requiring a report on residential mental healthcare facilities of the Veterans Health Administration (VHA).
- Creating a research program on comorbid PTSD and substance use disorders.
- Expanding assistance of mental health services for families of veterans.

It is imperative that we provide adequate mental health services for those who have sacrificed for this great nation and those who continue to serve. This bill takes a step in the right direction in providing our veterans with the care they have earned. I urge my colleagues to cosponsor this important piece of legislation, and I look forward to further action in this Committee.

Prepared Statement of Hon. John T. Salazar, a Representative in Congress from the State of Colorado

Good morning Mr. Chairman, Ranking Member Miller and distinguished members of this subcommittee.

I look forward to discussing the incidence of substance abuse and associated conditions plaguing our nation's veterans.

Our servicemen and women put their lives on the line to ensure that our nation is safe and that our freedoms are protected.

Unfortunately, the battle is not always over once these brave men and women return home.

The stress of wartime service puts our returning troops and veterans at risk for mental illness such as PTSD and Substance Use Disorder.

The rates of mental illness among service members are on the rise.

It is likely that the demand for mental health services will continue to grow among soldiers returning from active combat.

The 2007 National Survey on Drug Use and Health showed us that too many of our veterans suffer from Serious Psychological Distress and substance use disorder.

I am eager to hear today's testimony from the experts in veteran healthcare that are present.

I also look forward to your opinions regarding the legislation that addresses the issues we will discuss here today.

Thank you, Mr. Chairman, for the opportunity to discuss these issues that so many of our veterans face on a daily basis.

Prepared Statement of Patricia M. Greer
President, NAADAC, the Association for Addiction Professionals

Mr. Chairman, I would like to thank you and the members of this subcommittee for holding today's hearing on "Substance Abuse/Co-Morbid Disorders: Comprehensive Solutions to a Complex Problem." The challenges in creating a healthcare system capable of effectively treating co-occurring substance use disorders are significant, but experience has proven that there are practical steps which can improve outcomes for clients and their families.

As a brief note of introduction, NAADAC, the Association for Addiction Professionals, is the national professional association serving addiction-focused health professionals and educators. NAADAC has 10,000 members across the country and affiliate organizations in 46 states, two territories, and several foreign countries. Our

certification commission certifies addiction professionals in all fifty states and in numerous foreign countries.

Scope of Substance Use Disorders and Co-Morbidity

In 2004, Dr. Richard Suchinsky, Department of Veterans Affairs Associate Chief for Addictive Disorders, ranked substance use disorders among the three most common diagnoses made by the Veterans Health Administration (VHA).[1] Nevertheless, they remain under-diagnosed and under-treated in the VHA, which reflects a similar treatment gap in civilian society. Young veterans (under age 25) suffer from substance use disorder rates as high as 25 percent,[2] and veterans are more likely than their civilian peers to engage in heavy alcohol use and to take part in risky behavior like drunk driving.[3] In total, it is estimated that 1.8 million veterans suffered from a diagnosable substance use disorder in 2002 and 2003.[4]

Substance use disorders frequently co-occur with other physical and mental health conditions. In the case of diseases like HIV or hepatitis-C, co-morbidity with substance use disorders is often associated with the act of drug use itself—sharing needles, for example, or engaging in risky sexual behavior. In the case of mental health conditions like post-traumatic stress disorder (PTSD), depression, or bipolar disorder, substance use disorders frequently result from attempts to "self-medicate" with alcohol or other drugs rather than receiving needed mental healthcare.

The high number of mental health conditions reported by veterans of the conflicts in Iraq and Afghanistan has been associated with a surge of co-occurring substance use and mental disorders. Some experts estimate that about 40 percent of veterans who have served in Iraq or Afghanistan will experience a mental health problem, and that of those approximately 60 percent will have a substance use disorder.[5] In 2002 and 2003, the National Survey on Drug Use and Health estimated that 340,000 male veterans suffered from co-occurring substance use disorders and "serious mental illness," defined as a diagnosable mental condition that substantially interfered with a normal life activity.[6] Post-traumatic stress disorder—one of the most commonly diagnosed combat-related mental disorders—is frequently co-morbid with substance use disorders. During the Vietnam War, for example, 60–80 percent of veterans with PTSD also suffered from addiction disorders.[7]

There is reason to fear that co-occurring substance use disorders in veterans may be on the rise. Studies have shown that multiple deployments increase the risk of post-traumatic stress disorder, and National Guard forces report higher rates of psychological distress than do regular forces.[8] As redeployments continue and additional "citizen soldiers" serve overseas, the risk of co-occurring substance use disorders rise.

Co-occurring substance use disorders are difficult to treat, and the ongoing stigma against addiction and treatment discourages many people from seeking the help they need. This is particularly true for people from the military culture who fear seeming "weak" or in need of help.

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[1] Quoted in Smith, Thurston. "Overview." Resource Links: Substance Use Disorders and the Veterans Population. Northeast Addiction Technology Transfer Center. Summer 2004. Vol. 3, Iss. 1.

[1] National Survey on Drug Use and Health. "Serious Psychological Distress and Substance Use Disorder among Veterans." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 1 Nov. 2007.

[2] National Survey on Drug Use and Health. "Serious Psychological Distress and Substance Use Disorder among Veterans." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 1 Nov. 2007.

[3] National Survey on Drug Use and Health. "Alcohol Use and Alcohol-Related Risk Behaviors Among Veterans." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 10 Nov. 2005.

[4] National Survey on Drug Use and Health. "Serious Psychological Distress and Substance Use Disorder among Veterans." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 1 Nov. 2007.

[5] Quoted in Danforth, Kristen Inger. "Change in Mindset Brings Veterans Care Into a New Era." Resource Links: Issues Facing Returning Veterans. Northeast Addiction Technology Transfer Center. Fall 2007. Vol. 6, Iss. 1.

[6] National Survey on Drug Use and Health. "Serious Psychological Distress and Substance Use Disorder among Veterans." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 1 Nov. 2007.

[7] Mwisler, A.W. "Trauma, PTSD and Substance Abuse." PTSD Research Quarterly, 7, (4).

[8] Hope Yen. "Pentagon Panel Warns of Mental Strain." Associated Press. 3 May 2007: http://vawatchdog.org/07/nf07/nfMAY07/nf050507-1.htm. and "Mental Health Advisory Team (MHAT) IV Brief." General James T. Conway, Commandant of the Marine Corps. 18 April 2007: http://216.239.51.104/search?q=cache:505MsjAlGO4J:blog.wired.com/defense/files/mhat_iv_brief_to_marine_corps_commandant_gen_conway_18apr07.ppt+Mental+Health+Advisory+Team+(MHAT)+II+Brief&hl=en&ct=clnk&cd=1&gl=us.

Delivering Comprehensive Care

The Department of Veterans Affairs and Congress should be commended for having made mental health care for veterans a priority over the past several years. The publicly expressed concern for veterans with post-traumatic stress disorder, traumatic brain injury, and other mental health conditions has been far greater than in earlier conflicts. We thank Congress for its historic recent funding increases for veterans' health, which have the potential to significantly expand access to treatment.

As this hearing's title aptly suggests, co-occurring addiction and mental disorders are best treated comprehensively. This means that caregivers are most effective when they have demonstrated competencies in both addiction and mental health care. Treatment for substance use disorders is most effective when delivered by health care professionals with a certification or license in addiction-specific care; research has shown that addiction treatment is as effective as treatment for other chronic diseases such as diabetes, hypertension, and asthma.[9] Licensure and certification ensure that the practitioner has both the educational foundation and clinical experience in evidence-based and promising practices to provide the best possible care.

A commitment by the VHA to prioritize treatment for co-occurring addiction and mental illness must include a commitment to expand and train its addictions-focused workforce—staff intended for addiction treatment at some veterans hospitals are often reassigned or transferred, resulting in uneven treatment in some cases. Reports that the addiction-focused VHA workforce has declined by almost half in the past decade are particularly disturbing.[10] As the VA seeks to build its addiction treatment workforce, it should recruit addiction professionals who are certified or licensed in addiction treatment by their state of residence. The VHA should also provide resources to its current health care workforce to become certified or licensed in addiction-specific treatment.

Whether the clinician treating a client with a co-occurring substance use disorder has demonstrated competencies in both addiction and mental health trauma or works in partnership with other clinicians, it is important that the client have access to both areas of medical knowledge. Once comprehensive treatment has begun, it should be extended as long as necessary. For example, in-patient treatment for co-occurring PTSD and addiction can take several months, and outpatient treatment can take a year or longer. As with any extended treatment, the patient's family should be included in any treatment program whenever possible.

Early screening and intervention lead to more successful treatment outcomes for co-occurring substance use disorders. Almost 500,000 of the veterans who received any form of VA care in 2001 are estimated to have met the clinical criteria for substance use disorders, yet only 19 percent of them (about 91,000) received specialized addiction treatment.[11] This is primarily because these veterans presented at primary care facilities and their substance use disorders went undetected. Primary care health practitioners must be trained in identifying substance use disorders and co-occurring mental health conditions, and qualified addiction professionals should be on-call to provide intervention in cases where evidence of substance use disorders exists.

Routine screenings must be conducted in a manner that encourages honest responses and results in a seamless transition into treatment. Similarly, the VA should be transparent and accountable for cases where they deny treatment to a veteran claiming to have combat-related PTSD or substance use disorders and release public reports on those statistics. Because PTSD and substance use disorders are often late-onset conditions, screenings should be conducted as regularly as possible in the years following a veteran's return from combat.

Once receiving treatment for co-occurring substance use disorders, it is critical that clients receive culturally competent care. Familiarity with military culture is often essential for effective treatment. This is true both for addiction professionals in the VHA as well as for the civilian addiction professionals who treat veterans who seek treatment in the nation's non-VHA treatment systems.

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[9] National Institute on Drug Abuse. "Principles of Drug Addiction Treatment: A Research Based Guide." NIH Publication NO. 00–4180.

[10] Tracy SW, Trafton JA, Humphreys K. "The Department of Veterans Affairs Substance Abuse Treatment System: Results of the 2003 Drug and Alcohol Program Survey." Palo Alto, Calif, VA Program Evaluation and Resource Center and Center for Health Care Evaluation, 2004. Available at www.chce.research.med.va.gov/pdf/2004DAPS.pdf.

[11] McKeller, J., Che-Chin, L. & Humphreys, K. "Health Services for VA Substance Use Disorder Patients: Comparison of Utilization in Fiscal Years 2002, 2001 and 1998." 2002. Palo Alto, Ca.: Program Evaluation and Resource Center and Center for Health Care Evaluation, Department of Veterans Affairs Medical Center.

The current conflicts in Iraq and Afghanistan also require a new emphasis on gender-specific treatment strategies. Fifteen percent of the armed forces are women, and servicewomen are closer to combat than ever before. Rates of PTSD are higher in women than in men, and female veterans suffer from PTSD in numbers greater than their civilian counterparts.[12] The VHA should invest in studying gender-specific treatment and counseling strategies, and provide appropriate training to its addiction and mental health workforce.

The unprecedented number of women serving in the armed forces, combined with the high rates of Reservists and National Guard forces in combat and extended tours of duty, have made the current conflict particularly psychologically difficult for families. Addiction is a disease which affects the entire family—there are powerful genetic predispositions for addiction, and family stress increases the risk of drug use. Such stress exists both when a parent or child is deployed as well as when they return from duty—the process of "returning to normal" is rarely as seamless as a veteran's family might hope. In most cases, addiction treatment for a veteran should occur in the context of his or her family. The VHA should increase its outreach to family and include families in its treatment programs whenever possible. The VHA must prioritize family-centered care as it implements comprehensive care for comorbid substance use disorders.

Part of this family-centered treatment approach includes making access to treatment as client-friendly as possible. Compared with the civilian system, both public and private, substance use disorder-specific care in the VA takes place in hospitals that are more densely populated, and less geographically dispersed, than civilian treatment sites. A study found that VHA facilities (mostly hospitals) providing addiction treatment housed three times as many clients, on average, than did non-VHA facilities.[13] This indicates addiction treatment in the VA is more centralized in fewer, larger facilities than treatment in the civilian sector. This raises the concern that some veterans have more difficulty finding a convenient, easily accessible treatment site through the Department of Veterans Affairs than their civilian counterparts. This problem is particularly pronounced for veterans in rural areas and for those who lack the employment flexibility, funds, or family structure to travel long distances.

Despite the significant funding increases for veterans' health care, we encourage the Department of Veterans Affairs to more aggressively pursue partnerships with existing civilian treatment systems. No amount of new VA funding can rebuild the entire public and private treatment system which exists in the United States today, with well over 10,000 treatment facilities and tens of thousands of addiction professionals. The diminishing returns of such an attempt, particularly in rural areas and small communities, would not be an efficient use of funds. Rather, strategic partnerships that expand the capacity of existing treatment systems in underserved areas would provide veterans and their families with the care they need close to home. It would also expand access to care immediately, without the need for new facilities, employees, and programs to be established.

Conclusion

The current conflicts in Iraq and Afghanistan pose many new challenges to effective health care. While co-occurring substance use disorders and mental health conditions like PTSD are among the most complex of those challenges, comprehensive plans of action can dramatically improve veterans' health. In this case, "comprehensiveness" includes ensuring that a clinician with addiction-specific qualifications is part of every treatment plan, that the family is included to the greatest extent possible, that screening and intervention for addiction and mental illness is included in primary care settings, and that veterans can access the care they need conveniently and close to home. We commend the Department of Veterans Affairs, this subcommittee, and other policymakers who have worked to improve veterans' access to health care in the past several years. We look forward to working with other stakeholders to improve the nation's treatment systems for co-occurring substance use disorders. Thank you for the opportunity to testify today, and I would be happy to answer your questions.

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[12] Schnurr, P.P., et al. "Cognitive Behavioral Therapy for Posttraumatic Stress Disorder in Women." JAMA. 28 Feb. 2007. Vol. 297:820–830. and Kessler, T.C., Sonnega, A., et al. "Posttraumatic Stress Disorder in the National Comorbidity Survey." Arch Gen. Psych. Dec. 1995. 52(12):1048–60.

[13] Drug and Alcohol Services Information System. "Characteristics of Substance Abuse Facilities Owned and Operated by the Department of Veterans Affairs: 2000." Office of Applied Studies, Substance Abuse and Mental Health Services Administration. 11 Nov. 2002.

Prepared Statement of Richard A. McCormick, Ph.D.
Senior Scholar, Center for Health Care Policy and Research, Case Western Reserve University, Cleveland, OH

Mr. Chairman, Ranking Member and Members of the Subcommittee, I will attempt in my limited remarks to provide an independent, ground level assessment of the needs of veterans for substance use disorder services, and the current capacity of VA to provide them.

Let me first share the basis for my assessment. I retired a few years ago after 32 years in VHA, where I worked clinically primarily in substance abuse and then in various management positions, culminating as Mental Health Care Line Director for VISN10. I was the co-chair of the VA national Committee on the Care of Severely Mentally Ill Veterans, mental health representative on the VACO Task Force overseeing all practice guidelines, and co-chair of the group drafting VA evidence based practice guidelines for Dually Diagnosed veterans. After I retired I had the additional opportunity to personally site visit 39 VA facilities as a member of the CARES Commission, a member of a special Secretary's mental health task force established by Secretary Principi, and as consultant on mental health and substance abuse programming. The last two years I personally visited 23 military bases and reserve units, across the world, as a member of the congressionally mandated DoD Mental Health Task Force. On these visits I talked with literally thousands of service members, family, mental health providers and commanders about mental health and substance abuse issues. I continue to conduct NIAAA funded research at the Center for Health Care Policy and Research at Case Western Reserve University and am involved in two large DoD funded studies of returning National Guard and Reserve members.

Scope of the Problem

The need for comprehensive substance use disorder services is immense and growing. Multiple studies indicate high rates of alcohol and other drug related problems for returning service members. For example, returning reservists, who are veterans within weeks of their return, report rates as high as 52%, related to combat exposure, number of deployments.

This hearing importantly focuses on comorbidities. Substance misuse is a common comorbidity for all significant mental and social problems afflicting veterans. The veteran must have access to comprehensive substance abuse services not only to deal with the symptoms, complex personal, family and social problems addiction causes, but also to be able to engage in treatment for these comorbid conditions. Engagement in state of the art PTSD treatment requires first or concomitantly treating a substance abuse problem in at least a third of patients presenting. Up to one half of veterans with serious mental illness also have a substance problem that complicates care.

There is growing concern with suicidality. Military studies are consistent with VA long term studies linking suicidal behavior to substance misuse for many, if not most.

Access to comprehensive substance disorder services is also crucial in providing care for non-mental health conditions that are a priority for veterans. For example, engagement in treatment for Hepatitis C requires abstinence, and continued heavy drinking has long term medical consequences. A common symptom in TBI is disinhibitory behavior, which is often manifest as substance misuse or its close cousin problem gambling. Again medical advice is for patients with TBI to stop drinking.

VA's priority mental health and medical programs cannot provide state of the art care unless they are complemented by comprehensive substance use disorder services.

What is the state of substance use disorder care in VA?

VA has been a leader in drafting evidence based treatment guidelines for substance use disorders. We know much about what works.

In the past decade VA specialized access to substance abuse care has greatly eroded. Official VA reports document the decline. Much less is being spent on care. That could be attributed to increased efficiency, were it not for the fact that there has been a drastic decline in the unique number of veterans getting specialized substance abuse care. Nor is this due to lack of need. Three networks actually increased the number being served, while also becoming more cost efficient. The result is that today there are vast discrepancies in access to care across the country.

Very small improvements can be noted in the past two years as new money has been allocated to improve services. Even still, there are examples of medical centers taking expansion money for one mental health program while simultaneously cutting substance abuse services.

There are many dedicated staff working to provide care, but they are stretched and stressed. Many recognize that services need to be expanded and modernized to meet the needs of a new cohort of OIF/OEF veterans, but they have no resources to do so.

VA programs often focus on the most severe dependent substance abusers. These patients need and deserve much care.

But the new veteran often needs a different kind of service. He or she may be at the beginning of the long drop; binge drinking, getting DUI's, starting to destroy family relationships. In the private sector you will find many comprehensive substance use disorder programs that include a hefty component to provide short term, tailored interventions for those at the hazardous or harmful phase of abuse. These brief intervention experts coordinate closely with primary care staff, educating them, working with them to assure that these patients get effective early care. Such programming is alarmingly rare in VA.

Military and VA studies document the growth of problem gambling. This is especially true for the new veteran. VA was a pioneer in gambling treatment. Yet today even few VA substance abuse programs systematically screen for this common comorbidity of substance use.

I could go on and provide more details but let me end here with a true story. On a visit to a reserve unit last year I was approached by a reservist home from his second deployment. He was changed. He knew it. His sergeant knew it. His wife knew it. He was drinking too much. A patriotic rural judge had let him off from his first DUI with a stiff warning. He wasn't the father or husband he always saw himself being. He'd had a rough deployment, but that wasn't what he wanted to talk about. I don't know if his problems were related to the trauma he witnessed or the explosion near him. He wanted to know what he should do. He wanted to do something, though there were many things he worried about in seeking help, including his career. I directed him to the VA nearest where he lived. It was not one I had visited recently. I hope he found ready immediate access to the services he needed at that VA, before he talked himself out of sticking with it.

Then and now, I am not sure he would.

The war is now. Men and women like him need the best we can offer in substance disorder services, now. We are, based on my ground level view, falling tragically short in meeting our responsibility to them.

I have many thoughts on what should be done. Let me share just one, though a big one. VHA needs to immediately improve on the depth of the assessment I can provide. They must conduct a comprehensive comparison of each and every VA Medical Center and large outpatient clinic against VA's own practice guidelines for substance use disorders, including newer modern services for OIF/OEF veterans. This assessment should include site visits and confidential, non-attributional, discussion and surveys of substance abuse staff. A report detailing all short falls should then be used to deploy additional staffing to bridge some of the gap in services that has widened over the past 10 years. It should not be local option whether a full array of services are provided. VHA is a national system, there should be a national predictable, consistent continuum of care so that any veteran can be assured of ready access regardless of where he or she resides.

I would rejoice if such a comprehensive assessment found that my ground level view was in error.

Addendum on problem gambling as a rising comorbity of substance abuse among veterans:

Scope of the problem:

Problem gambling is a serious problem that affects veterans and active duty service members and a common complicating comorbitity for other serious conditions. It has disastrous consequences for the veteran and his or her family.

Nationally between 1.6% and 3.4% of the general population have a lifetime probability of experiencing a significant gambling problem. Rates among age matched veterans are significantly higher, and highest among minorities. Rates are even higher among veterans seeking treatment for some other condition. For example, studies have shown:

- A survey of veterans living in the community found that 9.9% of American Indian veterans and 4.3% of Hispanic veterans had a pathological gambling problem at some point in their lives.
- Up to one third of veterans in treatment for a substance abuse problem also have a significant gambling problem.
- Veterans in treatment for PTSD may be as much as 60 times more likely to have a gambling problem than age matched members of the general population.

- Among veterans hospitalized on a VA inpatient psychiatric unit, 28% were classified as problem gamblers and 12% as pathological gamblers.

Rates of depression among veterans with pathological gambling problems have been shown to be as high as 76%. Suicide is extremely common, with 40% of veterans seeking treatment for gambling reporting suicide attempts.

There is every reason to believe that gambling will continue to be a problem for veterans. Rates of gambling have been rising among active duty members, and of those seeking treatment for gambling, 42% have considered suicide. This parallels increasing concern with financial troubles among military members and their families.

New studies have suggested that gambling may be an increasing problem for older patients being treated for neurological conditions such as Parkinson disease. Rates of serious disorders of impulse control, mostly gambling, among patients receiving the most common pharmacological treatments (dopamine agonists) for Parkinson have been measured at 7%, well above the rate expected for age matched people in the general population.

A government commission estimated that the total costs (healthcare, legal, social) in the United States attributable to pathological gambling exceed $5 billion.

Availability of Treatment for Veterans with Gambling Problems

Specialized treatment programs for veterans with pathological gambling are rare. Even though VA was the site of the first intensive national program for pathological gamblers, established forty years ago, and responsible for much of the early research on this disorder, the number of specialized programs in VHA is meager.

Despite overwhelming evidence that pathological gambling is a common and serious complicating comorbidity, veterans seeking mental health or substance abuse care in VHA are not generally screened for gambling problems.

There is substantial evidence that pathological gambling, even in its most serious form, can be successfully treated, including among veterans with the disorder. Rates of success continue to climb as newer treatment approaches are developed and studied. Economical screening instruments for gambling are available and have been shown to be effective in veteran populations.

Recommended Action

VHA should significantly increase access for veterans to specialized treatment for pathological gambling. Initially at least one program should be established in every VHA Network.

All veterans receiving VHA treatment for substance abuse, PTSD and other mental health conditions should routinely be screened for gambling problems, using available standardized screening tools.

At least one staff member in every VHA substance abuse and PTSD specialized treatment program should be trained and competent in treating comorbid gambling problems.

VHA should establish a full-time position as national gambling coordinator within the office of the Mental Health Strategic Group. This person would be responsible for increasing access to treatment for veterans with gambling problems and assuring that veterans at risk for gambling problems are screened and referred to appropriate treatment when necessary.

References

Biddle D, Hawthorne G, Forbes D, Coman G. Problem Gambling in Australian PTSD Treatment Seeking Veterans. Journal of Traumatic Stress, 18, 759–67, 2005.

Daghestani AI, Elenz E, Crayton JW. Pathological gambling in hospitalized substance abusing veterans. Journal of Clinical Psychiatry, 57(8), 360–63, 1996.

Gerstein, D.R., Volberg, R.A., Harwood, R., Christiansen, E.M., et al. 1999. Gambling Impact and Behavior Study: Report to the National Gambling Impact Study Commission. Chicago, IL: National Opinion Research Center at the University of Chicago. Kennedy CH, Jones DE, Grayson R. Substance abuse and gambling treatment in the military. Military Psychology, Clinical and Operational Applications. Guilford Press, 2006.

Kausch O. Suicide Attempts Among Veterans Seeking Treatment for Pathological Gambling. Journal of Clinical Psychiatry, 64(9) 1031–1038, 2003.

Kim SW, Grant JE, Eckert D et al. Pathological gambling and mood disorders. Journal of Affective Disorders. 92, 109–116, 2006.

McCormick RA, Russo A, Ramirez L, Taber JI. Affective disorders among pathological gamblers. American Journal of Psychiatry, 141, 215–18, 1984.

Miller MA & Westermeyer J. Gambling in Minnesota. American Journal of Psychiatry, 135(6), 845, 1996.

Pallesen S, Mitsem M, Kvale G, et al. Outcome of psychological treatments of pathological gambling: A review and meta-analysis. Addiction, 100, 1412–22, 2005.
Taber JI, McCormick RA, Russo, A et al. Follow-up of pathological gamblers after treatment. American Journal of Psychiatry, 144, 7575–61, 1987.
Weintraub D, Siderowf AD, Potenza MN, et al. The Association of Dopamine Agonist Use with Impulse Control Disorders In Parkinson Disease, Archives of Neurology, 63(7), 969–973, 2006.
Westermeyer J, Canive J, Garrard J et al. Lifetime prevalence of pathological gambling among American Indian and Hispanic American Veterans. American Journal of Public Health, 95(5), 860–6, 2005.

Prepared Statement of Joy J. Ilem
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV), an organization of 1.3 million service-disabled veterans, to testify at this important hearing to discuss solutions for veterans dealing with substance use disorders and co-existing mental health conditions. We appreciate the opportunity to offer our views on Department of Veterans Affairs (VA) specialized programs for these conditions.

The misuse and abuse of alcohol and other substances continues to be a major health problem for many Americans, including many of our Nation's veterans. Substance use disorders result in significant health and social deterioration and financial costs to veterans, their families and the nation. Although substance abuse is a complex problem, there is clear evidence that treatments can be brought to bear to reduce these negative consequences.

The Scope of the Substance Use and Abuse Problem is Growing:

DAV has a growing concern about the reported effects of combat deployments in Iraq and Afghanistan on our newest generation of war veterans. There is converging evidence that substance abuse is a significant problem for many veterans of Operations Iraqi and Enduring Freedom (OIF/OEF)—and that the incidence of this problem will likely continue to rise. Over the past year there have been a number of research and media reports highlighting the prevalence of substance use and other mental health problems among OIF/OEF veterans and the challenges that many of these veterans and their families are facing post-deployment. Among the most notable are——

- In the most recent Department of Defense (DoD) anonymous Survey of Health Related Behaviors Among Active Duty Personnel, 23% acknowledge a significant alcohol problem;[1]
- Alcohol related incidents (e.g. DUI, drunk and disorderly) reported in the Army Forces Command data base increased from 1.73 per 1,000 soldiers in 2005, to 5.71 in 2006;[2]
- Alcohol contributed to 65% of the markedly increased incidence of suicidal behavior in the military;[3]
- In a recent study of returning National Guard, 24% reported alcohol abuse;[4]
- Reported rates of psychological problems increase with multiple deployments;[5] and,
- Reports of child abuse and increased incidence of marital problems in military families as a result of multiple deployments.[6]

Current research also highlights that OIF/OEF veterans are at higher risk for post traumatic stress disorder (PTSD) and other mental health problems as a result of combat exposure. VA reports that these veterans have sought care for a wide

[1] Bray, R., Hourani, L., Olmstead, K., et al (2006, August). 2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP). NC: Research Triangle Institute.
[2] An Achievable Vision: The Report of the Department of Defense Mental Health Task Force, June 2007.
[3] Ibid.
[4] Wheeler, E. Self Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).
[5] An Achievable Vision: The Report of the Department of Defense Mental Health Task Force, June 2007.
[6] Robert Davis and Gregg Zoroya, "Study: Child abuse, troop deployment linked," USA Today, 7 May 2007: http://www.usatoday.com/news/nation/2007-05-07-troops-child-abuse_N.htm

array of possible co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance abuse. Through January 2008, VA has reported that of the 299,585 separated OIF/OEF veterans who have sought VA healthcare since fiscal year 2002, a total of 120,049 unique patients had received a diagnosis of a possible mental health disorder. Almost 60,000 enrolled OIF/OEF veterans had a probable diagnosis of PTSD; almost 40,000 OIF/OEF veterans have been diagnosed with depression; and, more than 48,000 reported nondependent abuse of drugs.[7] These data are consistent with DoD studies of active duty OIF combat troops.

In a recent study, VA New Jersey-based researchers examined substance abuse and mental health problems in returning veterans of the war in Iraq. Researchers noted that although increasing attention is being paid to combat stress disorders in veterans, there has been little systemic focus on substance abuse problems in this population. Among the 292 National Guard members studied, an alarmingly high percentage (39 percent) reported one or more substance abuse-related problems. Rates were even higher among the subset who were youngest (e.g., "problem drinking" in 46 percent) and had high exposure to combat (e.g., 52 percent reported problem drinking). Yet access to substance abuse services for the group studied was very low (only 9 percent), compared with access to other mental health services (41 percent).[8]

Similarly, a study of returning Maine National Guard members found substance abuse problems in 24 percent of the troops surveyed.[9] In the most recent DoD anonymous *Survey of Health Related Behaviors Among Active Duty Personnel*, 23 percent of respondents acknowledged a significant alcohol problem.[10]

Lack of Seamless Detoxification-to-Rehabilitation Transition Services:

We have special concerns about VA's local policies on making detoxification services readily and widely available to veteran candidates who are interested in substance abuse rehabilitation services. VA officials have informed us that detoxification services provided by internal medicine bed sections should be readily available within all VA medical centers to veterans who need them as a precursor to admission to VA substance use disorder treatment programs. Physical detoxification, whether from dependent alcohol or other drug use, is the essential key in preparing a veteran for therapeutic rehabilitation and sobriety. However, we understand that, in many cases, VA's substance abuse treatment programs will not accept a veteran who is actively drinking or using drugs. We have received anecdotal stories from VA sources in field facilities to indicate that often, intoxicated veterans who come to VA for care are instead turned away, and occasionally they are even arrested for public drunkenness or property violations. We strongly believe that having a substance use disorder should not be a barrier to receiving care for that condition or entrance into any other VA specialized treatment program.

Current and former VA clinicians with expertise in substance use disorder treatment have informed us that VA medical centers with robust substance use treatment programs generally have clinical staff that maintain a close liaison with VA admitting offices, emergency rooms, internal medicine, and primary care clinics, for the purpose of identifying veterans who need detoxification services. When these patients are identified, liaison staff members ensure they receive proper referral to detoxification resources in internal medicine and then help these veterans make their transition to follow-on substance abuse treatment programs. In medical centers *without* fully integrated substance abuse services, patients may not be identified or properly referred, and even if they are detoxified, they might fall through the cracks, or refuse this critically important specialized follow on care, thus wasting significant healthcare resources and ultimately failing these veterans.

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[7] Department of Veterans Affairs, VHA Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization Among US Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom," January 2008.

[8] Kline, A., Falca-Dodson, M. Substance Abuse and Mental Health Problems in Returning Iraqi Veterans. VA New Jersey Healthcare System and New Jersey Department of Military and Veterans Affairs, 2007. (unpublished)

[9] Wheeler, E. Self Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).

[10] Bray, R., Hourani, L., Olmstead, K., et al. (2006, August). 2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP). NC: Research Triangle Institute.

Inadequacy of Substance Disorders and Co-Morbid Mental Health Treatments in VA

The past decade has been marked by unparalleled growth in VA clinical services. Unfortunately, substance use treatment and rehabilitation resources have declined during that same period and VA has made little progress in restoring them, even in the face of likely increased demand from veterans returning from OIF/OEF. In 1996 specialized substance abuse treatment services accounted for 3.8 percent of VA's clinical budget—but by 2006, this fraction had dropped to 1.8 percent. A number of national population surveys of the prevalence of substance abuse show no comparable decline in incidence of drug and alcohol addiction. Over the same period (1996 to 2006) the number of veterans receiving specialized substance abuse treatment services declined by approximately 18 percent, with the exception of a slight growth (2 percent) from 2005 to 2006, due to infusion of specifically directed supplemental funding. Furthermore, there has been a marked increase in the variability of access to a comprehensive continuum of care for substance abuse services. In 2006 (latest data available to DAV), VA's Veterans Health Administration (VHA) networks varied markedly in the proportion of their patient populations that were treated in substance abuse specialty care. The normalized rates for veterans treated for substance abuse ranged from 8.5 per 1,000 treated for any condition to 3.3 per 1,000.[11] Experts in this field have informed DAV that this variability cannot be explained by regional differences in the prevalence of substance abuse disorders. Finally, although it is known that many mental health conditions including PTSD, anxiety disorders and depression are frequently associated with substance use disorders, currently there are few integrated treatment programs available in VA to address these co-existing disorders.

Given the need we see for these specialized services not only in the older veteran population cohorts but especially in the latest generation of war veterans, these findings are of great concern to the DAV.

The Relationship Between Substance Use Disorders and Other Major Medical and Mental Health Conditions

According to experts and published literature, substance use disorders are common co-morbidities with other medical and mental health conditions. Some significant examples include—

- Veterans with PTSD often use alcohol or other drugs to blunt memory, escape pain and self-medicate for stress. In recognition of this tendency, VA's evidence-based treatment guidelines for PTSD generally require that veterans in treatment for PTSD also receive screening and treatment for substance use disorders.
- Abuse of substances is a significant risk factor in suicidal ideation.[12]
- Literature indicates that up to 50 percent of veterans with severe mental illnesses (e.g. schizophrenia, bipolar disorder) also have a substance use problem.[13]
- The most common means of contracting Hepatitis C (a condition notably higher in the veteran population than the general population), and other serious liver diseases, is through injection of illicit drugs. Furthermore, the most effective treatments for Hepatitis C require that the patient not be currently abusing alcohol or other drugs before treatment can commence.
- Excessive use of alcohol or other drugs complicates the treatment of diabetes, cardiac disorders and other major medical diseases and conditions.
- VA reports that approximately 70 percent of homeless veterans receiving services from VA suffer from alcohol or drug abuse problems.[14]

Conclusions

All the foregoing research, surveys, reports and experience validate that substance use disorders are prevalent among veterans, particularly younger veterans and those who have experienced combat or other significant trauma. Therefore, it is likely that OIF/OEF veterans will significantly increase demand for specialty sub-

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[11] Department of Veterans Affairs National Mental Health Program Performance Monitoring System, Fiscal Year 2006.

[12] An Achievable Vision: The Report of the Department of Defense Mental Health Task Force, June 2007.

[13] Department of Veterans Affairs National Mental Health Program Performance Monitoring System, Fiscal Year 2006 Report.

[14] United States Department of Veterans Affairs, Overview of Homelessness, March 6, 2008. http://www1.va.gov/homeless/page.cfm?pg=1.

stance abuse treatment services in VA. Unfortunately, many veterans, including younger OIF/OEF veterans, with substance use disorders do not have access to an array of comprehensive treatments across the VA healthcare system. Lack of access to such services will likely result in sub-optimal rehabilitation for thousands of veterans, including many with severe medical and mental health co-morbid conditions that require concurrent treatment of their alcohol and drug abuse disorders. Untreated substance abuse can result in severe physical consequences for the veteran, stress on the family, and marked increase in medical and social costs including loss of employment and in some cases, serious legal difficulties.

VA Policies and Treatment Programs Need Further Adaption

VA and DoD evidence-based treatment guidelines for substance use disorders document the substantial research supporting effectiveness of a variety of treatments. Based on these guidelines, we believe veterans should have access to a full continuum of care for substance use disorders including: screening in all care locations, particularly in primary care; short term outpatient counseling including motivational intervention; ongoing aftercare and outpatient counseling; intensive outpatient treatment; residential care for the most severely addicted; widely available detoxification and stabilization services; ongoing aftercare and relapse prevention; self-help groups; and, opiate substitution therapy and other pharmacological treatments, including access to newer drugs to reduce cravings.

Additionally, VA must continue to educate its primary care providers about, and fully implement these guidelines, including better detection of substance use disorders in veterans under VA care, to ensure that problems are identified early and that patients are referred for appropriate treatment. Substance use—common as a secondary diagnosis among newly injured veterans and others with chronic illness or injury—can often be overshadowed by acute care needs that may seem more compelling. Therefore, we urge VA and DoD to continue research into this critical area and to identify the best treatment strategies to address substance use disorders and other mental health and readjustment issues collectively.

A final concern we have is VA's practical policy to serve as a seemingly "rock bottom" program in substance abuse treatment and rehabilitation. It appears that VA's main focus in providing substance abuse treatment is to serve a population that has not abated their substance misuse and consequently have deteriorated to a point of social or medical disfunctionality. While we applaud VA's efforts to save individuals from the misery of chronic addiction, we are concerned about the locus of this program because of reports that "hazardous" and "non-dependent" use of drugs and alcohol in seemingly functional OIF/OEF veterans is significant. We believe VA's focus on the most severe dependent substance abusers to the exclusion of this newer generation of problem drinkers and occasional pre-dependent drug users will cause many newer combat veterans additional misery and decline that could be avoidable. We urge VA to revamp its programs to focus on earlier interventions in individuals' misuse of substances.

Recommended Legislative Action

With these views in mind, DAV recommends the Subcommittee advance legislation that—

- Mandates VA provide a full continuum of care for veterans with substance use disorders equitably across the country. These services should be available at all medical centers with outpatient counseling and pharmacotherapy available at all larger community based outpatient clinics. Residential substance abuse treatment should be readily available for those requiring a higher level of care in each network. Brief motivational interventions, particularly for hazardous drinkers, should be offered in primary care settings whenever possible. Additionally, VA should employ peer counselors for outreach to OIF/OEF veterans struggling with substance use problems.
- Allocates adequate funding to assure that this full continuum of substance use disorder care is provided, on an equitable basis, for all veterans who need it.
- Requires an annual update on the progress in providing equitable access to a full continuum of substance abuse care. This report should include meaningful data on the number of veterans provided specialty substance use disorder care; the results of universal screening for substance abuse in primary care; and, a measurement of the availability of services at each facility and in each network as specified by VA's adopted national clinical practice guidelines for substance use disorder care.
- Authorizes a pilot program specifically designed to offer web-based options for substance use treatment and group support targeted at OIF/OEF veterans who reside in rural or remote areas.

- Provides specifically designated funding for research projects to identify the best treatment strategies and practices to collectively address substance use disorders and other co-morbid mental health readjustment issues.

Closing

Mr. Chairman, the current overseas deployments to combat theaters in Iraq and Afghanistan (and other Global War on Terror deployments) are resulting in not only serious physical injuries to veterans but heavy casualties in what are considered the "invisible" wounds of war: PTSD, depression, family disruptions and divorce, hazardous drinking and drug use, and a number of other social and emotional consequences for those who have served. DoD, VA and Congress must remain vigilant to ensure that federal programs aimed at meeting the extraordinary needs of disabled veterans are sufficiently funded and *adapted* to meet them, while continuing to address the chronic health maintenance needs of older disabled veterans who served in earlier military conflicts. Also, Congress must remain apprised about how VA spends the significant new funds that have been added and earmarked for the purpose of meeting post-deployment mental healthcare and physical rehabilitation needs of veterans who served in OIF/OEF.

DoD and VA share a unique obligation to meet the healthcare and rehabilitative needs of combat veterans who have been wounded or who may be suffering from severe readjustment difficulties as a result of combat and hardship deployments. We owe our Nation's disabled veterans access to timely and appropriate healthcare services including specialized substance use treatment programs for those suffering with both mental health and substance use disorders. We must ensure that VA establishes and sufficiently funds effective programs now aimed at prevention, early intervention, outreach and education and training for veterans and their families to close the current gaps that exist. Finally, as we indicated earlier in this statement, DAV believes that having a substance use disorder should not be a barrier to receiving care for that condition or entrance into any other VA specialized treatment program. We deeply appreciate that the Subcommittee is addressing these issues with both oversight and legislation when appropriate. To that end, we note and thank the Chairman and Ranking Member for jointly introducing the "Veterans Substance Use Disorders Prevention and Treatment Act of 2008," an Act that would accomplish many of the goals we have identified in this testimony, to address substance use disorders in the veteran population.

Mr. Chairman, this concludes my statement, and I will be pleased to respond to any questions you may wish to ask with regard to these issues.

Prepared Statement of Thomas J. Berger, Ph.D.,
Chair, National PTSD and Substance Abuse Committee, Vietnam Veterans of America

Mr. Chairman, Ranking Member Miller, distinguished members of this Subcommittee, and guests, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on substance abuse and co-morbid disorders. Foremost, Vietnam Veterans of America thanks this Subcommittee for your leadership in holding this hearing today on a most serious concern within our veterans' community.

Each month hundreds of active duty troops, reservists and National Guard members return to their families and communities from deployment in Iraq and Afghanistan. Given the demanding and traumatizing environments of their combat experiences, many veterans experience psychological stresses that are further complicated by substance use and related disorders. In fact, research studies indicate that veterans in the general U.S. population are at increased risk of suicide.

Moreover, according to the results of a national Survey on Drug Use and Health report issued by SAMHSA in November 2007, among veterans of the wars in Iraq and Afghanistan who received care from the Department of Veterans Affairs between 2001 and 2005, nearly one-third were diagnosed with mental health and/or psychosocial problems and one-fifth were diagnosed with a substance use disorder (SUD). Substance dependence or abuse includes such symptoms as withdrawal, tolerance, use in dangerous situations, trouble with the law, and interference in major obligations at work, school, or home during the past year. Individuals who meet the criteria for either dependence or abuse are said to have a SUD.

In this NSDUH report, combined data from 2004 to 2006 indicate that an annual average of 7.0 percent of veterans aged 18 or older (an estimated 1.8 million persons annually) experienced serious psychological distress (SPD) in the past year. Veterans aged 18 to 25 were more likely to have had an SPD (20.9 percent) than vet-

erans aged 26 to 54 (11.2 percent) or those aged 55 or older (4.3 percent). Female veterans were twice as likely as male veterans to have had an SPD in the past year (14.5 vs. 6.5 percent). And veterans with family incomes of less than $20,000 per year were more likely to have had an SPD in the past year than veterans with higher family incomes.

Substance Use Disorders

The combined data from 2004 to 2006 also indicate that an annual average of 7.1 percent of veterans aged 18 or older (an estimated 1.8 million persons) met the criteria for a SUD in the past year. One-quarter of veterans aged 18 to 25 met the criteria for a SUD in the past year compared with 11.3 percent of veterans aged 26 to 54 and 4.4 percent of veterans aged 55 or older. There was no difference in SUD between male and female veterans (7.2 vs. 5.8 percent). And veterans with a family income of less than $20,000 per year (10.8 percent) were more likely to have met the criteria for a SUD in the past year than veterans with a family income of $20,000 to $49,999 (6.6 percent), $50,000 to $74,999 (6.3 percent), or $75,000 or more (6.7 percent).

Co-occurring Disorders

From 2004 to 2006, approximately 1.5 percent of veterans aged 18 or older (an estimated 395,000 persons) had a co-occurring SPD and SUD. Increasing age was associated with lower rates of past year co-occurring SPD and SUD, with veterans aged 18 to 25 having the highest rate (8.4 percent) and veterans aged 55 or older having the lowest rate (0.7 percent). There was no significant difference in co-occurring disorders among males and females (1.5 vs. 2.0 percent, respectively). And veterans with family incomes of less than $20,000 per year were more likely to have had a co-occurring SPD and SUD in the past year than veterans with higher family incomes.

These data can be summarized briefly below—

Combined data from 2004 to 2006 indicate that an annual average of 7.0 percent of veterans aged 18 or older experienced past year serious psychological distress (SPD), 7.1 percent met the criteria for a past year substance use disorder (SUD), and 1.5 percent had co-occurring SPD and SUD.

Veterans aged 18 to 25 were more likely than older veterans to have higher rates of past year SPD, SUD, and co-occurring SPD and SUD. Veterans with family incomes of less than $20,000 per year were more likely than veterans with higher family incomes to have had SPD, SUD, and co-occurring SPD and SUD in the past year.

And we must remember these data represent only those veterans who chose to seek help for their disorders from the VA. Vietnam Veterans of America has no reason to believe that the numbers cited above would not be higher if more of our OEF and OIF veterans were to seek VA care.

The medical, social, and psychological toll from substance abuse disorders is enormous, both for the military and civilian sectors. In the face of such overwhelming damage, two questions emerge: Why does substance abuse receive relatively little medical and public health attention and support compared with other medical conditions? And what can be done to reduce the harm from substance abuse disorders?

Despite their huge health toll, substance abuse disorders remain underappreciated and under-funded. Reasons include stigma, tolerance of personal choices, acceptance of youthful experimentation, pessimism about treatment efficacy, fragmented and weak leadership, powerful tobacco and alcohol industries, underinvestment in research, and difficult patients.

Stigma: Despite emerging scientific evidence that substance abuse alters neurotransmitter patterns, many still stigmatize smokers, alcoholics, and drug abusers for having made unwise choices. They feel that even if central nervous system changes result from substance abuse, the choices were wrong in the first place. Another factor is the popular (and spurious) association of substance abuse with minorities. All too often, substance abuse is seen as having a black face, even though differences between blacks and whites in the prevalence of smoking and alcoholism and drug abuse do not support such stereotyping. Finally, public exposure to substance abuse can be polarizing, whether through secondhand smoke, raucous drunks, endangerment by an intoxicated driver, or encounters with aggressive alcoholic or drug-abusing homeless persons.

Civil liberties/free choice: A strong theme of U.S. culture is respect for choice and individual freedom. When the public health evidence is sufficiently compelling—such as with secondhand smoke or drunk-driving fatalities—regulatory measures can trump that civil libertarian tilt, but usually only after a long struggle.

Tolerance of youthful experimentation: Most adults experimented in their youth with tobacco, alcohol, and drugs, and most drink responsibly as adults. They view these experiences as developmental rites of passage and may be unsympathetic to the minority who become addicted.

Futility/hopelessness: The problems of substance abuse have been around so long that they seem to be intractable. In reality, there has been slow but impressive progress. U.S. smoking rates have declined since 2000, youth smoking is lessening, alcohol-related motor vehicle fatalities have fallen despite major increases in miles traveled, and the prevalence of illicit drug use has fallen.

Pessimism about treatment efficacy: Public officials and clinicians share a double standard about treating substance abuse. Although they embrace aggressive treatment for diseases with miserable prognoses (for example, pancreatic cancer and malignant melanomas), they are skeptical about funding substance abuse treatment in which rates of one-year remissions may vary for smoking and for alcoholism and drug abuse. In clinical settings, this attitude is reinforced by clinicians' natural reluctance to encounter failures—smokers and drinkers who will not or cannot quit. One reason for this double standard is that substance abuse disorders are seen as volitional, while aggressive cancers are not. And recent data show declines in receipt of substance abuse treatment under private health insurance.

Leadership: In contrast to breast cancer or HIV/AIDS, there are no aroused citizen advocacy groups for substance abuse disorders. The important exceptions of Mothers Against Drunk Driving and Students Against Drunk Driving and DARE stand as lone outliers to this rule. Undoubtedly, stigma makes it difficult for concerned groups to coalesce for public action. Even the most successful citizens group, Alcoholics Anonymous (AA), works undercover by design. Thus, there is no national "race for the cure" against smoking-induced lung cancer and no national mobilized women's group fighting to stop alcoholism, smoking, or drug abuse.

Fragmentation in the substance abuse field: Not only is there failure to coalesce among the three categories of substances, but even within each class there is rivalry, such as tensions between those who advocate for a twelve-step approach to drug and alcohol treatment and those who promote pharmaceutical treatment.

Industries' power: The tobacco and alcohol industries spend billions on advertising and promotion, not to mention their contributions to political campaigns. These industries exert powerful political influence and have a track record of successful opposition to programs that would reduce use of their products. Investigators working to reduce harm from tobacco have been subjected to legal harassment, including suits requiring submission of voluminous primary data, depositions, and court testimony.

Underinvestment in research: Despite the huge toll exerted by tobacco, only a small percent of the National Institutes of Health (NIH) budget is devoted to tobacco research. Similarly, the combined budgets of the National Institute on Drug Abuse (NIDA) and the National Institute on Alcohol Abuse and Alcoholism (NIAAA) amounted to $1.38 billion in 2003, or less than 5 percent of total NIH expenditures.

Difficult patients: Clinicians find it hard to care for patients with substance abuse problems. This reflects the limited education and training most clinicians receive on this topic and disappointment that so few patients follow their advice about quitting. At least in the case of drug-seeking behavior (when patients seek narcotics from physicians), the doctors may stop trusting these patients.

Despite the obstacles noted above, VVA believes that a coordinated workable agenda within the military and the civilian population is possible to lessen the impact of substance use disorders. But this coordinated agenda must include the following—

Better approaches to treatment: Adequate treatment for substance abuse is particularly challenging for America's uninsured. Even for the insured, many policies, including most Medicaid programs, do not cover the time for counseling or the costs of drugs such as nicotine replacement therapy and bupropion for smoking cessation, methadone for drug addiction, or disulfiram for alcoholism.

As new, effective drugs come on the market, patients must have access to them. Clinicians and policymakers need to reframe how "successful treatment" is defined. Physicians caring for patients with asthma or diabetes understand that these are chronic illnesses and that the goal is to maximize functioning and minimize disability. By contrast, many clinicians become frustrated because it is difficult to "cure" smokers, alcoholics, or drug abusers. Rather than acknowledging that patterns of use often follow a waxing and waning course, that a year of sobriety is cause for triumph and social good, and that it may take many attempts before a patient is able to quit, they too often see the glass as half empty. Envisioning the goal of substance abuse treatment as managing chronic illness—including knowing appropriate referral sources within the community and the roles of non-physician

professionals—could help doctors celebrate the tangible benefits of such treatment, instead of lamenting the reality that cures for most chronic diseases are often elusive. Drug courts, which offer treatment as an alternative to incarceration, are a promising but greatly underused resource.

More support for research: Devote 20 percent of the current NIH budget to substance abuse research rather than the current amount. Beyond studying the basic science of addiction and exploring new pharmacologic treatments, research could help us understand why some people who experiment with substances become addicted while others do not, the comparative efficacy of different modes of treatment, the complexities of dual diagnosis (co-occurring mental illness and substance abuse), the social context of addiction, and the impact of various social policies on addiction and the harm it causes.

Better education of health professionals: Substance abuse receives minimal notice in undergraduate and graduate medical education, specialty board certifying exams, continuing medical education, standard clinical textbooks, and medical journals. Not only is content slighted, but it is rare for medical education to acknowledge the role of other health professionals in treating substance abuse or the workings of twelve-step programs such as AA. This relative under-emphasis reflects the reality that few medical faculty work in the area of substance abuse. The neglect is disappointing, given the extent to which substance abuse accounts for illness in Veterans Affairs (VA) and county hospitals—sites of intensive medical education for most academic medical centers.

Nongovernmental funding: Although government will continue to provide the bulk of substance abuse treatment and research dollars, there are gaps in its funding. Some interventions—such as needle exchanges for heroin addicts as a way to reduce the transmission of HIV and hepatitis—may challenge strongly held ideological views, thus precluding government support. Also, the power of the tobacco and alcohol industries may deter adoption of proven public health strategies such as raising cigarette taxes or lowering the permissible blood alcohol level for drivers. Because there are areas where government either will not or cannot take a stand, private support matters. Examples are the role of the ACS and the Robert Wood Johnson Foundation in establishing the CTFK, the counter-marketing of the American Legacy Foundation and the Partnership for a Drug-Free America, and the Conrad N. Hilton Foundation's support for substance abuse educational programs in public schools.

Stronger leadership needed: Greater recognition of substance abuse as a major health problem should encourage broader and more diverse leadership. Whether that leadership can or should transcend the individual substance categories is not clear. It may be that lumping together marijuana, beer, cigarettes, and heroin is too unwieldy to generate a unified constituency. Although substance abuse affects women's health, it has yet to surface on the advocacy agenda of the many women's organizations.

Drug policies: Providing adequate treatment for community-based and incarcerated people with drug addiction generates social and medical savings: lower crime, lower prison spending, less family dysfunction, and better health. A RAND report of mandatory minimum sentences for cocaine concluded that dollar for dollar, treatment is fifteen times more effective than incarceration in reducing serious crime. Another study showed that treatment for substance abuse in criminal justice settings lowers re-incarceration rates. Also, providing clean needles for heroin addicts reduces the transmission of blood-borne diseases.

Reform of the criminal justice system for substance abuse: Federal and state legislation imposes mandatory terms for possession of illicit drugs, thereby removing sentencing discretion from the hands of judges. Greater flexibility would reduce the cost and burden of incarceration and give many a chance for rehabilitation. Despite evidence that providing treatment and drug testing instead of incarceration can reduce both penal and social costs and increase the rate of drug rehabilitation, these approaches remain rare. Expansion will require permissive laws and knowledgeable judges. State corrections officials estimate that 70–85 percent of inmates need some level of substance abuse treatment. But in approximately 7,600 correctional facilities surveyed in 1997, less than 11 percent of the inmates were in drug treatment programs. Requiring substance abuse treatment as a condition of parole has been shown to increase treatment as well as abstinence from drug use.

Substance abuse remains a serious medical, public health, and social problem. Yet it lacks champions, is underfunded, and is relatively neglected by clinicians and the medical establishment. Despite some real progress in the past decade, the United States still lags behind virtually every developed country in measures of health status. Our current national strategy to close that gap involves funding biomedical research to yield new treatments and improving access to care for

Everyone, including America's veterans. Both are worthwhile goals but are doomed to failure unless they are coupled with effective policies to reduce harm from substance abuse.

Thank you again for the opportunity to offer our views on this issue and I shall be glad to answer any questions.

Prepared Statement of Todd Bowers
Director of Government Affairs, Iraq and Afghanistan Veterans of America

Mr. Chairman, ranking member and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America, and our tens of thousands of members nationwide, I thank you for the opportunity to testify today regarding veterans' substance abuse.

In particular, I would like to thank the committee for recognizing the issue of comorbidity. As the committee knows, among the hundreds of thousands of troops returning from Iraq and Afghanistan with a mental health injury, a small but significant percentage is turning to alcohol or drugs in an effort to self-medicate. Veterans' substance abuse problems, therefore, *cannot* and *should not* be viewed as distinct from mental health problems.

According to the VA Special Committee on PTSD, at least 30 to 40% of Iraq veterans, or about half a million people, will face a serious psychological injury, including depression, anxiety, or Post Traumatic Stress Disorder or PTSD. Data from the military's own Mental Health Advisory Team shows that multiple tours and inadequate time at home between deployments increase rates of combat stress by 50%.

We are already seeing the impact of these untreated mental health problems. Between 2005 and 2006, the Army saw an almost threefold increase in "alcohol-related incidents," according to the DOD Task Force on Mental Health. The VA has reported diagnosing more than 48,000 Iraq and Afghanistan veterans with drug abuse. That's 16% of all Iraq and Afghanistan veteran patients at the VA. These numbers are only the tip of the iceberg; many veterans do not turn to the VA for help coping with substance abuse, instead relying on private programs or avoiding treatment altogether.

Effective diagnosis and treatment of substance abuse is a key component of IAVA's 2008 Legislative Agenda. First and foremost, IAVA supports mandatory and confidential mental health screening by a mental health professional for all troops, both before and at least 90 days after a combat tour. Moreover, the VA must be authorized to bolster their mental health workforce in hospitals, clinics, and Vet Centers with adequate psychiatrists, psychologists and social workers to meet the demands of returning Iraq and Afghanistan veterans.

The shortage of mental health professionals in the VA is hampering the effectiveness of mental health and substance abuse treatment. A VA Deputy Undersecretary has admitted that waiting lists render mental health and substance abuse care "virtually inaccessible" at some clinics. In October 2006, almost one-third of Vet Centers admitted they needed more staff. By April 2007, more than half of the 200-plus Vet Centers needed at least one more psychologist or therapist. As a result of the staffing shortage, veterans seeking mental health care get about one-third fewer visits with VA specialists now, compared to ten years ago. Veterans in rural communities are especially hard-hit. For instance, Montana ranks fourth in sending troops to war, but the state's VA facilities provide the lowest frequency of mental health visits.

Effective treatment of veterans' mental health and substance abuse issues requires the real commitment of the Congress to fund an expansion of the corps of VA mental health professionals. But improving veterans' mental health care is not simply a legislative fix. That is why IAVA has partnered with the Ad Council, the nonprofit organization responsible for some of America's most effective and memorable public service campaigns, including "A Mind is a Terrible Thing to Waste," "Only You Can Prevent Forest Fires," and "Friends Don't Let Friends Drive Drunk." This summer, the Ad Council and IAVA will launch a multi-year campaign to destigmatize mental health care for service members and their families. The broadcast, print, web and outdoor ads will encourage those who need it to seek mental health care and inform all Americans that seeking help is a sign of strength rather than weakness. We are very excited to partner with Ad Council to help get troops, veterans, and their families the care they need and deserve.

I thank you for providing me the opportunity to testify before you this afternoon. I would like to point out that my testimony today does not reflect the views of the United States Marine Corps. I am here testifying today in my civilian capacity as the Director of Government Affairs for Iraq and Afghanistan Veterans of America.

All the data and IAVA recommendations I have cited are available in our Mental Health report and our Legislative Agenda. It would be my pleasure to answer any questions you may have for me at this time.

Respectfully submitted.

Prepared Statement of Antonette Zeiss, Ph.D.,
Deputy Chief Consultant, Office of Mental Health Services, Veterans Health Administration, U.S. Department of Veterans Affairs

Mr. Chairman and members of the Subcommittee, I am pleased to be here today to discuss the ongoing steps that the Department of Veterans Affairs (VA) is taking to treat substance abuse and co-morbid disorders. I am accompanied by Mr. Charles Flora, Associate Director of Readjustment Counseling Service. Mr. Flora is a clinical social worker and Vietnam veteran, and has a lifetime of experience in readjustment counseling at both the Vet Center and national levels.

Also accompanying me is Dr. John Allen, Associate Chief Consultant for Addictive Disorders. Dr. Allen is a national expert on substance use disorders and is a veteran of Operation Iraqi Freedom. His commitment to this work goes beyond the call of a doctor-patient relationship and echoes the pledge our service members make to one another. While VA has always taken the problem of substance use disorder (SUD) very seriously and has demonstrated our commitment to helping our veterans overcome this disease, we welcome Dr. Allen's personal connection to our returning veterans.

We thank the Committee and you, Chairman Michaud, for your active interest in this topic. Tragically, substance use disorders are common in our society, as they are in many societies. As all of you know, the incidence of substance use among veterans tends to exceed that of comparable civilian populations. One study by Todd Wagner, *et al.* from 2007 found veterans are more likely than non-veterans to report driving under the influence of alcohol, smoking daily, and using marijuana. In another study, by Dr. Charles Hoge and published in the New England Journal of Medicine in 2004, the number of respondents who admitted to using alcohol more than they intended increased seven percent among Army respondents after deployment to Iraq or Afghanistan. Alcohol and drug misuse are associated with a host of medical, social, mental health, and employment problems. Fortunately, these problems are treatable, and with treatment, the lives of our patients and their loved ones can be enriched.

Since the implementation of the Mental Health Strategic Plan, VHA has dedicated more than $458 million to improve access and quality of care for veterans who present with SUD treatment needs. We have authorized the establishment of 510 new substance use counselors and plan to continue expanding SUD services throughout Fiscal Year 2008 (FY 2008) and FY 2009. In FY 2008, for example, our mental health enhancement budget includes over $37.5 million for expanded SUD services. VA is developing plans to allocate medical care funds from the FY 2008 funding to hire even more new professionals, develop new programs, expand existing services, and create an appropriate physical environment for care by upgrading the safety and physical structure of inpatient psychiatry wards, as well as domiciliary and residential rehabilitation programs.

VA has increased the number of intensive outpatient SUD programs and plans further expansion. This reflects the continued transition from inpatient care to more effective intensive outpatient care for treating substance abuse problems.

These efforts will increase access to substance abuse services throughout VA.

Whenever a veteran is seen by a VA provider, he or she is screened for PTSD, military sexual trauma, depression, and problem drinking. We recognize screening is only valuable if we act upon positive screens and follow-up in a timely manner, and we are committed to doing that.

For those needing additional services, VA's outpatient and inpatient SUD programs are available; there are more than 220 programs in place, with more in development. Detoxification services may be offered in inpatient units such as medicine, psychiatry, or inpatient chemical dependency units, but the majority of patients requiring detoxification are managed on an outpatient or ambulatory basis. Following detoxification, substance use disorder patients are generally seen in outpatient specialty clinics. VA maintains extended care facilities, including 19 inpatient programs designed specifically to treat SUD patients for 14 to 28 days. Additionally, there are 44 SUD residential rehabilitation treatment facilities, 15 SUD compensated work therapy programs, and 19 SUD focused domiciliaries. We also offer mental health intensive case management, where teams of VA health care providers visit patients in their own living arrangements.

Most SUD patients are treated once or twice a week in outpatient clinics, while others may require more intensive outpatient care for a minimum of four hours per day. Thirty-four of the intensive outpatient facilities have the capability of offering treatment five days a week, and telemedicine services are offered to patients living in remote sites. Veterans with serious mental illness in addition to SUD, are seen in specialized programs, such as intensive outpatient substance use disorder clinics, mental health intensive case management, psychosocial rehabilitation and recovery day programs, and work programs.

Common elements of treatment for SUD include FDA-approved medications, employment of cognitive-behavioral therapies, incorporation of peer support groups (such as Alcoholics Anonymous), enlistment of the support of significant others, and linking the veteran to community services.

Mental healthcare, including attention to SUD, is being integrated into primary care clinics, and we also are integrating mental health services into VA's Community Based Outpatient Clinics (CBOCs), VA nursing homes, and residential care facilities. Placing mental health providers in the context of primary care for the veteran is essential; it recognizes the interrelationships of mental and physical health, as well as providing mental healthcare at the most convenient and desirable location for the veteran.

VA has allocated $57.6M over the last three years to expand the capacity of our Domiciliary and Residential Rehabilitation Treatment (DRRT) bed programs. This expansion relieves pressure on acute psychiatric and SUD beds, but more importantly, these Residential Rehabilitation programs provide a therapeutic placement for recovering patients in a longer term rehabilitation setting. They offer intensive therapy experiences, well beyond what is offered in acute inpatient programs, and thus are a more appropriate level of care for the veteran. VA funded eleven new DRRT programs between FY 2005 and FY 2007, and during that same period, enhanced staffing for specialized services, like SUD treatment, in fifteen others.

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 mental health services for veterans. We have steadily increased the number of these mental health professionals over the last two and a half years. Currently, we have hired over 3,800 new mental health staff in that time period, for a total mental health staff of over 16,500. Appropriate attention to the physical and mental health needs of veterans will have a positive impact on their successful re-integration into civilian life.

In addition to the care offered in medical facilities and CBOCs, VA's Vet Centers provide outreach and readjustment counseling services to returning war veterans of all eras. It is well-established that rehabilitation for war-related PTSD, SUD, and other military-related readjustment problems, along with the treatment of the physical wounds of war, is central to VA's continuum of healthcare programs specific to the needs of war veterans. The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the veteran as a whole person in his/her community setting. Vet Centers provide an alternative to traditional mental healthcare that helps many combat veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses and social workers, many of whom are veteran peers.

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

VA is currently expanding the number of its Vet Centers. In February 2007, VA announced plans to establish 23 new Vet Centers increasing the number nationally from 209 to 232. This expansion began in 2007 and is planned for completion in 2008. Fifteen of the new Vet Centers have hired staff and are fully open. Five Vet Centers have hired staff and are providing client services, but are operating out of temporary space while they finalize their lease contracts. The three remaining Vet Centers are actively pursuing and/or completing staff recruiting and lease contracting. They will all be open by the end of the fiscal year.

To enhance access to care for veterans in underserved areas, some Vet Centers have established telehealth linkages with VA medical centers that extend VA men-

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

Since hostilities began in Afghanistan and Iraq, the focus of the Vet Center program has been on aggressive outreach at military demobilization and at National Guard and Reserve sites, as well as at other community locations that feature high concentrations of veterans and family members. To promote early intervention, the Vet Center program hired 100 OEF and OIF veteran returnees to provide outreach services to their fellow combatants. These fellow veteran outreach specialists are effective in mitigating veterans' fear and stigma associated with seeking professional counseling services.

From early in FY 2003 through the end of FY 2007, Vet Centers have provided readjustment services to over 268,987 veteran returnees from OEF and OIF. Of this total, more than 205,481 veterans were provided outreach services, and 63,506 were provided substantive clinical readjustment services in Vet Centers.

VA's research program also demonstrates our commitment to providing the best care possible for veterans with substance use disorders. The VA Office of Research and Development (ORD) directly funds approximately 100 active research studies of addictive disorders, including basic biological mechanisms of dependence, abuse and relapse, as well as genetics of alcoholism, treatments of alcoholism, drug abuse, and nicotine addiction. Many of VA's most eminent scientists, including a large cadre of VA Research Career scientists and our 2004 Middleton Awardee (VA's highest honor for medical research), are devoting their careers to further understanding and treating substance use disorders in the veteran population. ORD is also working closely with the National Institutes of Health, specifically the National Institute of Mental Health and the National Institute of Drug Abuse, to forge research collaborations on substance abuse co-morbidities with mental illness, such as PTSD.

Substance use disorder is a real problem, and its manifestation along with other mental health conditions can lead to physical health concerns, difficulty readjusting to civilian life, and a host of other problems. One of VA's highest priorities is to reduce the impact of substance abuse and provide veterans with the care they need. Thank you for your time and for the opportunity to discuss this important issue with you. I would be happy to address any questions you may have.

Statement of Joseph L. Wilson
Deputy Director, Veterans Affairs and Rehabilitation Commission,
American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on "Substance Abuse/Co-Morbid Disorders: Comprehensive Solutions to a Complex Problem."

According to the Government Accountability Office (GAO), the Department of Veterans Affairs (VA) drastically reduced its substance-use disorder treatment and rehabilitation services between 1996 and 2006. The number of veterans receiving specialized substance abuse treatment services has since decreased by 18 percent. According to VA records, the total of mental health cases among war veterans grew by 58% from 63,767 on June 30, 2006, to 100,580 on June 30, 2007. These mental health issues include Post Traumatic Stress Disorder (PTSD), drug and alcohol dependency and depression.

VA's Antoinette Zeiss, Deputy Chief of Mental Health Services, acknowledged VA is seeing the increase (in mental health cases) and is preparing to deal with it. Mr. Chairman, these facts suggests a system that's experiencing an increase, which also warrants the appropriate increase in staffing, funding, and clinical inpatient, outpatient and outreach programs. As for the decrease of substance abuse treatment services, with the influx of veterans seeking treatment, the possibility of them falling through the cracks is heightening.

The Diagnostic Statistical Manual IV (DSM) defines substance-use disorders as dependence or abuse of drugs or alcohol. When discussing treatment for veterans within PTSD clinics, the terminology, substance abuse, is included in the definition of substance-use disorders.

Post Traumatic Stress Disorder and Substance Abuse

In veteran and population samples, substance-use disorders co-occur with Post Traumatic Stress Disorder (PTSD). Symptoms of PTSD include hyper-vigilance, irritability, outbursts of anger, sleeplessness and fatigue, and can be accompanied by alcoholism, depression, anxiety and substance abuse.

VA has acknowledged some veterans with PTSD treat their own symptoms with alcohol and wind up with diagnoses related to drug abuse. VA also acknowledges when veterans screen positive for symptoms of PTSD, they are interested in whether or not these also veterans have accompanied problems, such as, problem drinking and other problems.

According to VA, there was a time in the past when coexisting conditions may have been barriers to care, when it was difficult to treat patients with PTSD and substance abuse due to PTSD programs requiring veterans to be sober and substance-abuse programs requiring them to be stable. VA claims this no longer occurs due to evidence-based strategies for beginning PTSD and substance abuse treatment simultaneously. One approach, the program titled, "Seeking Safety," is being disseminated throughout the VA medical system.

H.R. 4053 Mental Health Improvement Act of 2007

Section 102 includes provision of substance-use disorder treatment services at each VA Medical Center (VAMC) and Community Based Outpatient Clinic (CBOC). These services are as follows:

- short term motivational counseling;
- intensive outpatient care; relapse prevention;
- ongoing aftercare and outpatient counseling;
- opiate substitution therapy;
- pharmacological treatments aimed at reducing craving for drugs and alcohol;
- detoxification and stabilization; and
- other services as deemed appropriate.

Section 103 recommends VA provide veterans either inpatient or outpatient care for a substance-use disorder and a co-morbid mental health disorder, and ensure that treatment for such disorders is provided concurrently by a team of clinicians with appropriate expertise.

Section 104 calls for the enhancement of care and treatment for veterans with substance-use disorders and PTSD, which is to be carried out through a competitive allocation of funds to facilities of VA for the provision of care and treatment to veterans who suffer from the aforementioned. Section 104 further suggests usage of Peer Outreach programs to re-engage veterans of Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) who miss multiple appointments for treatment of PTSD or substance use disorder.

Mr. Chairman, Congress and VA have acknowledged the appropriate treatment programs implemented to ensure inclusive treatment of substance abuse within the PTSD clinical environment. However, if studies are concluding a decline in treatment for substance abuse within the VA healthcare delivery system, this would suggest a gross lack of communication and outreach in which to ensure a high concentration of treatment, thereby maximizing the chance of the nation's veterans of slipping through the cracks, as well as continued substance abuse.

The American Legion holds the position that veterans who succumb to self-medication caused by their service-connected disability, such as PTSD, are entitled to a level of compensation that reflects all aspects of their disability. We also urge Congress to support the aforementioned proposals of H.R. 4053, to include assessing and/or auditing the implemented programs throughout the VA healthcare delivery system to ascertain whether or not all veterans have access or are accessing these programs.

Conclusion

As for programs and supporting regulations currently in place; the nation's veterans continue to be deprived of treatment for substance abuse secondary to PTSD, which suggests an interruption and or gap in comprehensive care that ensures adequate treatment. Not meeting this mark also implies incomplete treatment which further invalidates the term, "full continuum of care" for those who served this nation with honor.

In addition, if proposals such as H.R. 4053 are required to heighten outreach, disseminate appropriate treatment, and reassure acknowledgement of the implementation of related programs throughout the entire VA population, thereby guaranteeing the nation's veterans receive specialty care within the PTSD clinical environment,

we encourage execution of such proposals. The American Legion supports the consistency of treatment throughout the veteran population nationwide, to include clinical programs in VAMC's, CBOC's, Vet Centers and related VA facilities.

Mr. Chairman and members of the Subcommittee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues to resolve this critical issue. Thank you.

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

Thank you, Mr. Chairman:

The physical and mental demands of military service including exposure to combat trauma and balancing both military and family responsibilities make those who bravely defend our freedoms at a higher risk for developing substance use disorders.

I am very concerned about recent reports showing substance use disorders may be rising, particularly among younger veterans, and that many of these veterans suffering with substance use disorders also have other co-occurring mental health problems.

In recent years, the VA has made progress in screening veterans and expanding treatment programs for substance use disorders.

Still, the stigma associated with the substance use disorders and limited access to comprehensive treatment in many rural areas, keep veterans, especially those with co-occurring disorders, from getting the help and care they need.

Substance use disorders can be treated and recovery is possible. That is why it is critically important that we understand the nature of substance use disorder among our veterans and effectively break the barriers that prevent them from obtaining treatment services.

Chairman Michaud and I have joined in a bipartisan effort in introducing the Veterans Substance Use Prevention and Treatment Act of 2008.

Our bill, H.R. 5554, would require each VA medical facility to provide ready access to comprehensive care for substance use disorders. Screening would be required in all settings, including primary care. Detoxification, intensive outpatient care, relapse prevention services, residential treatment, peer-to-peer counseling and marital and family counseling would be among the required services.

The legislation will also direct VA to conduct a pilot program for Internet-based substance use disorder treatment for veterans of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF).

This new generation of veterans is comfortable with computer technology. This program will allow VA to utilize new and innovate ways to reach those in need and hopefully help overcome the stigma that can be a large barrier to care for many military personnel.

Substance use disorders complicated by co-occurring mental illnesses are difficult to treat. Underscoring the need for VA to focus on early detection, the dissemination of best practices and implementing a full continuum of care throughout the VA system.

I look forward to hearing from our witnesses today and working together to support effective treatment and empowering those veterans who develop a substance use disorder to overcome their condition and lead productive lives.

I want to thank everyone that is here today for taking the time to be a part of this important hearing and yield back the balance of my time.

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