

Written Testimony  
to the  
Committee on Veterans  
jointly with the  
Committee on Mental Health, Mental Retardation, Alcoholism,  
Drug Abuse and Disability Services

Concerning

Are NYC's Returning Veterans Receiving Appropriate Mental  
Health & Substance Abuse Treatment Services?

Submitted by:

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The Wounds of War  
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Just as the nature of war does not change, so, too, does the nature of the wounds of war seem never to change. Yet, each war era's service members return from the front lines with certain illnesses, disorders and disabilities that distinctively associate them with the conflicts in which they served. Civil War-era veterans will be remembered for their brutal assembly-line amputations, certain veterans of World War II and the Cold War for cancers due to exposure to ionizing radiation, Korean War-era veterans for cold weather injuries, Vietnam War-era veterans for diseases resulting from toxic exposures (most notably Agent Orange/Dioxin) and veterans of the First Persian Gulf War for undiagnosed illnesses, collectively called Gulf War Syndrome.

Accompanying these "signature" wounds is the ever-present post-traumatic stress disorder (PTSD), an often debilitating psychiatric disorder that is triggered by an extraordinarily stressful event such as combat, vehicular accidents and violent assaults. PTSD has been around since the dawn of war and has been commonly known through the ages by many names – shell-shock, battle fatigue, war neurosis, etc. The fact remains that like the signature wounds of any particular war, PTSD can become a life-long battle for not only the veteran, but his or her family and friends as well. Veterans of the Global War on Terror and Operations Enduring Freedom (OEF) and Iraqi Freedom (OIF) are no exception. Sadly, OEF and OIF veterans have developed their own signature wound: Traumatic Brain Injury (TBI).

**The Departments of Veterans Affairs (VA) and Defense (DoD) estimate that anywhere from one-third to upwards of 40% of returning OEF/OIF troops suffer from TBI and/or PTSD.** TBI, like PTSD, can be insidious, especially when it follows a closed-head injury where there is no external wound, but the brain is rattled in the skull like a bell clapper. Symptoms may not manifest for months or much longer after the injury, and not all of the symptoms are physical. Memory loss, decreased cognitive function, behavioral and personality changes, dementia and PTSD often result from TBI. These conditions can accompany neurological symptoms, such as seizures, headaches, impaired reflexes, nervous ticks, as well as post-concussive syndrome (PCS), which can manifest as dizziness, headaches, vertigo, nausea, insomnia and depression.

The prevalence of improvised explosive devices (IEDs), rocket-propelled grenade attacks as well as mortar- and small-arms fire in Iraq and Afghanistan have resulted in more reported brain injuries than in previous conflicts. IEDs are often packed with rocks, nails and other debris to inflict the most possible damage. Often, soldiers with open head wounds are immediately identified as potential TBI victims and are afforded state-of-the-art acute medical care and rehabilitation.

However, atmospheric concussion is just as effective in causing TBI as is a direct blunt impact or shrapnel to the head. Being concussed while wearing a helmet greatly enhances the danger of closed-head TBI. Because of the sometimes delayed onset of the symptoms that suggest that a veteran has sustained a TBI, the trick is to identify brain-injured personnel as soon as possible and to treat, or continually monitor, them if they are diagnostically clear or are asymptomatic.

In recognition of the need to identify TBI in OEF and OIF returnees, the VA recently adopted protocols to screen *any* veteran that served in either theater for TBI. **In April, 2007, the Veterans Health Administration issued Directive 2007-013, which imposed mandatory screening for all in-country veterans (i.e., personnel that were deployed to Iraq and Afghanistan), regardless of their military, occupational specialty. In other words, it doesn't matter if the individual served in the infantry or as a clerk or a truck driver. Since attacks can occur anywhere in either country, both are considered war zones in their entirety.** However, the VA does not solicit veterans for TBI screening. Rather, VA clinicians are instructed to determine whether any veteran who presents for treatment meets the screening criteria.

The screening process is triggered by a review of the patient's dates of military service and his or her deployment history. If the veteran served during OEF and OIF and were physically present in either theater, the veteran's service medical records are scanned for indications of injuries during service. If none are found, the veteran is asked a series of questions that are designed to elicit information about events and circumstances that might increase the risk of TBI, immediate or delayed symptoms following an event, new or worsening symptoms, and current symptoms. A yes to any of the questions should result in a neurological consultation. At least, that's the theory.

Previous experience with Vietnam- and First Persian Gulf War-era veterans screening programs has demonstrated that many VA clinicians were not aware of the programs at all, not trained in the screening protocols or simply did not perform the screenings. There is no reason to expect that things will work more efficiently with respect to the new TBI screening initiative. Consequently, OEF and OIF veterans and their family members must be proactive in helping to identify and treat TBI. If you or someone you know has served in either conflict and has experienced any event that might have resulted in TBI, the veteran should immediately go to the nearest VA medical facility and ask to be screened for TBI. The sooner that TBI is diagnosed, the better the chances of recovery become.

**Center for Independence of the Disabled, NY**



Testimony

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Committee on Veterans and Committee on Mental Health, Mental  
Retardation, Alcoholism, Drug Abuse and Disability Services

24 September 2007



Good Morning Chairmen Monserrate and Koppel. My name is Susan Dooha. I am the Executive Director of the Center for Independence of the Disabled of New York (CIDNY) with offices in Manhattan and Queens. CIDNY is a leading advocate for New Yorkers with disabilities. For nearly 30 years, we have been on the frontlines--helping to break down social, physical and perceptual barriers that can prevent people with disabilities from participating fully in mainstream life. We do this through policy and advocacy activities as well as benefits counseling and educational programming. All of our programming is geared to making sure that people with disabilities have the tools to live independently, provide for financial needs, and enjoy equal opportunities and that communities can identify and eliminate attitudinal barriers to full integration.

#### **The New York State Department of Health Traumatic Brain Injury Waiver**

Since October 2004, CIDNY has had a contract with the New York State Department of Health to provide oversight to persons with Traumatic Brain Injury who live in the community and receive services under the auspices of the New York State Department of Health Traumatic Brain Injury Medicaid Waiver Program (TBI Waiver). There are nine similar offices, called Regional Resource Development Centers, across the state. More than 2,000 New York State residents with significant traumatic brain injuries receive services under this program. As a person with a traumatic brain injury, I have a strong commitment to improving services available in the community.

The TBI Waiver Program allows people who otherwise would be forced to live in nursing homes, to live as independently as possible in the community with home-based assistance which can even include 24-hours a day, seven days per week coverage. Each waiver participant is eligible to access Medicaid providers offering case management services, independent living skills training, community integration counseling, and behavioral interventions, all done in the convenience of their home and or neighborhood. Additionally, there are three structured day programs in which waiver participants may participate (one in Brooklyn, one in the Bronx and one in Staten Island).

We are also fortunate that the Legislature appropriates money annually for a housing subsidy for those using waiver services, through which we can assist in paying rental costs. This allows us to help people who have been trapped in nursing homes because of the lack of affordable and accessible housing to return to the community. Each participant who is eligible pays one-third of their income towards their rent, the Department of Health pays the balance.

The TBI waiver program, in its early years, repatriated over 500 New Yorkers from out-of-state nursing homes, restoring dignity to waiver participants and reuniting families. Further, it continues to save the State and localities substantial money on Medicaid payments to nursing homes; approximately

\$20,000,000 this past year alone. This is documented annually in reports to the federal Center for Medicare and Medicaid (CMS).

#### **TBI the Costs**

The sobering reality of the costs and incidence of TBI are illustrated by the following data from the CDC presented at a meeting of the National Association of State Head Injury Administrators in September of this year:

- At least 1.6 million TBI's occur in the US each year (Rutland Brown et al, Journal of Head Trauma Rehab, 2006)
- In 2003, there were 51,000 deaths, 290,000 hospitalizations, 1,224,000 ED visits and an unknown number of TBI's treated in physicians' offices and in the military system.
- Each year an estimated 124,000 civilians hospitalized with TBI will have a life of long-term disability.

#### **TBI and Substance Abuse**

Much of the research dealing with substance abuse and TBI has been done under the auspice of the HRSA TBI Model Systems Grant at Ohio State University at the Ohio Valley Center for Brain Injury Prevention and Rehabilitation. Dr John Corrigan, a neuropsychologist has been the principal investigator associated with this research and the data that follows is from his work.

Approximately sixty percent of adolescents and adults treated for TBI in rehabilitation have prior history of substance abuse disorders. Substance abuse is positively associated with the likelihood of sustaining a TBI. A prior use of substances is associated with the severity of TBI, the more severe the TBI, the more likely a long history of substance abuse.

There has been little study of the effectiveness of standard substance abuse treatment with the population of persons with TBI. In fact, there is no screening for TBI in the majority of substance abuse treatment models, therefore making it highly likely that people with TBI are getting substance abuse treatment but the TBI is unknown both to the client and to the provider. In those cases where TBI is a known fact, our experience in New York indicates that most providers reject people with TBI because they claim they are unable to "handle" them.

Almost ten years ago now, Corrigan found that:

- "persons with traumatic brain injuries face several challenges when seeking treatment from substance abuse providers (Center for Substance Abuse Treatment, 1998). Cognitive impairments may affect a person's learning style, making participation in didactic training and group interventions more difficult. Misinterpretation of memory problems as resistance to treatment can undermine a treatment relationship. Damage to the frontal lobes affects executive thinking skills and promotes socially inappropriate behavior. Environmental cues may not be perceived,

creating consternation for fellow clients and staff. It is easy to interpret these behaviors as intentionally disruptive, particularly when the individual with a brain injury shows no visible signs of disability (Center for Substance Abuse Treatment, 1998)."

We also know that people with TBI are far more likely to discontinue treatment prematurely precisely because they are mischaracterized as non-compliant with the treatment regimen. In New York State, we have one inpatient substance abuse treatment center that has eight beds dedicated to men with TBI located at the Blaisdell ATC on the campus of Rockland State Psychiatric Center. While they provide an important service, even they, with specialized training in TBI, have difficulty integrating the TBI population with the current treatment modalities for substance abuse treatment.

#### **TBI and PTSD**

TBI can have a close relationship with Post Traumatic Stress Disorder (PTSD). Research seems to suggest that it can depend upon the specifics of the trauma.

When it does co-occur, PTSD and TBI together can be especially difficult to spot. The problem lies in the overlapping symptoms (increased anxiety, short attention span, limited concentration, problems with memory). This overlap is confusing to providers and it makes both detection and treatment very difficult.

As Dr Catherine Mindolovich points out:

"TBI would be distinguished by such symptoms as increased processing time, problems with abstract thinking, muscle fatigue, loss of coordination, and problems with speech, hearing, vision etc. On the other hand PTSD would have associated cognitive problems but be marked by specific symptom profile. ... [For PTSD, following a traumatic event] an individual may experience symptoms from three symptoms categories: 1. Re-experiencing; 2. Arousal; 3. Avoidance.

"So, similar to TBI, an individual may become anxious, agitated, startle easily, be irritable... but also express symptoms such as avoidance of situations where the TBI was acquired. For example, it's not hard to imagine someone who was injured in a car accident avoiding driving. But that person may also avoid walking along busy streets, or be hypervigilant when crossing a street. So, agitated arousal itself would not result in a diagnosis of PTSD, but that in combination with other symptoms might."

Although the human cost of TBI and PTSD is obvious and by far gives reason enough to do what we can to prevent such violent and life-changing injuries, there are financial considerations as well for every American taxpayer.

From a January 2006 paper, *The Economic Costs of the Iraq War: An Appraisal Three Years After the Beginning of Conflict* by Linda Bilmes and Nobel Prize-winning economist Professor Joseph E. Stiglitz:

"There is a special category of health care expenditures that go beyond those included in the above calculation -- for those with brain injuries. To date, 3,213 people - 20% of those injured in Iraq - have suffered head/brain injuries that require lifetime continual care at a cost of \$600,000 to \$5 million. The government will be required to commit resources through intensive care facilities, round-the-clock home or institutional care, rehabilitation and assisted living for these veterans.

"For the conservative estimate, we have used a midpoint estimate of a net present value of \$2.7 million over a 20 year expected survival rate for this group, which is about \$135,000 per year, yielding a cost of \$14 billion. This amount seems low for brain-injured individuals who will require round-the-clock care in feeding, dressing and daily functioning. For the moderate estimate, we use a higher cost estimate (\$4m) and assume longer life duration for a total cost of \$35 billion. In both cases we assume that the number injured will rise in a manner consistent with the duration of the conflict."

### **The Challenge of TBI, Substance Abuse, PTSD to all New Yorkers**

Today we confront a new challenge regarding Traumatic Brain Injury. TBI has been called the defining injury of the war in Iraq and Afghanistan.

In one of the early articles in the medical literature discussing TBI and the war, Dr Susan Okie writes,

"Among surviving soldiers wounded in combat in Iraq and Afghanistan, TBI appears to account for a larger proportion of casualties than it has in recent US wars...22% of the wounded soldiers from these conflicts who have passed through the military's Landstuhl Regional Medical Center in Germany had injuries to the head..." (NEJM 2005)

TBI occurs because of blast injuries primarily from the improvised explosive devices (IEDs) being used against US troops by resistance forces. Blast injuries can cause severe damage to the brain because of changes in air pressure when the devices explode producing brain concussion or brain contusion. The blast also creates high-speed winds and blast waves, which can propel bodies with a large amount of force also causing further injury to the brain. Up to twenty-five percent of people with blast injuries die from these in the field.

In order to cope with the influx of wounded vets, the Veteran's Administration has established a polytrauma system of care. They have designated four regional polytrauma centers for acute and comprehensive

rehabilitation of the severely injured. New York residents usually wind up in the Richmond, Virginia facility. They then come back to New York and most likely will be back at the Bronx Veterans Administration Hospital for rehabilitation-related services.

### **Our Concerns**

CIDNY is quite concerned that many returning vets with TBI will not be able to access services through the VA or elsewhere for a variety of reasons:

- Some were not screened for TBI in the field or upon return to the community. They may not be aware that they have a condition and the option of obtaining treatment.
- Others may have been dishonorably discharged for behaviors related to their undiagnosed TBI. They may not turn up in systems until they appear at a shelter or a jail.
- Family members are often unable to cope with the changes in their loved one, the veteran's relationship with family and friends may have been disrupted and therefore there may be no circle of support available to assist.
- As we have illustrated, some people with TBI exhibit behaviors that are similar to mental health or PTSD symptoms and when they do so are often relegated to systems of care not necessarily prepared to address their needs, particularly as providers are not necessarily well-schooled in dealing with TBI. It is also true that individuals with TBI often become depressed and it may be entirely appropriate to treat their depression, but the TBI may not be addressed.
- Over fifty percent of those enrolled in the TBI waiver program in Manhattan, Brooklyn, and Staten Island have a co-occurring substance abuse issue. Until last year, there was no inpatient OASAS-approved facility that was able to accept and successfully treat a person with TBI in New York State. The approved facility only treats men as we have already noted.
- The public health and social service delivery systems do not at present have a concrete plan for referral to community-based civilian systems of care or coordination of public and veteran benefits. Without Medicaid services in place, the TBI Waiver will not be able to serve this population, nor will veterans be able to access neighborhood-based mental health care services including substance abuse treatment.

We have been working with the New York State Brain Injury Association and the New York State Department of Health, under the auspices of a federal HRSA grant to attempt to meet with returning veterans and their families to elucidate these needs.

Chairpersons Monserrate and Koppel, we applaud your leadership in convening this hearing. We urge you to have the New York City Department

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Re: NYC Council Committee on Veterans Affairs; Committee on Mental Health,  
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of Health and Mental Hygiene convene a summit meeting on providing services to returning veterans. We would be happy to assist in the planning of such a meeting to allow for the development of an integrated care delivery system that focuses on both the cognitive disabilities associated with Traumatic Brain Injury as well as the substance abuse and psychiatric issues that are such common co-morbidities of TBI. As we have pointed out there is an urgent need for provider training, TBI and PTSD screening, and treatment facilities that can handle the expected influx of people requiring services. For every veteran that requires services, there are family members and friends whose needs we cannot fail to ignore.

The young men and women who have volunteered their services to their country deserve better than they are getting from the current federal administration. The experience of Viet Nam era veterans should not be repeated. New York City can and must do better.



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## Scientists: TBI from war worse than thought

By Gregg Zaroya - USA Today

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Scientists trying to understand traumatic brain injury from bomb blasts are finding the wound more insidious than they once thought.

They find that even when there are no outward signs of injury from the blast, cells deep within the brain can be altered, their metabolism changed, causing them to die, said Geoff Ling, an advance-research scientist with the Pentagon.

The new findings are the result of blast experiments in recent years on animals, followed by microscopic examination of brain tissue. The findings could mean that the number of brain-injured soldiers and Marines — many of whom appear unhurt after exposure to a blast — may be far greater than reported, said Ibolja Cernak, a scientist with the Johns Hopkins University Applied Physics Laboratory.

This cellular death leads to symptoms that may not surface for months or years, Cernak said. The symptoms can include memory deficit, headaches, vertigo, anxiety and apathy or lethargy.

"These soldiers could have hidden injuries with long-term consequences," he said. Physicians and scientists are calling TBI the "signature wound" of the Iraq war because of its increasing prevalence among troops.

In the animal studies, scientists said they have found a fundamentally different wound than the "brain concussor" historically associated with undetected brain injuries. A concussion, essentially a bruise on the brain, is a wound that can heal over time, doctors said.

But the newly discovered brain damage at the cellular level can be permanent — especially after repeated exposures to blasts — and lead to lasting neurological deterioration, Ling and Cernak said.

Military and civilian scientists worry whether a generation of service members could emerge from the Iraq and Afghanistan wars with some form of brain damage steadily more severe.

### Hidden injuries

Army Sgt. Gary Boggs may be such a case. When he was wounded by a roadside bomb in Iraq in 2003, doctors thought his worst injury was a blinded left eye, shrapnel wounds to his left arm and ruptured eardrums.

No one spoke of brain damage during his hospital treatment and convalescence. Boggs said he never considered the possibility until he took a medical retirement from the Army and started a job this year as a financial adviser. Boggs couldn't keep up with a job-study program, forgetting paragraphs he had just read.

"It was really getting hard for me," said Boggs, 32, of Melbourne Beach, Fla. "I finally swallowed my pride and asked for help from the [Department of Veterans Affairs]. I said, 'I think something is wrong with me.'"

He was diagnosed with mild traumatic brain injury and receives medication to focus his thoughts.

Brain injury experts such as Cernak fear Boggs may be at the front of a new wave of TBI victims.

Cernak's work on blast-related brain injury dates back 20 years to the study of wounded soldiers in her native homeland of the former Yugoslavia during the Balkan conflict of the 1990s.

It was in the Balkans where Cernak first discovered that soldiers exposed to blasts who suffered no apparent head wounds displayed brain damage symptoms over a period of months or more than a year.

"You can give her credit for being a pioneer," Ling said.

No detection with imaging tests

When the war in Iraq began, clinicians treating the wounded began noticing similar symptoms. Some screenings at military bases showed that 10 percent to 20 percent of returning troops may have suffered such head wounds.

"We've had patients who have been in a blast, who we tested. They looked OK. And they came back later, and they were not OK," said Maria Mouratidis, head of brain injury treatment at the National Naval Medical Center in Bethesda, Md.

To make matters worse, whatever damage occurred was so microscopic that it could not be found with imaging tests.

"This is a new beast," said Dr. Alisa Gear, a San Francisco-based traumatic brain injury specialist who treated soldiers this year at an Army hospital in Germany.

The microscopic damage changes brain cell metabolism, Cernak said, creating a cascading effect that leads to the premature aging and death of neurons that cannot be replaced.

In a presentation before a committee of the National Academy of Sciences last

month, Cernak said the damage was caused by the blast pressure wave, an invisible surge of compressed air traveling near the speed of sound. Kinetic energy from this pressure wave ripples through the body, injuring brain cells, Cernak said.

All of this occurs in less than a second after the blast, she said. Moreover, she said, body armor is no protection against this blast wave.

Ling said other factors can contribute to TBI, not just pressure.

"Pressure is our leading candidate for no other reason than it is the one we've studied the most," he said. "We are playing catch-up."

Concerned about the potential number of wounded, Congress this year authorized \$150 million for brain injury research in an emergency spending bill passed in May for the Iraq and Afghanistan wars.

Roadside bombs are the cause of most cases of brain injury and account for almost 80 percent of all wounds to U.S. troops. Many troops caught near these explosions can suffer symptoms such as perforated eardrums, ringing in the ears, blurred vision, memory lapses and headaches.

Soldiers often shake off the effects and return to combat.

Iraq and Afghanistan veterans treated by VA said they have been exposed to anywhere from six to 25 bomb blasts during their combat experiences, said Barbara Sigford, VA director of physical medicine. Ling and other scientists said repeated blast exposure can aggravate any brain damage.

Pentagon medical policy analysts have grappled with the idea of pulling troops out of combat after being exposed to multiple blasts.

However, the science is too preliminary for such a dramatic change in policy, said Army Col. Tony Carter, one of those analysts.

"If [soldiers] could have damage and they were otherwise functionally OK, but the damage could show up much later, then essentially what we would be saying is, 'Anybody exposed to blast leaves theater,'" Carter said. "That would be very, very difficult to do. You don't know [how many blast exposures is too many]. Half a dozen? One? I mean, what's the tipping point?"