REPORT TO THE CONGRESS

BY THE COMPTROLLER GENERAL OF THE UNITED STATES

Veterans Administration Program For Alcoholism Treatment Often Is Insufficient: More Action Needed

About 3 million veterans suffer from alcoholism, the number one health problem (diagnosis) in the Veterans Administration hospital system. VA started funding special alcohol treatment units in 1970. In view of the problem's magnitude and the relatively low impact of the VA program, GAO recommends VA take certain actions to improve its alcohol program.

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COMPTROLLER GENERAL OF THE UNITED STATES
WASHINGTON, D.C. 20548

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To the President of the Senate and the
Speaker of the House of Representatives

We reviewed the Veterans Administration Alcohol Treatment Program to determine what progress had been made in meeting the needs of veterans with alcohol problems. Our review showed that, because of the problem's magnitude among veterans and because of the Veterans Administration's low impact on resolving this problem, many improvements need to be made.

We made our review pursuant to the Budget and Accounting Act, 1921 (31 U.S.C. 53), and the Accounting and Auditing Act of 1950 (31 U.S.C. 67).

Copies of this report are being sent to the Director, Office of Management and Budget, and to the Administrator of Veterans Affairs.

Acting Comptroller General
of the United States

Contents

ABBREVIATIONS

ATU	alcohol treatment unit
GAO	General Accounting Office
NIAAA	National Institute on Alcohol Abuse and Alcoholism
VA	Veterans Administration
VACO	Veterans Administration Central Office
VAH	Veterans Administration Hospital
VARO	Veterans Administration Regional Office

GLOSSARY

Detoxification	Hospitalization process for sobering up an intoxicated person.
Follow-on treatment	Process of providing continued contact which will support and increase gains made to date in treatment.
Inpatient	Patient in hospital who receives lodging, food, and treatment.
Outpatient	Patient not receiving care in hospital but receiving diagnosis and/or treatment in a clinic or dispensary connected with the hospital.
Outreach	The process of systematically reaching into a community to identify persons needing services, alert veterans and their families to the availability of services, locate needed services, and enable veterans to enter the service delivery system.

COMPTROLLER GENERAL'S REPORT TO THE CONGRESS

VETERANS ADMINISTRATION PROGRAM FOR ALCOHOLISM TREATMENT OFTEN IS INSUFFICIENT: MORE ACTION NEEDED

D I G E S T

About 3 million veterans suffer from alcoholism--the number one health problem (diagnosis) in the Veterans Administration (VA) hospital system. (See p. 1.)

In view of alcoholism's magnitude among veterans and the low impact of the VA treatment program, the Congress should consider having VA confer with appropriate legislative committees on the goals and objectives of the VA treatment program and the resources necessary to implement a more comprehensive program.

During fiscal year 1974, VA hospitals treated, for alcoholism or alcohol-related problems, and discharged about 157,000 veterans. (See p. 1.) Alcohol treatment units treated about 47,900 of these veterans (see p. 3) as inpatients.

Alcohol treatment units are specialized units in some VA hospitals for treating alcoholism. VA started funding these units in VA hospitals during fiscal year 1970. (See p. 1.) By the end of the fiscal year 1975, 71 units had been established (see p. 3) within VA's 171 hospitals.

Treatment usually consists of inpatient treatment from 1 to 3 months and should provide most, if not all, of the following services--detoxification, extensive individual and group therapy, some behavorial and vocational testing, family counseling, and vocational rehabilitation. (See p. 10.)

While VA has made progress in its alcohol treatment program, the overall effect has been low. VA has not established overall program goals nor provided central operational direction to the units.

Nor has VA made the necessary commitment toward developing a comprehensive program for veterans with alcohol problems. (See p. 6.) Some of the most populous metropolitan areas with VA hospitals have no treatment units and no plans for any. (See p. 9.)

The availability of VA alcoholism services has not been adequately publicized. (See p. 12.) Veterans diagnosed as alcoholics upon admission to VA hospitals for other medical treatment usually were not referred to, nor contacted by, alcohol treatment unit staff located at these hospitals. (See p. 12.) Treatment programs have not generally been designed to meet the needs of working veterans. (See p. 14.)

Inconsistent admission criteria have been applied by the units (see pp. 14 and 15), and supporting services have not been emphasized. (See p. 16.)

Finally, VA lacks an evaluation system to find out how effective the treatment units have been. (See p. 19.)

VA should

--establish program objectives; i.e., the number of veterans and the types of patients to be treated--skid row or working--and the type of treatment they should receive;

--determine necessary funding and staffing levels;

--develop an evaluation system for the programs;

--identify the geographical distribution of alcoholism among veterans to set priorities for establishing units;

--define the veteran population with alcoholism problems and structure programs to meet their needs;

--publicize availability of alcoholism treatment for veterans at the national, regional, and local levels;

--instruct hospital directors to identify and encourage alcoholic patients to seek treatment;

--establish uniform admission and readmission criteria; and

--incorporate essential supportive services--vocational rehabilitation, follow-on treatment, and family involvement--into treatment programs, either through VA or community resources. (See p. 25.)

VA agreed generally with every recommendation and pointed out what action had been taken and/or what action it planned to take on each. (See app. I.)

CHAPTER 1

INTRODUCTION

Alcoholism ranks with heart disease, cancer, and mental illness as a major national health problem. Alcoholism was recognized as a treatable disease by the American Medical Association in 1956. While the National Institute on Alcohol Abuse and Alcoholism (NIAAA) recognizes there is no formal definition of alcoholism, it is generally considered

--a chronic disease or disorder of behavior,

--drinking in excess of customary dietary use or social drinking customs of the community, and

--drinking which adversely affects the drinker's health, interpersonal relations, or economic functioning.

An estimated 9 million Americans suffer from this disease, of whom 3 million are veterans. Alcoholism is the number one diagnosis in the Veterans Administration (VA) hospital system; in fiscal year 1974, VA hospitals treated and discharged about 157,000 veterans with a principal or associated diagnosis of alcoholism.

NIAAA stated alcohol-related problems are contributing causes in about 30,000 highway fatalities annually, and estimates alcoholism generates a $15 billion drain on the economy each year. Most alcoholics are functioning members of society, with fewer than 5 percent of alcoholics being categorized as nonfunctioning skid row types.

Alcohol rehabilitation treatment was first initiated at some VA hospitals during the 1950s. However, it was not until 1967 that VA established a central office staff to emphasize both alcohol and drug treatment as specialized medical programs. VA then decided to treat requests for hospitalization for the treatment of alcoholism the same way as any other disorder susceptible to cure or decided improvement. Specific funding of alcohol treatment units (ATUs) was initiated during fiscal year 1970.

VA guidelines state the average ATU consists of 30 beds and costs over $300,000 annually. VA Central Office (VACO) staffing guidelines suggest the average ATU employ 16 persons, including 1 physician, 4 registered nurses, 4 nursing assistants, 1 chaplain, 1 psychologist, 1 social worker, 1 physical medicine and rehabilitation therapist, 1 ward clerk, and 2 rehabilitation counselors.

ATU operating levels have been increased annually since 1970 as follows:

Fiscal year	Number of ATUs	Direct medical care FTEEs (note a)	Direct medical care Cost	Direct medical care plus administrative expenses FTEEs (note a)	Direct medical care plus administrative expenses Cost
1971	50	710	$ 8,386,000	1,000	$11,727,000
1972	52	1,010	13,185,000	1,390	17,984,000
1973	56	1,510	20,427,000	2,050	27,662,000
1974	70	1,910	27,566,000	2,630	37,265,000
Total		5,140	$69,564,000	7,070	$94,638,000

a/Full-time equivalent employment.

Alcohol rehabilitation treatment is authorized for veterans under title 38 of the United States Code, which provides that veterans who have medical disabilities--incurred or aggravated in the line of military duty--are entitled to all medical services reasonably necessary to treat service-connected disabilities. This care may be provided in a hospital, domiciliary, or on an outpatient basis. Inpatient care may also be provided veterans for treatment of non-service-connected conditions, without regard to their ability to pay, who

--were released or discharged from military service for a disability incurred or aggravated in the line of duty,

--have a compensable service-connected disability, or

--are 65 years of age or older.

Veterans of any war or of service after January 31, 1955, may also get free medical treatment if they certify inability to pay for such care. VA can provide medical services on an outpatient basis to any veteran eligible for hospital care where such services are reasonably necessary in preparation for, or to obviate the need of, hospital admission and to provide continuity of treatment for discharged inpatients.

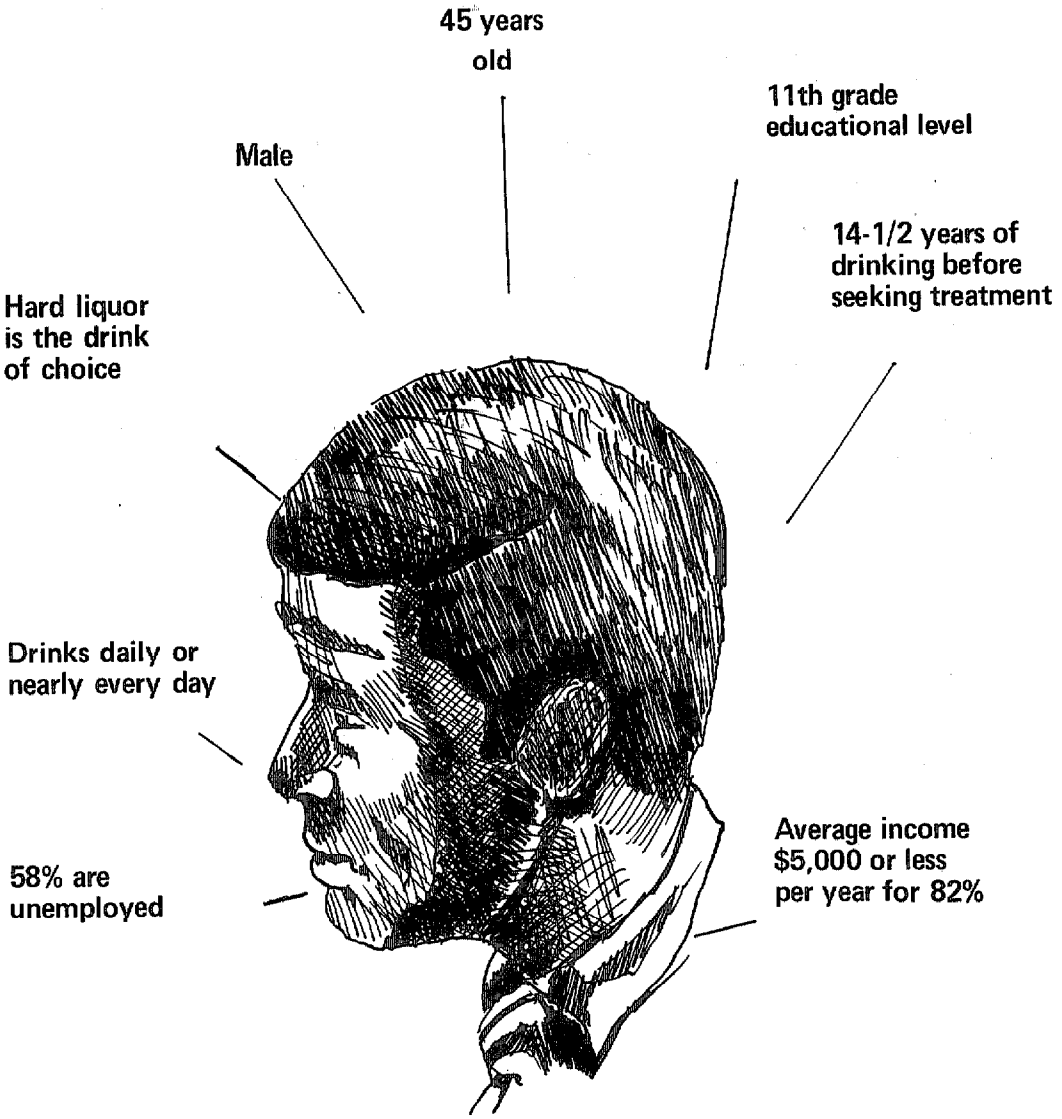
The following table compares VA's alcohol treatment effort with the overall VA medical care effort during fiscal year 1974.

	Alcohol rehabilitation treatment	Medical care in VA hospitals	Alcohol effort as a percent of total effort
Veterans treated:			
Inpatient (number of veterans)	47,900	1,043,300	4.6
Outpatient (number of visits) (note a)	105,400	10,457,800	1.0
Average daily patient census	4,400	91,000	4.8

a/ATUs we visited assign many veterans completing inpatient treatment to outpatient status. As a result, outpatient statistics will include veterans already in the inpatient statistics.

VA operated 70 ATUs in fiscal year 1974 and planned to add 33 new ATUs to the program during fiscal years 1975-76. VA activated 1 new unit in fiscal year 1975, for a total of 71 ATUs. VA planned to establish 32 new ATUs during fiscal year 1976; however, budget constraints through fiscal year 1976 will hold the total to 1975's 71 funded ATUs.

A profile of the average patient receiving treatment is shown below.



VA ALCOHOL REHABILITATION

PROGRAM PATIENT

Source: Determined from GAO review of veterans' records on file at seven alcohol treatment units listed in appendix II.

SCOPE OF REVIEW

Our review was concerned with progress made by VA in providing services to veterans through specialized treatment programs. Particular emphases were placed on the extent to

which VA has identified the alcoholism problem among veterans, developed a publicity effort to advise veterans of available alcohol treatment, contacted veterans to convince them to seek treatment, assisted veterans in entering programs, provided central office direction and evaluation to establish and maintain an effective and efficient treatment program, and provided supportive services essential for optimal program benefits. We also made observations on the differences in program length, intensity, treatment components, and results. We sent questionnaires to 665 veterans, selected randomly, who participated in the program. We received 309 responses; however, not all respondents answered every question. Hence, there will be differing totals for questionnaire responses cited in the report. We reviewed VA:

--Regulations and instructions relating to alcohol treatment services.

--VACO, VARO, and VAH procedures for implementing and operating an alcohol treatment program.

--Criteria for funding alcohol treatment programs.

--Admission criteria.

--Program evaluation efforts.

Our review was made at VACO in Washington, D.C., and at 8 regional offices and 10 hospitals listed in appendix II. Seven of these hospitals had ATUs and, during fiscal year 1974, reported treating 6,135 veterans as inpatients for alcoholism, or about 13 percent of 47,900 veterans receiving inpatient alcoholism treatment during the year.

CHAPTER 2

IMPROVEMENTS NEEDED IN VACO MANAGEMENT OF ALCOHOL TREATMENT PROGRAM

VACO should improve its management of the alcohol treatment program. VACO should establish overall program goals, including criteria for establishing ATUs, provide operating guidelines to participating ATUs, and develop performance-measuring criteria and procedures.

We found that VACO had not issued instructions nor established goals related to program design and operation. Instead, each ATU designed and operated its own program.

We recognize the benefits of exploring various approaches to new and untried programs such as this; however, after 4 years in operation, it appears timely to identify overall program aspects which appear workable and effective and to establish goals and objectives for maximum program benefits.

NEED TO ESTABLISH OVERALL PROGRAM GOALS

VACO has neither identified nor studied relative need for ATUs in communities before establishing them, and we found some larger cities without ATUs. VACO has not identified characteristics of the alcoholic veteran population and, consequently, programs have not been designed to meet needs of the majority. NIAAA has estimated that 95 percent of alcoholics and persons with drinking problems are family-centered individuals, either employed or employable. The VA program consists mainly of long-term inpatient programs (usually 1 to 3 months) that tend to exclude employed veterans. As an example, 58 percent of program participants in our sample were unemployed, and of those employed, 82 percent earned under $5,000 a year. In our opinion, VACO has not developed information adequate to define its role in treating alcoholic veterans and providing these veterans with necessary services.

A VACO official recognized the need for measurable goals and objectives in program management, but said personnel shortage prevented their establishing these goals. The Acting Director, Alcohol and Drug Dependence Division, said program effectiveness had not been measured because there were no goals against which to measure performance, and, in any event, there were insufficient staff to perform the evaluations. VACO has relied on ATUs to set their own goals

for alcohol treatment. In September 1973, it requested ATUs to submit one-time reports on their program goals. After reviewing and evaluating these reports, VACO developed eight treatment goals, and in February 1975, the goals were forwarded to the ATUs. (See app. IV.)

Although VACO established treatment goals, it has not developed a system to quantify, evaluate, or measure whether treatment goals are being met or to determine whether an acceptable degree of success has been attained. For example, there is no concept of what success criteria might be so that program effectiveness can be measured or compared with other ATU programs. (See ch. 5 concerning evaluations.)

Treatment goals had been established at seven ATUs visited, but generally, they were not measurable or, if measurable, were not expressed in terms facilitating measurement. For example, all units visited had established sobriety as one of their goals, and although this goal is measurable, none of the ATUs had established a measure to determine program effectiveness. Examples of other goals established by various ATUs include helping veterans to

--deal with personal problems and indifferent attitudes,

--achieve personal freedom and accept increased responsibility, and

--develop a lifestyle without need for alcohol.

Although VA has been providing alcohol treatment for several years, no ATU manuals or directives have been issued. In contrast, VA has been treating patients for drug dependence only since January 1971, but VACO issued, in November 1973, instructions for all aspects of this program, including evaluation.

A VACO official told us, in August 1975, that an ATU manual was being developed and that it should be published by March 1, 1976. VA has been taking some action. Suggested guidelines for the staffing, physical facilities, and equipping of ATUs were issued in April 1972. VACO also held conferences with ATU staff members to discuss ATU programs. We were informed that VACO personnel make suggestions at these meetings on overall program direction; however, ATU directors are not obliged to follow them.

The results of our review of VACO's management role in providing needed services to alcoholic veterans, operating

alcohol treatment units, and implementing an evaluation system demonstrate VA should take a much stronger role in the alcohol treatment program. The detailed results of our review are discussed in chapters 3 through 5.

CHAPTER 3

LACK OF VA ALCOHOL TREATMENT FACILITIES IN MANY LARGE METROPOLITAN AREAS

EVIDENCES NEED FOR CRITERIA ON ESTABLISHMENT

We found very little planning or direction on the part of VACO in identifying where ATUs were needed. Rather, ATUs were established principally at the requests of hospital officials. VACO officials stated basic criteria for funding ATUs were that the requesting hospitals demonstrate enthusiasm of proposed hospital staff, plus qualified personnel and space for the program. There are major metropolitan areas with VA hospitals which do not have ATUs. Veterans with alcoholism problems in these areas receive very limited treatment from VA hospitals without ATUs.

PLANS FOR ESTABLISHING ATUs

VA has not identified where veterans with alcohol problems live, for the purpose of planning and establishing ATUs. There are metropolitan areas with large veteran populations for which there are neither existing nor planned treatment units. Veterans living in those areas will have to depend upon availability of local community programs or be referred to VA hospitals with ATUs.

Of 28 most populous metropolitan areas with VA hospitals, 15 areas with an estimated 1.7 million veterans did not have ATUs when we began our fieldwork. (See app. III.) In fiscal year 1974, VA located units in 4 of 15 major metropolitan areas not previously served--Atlanta, Denver, Memphis, and San Diego.

VA planned, on the basis of hospital requests, to activate 32 more units during fiscal year 1976; budget constraints, however, will prevent these additions. Units were to have been placed in 4 of the remaining 11 large metropolitan areas--Chicago, Cincinnati, Cleveland, and St. Louis. There were no plans for units in the seven other major metropolitan areas without units.

Because no new units will be opened in fiscal year 1976, 11 of the 28 most populous metropolitan areas with VA hospitals will still be without ATUs. The 11 areas without ATUs, in addition to Chicago, Cincinnati, Cleveland, and St. Louis, are: Baltimore, Dallas, Detroit, Kansas City, New Orleans, San Antonio, and San Francisco. The estimated veteran

population in these 11 cities is about 1.3 million and, using VA data on the incidence of alcoholism among veterans, we estimate 130,000 (about 10 percent) of those veterans could have alcohol problems.

LIMITED ALCOHOLIC TREATMENT AT VA HOSPITALS WITHOUT ATUs

At VA hospitals in 3 of the 15 metropolitan areas which did not have ATUs when we initiated our review--Atlanta, Dallas, and Denver--we estimated (hospital officials concurred) about 2,800 of the veterans examined during fiscal year 1973 were diagnosed as alcoholics. Of that number, about 1,600 veterans were admitted for medical treatment of acute physical disorders and received limited treatment for alcoholism. The treatment for alcoholism was as follows:

--Patients at Atlanta were generally provided only advice on the effects of alcohol. Some veterans, approximately 12 percent, were referred to the ATU at the Augusta (Georgia) VA hospital, which was 150 miles from Atlanta.

--Patients at Dallas were provided detoxification, testing, and medication (antabuse, librium, or valium) and, in some cases, limited group therapy of 3 hours each week over an average period of 1 month and were referred to Alcoholics Anonymous meetings conducted at the hospital.

--Patients at Denver were generally provided medication (antabuse, librium, or valium). Patients needing detoxification only were generally sent to a local non-VA hospital. Occasionally patients were referred to the ATU at the Fort Lyons (Colorado) VA Hospital, a distance of 200 miles from Denver, or the Sheridan (Wyoming) VA Hospital, which is 400 miles from Denver.

In contrast, when veterans are treated in ATUs, they usually receive inpatient treatment for 1 to 3 months and all or most of the following services: detoxification, extensive individual and group therapy, some behavioral and vocational testing, family counseling, and vocational rehabilitation.

The other 1,200 veterans diagnosed as alcoholics were not hospitalized, although we were informed that, in many cases, they were counseled by social workers. If the veterans were motivated and desired treatment for alcoholism, they were

referred to VA hospitals with ATUs or were advised to seek treatment from community-sponsored alcoholism programs. The hospitals did not know, however, if the veterans received treatment at these places because there were no followup procedures.

To learn what happened to the veterans referred to ATUs, we followed up 65 individuals, selected at random. We found that 38 of the veterans went to the ATUs to which they were referred and that 24 were admitted for treatment. We could not determine what had happened to the other 27 veterans because the ATUs to which they were referred had no record of their arriving, nor was any followup made by the referring hospital. Of the 14 who contacted the ATUs and were not admitted, 11 were admitted to the VA hospital and provided other services. The remaining three were not provided any VA services; two because they were not motivated, and the remaining veteran was rejected as physically unable to participate.

CHAPTER 4

OTHER SIGNIFICANT PROGRAM ASPECTS NEEDING IMPROVEMENT

We believe the need for VACO to improve its management of the VA alcohol treatment program was further evidenced by these other problems. We found

--the program has not been adequately publicized to veterans,

--some ATU programs have not been structured to serve working veterans,

--veterans living in different areas do not have equal opportunity for treatment because ATUs have adopted different admission criteria, and

--aspects of treatment which authorities consider essential have not been included in some ATU programs.

SYSTEM NEEDED TO INFORM VETERANS OF ALCOHOL TREATMENT SERVICES

VA has testified before the Subcommittee on Health and Hospitals of the Senate Committee on Veterans' Affairs that efforts have been concentrated on identifying alcohol abuse in its early stages and on initiating timely rehabilitation for veterans. VA, however, does not have a specific program advising veterans alcoholic treatment services are available. We were told limited action to reach veterans was taken because additional demand could overtax available facilities. Our review at VACO, eight VA regional offices, and seven ATUs showed that

--servicemen released from active duty have not been provided alcoholism treatment information through the VA discharge assistance system,

--veterans with alcohol problems have generally not been actively sought out by VA regional offices or by ATUs, through the press, television, or radio, because outreach programs have not been developed,

--veterans found to be alcoholics when admitted to VA hospitals for other medical treatment were usually not referred to nor contacted by ATU staff at these hospitals.

NIAAA has emphasized the importance of identifying and reaching alcoholics in the early stage of the disease because the earlier treatment is started, the better prospects are for successful recovery. Officials of the VA Alcohol and Drug Dependence Division say they recognize the importance of outreach and believe it should be conducted, but VA has taken only limited action to avoid overtaxing their facilities. Its single action, after our inquiries, has been to issue a bulletin to all VA stations instructing them to provide veterans information on alcoholic treatment along with other benefits information.

Concerted efforts--through speeches, newspaper advertisements, and contacts with local agencies--to inform veterans of alcohol treatment services were undertaken by only two of the seven ATUs visited. ATU officials at the remaining five locations said they relied on other agencies, former patients, and the courts to provide outreach for the program. These officials said such reliance will attract the chronic alcoholic; however, it will not attract the working veteran who may be more easily motivated toward treatment.

None of the hospitals with ATUs that we visited had procedures to identify and encourage veterans with alcohol problems, admitted for medical treatment to other hospital wards, to enter alcohol treatment programs. The importance of making this contact was demonstrated in an NIAAA study of public hospital patients who appeared unwilling to consider long-term treatment for their drinking problems. The study showed that when these patients, who were admitted to the hospital for acute medical problems, were met from the outset with understanding, sympathy, and attention regarding their alcohol problem, they accepted treatment.

Information we obtained, by questionnaire, from veterans treated at seven ATUs confirmed VA has not been informing many veterans of its alcohol treatment services. Replies from 307 veterans showed that 86 percent had learned of the program through their own initiative or from non-VA sources. A listing of the means by which the 307 veterans first learned of the VA alcohol treatment program is shown below.

	Number of veterans		Percent	
Initial contact through VA:				
ATUs	6		2	
Other hospital wards	32		11	
Other sources	4	42	1	14
Initial contact by veteran through:				
Contacting the hospitals	139		45	
Private physicians	41		13	
Alcoholics Anonymous	13		4	
Police or court	20		7	
Former patients	34		11	
Other sources	18	265	6	86
		307		100

PROGRAMS FOR WORKING VETERANS NEEDED

VA had not established effective programs for providing alcoholism treatment to working veterans at six of the seven ATUs visited. The need for such programs is apparent since the National Institute of Mental Health and NIAAA reported in 1972 that at least 95 percent of alcoholics and persons with drinking problems (but not alcoholics) are employed or employable, family-centered individuals. ATUs, at six of the seven locations we visited, required veterans to complete long-term inpatient programs of up to 90 days, thus making it difficult for working veterans to participate. The seventh ATU, however, was treating working veterans in an outpatient program, and it was also developing a short-term 2- to 4-week inpatient program.

ADMISSION AND READMISSION PROCEDURES NOT UNIFORM

ATUs have established their own criteria for admitting and readmitting veterans for alcoholic treatment. As a result, whether a veteran is provided treatment depends, to an extent, on where he lives. Because this practice denies veterans equal access to treatment, we believe VA should insure all ATUs have comparable admission policies.

The VA manual requires that requests for alcoholism treatment hospitalization be processed the same as requests for treatment of any other disability, disease, or defect susceptible to cure or decided improvement. Only one of seven ATUs we visited followed this criterion alone. The other six added requirements for admission and readmission

to their alcohol treatment programs. The criteria were developed by local administrative or ATU officials, who believed it necessary to interview and evaluate veterans applying for treatment. VACO approval of ATU admission criteria was neither required nor obtained.

Inpatient admission

Conditions discouraging veterans seeking treatment for alcoholism at some ATUs were:

--Veterans seeking help at the ATU in Augusta were required to undergo detoxification for up to 6 days even if sober when applying for treatment. If sober veterans went to the other six ATUs, they did not have to undergo detoxification.

--Veterans going to ATUs in Mountain Home, Tennessee, and Salt Lake City, Utah, were required to go through screening or preadmission procedures lasting up to 8 days. If they went to ATUs in Augusta or Sheridan they would enter treatment without screening.

--Veterans going to ATUs in Mountain Home, Minneapolis, and Salt Lake City must agree, before they are admitted, to stay for a specific time or to complete the programs, which last up to 84 days. At ATUs in Augusta, Houston, Sheridan, or Temple (Texas), no agreement to stay was required.

--Veterans who had health insurance coverage, going to the ATU in Minneapolis, were sent to community treatment programs, so that the ATU could better provide for indigent veterans. Had these veterans gone to ATUs at the other six hospitals, having health insurance would not have barred them from treatment.

Hospital officials stated admission criteria involving screening and preadmission meetings--taking up to 8 days in some cases--were necessary to evaluate veterans before accepting them into programs. We believe that, in addition to discouraging veterans, this practice tended to exclude veterans from communities outside the ATU area who had no place to stay overnight during these screening meetings.

Inpatient readmission

Three hospitals having ATUs had established waiting periods, one of which had a participation limitation; i.e., two lifetime admissions to the treatment program for veterans seeking readmission to the ATU. The ATU which limited its

treatment to two lifetime admissions also required a 1-year waiting period between initial admission and readmission. Another ATU limited veterans to one 90-day program every 3 years, but allowed readmission for a 30-day treatment program if the veteran had been discharged for at least 3 months. The third ATU had a 6-month waiting period before readmission.

The remaining four ATUs visited had no limitations, but officials at some locations said that, before approving readmissions, they investigate the veterans' reasons for requesting readmission or assign them a treatment priority lower than that assigned veterans not previously admitted. Officials at one of these ATUs said previous treatment is considered as indicating the veteran's sincerity. Veterans maintaining extended periods of sobriety after treatment are considered good candidates for readmission.

ESSENTIAL SUPPORTIVE SERVICES NEEDED

The Acting Director, VACO Alcohol and Drug Dependence Division, said vocational and follow-on treatment services are desirable in alcoholism therapy programs. VACO has suggested to hospitals with ATU programs that they include vocational rehabilitation, follow-on care, and family involvement services in their programs; however, the decision to provide these services was left to hospital officials. Officials at most of the seven ATUs visited also believed these supportive services essential, but several did not believe available funds or staff were sufficient to provide them. Consequently, in some instances, only limited supportive services were provided veterans and their families.

Vocational rehabilitation

The Joint Commission on Accreditation of Hospitals' "Accreditation Manual for Alcoholism Programs," approved on May 20, 1974, requires that an alcohol treatment program include (1) an evaluation of a patient's vocational rehabilitation needs and (2) the preparation of an individual treatment plan to meet these needs. VACO officials said they had emphasized the importance of vocational rehabilitation at meetings with ATU officials, but they had not directed ATUs to provide this service.

We were told, at the seven ATUs visited, that, in most cases, this service was provided only to veterans who expressed interest and volunteered. Vocational rehabilitation services provided by the ATUs varied from limited counseling, which was directed at establishing the veteran's interest, to extensive procedures including testing, training,

vocational and educational guidance, and job referral or placement. The timing of the services varied from 5 weeks after admission to after discharge from the program.

Follow-on treatment

Studies conducted by two ATUs showed that continuing care is needed by veterans completing inpatient programs because their control over drinking declined without this support. The Joint Commission on Accreditation of Hospitals' "Accreditation Manual for Alcoholism Programs" lists follow-on treatment as mandatory for accreditation of an alcohol treatment program. The manual states, in part, that, if a program lacks capabilities for follow-on treatment, there must be a mechanism for referring patients to other resources and for insuring they receive care. An individual plan is required for follow-on treatment of each patient, including criteria for terminating treatment.

VACO recognized the need for follow-on treatment as early as 1968, but it has not mandated this care as part of ATU programs. Six of the seven ATUs visited did provide limited outpatient follow-on care. Officials at four of these stated they were unable to provide follow-on outpatient care to all veterans because of insufficient funds and staff. Officials also said it would be difficult to provide this care to veterans who lived great distances away from the ATUs.

Our review of 319 veterans' records, selected at random from files at the 7 ATUs, showed that only 54 veterans (17 percent), discharged from inpatient programs, were provided follow-on care by ATUs. Another 69 veterans (22 percent) were referred to other sources for this service. We were told referrals consisted of advising patients to visit programs in their home communities and, in some cases, advising community agencies of the referrals.

ATUs did not generally know whether the veterans referred to agencies outside VA had sought or received follow-on care. They did not follow up to obtain this information. Further, our contacts with 23 community agencies, located near the 7 ATUs, revealed that generally little or no follow-on coordination existed between them and the ATUs.

We contacted veterans, through questionnaires, who had participated in the seven ATU programs. Of the 305 responding, 171 (56 percent) reported receiving further help with their alcohol problem, and 134 (44 percent) said they had not. The 171 receiving help listed the following sources (some received help from more than one source): VA programs, 84; Alcoholics Anonymous, 94; and all other sources, 47.

Family involvement

NIAAA has stated that treatment programs are emphasizing the family as a whole, because it may include another member who is even more emotionally disturbed than the alcoholic and who may be partially responsible for the alcoholic's problem. At five of the hospitals with ATUs, alcoholism services involving the veteran's family generally consisted of evening meetings with ATU staffs to discuss the effects of alcoholism. Two of these hospitals also held separate Alcoholics Anonymous and Al-Anon meetings for patients and their spouses. Responses from the 308 veterans answering our question on family involvement showed that participation in these meetings by veterans having families ranged from 14 percent at one ATU to 48 percent at another.

The other two ATUs did not provide services for patients' families, and any services received were from other sources through the veterans' own initiative. Although recognizing the importance of family involvement in treatment, ATU officials at both hospitals told us the patients' homes were usually too far away from the hospitals for family participation. No arrangements had been made with other agencies to provide these services.

CHAPTER 5

NEED FOR VA TO ESTABLISH AN EVALUATION SYSTEM

Although evaluating the effectiveness of alcoholism treatment is difficult, VA should develop an evaluation system for ATUs, so it can identify opportunities to improve ATU operations, monitor program activities, report on program progress to VACO management and to the Congress, and determine ATU effectiveness in treating alcoholics. Moreover, VA could contribute significantly to advancing the state of the art in determining how alcoholism can be best treated, thereby benefiting all persons suffering from this disease.

VA has the largest single alcohol treatment program in the United States, consisting of 71 ATUs in fiscal year 1975, each operating relatively independently of the others. However, no system has been developed to evaluate the effectiveness of the ATUs to identify the more effective aspects of each ATU program, nor to disseminate that information to other ATUs for optimal treatment of veterans.

We recognize alcoholism treatment evaluation has not progressed to the point where measures of success and evaluation techniques have been fully developed or agreed upon by evaluators. Nevertheless, evaluation problems need to be addressed because the ultimate measure of the effectiveness of ATU programs will be best determined by the number of veterans who have recovered or whose condition has substantially improved. At the onset, evaluations may, in fact, help contribute to research. VA, with the single largest treatment program, has an opportunity to determine how best to treat alcoholism.

The need for evaluation was stated by NIAAA in its 1972 report, "Alcohol and Alcoholism; Problems, Programs, and Progress."

> "Intensive, controlled, theory-based studies on the various types of treatment now being used should be conducted to measure their relative efficiency, and to determine the types of patients for which each is most suitable. It is equally important to discover why certain treatment programs fail--and to identify the reasons why some patients drop out of treatment. Well-designed followup studies which

compare the types and degrees of success obtained with a number of patient-treatment combinations should be encouraged. Assessment should be built into the design of all demonstration and community projects so that they are appropriately staffed to conduct evaluations. Treatment techniques proven to be effective with various types of patients should be more widely disseminated and used."

Three of the seven ATUs visited were conducting evaluations, although VACO doesn't require them. However, each effort was independent of the others and of VACO.

The three ATUs had obtained information on the extent of drinking among veterans completing their programs.

The most current available data follows:

Sheridan ATU (Patients discharged July 1965 to Aug. 1967)

Drinking categories	Percent
Complete abstinence	18
Much improved	5
Improved	22
Unchanged	15
No data	40

Temple ATU (Patients discharged during calendar year 1972)

Drinking categories	Percent
Maintained sobriety	20
Improved	35
Unchanged	22
No information available	23

Houston ATU (Patients discharged July 1964 to Oct. 1975)

Drinking categories	Percent
Abstinent	25
Drank once	3
Mild social drinking	23
Weekend drinking	9
Short periods of drinking with longer period of sobriety	34
Short periods of sobriety with longer periods of drinking	1
Daily drinking	5

We obtained additional information on the drinking habits of veterans who had completed treatment at the 7 ATUs from the questionnaires we sent to the 665 veterans selected at random. These veterans had participated in the program between April 1, 1972, and March 31, 1973, and had been out of the program at least 6 months. Responses from 294 veterans who answered the question related to drinking habits follow:

--112 (38 percent) were abstaining.

--116 (40 percent) were drinking considerably less than before receiving ATU treatment.

--66 (22 percent) were drinking slightly less, as much as, or more than before receiving ATU treatment

ATU officials said VACO had not requested information on their evaluation efforts before September 1973, but two of the seven ATUs had filed annual reports with VACO because their evaluations were supported by VA research funds allocated to the ATUs by the hospitals. The third ATU had reported results for 1 year to VACO, but we were told they discontinued this practice when VACO did not comment on the report.

Our inquiries at the three ATUs showed that two had developed particularly useful or potentially useful findings.

--Evaluation studies at the Houston ATU were used to compare the relative effectiveness of 60- and 90-day inpatient programs. Because this evaluation indicated that success in the two programs was about equal, only a 60-day program is being used. This change increased the inpatient capacity of the ATU by 50 percent with, we feel, only a small added cost for related outpatient service.

--The above ATU was also comparing the success of two treatment programs involving different approaches. Although this study is incomplete, preliminary results show significant differences.

--At the Sheridan ATU, evaluation of treatment provided to two types of drinkers--those experiencing periods of excessive drinking followed by periods of sobriety and those experiencing long periods of continuous drinking--showed that probably more success could be achieved by using different treatments for each type of drinker.

These findings would be useful to other ATU managers, and VACO could obtain and disseminate such findings.

Each ATU used different alcoholic treatment practices. The relative effectiveness of these approaches is unknown, but the very fact that different approaches are being used demonstrates that VA can contribute to the evaluation and research effort which NIAAA said is needed. Some of the treatment differences were:

--Program length varied from 30 to 90 days.

--Scheduled activities varied from 15 to 51 hours a week.

--Staff ratios varied from 1.1 to 2.4 patients per staff member.

--Staff treatment approaches varied greatly. For example, antabuse (a drug that results in physical discomfort when alcohol is used) was required at some ATUs, while at others the use of antabuse as a chemical crutch was discouraged.

Because VACO had no evaluation system, it could not identify nor evaluate the success or relative merits of the differing treatment approaches.

To learn what ATUs were doing in the evaluation area, VACO in September 1973, for the first time since ATU-type programs were begun in the mid-1950s, asked all ATUs to submit--on a one-time basis--reports covering their evaluation efforts.

As of February 1975, the material had been received and reviewed; however, because the information was minimal and, to a great extent, related to uncompleted individual ATU

evaluation projects, VACO is planning to request additional data from the ATUs concerning completed evaluations.

Historically, VA has treated patients with primary alcohol abuse problems in settings separate from those patients who have primary drug abuse problems. During fiscal year 1974, VACO was developing a pilot alcohol and drug abuse treatment project to determine the feasibility of treating both alcohol and drug dependent patients in the same setting and to compare the effectiveness of such treatment with treatment in separate conventional settings.

VACO selected 10 VA hospitals with drug treatment units (7 also had ATUs) to conduct the combined alcohol and drug treatment projects and 7 hospitals with ATUs as a comparison base for alcohol treatments. Accordingly, VACO will be evaluating the effectiveness of the pilot project and the seven selected ATUs. "Effectiveness" is defined by VACO as the patient's progress toward the eight treatment goals developed by VACO. (See app. IV.)

VACO stated results of this project could have great implications for planning and treatment of these two groups of patients. As of March 1975, VACO estimated that data on results of the project would not be available until mid-1976.

CHAPTER 6

CONCLUSIONS, RECOMMENDATIONS, AND MATTERS FOR CONGRESSIONAL CONSIDERATION

CONCLUSIONS

VACO officials have not established program goals for the VA alcoholism treatment program, nor have they provided central direction to ATUs' operating programs. VA has also not made the commitment necessary to develop a comprehensive program for veterans with alcoholism. ATU programs have not been, or only recently have been, started in many major metropolitan areas; availability of alcoholism services has not been adequately publicized to veterans; treatment programs have not generally been structured to meet the needs of working veterans; inconsistent admission criteria have been applied at the ATUs; and too little emphasis has been placed on supportive services. Further, VACO has not developed an evaluation system to monitor the program or to determine its effectiveness.

RECOMMENDATIONS TO THE ADMINISTRATOR OF VETERANS AFFAIRS

To insure effective and equitable alcoholism treatment services for veterans, we recommend the Administrator

--establish overall program objectives; i.e., the number of veterans to be treated, types of patients to be treated (skid row or working), treatment they should get, and criteria for establishing ATUs in furtherance of these objectives,

--determine needed funding and staffing levels,

--develop an evaluation system for ATU programs,

--identify geographical distribution of alcoholism among veterans to set priorities for establishing ATUs,

--define the veteran population with alcoholism problems to be served and structure programs to meet their needs; such as, short-term inpatient programs for the working veterans,

--better publicize availability of alcoholism treatment for veterans, at the national, regional, and local levels,

--instruct hospital directors to identify and encourage alcoholic patients to seek treatment at ATUs,

--establish uniform ATU admission and readmission criteria, and

--incorporate essential supportive services--vocational rehabilitation, follow-on treatment, and family involvement--into ATU programs, either through VA or community resources.

MATTERS FOR CONSIDERATION BY THE CONGRESS

In view of the magnitude of the alcoholism problem among veterans and the low impact of the VA program, the Congress may wish to consider having VA confer with appropriate legislative committees on the goals and objectives of the VA program and the resources necessary to implement a comprehensive program.

AGENCY RESPONSE

VA agreed generally with every recommendation and indicated action taken and/or planned on each. (See app. I.)

APPENDIX I

VETERANS ADMINISTRATION
OFFICE OF THE ADMINISTRATOR OF VETERANS AFFAIRS
WASHINGTON, D.C. 20420

July 24, 1975

Mr. George Peck
Assistant Director
Manpower and Welfare Division
U. S. General Accounting Office
Room 268, VA Central Office
Washington, D. C. 20420

Dear Mr. Peck:

We appreciate the opportunity to review and comment on your draft report relating to alcohol treatment services provided to veterans. The Veterans Administration recognizes that alcoholism is a major problem of veterans, and the agency's program represents an important link in the federal government's strategy in combatting the disorder.

We agree with the recommendation to establish overall program objectives regarding the number of veterans to be treated, the type of patients to be treated (employed or unemployed) and the type of treatment to be rendered, and the criteria for establishing Alcohol Treatment Units (ATU's). Guidance toward overall program objectives is currently being reviewed and the findings will be issued later this year. Cross-sectional data on the health status of the veteran population is generally lacking for statistics on alcoholism. Consequently, it is difficult to establish the number of veterans to be treated. The VA will not exclude any eligible veteran from care whether employed or not. However, since alcoholism is usually not a service-connected disability, an employed veteran may not so easily qualify for treatment as one who is not employed. This is because in the case of a non-service-connected alcoholism problem, the veteran must certify an inability to pay for such care. The criteria for attaining these program objectives, and for the development and organization of the treatment services provided, are being promulgated in the Mental Health and Behavioral Services Manual which is currently in the process of revision.

The recommendation concerning the determination of funding and staffing levels necessary to accomplish these objectives is also concurred in. Currently, there are studies underway to identify these resource requirements. Since the VA hospital is considered to be a community resource and responsive to the health care needs of a particular area; it is appropriate that local initiatives by the hospital staff who are in working contact with the surrounding veteran population should provide the first level estimate of funding and staffing levels needed. Augmentation of our capability for treatment of alcoholism at a number of VA hospitals is being addressed in our current plans for the FY 1977 budget submission. This can bring increased specificity and quality in the treatment of the veteran who suffers from alcoholism to a significant number of communities now deprived.

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Mr. Gregory Peck
Assistant Director
Manpower and Welfare Division

For major metropolitan areas where the VA does not currently have a hospital, plans are being suggested to establish Limited Alcohol Abuse Treatment Clinics. These would provide for the ambulatory care of veterans with alcohol abuse problems and for the post-hospital care of veterans referred from ATU's. The establishment of such clinics would provide for continuing care of veterans who reside in areas where follow-up treatment is difficult or impossible because of the absence of a VA outpatient clinic. Preliminary plans call for the development of twelve such satellite clinics.

Regarding the recommendation to develop an evaluation system for the ATU programs, such a system is almost completely assembled. The VA staff has been working to develop an integrated system for evaluating the effectiveness and efficiency of the ATU's. Measurement instruments for program effectiveness have been constructed and tested and are planned for implementation in FY 1976. Statistics to evaluate the efficiency of program operation have been collected on a regular monthly basis since July 1972. Locally initiated evaluation and research, sensitive to local variables, is a critical component in a comprehensive evaluation system. Continued feedback from these two levels will provide data for evaluation of the relative effectiveness of different treatment approaches.

In addition to the VA's own evaluation system, the Joint Committee on Accreditation of Hospitals, with VA assistance, has developed national standards for alcoholism treatment programs. These have been distributed to all ATU's along with the notification that JCAH standards represent primary measures by which VA programs will be evaluated.

We concur with the proposal to identify the geographic distribution of alcoholism among veterans for the purpose of setting priorities for the establishment of ATU's. The monitoring of clinical load factors at all VA locations is currently being accomplished. A review of proposed new program starts was accomplished in March 1975 to update them for priority in support. The criteria applied in these determinations included the size of the veteran population in need of treatment for alcoholism, the location of the hospital, and the length of time the hospital staff has been requesting activation of such a unit.

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Manpower and Welfare Division

The recommendation to define the veteran population with alcoholism problems and structure programs to meet their needs is agreed with. Program guidance is currently being prepared to emphasize the ambulatory treatment modality. Our target population is limited by eligibility requirements to those veterans who have a history of a service-connected disability or certify an inability to pay for the care of their alcoholism. The recent increase in specialized alcoholism treatment units in general medicine and surgery and neuro-psychiatric hospitals has made possible the diversification necessary to address the needs of all subtypes of problem drinkers, including working veterans in a number of locations.

Within the following constraints, the proposal for better publicizing of the availability of alcoholism services to veterans at the national, regional, and local levels is concurred in. An active program of outreach into communities to advertise the availability of services was initiated by the VA in 1974. Publicity for VA ATU's is being expanded, tailored to local needs. However, we must be careful to describe accurately the resources currently available in a particular community area, and to avoid false promises of specific quality care of alcoholism.

Your recommendation concerning the instructing of hospital directors to identify and encourage patients with alcoholism problems to seek treatment at ATU's is deemed valid. Recognition of the medical gravity of alcoholism and the urgency for specialized treatment often suffers from the abusive stereotype assigned by the lay community to this particular group of medical disorders. Major efforts have been made to increase the sensitivity and shorten the reaction time of hospital personnel in this area of function. Consultations are frequently provided for alcoholism patients throughout the hospital involving referral and treatment questions. Hospital directors, through their professional staff will advise those patients with alcoholism problems to seek treatment in ATU's. If a veteran applies for admission for treatment and rehabilitation to any VA hospital which does not have an ATU, every effort will be made to refer him to a VA hospital with an ATU.

Within certain limits and constraints, we agree with the recommendation to establish uniform ATU admission and readmission criteria. Alcoholism is not a disorder which will always exhibit the same symptoms. The symptoms which manifest themselves in one patient as evidence of alcoholism will not necessarily appear in another patient. Also, problem drinkers may be admitted for treatment at different stages of their illness and recovery, with varying levels of motivation and varying medical complaints.

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Assistant Director
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Differences in settings used to treat alcoholic veterans, as well as differences in training and experience of the professional staff in ATU's and admitting offices are additional variables. With the prevailing salary limitations, there are serious problems experienced in retaining and even recruiting well-qualified physicians for such programs. It is, therefore, difficult and may very well be premature at the current stage of program development for the VA to specify fixed and arbitrary criteria for admission and/or readmission. Eventually, more nearly standardized admission criteria will evolve and be provided for program direction. However, it may be counterproductive at this time to limit the ATU's flexibility of response to the variables of local patient populations and other salient factors.

The proposal to incorporate essential supportive services such as vocational rehabilitation, follow-on treatment, and family involvement into ATU programs has already been incorporated as an integral part of the VA treatment programs. All VA ATU's provide for vocational rehabilitation and each one has veterans benefits counselors available to assist veterans in filing claims for benefits. Each ATU also provides a full range of supportive vocational and rehabilitative services including psychological testing and assessment.

Follow-on treatment modules for continued support of veterans discharged from the hospitals have been developed by each ATU. These have been in the form of outpatient treatments and follow-up contacts of various types by ATU staff personnel.

A majority of programs have developed family therapy activities wherein the direct involvement of family members contributes to the rehabilitation of the veteran. In addition, beginning in the fall of 1975, each ATU will be required to report the number of veterans receiving job, educational and vocational placements and all other referrals of patients for assistance.

We will continue to focus on improving the quality of treatment and facilitating the access to treatment until each veteran in need has been supported. As current difficulties experienced in the recruitment and retention of highly qualified physicians are solved, we can expect further improvements in the quality of care.

Sincerely,

Odell W. Vaught

Deputy Administrator - In the absence of

RICHARD L. ROUDEBUSH
Administrator

APPENDIX II

VA FACILITIES AND REGIONAL OFFICES REVIEWED

VA Facilities

Hospitals with ATUs	Location	Number of funded ATU beds
Salt Lake City, VAH	Salt Lake City, Utah	44
Sheridan VAH	Sheridan, Wyo.	97
Minneapolis VAH	Minneapolis, Minn.	30
Houston VAH	Houston, Tex.	84
Temple VA Center	Temple, Tex.	30
Mountain Home VA Center	Johnson City, Tenn.	40
Augusta VAH	Augusta, Ga.	95

Hospitals without ATUs (note a)

Denver VAH	Denver, Colo.
Dallas VAH	Dallas, Tex.
Atlanta VAH	Atlanta, Ga.

VA Regional Offices

Atlanta, Ga.
Cheyenne, Wyo.
Denver, Colo.
Houston, Tex.
Minneapolis, Minn.
Nashville, Tenn.
Salt Lake City, Utah
Waco, Tex.

a/ATUs funded at Denver and Atlanta after we began our review.

STATUS OF ATUs

IN 28 MOST POPULOUS U.S. CITIES WITH VA HOSPITALS

AS OF 12/31/73

City	Veterans (note a)	Has ATU	Lacks ATU
New York, N.Y.	970,200	X	-
Chicago, Ill.	422,600	-	X (note b)
Los Angeles, Calif.	408,400	X	-
Philadelphia, Pa.	274,300	X	-
Detroit, Mich.	193,400	-	X
Houston, Tex.	171,700	X	-
Dallas, Tex.	121,500	-	X
Baltimore, Md.	117,000	X	-
San Francisco, Calif.	106,500	-	X
Indianapolis, Ind.	105,700	X	-
San Diego, Calif.	103,700	-	X (note c)
Washington, D.C.	102,400	X	-
Milwaukee, Wis.	98,000	X	-
Cleveland, Ohio	96,700	-	X (note b)
Phoenix, Ariz.	87,000	X	-
San Antonio, Tex.	86,700	-	X
Seattle, Wash.	84,400	X	-
Boston, Mass. (note d)	83,300	X	-
Memphis, Tenn.	83,200	-	X (note c)
St. Louis, Mo.	80,800	-	X (note b)
Denver, Colo.	77,400	-	X (note b)
New Orleans, La.	76,500	-	X
Pittsburgh, Pa.	76,100	X	-
Kansas City, Mo.	75,700	-	X
Atlanta, Ga.	63,300	-	X (note c)
Buffalo, N.Y.	62,200	X	-
Cincinnati, Ohio	57,900	-	X (note b)
Nashville-Davidson, Tenn.	61,500	X	-
Total	4,348,100		

a/Veteran population estimates furnished by VA.

b/ATU planned for future if funds are available.

c/ATU funded in fiscal year 1974.

d/Outpatient clinic only--VA planned to establish an inpatient ATU in fiscal year 1976 if funds were available.

APPENDIX IV

Veterans Administration Goals for Treatment of Alcohol and Drug Dependent Patients

It is expected that upon completion of treatment, a patient will:

1. Not use drugs or alcohol in a manner that is illegal; that is damaging to physical health, family or job adjustment; or that threatens personal safety.

2. Be free of pain, illness, and disability to the extent reasonable to expect from currently available medical practice.

3. Be free of serious disorders of perception, cognition, mood and self-esteem.

4. Interact with people in a way that is not seriously stressful to the patient himself or to others.

5. Support himself in the community to the extent that age and physical health permit.

6. Manage his affairs in such a way that his immediate needs for food, clothing, shelter, transportation, and medical care are met in a responsible manner.

7. Not assault others, steal, drive while impaired by drugs or alcohol, or engage in other activities that endanger the public safety or welfare.

8. Obtain satisfaction from socially acceptable sources such as work, relationships with family and friends, and leisure time activities.

536864

PRINCIPAL VA OFFICIALS

RESPONSIBLE FOR ADMINISTERING

ACTIVITIES DISCUSSED IN THIS REPORT

	Tenure of office	
	From	To
ADMINISTRATOR OF VETERANS AFFAIRS:		
R. L. Roudebush	Oct. 1974	Present
R. L. Roudebush (acting)	Sept. 1974	Oct. 1974
D. E. Johnson	June 1969	Sept. 1974
DEPUTY ADMINISTRATOR:		
Vacant	Oct. 1974	Present
R. L. Roudebush	Jan. 1974	Oct. 1974
F. B. Rhodes	May 1969	Jan. 1974
A. W. Stratton	Nov. 1967	May 1969
DIRECTOR, VETERANS ASSISTANCE (note a):		
J. P. Travers	Aug. 1973	Present
W. P. Hardwick (acting)	July 1973	Aug. 1973
J. G. Miller	May 1963	July 1973
CHIEF MEDICAL DIRECTOR:		
J. D. Chase, M.D.	Apr. 1974	Present
J. D. Musser, M.D.	Jan. 1970	Apr. 1974
H. M. Engle, M.D.	Jan. 1966	Jan. 1970

a/From May 1, 1972, to August 1, 1973, the position title was Director, Veterans Assistance and Administrative Service. Before May 1, 1972, the position title was Director, Contact and Administrative Service.

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