Statement for the Record
of
VIETNAM VETERANS OF AMERICA

Submitted By

Thomas J. Berger, Ph.D., Executive Director
Veterans Health Council

Before the

U.S. Sentencing Commission

Regarding

Mental Health & Substance Abuse Issues Facing Returning Veterans

Relating to Criminal Justice and Alternatives to Incarceration

March 17, 2010

Distinguished Members of the U. S. Sentencing Commission, Vietnam Veterans of America (VVA) and its Veterans Health Council (VHC) thank you for the opportunity to present our comments on the proposed amendments to "Alternatives to Incarceration with Respect to Offender Characteristics." Although the Commission has requested comment regarding five specific offender characteristics: 1) age; 2) mental and emotional conditions; 3) physical conditions including drug dependence; 4) military, civic, charitable or public service, employment-related contributions and record of prior good works; and 5) lack of guidance as a youth, I shall confine my remarks only to the mental and/or emotional and drug dependence conditions suffered by our nation's veterans and troops as a result of their military service.

2010 marks the ninth straight year of America at war. There are now more than 23 million U.S. veterans, including 1.7 million and counting from the wars in Iraq and Afghanistan. Almost 5,300 OIF/OEF warriors have paid the ultimate price, and at least another 37,000 will forever bear the physical wounds of combat. And despite efforts by military health officials, we must also not forget that between 20 and 30 percent of OIF/OEF veterans have symptoms of a mental health disorder or cognitive impairment and that one in six suffers from a substance abuse challenge. Research studies at the National Center for PTSD continue to link substance abuse and combat-related mental illness as a co-morbid condition, as well as demonstrate the unequivocal correlation between PTSD, aggressive behavior and male perpetrated domestic violence. However, this correlation was well established long before the current OIF/OEF conflicts in the National Vietnam Veterans Readjustment Study of the late 80's where it was found that "one-third of Vietnam veterans with PTSD engaged in intimate partner violence over the previous year, compared with a 13.5 percent rate for those without PTSD." Researchers are also now studying the possible links among the effects of combat duty, posttraumatic psychopathology, violence, and abusive behavior in relationships. Early results show that multiple combat exposures, as well as perceived war zone danger, correlates with higher incidences of domestic violence, primarily due to PTSD symptoms and substance abuse.

Either because of, or in addition to, these untreated diseases and compounded social issues, unprecedented numbers of veterans are appearing in our courts. Where do many end up? Today, an estimated 60 percent of the 140,000 veterans in prisons have a substance abuse problem, and tonight, roughly 130,000 veterans will be homeless, 70 percent of whom suffer from a substance abuse and/or mental illness condition related to their military service.

Americans are grateful for our veterans' service to our nation, but we must ensure that our gratitude is extended to *all* our veterans. The unique consequences of combat call for unique solutions to reduce the number of veterans being processed through the criminal justice system. It is our belief that alternatives to sentencing which incorporate court-mandated, evidence-based dual diagnosis treatment programs such as those already utilized in Veterans' Courts (see below) in combination with biopharmaceuticals can be important steps in that direction.

Section 531 offers an alternative to sentencing at an opportune time in the evolution of mental health and substance use disorder (SUD) treatments for veterans (and indeed for all citizens suffering from this co-morbid condition who may encounter the criminal justice system). As referenced in the recent study of the National Center on Addiction

and Substance Abuse at Columbia University entitled “Behind Bars II: Substance Abuse and America’s Prison Population“, the tragedy is that we know how to stop spinning this costly and inhumane revolving door. It starts with acknowledging the fact that addiction is a disease for which evidence-based prevention and treatment programs exist and that these programs can be administered effectively through the criminal justice system (1).

I’d like to take some time to explain what I mean by this from the perspective of emerging biologic and pharmaceutical SUD treatments with some specific examples of treatments that could revolutionize our opportunities to assist those who are sent into the community for alternative sentencing. Although some communities may be able to offer a full range of support services, it is well recognized that others simply cannot, and it is here that innovations in pharmaceutical care may also be able to step into the void and provide badly needed augmentation to the funding shortfalls in such care. Like peer-to-peer PTSD treatment programs, these might support veterans suffering from substance use disorder who would otherwise not be able to receive the help they need.

For example, TA-CD is the sponsor name (Celtic Pharma) of the combination of a traditional vaccine target with multiple cocaine molecules attached to it. This conjugated vaccine is now ready to enter Phase 3 in clinical trials, which is the final phase before FDA approval. It is also an indication that the vaccine is proving to be both safe and effective. The purpose of this new vaccine is to provoke the body to produce antibodies against cocaine in order to prevent the stimulatory effects of cocaine use. In essence, when the cocaine is bonded with human antibodies, it becomes too large to cross over the blood brain barrier and is therefore prevented from giving its cocaine or crack cocaine user a drug high (2).

Right now cocaine is the largest cause of drug felony incarcerations in the US, and likely for veterans as well. You are probably aware that, according to the most recently posted figures available from the Office of National Drug Control Policy, over a third of arrests by the US Drug Enforcement Agency are the result of cocaine and crack-related use. The two most interesting things about the potential for the use of this vaccine in terms of the alternative sentencing program are that:

1. Unlike earlier interventions in drug addiction therapies, the cocaine vaccine is not a substitute addiction like methadone. That means that we are creating an opportunity for an intervention that can be used for a set duration of time. This is still to be determined through the clinical trial and dosing studies, but, I repeat, it is not a substitute of one addictive substance for another.

Therefore we do have hope that we can, through new therapies, help those with substance use disorder return to normal functioning without the need for permanent reliance on drug or interventions. Unfortunately, we cannot expect a medication of this nature to either reduce the cravings or withdrawal syndrome from the substance-abusing veteran, but this is a good start.

2. It also means that we can expect to administer the vaccine on an infrequent basis in order to get results. Clinical trials are demonstrating that after several immunizations to obtain protection, boosters may be required as infrequently as on a two to three month basis.

While I am not advocating that medications are the sole answer to substance use disorder, I am suggesting that we can look at a treatment such as this one to create the possibility for cost-effective, directly observed therapy. This is one of the strategies known to create a practical means of patient compliance. In directly observed therapy, the patient receives their administered dose in front of the health care practitioner, thus serving two vital roles:

a. Ensuring patient compliance with the treatment program, and
b. Enabling an augmentation of the medication treatment regimen with an appropriate psychosocial intervention.

Directly observed therapy, first begun as a treatment program for tuberculosis, has been credited by the CDC as playing a major role in the overall reduction in TB rates in the United States since 1992 (3). Perhaps in like fashion, directly observed therapy can again play a supportive, but critical role in helping reduce the public health problems surrounding substance use disorder.

Ironically, methadone treatment programs followed TB treatment programs as they offered an ideal setting to implement directly observed therapy. This program ensured that injecting drug users completed the full course of treatment because patients were coming in daily for their methadone anyway (3). The key advantage with the cocaine vaccine, however, is that the burden on the health care system is considerably lower and the propensity for addiction with the medication is virtually non-existent.

Thus, by taking advantage of the new biopharmaceuticals, we can make certain that those who are supporting substance abuse sufferers will have accountability on the part of the patient WITHOUT daily or even weekly supervision. Aided by the infrequent medication administration, TA-CD serves as a good example of how a new development in a medical intervention is keeping pace with equally significant advances on the other treatment fronts such as psychological counseling. Moreover, animal models for other vaccine studies on methamphetamine, heroin, PCP, and morphine are also being examined and supported by funding from the National Institute for Drug Abuse and the private sector (4).

This potential for the application of long acting anti-addiction medications was recognized very early by the National Institute of Drug Abuse. As long ago as 1976 and 1981, research monographs on the subject of long acting formulations of naltrexone were published (5, 6). Naltrexone (Vivitrol® Alkermes) in a once monthly injection for opioid addiction is slated for FDA approval at the end of this year. It is currently available in the market for alcohol abuse (7). Most significantly, this drug is already being tested in opioid-dependent parolees and probationers in clinical trials. These trials will specifically test its impact on such endpoints as retention in treatment, drug use, re-arrests, psychosocial and medical/psychiatric functioning, and economic costs and benefit costs compared to usual community treatment programs. Furthermore, these endpoints are being reviewed at six, twelve and eighteen months into the study (8). I think it is fair to expect that the impact on reducing opioid use could have significant economic outcomes for everyone involved in terms of the costs of recidivism. Another key point about naltrexone is that like TA-CD, it is not the substitution of one addictive substance for another.

In general, biopharmaceutical products represent only 10-15% of the total cost of health care expenditures, but can have a huge impact in overall health and societal resource utilization (9). This work is being conducted under the auspices of a grant from the National Institute of Drug Abuse. As I have previously emphasized – where community support resources are not there to provide services as often as they are needed – the science is stepping up to support our efforts to make it easier to progress our compassion and necessity to change the way we approach drug felonies. In 2004, the Institute of Medicine published findings from the Committee on Immunotherapies and Sustained-Release Formulations for Treating Drug Addiction at the National Academies. Among the many recommendations presented, it was determined that the National Institute on Drug Abuse should indeed support these clinical effectiveness studies and financing models that integrate the new pharmacotherapies with psychosocial services in specialty addiction and primary medical care settings (10). So clearly there is a consensus in the research community that an integrated model – sensitive to the cost benefit ratio of these new treatment options will advance our efforts in changing the paradigm for dealing with substance use disorder. Clearly the time is now to also make these important changes to our criminal justice system.

Therefore, the future holds the ability to yield another important new treatment option that will have a finite duration of length. In fact, multiple advances in the treatment of drugs like opioids, cocaine and methamphetamine are now being studied – many with unique mechanisms of action - in recognition of the growing complexities of the science of addiction (11).

Furthermore, it has now been documented that stress has an established role in the induction of relapse in substance abusers, and that exposure to stress is a potent cue for relapse.in these individuals. Given the disproportionately high rate of co-morbidity with post traumatic stress disorder in veterans, and the even higher rate of military sexual trauma in women veterans, it is important to see why more compassion, more treatment options and greater sentencing leeway – such as Section 531 - should be given to our nation's veterans. Certainly further research into the role of stress and addiction will be necessary in order to develop the most important advances in neurobiological care. But we are on the way there.

However, another addiction challenge is beginning to re-surface as veterans seek relief from the chronic pain that accompanies their war wounds -- opioid addiction, as in prescription drug addiction to pain killers such as OxyContin, Demerol, Dilaudid, Vicodin and Codeine, which are available to veterans at virtually no cost through the Veterans Health Administration (i.e., in contrast, many of the more expensive and non-addictive pain management drugs used in private sector health plans such as anti-inflammatory biologics, are not available to veterans because of their costs)(12). I say re-surface because the American history of opioid use and addiction began with her veterans during and after the Civil War, when opioids were widely prescribed to alleviate soldiers' acute and chronic pain (13). Moving forward one hundred thirty years later, soldiers returning from the current conflicts in Iraq and Afghanistan, like those in wars before them, frequently experience persistent pain (14,15). Unlike other wars, however, current service personnel are being deployed for a longer duration and with greater frequency. This creates psychosocial stressors that may increase the likelihood of chronic pain syndrome, even in the absence of physical injury (16). Of the first two hundred thousand OEF and OIF veterans accessing the Veterans Health Administration, the number one

reason for presentation was various types of somatic pain - primarily back and joint pain (17).

Furthermore, among 100,000 OEF/OIF veterans first seen at the VHA facilities between 2001 and 2005, 25% received mental health diagnoses (18) and the research shows a significant interrelationship between mental health issues and substance use disorder, including opioids (19, 20). In addition, it has been demonstrated in civilian populations that "telescoping" or rapid progression from appropriate use to abuse of opioids occurs more frequently in women versus men (21, 22). This makes prescribing safe and effective pain medicines for the female veteran population more challenging.

Currently, women represent a larger proportion of U.S. military forces than ever before, comprising approximately 14% of forces deployed in support of OEF/OIF, and representing over 180,000 deployed female troops (23). The proportion of women in active military service is increasing and is expected to double in the next 5 years (23). These new female veterans are younger, more likely to identify as belonging to a racial minority, have a high prevalence of mental health disorders, have higher rates of exposure to combat trauma than previous cohorts of women veterans, and may have high rates of exposure to sexual trauma (23, 24, 25, 26). All of these factors place them at risk for chronic pain syndromes (23, 24, 25).

Although prescription opioids remain indispensable for the management of acute pain, long-term solutions to opioid addiction are not as readily accessible. So this is to put everyone here on notice that we should have deep concerns about our female veterans, and their propensity for rapidly developing substance use disorder. And because our current health care systems are NOT able to effectively manage or handle this growing crisis, we could reasonably expect to see our women veterans knocking at the doors of the criminal justice system.

But two interesting studies published this year, point the way to successful resolution of this problem. In a group of 353 women with PTSD and co-occurring substance use disorder, subjects in the randomized controlled treatment group for their PTSD demonstrated an improvement in their substance use disorder by being treated for their PTSD relative to those who did not have trauma-related therapy (27). Similarly, in the second study of cocaine dependent individuals with PTSD, again, improvements in PTSD scores were positively associated with significant reductions in drug use (28). An improved and integrated dual diagnosis treatment model, offered by a criminal justice system that recognizes the challenges of post military service, trauma, pain management and addiction is one in which optimized health and societal outcomes can occur.

Veterans Treatment Courts -- An Emerging Movement at Local and State Levels

Another unique solution to the burgeoning number of veterans appearing in the criminal justice system with a history of mental illness or substance abuse is the development of the Veterans Treatment Court. Building upon the infrastructure that already exists within drug courts, Veterans Treatment Courts combine rigorous treatment and accountability for veterans facing incarceration. Veterans Treatment Courts are hybrid drug and mental health courts which promote sobriety, recovery and stability through a

coordinated response involving collaboration with local social service partners, including the U.S. Department of Veterans Affairs health care networks, the Veterans Benefits Administration, State Departments of Veterans Affairs, volunteer veteran mentors, and veterans family support organizations. And they are proving successful. The first specialized Veterans Treatment Court was begun in January 2008 in Buffalo, New York under the leadership of Judge Robert Russell. To date there are eight Veterans Treatment Courts in operation: Buffalo and Rochester, New York; Orange, Santa Clara, and San Bernadino counties in California; Tulsa, Oklahoma; Anchorage, Alaska; and Madison county, Illinois. In addition, more courts and states have expressed interest in developing their own Veterans Treatment Courts and are in various stages of developing them.

Vietnam Veterans

As I noted at the beginning of my statement, VVA and the VHC appreciate the opportunity to provide some observations in regards to the U. S. Sentencing Commission proposals to amend Federal sentencing guidelines for Alternatives to Incarceration for veterans. We are supportive of the increasing sensitivity of the Courts for the unique circumstance of veterans encountering the justice system upon return from combat in Iraq and Afghanistan. But we would be quite remiss not to emphasize the alternative and diversionary veteran courts initiatives come too late for many veterans of the Vietnam War era.

There is little doubt and ample statistical data, to substantiate the dismal record of neglect Vietnam veterans experienced, as we readjusted to our homecoming. The grassroots emergence of veteran courts is recognition of the catastrophic failure to recognize, identify and treat veterans for the myriad of quasi-legal mental health related behaviors closely associated with PTSD. The Vietnam veterans' legacy documents a country unprepared and unsympathetic to our struggle with mental illness, which so often was inextricably bound with alcohol and substance abuse behaviors. The DOJ/BJS reports reflect that by 1985 almost ¼ of the federal and state prison population were veterans. Although, the early BJS reports noted reporting discrepancies- i.e., the failure of state and local justice agencies to accurately identify veterans. Despite this discrepancy, the veteran data is alarming as the country anticipates readjustment issues facing the almost 2 million new veterans returning from Iraq and Afghanistan. The 2004 BJS Special Report substantiated the numbers of 'justice involved' veterans noted in the VA's *National Vietnam Veteran Readjustment Study* of 1987 (NVVRS), which estimated fully 36% of Vietnam veterans had been arrested and 11% with felony convictions. The Washington DC-based *Sentencing Project* estimated that 585,355 Vietnam veterans have been felony disenfranchised.

In summary, VVA and the VHC solidly support Veteran Court diversion and alternative sanctions as the principle method of treating veterans encountering our nation's first responders and justice agencies. VVA would remind the US Board of Parole Commissioners to consider that today a veteran like Audie Murphy, the most highly decorated WW II veteran, would be placed behind bars or worse, as he struggled with PTSD and adjusted to domestic life after his military service. We also endorse veteran specific state and federal legislation that identifies veterans as they encounter the justice authorities. We support treatment and diversionary resources that address the

underlying issues associated with PTSD, TBI and military service as addressed in Minnesota's Veterans Sentencing Mitigation Statute (2208). And finally, we ask the US Sentencing Commission to review Section IV of the ABA's Justice Kennedy Commission Summary Recommendation and consider military service as a presumptive exceptional circumstance to expand use of executive clemency to reduce sentences and facilitate pardons, restoration of legal rights and relief for collateral disabilities at the federal and state levels of government.

Lastly, those who are struggling with re-entry challenges from BOTH military service and incarceration have incredible challenges with stress. Further incarceration is not the answer to their mental health issues or substance use disorders. However, the criminal justice system can play an important role in supporting access to the answer for their conditions. With the newest advances in biomedical and psychosocial interventions that are evidence-based, we can give hope to those who have served our country and to show them that we have not abandoned their care. Our nations' veterans do not have to end their service in disgrace or dishonor. It is our societal responsibility to give them the opportunity to be proud of the country that they offered their lives to defend.

Thank you. I shall be glad to answer any questions.

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Thomas J. Berger, Ph.D.

Dr. Tom Berger is a Life Member of Vietnam Veterans of America (VVA) and founding member of VVA Chapter 317 in Kansas City, Missouri. After serving as chair of VVA's national PTSD and Substance Abuse Committee, he recently joined the staff of the VVA national office as Senior Analyst for Veterans' Benefits & Mental Health Issues. As such, he is a member and Chair of the Veterans' Healthcare Administration's (VHA) Consumer Liaison Council for the Committee on Care of Veterans with Serious Mental Illness (SMI Committee), the Executive Committee of the Mental Health Quality Enhancement Research Initiative Depression Work Group (MHQUERI), and the South Central Mental Illness Research and Education Clinical Center (SC MIRECC).

In addition, Dr. Berger holds the distinction of being the first representative of a national veterans' service organization to hold membership on the VHA's Executive Committee of the Substance Use Disorder Quality Enhancement Research Initiative (SUD QUERI). Dr. Berger also serves as a reviewer of research proposals for DoD's "Congressionally Directed Medical Research Programs". He is a member of VVA's national Health Care, Government Affairs, Agent Orange and Toxic Substances and Women Veterans committees. Dr. Berger served as a Navy Corpsman with the 3rd Marine Corps Division in Vietnam, 1967-68. Following his military service and upon the subsequent completion of his postdoctoral studies, he held faculty and administrative appointments at the University of Kansas in Lawrence, the State University System of Florida in Tallahassee, and the University of Missouri-Columbia, as well as program administrator positions with the Illinois Easter Seal Society and United Cerebral Palsy of Northwest Missouri. His professional publications include books and research articles in the biological sciences, wildlife regulatory law, adolescent risk behaviors, and post-traumatic stress disorder.

Dr. Berger now devotes his efforts full-time to veterans' advocacy at the local, state and national levels on behalf of Vietnam Veterans of America. He presently resides in Silver Spring, Maryland and his hobbies are cycling, music, cooking, and reading.

VIETNAM VETERANS OF AMERICA

Funding Statement

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:
Executive Director of Policy and Government Affairs
Vietnam Veterans of America.
(301) 585-4000, extension 127