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Senate Committee on Veterans' Affairs

VA MENTAL HEALTH CARE: ENSURING TIMELY ACCESS TO HIGH-QUALITY CARE

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I. Introduction

Chairman Sanders, Ranking Member Burr and distinguished members of the committee, on behalf of NAMI (The National Alliance on Mental Illness) I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding *VA Mental Health Care: Ensuring Timely Access to High-Quality Care*. NAMI applauds the committee's continued dedication in addressing the critical issues surrounding mental health care and NAMI looks forward to working closely with the committee in addressing these and other issues throughout the 113th congressional session.

NAMI, the National Alliance on Mental Illness, is the nation's largest grassroots mental health organization dedicated to building better lives for the millions of Americans affected by mental illness. NAMI advocates for access to services, treatment, support and research and is steadfast in its commitment to raising awareness and building a community of hope for all of those in need.

Historically, NAMI has recognized the psychological needs of veterans and their families. In recent years NAMI has moved aggressively to position itself to address the needs of our newest veterans who require post-deployment services essential to maintaining or restoring a state of mental well-being for themselves and their families.

NAMI honors veterans and their service to our country and endorses the Independent Budget and our Veteran Service Organization colleague's efforts to independently identify and address legislative and policy issues that affect the organizations' memberships and the broader veteran's community.

NAMI's Veterans and Military Council (NVMC) is organized under the authority of the NAMI Board of Directors to ensure that the requisite attention is given to veterans' mental health issues and to advise the Board on measures to improve the continuum of care for veterans and their families. Members of the Council are from virtually every state - including those which you represent, and work voluntarily in cooperation with NAMI state and local leaders. Most of our Council members are former military or family members and many conduct free NAMI training programs - including our Family-to-Family twelve week course offered at many VA centers around the nation pursuant to a Memorandum of Understanding between NAMI and the VA dating back to 2008. A description and status of that MOU is an appendix to this testimony.

I am the nationally elected Chair of NAMI's Veterans and Military Council. I am a retired U.S. Army Officer, with service from 1970 to 1990. I am a former classroom high school and college teacher. I am trying to be a Tennessee farmer, but spending much of my time volunteering as a mental health advocate focusing warriors, veterans and their families. I have utilized the VA health-care and, until recently, the dental care system for twenty-three years. I have the honor to lead a team of volunteer veteran advocates, including Clare, our Secretary from Vermont; MOJO, our first Vice President from Missouri and Samuel, our Second Vice President from North Carolina. We meet via a monthly conference call with our State Representative members who send you greetings and appreciation from throughout the nation. Our volunteers are extremely dedicated – "Amy from Hawaii" joins our monthly calls at 7:00 am with a cheery "Aloha" when many of us are starting our afternoon.

I am a former Army Airborne Ranger Infantry Officer, opposing force commanding officer, Military Intelligence Battalion Commander of a mixed-gender unit with service in the Middle East before Desert Storm. I am also a former helicopter and fixed wing US Army aviator who flew reconnaissance aircraft missions against both Cold War and combat targets. I was awarded the Armed Services Expeditionary Medal and the Joint Meritorious Unit Award for our team's significant classified intelligence work.

I am a graduate of the Military Intelligence Officers' Advanced Course, the Mohawk Aircraft surveillance and reconnaissance course, Army Photo Interpretation School, U.S. Air Force Defense Sensor Course, U.S. Army Command and General Staff College, Tennessee Tech University (BA, Marketing) and Kansas University (MS, Middle East & Russian History and Remote Sensing).

I served in Europe, Australia, Central America, Asia and the Middle East and as a force integration staff officer and congressional briefing writer at the Pentagon. I am published in both Military Intelligence and in Military Review Magazines. I developed instruction and taught for the Australian Schools of Military Intelligence and Aviation, U.S. Army Intelligence Center and School, Roane State Community College and University of Tennessee Medical Center in both personal contact and interactive distance learning settings. After military retirement, I taught leadership to young men and women high school students for fourteen years in our Army Junior Reserve Officers Training program at two rural Tennessee high schools.

I am a member of the American Legion, Disabled American Veterans, Military Officers' Association of America, AMVETS and the League of Women Voters. I served as Chair of the

Tennessee Governor's Veterans' Task Force and currently serve as a member of an Inter-agency Behavioral Health Advisory Council and as a member of a Crisis Intervention Team advisory group representing veterans' interests to the law enforcement community. In 2009, I received the NAMI Tennessee President's Award for my mental health advocacy efforts. I live and farm in East Tennessee.

II. More accountability in how the VA spends MH dollars

It is critical that our very scarce resources have full and transparent accountability. Every dollar spent is a reflection of the total cost of military service. NAMI fully supports the Independent Budget - the diligent effort of our collaborative Veteran Service organizations, and agrees that Congress should require the VA to develop performance measures and provide an assessment of resource requirements, expenditures, and outcomes in its mental health programs, as well as a firm completion date for full implementation of the components of its reformed program and the full Uniformed Mental Health Services package. NAMI also agrees that the VA should provide periodic reports that include facility-level accounting of the use of mental health enhancement funds, with an accounting of overall mental health staffing, the filling of vacancies in core positions, and total mental health expenditures, to Congressional staff, veterans service organizations, and the VA Advisory Committee on the Care of Veterans with Serious Mental Illness and its Consumer Liaison Council.

Particularly important is the need to increase research funding which has not seen the increases in the same manner as other areas of VA spending at a time when the VA budget has been fully funded and beyond. The VA should conduct health services research on effective stigma reduction, readjustment, prevention, and treatment of acute post-traumatic stress disorder and substance-use disorder in combat veterans, and increase funding and accountability for evidence-based treatment programs. VA should also conduct an assessment of the current availability of evidence-based care, including services for PTSD; identify shortfalls by sites of care; and allocate the resources necessary to provide universal access to evidence-based care.

III. Veterans Preferences in Hiring

A key ingredient of psychological health is the feeling of self-worth from productive employment. Sadly, veteran unemployment, which is higher than civilian unemployment in all age groups across the nation, is especially high among our younger veterans. And among our National Guard and Reserve, many in remote, rural areas, military service often is their only employment. Unfortunately those National Guard and Reservists are not eligible for Veteran health benefits unless they have been activated for federal service. They account for fully 25% of the suicides of those in uniform.

NAMI advocates strongly for Veterans health benefits and for psychological service providers as embedded advisors in all of our National Guard and Reserve units. NAMI also advocates for hiring preferences for veterans in the civilian workforce. On the bright side, many civilian employers are now recognizing the value of employing Veterans and are stepping up with

preferential hiring and some are even guaranteeing employment to any veteran. This is good for the hiring companies, good for the economy and good for the veterans and their families. The trail of unemployment is often financial and family troubles are often followed by depression, withdrawal and isolation and sometimes suicides.

Many of our Veterans have received top flight training to become certified in occupational areas such as Medic or Mechanic, but the military certification is often not recognized in the civilian community. Thus, these Veterans must start anew at the beginning of civilian training to qualify for state certification and land a job immediately based on military certification. This exclusion and discrimination should end and veteran skills, especially in technical and technology areas. Military training should be put to immediate use and veterans should be given preference in hiring and extra points on government exams with a guaranteed interview for any local, state or federal job. Local, state and federal governmental entities that do not recognize these preferences for veteran hiring, and who have any form of federal funding, should be strongly encouraged to change their policies. Consideration should be given to having federal funds withheld until their hiring practices include preferential status for veterans.

Veterans hiring preferences should include the spouses of deceased and disabled veterans and special attention and help should be given to the nearly three hundred thousand caregivers who are already working full time in the home to care for r those they love. This is often done at the sacrifice of their own jobs and income.

To be sure, I have seen many examples of caring that have helped veterans in need. One example is a friend of mine, Joe, who had both of his legs blown off by an improvised explosive device on his second tour of duty in Iraq. Joe and his wife were overwhelmed and feeling hopeless by his lack of job prospects upon his return I spoke with a VA manager, Deb. Who took it upon herself to take instant action both to ramp up Joe's care within the VA and to use her civilian job contacts to help Joe find a job. Today, Joe, his wife and their two daughters are enjoying family life near Nashville, TN. Thank you Deb for your kindness!

IV. Reduce Stigma and Strengthen Suicide Prevention

NAMI believes that the key to reducing stigma and strengthening suicide prevention is a change in the way we approach these problems. It is absolutely unacceptable to be applying the resources we have for the last ten years and to see suicides grow at a rate of twenty-percent among veterans from eighteen to twenty-two a day. Many of these suicides are occurring among those who have never been in combat. In 2012, suicide deaths among soldiers were higher than combat deaths. We strongly support parity, accountability, collaboration and action to end the stigma of seeking mental health treatment both in our active forces and among our Veterans and National Guard and Reserve as a means to reduce stigma and suicide. NAMI's recently issued "Parity for Patriots" report is enclosed for the record and contains a number of recommendations for addressing stigma and strengthening suicide prevention.

Parity must be given to all wounds, physical and mental, whether from combat or other forms of trauma and injury. Sexual trauma and full access to health services for all victimized by this

crime is a particular NAMI concern. As the former Battalion Commander of a mixed-gender unit with males and females at the "front line of troops" I know that all warriors will do their duty in a professional manner when given opportunity and caring leaders, and it is unconscionable for any to be distracted or victimized by the crime of sexual trauma. NAMI applauds the work of the Committee to stop the crime of sexual trauma and punish the perpetrators.

We also believe that award of the Purple Heart for combat induced physical and mental wounds will legitimize the equality of the mental or invisible wound and encourage veterans to seek treatment. Some oppose this award on the basis that the mental wound cannot be seen, but with the approval of the Purple Heart for combat induced Traumatic Brain Injury the way is open for the next step towards de-stigmatizing mental wounds of war. Rather than be associated by the regulations in the same category as "trench foot," Post-Traumatic Stress and other mental wounds of war should be accorded the honor of being classified as a legitimate combat wound. Congress, the President or the Department of Defense have authority to make this change and should do so now to achieve parity and equality of all combat induced wounds.

Accountability must be accepted by leaders at all levels for any stigma, bullying, hazing, suicide or denial of mental health services. Though many publically support the need for mental health, there is no formal mechanism for holding leaders accountable in a standardized, systemic manner, and there have been instances of leaders seeming to ridicule those who showed the "weakness" of taking their own lives. Performance evaluations should immediately and specifically include measurements of how leaders are or are not ending stigma, bullying, hazing and suicide.

Leaders focus on the areas that affect their careers and job security, and they will find a way to reduce the epidemic of suicide if held accountable on evaluation reports. In the system of VA care, there are often "silos" especially in the specialty care areas that are either derisive or dismissive of the reality of wounds such as Post Traumatic Stress. This may be seen in the callous remarks of someone who is not a provider of mental health services or in directives from a VA Dental Chief to deny certain treatments to veterans with mental health conditions. An example of one such communication to a community fee basis provider from the VA is offered for the record as part of this testimony. The impression of that provider of the deteriorating relationship with VA affecting the care of patients is also enclosed and is a courageous statement given the power of VA approval for payment of community providers.

Collaboration in combatting the stigma of seeking help for invisible wounds of military service is essential and is certainly represented well by this Committee's invitation to testify today. Another excellent example of collaboration is NAMI's partnership with AMVETS to establish organizational relationships from local to national level and bring veterans and mental health advocates together. We expect this to be the first of many Veteran Service Organization collaborations to bring the synergy of organizations with the common interest of veterans, and particularly veteran's mental health, together. An additional excellent and appreciated collaboration is the VA Office of Mental Health Services quarterly stakeholder meeting to gather information and discuss veterans mental health needs.

NAMI is also appreciative of a vigorous interaction with the mental health providers of the Office of the Army Surgeon General. Whether in combat or peacetime settings, our warriors, male and female and our veterans deserve respect, honor and gender appropriate privacy when seeking or receiving care. Unfortunately, many of those who wear or have worn the uniform have been subjected to sexual trauma that has been left untreated and has its own particular brand of debilitating stigma. This is absolutely unacceptable and NAMI recognizes with approval the efforts made by this committee to hold accountable those who perpetrate this unspeakable crime. I have had the honor of commanding wonderful soldiers of both genders, and those who know this crime will not be tolerated always perform well even in mixed units in field settings.

Finally, action is needed to energize those throughout the VA system to take charge in a positive manner to improve the health care and claims processing that is deficient and slow creating tremendous backlogs. VA employees should be empowered to say "yes" but not "no" at the lowest levels. "No" should only be the response of the equivalent of a field-grade officer. A great deal of power is bestowed on those making decisions about health care and veteran compensation and pensions and progress has been made with the latest rulings on documenting mental wounds, but more must be done to move claims faster.

Current technology can be leveraged to consolidate appointments and reduce travel expense and risk and to deliver counseling via distance means such as computers and telephones. Adding community based providers as a major component of treatment offers hometown service with a hometown stake in the recovery and builds a sense of ownership for the total cost of military service. Relaxing barriers, possibly by sharing phone numbers and first names for those who choose, and encouraging more direct veteran communication and interaction could be a helpful step short of professional counseling, group therapy or a crisis line and allow shared experiences, sometimes across generations of veterans to help with the mental healing process and reduce stigma. Some believe that VA use of a veteran's former rank when providing care would honor the service and sensitize providers to that veteran's service.

A concern expressed by some veterans as a significant and possibly growing barrier to seeking treatment by VA or identifying themselves as having conditions such as Post Traumatic Stress, is the fear that they will lose their right to own or possess a firearm solely due to receiving mental health care. For example, there are reports that veterans who have a fiduciary representative appointed are identified by the VA as not being permitted to possess firearms. Were the VA to publicize that this is not the case, it would help assuage the fears of these veterans and encourage them to seek treatment. NAMI supports access to mental health services for all without denial of any constitutional rights only because of treatment for mental illness.

NAMI has long been and is proud of being an advocate for a diverse population of veterans who, as conscripts or volunteers, have defended America's freedom. We express our support for veterans of all ages - some of whom have special language or cultural needs and who come from a variety of ethnic groups and lifestyles. With older veterans having a suicide rate twice that of younger veterans, it is particularly important to find a way to mix and strengthen the entire veteran population. VA help in this endeavor is requested. For the veteran organizations to which I belong, it is common to attend meetings with an aging group, dwindling in number and on a path to extinction unless we find a creative way to "pass the torch" to those who follow us.

Finally, attached as an appendix is a summary of "Talking Points" delivered by NAMI's Veterans and Military Council at the White House Interagency Task Force on Mental and Veterans Mental Health is enclosed.

These recommendations include:

- Holding military and civilian leaders accountable for bullying, hazing and suicide by way of the performance rating system. Current Combat Lifesaver Training should include training and a qualification badge for Mental Health First Aid

- Reviewing Personality Disorder and Adjustment Disorder discharges with a view to establishing veterans' benefits for those who do have or may have had legitimate mental illness, if properly diagnosed at the time

- Promoting coalition building and collaboration with federal, state and local government agencies, Veteran Service Organizations, for profit organizations, non-profit organizations and communities to enhance outreach to veterans and military families to decrease the impact of psychological wounds of military service

- Collaborating to improve access, training and utilization of veteran families, peers, and housing. Consider use of Neurofeedback treatment, and improve access to and certification of service animals to avoid crises

V. Address Appointment Wait Times

We should provide broader and quicker care (within 14 days) for veteran mental health complaints. Resolution of these complaints should be fast-tracked (within 30 days) and decision-making and approval of compensation and pension claims for veterans with a diagnosed mental illness should be decentralized. Authority to deny claims should occur only at the highest levels. Outreach to underserved populations, including women and other diverse populations, should be expanded.

In Tennessee, I have seen promising models that fall outside the traditional, expensive VA system of care. For example, telemedicine, self-help groups, peer counselors and NAMI In Our Own Voice training to share the journey of recovery and heal. Reaching veterans in rural areas that may not have VA facilities is particularly a problem. Providing VA resources to Community Mental Health Centers and other non-VA mental health services could help to address this problem. Under a Memorandum of Understanding (MOU) originating in 2008 with the Veterans Health Administration (VHA), NAMI offers Family-to-Family Education Program (FFEP) in select VHA facilities across the country. The NAMI FFEP is a free 12-week course for family caregivers of individuals with mental illness, taught by trained family member volunteers, using a highly structured and scripted manual. In weekly 2 to 3 hour sessions, family caregivers receive information about mental illness, treatment, medications, and recovery. There are many

other community agencies providing treatment and services to veterans with Post-Traumatic Stress and other mental disorders that fall outside the VA system.

Attention must also be given to addressing the health and mental health care needs of National Guard and Reservists who are not considered "veterans" despite their service. These individuals have frequently experienced the same challenges and trauma as those in the more traditional branches of the military.

Consider use of fee-based psychological services, including telephone counseling, for psychologically homebound veterans and those in rural and other remote areas – to include National Guard and Reserve who have not been activated for federal service and are not considered veterans.

Recovery from PTSD and other mental illnesses requires more than medical treatment. Housing, employment, substance abuse counseling, and other psychosocial supports are also key to recovery. A national policy giving special preference to veterans in interviewing and hiring for jobs would be a significant step in the right direction. Veterans should also be given preference and subsidies for appropriate housing and landlords, particularly in rural areas should be encouraged to provide housing at a reduced rate with preference for housing subsidy priorities.

The national scourge of homeless veterans, many of them with mental health issues, must end as promised by Secretary Shinseki. Additionally, student veterans who often have difficulty fitting in with the more traditional student population, and drop out of higher education and training at a greater rate than non-veterans, must continue to be provided with adequate and timely financial support and counseling services.

Continue federal programs which support veteran employment and hiring preference, and encourage state and local governments to continue and or adopt preferential hiring practices for veterans - to include National Guard and Reserve who have not been activated for federal service and are not considered veterans.

VI. Summary

Barriers to treatment of veteran mental health issues can be overcome and recovery is possible. Some barriers can be resolved easily, while others will take much time and effort to resolve. Some barriers will likely never be completely resolved, but all of us must keep trying to end the epidemic of veteran suicide that has taken more lives than those killed in Vietnam and continues at the unacceptable rate of almost one each hour.

NAMI will continue to play a vital role in increasing awareness of the critical link between treatment, successful re-integration, and living a productive life. We agree that the long-term societal costs of unmet veterans' mental health needs will be significant - especially, if the government does not act now.

The National Council for Behavioral Health's November 2011 Report on Meeting the Behavioral Health Needs of Veterans of Operation Enduring Freedom and Operation Iraqi Freedom summarizes best what specific action needs to be taken and is enclosed:

To fulfill our national obligation, we need a mandate and the funding to deliver proper outreach and assessment techniques and evidence-based treatments for our veterans. This effort must occur where veterans receive care – the behavioral health care systems of the Department of Defense (DOD), Department of Veterans Affairs (VA), and community-based care including the nation's system of Community Behavioral Health Centers. Accomplishing this will save lives and money.

Thank you for affording me this opportunity to testify before you today.

Enclosures:

1. NAMI Family-to-Family/Veterans Health Administration (VHA) MOU Project
2. NAMI Parity for Patriots Report
3. Communication to a community fee basis provider from the VA
4. Provider impression of deteriorating relationship with VA affecting patient care
5. White House Talking Points