HEARING ON VA MENTAL HEALTH CARE:

ENSURING TIMELY ACCESS TO HIGH-QUALITY CARE

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WEDNESDAY, MARCH 20, 2013

United States Senate,

Committee on Veterans' Affairs,

Washington, D.C.

The committee met, pursuant to notice, at 10:00 a.m., in Room 418, Russell Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Murray, Tester, Blumenthal, Burr, Isakson, Johanns, and Boozman.

OPENING STATEMENT OF CHAIRMAN SANDERS

Chairman Sanders. This hearing of the Senate Veterans' Committee is beginning and I want to start by thanking all of our wonderful panelists who have years of experience in the area, the very important areas that we are going to be delving into today. I want to thank them very much for coming here today and I want to thank the VA for being here as well.

As I think we all know, it is now 10 years since the United States went to war in Iraq and we went to war in Afghanistan before that, and what we have learned in a variety of ways is that the costs of those wars has been very, very high.

And, they have been high not just in the loss, tragic loss of life that we have experienced, not just in terms of those who come home without arms or legs or without eyesight or hearing problems but also in term of what is called the invisible wounds of war which are quite as real as any other kind of wounds.

And, those wounds include Post Traumatic Stress Disorder, PTSD, Traumatic Brain Injury, TBI, and all of the symptoms associated with those very serious illnesses.

Further, and tragically, it includes the serious problem of suicide. We are losing about 22 veterans every single day as a result of suicide. That is more than 8,000 veterans every year.

And, while suicide is a major, major problem in the United States as a whole for our civilian population, it is a terrible, terrible tragedy for the veterans' community and is something that must be addressed.

Let me preface my remarks by saying what I think everybody understands. The issues that we are dealing with today are very, very tough issues; and if anyone had any magic solution to the problems of mental illness in general, trust me, we would have heard about them a long, long time ago.

So, this is a tough issue and we are going to do our best today to figure out where we are in terms of the needs

of our veterans and where we are going to go forward.

I think everyone is in agreement that ensuring timely access to high-quality mental health care is critical not only for our veterans but for their loved ones as well.

And, what we are going to hear today from our panel is that mental health issues impact not only the soldier or the veteran but the wife, the husband, the children as well.

As a Nation, our goal must be to ensure that veterans get the best mental health care possible, and that they get it in a timely, non-bureaucratic way. How that health care is delivered is of enormous consequence.

I want to commend the VA for its work in this area. The department has made important strides forward in providing mental health to our veterans. In fact, in many ways, the VA is leading the Nation in terms of PTSD research.

But clearly, with all of the accomplishments, much, much more must be done because we are entering into an area that is impacting tens and the tens of thousands of veterans and we must find the best solutions that we can.

We know that our veterans who need mental health services need them quickly. Today, all first-time patients referred to or requesting mental health care services are required to receive an initial evaluation within 24 hours and a comprehensive evaluation within 14 days.

In April of last year, the Office of the Inspector General found that VHA was not meeting these benchmarks. Some veterans were waiting as many as 60 days for an evaluation, and in the real world if somebody is struggling, if somebody is hurting internally, if somebody is drinking too much, if somebody is doing drugs, clearly waiting 60 days is not acceptable, and that is, in fact, a deeply troubling finding.

A year after those negative findings, it appears that the VA has made progress in implementing recommendations from the IG report and in many ways people are now, as I understand it, getting their evaluations within 24 hours but that is an issue we are going to explore this morning with the VA.

But the point here is if people are hurting, we need to get them in the door. We need to have them see somebody. We need to get them into the system, and waiting two months certainly is absolutely unacceptable.

One issue that I remain very concerned about, both in the VA, and I am also a member of the health and education committee, and this is not just a veterans' issue. It is an issue for our entire Nation, is the shortage that we have in terms of mental health providers.

These long wait times that I mentioned are partially caused by staffing shortages. I am pleased that Secretary

Shinseki has implemented the executive order to hire 1600 mental health clinicians.

I understand that as of March 13, VA has hired more than 3000 mental health professionals and administrative support including more than 1100 of these new mental health conditions. This is good progress toward teaching VA's goal.

However, let me emphasize this point, I am concerned, very concerned that VA has hired only 47 clinicians in the last two months. I understand the challenges, and I think we all understand the challenge here.

You do not want to run out on the street and pick up the first clinician you can. You want to make sure that the people you are hiring are well trained and they are of the quality that our veterans deserve.

But clearly, VA must step up the pace of hiring if it intends to meet its goal of 1600 new clinicians by the end of June of this year. In order to meet this goal, VA will need to hire almost 500 clinicians in the next two months. Frankly, I do not see how that is possible and I will want to talk to the VA about how they are moving forward in this area.

So, the goal is not just rushing out, bringing people into the system, making sure they are of good quality. But we have got to get people into the system as rapidly as we

can.

Terms of quality. It is clear that we all want our veterans to be seen by properly trained mental health counselors who can provide the high quality care that our veterans deserve. VA has made some important steps forward in this area.

VA clinicians are now trained in evidence-based therapies such as cognitive behavioral therapy and prolonged exposure therapy. While VA clinicians are trained in these therapies, VA must do a better job tracking utilization so we may ensure that what these clinicians are trained to do is being put into practice all across the country.

Access to timely and high quality care only matter if the care is delivered to veterans in the appropriate way. VA must continue to provide care in a variety of settings to meet the needs of each veteran.

Medical Centers, Community-Based Outpatient Clinics, CBOCs, Vet Centers, and Telehealth services each play important roles in appropriate care delivery.

VA Medical Centers are equipped to treat the most severe cases, such as PTSD. They are also critical in addressing the mental health care needs of patients admitted to the hospital for physical injuries.

Vet Centers, and I am a great supporter of Vet Centers, and I am not sure that we utilize them as much as we should.

Vet Centers provide a safe, welcoming, home-like environment for veterans to receive care both on a one-on-one counseling as well as in group settings. Veterans often feel very comfortable in that nonbureaucratic environment.

Additionally, Community-Based Outpatient Clinics, or CBOCs, offer mental health care services that are often closer to veterans' homes. In certain situations, CBOCs use telemedicine to link veterans to clinicians at VA Medical Centers. And the VA has done an excellent job, by the way, in terms of telehealth in general.

It is critical that VA provide these various options of care. We must ensure not only that these options remain available but veterans know about them. And, one of the issues, and I believe the next hearing that we are going to have, deals with outreach in general. You can have the best care in the world. If a veteran does not know about that care, it does nobody any good at all.

While VA has made significant strides forward in improving mental health care to our veterans, we must do more to ensure better prevention, prevention for today's service members, the veterans of tomorrow.

The Army--and I think we are all aware of the frightening level of suicides within member of the Armed Services today, approximately one a day--has got to help us address this issue.

And, based in large part on the efforts of this Committee, the Army task force on behavioral health recently completed a comprehensive review of behavioral health care and the report provided multiple recommendations for improving mental health counseling.

In other words, what we are beginning to also understand, and an issue this Committee will deal with, is that a soldier is a soldier from the first day of enlistment, first day in the military to his last day on earth when he is in the VA and that continuity of care has got to be extremely important.

While we often think of the military and VA as providers of mental health care for our service members and veterans, community organizations like the ones that will testify here today play a key, key role in helping veterans access the care they need.

These organizations can partner with VA to identify veterans in need of care, work with veterans to help them prepare for care and provide direct care to veterans. And we are going to hear from these wonderful organizations, and again I want to thank you all very, very much for the work you do and thank you so much for being with us today. I will be introducing you in a few minutes when you testify.

These organizations do not shy away from the worst consequence of serious mental illness, including suicide.

In my home State of Vermont, the Vermont Veterans Outreach Program, operated by the Vermont National Guard, has intervened to prevent suicides from occurring; and that is certainly true with all of the organizations that are here today.

So, let me just conclude by saying that by saying that the issue that we are dealing with today is a very difficult one. It is an issue of enormous consequence. It is an issue that impacts the lives of tens and tens and tens of thousands of men and women who put their lives on the line to defend this country, whether it is PTSD, whether it is traumatic brain injury, whether it is suicide, these are issues that we must delve into and we must succeed in improving our outcomes.

So, thank you again very much for being here and I would like to give the mike over to Senator Burr.

OPENING STATEMENT OF SENATOR BURR

Senator Burr. Thank you, Mr. Chairman. Thank you for calling this hearing. I welcome our witnesses today and look forward to the insight that you can provide to us.

Kim and Jake, I want to especially thank you two for sharing your experiences with us. I know some of it will be painful to recount but we are grateful for the insight that you can give members of this Committee.

It is important that we hear first-hand from veterans,

their families, and friends about the experience in seeking mental health services. So, it is absolutely vital to us.

As you know, this hearing follows three mental health hearings we held last Congress. At those hearings, we heard from veterans and providers about the barriers veterans faced in receiving mental health care in the VA facilities.

After the first mental health hearing, VA at the request of Senator Murray conducted a poll of its mental health care providers which painted a stark picture of VA's mental health program and its ability to provide the care our veterans need and deserve.

Following the second hearing, the Committee requested the Inspector General audit the VA mental health program. The IG found that VHA's schedulers were not following directives for scheduling appointments and providers frequently scheduled patients for follow-up appointments based upon their availability, not on the clinical needs of patients. In my mind, this revealed a complete breakdown in VA's mental health program.

In response to the IG report, VA announced the hiring of 1600 additional mental health providers. While I am glad VA has finally admitted to having a problem, I still have questions regarding that initiative. For instance, did VA conduct in staffing analysis to determine the type and how many mental health providers were needed; and when 70

percent of VA providers indicated in a survey that there was not enough space in mental health clinics, I cannot help but wonder where additional staff will be placed.

I believe this problem could be larger than just providing mental health services to a current generation of veterans. VA is seeing an increase in demand not only from veterans of Iraq and Afghanistan, VA is seeing an increase in demand from Vietnam vets and other generations as well.

Vet Centers have already noticed an increase in the number of Vietnam era veterans returning for counseling. As Vietnam era veterans retire and seek services, I fear we are going to find ourselves back here again trying to fix the same problem.

While VA has the authority to improve access to mental health services by changing outcome measures, hiring more staff, and fixing broken scheduling processes, the VA cannot solve, cannot fix this problem alone.

VA needs to look outside the box for answers and engage the private sector and charitable organizations for help in treating veterans in need of mental health services. Without a realistic plan that combines partnerships with outside providers and charities, the outcomes of a staffing analysis and fixes to VA's internal problems, they will not see an improvement in mental health services especially with those veterans who need it the most.

This is a problem that cannot be solved with one or two changes. It needs a comprehensive approach that incorporates solutions both from within and outside the VA system.

What does that all mean? It means I still think we are hung up with process and not with outcome. We are hung up with how many people can we hire, how much space can we get, have we have enough access versus are we fixing people who come in the front door and fixing them when they go out the back door that they are well.

Let me just say to my colleagues. If we allow mental health to be treated like the disability claims backlog where we focus only on how many people can we hire, I will assure you we will get the same outcome. Less productivity and a backlog that continues to grow.

We have got to focus on fixing these kids. We have got to get the talent that we need regardless of whether it is inside or outside the VA to fix these kids, to make sure they are better on the back-end. That is hopefully where the focus of this Committee will be.

Finally, I want to take a minute to address my concerns regarding the recent quality of care issues including the single-use insulin pens at Buffalo and Salisbury VAMCs and the ongoing issues at Jackson. I am even more frustrated by how these issues were handled and how Congress was notified.

There is a broader discussion to be had on these issues, Mr. Chairman, but this is not the venue for it but it should be the focus of the Committee with the appropriate folks from the VA.

Mr. Chairman, I want to thank you. I want to encourage my colleagues if you can pass on opening statements if you would do it today and limit your questions because we have got a vote and we want to try to accommodate both panels before we go into those votes.

Thank you.

Chairman Sanders. Senator Tester.

OPENING STATEMENT OF SENATOR TESTER

Senator Tester. I have just got to say a few words, Ranking Member Burr, but I just want to thank the Chairman and you for doing this.

First of all, this is a signature injury coming out of Iraq and Afghanistan now. This is not new news. It has been here forever.

If we knew how to treat mental illness in a way that was very, very effective in this country, this issue would not even be on the; but we have run from it for decades.

We ran from it in Vietnam, and now we are trying to address it, and I just want to say that I think the folks that are working in the VA, they do need to think outside the box and we do need to get more medical professionals on

the ground especially in rural places like Montana, and I am a little bit prone to be anyway.

On the other side of the coin, I do not think this issue is going to be solved tomorrow. It is going to take some time and I think but if we work at it and we work at it together and we do not call for people's resignations but rather work with them, I think that we can get a lot more done.

Thank you very much.

Chairman Sanders. Thank you, Senator Tester.

Senator Johanns.

OPENING STATEMENT OF SENATOR JOHANNS

Senator Johanns. Thank you, Mr. chair. I am mindful of the vote that is coming up here so I will pass on opening statement. If I have anything, I will submit it for the record.

[The prepared statement of Senator Johanns follows:]

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Chairman Sanders. Thank you very much.

Senator Isakson.

OPENING STATEMENT OF SENATOR ISAKSON

Senator Isakson. I will submit a statement for the record.

[The prepared statement of Senator Johanns follows:]

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Chairman Sanders. Let me introduce our very wonderful panel. Again, we are very appreciative that they are with us today. We are going to hear first from Jacob Wood, who is the President and Co-Founder of Team Rubicon. Next, we are going to hear from a fellow Vermonter and the Team Leader, Vermont Veterans Outreach Program, Andre Wing. Then, we are going to hear from the Director of the Suicide Postvention Program at the Tragedy Assistance Program for Survivors, Kim Ruocco.

Next, we will hear from retired U.S. Army Lieutenant Colonel and Chair of the veterans and Military Counsel at the National Alliance on Mental Health, Kenny Allred; and then, we will hear, we will close out the panel with Dr. Barbara Van Dahlen, Founder and President of Give an Hour.

So, I just again thank you for the work that you are doing and for the testimony you are about to give us.

Jacob, let us begin with you.

STATEMENT OF JACOB WOOD, PRESIDENT AND CO-FOUNDER, TEAM RUBICON

Mr. Wood. If you please will bear with me while I read you a few names. McShan, Jensen, Stuart, Ross, Rios, Marco, Rocha, Clay Hunt.

In 2008, my unit redeployed home to the U.S. after a long and bloody tour in Helmond Valley, Afghanistan. In seven months, we lost 20 men, suffered nearly two dozen amputations, and took over 150 casualties.

The names I just read, however, were not among those grim statistics. No. The names I just read are the names of the men we have lost in the last four years; names of the men we have lost to suicide while pursuing our peace.

That last name, Clay Hunt, belonged to my dear friend and sniper partner. Clay was a good man, a great Marine, and an incredible humanitarian. Clay helped me start an organization called Team Rubicon, a nonprofit which using the skills and experiences of returning combat veterans for continued service following natural disasters.

My cofounder and I launched Team Rubicon after the Haiti earthquake in 2010 We arrived only a few days after the devastating quakes struck, provided medical triage in the hardest hit areas of Port au Prince; essentially using the principles of Counter-Insurgency warfare to mitigate risk, move quickly, gain the trust of an unstable populace,

and render critical aid.

It was in Clay's suicide, however, that we realized a critical truth: Team Rubicon is more than a high-speed disaster response organization. Rather, it is a veteran service organization that is using natural disasters as an opportunity for veterans to continue their service and regain what they have lost since leaving the military.

Ladies and gentlemen, many will come that jobs or education or access to health care is what will keep our Nation's warriors from killing themselves here at home.

But as a simple Marine sergeant, I am going to argue that it is much simpler. You see, returning from a decade long war that has suffered from ambiguous political leadership, an unclear mission, and a disengaged and disinterested public takes a heavy mental and emotional toll on servicemen and women.

Picture for a moment an 18 year old boy from Omaha, Nebraska. That 18 year old boy graduates high school and joins the Army. The Army sends him to boot camp and gives him a rifle, and later he deploys to Iraq and is promoted to the rank of Sergeant.

This young man spends twelve months and every day he leads his men outside the wire to pacify a countryside and protect his comrades from insurgent attacks. He has purpose. Every night, back inside the wire, he checks on

his men, ensuring that they have what they need. They laugh together, they cry together. He has a community.

Twelve months later his unit returns home. The young man walks through the airport in his uniform and is slapped on the back and thanked from all around. He has an identity. A few short months later the man leaves the Army and returns home to Omaha, Nebraska. He gets a job and reconnects with old high school friends.

Soon, however, he discovers a serious void. Things are not the same. No job can replace the purpose he once felt. Distant high school friends simply cannot understand or replace the community he has left behind. And no mechanics overalls or pinstripe suit will ever give him the identity he once felt while proudly wearing the uniform of his beloved Nation.

He is not whole; and now left to his own devices, he questions his war because everyone around him questions it. He now finds himself trying to justify the lives lost, the lives taken, and the moral code that war inevitably compromises. For some this is the most difficult part because the mission may no longer feel noble and the threat no longer imminent.

We at Team Rubicon believe that the foundation to a healthy transition lays in those three simple concepts: Purpose, Community, and Identity. By providing veterans

with a new, noble mission, helping those afflicted by disasters, veterans not only help their neighbors, they help themselves.

Through disaster response, our veterans find a new method of employing the skills that they learned for war. Combat medics treat young children. Combat engineers build refugee camps, and squad leaders bring order to ravage communities.

They raise their right hand and let their neighbors know that when disasters strike, they will once again lace up their boots and answer the call. They look around themselves and discover a new band of brothers. Men and women with a similar ethos and desire for community.

Lastly, they wear our T-shirt with pride, a pride of belonging to something bigger than themselves. If done right, we can make them feel whole again.

Earlier, I mentioned community and community can not be undervalued. Today's service members come together from communities all across the country and the form tightknit units. But when they leave the military, they go back to their hometowns, losing that connection, that brotherhood that they had when they were in the service.

To help build a 21st century veteran community, I have also cofounded a technology company called POS REP or Position Report. POS REP was also inspired by Clay Hunt,

when, at his funeral, I discovered that there were three Marines who lived within 10 miles of him in Houston, Texas that we had served with in Iraq. Clay had, in fact, not been alone.

Frustrated with the VA and the DOD's inability to connect veterans with one another after they leave the service, we set out to solve the problem using the most ubiquitous tool on the planet, our smartphones.

Using the GPS capability of smartphones, we have created an application exclusively for military veterans. It connects veterans not only with the veterans they already know, but more importantly it helps them discover and communicate with the veterans all around them.

It also serves as a unifying platform for veteran service organizations, helping numerous nonprofits reach veterans in order to provide critical transition services. In later versions, we hope to help veterans connect with VA services based on their proximity to those resources.

The app can serve as a hyper-local, veteran version of Foursquare. However, to do so, requires cooperation with the federal and state government, which has proven to be tremendously cumbersome for a young, underfunded startup like POS REP.

In closing, it is my humble opinion that at the root of this issue of transition lays three core tenets: purpose,

community, and identity. Team Rubicon is working to provide all three through a new, exciting mission; and POS REP is trying to create a new offline community through an innovative online discovery tool.

Thank you for your time.

[The prepared statement of Mr. Wood follows:]

Chairman Sanders. Thank you very much, Mr. Woods.

Andrew Wing is a Team Leader for the Vermont Veterans Outreach Program. Andre.

STATEMENT OF ANDRE WING, TEAM LEADER, VERMONT VETERANS OUTREACH PROGRAM

Mr. Wing. Chairman Sanders and members of the Committee, thank you for your invitation to discuss the Vermont Veterans Outreach Program. I have been the Vermont Veterans Outreach Team Leader since April 2010. In that time, my team has conducted needs assessment surveys with over 4300 veterans to discuss their needs and the needs of their families.

The Vermont Veterans Outreach Program has evolved and expanded beyond its original 2007 mandate of helping only OIF/OEF veterans. We now also assist service members from other war-time conflicts.

One of the reasons the Vermont Veterans Outreach Program has been so successful is our grassroots, "sliding our feet under their kitchen tables" way of doing business. We are the ones going to the veterans' homes and working with them to find what they really need. The issues range from health care, emotional support, disability benefits, homelessness, employment, or financial assistance.

One of the most innovative components of our Veterans Outreach Program is the Veterans' Administration Medical Center liaison we established to help veterans navigate the VA system. Our liaison is located at the White River Junction Welcome Center which is the entry point into the VA

system for Vermont.

Our outreach specialist will often use this resource to establish a soft handoff to someone who understands how to navigate the VA system effectively. The liaison also works with many walk-ins which are typically active duty veterans who come on their own not realizing how overwhelming the process could be.

In addition, the liaison attends the VA Patient Centered Care Committee meeting which discusses ways to improve relationships with the veterans and how best to implement any changes recommended.

Having the liaison attend these meetings helps our Veterans Outreach team learn of new initiatives the VA is implementing, as well as improved communication between the specialists out in the field and the VA.

We have increased awareness of the Vermont Outreach Program working through one of our community partners, Vermont 211, and our own 24/7 phone service line. Calls will often come through these two services and allows us to act upon each situation in a very timely manner.

Our outreach specialists established relationships with our Vermont State Police as well to go out with them to make wellness calls to assess a situation with a veteran and call upon professional services as needed.

I have established a strong rapport with the local

OEF/OIF/OND Program Manager. This relationship has helped my team capture returning veterans that may have fallen through the cracks.

An example of this would be that I received a call from a mother in Florida that works for Cabot Cheese. Her son, an OIF veteran, was struggling in Florida with substance abuse and PTSD. She took the chance. She flew him to Vermont where my team picked him up at the airport, brought him to the Veteran Administration Medical Center in White River Junction, where he was enrolled in the six-week Intensive Outpatient Program. My team also helped with a disability claim issue. The veteran completed the program successfully and is now a contributing member of his community, now living in Colorado.

Without this kind of partnership from the program manager who facilitated care in Vermont, this veteran may not be here today. As a matter of fact, the mother told me that my team saved his life.

We are a very rural state that does not have any active duty military installations nor do we have an established public transportation infrastructure outside our largest county, which is Chittenden County. For that reason, our Outreach Specialists transports our veterans to the White River Junction VA or the CBOCs throughout Vermont for their first couple of visits.

While this windshield time reduces the time available to contact other veterans, my team members have noted that this drive time is, in reality, a short decompression period for the service member. Faced with the decision between helping a soldier right in front of them or those yet to be contacted, the Outreach Specialist always tends to the more immediate need.

The person-to-person time spent by our Outreach Specialists with each individual service member and/or their family is an extremely important component of the program. In the past many veterans would miss appointments or did not bother enrolling because they could not afford the travel or did not have transportation and thereby jeopardizing their health or access to benefits.

A critical piece of our success is our follow-up with the service members. Our outreach specialists often meet with CBOC counselors and the service members to go over the follow-up plan needed for the veteran. It might be to make sure that they show up for their follow up appointments with the VA or getting them linked with a community partner such as Veterans, Inc., for financial help, or with the Department of Labor or the employer support of the Guard and Reserve for employment issues.

The bottom line is we established a relationship with these veterans and their families. We have the resources.

We have the skills, and we have the tenacity needed to make sure our veterans, from all combat conflicts, get the services they deserve.

Our hope is to continue this work until every service member and their family that needs help, gets help.

Thank you for this opportunity to discuss Vermont's outreach program and I look forward to answering any questions you may have.

[The prepared statement of Mr. Wing follows:]

Chairman Sanders. You, Andre.

Kim Ruocco is the Director of the Suicide Postvention Program at the Tragedy Assistance Program for Survivors.

Kim, thanks so what are being with us.

STATEMENT OF KIM RUOCCO, DIRECTOR, TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS

Ms. Ruocco. Thank you for having me, Mr. Chairman. I am honored to present this testimony on behalf of the Tragedy Assistance Program for Survivors, also known as TAPS.

Last year, we sadly welcomed 931 people seeking help in coping with a suicide loss of a loved one who was in the military or had recently left the military and was transitioning back to the community.

That is at least two people per day seeking help in coping with a suicide, and these military families comprise at least 19 percent of our current caseload. These numbers are actually a lot higher because once we get them into our caseload we realized that they came in not admitting that it was a suicide or had a different kind of cause of death listed.

We have built a supportive, comprehensive community of care at TAPS for these families with more than 3000 family members grieving a death by suicide in our data bank as of today.

Our survivors receive multidimensional services including connection to trauma support, emotional support and risk assessment and reduction among the survivors.

My name is Kim Ruocco, and I am also the surviving

widow of a Marine major John Ruocco, who died by suicide in 2005. He was preparing for his second combat to tour to Iraq. He died soon after his return from his first one.

I am the Director of Suicide Postvention Programs and survivor care at suicide support at TAPS and a clinical social worker.

I am speaking today about the challenges facing our returning veterans in getting quality mental health care. I have submitted my written testimony that presents many cases with family members that they have shared information around this issue. They have come to us in seeking supporting in coping with the suicide of a recent veteran. It is our hope that sharing this information services for veterans can be improved and lives can be saved the.

Many common themes emerged while talking with survivors grieving the death of a recent veteran of suicide, and one can almost paint a picture or roadmap of a veteran who dies by suicide.

After being discharged from the military, these veterans struggle in multiple areas of their lives. They usually are not discharged with the treatment plan or an appointment.

They attempt to go to college but have trouble accessing G.I. Bill benefits and find their disability benefits delayed or denied. They struggle to find

employment; and if they do get employment, they have concentration problems insomnia, anxiety, and other issues that prevent them from keeping that job.

Physical injuries complicate the situation further. The stress of all of this begins to adversely affect their relationships, especially those significant relationships.

What I have gathered from my families is that these service members can become barriers to their own care because of issues. People who are not in the right state of mind cannot stand in line or in crowded waiting rooms to complete complicated paperwork or wait two months for an appointment or tolerate staff turnovers in counselors who are not staying or who are frequently changing.

Sadly, the information we gather at TAPS from survivors always ends with a tragic ending but it does not have to be that way. Suicide is not inevitable. There are many good programs addressing veterans mental health care at the VA and we have seen treatment work among veterans if they can get into the system and really get the kind of treatment plan and care that they need.

What we really need is to focus on how we can reduce or eliminate the barriers to getting into that treatment and getting it to be comprehensive. It takes a warrior to ask for help is the slogan used at the VA but few know what help can look like. They hear the word seek treatment, seek help

but stigma prevents them from help seeking. Veterans do not know or believe initially that treatment can work.

They do not really know what treatment is. They need to be educated about how mental health care treatment can work. It is vitally needed for this education.

Many of these veterans delay seeking care because of the stigma about mental health care; and when they do finally go, they are so sick that they can barely function and need immediate care which is not often available.

We need a campaign to get these veterans into care earlier before they are in crisis and demonstrate what help looks like and show them that treatment can work.

For those who are in crisis, a fast lane screening effort for mental health needs would help them get past these paperwork hurdles and get those in need to urgent care into care more quickly.

Peer support can play a vital role in helping veterans access their benefits and support that in between appointments at the VA. Improving connections between the VA and nongovernmental agencies could help the VA more fully integrate care-based support programs into these programs. These improvements and care-based support could help save lives.

We have the following recommendations based on the information that we have gathered.

Number one, provide more funding for peer-based programs to assist veterans through organizations such as Vets4Warriors and VA Vet Centers.

Number two, assign peer advocates at first contact to navigate system, support the veteran and connect with support systems.

Number three, decrease the amount of paperwork and red tape required before first appointments; and finally, create public awareness campaigns to describe what mental health treatment is and emphasize that treatment can work and highlight the rewards of working with veterans in that it is also serving your country to help a vet.

Thank you very much.

[The prepared statement of Ms. Ruocco follows:]

Chairman Sanders. Ms. Ruocco, thank you very much for your testimony.

Kenny Allred is a retired U.S. Army Lieutenant Colonel and Chair of the Veterans and Military Council at the National Alliance on Mental Illness.

Thank you very much for being with us.

STATEMENT OF KENNY ALLRED, LTC, USA [RET.], CHAIR, VETERANS AND MILITARY COUNCIL, NATIONAL ALLIANCE ON MENTAL ILLNESS

Colonel Allred. Chairman Sanders, Ranking Member Burr, and distinguished members of the Committee, NAMI, The National Alliance on Mental Illness, is grateful for the opportunity to share our views and recommendations regarding the VA mental health care ensuring timely access to high-quality care.

As my full statement is part of the record, I offer this summary. NAMI applauds the Committee’s continued dedication in addressing veterans' mental health care issues and looks forward to working closely with the Committee.

NAMI is the largest grassroots mental health organization in the Nation dedicated to building better lives for the millions of Americans, including warriors, veterans, and their families, affected by mental illness. I am proud to lead the NAMI Veterans and Military Council.

I am a retired U.S. Army officer with service from 1970 to 1990 as an Army airborne Ranger infantry officer, Army aviator, and military intelligence battalion commander of a mixed gender unit.

I am a member of the American Legion, Disabled American Veterans, Military Officers Association of America, and AMVETS; and I have use the VA health care system for 23

years.

I offer the following key points. It is critical that our scarce resources have full and transparent accountability. We fully support VA adoption of the recommendations in the fiscal year 2014 Independent Budget while keeping stakeholders fully informed.

NAMI also urges increased funding for research to keep pace with other areas of VA spending particularly with respect to stigma reduction, readjustment, prevention, and treatment of acute posttraumatic stress and substance abuse and increased funding and accountability for evidence-based treatment programs.

Veteran unemployment is higher than civilian unemployment and is especially high among our younger veterans. For our National Guard and Reserve, many of them in remote and rural areas, military service often is their only employment and many are not eligible for VA benefits and health care. NAMI supports hiring preferences for all who have served.

NAMI believes that the key to reducing stigma and strengthening suicide prevention is a change in our approach. It is absolutely unacceptable that veteran suicides have grown from 18 to 22 a day in the last 10 years.

In 2012, suicide deaths among soldiers, many of whom

who had never deployed, were higher than combat deaths. We strongly support parity, accountability, collaboration, and action to end the stigma of seeking mental health treatment.

NAMI also believes that award of the Purple Heart for all combat-induced wounds will encourage veterans to seek treatment for mental wounds and reduce stigma and suicide.

Leaders at all levels must be held accountable on written performance evaluations for eliminating stigma, hazing, bullying, and suicide. VA providers in all health disciplines must proactively encourage veterans to seek mental health treatment.

Collaboration to end the stigma of seeking help for invisible wounds of military service, including sexual trauma, is essential. The NAMI VHA memorandum of understanding for training at VHA facilities should be expanded.

Finally, action is needed to energize those throughout the VA system to improve and encourage mental health and expedite claims processing. Technology to consolidate appointments and reduce travel expense and risks, to deliver counseling via distance means, increase the community providers to create a hometown stake in veteran recovery, and build a sense of ownership for the total cost of military service, diagnose veterans within 14 days of their mental health complaints and approve compensation and

pension claims for veterans with a diagnosed mental illness within 30 days, expand outreach to underserved populations including women, student veterans, older veterans, and other diverse populations.

Additional recommendations are in my written statement.

Mr. Chairman, in summary, barriers to veteran mental health treatment can be eliminated and recovery is possible. We must end the epidemic of veterans suicide that is now at the horrific rate of almost one in each hour.

The long-term cost of unmet veterans' mental health needs will be significant especially if the government does not act now.

Thank you for this opportunity to offer National Alliance on Mental Illness views to the Committee. We look forward to working with you to improve the lives of all veterans and their families living with mental illness.

[The prepared statement of Colonel Allred follows:]

Chairman Sanders. Colonel Allred, thank you very much for your testimony.

Dr. Barbara Van Dahlen is the Founder and President of Give an Hour. Dr. Van Dahlen, thank you so much for being with us.

STATEMENT OF BARBARA VAN DAHLEN, PHD, FOUNDER AND PRESIDENT, GIVE AN HOUR

Ms. Van Dahlen. Chairman Sanders, Ranking Member Burr, and Members of the Committee, thank you for this opportunity to provide testimony.

As a clinical psychologist who has spent the last eight years of my career devoted to this cause and as the daughter of a World War II veteran, I am honored to appear before this Committee, and I am proud to offer my assistance to those who serve.

The Department of Veterans' Affairs remains the principal organization in our Nation's effort to ensure that all who wore the uniform receive the mental health care they need. Clearly, the VA has worked hard to keep up with the changing landscape and the growing demands over the last 11 years of war.

And, as we have heard, the VA has increased the number of mental health professionals providing services. It has increased the number of Vet Centers across the country, and it has added additional mobile vet centers in its efforts to serve our rural communities.

Further, the VA has expanded its call centers and launched the Veterans Crisis Line. Indeed, my organization, Give an Hour, is pleased that we now have a memorandum of agreement with the VA in coordination with the Veteran’s

Crisis Line.

Finally, the VA has become a National leader in integrating mental health care into primary care settings. But as many of us who come before this Committee are fond of saying, no organization, agency, or department can provide all of the education, support, and mental health treatment that every veteran and his or her family needs.

It is actually more helpful to those who serve and their families to see numerous endeavors coordinated on their behalf so that they understand that our country--not just our government--supports them and is committed to their health and well-being.

Give an Hour is but one example of a community-based effort designed to complement the important work of the VA. Give an Hour providers provide free mental health care and support to service members, veterans, and their families in communities across the country.

We have nearly 6,800 providers who have collectively given over 82,000 hours of care. This translates into over $8.2 million worth of mental health care. If every one of our providers was utilized on a weekly basis, we could provide over $36 million of mental health care each year. And Gave an Hour is able to do this all at a cost of about $17 an hour.

We are honored to do our part but we are eager to do

more. While we have been assured that sequestration will not directly affect VA programs, the impact across government agencies will certainly affect veterans.

So, we must think collaboratively, creatively, and collectively about how best to knit together the array of resources and services that every community has to offer.

Although progress has been made, we have yet to develop an effective strategy for consistently delivering coordinated care in communities where veterans and their families live and work.

To move toward our goal of ensuring timely access to high quality care, it is important to consider several important points. One size does not fit all with respect to support and treatment for our veterans nor is there a specific progression of care and intervention that is appropriate for every individual in need.

For example, some veterans want, need, and will benefit from traditional psychological treatment that can be delivered by the VA or by a community provider like those who volunteer with Give an Hour.

In contrast, other veterans are not yet willing or able to accept traditional care even though they are suffering. These veterans might respond more favorably to alternative opportunities and approaches that are available in their communities. And perhaps an alternative approach is all a

veteran needs to move forward in life.

Or perhaps an alternative form of care might lead to a willingness to seek more traditional treatment for the issues that come home from war.

There are successful models currently being implemented across the country to facilitate the coordination and collaboration of community efforts.

Give an Hour's work in North Carolina and in Virginia regularly brings community organizations together to assess gaps and develop solutions.

The Community Blueprint, an initiative now with the organization Points of Light, has launched efforts in 42 communities. The focus of this initiative is to identify and coordinate local efforts and to provide opportunities and support for our military and veteran community.

Got Your 6, a campaign created by Service Nation, is bringing the entertainment industry together with over two dozen respected nonprofits. TAPS, Team Rubicon, Give an Hour, and others are part of that effort.

These nonprofit organizations work together to further the missions of each organization and to improve the reintegration of veterans into our communities.

The VA has participated locally and nationally in discussions and efforts associated with the two initiatives I just talked about. Give an Hour has seen the positive

impact the coordination with VA can have in our work in Fayetteville and in other communities, but we can and must create a more systematic process to knit efforts together if we are to ensure that all who are in need receive the proper care that they deserve.

When I first developed the concept for Give an Hour, it was with the perhaps idealistic notion that I would build a network of mental health professionals who were prepared to serve and I would give this resource to the VA and to DOD.

Although we have successfully built the network, giving this service to these agencies has proven to be very challenging and Give an Hour is but one of many organizations that has much to offer veterans and their families.

So, how do we get there? The VA has tremendous potential to function both as a catalyst and a convener to engage and encourage national nonprofits and local efforts in the service of our veterans.

The VA can identify without necessarily endorsing organizations doing important work to support those who serve. It can bring these organizations together here in Washington and in communities wherever there are VA facilities to explore needs and develop specific strategies that result in actions and outcomes.

And, if there are policies and regulations that prevent

the VA from functioning in this manner, then it is time to review and adjust these policies. We can no longer be hampered by restrictions that prevent us from leveraging all of the resources and expertise available in our offices and in our communities.

There is no doubt the greater coordination and collaboration will improve well-being and save lives. There is no doubt that we have the resources needed to attend to those in need. The only doubt is whether we have the will and the determination to meet the challenge together.

Thank you so much.

[The prepared statement of Ms. Van Dahlen follows:]

Chairman Sanders. Thank you very much Dr. Van Dahlen.

If there is no objection, Senator Murray, the former chair who is now Chairman of the Budget Committee, and she has to run in a few minutes, and I would like her to be able to say a few words.

Senator Murray.

OPENING STATEMENT OF SENATOR MURRAY

Senator Murray. Mr. Chairman, thank you very much and I just want to be sure, I know you have another panel, I just wanted to thank you for having this hearing.

I really appreciate the focus on providing timely access to health care. It is so important for our veterans, for our service members, and for their families.

And, I wanted to thank the panelists as well for coming. I know it often takes a lot of courage to share personal stories but your insight is critically important.

It is so clear that VA and Congress have made some important strides towards addressing the invisible wounds of war but we have a lot more to do. VA's recent report on suicides among the Nation's veterans is really troubling and I was really sad to note that my home State of Washington has a very high percentage of known veteran suicides.

So, over the coming year, VA has its work cut out for it. We have to implement the Mental Health Care ACCESS Act. We need to meet the goal of hiring 1600 new mental health

care professionals. We have got to get these wait times down as we just heard and we need to partner with our community providers.

But the Army and the DOD have their work cut out for them as well. They have got to reform the process and diagnose mental health care conditions accurately. We have got to address the issue of this integrated electronic health care records that plagues us and we have to end the unacceptably high rate of military sexual trauma.

So, Mr. Chairman, I want to thank you for really focusing on this and I want to thank everyone who is working on this and giving my support to continue to do that.

Thank you.

Chairman Sanders. Thank you for much, Senator Murray.

As I think Senator Tester indicated earlier, if we knew the magical answer to mental illness, this country and this world would have solved this problem a long time ago. There is no easy answer but what I am hearing from all of you--and I appreciate all of your testimonies--is that in a sense we have got to think outside the box, that we have to understand that something as simple as an unpleasant person at a desk or a wait for two hours or a missed appointment can be life and death with somebody who is struggling to stay alive, keep themselves together. When you are healthy, oh, God, it is an hour wait, who cares. But that is the

reality for people who are struggling.

I think all of you have indicated that peer-supported efforts of veterans talking to veterans is enormously important, that occasionally we have to go outside of the box. I think one of you said not everyone is alike and different individuals will respond to different types of approaches.

So, let me just start off with you, Dr. Van Dahlen. In terms of how the VA which, as we all know, is a huge bureaucracy--there are no ifs, buts about that--how do we enable them to become more flexible, to reach out to define community-based groups, to peer support groups that are out there, how do we do that?

Ms. Van Dahlen. Thank you. What we find in communities is--and I know this from my work with several of my colleagues at the VA--the desire often in the individual is there to work in a collaborative way but they are unclear whether they are allowed to.

And so, one of the things that I would like to suggest is that we literally work on what are the messages at each of the local, every VA, whether it is a hospital center, whether it is a vets center, they will know and have access to the community.

And so, what we should do--and I think it would be pretty easy to do--is determined what gets in the way of

having regular, as we have done in the community and others have done, gatherings where the VA serves as the convener and the catalyst, what stops that from happening. So that people begin to talk to each other. They know then that if my organization cannot serve that need TAPS can do it or NAMI can do it.

That is what needs to happen.

Chairman Sanders. Let me ask this. One of the cultural issues that we are struggling with, the military is struggling with, the VA, is the culture of the stigma that I think Colonel Allred used. Am I a real man if I have an emotional mental problem?

We understand if I lost an arm or a leg, I would go and get treatment. How do we deal with the culture that says from a military perspective, ah, there is something not quite manly about you if you have PTSD or you have TBI, how do we deal with that?

Mr. Wood, do you want to respond to that?

Mr. Wood. I think it is very challenging. It is not a problem that we are going to solve overnight. As a Marine sniper, I was a part of one of the more elite units in the military and certainly one that carries that stigma very heavily.

We do not often go to seek counseling. If you do go to seek counseling like Clay actually did after being wounded

in Iraq before being redeployed to Afghanistan, you are often seen as a weaker link; and that is a stigma that we have to fight absolutely.

I myself have gone to seek mental health counseling since getting out of the military. I have worked with the VA and their "make the connection.net" initiative to provide a video testimonial to that.

I think what it does though require regular convenings, as Dr. Van Dahlen mentioned, where veterans can get together. You know, we need to get veterans together in their hometowns. We need to get Marines together with soldiers, together with airmen, together with sailors in Omaha, Nebraska, in Davenport, Iowa, in Oakland, California where they can talk and share with one another their experiences after transitioning out of the military.

Chairman Sanders. Okay. Thank you.

Andre, if you could--in Vermont we are a very, very rural State. We sent a lot of National Guard people to Iraq and Afghanistan--tell me about the peer-to-peer effort.

Is it important that veterans, just as Mr. Wood was saying, that veterans themselves who have been through that experience reach out to other veterans and how do we do that?

Mr. Wing. Thank you, Senator. As you know, we have 10 folks on my team. We are all combat veterans. So, we all

had struggles with reintegration issues. We all had struggles, you know, transitioning back to civilian life.

I think in our State with a National Guard, I do not think it is as severe, the stigma, as it is maybe on an active duty base only because, you know, I hear at this panel that we talked about community partnerships and we have really forged those ahead in the State of Vermont with different initiatives that we stated.

We have a Director of Psychological Help that works directly for the National Guard on the Air side and the Army side. That stigma, I think, is more so on the military side; but as far as peer-to-peer goes, as you know, we go out or we meet the folks.

Chairman Sanders. You knock on doors.

Mr. Wing. We knock on doors; and as I said, we have our feet underneath the kitchen table. I know that the President has got a new initiative of 800 peer support folks going on out there. But I think you heard this. The common denominator there is the peer-to-peer. It is very, very important because we can talk.

The other thing too that is important with the community is we have the military culture. So, I can go into AHS with a field directors and tell them, hey, this is how you need to maybe approach some of these veterans, as an example.

Chairman Sanders. Thanks very much.

Senator Burr.

Senator Burr. Mr. Chairman, thank you.

What you guys have provided are great suggestions, directions for us to turn; and I want to thank you for doing that. It is important to the Committee. It is as important to the Veterans' Administration and I think they have heard everything that you said. It will stimulate additional questions on my part that I am not prepared to ask today.

So, I would ask you, Mr. Chairman, on behalf of all of us if unanimous consent that we would be allowed to follow up with questions with this panel.

Chairman Sanders. Of course, without objection.

[The questions follow:]

/ COMMITTEE INSERT

Senator Burr. For the sake of time, I am going to turn to Barbara for just a second. You mentioned the community blueprint specifically in Fayetteville. Can you share in a little greater detail how that effort improved outcomes?

Ms. Van Dahlen. So, there are lots of ways. For example, when we first started that work, and that work is a very action-oriented plan to bring groups together, identify specific gaps in services including bringing the VA in, bringing in Fort Bragg, and it took us quite a while to get all the stakeholders to come regularly but now it is happening.

One of the things that we recognize and one of the things I want to highlight about the peer-to-peer and availability of mental health care, one of the things that we identified was that in that community the behavioral health providers did not know each other, were not talking to each other, and there was not an easy access from the base to identify those who were in the end and which providers had cultural training.

So, through that effort, we have now created an ongoing dialog so that the base knows. The VA knows what the resources are, more families are being served whether it is because of they know each other, whether it is because they are developing specific plans.

One of the other things that we identified in

Fayetteville is that there are not enough behavioral health care providers there. It is believe there will not be enough to meet the need.

Now, before we got there, there was a lot of okay, well, I do not know what we are going to do, try to recruit them which is not going to happen.

What we need to do is look at how do we leverage the people in the communities who have mental health knowledge and expertise to give that to peer-based efforts like we do with TAPS, like we are building with Team Rubicon, how can we train teachers to understand the signs better, how can we reach out to first responders, primary care physicians.

So, if we have these models, and there are many, where the community is bringing together and developing specific programs, that is what we have seen in Fayetteville over and over again.

Or a family at the end of the weekend that contacted us because everybody else said we do not have resources. We were able, because of the network, to find a home for this family that was homeless with three young kids and then get them long-term care.

So, many examples, and it is all about bringing the right folks together and then having regular ongoing conversations, not a one off, not a one time and then everybody goes home and continues to do what they have done.

Senator Burr. Thank you.

Thank you, Mr. Chairman.

Chairman Sanders. Thank you, Senator Burr.

Senator Tester.

Senator Tester. Thank you, Mr. Chairman.

My staff has got some questions but you guys testimony has invoked even more so I am going with my gut.

Dr. Van Dahlen, you talked about--and I do not want to put words in your mouth and I hope you are right--that there are enough resources out there and you also said with the previous question that you wanted to make sure that VA allows those folks to be a part of the mix if they want to be a part of the mix. And, I know you probably do not know the whole country from Arkansas, is that right?

Ms. Van Dahlen. No.

Senator Tester. But the question is that, I mean, do you really feel that way, because I think that is really a good sign if you think there are resources out there that we can use, then we have to talk to the VA about how we can best help them integrate in the places where they have vet centers where the peer-to-peer stuff goes on. You can also insert somebody who actually knows the problems from a clinical standpoint.

Ms. Van Dahlen. I think there is a tremendous number of resources in communities that are not being tapped, they

are not being coordinated, and without the coordination, they are not being fully utilized.

Just looking again at our organization, we have got 7000 people. They are not being used. All of them are not being used. Would they step up and give more in their communities if they were being asked? Absolutely. That is what they are therefore.

When we work with TAPS and we coordinate our efforts, it is a value add. We know how to reach them, et cetera. So yes, I believe there is tremendous opportunity that we have not yet tapped.

Senator Tester. That is good news and we will probably be talking to Dr. Petzel about that same thing about ways we can get VA involved in this.

Lieutenant Colonel Allred, first of all, I want to say I have a tremendous amount of respect for your organization. You guys do some incredible work in my State of Montana, and I want to thank you for that.

You mentioned something in your testimony that I heard before in that the rate of suicide amongst noncombat is higher than combat vets. Are you guys aware of why that might be? Is there a reason for that?

Colonel Allred. Well, I am not a clinician, Senator. So, I cannot give you a clinical answer on that, but my understanding is that the veterans face a lot of the same

stresses that civilians do and it sometimes starts with the unemployment, the financial issues, the family issues and the hopelessness.

The National Alliance on Mental Illness has programs if we can be brought together.

Senator Tester. Okay. Well, like I say, I appreciate your work.

This goes to anybody who wants to answer this. There are a lot of investments being made by the VA. Have you guys been able to identify some of the smarter investments that we have made through them?

Any of you can answer. You are nodding your head, Doctor.

Ms. Van Dahlen. One wonderful program that the VA has developed is the SSVF programs, Support Services for Veterans Families, but those programs, it is my understanding, do not --because we have not been able to work with that program because mental health is not a piece of that.

And so, that is a really wonderful program. There is a lot going on in New York State, for example, where communities are coming together, organizations are fitting together, applying for that funding, receiving that funding. But mental health is not a piece.

So, I would say that is a great example of what is

working well and there are many others. But I would like to expand that to include also mental health care as part of that package because then it would bring a lot more of those programs into that combined effort but that is a great program, SSVF.

Ms. Ruocco. The veterans crisis line has also been an incredible asset for our veterans who are in crisis to have an immediate place to call and get help and get hooked up with care if they are in crisis.

And offshoot of that, the Vets4Warriors who are a peer-to-peer support call line. They are answered by a peer 24/7, and I could see a real value in increasing those kinds of portals where veterans call, talk to another veteran, and get families involved in being able to call those numbers too and say this is what I am seeing in my veteran, what am I seeing, what do I do with it, what will happen when I take him to treatment, because there is a real lack of education around what treatment looks like and that you can get better.

And so, more portals like that, like the NVCL and Vets4Warriors I think is incredibly valuable and I think it is working well.

Senator Tester. I just want to thank you all for your testimony. I have like 15 pages of questions. We could do this all afternoon. I appreciate your levels of expertise

and your willingness to help. Thank you.

Thank you, Mr. Chairman.

Chairman Sanders. Thank you, Senator Tester.

Senator Johanns.

Senator Johanns. Thank you, Mr. Chairman, and let me say to all of you, thanks for being here. Tremendous insight is gained from just listening to you.

Let me start with Mr. Wood. You said something that I must admit gave me a different perspective of suicide and what veterans are going through. At the risk of oversimplifying your message, I found it very interesting that you were saying, you know, a veteran comes home. They are out of the service. They put in the uniform away. The community that they have known, lived with, trusted, prayed with, has pride with disappears.

Now all of a sudden, this life experience is behind them and the adjustment to that for anybody would be very, very difficult.

Tell me a little bit more about that. Are you sensing as you work with veterans that it is the break in that tie that is maybe a first step or were problems develop that may lead to suicide?

Mr. Wood. Absolutely. We see it all the time. Veterans typically, you know, they enter active duty right out of high school and they grow up in their formative years

in the military and they experience incredible experiences, both good and bad, during those formative years with a very close, cohesive unit of men and women.

It creates a certain resiliency in that veteran, in that service member while they are in. They are able to cope with extraordinary things.

When they come out, they are ripped out of that fabric. They are now a single thread instead of that tightly woven, you know, fabric and unit that they had while they were in. Part of that is that elimination of that purpose, that community, that sense of self that they had that they formed while they were in.

So, how is it that we can re-create that. I think the very first step is helping veterans identify one another in their hometowns so that they can re-create it through something else.

Obviously with Team Rubicon, we are trying to give them a new mission that can provide all three of those things; and with POS REP, we are trying to create, you know, an application for their iPhones, for the android devices, that helps them discover one another so that they have a tool that is not the VA, because the VA has got a horrible brand that a lot of veterans do not trust.

So, we need to supplement what the VA can provide which is first class mental health services and health services

with something else. And that something else is community and it has to come from outside the VA.

Senator Johanns. I would like to hear from you on this issue, Ms. Ruocco, this thought that once home that support group is not there; kind of the fabric that get things together all of a sudden is torn apart.

What is your sense of that? Is that part of what we are dealing with here?

Ms. Ruocco. It is a huge issue. We see veterans all the time trying to transition back into communities and having a lot of hope and a vision about what that is going to be like, that there is going to be able to be a job, that they are going to have people appreciating their service, that they are going to be able to use their military experience to find a job, and then that does not happen.

They have difficulty finding jobs. They have dramatic brain injuries and concussions and anxiety attacks and sleeplessness and addiction issues and self-medicating that all get in the way of that transition. And then, they cannot find somebody else to talk to about what they have been through.

We had an example of one of our veterans who was out in Wyoming in a very rural area. He went back. He started to find a job and he had severe posttraumatic stress disorder. Got a job for like nine dollars an hour but all of the chaos

within the job he could not deal with his PTS and ended up, you know, quitting his job, losing his job. But he wanted to hear support.

So, he started going to the American Legion every day and sitting on that bar stool trying to talk to other veterans so he could heal the moral injuries he had, the posttraumatic stress, the survivor guilt that he had. And, he actually ended up committing suicide on that bar stool at the American Legion without his needs being met.

So, we see a terrible self-destruction path there. We need to get them integrated into a community with good jobs, good care, and care support where they find some sense of purpose, a sense of meaning in their life, and they create a new Identity that is separate from the military that they are losing.

Senator Johanns. I am out of time. I am like Senator Tester I could go on and on. But the lightbulb that comes on for me here is this.

If what is lacking here is that community, that force that kind of pulls things together emotionally and mentally, and then the peer support, the, I do not know, the group counseling, those kinds of things seem to me to be a real path way forward here in terms of dealing with suicide.

I had kind of come into this hearing thinking that this was all about the trauma of war, and I am sure that is a

piece of it, and for some that might even be the dominant piece.

But you have given me a different insight that a major piece of this may be that the community they relied on, lived with, is not there anymore in the way of this support group. And, like I said, that turned on the lightbulb for me.

Thank you Mr. Chairman.

Chairman Sanders. Thank you Senator Johanns.

Senator Isakson.

Senator Isakson. I want to thank everybody for their testimony and for their service. But I want to follow up on what Senator Johanns said, because my lightbulb went off too particularly with the testimony of Mr. Wood talking about that sense of purpose.

My lightbulb went off because it makes sense. I understand. When you told the story about the guy leaving Omaha, Nebraska going to Afghanistan coming home and getting out of the service; and all of the sudden the structure he was in, the men he served with, the purpose that he had is all gone and it is hard to find.

I think that is a tremendous observation. You sought counseling you said yourself at the VA, is that correct?

Mr. Wood. I did attempt to seek counseling with the VA. I was completely underwhelmed with the care that I

received and I ended up pursuing counseling in the private sector.

Senator Isakson. You answered my question before I asked it, because I was going to ask you if you felt like the counselors there had an awareness of what the real problem was. But obviously, you do not think so.

Mr. Wood. The counselor that I spoke to was a combat veteran from Vietnam. A tremendous individual. However, after spending my first three sessions doing nothing but data entry with something that, through technology, probably could have taken about five minutes but instead took probably cumulatively five hours of my life, I was too frustrated to continue and sought private sector care.

Senator Isakson. Well, I have a question for you regarding Ms. Ruocco's testimony. She had two of her four major recommendations. One was at first contact assign a peer to help the veteran navigate through the system before they have their first counseling session, is that not right? That was observation number one what I think is terrific.

Observation number four that she had was cut out the paperwork that it takes to get from making the appointment to the appointment. From what I hear from you, both those, if adopted, would be a tremendous help for the Veterans' Administration and for the veteran.

Mr. Wood. Absolutely. And particularly number four.

There is no excuse in the age of Google and Facebook and Twitter to have three straight sessions of nothing but data entry. There is a simpler solution out there. We need to find it and we need to implement it sooner rather than later.

Senator Isakson. Is RES PRO operational, the app that you have developed, is it operational?

Mr. Wood. Yes. We launched live eight weeks ago, Mr. Senator.

Senator Isakson. What has been the response so far?

Mr. Wood. It has been absolutely tremendous. It is still in beta phase. We have got about 3000 users on the platform. Through the data that we have gathered and through the observations that we have made, we know it has already saved lives. We have seen connections happen in real life.

I could fire it up right now and we could find veterans around the DC area who are using it. We could connect with them. Veterans that I do not know myself personally but they are out there.

Senator Isakson. This generation of war fighter and soldier that we have is already connected when they get in the military and connectivity in the military is a key part of the organization.

So, you have a user-friendly group out there that just

needed your catalyst to really put them together if I am not mistaken.

Mr. Wood. They just need to find one another.

Senator Isakson. My age group is probably not as connected as that age group.

Mr. Wood. Well, the new generation of veterans, they do not use the American Legion and the VFW like they used to. Those are both tremendous organizations and they have a real role in the veteran space moving forward. Absolutely, they do.

But our generation of veterans, the post 911 generation, we live in technology. It is a part of us. It is an extension of our body, and for us not to be leveraging technology to make these connections is foolish and it is not using the resources that we have available.

Senator Isakson. Well, in the interest of time, I will submit my other questions for the record but I just want to thank all five of you for your testimony. It has been very illuminating hearing for all of us.

[The questions of Senator Isakson follows:}

/ COMMITTEE INSERT

Chairman Sanders. Thank you, Senator Isakson.

Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman, and thank you for the hearing today which is so important, you and Senator Burr, especially having people that are on the front line.

You guys are out fighting the battle and we really do appreciate your service in so many different ways and affecting a very positive outcome for so many.

You know, this is such a, it is just an interesting, very difficult problem. You know, we talk about the stress of a war and yet many were not deployed and in situations that were stressful in the sense of a job but not stressful in the sense of combat.

We are having a lot of problems in the private sector just in society in general in the same way. We have the reintegration problems like you have experience, Mr. Wood, which again is so, you know, so common and you can see how that happens and yet a lot of these individuals are 50 years old. In fact, a pretty significant portion of these.

So, I guess really what I am wondering about is the root cause. You know, how can we identify and get to the point before they are actually on the phone, you know, with the suicide call.

I guess what I am wondering is what factor does marital

difficulties play, the financial problems? I used to VA a Ranking Member and Chairman of the Economic Opportunities. I always felt like if you could put people to work and get them where they could support their families and things like that, a lot of this, you know, would diminish.

But besides, you know, the suicide counseling you almost wonder about financial counseling, marriage counseling, you know, things like that again to the root cause.

The other thing I would like for you to comment on, I think in an effort to help people society today and used to be doing something in very difficult situations, I think we are over medicating people. And I would like for you to comment about that.

I think that is a real problem and I think in some individuals, you know, I think the facts are there that they go the other way and can become suicidal from being over medicated.

So, if you guys would just like to comment on that. Mr. Wood, you can start if you like or just really whatever your thoughts are about some of those things.

Mr. Wood. Well, I will echo Colonel Allred. I am not a clinician. I am not a doctor, and so please take my testimony simply for what it is worth.

Senator Boozman. It is worth a lot.

Mr. Wood. My experience, I have never been medicated for mental issues myself. The experience that I have with it is that most veterans that I know, particularly Clay Hunt found themselves--

Senator Boozman. Did you self-medicate? Did you have problems with alcohol and things like that?

Mr. Wood. No, I have not. No.

Clay Hunt was certainly over medicated; and in his experiences with the VA, he would jump from medications to medication, dosage to dosage, trying to figure out something that would work.

He was medicated the day he died. He had a very telling quote, though, at one point that we actually have on video. After he got back from Port-au-Prince, Haiti, he said that his experiences with Team Rubicon, his experiences helping others in serving his community once again were more therapeutic, more cathartic than any cocktail of drugs that the VA had ever put him on

And, that is something that I believe that we can use to get away from over medicating our veterans.

Senator Boozman. Ms. Van Dahlen.

Ms. Van Dahlen. If I might, because you brought up something very important that I think an important thing that I continue to hear is that one size does not fit all. That is the issue. That is why we have not found the

solution.

As a mental health professional who has been working in this field, you know, for 20 plus years and what is critical now is that we figure out how do we ensure that in communities there are different options of care, whether it is financial, absolutely sometimes that financial counseling, that is what that family needs and they are off on the right track. Or marriage.

Or a physician who can step in and say this young man is way over to medicated. We need to send them to Team Rubicon or send him to get some equine therapy out in nature with horses.

It is that, and because even though there are many things that we know are helpful, even the very best evidence-based treatment is only helpful for a certain percentage.

As a mental health professional, that is what I think we, our community, can offer, our knowledge and expertise to ensure that we identify other efforts and then make sure those are accessible and link them together.

Senator Boozman. No, I agree. I think sometimes the easiest thing to do is write a prescription, and that is kind of what we have gotten into a little bit.

Colonel Allred. Senator, if I might, you are absolutely correct. Older veterans are taking their own

lives at twice the rate that younger veterans are, and it is still to be determined why that is.

As the Chairman said, and ranking member, if we had the answers. But there is such a dissimilarity of cultures and that is why the technology age sometimes is not in touch with the telegraph age, you know, my age. I go to some of these veterans service organization meetings and I am the youngest one there.

So, we have got to figure out a way to get these folks together, the young folks and old. The National Alliance of Mental Illness, if I may say, has a number of programs that address exactly what you are talking about. We have over 1100 chapters around the Nation, in every state.

I would suggest that just from the standpoint of our relationship with the VA, get on the computer, find your nearest NAMI affiliate, call them up and say, bring that organization in with your volunteer training. It is free. There has to be a push and a pull, and that is the pull part of it.

But many people, even though there is a crisis line, will not call it. We have got to find them. POS REP is a good way to do it for the young folks but what about all of us old people. And so, thank you, sir.

Chairman Sanders. Senator Burr, did you want to ask a follow-up.

Senator Burr. Jake, how long did it take you to put together that app, to develop it?

Mr. Wood. It was in development for approximately eight or nine months.

Senator Burr. And what are the plans to market awareness of that app to OEF/OIF vets?

Mr. Wood. We are working with various nonprofit organizations across the country. We are providing organizations like Give an Hour an opportunity to use the platform to reach vets so long as they are using their social media channels to push the application down to their followers.

So, we are trying to use a grassroots efforts to do it.

Senator Burr. If you recognize anything that this Committee can do through government to facilitate the awareness of that, would you let us know?

Mr. Wood. 100 percent. I will shoot you something over as soon as we are done here.

Senator Burr. Thank you.

[Laughter.]

Chairman Sanders. Thank you, Senator Burr.

Let me just wind this up by once again thanking each of you for the extraordinary efforts you are making on behalf of veterans. We have learned a lot from your testimony and thank you very much for being here. Take care.

[Pause.]

Chairman Sanders. We would like to welcome our second panel, and representing the VA is Under Secretary for Health, Dr. Robert Petzel. Dr. Petzel, thanks for a much for being here.

He is accompanied by Dr. Janet Kemp, who is the Director of Suicide Prevention and Community Engagement for VA's National Mental Health Program; also with Dr. Sonja Batten, Deputy Chief Consultant at VA Specialty Mental Health Program; and Dr. William Busby, Acting Director of the Readjustment Counseling Service of VA and Regional Manager for the Northwest Region.

And from the Department of Defense, we have Colonel Rebecca Porter, Chief of the Behavioral Health Division for the Army's Office of the Surgeon General.

Thanks very much for being with us.

Dr. Petzel, why do we not begin with you.

STATEMENT OF ROBERT PETZEL, MD, UNDER SECRETARY FOR HEALTH, VETERANS' HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS' AFFAIRS; ACCOMPANIED BY: JANET KEMP, RN, PHD, DIRECTOR OF SUICIDE PREVENTION AND COMMUNITY ENGAGEMENT, NATIONAL MENTAL HEALTH PROGRAM, OFFICE OF PATIENT CARE SERVICES; AND SONJA BATTEN, PHD, DEPUTY CHIEF CONSULTANT, SPECIALTY MENTAL HEALTH PROGRAM, OFFICE OF PATIENT CARE SERVICES; AND WILLIAM BUSBY, PHD, ACTING DIRECTOR, READJUSTMENT COUNSELING SERVICE AND REGIONAL MANAGER FOR THE NORTHWEST REGION

Dr. Petzel. Good morning, Chairman Sanders, Ranking Member Burr and members of the Committee.

I appreciate the opportunity to discuss VA's comprehensive mental health care and services for our Nation's veterans. I am accompanied, as the Chairman mentioned, by Dr. Batten, Dr. Kemp and Dr. Busby.

Since early 2009, VA has been transforming and expanding its mental health care delivery system. We have improved our services for veterans but we do know that there is much more work, much more work that has to be done.

My written testimony has more detailed information. I would submit that for the record. This morning I will summarize those remarks and update you on some of our major

accomplishments.

We are progressively increasing veterans access to mental health care by working closely with our federal partners to implement the President's Executive Order to improve access to mental health services for veterans, service members, and military families as well as the 2013 National Defense Authorization Act.

We know these changes require investments. Last year, VA announced an ambitious goal to hire 1900 new mental health providers and administrative support. As of March 12, 2013, VA has hired 1300 new clinical and administrative staff in support of that goal. We are on track to meet the requirements of the Executive Order by 30 June 2013.

VA has many entry points for care including 152 medical centers, 821 Community-Based Outpatient Clinics, 300 Vet Centers, the veterans' crisis line, and many more to name just a few.

We have also expanded access to care by leveraging technology, telehealth, phone calls, online tools, mobile apps and through outreach, primary care, primary care integration of mental health, community partnerships, and our academic affiliations.

Outpatient mental health visits have increased to over 17 million in 2012 up from 14 million in 2009. The number of veterans receiving specialized mental health treatment

rose to 1.3 million in 2012.

In part, this is because our primary care clinicians proactively screen veterans for depression, PTSD, problem drinking, and military sexual trauma to help veterans identify that they may be in need of mental health care and to actually get the treatment that they need. We are also refining how we measure access and outcomes to ensure that we accurately reflect the timeliness of the care we provide.

VA has chartered a workgroup to set wellness-based outcome measures. Currently, five metrics have been selected and others will be identified to include patient satisfaction, did they get the appointment when they felt they wanted it and when they needed it; clinical quality effectiveness measures; and clinical process assessment.

In 2012, we conducted site visits to all VHA health systems, met with the leadership, the front-line staff, veterans and identified a number of areas for improvement in staffing and scheduling.

VA is updating its scheduling practices, strengthening its performance measures and changing our timeliness measures. We will continue to measure performance and to hold employees and leadership accountable to ensure that the resources are devoted where they are needed for the benefit of veterans.

VA has been working with partners to address access and

care delivery gaps. In response to the Executive Order, we are collaborating with the Department of Health and Human Services to establish 15 pilot projects using federally qualified health plans.

VA is also partnering with DOD to advance a coordinated public health model to improve access, quality, and effectiveness of mental health services through an integrated mental health strategy developed jointly by VA and DOD.

We are committed to ensuring the safety of our veterans. Even one veteran suicide is one too many. July 25, 2012 marked in the fifth year since the establishment of a veterans' crisis line. VA offers this 24/7 assistance, and last year the crisis line received more than 193,000 calls, resulting in over 6000 life-saving rescues. The crisis line has totaled over its lifetime 750,000 calls.

Earlier this month the VA released a suicide report. This report includes data on the prevalence and characteristics of suicide amongst the veterans, including those that were not being treated by the VA.

The report provides us with valuable information to identify populations that need target interventions such as women and Vietnam veterans. The report also makes clear that, although there is more work to be done, we are making a difference.

There is a decrease in suicide re-attempts by veterans getting care in the VA. Calls to the crisis hotline are becoming less acute, also demonstrating that VA's early intervention is working.

Mr. Chairman, we appreciate your support in identifying and resolving challenges as we find new ways to care for this Nation's veterans.

My colleagues and I are prepared to respond to your questions.

[The prepared statement of Dr. Petzel follows:]

Chairman Sanders. Thank you very much, Dr. Petzel.

Colonel Porter.

STATEMENT OF COLONEL REBECCA PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, UNITED STATES ARMY

Colonel Porter. Chairman Sanders, Ranking Member Burr, and Distinguished Members of this Committee, thank you for the opportunity to appear before you to discuss the Army's initiatives to improve soldier readiness and resiliency. I would like to have my full statement entered into the record.

The United States Army has fought for over eleven years, the longest period of conflict in our Nation's history. The unprecedented length and the persistent nature of conflict during this period have tested the capabilities and the resilience of our soldiers and the Army as an institution and of our supporting families.

Taking care of our own, mentally, emotionally, and physically, is the foundation of the Army's culture and ethos. The Army is keenly aware of the unique stressors facing soldiers and families today and continues to address these issues on several fronts.

The Army's Ready and Resilient Campaign Plan and Behavioral Health Service Line are two major groups of initiatives that address stressors and improve resiliency across the Wellness Continuum, from pre-clinical prevention activities through clinical treatment and surveillance

efforts.

The Ready and Resilient Campaign Plan was mandated through a directive issued on February 4th, 2013. This campaign integrates and synchronizes multiple Army-wide programs aimed to embed resiliency into day-to-day operations. The campaign directs us to review programs, processes and policies to ensure effectiveness and reduce redundancies, improve methods for commanders to understand high-risk behaviors and intervene early, and continue improvements to the Integrated Disability Evaluation System.

The Behavioral Health Service Line is the treatment component of the Ready and Resilient Campaign Plan. The Behavioral Health Service Line codifies 28 Behavioral Health enterprise programs identified to support the behavioral health and well-being of soldiers and their families. Its key areas of focus are Embedded Behavioral Health, child and family services, integrated behavioral health support in the Army's Patient Centered Medical Homes, and the Behavioral Health Data Portal.

I want to highlight the success of some of our programs. The Embedded Behavioral Health program provides multi disciplinary behavioral health teams to provide community behavioral health care to soldiers in close proximity to their units and in coordination with their unit leaders.

Utilization of this model has demonstrated statistically significant reductions in inpatient behavioral health admissions; off-post referrals; high risk behaviors; and the number of non-deployable soldiers for behavioral health reasons.

Leaders have a single trusted behavioral health point of contact and subject matter expert for questions regarding the behavioral health of their Soldiers. Embedded team members know the unit and are known by the unit, knocking down access barriers and stigma commonly associated with behavioral health care in the military setting.

Our Tele-Behavioral Health program increases access to specialty care in geographically isolated areas to include more than 60 sites in Afghanistan. It enables greater continuity of care and provides surge capacity for enhanced behavioral health evaluations at soldier Readiness Processing sites.

Furthermore, Telehealth is being leveraged to recruit behavioral health providers for hard to fill locations, by allowing clinicians to provide care from alternate geographic areas where it is easier to hire clinical professionals.

The Army is also implementing new programs to provide care to spouses and children in the communities where they live through school based programs and by placing behavioral

health providers in our Patient Centered Medical Home primary care clinics.

The Behavioral Health Data Portal is an IT platform that tracks patient outcomes, patient satisfaction, and risk factors by way of a web application, enabling improved surveillance and assessment of program and treatment efficacy.

While the Army continues to improve behavioral health care to our soldiers and families, we recognize that we must pay special attention to soldiers in transition, whether they are relocating to another assignment, returning from deployment, transitioning from active duty to reserves, or preparing to leave the service.

The Army has established a system internally to ensure continuity of care for soldiers moving from installation to installation. We also support the DOD In Transition Program, which provides ready access to Nationwide cadre of experienced and independent Behavioral Health professionals for soldiers pending transition. We also utilize Military OneSource as an equivalent resource for soldiers that are transitioning.

We work actively with the VA to ensure continuity of care for soldiers transitioning to leave military service. For complex medical conditions, these include Warrior Transition Units and the Integrated Disability Evaluation

System.

Behavioral Health care and resiliency are important factors in the readiness of the Army and important issues for our veterans. The Army's capable and honed behavioral health personnel, evidence based practices and far-reaching programs comprise key pillars in its commitment to an Army that is ready and resilient.

Thank you again for the opportunity to testify before the Committee.

[The prepared statement of Colonel Porter follows:]

Chairman Sanders. Colonel, thank you very much.

Let me begin with Dr. Petzel. I mentioned in my opening remarks that as we and 10 years of war in Iraq and 11 in Afghanistan or so, the cost of war, I think, is a lot heavier and more tragic than many people realize.

So, let me start off with a very simple question. I do not know if you have the answer in front of you. When we are talking about posttraumatic stress disorder and when we are talking about traumatic brain injury, how many human beings are we talking about who are suffering from these illnesses?

Dr. Petzel. Thank you, Mr. Chairman. Right now, the VA is taking care of slightly over 500,000 people with posttraumatic stress disorder.

Chairman Sanders. Let us stop right there. 500,000 returning soldiers.

Dr. Petzel. Correct. Not just returning. This is our whole population, Mr. Chairman.

Chairman Sanders. This is not just Iraq and Afghanistan.

Dr. Petzel. I was about to get to Iraq.

Chairman Sanders. Okay.

Dr. Petzel. We have about 119,000 people from the present conflicts that carry the diagnosis of posttraumatic stress disorder.

Chairman Sanders. Okay. There is an issue, I mean, that is just a huge number; and it gives us an indication of the enormity of the problem that we are trying to address here. It is a lot of people.

There is an issue that we did not talk about very much today or in your testimony, and that is TBI, traumatic brain injury. As we all know, this is one of the signature illnesses of these wars, Iraq and Afghanistan, with the incredible amount of explosions that our soldiers were exposed to.

Talk a little. How many folks are we talking about who you think have the diagnosis of traumatic brain injury?

Dr. Petzel. We have tested since several years ago, more than five I believe, everybody that comes back from combat experience, we have evaluated them for posttraumatic, for traumatic brain injury. There are three levels of traumatic brain injury.

There is severe PTSD. I think we are all familiar with that. These are people who are often cared for in our polytrauma centers and have many other complications such as amputations and blindness. A relatively small number of people measured in the couple of thousand.

395,000 people have been screened. We identified 54,000 of those people who screened positive so far for possible traumatic brain injury and, out of that with quite

sophisticated testing, have identified 35,000 people that have mild to moderate traumatic brain injury.

Chairman Sanders. You are telling us that we have some 35,000 people from Iraq and Afghanistan who have mild to moderate traumatic brain injury.

Dr. Petzel. Yes. Most of them are from Iraq and Afghanistan. There are some who have been injured in training accidents, et cetera, but the vast majority are from the conflict.

Chairman Sanders. And TBI is a tough illness to deal with, is it not?

Dr. Petzel. Mr. Chairman, the biggest issue there is that we do not know what the long-term consequences are of mild to moderate traumatic brain injury. This is one of the reasons why we have a registry, why we tested all of these people, identified people with that diagnosis, had them on a registry and now can follow them over and extended period of time with a very good baseline evaluation.

It is speculated that depression, anxiety, PTSD, and endocrine disorders may be more common in those people with mild to moderate TBI going forward.

Chairman Sanders. Okay. We are going to have a second round of questions but let me conclude my questions with Dr. Petzel in asking, you have engaged in a very ambitious effort to hire mental health clinicians. My understanding

is that in order to reach her goal, and that is at the end of June, I believe, is that correct?

Dr. Petzel. Correct.

Chairman Sanders. You are going to need to hire some 495 more mental health conditions.

Dr. Petzel. Correct.

Chairman Sanders. Are you really going to be able to hire the quality people that you want in that period of time?

Dr. Petzel. We believe so, yes. We are involved in a stand down and blitz, if you will, to look at--the big interval, the big problem for us in hiring is 100 days plus that occurs after the person has applied, after we have sorted through the applications, the process of vetting them for criminal activity, credentialing them, and interviewing all of them is what is taking the time, and we have plans to compress that substantially.

Chairman Sanders. I am going to take a little bit extra time which I will give to my colleagues up here as well because I wanted to get to Colonel Porter on an issue.

Look, I think the issue on everyone's mind with regard to the military right now is the tragedy as we understand it that last year we lost more soldiers to suicide than two armed combat, and we are talking somewhere around 350 or so.

Let me just throw out, the first question is, why is

this number so incredibly high? Why is that occurring? And later on we will talk about what you guys are trying to do to address it.

But tell me in your judgment, I think the average American says, what, we are losing more people to suicide than to armed combat. I think that comes as a shock.

Why do you think that number is as high as it is?

Colonel Porter. Thank you, Mr. Chairman, that is, as you indicated earlier, a very complex issue and a complex question. I think a couple of things if you want to compare the number lost to the suicide to the number lost in combat, part of that is attributable to the fact that we have a high survivability rate in combat right now. So, the number that we are losing in combat is decreased significantly from past combat.

With regard to suicide in particular, though, sir, I think what we can say is that it is a complex issue, as you noted, that will take more than just behavioral health people to solve; and that is why the senior Army leadership is looking at bringing in our senior leaders all the way down to our squad leaders to try to combat this with respect to improving resilience in our soldiers, improving resilience in our family members, and giving our soldiers coping skills for whatever life throws at them, whether it is a combat situation or just the daily stressors of being

in the Army or being an American citizen.

Chairman Sanders. Okay. Thanks very much.

Senator Burr.

Senator Burr. Dr. Petzel, let me pick up where Senator Sanders left off. When the VA started the increase of 1600 mental health staff and the administrative staff, were facilities given any options other than hiring this additional staff, like memorandums of understanding with organizations in their community that would enhance and beef up their mental health ability?

Dr. Petzel. Senator Burr, those options have always been there but the short answer is no. This was aimed at how many people do you need to bring your staffing up to the levels you think you need in order to provide the access that we have said we do.

Senator Burr. Was there a matrix that you created that came up with the number 1600 mental health providers?

Dr. Petzel. It was a combination of using the only existing staffing outpatient model for mental health. I think, as you know, there are not very good staffing models for mental health. In fact, the VA is probably a pioneer in developing staffing models for mental health.

We used to that and we used discussions with the individual medical centers about what their view of their needs were.

I want to emphasize the fact that this is not an end. This is going to be an ongoing evaluation.

Senator Burr. I am confident that is an accurate statement.

Dr. Petzel. We are going to be, in an ongoing way, evaluating whether we have got the resources available and properly deployed.

Senator Burr. But what you are saying is that every facility has the option to partner with community-based organizations. Not all of them choose to do it; and in the absence of that, we said you have got to have more people. We did not necessarily look to see to what degree there was outreach for community-based solutions.

Dr. Petzel. That was not a part of the original assessment. But I have to say that I am taking away from this hearing a reinforced desire to go out and do as we did with homeless, have a summit in the community of mental health providers.

Senator Burr. I remember a similar stimulation that you had last year.

Dr. Petzel. What was that?

Senator Burr. Because I am not sure that we heard anything from the witnesses this year that we did not hear last year about the need for community collaboration between DOD, in the case of Fayetteville and other military towns,

between VA and the community-based providers.

What do you think of the VA system when you hear somebody's testimony like Mr. Woods about their firsthand experience?

Dr. Petzel. I am sad that he did not have a better experience. I want to find out what went wrong and where it was and corrected.

Senator Burr. Do you think he is one out of everybody that went in or is this--

Dr. Petzel. I do not think he is a one off. I think that it is a relatively uncommon experience out of the 17 million outpatient visits that we have.

Senator Burr. What outside-the-box options have been stimulated for you that stick out right now if the VA could pursue that they are not?

Dr. Petzel. Well, first of all, enhancing the effort that we are making with the federally qualified health plans.

Secondly, bringing together--and we have done this in some communities but I do not think it has been done universally--bringing together NAMI, these other organizations that testified earlier.

We have worked with NAMI and we have worked with Give an Hour but doing this in a systematic way across the country with everyone of our medical centers and large

Community-Based Outpatient Clinics to, indeed, do an inventory of what is available and to stimulate our people to think about using the community in a larger sense.

Senator Burr. Every person who testified in one way or another referred to the fact that veterans could not get mental health treatment when they needed it through the VA.

So, I guess I would ask you. Are your measurement tools flawed and they are not picking this up or have your measurement tools shown this and we just have not addressed it?

Dr. Petzel. Well, when we talk about access, Senator, we talk about 95 percent of the people can get an appointment within 14 days. When we are talking about 17 million appointments, there are a substantial number of people who are not getting scene that quickly.

I cannot deny the fact that there are people who are not being seen as quickly as we want, and I want to provide them with whatever they need in order to get a hold of and get involved in the mental health services that they have to do, and I think that partnering with the community will help that.

Senator Burr. I am glad to hear you say that. There is a huge difference between reality and goals; and I think what we heard today were realities; and I think what you have stated to us are the goals of what VA would like to

hit; and unfortunately, I do not think the proof suggests that we hit it.

Dr. Batten, in September 2012, VA surveyed its mental health providers to measure their opinions regarding VA's mental health program. Can I ask you today? Would you provide to the Committee, for the record, the results of that survey and the individual responses to the open-ended question additional concerns about mental health services at my facility?

Ms. Batten. Thank you, Senator. I believe we have just been finalizing the report. We will have to take for the record exactly what is available. Perhaps, Dr. Petzel would like to speak.

Dr. Petzel. The intention is to share that, Senator Burr.

Senator Burr. Do I have your assurance that you are going to share it with the Committee?

Dr. Petzel. We will share the report with you, yes, sir.

Senator Burr. Thank you. As well as the open-ended question.

Dr. Petzel. I think that we are able to do that as well.

Senator Burr. Thank you, Dr. Petzel.

The Executive Order also that the President, that you

have addressed with the 1600 people, the Executive Order also created the Military and Veterans Mental Health Interagency Task Force; and it was directed to provide the President with recommendations to improve health services and substance abuse by February of 2013.

As the task force provided its recommendations to the President, and if so, could you provide the Committee with a copy of that report?

Dr. Petzel. The task force has provided its report to the President. That was on, I believe, the 1st of March. It is my understanding that that is going through coordination and concurrences by a number of federal departments and you will have it available to you as soon is released.

Senator Burr. What does that mean, going through coordination.

Dr. Petzel. I do not know. I am sure that there are numbers of bases that need to be touched in terms of what the report said. When it is released by the President, you will be able to have it.

Senator Burr. You do not suggest that it is going through a process of being changed?

Dr. Petzel. No, sir.

Senator Burr. Okay. Thank you, Mr. Chairman.

Chairman Sanders. Thank you, Senator Burr.

Senator Tester.

Senator Tester. Thank you, Mr. Chairman.

On these reports that we are getting back, is it possible maybe we could look at them as a Committee, because I hear a lot of requests for reports and quite frankly I do not get them and I would love to have a discussion on the Committee about these reports once we get them if we have got time.

I think that if we are going to ask the VA for these reports, I think we owe it to them to make sure we discuss them and find out what is in them and make sure they are worthwhile.

Chairman Sanders. I think that is an excellent suggestion.

Senator Tester. Thank you, Mr. Chairman. I appreciate your leadership.

I want to visit on a couple of different things. I do not know if I have ever asked you this, Dr. Petzel. Does the VA have a definition for "rural"?

Dr. Petzel. They do. It is not a definition that is really exclusive to the VA. It can be defined in two ways. One is the travel distance to a metropolitan area or the distance, and we have used both of those measurements and a finding rural.

Senator Tester. Well, the reason I want to come to

this is that we are hiring, we have got 1300 and another 600 or so people you are hiring in mental health professionals.

And Dr. Van Dahlen was up earlier and we have some issues. I guess if you were up again I would ask you how widespread countrywide your program is because I think those resources are great where they exist.

But I am more concerned about rural where there is no resources. My question is. When you assign these folks, what is the priority you do it on? Is it based on where there is limited service or no service or how do you make that decision?

Dr. Petzel. Well, we do not assign them. We ask, as an example in your instance, we would ask the Fort Harrison and the VISN what are the needs out there. They would tell us that they need an additional two psychiatrists, let us say, and four psychologists and five psychiatric social workers.

That would be then what we would expect them to go after and expect them to try to hire. We do not hire people and then assign them someplace.

Senator Tester. So, you get the recommendations ahead of time before you hire the folks. If you need somebody in Plentywood, Montana, for example, at that CBOC, and I do not even know if that is the way you work it; but if you need somebody in Plentywood, Montana, far northeastern corner,

600 miles away from the nearest medical VA hospital, then you hire that person to fill that slot.

Dr. Petzel. That is what we would try to do. I have to say, Senator, that a better alternative would be to use telehealth.

Senator Tester. Got you.

Dr. Petzel. And provide that service remotely by having it done by a psychiatrist back in Helena.

Senator Tester. Point well taken, and I am going to get to you, Colonel Porter, in a second.

Veteran suicides is a huge issue and an incredible worry and something we have got to do. Have you done any work with the veterans that have contacted the VA and their suicide rate versus the veterans who you never can get out and touch and their suicide rate?

Dr. Petzel. Yes, Senator, we have. The people that are under mental health care in the VA have a lower and a declining suicide rate than those veterans who are not in contact with the VA, not getting care in our system.

Senator Tester. Any figures on that, because I know there is a pile of vets out there that do not utilize the VA?

Dr. Petzel. I would have to ask Dr. Kemp, who is our expert in suicide.

Ms. Kemp. I think, as you know, we are just now

beginning to be able to gather that information directly from the states; and as a result, we were able to put out that first suicide data report just this year.

Senator Tester. Okay.

Ms. Kemp. As we add states, we will be able to firm up those numbers.

Senator Tester. Very good. As soon as you get those, I would love to see them to see, you know, then you have metrics you give us.

Ms. Kemp. Yes.

Dr. Petzel. Senator, could I just make a couple of other comments about suicide. There was a discussion about combat experience and suicide earlier. I think it is important to point out that in veterans, not service members but in veterans, there is no relationship necessarily between their combat experience and whether or not they take their lives.

Senator Tester. I have got you in that, and I think that was a question I asked the gentleman from NAMI that was up if there was any idea on that. I guess the point is that you cannot help the people you do not have access to; and that is what I want to see, whether they served in combat or not, they have earned the benefits. We have got to encourage them to step up to the VA because I think there is a good health care system there. But if we cannot get them

in, we cannot help them come if you know what I mean.

Dr. Petzel. That is absolutely right.

Senator Tester. Okay. One last question. Oh good, I have more minutes than I thought.

[Laughter.]

Senator Tester. Colonel Porter, you talked about 350, or maybe it was the Chairman actually, 350 suicides a year in the active military. Is that number correct for last year?

Colonel Porter. I do not know that we finalize the number from last year.

Senator Tester. Is it close?

Colonel Porter. I think it is close, Senator.

Senator Tester. Okay. Is that all the branches of the military?

Colonel Porter. I think it does include all of the military.

Senator Tester. Okay.

Colonel Porter. Including the Reserve components.

Senator Tester. It does include the Guard and Reserve component?

Colonel Porter. Yes.

Senator Tester. That is good to know. Thank you.

Continuing to you, we talked about the stigma attached. Is the military doing anything about that stigma because we

are seen, well, we are seeing unacceptable levels quite frankly; and we do not do a good job as a society, I do not know that any society does a good job with mental health issues and they can be fixed. We talked about all that stuff.

But is the military doing anything to address the stigma challenge associated with mental health?

Colonel Porter. Senator, what the Army is doing is they have a stigma reduction campaign that is intended to educate soldiers and leaders about the benefits of accessing mental health care.

But I think what really makes a difference is, and what we know actually from literature about behavior change and attitude change, is that having the behavioral health providers around soldiers and having the soldiers have access in their brigade areas to those soldiers, like our embedded behavioral health program where we take the behavioral health providers from the hospital and actually make their place of duty a building that is authorized for health care use in the brigade area so that the brigade leaders know those behavioral health providers and vice versa.

Senator Tester. Is this widespread throughout?

Colonel Porter. We are rolling it out across the Army.

Senator Tester. Okay. When do you anticipate it will

be fully implemented?

Colonel Porter. We anticipate that we will have all operational units supported by this program by the end of fiscal year 2016.

Senator Tester. Okay. There is a huge problem here and this is the VA Committee and we will all be VA accountable. But I think the Department of Defense has a responsibility here to train people of what they are going into and what they need to expect so that they understand what to expect as they go through their military service.

I just want to thank everybody for their testimony today and I want to thank you, Mr. Chairman.

Chairman Sanders. Thank you, Senator Tester.

Senator Boozman.

Senator Boozman. Thank you, Mr. Chairman.

Dr. Petzel, do we have a good idea of, you know, we heard about the community-based, we have heard about different things that seem to work.

You have got the classic therapy. You have got one of our witnesses talked about an individual that was in Haiti helping other people and that seemed to help a lot. I heard a young guy that was an amputee that literally a golf pro tapped him on the shoulder and said I am going to teach you how to play golf when he was lying in the bed suicidal, and that changed his life.

There are all of these ancillary things. Do we have good metrics to know what is working and what does not work?

Dr. Petzel. That is an excellent question, Senator Boozman. We do know there are a group of evidence-based therapies that have been developed relatively recently. Two of them for posttraumatic stress disorder. There are some relatively new evidence-based therapies for depression and anxiety and other things.

So, yes, there are areas where we do know what to do. There are lots of areas, however, where we do not know what to do.

I really want to hearken back to what in the previous panel, Mr. Wood said, this idea of purpose and community is very important. The idea of people having purpose in their lives, something that they look forward to, I think, is very important.

I would ask Dr. Batten if there are any other comments about what we have available that is effective in treating the multiplicity of mental health disorders, not just PTSD.

Ms. Batten. I am happy to be able to speak that. I think that we want to make sure that all veterans have access to our evidence-based psychotherapies and want to make sure that they understand that treatment works because that is one of the biggest barriers for people coming into care is to know that there is something there that will help

them.

But we know that not any one thing is going to apply to everybody. So, what we need to do is we need to have our clinicians ready to ask the questions about what is important to that individual veteran when he or she walks through the door.

It may be reducing symptoms but it may be about getting out and getting a job. It may be about being able to go to their grandchild's T-ball game and not have to be looking over their shoulder.

It is important to find out what is important to that veteran, and we want to make sure that we use a wide array of services that include peer support, getting back out into the community, and really living a healthy lifestyle overall.

Senator Boozman. No, I agree, and I think, you know, one of our previous witnesses said the same thing in the sense that one size does not fit all.

But I would really encourage you. You mentioned having a summit and I would encourage you to have a summit along those lines as to, you know, with the community-based and stuff.

My concern is, you know, in an effort, and you guys were very, very hard to try and solve this problem. The trouble is that you are getting the patient at the end of

stage. You know, we are not addressing the cause of the problem.

So, you are having to deal with this, and I think many times and probably the least expensive thing is to write a prescription. I think you really need to look very hard, and we can help you with that but you need to look very hard to over prescribing.

And we are seeing this in the private sector, what has happened with the pain management. That is consuming more opiates than all the rest of the world put together. And so, all of the stuff goes together.

The other thing that you might consider having a summit about is looking at the causative thing and treat this as a whole in this sense we need to look at the divorce rate in the military. You know, that is every bit as important as this because it all goes together.

We need to look at, you know, how our soldiers are doing financially and almost have a, and maybe we do but we need to have a marital hotline as importantly at the bases, again to get our guys and girls in a situation where they are dealing with those problems while in the military when they get out.

Then also, the employment picture is so important, getting them where they can, but what I see is so often, you know, we get to that, the multiple deployments that you

might not come back with PTSD but I can tell you you are probably coming back with family problems if you have had seven or eight deployments in the last 11 years. That is a tough thing.

Dr. Petzel. Senator, can I make two comments? Those are excellent, by the way, comments and I think you put your finger on what we really are trying to work on.

First of all, we need to be able to identify these people much earlier in the course of these illnesses. The new transition assistance program that is mandated for everybody that the VA is devoting almost half $1 billion to is going to go a long ways towards helping us see these issues very early before patients, before the soldiers are discharged. We can identify people in trouble and we can also make them aware of everything that is available.

But the other part of what you said identifying the antecedents, you know, the VA population that harms themselves is the 60 plus population. That is the big group, the majority of people who commit suicide in the VA.

In that instance, we are talking about depression. We are talking about chronic pain. We are talking about sleep disorders. We are talking about substance misuse and, as you mentioned, life stressors.

Loss of a job. They are often retiring and it is a big change. Just like leaving the military, retirement can be a

huge change in someone's life.

We have chartered a workforce group that is going to be looking at new approaches to those five things, doing these things differently so that we can do a better job of identifying people who may be at risk.

So, I think you are right on the issue.

Senator Boozman. I agree. As you said earlier and in our previous panel, loss of purpose.

Dr. Petzel. Right.

Senator Boozman. In that group in particular, you know, feeling like--

Dr. Petzel. Life is over.

Senator Boozman. Life is over, exactly.

Thank you, Mr. Chairman.

Chairman Sanders. Thank you, Senator Boozman.

I believe that Senator Blumenthal will be here in a second but let me bring some other issues and ask some questions.

I think it is fair to say that both the VA and the DOD, DOD military structure, DOD health care operations have a very good reputation for treating the wounds of war in terms of prosthetics, in terms of how we take care of amputees. Probably, there are no institutions in the world that do a better job than the VA and DOD. You are leaders in the world on that.

Mental health is a different issue, and it is a much more complicated issue whether it is in the private sector or within the military and the VA.

And on top of that, if we take a deep breath and we look at the magnitude of the issues that VA has to deal with, tens and tens and tens of thousands of soldiers coming back with PTSD or TBI on top of the problems that our older veterans have from Korea, Vietnam, World War II, that is a mammoth issue, number of issues that you are dealing with.

I think a recurring theme in the previous testimony that we heard was that every soldier is different. Every problem is different, and that we have got to think a little bit outside of the box, and I think Senator Boozman raised that issue.

Talk a little bit of out-of-the-box therapies, talk a little bit about complementary medicine. There was a piece. I do not know whether you saw it, John, on CNN just the other day and they were talking about over medication which is a real, real issue.

Some of the over medicated were then moved toward acupuncture, for example, as pain relief which apparently, in what we saw on CNN at least, worked pretty well. To what degree is the VA aggressively looking at complementary medicine, acupuncture, meditation, massage therapy? Talk about that.

And the second issue, and Senator Boozman raised that as well, you know, what we are dealing with our real-life problems; and life is complicated; and it is not necessarily just dispensing some medicine. It is certainly not filling out pages and pages of forms which would drive me, among many other people, quite nuts if I needed help.

And I want to talk to you about how we break through that old bureaucracy stuff but things like Senator Boozman said playing golf. If four veterans spend an afternoon out playing golf and feeling good about each other and talking and come back feeling a little bit better about themselves or they go trout fishing or they go camping together, those are real improvements which may mean a lot more to the veterans than getting some more medication.

So, the question is to what degree are we thinking out of the box to make people feel better about themselves in whatever way; and then, by the way, Senator Boozman, what we have to be careful when we make these recommendations is not to see front-page stories that VA pays for golf outings on the part of veterans. That is a very easy target for the media.

Senator Boozman. No. I agree totally and that is why I was asking if they had some evidence-based as to what is working, you know.

Chairman Sanders. Yes. Okay. But that is the

question I want to throw out if you could answer it.

Dr. Petzel. Thank you both. Let me first deal with a little bit about the out-of-the-box. We partner with a tremendous number of organizations around the country. Give an Hour as an example of psychotherapy.

The professional golf association and the local professional golf associations have programs in virtually every city where we have a medical center that provide the opportunity for handicapped people particularly to play golf. We actually sponsor a blinded golf tournament that occurs every year in Iowa City.

There are many other examples of recreational activities, horseback riding, fishing, kayaking, where individual veterans and service organizations have put together these nonprofits that provide these opportunities.

We are looking for them everywhere we can find them. Whether or not there are enough and whether we are using it enough is I think an open question. But we are very much open to those opportunities.

Chairman Sanders. I want to get back to the issue again that Senator Boozman appropriately raised and that is over medication and perhaps looking at other ways to deal with pain and other distress.

Dr. Petzel. Again, excellent. Let me deal first with opioids which is the most dangerous, in my mind, of our over

medication issues. We have got a three-pronged approach. There is, first of all, what we call the stepwise process where you begin with the least invasive, least dangerous, least risky things to manage chronic pain; and this is being done at all of our medical centers.

And, that may include acupuncture. We provide acupuncture at the vast majority of our medical centers. And then progressively, more complicated things such as rehabilitation, et cetera; and eventually when you are not able to manage the pain in any other way, it is opioids. And then, there are very careful protocols about how that prescribing should be done.

The second step in that is that we have just begun producing the computer program that provides to the medical center the listing of patients who are taking unusually large number of opioids and prescribers who are prescribing an unusually large number, and that is transmitted back to medical center. A person is responsible for tracking that down at the medical centers and seeing what the issues are.

Then, the third thing is that we are participating now in the state reporting of opioids. That is very important because some of our patients are getting prescriptions outside of the VA and we need to be able to bring that data together. So, we fully understand the extent of the problem.

So, we will be giving them our data and we will be able to have access to the state-wide data.

Chairman Sanders. Thanks very much.

Senator Blumenthal.

Senator Blumenthal. Thank you, Mr. Chairman.

First of all, my thanks to Senator Sanders for having this hearing which I hope will be just the first of a number of steps to really dig deeper into this issue of mental health and to pursue the line of questioning that Senator Sanders has raised, and thank you all for your service on this issue.

The collection of data on the use of pain medications, you know, this issue has bedeviled our society, state authorities. I know from my own experience as state attorney general where we were finally able to establish an electronic and computerized records system that keeps track of who is prescribing and who is taking pain medication like opioids.

My first question is. Would it not be helpful to have a single system of record keeping that applies to men and women of our military while they are on active duty and then seamlessly with the Veterans' Administration, a system that was on track to go forward, a billion dollars has been spent on it, and now apparently it has been scrapped.

Would it be advisable and desirable to have that kind

of system for the purposes of tracking exactly this kind of potentially useful but also highly dangerous medication.

Dr. Petzel. Senator Blumenthal, the integrated medical record between DOD and VA will enhance greatly our capacity to manage patients in general and some of the specific things such as medication issues even better.

The integrated medical record has not been scrapped. That is going forward as we speak, and we are expecting that by 2014 we will have the initial operating capacity for that integrated record.

Senator Blumenthal. Well, I am glad to hear you say that.

Dr. Petzel. VA is absolutely committed to doing that. Absolutely committed.

Senator Blumenthal. I know but as in dancing it takes two.

Dr. Petzel. Yes.

Senator Blumenthal. And, the announcement publicly by Secretary Panetta and General Shinseki was certainly not encouraging. I have since heard conflicting reports and my concern is that this interoperability system may not be the same as a seamless, fully-integrated system that enables realtime tracking of how opioids and other highly powerful medications may be prescribed.

Dr. Petzel. I am not an expert in IT. I will confess

from the beginning, probably one of the least literate physicians around IT. But I am told that this will be a seamless record. And, I share your concern, though. I mean, I do share your concern. This is a thing that the VA particularly as being constant attention to. Our Secretary is absolutely relentless in pushing forward the need for having this integrated record.

Senator Blumenthal. And I am really delighted to hear that point reaffirmed. I have spoken to him about it and I know of his personal interests and his commitment to it which I command fully and enthusiastically.

Let me ask you about, again to take Senator Sanders point about thinking a little bit outside the box, what about take-back programs?

Dr. Petzel. By the way, thank you for the sponsoring I believe of that legislation with the FDA. We think it is an excellent idea. Anything that can get these dangerous medications out of people's hands who do not need them, keep them away from teenagers who tend to sometimes rifle their parents medicine chest, et cetera.

And, we are looking at how we can do this. Certainly, mailing back is no problem for us and we will institute that as quickly as we can. The receptacle collection depends on a ruling that our police are actual law enforcement officers. We think that is going to come but we need to

establish, in fact, that they are.

And then, I believe the other provision was handing these over, at the time of a visit, to practitioners. We are looking at whether we legally can do that or not. It is an excellent idea, and we fully endorse it and are going to do everything we can to participate.

Senator Blumenthal. Great. Well, anything we can do or at least I can do I would be delighted to undertake.

You know, I have seen ESCAPE FIRE, the documentary. I think the Chairman mentioned it earlier during the proceedings and I hope that more people can be exposed to it, be given the opportunity to view it because I think it makes a very graphic and dramatic case for the need to be vigilant on this issue particularly where we are using medications that may be every bit as advanced as some of the equipment of warfare that are used on the battlefield in terms of their effect on individual people and so I hope that you will continue, all of you will continue to do the good work that you are doing in this area.

Let me ask you on a more general level, and I do not know whether you have had a point on this. You looked like you were about to say something. I did not mean to interrupt you.

Dr. Petzel. I do not want to take up your time.

Senator Blumenthal. Well, that is why you are here is

to take up our time.

[Laughter.]

Dr. Petzel. I was just going to remark on the wonderful vignette about acupuncture in ESCAPE FIRE and the transportation of patients from Landstuhl back to United States where they used acupuncture in substitution for opioids and how effective that was. I thought that was a very moving vignette. That was all.

Senator Blumenthal. Well, that leads to the question I was going to ask. In your experience as professionals having dealt with veterans, particularly individuals exposed to combat, is there a factor, a tendency, and an experience that leads veterans to be more likely to over medicate on pain medication? And I do not mean to suggest that they do but that is part of the question.

Dr. Petzel. I will make a brief comment and then I will ask of anybody else here. The tremendous physical stress that they undergo, marching with 80 pound packs, et cetera, when you look at the complaints that returning veterans have, musculoskeletal are far and away the leaders. 45 percent of people returning to this country after deployment complain about neck, arm, shoulder back pain, et cetera. That is the only thing that I personally can testify to.

I would ask if anyone else, Sonja.

Ms. Batten. Thank you. I think these are the sorts of questions that we need to ask if we want to really move from just saying, okay, here is the diagnosis, here is the treatment.

I think we need to understand some of those underlying mechanisms that are going on that influence both physical and mental health functioning.

So, one of the examples I will give is when we think about the etiology of PTSD. So, why do some people develop PTSD and some people do not? One of the factors that is involved with the development of PTSD and its maintenance is when somebody, you know, it is natural for any of us, if we experience an unpleasant or traumatic event, to try not to think about it, to try not to have those memories, those sensations, and feelings.

So, that sort of initial level of avoidance, that is just natural. That is human nature. But when somebody uses avoidance or numbing as their primary way of coping with that sort of trauma, then they are going to be more likely to develop something like posttraumatic stress disorder.

And, it is not a far step to say that when somebody is not willing to experience emotional pain, it is probably also the case that they are not willing to experience that physical pain.

And so, we need to look at some of those underlying

factors around avoidance and difficulty sitting with uncomfortable thoughts, feelings, emotions, and physical sensations that may tie some of those propensities together.

So, if you are not willing to have the emotional pain, it may be also that it is difficult to sit with the physical pain and you may be more likely to turn toward things like pain medication rather than psychotherapy or other techniques to cope.

Senator Blumenthal. Thank you.

Thank you, Mr. Chairman.

Chairman Sanders. Senator Blumenthal, thank you for your questions.

Let me just conclude by thanking all of you. The enormity of the problem at both the DOD and the VA is facing is extraordinary, in many ways unprecedented.

I appreciate where much of the hard work the VA is doing, the seriousness upon which they are addressing this issue. Clearly we have a long way to go. Clearly, we have a lot of problems out there.

This Committee looks forward to working with you to address those problems.

Thank you all very much for being here.

[The statements for the record follow:]

/ COMMITTEE INSERT

[Whereupon, at 12:26 p.m., the Committee was adjourned.]