CLARENCE JORDAN, MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

STATEMENT OF
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MEMBER, NATIONAL BOARD OF DIRECTORS
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SUBMITTED TO
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE
WASHINGTON, D.C.

MARCH 3, 2010

Chairman Akaka, Ranking Member Burr, and Members of the Committee –

On behalf of the National Alliance on Mental Illness (NAMI), please accept NAMI's collective thanks for this opportunity to provide testimony at today's oversight hearing to assess the Department of Veterans Affairs' (VA) mental health programs.

I am privileged to serve on the national Board of Directors of NAMI, the nation's largest grassroots consumer organization dedicated to improving the lives of individuals and families affected by mental illness. Through NAMI's 1,100 chapters and affiliates in all 50 states NAMI supports education, outreach, advocacy and research on behalf of persons with schizophrenia, bipolar disorder, major depression, severe anxiety disorders, post-traumatic stress disorder (PTSD), and other chronic mental illnesses that affect both adults and children. In my opinion what NAMI does best as an organization is to advocate for, train and educate family members of persons living with mental illness. In recent years NAMI began to realize that the lives of our newest veterans and the experiences that they've had while serving our country in combat necessitate not only that they receive post-deployment services essential to get well afterward, but also that their families have needs that must be addressed to ensure that a family recovers from the experience.

NAMI is very proud that the VA has recognized that NAMI can play an important role within VA mental health in helping families of veterans cope with, and recover from, mental illness, whether acute or chronic. One NAMI signature program in particular, Family-to-Family, is designed to meet the needs of family members who have questions relative to what their loved one—the veteran home from deployment in war—is experiencing, not only from the standpoint of what the illness is, but the treatment protocol, the various medications and prognosis, and what they can expect in supporting and caring for their loved one in gaining the ultimate goal of recovery.

As a case in point, I am a 15-year veteran of U.S. Navy aviation. I know how combat situations,

as well as other more basic tenets of military life, put unique stressors on those of us who have served, as well as on our families. In my case, while the signs of a problem were there, and more than one person tried to point them out to me, I completely denied the problem at that time. With the clarity of hindsight now, I can say that I struggled for years with mental illness when I was on active duty in the United States Navy. I know now that I was not alone.

My struggle with mental illness ultimately led me to leave military service, and for nearly a decade afterward I bounced from one job to another and from city to city. In 1998 I finally had to face the fact that I had a problem. At the time, I was using alcohol and other drugs to keep me from dealing with the realities of my life, and that approach ultimately led me to trouble with the law. I owe a debt of gratitude to a judge who gave me a choice of going to jail or going into mental health treatment. It was the push I needed to start turning things around. In my case I went to a local community mental health center in Nashville, Tennessee, and met with several doctors who evaluated my condition. I ultimately was diagnosed with major depression.

I stayed in treatment at that health center for 12 months to work through the issues I was experiencing. I believe I have achieved recovery to enable me to live a better life. I believe I am living proof that a mental illness does not mean that one cannot live a happy, productive life. Since leaving that initial treatment, I have not only held responsible jobs but I've become actively involved in NAMI, where I now train others and do advocacy work to help those with these problems achieve their potential.

It's important for people, veterans and non-veterans, to realize that there are different types and levels of mental illness and that the most important thing they can do if they think they have a problem is to step forward and talk to a mental health professional to find out.

When I served in the Navy, I personally had no base of experience or knowledge about mental illness that would have led me to believe I had a problem. Furthermore, my personal "image" of someone with a mental illness when I was in the Navy was definitely not me. I knew next-to-nothing about the VA and its mental health programs. I believe I share this experience with thousands of military service members and veterans who could benefit from VA services but may not be getting them.

I believe that the VA must do a better job of reaching out and making its services known to a larger share of the veteran population (both those recently discharged-demobilized and older generations), and work more cooperatively with the military service branches, other federal agencies, state governments, and private mental health providers. Today, we have over 23 million living veterans, yet VA sees only a quarter of them in its health care programs, and even a smaller fraction in its mental health services. Given our experience to date in the wars in Afghanistan and Iraq, plus the overlay of combat experiences of prior generations of veterans, it is obvious that more veterans need readjustment and mental health counseling and other mental health services than those who are appearing at VA facilities to seek these services.

No one to my knowledge is studying what happens to veterans after combat if they do not enroll in VA health care. VA participates in the national suicide hotline program, 273-TALK, and recently reported that over 60,000 veterans had contacted that resource since it was established. I believe much insight about veterans who do not use VA health care could be gleaned from surveying those veterans who have called 273-TALK, and would urge this Committee to consider requiring such a study by VA or the Substance Abuse and Mental Health Services Administration (SAMHSA) to determine how much VA is aiding these callers. Make no mistake: NAMI deeply appreciates the existence of 273-TALK. We have commended VA's Office of Mental Health Services for having established this vital link to VA counselors who have

saved the lives of thousands of veterans, but we believe a larger group of veterans still is in need and is not being reached.

Despite our concerns about the need for broader outreach, not only to prevent suicides but to ensure that more veterans can become aware of VA services, NAMI has enjoyed a long-term interest and involvement in mental health programs within the VA. For 30 years NAMI has served as an advocate for veterans under care in VA programs, because VA is caring for our family members. NAMI and its veteran members formally established a Veterans Council in 2004 to assure close attention is paid to mental health issues and policies in the VA, especially within each Veterans Integrated Services Network (VISN) and programs at individual VA facilities. Council membership includes veterans who live with serious mental illness, family members of these veterans, and other NAMI supporters with an involvement and interest in the issues that affect veterans living with and recovering from mental illness. The Council members serve as NAMI liaisons with their VISNs; provide outreach to veterans through local and regional veterans service organization chapters and posts; increase Congressional awareness of the special circumstances and challenges of serious mental illness in the veteran population; and work closely with NAMI's State and affiliate offices on issues affecting veterans and their families.

Our members are directly involved in consumer councils at more than one-third of VA medical centers and we advocate for even more councils to be established throughout the VA system. Also, VA and NAMI executed an important memorandum of understanding in 2007 formally promoting our signature "Family to Family" education program within VA facilities. As I mentioned above, Family to Family is a formal twelve-week NAMI educational program that enables families living with mental illness to learn how to cope with and better understand it. The program provides current information about schizophrenia, major depression, bipolar disorder (manic depressive illness), post traumatic stress disorder (PTSD), panic disorder, obsessive-compulsive disorder, borderline personality disorder, co-occurring brain disorders and addictive disorders, to family members of veterans suffering from these challenges. Family to Family supplies up-to-date information about medications, side effects, and strategies for medication adherence. During these sessions participants learn about current research related to the biology of brain disorders and the evidence-based, and most effective, treatments to promote recovery from them.

Family members of veterans living with mental illness gain empathy by understanding the subjective, lived experience of a person with mental illness. Our Family to Family volunteer teachers provide learning in special workshops for problem solving, listening, and communication techniques. They provide proven methods of acquiring strategies for handling crises and relapse. Also, Family to Family focuses on care for the caregiver, and how caregivers can cope with worry, stress, and the emotional overload that attends mental illness in families. We at NAMI are very proud of Family to Family, and we were especially pleased that former VA Under Secretary Michael Kussman and VA's Office of Mental Health Services saw the wisdom of formally bringing NAMI resources like Family to Family into VA mental health programs at the local level.

I believe I can fairly report that this effort has been a great success to date, functioning in about 100 VA medical centers. We at NAMI are hoping to continue building on that success, including renewing the existing Family to Family memorandum of understanding with VA, and to introduce more of NAMI's signature programs, such as our Peer to Peer and NAMI Connections programs, into VA mental health care.

Mr. Chairman, in March of last year NAMI issued its biennial Grade the States report, an effort to survey state mental health program directors on the types and scope of mental health programs available within their states for all residents. I hope the Committee's professional staff will take the opportunity to review the results. NAMI found that while 14 States had improved their grades since NAMI's 2006 survey, 12 fell backwards, and that the national average grade for state-sponsored public mental health programs still remained unchanged, a grade of "D." You can see the full Grade the States report at www.nami.org/grades09 .

For the first time ever, the Grade the States report last year asked a series of questions about whether states offered any readjustment or other mental health programs for service members and family members of the state National Guard units returning from deployments in Afghanistan and Iraq. Very few states responded in the affirmative, but we have learned that the states of Massachusetts and Vermont are two good models of programs that effectively provide peer-outreach and direct delivery of coordinated services to their returning Guardsmen. These appear to be state-funded efforts, but in the case of Vermont they are subsidized by a VA cooperative funding agreement. This is good information that might encourage some States to look to Massachusetts and Vermont for ideas. We call your attention also to similar efforts in California, Connecticut, Maine, Maryland, New Hampshire, New Jersey, New Mexico, New York, North Carolina and South Carolina. Of special note, the State of Montana launched an ambitious program of post-deployment screening and referrals for Montana National Guard members home from Afghanistan and Iraq. NAMI commends Congress for including Senator Tester's bill, modeled on the Montana program and based on advocacy by NAMI Montana, in last year's National Defense Authorization Act (NDAA). That new law requires the Department of Defense (DOD) to conduct three face-to-face mental health screenings of every servicemember returning from a contingency operation. NAMI is also pleased that Congress included Senator Shaheen's legislation based on a New Hampshire NAMI suicide prevention training initiative, the "Yellow Ribbon Reintegration Program," also called "Yellow Ribbon Plus," in the NDAA. Unfortunately, while Congress authorized these two new programs, it did not provide designated funding for them. We hope directed funding to support these efforts will be provided in the next DOD appropriations act, in Fiscal Year 2011.

Mr. Chairman, as you can see from some of these examples, NAMI is deeply concerned about the newest generation of repatriated war veterans, whether they remain on active duty, serve in the Guard or Reserves, or return to civilian life following service. We want to see the Department of Veterans Affairs take a more leading posture in coordinating both inter-governmental and public-private arrangements that would do a better job at outreach, screening, education, counseling and care of the veterans who fought and are still fighting these wars, and to help their families recover from these experiences. NAMI is committed to recovery, whether from transitional readjustment problems coming to a family that welcomes an Army or Marine infantryman back from war, or one dealing with chronic schizophrenia in a young adult who never served in the military. In the case of our professional military services, we want to ensure that those serving in the regular force are well cared for by DOD when they return to their duty stations after combat deployments; by both DOD and VA for those in the National Guard or Reserve components when they return to garrison in their armories; and, by VA for those who

become veterans on completion of their military service obligations and return to their families – whether in urban or rural areas.

NAMI believes many tailored approaches will need to be made for these new veterans, but that all of the civilian efforts should be led by VA, in coordination with other agencies (including DOD, SAMHSA, the Public Health Service and the Indian Health Service), the National Guard Bureau, State Guard leaderships, and the leaders of State public mental health agencies, as appropriate to the need. In some cases, private mental health providers should be enlisted and coordinated by VA to ensure they can provide the quality of care veterans may need, and are trained to do so in the case of post traumatic stress disorder and other disorders consequent to combat exposure and military trauma, including military sexual trauma. We realize that finding qualified private mental health providers in highly rural areas is an extreme challenge and will require VA and other public agencies to be creative. Nevertheless, we believe these unmet needs can be dealt with if VA establishes a firm will to do so.

NAMI also urges this Committee and other relevant groups in Washington and in state capitals, to expand the establishment of diversionary courts for veterans. I mentioned my personal experience with a judge who gave me an opportunity to turn my life around, and I believe that my military experience was part of that judge's consideration in diverting me to treatment rather than sending me to jail. In the few instances where veterans courts exist, they have become effective tools to get veterans who are struggling with mental illnesses the help that they need. NAMI urges the Committee to support the development of diversionary courts for veterans, and especially combat veterans, and to make sure that VA reaches out and coordinates with the existing courts systems in cities and States to ensure post-deployment veterans receive the most timely and effective care possible, rather than allowing sick and disabled veterans suffering with mental illnesses consequent to their war service to be convicted and sent to jail or prison.

Mr. Chairman, the National Alliance on Mental Illness is committed to supporting VA efforts to improve and expand mental health care programs and services for veterans living with serious mental illness. Until recently, forward motion had been stalled on VA's "National Mental Health Strategic Plan," to reform its mental health programs – a plan that NAMI helped develop and fully endorses. NAMI wants to see VA stay on track to provide improved access to mental health services to veterans returning from Iraq and Afghanistan today, as well as to other veterans diagnosed with serious mental illness – all important initiatives within the VA strategic plan. In 2008 VA announced its establishment of a "Uniform Mental Health Service" benefits package, one that NAMI supports as beneficial to ensuring VA progress toward full implementation, and will provide help to the newest war veteran generation and all veterans who live with mental illness.

Finally, NAMI is an endorser organization of the Independent Budget for Fiscal Year 2011. In that budget and policy statement, AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States recommend a series of good ideas that, if implemented would further improve VA's mental health programs. I ask the Committee to closely consider these recommendations and to ensure, either with oversight or legislation that VA (and the Department of Defense in some instances) carries out the intent and spirit of these

recommendations. For the benefit of the Committee, I am attaching these Independent Budget recommendations to this testimony.

This concludes my testimony on behalf of NAMI, and I thank you for the opportunity.