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

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED THIRTEENTH CONGRESS

FIRST SESSION

MARCH 20, 2013

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MARCH 20, 2013

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

WEDNESDAY, MARCH 20, 2013

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10 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 HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

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 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. What we have learned—in a variety of ways—is that the costs of those wars has been very, very high.

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

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 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 meeting the needs of our veterans and where we go from here.

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

But clearly, with all of the accomplishments, much, much more must be done because this is an area that is impacting 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 long as 60 days for an evaluation. In the real world, if somebody is struggling, if somebody is hurting, drinking too much or doing drugs, clearly waiting 60 days is not acceptable. Therefore, this was a deeply troubling finding.

A year after those negative findings, it appears that 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. That is an issue we are going to explore this morning with VA.

The point here is that 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 2 months is absolutely unacceptable.

One issue that I remain very concerned about, both as Chairman of this Committee and as a Member of the Health and Education Committee, is the shortage that we have of mental health providers. This is not just a veterans' issue, it is an issue for our entire Nation.

The 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 3,000 mental health professionals and administrative support including more than 1,100 of these new mental health conditions. This is good progress toward teaching VA's goal.

However, let me emphasize this point, I am very concerned that VA has hired only 47 clinicians in the last 2 months. 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 that they are of the quality 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 2 months. Frankly, I do not see how that is possible and I want to talk to VA about how they are moving forward in this area.

So, the goal is not just rushing out, bringing people into the system. We must make sure they are of good quality so we can get people into the system as rapidly as we can.

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 these clinicians are doing what they are trained to do and that these therapies are 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 of mental health diagnoses, such as PTSD. They are also critical in addressing the mental health care needs of patients admitted to the hospital for physical injuries.

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 and in group settings. Veterans often feel very comfortable in that nonbureaucratic environment.

Additionally, 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. VA has done an excellent job, by the way, with telehealth in general.

It is critical that VA provides these various options of care. We must ensure not only that these options remain available but veterans know about them. In fact, the next hearing 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 doesn't do anyone any good at all.

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

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

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 understand, one which this Committee will deal with, is that a soldier is a soldier from the first day of enlistment to his or her last day on earth. When that veteran is in the VA, that continuity of care is extremely important.

While we often think of the military and VA as providers of mental health care for our servicemembers and veterans, community organizations like the ones that will testify here today play a 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. 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 homestate 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 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 of thousands of men and women who put their lives on the line to defend this country. Whether it is PTSD, Traumatic Brain Injury, or 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 mic over to Senator Burr.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

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 any 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 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 outcomes. We are hung up with how many people can we hire, how much space can we get, do 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, confirming 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 assure you we will get the same outcomes—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, and 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 to 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.

STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA

Senator TESTER. I have just got to say a few words, Ranking Member Burr. First I want to thank the Chairman and you for having 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 radar; but we have run from it for decades.

We ran from it in Vietnam, and now we are trying to address it. I just want to say that I think the folks that are working at the VA need to think outside the box and we do need to get more medical professionals on the ground, especially in rural places like Montana, which I am a little bit biased about.

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 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.

STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEVADA

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

Chairman SANDERS. Thank you very much.

Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA

Senator ISAKSON. I may submit a statement for the record.

Chairman SANDERS. Thank you, Senator Isakson.

Let me introduce our 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 close out the panel with Dr. Barbara Van Dahlen, Founder and President of Give an Hour.

So, I just thank you again 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, Jenson, Stewart, Ross, Rios, Markel, Rocha, and Clay Hunt.

In 2008, my unit redeployed home to the U.S. after a long and bloody tour in Helmond Valley, Afghanistan. In 7 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 4 years; names of the men we have lost to suicide while pursuing 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 uses 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 testify here 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, NE. 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 12 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, NE. 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 ravaged 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.

Last, 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 servicemembers 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, TX, 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 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:]

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

McShan, Jenson, Stewart, Ross, Rios, Markel, Rocha * * * Clay Hunt.

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keep our Nation's warriors from killing themselves here at home. But, simple Marine Sergeant, I'm going to argue that it is much simpler.

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A few short months later, that 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 just aren't 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 war inevitably compromises. For some this is the most difficult part because the mission may no longer feel noble, the threat no longer imminent.

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Earlier I mentioned community, and community cannot be undervalued. Today, servicemembers come together from communities all across the country and form tight-knit units. But when they leave the military, they go back to their home towns, losing that connection—that brotherhood—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 Clay had lived within 10 miles of three Marines we'd served with in Iraq—Clay, in fact, had not been alone. Frustrated with the VA and 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 to the vets they already know, but more importantly it helps them discover and communicate with the unseen network of veterans around them, unlocking a peer support network that we all know is critical to stemming the tide of veteran suicide. It also serves as a unifying platform for veteran service organizations, helping numerous nonprofits reach veterans in order to provide critical transition services. POS REP is an innovative attempt to solve an age-old problem.

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, such as POS REP.

In closing, it is my humble opinion that at the root of this issue lays three core tenants: purpose, community and identity. Team Rubicon is working to provide all

three of those through a new, exciting mission in disaster response, and POS REP is looking to create offline communities through innovative online discovery tools. In order for us to adequately address what has become a national epidemic—one in which 22 veterans a day are successfully killing themselves—we must have the public and private sectors come together to propose and execute bold, innovative solutions. At this stage inaction is not an option.

Thank you for your time, and I'd be happy to answer your questions.

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. Since 2007, my team has conducted needs assessment surveys with over 4,300 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 OEF/OIF veterans. We now also assist servicemembers 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 6-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 servicemember. 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 servicemember 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 servicemembers. Our outreach specialists often meet with CBOC counselors and the servicemembers 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 servicemember 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:]

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

Chairman Sanders and Members of the Committee, Thank you for your invitation to discuss the Vermont Veterans Outreach Program. My name is Andre Wing, I have been the Vermont Veterans Outreach team leader since April 2010. In that time, my team has conducted "needs asssement"surveys with over 4300 veterans to discuss their needs and the needs of their families.

Before I begin, let me say that my testimony today reflects my personal views and does not necessarily reflect the views of the Army, the Department of Defense, or the Administration.

The Vermont Veterans Outreach Program has evolved and expanded beyond its original 2007 mandate of helping OIF/OEF servicemembers. We now also assist servicemembers 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' home 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 VAMC 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 specialists 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 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 improve 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, VT 211, and our own 24/7 phone service. 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 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 flew him to Vermont where we picked him up at the airport, brought him to the VAMC in WRJ, where he was enrolled in the 6 week Intensive Outpatient Program. My team also helped with an issue with a disability claim. The veteran completed the program successfully and is a contributing member of his community, now 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, Chittenden County.

For that reason, our Outreach Specialists transports our veterans to the White River Junction VA Medical Center, or the CBOCs throughout Vermont for their first couple of visits. While this "windshield time" reduced the time available to contact other veterans, Outreach Team members have noted that this drive time is, in reality, a short decompression period for the servicemember. Faced with the decision between helping a soldier right in front of them and 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 servicemember and/or their family is a very important component of the program. In the past many veterans would miss their appointments or didn't bother enrolling because they could not afford the travel and/or didn't have transportation and thereby jeopardizing their health or access to benefits.

A critical piece of our success is our follow-up with the servicemembers .Our outreach specialists often meet with CBOC counselors and the servicemember to go over the follow-up plan needed for the veteran. It might be to make sure they show

up for their follow up appointments at the VA, or getting them linked with a community partner such as Veterans, Inc. for financial help or with ESGR/DOL for employment issues. The bottom line is we establish a relationship with these veterans and their families and we have the resources, skills and 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 servicemember 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.

Chairman SANDERS. Thank you, Andre.

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

Kim, thanks so much for 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 3,000 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 home from the 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 written testimony that presents many cases with family members where they have shared information around this issue. They have come to us seeking support in coping with the suicide of a recent veteran. It is our hope that by sharing this information, services for veterans can be improved and lives can be saved.

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 a 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 like 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 servicemembers 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 2 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 in tragedy 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 to 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 terms "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 of urgent care into care more quickly.

Peer support can play a vital role in helping veterans access their benefits and support 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 1, provide more funding for peer-based programs to assist veterans through organizations such as Vets4Warriors and VA Vet Centers.

Number 2, assign peer advocates at first contact to navigate the system, support the veteran, and connect with support systems.

Number 3, 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, 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:]

PREPARED STATEMENT OF KIMBERLY RUOCCO, DIRECTOR OF SUICIDE POSTVENTION & SURVIVOR SUPPORT, TRAGEDY ASSISTANCE PROGRAM FOR SURVIVORS (TAPS)

EXECUTIVE SUMMARY

I. Introduction

Because of its role in caring for thousands of surviving families left behind by America's fallen military and recent veterans since 1994, the Tragedy Assistance Program for Survivors (TAPS) works extensively with bereaved military families, including those grieving a death by suicide. TAPS receives an average of at least two people per day seeking help and support in coping with the death by suicide of a servicemember, Guard member, activated Reserves member, or recent veteran.

In this testimony, Marine Corps widow Kim Ruocco, an expert in suicide postvention programs, shares critical information reported by surviving families of a suicide loss to TAPS and offers insights on improving the quality of mental health care within the VA system. The testimony discusses insights and observations gained from surviving families of recent veterans who died by suicide and examines the following:

(1) how extensive wait times and paperwork for initial mental health screenings, referrals to specialists, and complex disability ratings interfere with the mental health and well-being of our veterans;

(2) the value of peer-based support programs in filling gaps in mental health care; and

(3) how national non-governmental organizations link veterans to mental health services.

II. Recommendations for Improvement

(1) Provide continued funding for peer-based support programs to assist veterans through organizations such as Vet4Warriors and through the VA Vet Centers.

(2) Create incentive systems within the VA and the Vet Centers to encourage peer-support program managers and counseling staff, especially those who are veterans, to continue working at the VA and in the Vet Center.

(3) Assign an advocate at first contact, preferably a peer, to provide support to the veteran and help navigate the system while waiting for the first appointment.

(4) Decrease the amount of paperwork and "red tape" involved in getting veterans to their first mental health appointment.

(5) Create and implement a national public awareness campaign to support VA and Vet Center mental health staff recruitment focused on the rewards of working with veterans and issue a call to national service for mental health workers.

(6) Create and implement a national public awareness campaign that emphasizes the messages that veterans who are struggling can get help and that treatment can work. Suicide is not inevitable.

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE: I am pleased to have the opportunity to submit this testimony on behalf of the Tragedy Assistance Program for Survivors (TAPS).

TAPS is the national organization providing compassionate care for the families of America's fallen military heroes. TAPS provides peer-based emotional support, grief and trauma resources, grief seminars and retreats for adults, 'Good Grief Camps' for children, case work assistance, connections to community-based care, and a 24/7 resource and information helpline for all who have been affected by a death in the Armed Forces. Services are provided to families at no cost to them. We do all of this without financial support from the Department of Defense. TAPS is funded by the generosity of the American people.

TAPS was founded in 1994 by Bonnie Carroll following the death of her husband in a military plane crash in Alaska in 1992. Since then, TAPS has offered comfort and care to more than 40,000 bereaved surviving family members. The journey through grief following a military or veteran death can be isolating and the long-term impact of grief is often not understood in our society today. On average, it

takes a person experiencing a traumatic loss five to seven years to reach his or her "new normal."

TAPS has extensive contact with the surviving families of America's fallen military servicemembers and recent veterans. TAPS receives an average of 13 newly bereaved survivors per day through our protocols with the Services' casualty officers and direct contact from those who are grieving the death of someone who died while serving the Armed Forces or in recent veteran status.

In 2012, 4,807 new survivors came to TAPS for comfort and care. This means that TAPS received in 2012, 13 new people each day seeking care and support in coping with the death of a servicemember or recent veteran. It should be noted that on average, TAPS received 7 new survivors on average per day in 2011. The number of grieving survivors turning to TAPS in 2012 seeking help and support increased by 46% over the previous year.

Thirty percent of the survivors coming to TAPS were grieving the death of a loved one in combat or in hostile action. Twelve percent were grieving the death of a loved one by sudden illness, and nine percent lost a loved one in an auto accident. Six percent lost a loved one in an accident and four percent were grieving someone who died in an aviation accident (typically a military training accident). Three percent were grieving the death of a loved one by homicide. One percent were grieving a death in a non-hostile incident, 0.7 percent lost a loved one in a noncombat incident, and 0.3 percent to friendly-fire.

Nineteen percent of the survivors coming to TAPS in 2012 were grieving the death of a loved one who died by suicide or in a suspected suicide under investigation. At least two new survivors per day on average contact TAPS for support who are grieving the death by suicide of a servicemember or recent veteran. Fifteen percent of survivors reported a cause of death as "unknown" for their servicemember which often means a death is under investigation. Many of these "unknown" deaths are later ruled suicides, so the true number of families coming into TAPS grieving a death by suicide is actually closer to 30% or about four per day.

In 2012, approximately sixty-two percent of the family members coming to TAPS for support were grieving the death of a loved one who had served in the Army. Sixteen percent of the families were grieving a loved one who had served in the Marine Corps. Thirteen percent were grieving a loved one who had served in the Navy, six percent were grieving the death of someone who had served in the Air Force, and three percent were grieving the death of someone who served in the Coast Guard or another area.

TAPS also engages in suicide prevention programs for its survivors. As the Wall Street Journal reported in December 2012 in a front-page story, there have been a handful of suicides among surviving families of the fallen where a family has lost one family member to war, and then a second family member to suicide.

Nearly all of the bereaved who come to TAPS seeking care and support are grieving the traumatic, unexpected, and often violent death of a loved one who served in the military or recently left military service. Many of these families grieving a suicide have experienced the additional trauma of finding their loved ones body or being present when they died.

Suicide risk also goes up for the families left behind by our veterans and servicemembers who die by suicide. While it is important to note that suicide is never inevitable, family members grieving a suicide loss are two to five times more likely to die by suicide themselves.

It's very important that organizations undertaking work with traumatized populations like TAPS does have in place good suicide prevention protocols that ensure safety and support help-seeking. On average, our 24/7 resource and information helpline receives at least one contact from a survivor in danger of imminent self-harm per week. Our online peer based support groups run 24/7 and are monitored by peer professionals in case a survivor posts something concerning. If a survivor is in crisis and appears to be in danger of self-harm, a TAPS staff member can immediately reach out to this survivor to assess risk and connect with support.

Additionally, the TAPS helpline occasionally receives calls from servicemembers or recent veterans who are struggling and need care. We have built a comprehensive support network that we can warmly connect these servicemembers and recent veterans to, including chaplains, Vet Centers and the National Veterans crisis line (NVCL).

My name is Kimberly Ruocco. I am the national director of suicide postvention and survivor support programs at TAPS. I am also the surviving widow of U.S. Marine Corps Major John Ruocco. My husband was a decorated Cobra helicopter pilot who proudly served his country in the Marine Corps for fifteen years. He died by suicide in 2005 while preparing for his second combat deployment to Iraq.

I first came to TAPS in 2005 with my 8 and 10-year-old boys, Billy and Joey. I was seeking help and support for my children and myself, in coping with the death of my husband. He was my best friend and we had been together for 23 years. My family was devastated and I did not know how to begin to heal. The challenges were overwhelming. How do you tell two young boys that their Dad, their coach, their hero made it home safely from combat and then took his own life? How would I keep my husband's death from defining his entire life? How would I keep my children from seeing suicide as an option? How would I keep my children from thinking that their Dad had chosen to leave them? These and other questions propelled me on a journey to heal my family and gather information and skills to help others and prevent suicide.

I have a master's degree in clinical social work from Boston University and I used my education and experience to come to help me understand how this could happen to my family. I read whatever I could find on the subject, I talked to experts in the field and spoke to survivors of suicide attempts. I reflected on our lives and worked to assemble a timeline of how my husband's struggles developed and what could have been done to save his life.

I came to understand that my husband was suffering from untreated post-traumatic stress injuries and depression. The military culture and his sense of who he was and who he was supposed to be conflicted with asking for help. On the day he died, he was having difficulty functioning in all areas of his life and he felt that this was all his fault. He had been resilient for years, fighting off his injuries and illness by exercising, praying, and giving back to his country, community and family. On the day he died, his resilience had been exhausted and he felt hopeless and helpless. He may have thought of the words he lived by, such as "death before dishonor," "you are only as strong as your weakest link," and of course "Semper Fidelis." He saw himself as the weakest link and the problem. He was supposed to re-deploy in just a month and due to his struggles he was no longer able to fly his aircraft. He worried that he was letting everyone down, or worse, that he would get someone killed. As a Marine, he was used to making life and death decisions in a split second. He was a problem solver. He was fiercely loyal and cared for his Marines more than himself. I believe that in that moment of intense emotional pain and cognitive constriction he killed himself thinking that the world would be better off without him. How wrong he was.

With the support and assistance of TAPS and their trained mentors at the Good Grief Camp, my children and I began to heal and create a healthy new life. Over time, more families came to TAPS grieving deaths by suicide. I began to work with TAPS to create a program specifically focused on helping suicide survivors grieving the death of a servicemember or a recent veteran. We applied the best practices in peer-based emotional support and created a support program at TAPS to address the specific needs of military and recent veteran families grieving a death by suicide. By 2007, we were receiving two to three suicide survivors per week. By 2009, we were receiving, on average, one or two suicide survivors per day. Now, the average is more than two people per day who are grieving the death of a loved one by suicide. It should be noted that there may be multiple people grieving each death as TAPS provides care to parents, siblings, spouses, children and all others who are grieving a death in the Armed Forces, and multiple family members often come to TAPS hand-in-hand seeking help.

In 2012, TAPS sadly welcomed 931 people seeking care and support grieving the death by suicide of a loved one who served in the military. However, the true number is actually closer to thirty percent of our total caseload, or around 1,400 to 1,500 people, because so many families coming to TAPS tell us the cause of death was "unknown," either because they are in denial or feel shame to say that suicide is suspected, or because the death is under investigation and they are waiting for the outcome of that investigation. Many of these "unknown" deaths are later ruled suicides.

The war in Iraq is now over and the war in Afghanistan is drawing down, but the number of families coming to TAPS for bereavement support continues to increase. While these wars had some of the lowest casualty rates in our country's military combat history, there is no official count of the impact on families left. Nor is there an accurate accounting of the impact that many years at a high state of readiness has left on our troops. At TAPS we also see increasing numbers of bereaved military families and the families of recent veterans, who are grieving deaths by suicide or accidental deaths following high risk and self-destructive behavior. These "accidents" include high-speed head on vehicle or motorcycle collisions with no signs of braking. We are also beginning to see more families grieving deaths from sudden illnesses linked to toxic exposure while deployed.

Recently we have seen at TAPS increasing numbers of veterans who die by suicide within a couple of months or years of being discharged from active duty service in the military. It is this population that gives insights into the struggles that our veterans encounter in trying to reintegrate into their communities. It also highlights weaknesses and gaps in our system. While there are many veterans who receive outstanding care and thrive, TAPS sees those families who could not navigate the complex challenges of reintegration and lost hope. These families come to us heavily grieving and asking the question I asked myself, why?

One of the ways some families grieving a suicide cope with their loss is by sharing with each other what happened to their loved one. I have heard many families recount their narratives of what happened to their loved ones over the years. This desire and need to share is part of grieving and is part of the processing that many survivors do to cope with their grief. In many cases, I have seen surviving families gather voluminous amounts of information, interview people who were close to their loved ones, and work very hard to answer a simple question, "why?" It's a very legitimate question for our families to ask. They wonder how their loved ones reached the point of dying by suicide. Answering that question can take families years. Many of them do not really begin addressing their grief until after they have completed this information-gathering and fact-finding process.

I wish to submit our testimony with information gathered by our surviving families in the wake of a suicide as part of their search for clues and inquiries made to understand what happened to their loved one. Families who come to TAPS, are traumatically bereaved after a death. Our testimony does not offer success stories of lives saved and deaths by suicide prevented, although many exist. Our families speak from a place of loss and often can point out lapses in care and areas for improvement so future deaths can be prevented and lives saved. Our testimony should be viewed with this perspective in mind.

The focus of this hearing is on timely access to high-quality mental health care. We believe that the experiences of our surviving families and the information that they have gathered about their loved ones and their treatment prior to their tragic deaths, can inform the Committee's discussions about prevention efforts.

In order to properly explain the challenges that these military families and their loved one faced, it is important to first discuss what this journey can look like for a veteran who dies by suicide. There are many variations to this story but there are common threads we hear within them. Many of the families who come to TAPS grieving the death by suicide of a recent veteran describe a similar scenario of a servicemember who is discharged with the hope of making it in civilian life, but instead face obstacles and frustrations that leave them feeling unappreciated and forgotten. They struggle to succeed in all areas of their lives—finding difficulty getting jobs, going back to school, connecting with civilian peers, and communicating with their significant others. If they suffer from illness or injury related to their service, then this complicates matters further. If they do manage to get a job, often concentration problems, sleep deprivation and anxiety can make it difficult to maintain employment. They may begin school to try to better themselves, but the combination of fighting for reimbursement for classes and struggling with emotional and physical challenges interferes with their ability to succeed.

At some point, the veteran may decide to go to the VA because he or she is struggling and needs help. Often this happens after a long battle and the servicemember's life is already falling apart and he or she is very sick. The servicemember then contacts the VA looking for help with his or her symptoms, whether it is addiction, anxiety, depression, uncontrollable outbursts of rage, etc. This is a critical time for the veteran. He or she may have shame about asking for help. He or she may feel disconnected from his or her unit and military peers. He or she has lost a sense of purpose and identity. He or she may have a relationship breakup and/or legal and financial issues due to their struggles. Very often the veteran's suffering is complicated with combinations of physical and emotional pain including issues like Traumatic Brain Injury, post-traumatic stress, depression, moral injury, and survivor guilt. These issues become the veteran's own personal barriers to care. In this population we see avoidance, anxiety and trouble concentrating. Symptoms like panic attacks, flashbacks and hyper-vigilance among this population of veterans are often described to us by our surviving families.

These symptoms run counterintuitive to navigating a complex system of paperwork, crowded waiting rooms, extended wait times for appointments, referrals and disability ratings. The veteran enters this system tentatively with trepidation and some fear. The veteran is barely holding on. The veteran may feel like people do not understand him and that the public does not appreciate what he or she has sacrificed for this country. He or she may feel that his or her service did not matter or that they are now unprepared for the civilian world. He or she may feel as

though he or she is losing everything that he or she has worked so hard for. When the veteran asks for help, he or she is desperate, and may be thinking of killing himself or herself because he or she is losing hope that things will get better. This is the composite profile of the veteran who dies by suicide, who initially approaches the VA for help.

At this point, the veteran and his or her family need immediate, comprehensive and quality care. One widow said to me "It was like finally making it to the people with the water after walking for days in the desert without it. I wanted them to wrap their arms around us and say "we've got you now" and give us water and clothes and instruction on how to proceed. Instead, while we could see them, we couldn't get to them, and when we finally got to them, they said "you can get water in two months" and turned us away to wonder in the wilderness once again.

In my testimony I will discuss: (1) how extensive wait time and bureaucracy for initial mental health screenings, referrals to specialists and complex disability ratings interfere with the mental health and well-being of our veterans; (2) discuss the value of peer based support in filling gaps; (3) highlight how national non-governmental organizations can link veterans to mental health services; and (4) offer recommendations for improvement.

It is important to state that our families are in every state of this country and therefore are seeking services in many different VA settings. I encountered many issues that were specific to only one clinic or location, but I attempted to gather those examples that demonstrated a common issue or struggle. The following stories were gathered for the purpose of understanding some of the contributing factors to the death by suicide of our veterans. These families are presently under the care of TAPS.

A young Marine was discharged from active duty eighteen months before he died by suicide in August 2011. He did not want to leave the Marine Corp but while deployed to Iraq he suffered from multiple physical and emotional issues that were so severe that he was sent home half-way through his deployment. Back in the states he continued to struggle and was eventually "medical boarded out." He had a young family with a fiancé and a little daughter. His fiancé and his parents tell us that he had a lot of difficulty "making it" when he got out. He had dizzy spells and anxiety attacks. He had difficulty sleeping and would wake up in a cold sweat with nightmares. His fiancé states that she tried to talk to him about his nightmares and all he would say is "I've never seen so much blood." She asked "in Iraq?" and he said "yes" but he would not elaborate.

She encouraged him to go to counseling and he would say "we don't do that, I need to suck it up." He also expressed fear about what would happen to him if he went for help. He worried, "What would they do?" He questioned why he needed to go while his peers didn't seem to need help and they had stayed for the whole deployment. He felt he was weak and should be able to handle it. In the meantime he couldn't get a job, his finances were suffering and his family was depending on him. He went to his parents for financial help because he was six months behind on his truck payment. He became more and more depressed and had angry outbursts.

His fiancé finally convinced him to call the VA. He called and asked for an appointment stating that his life was falling apart and he was depressed and anxious. The first appointment was two months away. He got a mental health evaluation and a referral to a psychiatrist. His fiancé states that "it took a long time to see him." He saw a psychiatrist approximately two months before his death. He was put on medications and according to his family was not offered counseling or peer-based support and he also did not have a follow up appointment. His fiancé states that he did not improve on the medication he was placed on. In fact, he complained a lot about how it made him feel. The night before he killed himself he called his Dad and said that the VA "put him on medications" and he just "felt worse." He stated that he just wanted to talk to someone else who had been through the same thing. His fiancé was six weeks pregnant when he died. She has been denied survivor benefits for his children because there is not enough proof that his death was connected to his military service.

The parents of another Marine veteran came to us for support after their son died by suicide in November 2012. Their son served eight years in the Marine Corps and was honorably discharged. He had a one year deployment as a diesel mechanic. According to his parents he had a successful career in the Marines but had a lot of difficulty transitioning in to the community. His parents state that he was diagnosed with post-traumatic stress and Traumatic Brain Injury before he was discharged from the military. He was given a number and told to contact the VA. His Dad says that his son had a lot of trouble "getting on his feet" and said that his son had trouble concentrating, experienced difficulty sleeping, and had a lot of anx-

iety. He applied for a number of jobs but could not get one. He enrolled in school but the paperwork for the tuition was daunting and seemed impossible for him to complete. His classes were canceled due to non-payment. His parents finally convinced him to go to the VA and ask for help. He was given an appointment for the next month. At his appointment he was given referrals for a specialist for the Traumatic Brain Injury and depression but the specialist was located an hour and a half from where he lived and it was months before the first appointment could be scheduled. His parents feel that their son lost hope and felt disconnected from his Marines. They state that they wished they knew more about how to help him and could have been involved in his treatment.

A wife of an Army veteran came to us for support after her husband died by suicide in December 2012. She stated that her husband had a one year deployment to Iraq and was "completely different when he returned." He separated from the Army in 2010 after the two of them decided it would be better for their family. One week after his discharge she went looking for him in the house and found him on their deck with a gun and "a crazy look in his eyes." She called his name but he would not respond. She became extremely frightened and called the police. The police responded and he was charged with "felony menacing." After meeting with the lawyer, the lawyer suggested that he may have post-traumatic stress and should go to the VA. His wife stated that they contacted the VA and were given an appointment for one month out. She claims that days before the appointment the VA called and rescheduled for another month away. She states that he attended the appointment and was offered medication which he refused to take. After several attempts, she was able to get him into counseling. She claims that the time and paperwork it took to get to the counseling was "overwhelming." For about a year her husband went to counseling and he seemed to be getting better. She states that she wishes the counseling were more often and included her and maybe a support group. She claims that due to the wait for appointments and cancellations and rescheduling he only went to five appointments in a year. Six months before his death his counselor left the VA. His wife says that the appointment was canceled with no follow up. His wife claims that they were under a lot of stress at the time with financial, legal and relationship issues. She was worried about him and feared that things were going to get worse. She states that her husband was suffering with anxiety and depression. She claims that in the first week of December 2012 her husband called the VA and said he needed an appointment. He was told the first available appointment was January 18th. On December 29th this young widow says she and her husband had a good evening. They talked about their future and he moved the furniture out of the living room so that they could dance together. After dancing he went to bed first and she went to join him about an hour later. When she got into bed she saw that "crazy look in his eyes" and noticed that he had a gun. Before she could react he shot himself in the head and died instantly. This widow tells us that she wishes that the care was more consistent and focused more on why he was acting this way instead of treating his symptoms. She also wishes that they could have worked on his problems together as a couple in a consistent and comprehensive manner.

A surviving father who came to TAPS and was grieving the death of his veteran son by suicide, who is himself a veteran, and he talked with me about his and his son's experiences accessing care through the VA. I think this case illustrates some of the challenges in providing quality mental healthcare. The stressor of his son's suicide was so severe, that the father's own service-connected post-traumatic stress re-emerged. The father went to the VA seeking help and waited for four months to get a mental health evaluation. After the evaluation, he saw a counselor once a week and things seemed to stabilize for him. But every few months, the counselor would change and he would have to start all over again. The breaking of the bond with the counselor has hampered his healing. He became depressed. He requested to see a VA psychiatrist six months ago, and is still waiting for an appointment. He tells TAPS that he feels abandoned. This father's son had been medically discharged from the Army at Fort Hood after two combat deployments overseas where he saw two of his friends blown up. All that was left of one of his friends was his glove, which he photographed and carried on a photo in his wallet. The young soldier attempted suicide immediately after his discharge from the military. His veteran father and his mother took him to the VA after the suicide attempt seeking care and help. He received inpatient care and outpatient treatment but there were wait times to get him appointments and into care. While the care for the young soldier addressed some of his mental health needs, his father felt the care never addressed the loss of his friends and the grief and pain he was carrying over their deaths in combat. The young veteran lost his job and a significant relationship, and then the young veteran died by suicide fourteen months ago. His father began to cry when he shared with us that he took in two neighborhood teens that had lost

their parents. He mentored them and convinced them to join the military. One of them just returned to his home because he is getting divorced and is suffering from depression and lost his job. He is attempting to get him "in at the VA."

In the past five years, significant expansion of specific services to benefit returning Veterans has occurred at the VA. These services include: VA Vet Centers that are staffed by clinicians who are veterans themselves and Suicide Prevention Coordinators as well as the peer partners program and clinic specifically for issues such as post-traumatic stress.

After talking to these families and many more, it became clear that there are many promising programs and outstanding clinicians at the VA, but we must do something to ensure that our veterans can get the kind of comprehensive quality care they need in a timely fashion. We must also look at the kind of care we are giving for the type of injuries and illnesses they are suffering from. We must not only address the symptoms but provide care that helps heal the cause of the symptoms. I have spoken at many military bases to thousands of troops. I have never left one of those presentations without a Soldier, Marine, Airman or Sailor coming to me in tears and saying "I just want to talk to someone who has been there, who knows what this is like."

We have found at TAPS that peer-to-peer support plays a key role in helping traumatized families find healing and comfort. We also find that peer-to-peer contact opens up lines of communication and helps families better access the support and services they need. Similarly, veterans also benefit from peer-to-peer connections.

We believe that peer-based support can help maintain an umbrella of care for our veterans that is critically needed. We believe that peer-based support can provide a needed safety net for veterans who may be waiting for appointments or waiting on benefits.

VA Vet Center treatment can be successful when it is grounded in a veteran-connection that gets established between a veteran clinician and the veterans who use the service. TAPS is very familiar with the services offered by the VA's Vet Centers. Many of our survivors are eligible for bereavement counseling through the Vet Centers and find these services have proven to be a helpful part of their journey toward healing.

Peer support can play a powerful and transformative role when coupled with treatment. The VA has begun to implement many peer-based programs and veterans tell me that this has been invaluable in helping them "keep it together" especially while waiting or in between appointments. The "peer partners program" is one such program. I work closely with one of these peers who has made it his life's work to advocate and support veterans. He became a trained peer partner through the VA and is available whenever a veteran is in need.

He recently told me about a young veteran who was discharged from active duty and was suffering from severe post-traumatic stress and was self-medicating with alcohol. His life was spiraling out of control, he couldn't find a job, he lost his home, and his wife left him. His post-traumatic stress symptoms kept him from going to the VA because of the crowds and his avoidance and anxiety. He made one attempt to get care and became overwhelmed with the paperwork and the wait. The peer partner was called because another veteran thought this veteran was suicidal. The peer partner was able to escort him to the VA, help him fill out the paperwork and secure an appointment which was scheduled for a date in three months. The peer partner then took him to a home for homeless veterans and got him a room. While waiting for his VA appointment, the peer partner was able to get the veteran into free counseling at the Andrews center, a private mental health center that got a grant from the State of Texas to provide free counseling to veterans. This veteran now had weekly counseling appointments, peer-based support groups and a place to live. Six months later this veteran was enrolled in a specialized post-traumatic stress clinic at the VA and was doing very well. What I love most about this story is the healing and sense of purpose the peer partner found in helping another vet.

There are limitations to the VA Vet Centers which can be addressed. Their capacity is stretched for staffing, and there are not enough centers, particularly in geographically challenging areas in the Mid-West and West. I know of a surviving sibling who drives over one hundred miles roundtrip to see her Vet Center counselor for bereavement counseling support and across a state line because that is the closest location to her home. In addition, the prioritization given to deployed or combat veterans limits the support available at the Vet Centers for the non-combat veterans in crisis who may also need access to care.

Unfortunately, staff turnovers at the Vet Centers have often impacted peer-based support programs, like veteran support groups and support groups for their families. A family of a veteran who died by suicide shared with TAPS that the veteran was

in despair after his peer-based support group at the Vet Center stopped meeting because the Vet Center did not have anyone on staff to run it. "I miss going to my group," is what the veteran said to his family. His family was also missing the peer support they found at the Vet Center in a support group that was structured for their needs. Sadly, the veteran died by suicide.

Because peer support can play such an important role in helping veterans we need to look at other ways it can be offered. Much synergy and better service could be provided by VA Vet Centers if there was a direct connection between the VA Vet Centers with a veteran peer support line such as Vets4Warriors where Vets4Warriors could bridge the gap in capacity (before and between appointments) and geographic access.

Vets4Warriors, funded by the Department of Defense as a 24/7 Veteran peer support help line, has fielded more than 55,000 incoming and outgoing calls, chats and emails since Dec 2011. The majority of callers, more than 63%, are routine callers who are looking to connect with another veteran and get information about VA benefits and entitlements or employment/financial/legal/counseling resources. They are not in crisis and can benefit from peer-based support. All callers receive follow up calls if they give permission. Vets4Warrriors has also made initial calls to the soldiers in the Individual Ready Reserve (IRR) with great success (70% of those contacted wanted follow up).

Vets4Warriors has an established, formal referral relationship with the National Veterans Crisis Line (NVCL) where warm transfers are made for the small (less than 2%) number of callers in crisis. The partnership between the NVCL and Vets4Warriors has yielded benefits for the veterans utilizing both call lines in that the NVCL transfers all non-crisis or non-emergent callers that just want to connect with a veteran peer. Additionally, Vets4Warriors has a unique capability, because of the follow up provided to callers to further support the NVCL with follow up calls to those veterans who only called the NVCL and were at risk.

Many other amazing non-profit organizations have also emerged to fill these gaps in service. One such organization is "Give an Hour." This organization, founded by Dr. Barbara Van Dahlan, provides free mental health care services to US military personnel and families affected by the current conflicts in Iraq and Afghanistan.

Thank you for the opportunity to submit this testimony on behalf of the Tragedy Assistance Program for Survivors (TAPS).

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 used 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 post traumatic 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:]

PREPARED STATEMENT OF LTC KENNY ALLRED, U.S. ARMY (RET.), CHAIR, VETERANS AND MILITARY COUNCIL, THE NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

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 a.m. 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 toward 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 decisionmaking 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.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO KENNY ALLRED, LTC, USA (RET.), VETERANS AND MILITARY COUNCIL CHAIR, NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

Question 1. Your testimony recommends including Mental Health First Aid in current combat lifesaver training. Many of us on this Committee are familiar with the immense benefits of this kind of training. As you may know, I recently joined Senator Begich, Senator Ayotte, and a bipartisan coalition of our colleagues (including Senator Tester, who also sits on this Committee) in introducing the Mental Health First Aid Act of 2013 in the wake of the Newtown tragedy. This legislation provides resources for training programs to help people like school officials, law enforcement professionals, and emergency personnel identify, understand, and safely address crisis mental health situations. Though this legislation is not necessarily directed at programs for veterans, I believe it's an important step toward better understanding and addressing mental illness in our greater communities. Would you please expand on any current Mental Health First Aid efforts that you are aware of in the veterans and military communities, and explain the importance of this training for these groups?

Response. A large amount of training is occurring in the state of Missouri where our NAMI Veterans and Military Council (NVMC) First Vice President and Missouri State Representative—Lieutenant Commander Michael O'Neil Jones, Ph.D. (Ret.) is a senior instructor for Mental Health First Aid. Dr. Jones has taught more than 60 NAMI-facilitated courses since 2008; and is a staunch advocate for utilizing Mental Health First Aid training as a measure to improve continuum of care for active duty military, National Guard and Reserve personnel, andveterans and military families impacted by serious mental illness.

The Community Partnership of Southern Arizona (CPSA) adapted Mental Health First Aid for use with servicemembers, veterans and their families; and hosted a pilot training for a new, veteran/military-focused version of Mental Health First Aid earlier this year. Reportedly, the training was only the third of its kind ever offered in the U.S. The partnership included the Western Interstate Commission for Higher Education, the Arizona National Guard and its "Be Resilient" Program and the National Guard Bureau's Psychological Health Program. NAMI Southern Arizona supported CPSA's initiative by promoting the Mental Health First Aid training at NAMI signature programs such as Family to Family and other educational programs.

The importance of Mental Health First Aid training for veterans and military communities is very important. Mental Health First Aid covers the symptoms and risk factors associated with mental health crises situations—including suicidal thoughts and behaviors. Mental health intervention strategies conveyed in Mental Health First Aid training may help de-escalate crises and therefore stem the tide of the nearly 23 suicides per day that occur among veterans and active duty members.

Also, considering the fact that roughly 20 percent of soldiers returning from Iraq and Afghanistan develop PTSD, and many do not seek treatment for fear of being stigmatized, Mental Health First Aid training can serve as an intervention effort to minimize barriers to treatment for PTSD for OEF/OIF veterans. One of the training program's main goals is to erase the stigma associated with mental health illnesses. Furthermore, educating community members in Mental Health First Aid creates a healthy community perspective that is responsive to the needs of veterans and military families and supportive of their recovery.

Finally, community collaboration is essential to achieving truly integrated care. Given rising U.S. Department of Veterans Affairs (VA) medical care and benefits compensation costs, as well as limited states' resources for mental health services, Mental Health First Aid training provides opportunities for collaboration and is a great opportunity for the VA to engage community partners.

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, Ph.D., 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 8 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 Veterans' 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 servicemembers, 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 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:]

PREPARED STATEMENT OF BARBARA VAN DAHLEN, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR

Thank you for this opportunity to provide this testimony. It is an honor to appear before this Committee and I am proud to offer my assistance to those who serve our country.

As a psychologist and the Founder and President of Give an Hour™, a national nonprofit organization providing free mental health services to returning troops, their families, and their communities, I am well aware of the mental health issues that now confront the men, women, and families within our military and veterans community. As an American I share your commitment to ensure that all veterans in need of mental health services receive the care and treatment they deserve.

THE IMPACT OF NEARLY TWELVE YEARS OF WAR

Since September 11, 2001, more than 2.6 million servicemembers have deployed to Iraq or Afghanistan. This increased exposure to combat—and the associated stress—has taken its toll on those who have served. In addition, over a decade of war has put significant strain on our military families. And as we know, the failure

to provide effective mental health education, support, and treatment to military personnel, veterans, and their families will have dire consequences for generations to come.

Traumatic Brain Injury (TBI) and Post Traumatic Stress Disorder (PTSD)

The Congressional Research Service released two reports in February 2013 examining the number of military servicemembers diagnosed with mental health problems while serving on active duty. These reports included all servicemembers serving in Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND). From January 1, 2002, through August 20, 2012, 253,330 servicemembers were diagnosed with TBI. From January 2002 through December 12, 2012, 131,341 servicemembers in OEF/OIF/OND were diagnosed with Traumatic Brain Injury TBI.

The Department of Veterans Affairs examined the cumulative prevalence of PTSD in all OEF/OIF/OND veterans utilizing healthcare within its system. Among the 56% of OEF/OIF/OND veterans who utilize health benefits through the Department of Veterans Affairs the cumulative prevalence of PTSD was calculated to be 29%. This covered the period from 1st Quarter FY 2002 through 4th Quarter FY 2012.

As the Congressional Research report states, "From FY 2002 through FY 2012, 1.6 million OEF/OIF veterans (including members of the Reserve and National Guard) left active duty and became eligible for VA health care; by the end of FY 2012, 56% of them had enrolled and obtained VA health care."

The National Center for PTSD reported in 2010 that studies utilizing the "gold standard" in TBI diagnosis calculated the prevalence of TBI among OEF/OIF postdeployers to be 22.8%. Other studies using screening methods or other self-reporting methods such as mailed surveys found a prevalence ranging from 12% to 20%. In studies of OEF/OIF veterans, screening methods have yielded a prevalence of 20%.

Military Sexual Trauma (MST)

Military sexual trauma is sexual assault or repeated, threatening sexual harassment that occurs in the military. It can happen to men and women, and it can occur during peacetime, training, or war. According to the Department of Veterans Affairs, about 1 in 5 women and 1 in 100 men seen in Veterans Health Administration facilities respond "yes" when screened for MST.

MST is an experience, not a diagnosis or a mental health condition and as with other forms of trauma, there are a variety of reactions that veterans can have in response to MST. The type, severity, and duration of a veteran's difficulties vary based on factors such as whether he/she has a prior history of trauma, the types of responses from others he/she received at the time of the MST, and whether the MST happened once or was repeated over time. Many who have experienced sexual assault also develop PTSD, depression, and other mood disorders, as well as substance abuse following the assault.

Homelessness

The "Homeless Incidence and Risk Factors for Becoming Homeless in Veterans" study conducted by the VA reported the following factors about homelessness among Veterans.

1. OEF/OIF and women veterans experienced higher homeless incidences after military separation than their non—OEF/OIF and male counterparts.
2. Veterans who experienced homelessness after military separation were younger, enlisted with lower pay grades, and more likely to be diagnosed with mental health issues and/or TBI at the time of separation from active duty.
3. Homeless veterans who had served in OEF/OIF were more likely to be diagnosed with mental health issues prior to their first homeless episode than non—OEF/OIF homeless veterans.
4. In the majority of cases, newly homeless veterans diagnosed with mental health disorders and substance-related disorders were diagnosed before they became homeless.
5. Homeless veterans, especially women, received disproportionally higher MST-related treatment than non-homeless veterans.

Effect of War on Children

We have ample evidence of the impact of prolonged deployment and trauma-related stress on military families, particularly in spouses and children. There are approximately 700,000 military spouses and an additional 400,000 spouses of Reserve members. More than 700,000 children have experienced one or more parental deployment. Currently, about 220,000 children have a parent deployed. The cumulative impact of multiple deployments is associated with more emotional difficulties among military children and more mental health diagnoses among spouses.

A 2010 study reports an 11% increase in outpatient visits for behavioral health issues among a group of 3- to 8-year-old children of military parents and an increase of 18% in behavioral disorders and 19% in stress disorders when a parent was deployed. Children's reactions to a parent's deployment vary by child and, more broadly, by a child's developmental stage and age and the presence of any preexisting psychological or behavioral problems. Very young children may exhibit separation anxiety, temper tantrums, and changes in eating habits. School-age children may experience a decline in academic performance and have mood changes or physical complaints. Adolescents may present as angry and may act out, withdraw, and show signs of apathy. The mental health of the at-home parent is often a key factor affecting the child's distress level. Parents reporting clinically significant stress are more likely to have children identified as "high risk" for psychological and behavioral problems.

THE EFFECTS OF SEQUESTRATION

In addition to navigating the already challenging tasks associated with reintegration, our military families and veterans must now confront as a result of sequestration cuts to programs and services that were once available to them.

The Federal sequestration order cancels $85 billion in resources across the Federal Government for the remainder of FY 2013. Although the Department of Veteran Affairs has been exempted from these budget cuts, numerous other Federal programs supporting military servicemembers, veterans, and their families will be negatively affected by the sequester. Some of these consequences will be delayed; others are already being felt.

The Department of Defense (DOD) recently advised the service branches to suspend their distributions of the $560 million DOD tuition assistance program. According to the Associated Press, the Army, Air Force, Coast Guard, and Marine Corps have already suspended these benefits for the duration of FY 2013. Any students utilizing tuition assistance for the current semester will not lose these benefits for any courses already in progress. However, these benefits will be unavailable beginning next semester.

This cut interrupts and in some cases derails servicemembers' pursuit of higher education. Thousands of our returning troops take advantage of this tuition assistance program, which affords them up to $4,500 in tuition assistance per year, allowing them to take college courses that prepare them for jobs in the military or for positions as they transition to the civilian workforce. The army's utilization of this program in 2012 involved 201,000 soldiers, totaling $373 million of assistance for tuition. These setbacks will produce difficulties for a great many military families and veterans who cannot afford higher education without tuition assistance.

Sequestration also requires cuts to the Veterans Employment and Training Service (VETS), a Department of Labor job training program. About 55,000 veterans and 44,000 servicemembers will not receive employment and other transition assistance to help them enter the civilian job market. This is the same program that has been implemented to reduce the high unemployment rate among post-9/11 veterans (9.4%), as the veteran rate remains higher than the overall unemployment rate (7.7%).

In addition, the Pentagon plans to put most of its 800,000 civilian employees on unpaid leave for 22 days, cut ship and aircraft maintenance, and curtail training. Aside from the impact this may have on our military's readiness to fight, such DOD budget cuts have real effects on military families. Civilians make up 40% of the Defense Department's medical providers at military hospitals and clinics. They are all subject to furlough. As Jonathan Woodson, the Pentagon's assistant secretary for health affairs, recently blogged, "this may mean a decrease in clinic appointment availability or longer wait times to see providers." As a result, we will have military personnel—future veterans—who are not receiving the care they need and deserve.

Sequestration cuts will increase the already lengthy, month-or-more waiting time for burial at Arlington National Cemetery, with the number of daily burials expected to drop from 31 to 24. The wait that grieving family members and friends must endure before their loved one's military burial will be prolonged. This specific cut will clearly affect the emotional well-being of the families of our fallen servicemembers and veterans.

And sequestration will affect the progress being made to end homelessness among our veteran population. Housing and Urban Development (HUD) vouchers for homeless veterans are credited with reducing the number of homeless veterans by 17% since 2009. Although these vouchers are exempt from the cuts, administrative funding will certainly be affected. Consequently, the number of local housing authorities willing to accept the vouchers are expected to decrease because in order to use these

vouchers, local housing authorities will have to close the gap in funding created by the Federal cuts.

Sequestration will also have a negative effect on the Department of Justice's ability to fund alternative sentencing programs for veterans. The loss of grant funding for diversion programs will lead to incarceration with little consideration of treatment for veterans with mental health issues who are arrested for a crime. Diversion programs have been found to be very successful when treatment is available as an option. According to Dan Abreu, who oversees the Justice Department's Jail Diversion Trauma Recovery Grant, there were over 1.1 million arrests of veterans in 2007 (U.S. Department of Justice, Bureau of Justice Statistics) and trauma history has been found to be present in up to 73% of those arrested. Diversion programs have been established to address the unique needs of these veterans, of which over 50% are from OEF/OIF.

Finally, budget cuts are expected to have an impact on current programs that encourage and support service-disabled veteran-owned small businesses. As the U.S. Small Business Administration reports, there were over 203,000 service-disabled veteran small-business owners across America in 2007. More generally, veteran-owned firms represented 9% of all U.S. firms, employed 5.793 million employees, and amassed an annual payroll of $210 billion in 2007.

THE DEPARTMENT OF VETERANS AFFAIRS

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 to lead healthy and productive lives once they complete their service.

VA Structure, Sites, and Basic Services

The VA operates the Nation's largest integrated health care system, with more than 1,700 hospitals, clinics, community living centers, domiciliaries, readjustment counseling centers, and other facilities. The VA serves over 8.3 million veterans each year. As of September 30, 2012, there were 821 VA Community-Based Outpatient Clinics, 300 Vet Centers, 152 VA Hospitals, and 56 Veterans Benefits Administration Regional Offices. In addition, the VA has the 70 Mobile Vet Centers (MVCs), which are intended to increase access to readjustment counseling services for veterans and their families in rural and underserved communities across the country. In fiscal year 2011, MVCs participated in more than 3,600 Federal, state, and locally sponsored veteran-related events. VA sites are located in 23 regions or VISNs (Veteran Integrated Service Networks) in the 50 states, Puerto Rico, Virgin Islands, Guam, America Samoa, and the Philippines. The VA has 300 permanent Vet Centers across the country, which provide veterans and their families with readjustment counseling and outreach services. Depending on the location, Vet Centers can also provide the following services:

- Individual and group counseling for veterans and their families
- Family counseling for military-related issues
- Bereavement counseling for families who experience an active duty death
- Military sexual trauma counseling and referral
- Outreach and education
- Substance abuse assessment and referral
- Screening and referral for medical issues including Traumatic Brain Injury and depression
- PTSD programs

OEF/OIF Utilization Statistics

According to the latest Defense Manpower Data Center statistics on the VA Web site (www.va.gov), as of September 30, 2008, there were 957,441 living OEF/OIF veterans, 89% male and 11% female. Of these living OEF/OIF veterans, 498,737 (52%) received VA benefits and/or services in FY 2008. In terms of program usage during FY 2008, 277,907 (56%) OEF/OIF veterans used only one VA program. Of these OEF/OIF program users, 88% (246,000) were male, and 85% (235,000) were 44 years old or younger. Also during FY 2008, 220,830 (44%) of OEF/OIF veterans used multiple VA programs. Of these recipients, 87% (192,000) were male, and 81% (180,000) were 44 years old or younger. As of FY 2008, 39% (84,000) of the OEF/OIF veterans receiving disability compensation did not use VA health care.

The VA has worked hard to keep up with the changing landscape and the growing demands over the last decade as a result of the wars in Iraq and Afghanistan. The VA has increased the number of mental health professionals providing services since 2006. It has also expanded its call centers to help connect veterans in need with counseling services and launched the Veterans Crisis Line, which allows veterans and their families to call 24 hours a day, seven days a week for assistance. More-

over, the VA has become the national leader in integrating mental health care into its primary care settings.

But 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. Indeed, I would argue that it is 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 one example of a community-based effort to complement the good work of the Department of Veterans Affairs. We are honored to do our part.

GIVE AN HOUR

I founded Give an Hour in 2005. As the daughter of a World War II veteran, I became concerned about the stories coming home about those who were serving. Although the Departments of Defense and Veterans Affairs were doing more than ever before in their efforts to care for the invisible injuries of war, servicemembers were clearly struggling and their families were suffering. Early studies by Dr. Charles Hoge and others indicated that significant numbers of servicemembers would continue to come home with post-traumatic stress, Traumatic Brain Injury, depression, anxiety, and other understandable consequences of exposure to the brutality of war.

The idea behind Give an Hour is really quite simple: ask licensed civilian mental health professionals across the country to provide an hour a week of free mental health support to any post-9/11 servicemember, veteran, or loved one in need. Those looking for services visit our Web site, at www.giveanhour.org, type in their zip code, and get a list of providers located near them and eager to help. Though not required, those who receive care through GAH are given the opportunity to give back by volunteering in their own communities.

We have developed excellent relationships with all of the major mental health associations, and we accept mental health professionals from all of the major disciplines. Give an Hour providers offer a wide range of options with respect to available appointment times to those who seek services including evenings and weekends. In addition, they bring a wealth of treatment options and areas of expertise to their work. We know that one size does not fit all with respect to this population or any. Flexibility and treatment based on individual needs and preferences are critical elements if we are to reach and successfully support the mental health needs of veterans and their families. There is no limit to the number of sessions that servicemembers receive, and all services are free.

Believing that collaborating with other organizations, agencies, and communities is the key to successfully serving military families, we and our providers also consult to schools, first responders, employers, and community organizations. For example, we have enjoyed a long-standing relationship with organizations such as TAPS (the Tragedy Assistance Program for Survivors) and SVA (Student Veterans of America), providing direct assistance with referrals and participating in their events. We are also regularly asked to join Yellow Ribbon events and similar community gatherings across country. Our staff members present at conferences and are key members of advisory groups addressing the needs of those in our Armed Forces.

We are proud that Give an Hour is successfully harnessing the knowledge, wisdom, skill, and compassion of our civilian mental health professionals and exemplifying a highly collaborative approach in offering these resources to supplement the critical mental health services provided by the Departments of Defense and Veterans Affairs in our Nation's efforts to assist those who serve, our veterans, and their families in communities across the country.

In fact, since it began providing services in 2008, Give an Hour has:

- Increased its volunteer provider network by 570% from 1,000 in February 2008 to 6,700 in January 2013
- Increased volunteer hours given by mental health providers from 1,415 in August 2008 to 82,000 hours in January 2013
- Been selected one of five winners of the White House Joining Forces Community Challenge, sponsored by First Lady Michelle Obama and Dr. Jill Biden in April 2012

In addition, I was personally honored when named to the TIME 100 of the Most Influential People in the World in 2012.

We are also proud that Give an Hour was chosen to lead the health pillar of the Got Your 6 campaign, a nationwide initiative uniting the entertainment industry and top-tier nonprofits to shine a spotlight on veterans as civic assets and leaders. The campaign focuses on six pillars of reintegration: jobs, housing, education,

health, family, and leadership, and offers pathways for the American public to connect and engage with these issues and bridge the military-civilian divide.

THE COMMUNITY BLUEPRINT AND THE POWER OF COLLABORATION

Got Your 6 is a prime example of applying a comprehensive approach to meeting the needs of the men, women, and families who serve our Nation. Similarly, to address these needs by leveraging the combined experience and expertise of collaborating organizations, volunteers from several leading nonprofits created an initiative and an online tool called the Community Blueprint, which is already helping local community leaders assess and improve their community's support for veterans, servicemembers, and their families. The initiative is now formally being administered by Points of Light and is being implemented in several communities across the country.

Give an Hour and the Community Blueprint History

In January 2010 the "America Joins Forces with Military Families" retreat in White Oak, Florida, brought together representatives of 55 nonprofits, veterans and military family service organizations, government agencies, faith-based groups, and senior DOD officials to discuss the challenges facing America's military families and how our Nation must come together to address them. I and other nonprofit leaders concerned about these issues began to refine a concept that had been percolating in the veterans support community for years—that of a blueprint to assist communities in more effectively and strategically supporting veterans and military families. Since then the Community Blueprint has developed into a national initiative with multiple Blueprint demonstration sites.

Give an Hour acted as the first nonprofit to implement the Blueprint initiative on a large scale, thanks to a two-year grant from the Bristol Myers Squibb Foundation to lead implementation of the Blueprint in two demonstration sites—Fayetteville, North Carolina, and Norfolk/Hampton Roads, Virginia. Since early 2011 Give an Hour has been working with the local communities, and in late 2011 the nonprofit organization Points of Light stepped up to serve as the national Community Blueprint umbrella organization. Due to Give an Hour's pioneering role in this initiative, Points of Light and various communities consult and look to Give an Hour as thought-leaders and subject matter experts on the Blueprint.

Definition of the Community Blueprint

The Community Blueprint is both an approach and a tool. The approach provides a forum to enable local veteran-focused organizations in the nonprofit, for-profit, and government sectors to communicate and collaborate to address needs. The Blueprint founders identified eight Blueprint focus areas: behavioral health, education, employment, family strengths, financial/legal assistance, volunteerism, homelessness, and reintegration. As a tool, the Blueprint catalogs "promising practices" (defined as action steps, initiatives, and events) for meeting needs and makes them available in a Web-based toolbox located at www.the-communityblueprint.org.

Promising Practices and Accomplishments

Give an Hour has held numerous events covering the eight areas of focus in the demonstration sites. The following examples highlight our promising practices.

Behavioral Health

Give an Hour staff learned that Fayetteville is home to multiple behavioral health groups. Through the Blueprint working group process, staff contacted the various behavioral health groups and helped to form one consolidated group, called the Behavioral Health Professional Association (BHPA). The BHPA includes a cross-section of behavioral health leaders from nonprofits, private practice, the VA, and Fort Bragg.

Education

In Norfolk/Hampton Roads, the Give an Hour Blueprint leveraged the creation of the Military Alliance at Old Dominion University (ODU) to coordinate faculty and students to create a campus-wide initiative to support ODU servicemembers and their dependents. The Military Alliance increased collaboration between Tidewater Community College (TCC) and ODU to create joint events to assist the student military population. Also, thanks to a Blueprint—Walmart Foundation grant, TCC's Center for Military and Veterans Education was able to launch a pilot program (the Military Spouse Career Readiness Training Program) to help military spouses prepare for meaningful work and careers.

Employment

Through the Blueprint, Give an Hour has worked closely with the U.S. Chamber of Commerce to help sponsor and promote multiple Hiring Our Heroes (HOH) Job Fairs in both demonstration sites. At the Fayetteville February 2011 HOH event, Give an Hour asked that booth space be expanded to include resource-based organizations, which created a more inclusive event. As a result of Blueprint support and advertising, the event received high attendance from job seekers and booth sponsors that far surpassed the target goal.

Family Strengths

For the April Month of the Military Child, the Fayetteville Blueprint organized a bracelet-making project to honor the resiliency and bravery of military children. It resulted in a successful technique for engaging and honoring military children, which was replicated at other events. Over two days, Blueprint volunteers spoke with over 250 individuals, and many of the families were unaware that April was the Month of the Military Child. Families were able to strengthen family bonding while enhancing knowledge of the unique culture and needs of military families.

Financial/Legal Assistance

In September 2012, the Norfolk/Hampton Roads Blueprint hosted a free Military Family Financial Summit at ODU, open to all servicemembers, veterans, and their families. The event was family-friendly with on-site day care, which encouraged family attendance. Community Blueprint participants collaborated closely with ODU, Fleet and Family Support Center, and Blue Star Families to sponsor this event. Conference attendees gained valuable insight on personal financial planning, post—military career planning, and portable entrepreneurship, while connecting with other military families to expand their network of support.

In November 2012, Give an Hour co-sponsored a Veterans Court Summit with Booz Allen Hamilton in Virginia Beach, Virginia. The event engaged stakeholders from across the community (legal, behavioral health, nonprofit, military, government, corporate), who provided direct input and leverage to move the Veteran's Court initiative forward. I spoke about the importance of cross-sector collaboration and how that fit with the Veterans Court model. Judge Robert Russell, who initiated the Nation's first Veterans Court, served as an expert panelist and shared lessons learned. The summit resulted in actionable items to begin the process of implementation of a Veterans Court in Norfolk, which have continued to date.

Volunteerism

Volunteer Hampton Roads received a Blueprint—Walmart Foundation grant it used to host, in March 2012, a free "Volunteer Management Training" course emphasizing engaging volunteers from the military community. Key Hampton Roads military personnel discussed how to reach out to the active duty, reserve, dependent, and retiree military communities. The training demand was so high that Volunteer Hampton Roads held a second event several months later.

Homelessness

In 2011 the Fayetteville Blueprint working group participated the Veterans Affairs Homeless Stand Down. Participants included a large cross-sector of the community and directly served veterans that were homeless by providing material goods, food, and information and access to resources.

Reintegration

In July 2012, the Fayetteville Blueprint hosted a free screening and panel discussion of the Oscar-nominated documentary Hell and Back Again, which features a Marine's combat experience in Afghanistan and his reintegration process after being wounded. As a promising practice, the event raised awareness about reintegration issues and created a community dialog among civilians, servicemembers, and their families. At a post-screening panel discussion, I was joined by local subject matter experts Captain Jenny Hartsock, Military Liaison to U.S. Senator Kay Hagan, and Staff Sergeant Kelly Schoolcraft, President of Fayetteville State University Student Veterans of America. The panelists provided information about local and national resources and stressed the importance of community collaboration to assist with reintegration for servicemembers and help family members as well.

Blueprint Engagement with the Department of Veterans Affairs

The Blueprint approach of increased collaboration and connecting resources has directly assisted servicemembers—including those that receive VA services. In both Community Blueprint demonstration sites, Give an Hour staff members collaborate with the local VA offices on various initiatives and events. As a result of this out-

reach, VA staff members have become more involved in community efforts and have connected with a wider range of organizations. Some examples of VA and Blueprint partnerships include the following:

• Fayetteville Community Blueprint Summit on Women Veterans: In November 2011, Give an Hour collaborated with Booz Allen Hamilton to hold a one-day Community Blueprint event entitled "Fayetteville Military Family Community Summit: Ensuring the Well-Being of Our Women Veterans." Give an Hour invited the Director of the Fayetteville VA Medical Center, Dr. Elizabeth Goolsby, to serve as a panelist at the event along with other local female veterans. The event combined engaging discussion and thoughtful, innovative approaches on how to improve the lives of women veterans in the Fayetteville area.

• Fayetteville Behavioral Health Professional Association: As mentioned above, the Blueprint working group process helped consolidate the multiple behavioral health groups in Fayetteville into one consolidated group, the Behavioral Health Professional Association (BHPA). Since December 2011, the BHPA group has been meeting on a monthly basis, and among its active participants is a VA psychologist in the area. The group focuses predominately on military issues and includes a large cross-section of behavioral health leaders from the Fort Bragg/Womack Army Hospital and the VA, as well as private practitioners, Military Family Life Consultants (MFLCs), substance abuse providers, faith-based providers, employees from the public school system, and state-level affiliates.

• Military Spouse Appreciation Day Event: Give an Hour Blueprint staff reached out to Fayetteville VA Medical Center Director Dr. Elizabeth Goolsby and invited her to serve as a guest speaker at the May 2012 Military Spouse Appreciation Day Ceremony. The Give an Hour Fayetteville Blueprint collaborated with the office of U.S. Senator Kay Hagan to honor the sacrifice, resiliency, and courage of the military spouses that serve on the home front.

• North Carolina Dental Clinic /Mental Health Resource Event: The Fayetteville Blueprint reached out to the VA to provide mental health resources at the June 2012 North Carolina Dental Clinic/Missions of Mercy Mobile Dental Clinic, which served individuals with incomes below the poverty line. Give an Hour and Blueprint volunteers handed out 400 resource bags with information on behavioral health resources and other items such as coupons for free food. The free mobile dental clinic served over 1,000 people—of which approximately 20% were identified as military-affiliated. This event reached an underserved segment of the population, including low-income veterans and their families, and connected them with behavioral health resources alongside free dental services.

Give an Hour Blueprint Lessons Learned

Even when a community determines that cross-sector collaboration offers the greatest promise to solving a complex social problem, the process is by no means easy. Grass-roots community collaboration and implementation centered on systemic change requires heavy lifting. The primary lesson we have learned is to be prepared to work hard and not expect the process to be quick or easy. Give an Hour staff found that cross-sector collaboration and the development of working groups depend on an open philosophy and long-range perspective. We learned to promote a "big tent" concept and invite Blueprint members from among the "willing and interested." In other words, collaboration requires just that—no exclusivity. As long as members act with respect and embody and uphold the principles of the Blueprint, they should be encouraged to join. The other Blueprint lessons learned are as follows:

• Focus on the servicemember and leave personal agendas at the door: This philosophy has resulted in cohesive, thriving groups. Positive, persistent collaboration results in creating larger, more effective groups.

• Take Quick Action: "Pick something—anything—and do it!" People lose interest if a group does not appear to have a purpose. Ensure that each Blueprint xmeeting has at least one action item that leads to a promising practice or an initiative serving the point of the Blueprint, i.e., to increase community collaboration and improve the lives of servicemembers and their families.

• Piggy-Back off Existing Events: Give an Hour staff learned early in the process that time and money was saved and duplication avoided by joining another community. Look for existing opportunities to leverage or expand upon a community event.

THE NEXT STEP: GREATER COORDINATION BETWEEN THE VA AND COMMUNITY ORGANIZATIONS

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 I 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.

Fortunately, we have made progress. Over the past year Give an Hour and DOD have worked together to expand mental health services to military personnel and their families. Give an Hour and the Veterans Crisis Line signed a memorandum of agreement (MOA) to enhance the quality and effectiveness of the services both organizations can provide by sharing information about each other with those seeking services. And a recently signed memorandum of understanding (MOU) between Give an Hour and the Army National Guard will ensure that National Guard servicemembers and families have factual information about our services.

But we can do so much more. The question is how to get there. The VA has tremendous potential to function as both 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.

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 that 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.

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

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

Senator Murray.

STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON

Senator MURRAY. Mr. Chairman, thank you very much. I want to thank you for having this hearing. I know you have another panel, so I appreciate you allowing my statement.

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

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 really clear that VA and Congress have made some important strides toward 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 homestate 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 1,600 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 IDES process and diagnose mental health care conditions accurately. We have got to address the issue of the integrated electronic health 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 mental health care. I want to thank everyone who is working on this and give you my support to continue to do that.

Thank you.

Chairman SANDERS. Thank you very 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 we have got to think outside the box. We have to understand that something as simple as an unpleasant person at a desk or a wait of 2 hours, or a missed appointment can be the difference between life and death with somebody who is struggling to stay alive, keep themselves together. When you are healthy, an hour wait might not matter. But that long of a wait does matter for people who are struggling.

I think all of you have indicated that peer-supported efforts of veterans talking to veterans is enormously important. 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. How do we enable VA, which we all know is a huge bureaucracy—there are no ifs, ands, or buts about that—to become more flexible, to reach out to community-based groups and peer support groups?

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.

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.

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 question: one of the cultural issues that we are struggling with—that the military and VA are struggling with—is the culture of the stigma which Colonel Allred discussed. The idea of questioning whether I am a real man if I have an emotional or mental problem?

We understand if I lost an arm or a leg, I would go and get treatment. How do we deal with a culture that says from a military perspective, that, 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 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, is 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, NE, in Davenport, IA, in Oakland, CA, where they can talk and share with one another their experiences after transitioning out of the military.

Chairman SANDERS. OK. Thank you.

Andre, as you know, Vermont is 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, who have been through that experience reach out to other veterans. How do we do that?

Mr. WING. Thank you, Senator. As you know, we have 10 Outreach Specialists on my team. We are all combat veterans. We all had struggles with reintegration issues and transitioning back to civilian life. I do not think the stigma is as severe in the Reserve Component compared to the Active component. I hear at this panel that we talked about community partnerships which we have really forged in the State of Vermont with different initiatives that I stated earlier in my statement.

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

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 to train and hire 800 peer support specialist in the coming year, that is the best way to connect with veterans and help with awareness and success to health care. But I think you are hearing this today. The common denominator here is the peer-to-peer approach. It is very, very important because we veterans can communicate and have experienced some of the same reintegration issues.

The other thing too that is important with the community partnerships, is that my team understands the military culture. So, I can go into AHS with the 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 and it is as important to the Veterans Administration. 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 for unanimous consent that we would be allowed to follow up with questions with this panel.

Chairman SANDERS. Of course, without objection.

Senator BURR. For the sake of time, I am going to turn to Barbara for just a second. You mentioned 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. There was not an easy access from the base to identify those who were in need 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 they know each other or 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. I believe there will not be enough to meet the need.

Before we got there, there was a lot of talk like, 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 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 they did 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 got them long-term care.

There are so many examples. It is all about bringing the right folks together and then having regular ongoing conversations, not 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 great questions but you guys's 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, 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 7,000 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 there for.

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 unemployment, the financial issues, the family issues, and then hopelessness.

The National Alliance on Mental Illness has programs to address that, if we can be brought together.

Senator TESTER. OK. 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—we have not been able to work with that program because mental health is not a piece of that. Yet, 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, and receiving that funding. But mental health is not a piece of it.

So, I would say that is a great example of what is working well and there are many others. I would like to see VA expand that to include 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 in crisis to have an immediate place to call to get help and get hooked-up with care if they are in crisis.

An offshoot of that, Vets4Warriors, are a peer-to-peer support call line. They are answered by a peer 24/7. I could see a real value in increasing those kinds of portals where veterans call and 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 whether you can get better.

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

Senator TESTER. I just want to thank you all for your testimony. I have about 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 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 where problems develop that may lead to suicide?

Mr. WOOD. Absolutely. We see it all the time. Veterans typically 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 servicemember 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 also that elimination of 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 or their 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 and medical health services with something else; and that something else is community which 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 kept 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 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 traumatic 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 Post Traumatic Stress Disorder. Got a job for like $9 per hour, but all of the chaos within the job he could not deal with having PTSD and ended up, you know, quitting his job, losing his job. But he wanted peer 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 post traumatic stress, and 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 peer support where they find some sense of purpose, a sense of meaning in their life, where they create a new identity that is separate from the military identity they are losing.

Senator JOHANNS. I am out of time. 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, the peer support, the group counseling, that force that kind of pulls things together emotionally and mentally, those kinds of things seem to me to be a real pathway 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 and lived with is not there anymore in the way of this support group. 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.

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, NE, 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 recreate.

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 5 minutes but instead took probably a cumulative of 5 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. 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 1, which I think is terrific.

Recommendation number 4 that she had was to cut out the paperwork that it takes to get from making the appointment to the actual appointment. From what I hear from you, both of those, if adopted, would be a tremendous help for the Veterans' Administration and for the veteran.

Mr. WOOD. Absolutely, particularly regarding number 4. 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, the app that you have developed, operational?

Mr. WOOD. Yes. We launched live 8 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 testing phase. We have got about 3,000 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-9/11 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, 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.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Boozman.

STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Mr. Chairman, and thank you for the hearing today which is so important; you and Senator Burr, especially inviting 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 just an interesting, very difficult problem. We talk about the stress of a war and yet many were not deployed, though were 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, in society in general, in the same way. We have the reintegration problems like you have experienced, Mr. Wood, which again is so common; and I can see how that happens and yet a lot of these individuals are 50 years old; in fact, a pretty significant portion.

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

I guess what I am wondering is what factor does marital difficulties play and financial problems? I used to be a ranking member and chairman of the House Economic Opportunities Committee. I always felt that if you could put people to work and get them where they could support their families and things like that, a lot of this would diminish.

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

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

I think that is a real problem and I think in some individuals—I think the facts are there that they go the other way and can become suicidal from being overmedicated.

So, if you guys would just like to comment on that. Mr. Wood, you can start if you like; share 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 overmedicated; and in his experiences with the VA, he would jump from medication to medication, and 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 overmedicating our veterans.

Senator BOOZMAN. Ms. Van Dahlen.

Ms. VAN DAHLEN. If I might—you brought up something that I think is very important that I continue to hear which 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+ years, what is critical now is that we figure out how to ensure that in communities there are different options of care, whether it is financial or marriage—absolutely sometimes financial counseling is what that family needs and they are back on the right track.

They may need a physician who can step in and say, "This young man is way overmedicated. Perhaps we need to send them to Team Rubicon or send him to get some equine therapy out in nature with horses."

It is having options, 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. 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 and Ranking Member both said, if we had the answers. But there is such a dissimilarity of cultures which 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 1,100 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. 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 8 or 9 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. One hundred percent. I will shoot you something over as soon as we are done here.

Senator BURR. Thank you.

Chairman SANDERS. Thank you, Senator Burr.

Let me just include by once again thanking each of you for the extraordinary efforts 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. Representing the VA is Under Secretary for Health, Dr. Robert Petzel. Dr. Petzel, thanks 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; 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 don't we begin with you.

STATEMENT OF ROBERT PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS' HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS' AFFAIRS; ACCOMPANIED BY JANET KEMP, RN, Ph.D., DIRECTOR OF SUICIDE PREVENTION AND COMMUNITY ENGAGEMENT, NATIONAL MENTAL HEALTH PROGRAM, OFFICE OF PATIENT CARE SERVICES; AND SONJA BATTEN, Ph.D., DEPUTY CHIEF CONSULTANT, SPECIALTY MENTAL HEALTH PROGRAM, OFFICE OF PATIENT CARE SERVICES; AND WILLIAM BUSBY, Ph.D., 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, servicemembers, 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 1,900 new mental health providers and administrative support. As of March 12, 2013, VA has hired 1,300 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, and veterans and identified a number of areas for improvements 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 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 6,000 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 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:]

PREPARED STATEMENT OF ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Sanders, Ranking Member Burr and Members of the Committee. Thank you for the opportunity to discuss VA's delivery of comprehensive mental health care and services to our Nation's Veterans and their families. I am accompanied today by Dr. Sonja Batten, Deputy Chief Consultant for Specialty Mental Health; Dr. Janet Kemp, National Mental Health Program Director, Suicide Prevention and Community engagement, Mental Health Services, and Dr. William Busby, Acting Chief Officer for Readjustment Counseling Service.

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan with unprecedented duration and frequency. Long deployments and intense combat conditions require optimal support for the emotional and mental health needs of our Veterans and their families. VA continues to develop and expand its mental health delivery system. VA has learned a great deal about both the strengths of our mental health care system, and the areas that need improvement.

VA is working closely with our Federal partners to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Servicemembers, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts by increasing capacity at the Veterans/Military Crisis Line and through supporting the implementation of a national suicide prevention campaign. The executive order supports recovery-oriented mental health services for Veterans by directing the hiring of 800 peer specialists, to bring this expertise to our mental health teams. It also supports VA in using a variety of recruitment strategies to hire 1,600 new mental health clinicians and 300 administrative personnel in support of the mental health programs. Furthermore, it strengthens partnerships between VA and community providers by directing VA to work with the Department of Health and Human Services (HHS), to establish 15 pilot agreements with HHS-funded community clinics to improve access to mental health services in pilot communities, and to develop partnerships in hiring providers in rural areas. Finally, it promotes mental health research and development of more effective treatment methodologies in collaboration between VA, Department of Defense (DOD), HHS, and Department of Education.

VHA has begun work on implementing the Fiscal Year 2013 National Defense Authorization Act (P.L. 112–239) (NDAA), signed on January 2, 2013, including developing measures to assess mental health care timeliness, patient satisfaction, capac-

ity and availability of evidence-based therapies, as well as developing staffing guidelines for specialty and general mental health. In addition, VA is developing a contract with the National Academy of Sciences to consult on the development and implementation of measures and guidelines, and to assess the quality of mental health care.

My written statement will describe VA's mental health care delivery system with specialized programs in suicide prevention, Post Traumatic Stress Disorder (PTSD), and military sexual trauma as well as readjustment counseling. It highlights ongoing research in mental health, our process for continuous quality improvement as well as the measurement of that improvement. It also describes our outreach and access initiatives and VA's recent enhancement of mental health staffing.

I. MENTAL HEALTH CARE

VA operates one of the largest, highest-quality integrated healthcare systems. VA is a pioneer in mental health research, discovering and utilizing effective, high-quality, evidence-based treatments. It has made deployment of evidence-based therapies a critical element of its approach to mental health care. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, such as PTSD, consequences of military sexual trauma, substance use disorders, and suicidality. While VA is primarily focused on evidence-based treatments, we are also assessing those complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD.

VHA provides a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. VA has trained over 4,700 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD: Cognitive Processing Therapy and Prolonged Exposure Therapy. Veterans treated with these psychotherapies report fewer PTSD symptoms. The reported reduction in PTSD symptoms, an average of 19–20 points on the Post-Traumatic Stress Disorder Checklist,[1] is clinically significant. Furthermore, VA operates the National Center for PTSD, which guides a national PTSD Mentoring program, working with every specialty PTSD program across the VA system to improve care. The Center has also begun to operate a PTSD Consultation Program open to any VA practitioner (including primary care practitioners and Homeless Program coordinators) who requests expert consultation regarding a Veteran in treatment with PTSD. So far, 500 VA practitioners have utilized this service. The Center further supports clinicians by sending subscribers updates on the latest clinically relevant trauma and PTSD research, including the Clinician's Trauma Update Online, PTSD Research Quarterly, and the PTSD Monthly Update. As IOM observed in its recent report, "Spurred by the return of large numbers of veterans from [Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND)], the VA has substantially increased the number of services for veterans who have PTSD and worked to improve the consistency of access to such services. Every medical center and at least the largest community-based outpatient clinics are expected to have specialized PTSD services available onsite. Mental health staff members devoted to the treatment of OIF and OEF Veterans have also been deployed throughout the system."[2]

Specialized care is available for Veterans who experienced military sexual trauma (MST) while serving on active duty or active duty for training. All sexual trauma-related care and counseling is provided free of charge to all Veterans, even if they are not eligible for other VA care. In fiscal year (FY) 2012, every VHA facility provided MST related outpatient care to both women and men, and a total of 64,161 Veterans who screened positive for MST received a total of 725,000 outpatient MST-related mental health clinical visits. This is a 13.3 percent increase from the previous year (FY 2011). Additionally, in FY 2012, of those who received care in a VA medical center or clinic, over 500,000 Veterans with a Substance Use Disorder (SUD) diagnosis received treatment for this problem. VA developed and disseminated clinical guidance to newly hired SUD-PTSD specialists who are promoting integrated care for these co-occurring conditions, and provided direct services to over 18,000 of these Veterans in FY 2012.

Use of complementary and alternative medicine (CAM) for treating mental health problems is widespread in VA. A 2011 survey of all VA facilities by VA's Healthcare

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[1] A self-report instrument that has been extensively used in research and is well regarded. Chard, Ricksecker, Healy, Karlin, & Resick, 2012; Eftekhari, Ruzek, Crowley, Rosen, & Karlin, in press.

[2] Institute of Medicine of the National Academies. *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations Initial Assessment*. July 13, 2012.

Information and Analysis Group found that 89 percent of VA facilities offered CAM. VA's Office of Research and Development (ORD) recently undertook a dedicated effort to evaluate CAM in the treatment of PTSD with the solicitation of research applications examining the efficacy of meditative approaches to PTSD treatment. The result was three new clinical trials; all are currently underway, recruiting participants with PTSD. VA has also begun pilot testing a mechanism for conducting multi-site clinical CAM demonstration projects within mental health that will provide a roadmap for identifying innovative treatment methods, measuring their efficacy and effectiveness, and generating recommendations for system-wide implementation as warranted by the data. Nine medical facilities with meditation programs were selected for participation in the clinical demonstration projects. A team of subject matter experts in mind-body medicine from the University of Rochester has been asked to provide an objective, external evaluation. The majority of the clinical demonstration projects are expected to be completed this month, and the aggregate final report by the outside evaluation team is due later in 2013.

Veteran Suicide

Even one Veteran suicide is too many. VA is committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on the principle that in order to decrease rates of suicide, we must provide enhanced access to high quality mental health care and develop programs specifically designed to help prevent suicide. In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line (VCL) connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline that offers 24/7 emergency assistance. VCL has recently expanded to include a chat option and texting option for contacting the Crisis Line. Since its establishment five years ago, the VCL has made approximately 26,000 rescues of actively suicidal Veterans. The program continues to save lives and link Veterans with effective ongoing mental health services on a daily basis. In FY 2012, VCL received 193,507 calls, resulting in 6,462 rescues, any one of which may have been life-saving. In accordance with the President's August 31, 2012, Executive Order, VA has completed hiring and training of additional staff to increase the capacity of the Veterans Crisis Line by 50 percent. However, VCL is only one component of the VA overarching suicide prevention program that is based on the premise that ready access to high quality care can prevent suicide.

VA has placed Suicide Prevention Teams at each facility. The leaders of these teams, the Suicide Prevention Coordinators, are specifically devoted to preventing suicide among Veterans, and the implementation of the program at their facilities. The coordinators play a key role in VA's work to prevent suicide both in individual patients and in the entire Veteran population. Among many other functions, coordinators ensure that referrals from all sources, including the Crisis Line, e-mail, and word of mouth referrals are appropriately responded to in a timely manner. Coordinators educate their colleagues, Veterans and families about risks for suicide, coordinate staff education programs about suicide prevention, and verify that clinical providers are trained. They provide enhanced treatment monitoring for veterans at risk. They assure continued care and treatment by verifying that each "high risk" Veteran has a medical record notification entered; that they receive a suicide-specific enhanced care package, and any missed appointments are followed up on. The coordinators track and monitor all suicide-related events in an internal data collection system. This allows VA to determine trends and common risk factors, and provides information on where and how best to address concerns.

VA has developed two hubs of expertise, one at the Canandaigua Center of Excellence for Suicide Prevention (Canandaigua, NY), and another at the VISN 19 Mental Illness Research Education and Clinical Center (Denver, CO), to conduct research regarding intervention, treatments and messaging approaches and has developed a Suicide Consultation Program for practitioners that opened in 2013 and is already in use.

On February 1, 2013, VA released a report on Veteran suicides, a result of the most comprehensive review of Veteran suicide rates ever undertaken by the VA. With assistance from state partners providing real-time data, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA to identify where at risk Veterans may be located and improve the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. The data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary

care in order to replicate effective programs in other areas. VA is continuing to receive state data and will update the Suicide Data report later this year. Thus far, 39 states have reported suicide data to VA; 6 additional states are preparing data for shipment. VA reviews the data submitted by states to validate Veteran status.

In addition, VA has established the Mental Health Innovations Task Force, which is working to identify and implement early intervention strategies for specific high-risk groups. For example, Veterans with PTSD, pain, sleep disorders; depression and substance use disorders are at high risk for suicide. Through early intervention, we hope to reduce the likelihood that Veterans in these groups will progress into even higher risk status.

II. MENTAL HEALTH CARE ACCESS

At VA, we have the responsibility to anticipate the needs of returning Veterans. Mental health care at VA is an extensive system of comprehensive treatments and services to meet the individual mental health needs of Veterans. We have many entry points for VHA mental health care: through our 152 medical centers, 821 community-based outpatient clinics, 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, VA staff on college and university campuses and other outreach efforts.

Since FY 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from 927,052 to more than 1.3 million in FY 2012, partly due to proactive screening to identify Veterans who may have symptoms of depression, PTSD, problematic use of alcohol, or who have experienced MST. Outpatient visits have increased from 14 million in FY 2009 to over 17 million in FY 2012. Vet Centers are another avenue for access, providing services to 193,665 Veterans and their families in FY 2012. The Vet Center Combat Call Center, an around-the-clock confidential call center where combat Veterans and their families can talk with staff, comprised of fellow combat Veterans from several eras, has handled over 37,300 calls in FY 2012. The Vet Center Combat Call Center is a peer support line, providing a complementary resource to the Veterans Crisis Line, which provides 24/7 crisis intervention services. This represents a nearly 470 percent increase from FY 2011.

In response to increased demand over the last four years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that services can be more readily accessed by Veterans. VA believes that mental health care must constantly evolve and improve as new research knowledge becomes available. As more Veterans access our services, we recognize their unique needs and needs of their families—many of whom have been affected by multiple, lengthy deployments. In addition, proactive screening and an enhanced sensitivity to issues being raised by Veterans have identified areas for improvement.

For example, in August 2011, VA conducted an informal survey of line-level staff at several facilities, and learned of concerns that Veterans' ability to schedule timely appointments may not match data gathered by VA's performance management system. These providers articulated constraints on their ability to best serve Veterans, including inadequate staffing, space shortages, limited hours of operation, and competing demands for other types of appointments, particularly for compensation and pension or disability evaluations. In response to this finding, VA took three major actions. First, VA developed a comprehensive action plan aimed at overcoming barriers to access, and addressing the concerns raised by its staff in the survey as well as concerns raised by Veterans and Veterans groups. Second, VA conducted focus groups with Veterans and VA staff, conducted through a contract with Altarum, to better understand the issues raised by front-line providers. Third, VA conducted a comprehensive first-hand assessment of the mental health program at every VA medical center and is working within its facilities and Veterans Integrated Service Networks (VISNs) to improve mental health programs and share best practices.

Ensuring access to appropriate care is essential to helping Veterans recover from the injuries or illnesses they incurred during their military service. Access can be realized in many ways and through many modalities, including:

- through face-to-face visits;
- telehealth;
- phone calls;
- online systems;
- mobile apps and technology;
- readjustment counseling;
- outreach;
- community partnerships; and
- academic affiliations.

Face-to-Face Visits

In an effort to increase access to mental health care and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. The ongoing transfer of VA primary care to Patient Aligned Care Teams will facilitate the delivery of an unprecedented level of mental health services. As the recent IOM report on Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations noted, it is VA policy to screen every patient seen in primary care in VA medical settings for PTSD, MST, depression, and problem drinking.[3] The screening takes place during a patient's first appointment, and screenings for depression and problem drinking are repeated annually for as long as the Veteran uses VA services. Furthermore, PTSD screening is repeated annually for the first 5 years after the most recent separation from service and every 5 years thereafter. Systematic screening of Veterans for conditions such as depression, PTSD, problem drinking, and MST has helped VA identify more Veterans at risk for these conditions and provided opportunities to refer them to specially trained experts. The PTSD screening tool used by VA has been shown to have high levels of sensitivity and specificity.

Since the start of FY 2008, VA has provided more than 2.5 million Primary Care-Mental Health Integration (PC-MHI) clinical visits to more than 700,000 unique Veterans. This improves both access by bringing care closer to where the Veteran can most easily receive these services, and quality of care by increasing the coordination of all aspects of care, both physical and mental. Among primary care patients with positive screens for depression, those who receive same-day PC-MHI services are more than twice as likely to receive depression treatment than those who did not. Treatment works and there is hope for recovery for Veterans who need mental health care. These are important advances, particularly given the rising numbers of Veterans seeking mental health care.

Telehealth

VA offers expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate rapid access to mental health services. Telemental health allows VA to leverage technology to provide Veterans quicker and more efficient access to mental health care by reducing the distance they have to travel, increasing the flexibility of the system they use, and improving their overall quality of life. This technology improves access to general and specialty services in geographically remote areas where it can be difficult to recruit mental health professionals. Currently, the clinic-based telehealth program involves the more than 580 VA community-based outpatient clinics (CBOCs) where many Veterans receive primary care. In areas where the CBOCs do not have a mental health care provider available, VA is implementing a new program to use secure video teleconferencing technology to connect the Veteran to a provider within VA's nationwide system of care. Further, the program is expanding directly into the home of the Veteran with VA's goal to connect approximately 2,000 patients by the end of FY 2013 using Internet Protocol (IP) video on Veterans' personal computers.

Mobile Apps and Technology

VA has made good progress toward providing all of those in need with evidence-based treatments, and we are now working to optimize the delivery of these tools by using novel technologies. From delivery of the treatments to rural Veterans in their homes, to supporting treatment protocols with mobile apps, VA's objective is to consistently deliver the highest quality mental health care to Veterans wherever they are. The multi-award winning PTSD Coach, co-developed with the DOD, has been downloaded nearly 100,000 times in 74 countries since mid-2011. It is being adapted by government agencies and non-profit organizations in 7 other countries including Canada and Australia. This app is notable as it aims to assist Veterans with recognizing and managing PTSD symptoms, whether or not they are comfortable engaging with VA mental health care.

For those who are kept from needed care because of logistics or fear of stigma, PTSD Coach provides an opportunity to better understand and manage the symptoms associated with PTSD as a first step toward recovery. For those who are working with VA providers, whether in specialty clinics or primary care, this app provides evidence-informed tools for self-management and symptom tracking between sessions. VA is planning to shortly roll out a version of this app that is connected to the electronic health record for active VA patients.

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[3] Institute of Medicine of the National Academies. *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations Initial Assessment*. July 13, 2012.

A wide array of mobile applications to support the evidence-based mental and behavioral health care of Veterans will be rolled out over the course of 2013. These apps are intended to be used in the context of clinical care with trained professionals and are based on gold-standard protocols for addressing smoking cessation, PTSD and suicidality.

Apps for self-management of the consequences of Traumatic Brain Injury and crisis management, some of the more challenging issues facing Veterans and our healthcare system, will follow later in the year. Mobile apps can help Veterans build resilience and manage day-to-day challenges even in the absence of mental health disorders. Working with DOD, VA will release mobile apps for problem-solving and parenting in 2013 to help Veterans navigate common post-deployment challenges. Because we understand that healthy families are at the center of a healthy life, we are creating tools for families and caregivers of Veterans as well, including the PTSD Family Coach, a mobile app geared toward friends and families that is expected to be rolled out in mid-2013.

Technology allows us to extend our reach, not just beyond the clinic walls but to those who need help but have not yet sought our services, and to those who care for them and support their personal and professional missions. In November 2012, VA and DOD launched www.startmovingforward.org, interactive Web-based educational life-coaching program based on the principles of Problem Solving Therapy. It allows for anonymous, self-paced, 24-hour-a-day access that can be used independently or in conjunction with mental health treatment.

Readjustment Counseling Service—Vet Centers

VA's Readjustment Counseling Service (RCS) provides a range of readjustment counseling services to those who have served in combat zones and their families. In addition to the integration of mental health with primary care, VA also provides comprehensive readjustment counseling for Veterans who have experienced military sexual trauma, as well as, bereavement counseling to families whose Servicemember died while on active duty. These services are provided in a safe and confidential environment through a National network of 300 community-based Vet Centers located in all 50 states, the District of Columbia, American Samoa, Guam, and Puerto Rico, 70 Mobile Vet Centers, and the Vet Center Combat Call Center. In FY 2012, through Vet Centers, RCS provided over 1.5 million visits to Veterans and their families, a 9 percent increase in visits from FY 2011. The Vet Center program has cumulatively provided services to 458,795 OEF/OIF/OND Veterans and their families. This represents over 30 percent of the OEF/OIF/OND Veterans who have left active duty. Furthermore, in FY 2012, Vet Center staff provided over 21,000 unique families with over 117,500 visits to help aid in the readjustment of their Veterans. This represents a 15 percent increase in the number of families and 28 percent increase in the number of visits when compared to the previous fiscal year. The increase in services provided to families is a direct result of the Secretary of Veterans Affairs Initiative to place a licensed and qualified family counselor at every Vet Center.

A core component of the Vet Center mission is to help those who served and their families overcome barriers they may have to accessing VA care and services. This is accomplished through an extensive program of face-to-face community outreach. Since the onset of the program in 1979, Vet Center staff have actively engaged their fellow Veterans and family members at targeted community events and provided them with access to services. Recently, RCS has enhanced its outreach capacity to recently returning combat Veterans through a fleet of 70 Mobile Vet Centers (MVC). To ensure early intervention and access to services the MVCs provide outreach and onsite confidential readjustment counseling to Veterans who are geographically distant from existing Vet Centers. RCS also offers services through the Vet Center Combat Call Center (877-WAR-VETS), an around the clock confidential call center where those that served in combat zone and their families can call and talk about their military service and transition home. The call center is staffed by combat Veterans from different eras as well as family members of combat Veterans.

In 2010, Public Law 111–163 expanded eligibility of Vet Center services to members of the Armed Forces (and their family members), including members of the National Guard or Reserve, who served on active duty in the Armed Forces in OEF/OIF/OND. VA and DOD are finalizing the regulatory process outlined in the law and are working together to implement this expansion of services. The recently passed FY 2013 NDAA also includes provisions that expand Vet Center eligibility to members of the Armed Forces who served in any theater of combat and to certain members of the Armed Forces, Veterans, and their family members indirectly exposed to the trauma of war. One cornerstone of the Vet Center program's success is the added level of confidentiality for Veterans and their families. Vet Centers

maintain a separate system of records, which affords the confidentiality vital to serving a combat-exposed warrior population. Without the Veteran's voluntary signed authorization, the Vet Centers will not disclose Veteran clients' information unless required by law. Early access to readjustment counseling in a safe and confidential setting has proven an effective way to reduce the risk of suicide and promote the recovery of Servicemembers returning from combat. Furthermore, more than 72 percent of all Vet Center staff members are Veterans themselves. This allows the Vet Center staff to make an early empathic connection with Veterans who might not otherwise seek services even if they are much needed.

Outreach

In November 2011, VA launched an award-winning, national public awareness campaign, *Make the Connection*, aimed at reducing the stigma associated with seeking mental health care and informing Veterans, their families, friends, and members of their communities about VA resources (www.maketheconnection.net). The candid Veteran videos on the Web site have been viewed over 4 million times, and over 1.5 million individuals have "liked" the Facebook page for the campaign (www.facebook.com/VeteransMTC). AboutFace, launched in May 2012, is a complementary public awareness campaign created by the National Center for PTSD (www.ptsd.va.gov/public/about—face.html). This initiative aims to help Veterans recognize whether the problems they are dealing with may be PTSD related and to make them aware that effective treatment can help them "turn their lives around." The National Center for PTSD has been using social media to reach out to Veterans utilizing both Facebook and Twitter. In FY 2012, there were 18,000 Facebook "fans" (up from 1,800 in 2011), making 16 posts per month and almost 7,000 Twitter followers (up from 1,700 in 2011) with 20 "tweets" per month. The PTSD Web site, www.ptsd.va.gov, received 2.3 million visits during FY 2012.

VA, in collaboration with DOD, continues to focus on suicide prevention though its year-long public awareness campaign, "Stand By Them," which encourages family members and friends of Veterans to know the signs of crisis and encourage Veterans to seek help, or to reach out themselves on behalf of the Veteran using online services on www.veteranscrisisline.net. VA's current suicide awareness and education Public Service Announcement titled "Common Journey" has been running in the top one percent of the PSA Nielsen ratings since before the holidays. It is now being replaced with a PSA designed specifically to augment the Stand By Them Campaign titled "Side By Side," which was launched nationally in January 2013.

In order to further serve family members who are concerned about a Veteran, VA has expanded the "Coaching Into Care" call line nationally after a successful pilot in two VISNs. Since the inception of the service January 2010 through November 2012, "Coaching Into Care" has logged 5,154 total calls and contacts. Seventy percent of the callers are female, and most callers are spouses or family members. On 49 percent of the calls, the target is a Veteran of OEF/OIF/OND conflicts; Vietnam or immediately post-Vietnam era Veterans comprises the next highest portion (27 percent).

Community Partnerships

VA recently developed and released a "Community Provider Toolkit" which is an on-line resource for community mental health providers to learn more about mental health needs and treatments for Veterans. The Veterans Crisis Line has approximately 50 Memoranda of Agreement with community and internal VA organizations to refer callers, accept calls, and provide and receive services for callers. Furthermore, suicide Prevention Coordinators at each VA facility are required to provide a minimum of 5 outreach activities a month to their communities to increase awareness of suicide and promote community involvement in the area of Veteran suicide prevention.

VA has been working closely with outside resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes. In response to the Executive Order, VA is working closely with HHS to establish 15 pilot projects with community-based providers, such as community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of Veterans in a timely way.

VA will continue to work closely with DOD to educate Servicemembers, VA staff, Veterans and their families, public officials, Veterans Service Organizations, and other stakeholders about all mental health resources that are available in VA and with other community partners. VA has partnered with DOD to develop the VA/DOD Integrated Mental Health Strategy (IMHS) to advance a coordinated public health model to improve access, quality, effectiveness and efficiency of mental

health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

III. MENTAL HEALTH CARE QUALITY IMPROVEMENT

VA is committed to hiring and utilizing more mental health professionals to improve access to mental health care for Veterans. Access enables VHA to provide personalized, proactive, patient-driven health care; achieve measurable improvements in health outcomes, and align resources to deliver sustained value to Veterans.

To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and is increasing the number of staff in support of mental health services. VA has taken aggressive action to recruit, hire, and retain mental health professionals to improve Veterans' access to mental health care. VHA has made significant progress to this end, by hiring a total of 3,354 clinical and administrative support staff to directly serve Veterans since May 2012. This progress has improved the Department's ability to provide timely, quality mental health care for Veterans.

As a result, VA is able to serve Veterans better by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capability to deliver services.

Site Visits

In FY 2012, the Office of Mental Health Operations (OMHO) conducted site visits at all 140 VHA Healthcare Systems. The site visits reviewed the implementation of the Uniform Mental Health Services Handbook (UMHSH) and involved meetings with facility leadership; mental health leadership; mental health program leadership; front-line staff, including clerks and schedulers; Veterans who receive mental health care and their families or supportive others; and community stakeholders and partners. In addition to interview data obtained in the 2 day visit, administrative data was reviewed for each healthcare system, including: Mental Health Information System data, relevant reports provided by the facility (e.g., The Joint Commission, System-wide Ongoing Assessment and Review Strategy, Commission on Accreditation of Rehabilitation Facilities, etc.), and other data obtained from multiple sources across VHA (e.g., Office of Productivity, Efficiency and Staffing, Allocation Resource Center, Mental Health Services, etc.).

- Areas identified for systemic improvement included:
  - Ensuring adequate Mental Health staff;
  - Improving the timeliness of Mental Health services;
  - Improving scheduling of Mental Health services; and
  - Increasing provision of required Mental Health services at Community-Based Outpatient Clinics (CBOC).
- Areas that were identified as for systemic improvement and also identified as systemic strengths included:
  - Integration of mental health services into Primary Care;
  - Care coordination across levels of care;
  - Implementations of evidence-based treatments; and
  - Implementation of recovery-oriented care.
- Areas identified as systemic strengths included:
  - Suicide prevention services; and
  - Development of diverse community partnerships.

Systemic actions that have resulted from the visits include

- The use of targeted facilitation processes for programs at VHA healthcare systems which may experience challenges in implementation, including Primary Care-Mental Health Integration and evidence-based psychotherapy;
- Continued monitoring of Mental Health staffing levels, access and scheduling, in conjunction with education and support for new wait time metrics;
- Expansion of telehealth services to outlying CBOCs and in the home; and
- Expanded dissemination of Strong Practices SharePoint for Mental Health to support cross facility learning.

In addition, VHA healthcare systems are implementing site specific action plans in response to recommendations from each facility site visit. These plans are monitored quarterly. OMHO will be visiting approximately 1/3 of VHA healthcare systems each year (45 in FY 2013) from FY 2013 forward to review continued implementation of the UMHSH, visiting each facility once every 3 years.

Mental Health Staffing

VHA began collecting monthly vacancy data in January 2012 to assess the impact of vacancies on operations and to develop recommendations for further improvement. In addition, VA is ensuring that accurate projections for future needs for mental health services are generated. Finally, VA is planning proactively for the expected needs of Veterans who will soon separate from active duty status as they return from Afghanistan.

Since there are no industry standards defining accurate mental health staffing ratios, VHA is setting the standard, as we have for other dimensions of mental health care. VHA has developed a prototype staffing model for general mental health delivery and is expanding the model to include specialty mental health care. VHA developed and implemented an aggressive recruitment and marketing effort to fill existing vacancies in mental health care occupations. To support implementation of the guidance, VHA announced the hiring of 1,600 new mental health professionals and 300 support staff in April 2012. Key initiatives include targeted advertising and outreach, aggressive recruitment from a pipeline of qualified trainees/residents to leverage against mission critical mental health vacancies, and providing consultative services to VISN and VA stakeholders. Despite the national challenges with recruitment of mental health care professionals, VHA continues to make significant improvements in its recruitment and retention efforts. Focused efforts are underway to expand the pool of applicants for those professions and sites where hiring is most difficult, such as creating expanded mental health training programs in rural areas and through recruitment and retention incentives.

As part of our ongoing comprehensive review of mental health operations, VHA has considered a number of factors to determine additional staffing levels distributed across the system, including:

- Veteran population in the service area;
- The mental health needs of Veterans in that population; and
- Range and complexity of mental health services provided in the service area.

Specialty mental health care occupations, such as psychologists, psychiatrists, and others, are difficult to fill and will require a very aggressive recruitment and marketing effort. VHA has developed a strategy for this effort focusing on the following key factors:

- Implementing a highly visible, multi-faceted, and sustained marketing and outreach campaign targeted to mental health care providers;
- Engaging VHA's National Health Care Recruiters for the most difficult to recruit positions;
- Recruiting from an active pipeline of qualified candidates to leverage against vacancies; and
- Ensuring complete involvement and support from VA leadership.

Mental Health Hiring

VA is committed to hiring and utilizing more mental health professionals to improve access to mental health care for Veterans. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and is increasing the number of staff in support of mental health services. VA has taken aggressive action to recruit, hire, and retain mental health professionals to improve Veterans' access to mental health care. The department also has used many tools to hire the mental health workforce, including pay-setting authorities, loan repayment, scholarship programs and partnerships with health care workforce training programs to recruit and retain one of the largest mental health care workforces in the Nation. As a result, VA is able to serve Veterans better by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capability to deliver services.

In April 2012, VA announced a goal to hire an additional 1,600 clinical providers and 300 administrative support staff. As of March 5, 2013, VA has hired 1,089 clinical providers and 230 administrative staff in support of this specific goal. President Obama's August 31, 2012, executive order requires the positions to be filled by June 30, 2013.

Academic Affiliations and Training

VA is strategically working with universities, colleges and health professional training institutions across the country to expand their curricula to address the new science related to meeting the mental and behavioral needs of our Nation's Veterans, Servicemembers, Wounded Warriors, and their family members. In addition to ongoing job placement and outreach efforts through VetSuccess, VA has implemented a new outreach program, "Veterans Integration to Academic Leadership,"

that places VA mental health staff at 21 colleges and universities to work with Veterans attending school on the GI Bill.

VA's Office of Academic Affiliations trains roughly 6,400 trainees in mental health occupations per year (including 3,400 in psychiatry, 1,900 in psychology, and 1,100 in social work, plus clinical pastoral education positions). Currently, VA has one of only two accredited psychology internship programs in the entire state of Alaska. VA is committed to expanding training opportunities in mental health professions in order to build a pipeline of future VA health care providers. VA continues to expand mental health training opportunities in Nursing, Pharmacy, Psychiatry, Psychology, and Social Work. For example, over 202 positions were approved to begin in academic year 2013–2014 at 43 VHA facilities focused on the expansion of existing accredited programs in integrated care settings such as General Outpatient Mental Health Clinics or Patient Aligned Care Teams (PACT). These include over 86 training positions for Outpatient Mental Health Interprofessional Teams and 116 training positions for PACTs with Mental Health Integration, specifically 12 positions in Nursing, 43 in Pharmacy, over 34 in Psychiatry, 62 in Psychology, and 51 in Social Work. The Office of Academic Affiliations is scheduled to release the Phase II Mental Health Training Expansion Request for Proposals in Spring 2013 which will further assist with VA future workforce needs.

Peer Support

There are many Veterans who are willing to seek treatment and to share their experiences with mental health issues when they share a common bond of duty, honor, and service with the provider. While providing evidence-based psychotherapies is critical, VA understands Veterans benefit from supportive services other Veterans can provide. To meet this need in accordance with the Executive Order and as part of VA's efforts to implement section 304 of Public Law 111–163 (Caregivers and Veterans Omnibus Health Services Act of 2010), VA has hired over 140 Peer Specialists and Apprentices in recent months, and is hiring and training nearly 660 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams. Simultaneously, VA is providing additional resources to expand peer support services across the Nation to support full-time, paid peer support technicians.

Performance Measures

VA is reengineering its performance measurement methodologies to evaluate and revamp its programs. Performance measurement and accountability will remain the cornerstones of our program to ensure that resources are being devoted where they need to go and are being used to the benefit of Veterans. Our priority is leading the Nation in patient satisfaction regarding the quality, effectiveness of care and timeliness of their appointments.

Recognizing the benefit that would come from improving Veteran access, VA is modifying the current appointment performance measurement system to include a combination of measures that better captures each Veteran's needs. VA will ensure this approach is structured around a thoughtful, individualized treatment plan developed for each Veteran to inform the timing of appointments.

In April 2012, VA's Office of Inspector General (OIG) report on VA's mental health programs gave four recommendations: (1) a need for improvement in our wait time measurements, (2) improvement in patient experience metrics, (3) development of a staffing model, and (4) provision of data to improve clinic management. Further, in January 2013, the U.S. Government Accountability Office reviewed VA's healthcare outpatient medical appointment scheduling and appointment notification processes, specifically focusing on Veterans wait times, local VA Medical Center implementation of national scheduling policies and processes as well as VHA initiatives to improve Veterans' access to medical appointments.

In direct response, VA is using OIG and GAO results along with our internal reviews to implement important enhancements to VA mental health care. Based on OIG and GAO findings, VA is updating scheduling practices, and strengthening performance measures to ensure accountability. VA has examined how best to measure Veterans' wait time experiences and how to improve scheduling processes to define how our facilities should respond to Veterans' needs and commissioned a study to measure the association between various measures of appointment timeliness and the resulting patient satisfaction. Based on the results of this study, VA is changing its timeliness measures to best track different populations (new vs. established patients) using the approach which best predicts patient satisfaction and clinical care outcomes. The study showed that new and established patients have different needs

and require different approaches for capturing wait times. The data identified that the Create Date, the date that an appointment is made, is the optimal method for new patients, since most new patients want their visit or clinical evaluation to occur as close to the time they make the appointment as possible. For established patients, VHA has determined that using the Desired Date is the most reliable and patient-centered approach. Desired Date is the ideal time a patient or provider wants the patient to be seen. Armed with evidence that the Create Date and the Desired Date best predict patient satisfaction and health outcomes for new and established patients respectively, VHA adopted these methods on October 1, 2012. With the recent evidence from our wait time study, ongoing VHA performance measures, as well as findings and recommendation from oversight entities, VHA believes it now has reliable and valid wait time measures that allow VHA to accurately measure how long a patient waits for an outpatient appointment. In addition, VA is developing measures based on timeliness after referral to mental health services, patient perceptions of barriers to care, and measures of clinic capacity. VHA's action plan is aimed at ensuring the integrity of wait time measurement data so that VHA has the most reliable information to ensure Veterans have timely access to care and high satisfaction.

Outcome measures

VHA provides Veterans with personalized, proactive mental health care to optimize their health and well-being. The ultimate unit of outcome is the improvement in the quality of life for each Veteran. As part of its commitment to transparency, stewardship, and exceptional health care services, VHA is also eager to have a set of outcome metrics to evaluate its mental health care system. There is no national standard for measuring outcomes in mental health care. The literature indicates the best approach is to use a variety of measures including patient satisfaction, clinical quality effectiveness, and clinical process assessment. In 2011, the National Quality Forum (NQF) published a consensus report outlining a framework for mental health and substance use outcome measures. VHA has chartered a workgroup to identify a set of population-based, outcome-oriented metrics. The development and use of these measures will be an iterative process over a period of months and years, and additional metrics will be developed using additional data sources. At present, VA has selected five initial metrics, including standardized mortality ration, rates of suicide re-attempt, drug screening of patients on opioid therapy, antipsychotic medication adherence among patients with schizophrenia, and flu vaccination rates in VA mental health patients.

In 2011, VHA raised the bar for the industry by setting a wait time goal of 14 days for both primary and specialty care appointments. Last year, VHA added a goal of completing primary care appointments within 7 days of the Desired Date. The intent is to come as close as possible to providing just-in-time mental health care for patients. The ultimate goal is same day access. VHA is focused on implementing new wait time measurement practices, policies, and technologies along with aggressive monitoring of reliability through oversight and audits. By taking these steps, we are confident that we will be able to deliver accessible, high quality, timely mental health care to Veterans. The development of improved performance metrics, more reliable reporting tools, and an initial mental health staffing model, will enable VHA to better track wait times, assess productivity, and determine capacity for mental health services. All of these tools will continue to be evaluated and improved with experience in their use.

CONCLUSION

Mr. Chairman, we know our work to improve the delivery of mental health care to Veterans will never be truly finished. However, we are confident that we are building a more accessible system that will be responsive to the needs of our Veterans while being responsible with the resources appropriated by Congress. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. VA is committed to providing the high quality of care that our Veterans have earned and deserve, and we continue to take every available action to improve access to mental health care services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. A recent report found that 30 percent of veterans seeking health care through VA seek treatment for PTSD. What is the overall number of veterans in the VA system receiving mental health care? How does this number compare with your estimate of those who actually "need" mental health care?

Response. During fiscal year (FY) 2012, over 500,000 Veterans from all eras of service received mental health treatment in VA for Post Traumatic Stress Disorder (PTSD). Within the population of returning Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans, VA estimates 13–20 percent of those Veterans may experience PTSD as a result of their military service. Given that 1,604,359 OEF/OIF/OND Veterans have become eligible for VA health care between October 1, 2001, and December 31, 2012, that would mean that between 208,567 and 320,872 eligible returning Veterans might experience PTSD. As of December 31, 2012, 486,015 OEF/OIF/OND Veterans have been seen in VA for a potential mental health diagnosis, 261,998 of whom have been seen in VA for a potential diagnosis of PTSD.

Regarding how this number compares with an estimate of the "need" for mental health care, VA assumes there are additional Veterans from all eras of service who could benefit from VA's mental health care system. There is no reliable way to estimate that number, however VA monitors mental health treatment workload and staffing to ensure sufficient capability is available to meet mission needs. In response to the President's executive order on veterans' mental health, we have increased our mental health staff to help meet this need.

Question 2. While many veterans receive mental health care through VA, others elect to receive these services from community providers. Under existing regulations, veterans enrolled in VA health care will be ineligible to receive subsidies to purchase health insurance, even if those veterans have not received care through VA in a number of years. What steps are you taking to educate veterans about this and to help them to understand their options for obtaining access to health care and health insurance in the future?

Response. VA employs multiple methods to educate Veterans about access to health care, to include options under the Affordable Care Act. Methods include phone calls, letters, briefings, and Web site postings by VA's 152 VA medical centers (VAMC), 817 Community-Based Outpatient Clinics (CBOC) and 300 Vet Centers. Also, VA proactively provides content to its local and national social media sites and bulletin newsletters, etc. VA has created a specific portion of our Web site to help inform Veterans about the Affordable Care Act: http://www.va.gov/health/aca/.

VA continues to speak directly to Veterans using all available communications avenues. It is important to demonstrate that mental health is an extremely high priority for VA, and that Veterans who receive VA's high quality health care services experienced improved health.

VA promotes the importance of Veterans visiting their local VA health care facility to learn more about VA enrollment and enrollment options. VA encourages Veterans to learn more about their VA health care system by going to http://www.va.gov/health/default.asp.

Also, VA engages with other stakeholders regarding VA mental health to include, Members of Congress, Congressional committees of jurisdiction, and staffs to provide information on mental health services and initiative for Veterans. Also, VA works with other government agencies such as the Department of Health and Human Services and Department of Defense (DOD), to provide awareness of VA mental health announcements.

Finally, VA media messaging will follow updates on all social media platforms (to include Facebook, Twitter, Vantage Point, etc.) The Veterans Health Administration (VHA) will also amplify announcements on the www.facebook/com/VeteransHealth and www.twitter.com/VeteransHealth accounts.

Question 3. Now that the Department has concluded its first round of site visit reviews of mental health care services, please describe any systemic areas that require improvement across the system and how VA intends to implement these improvements. Please also describe any best practices that you could be shared across the system.

Response. Qualitative data were analyzed from all site visit reports to identify the most common strengths and opportunities for improvement across all facilities. Areas identified for systemic improvement in the action plans were:

• *Ensuring adequate mental health staff*—VA is aggressively monitoring mental health staffing levels, including actions to fill new positions and backfill vacancies.

VA has expanded its Mental Health Staffing Model to include specialty mental health team care with the goal of implementing a general mental health team in each facility by the end of FY 2013. Additionally, the Mental Health Productivity Directive is nearing completion. Once published, this directive will be used by sites to establish systems that monitor staff productivity and staffing requirements.

• *Improving the timeliness of mental health service delivery*—VA made targeted interventions to address access to services. For example, hiring for vacancies and adding new mental health staff is enhancing access in locations with staffing deficiencies. Facilities with access shortfalls developed action plans to improve inefficient system design. Sites are expanding the use of telemental health or contracting where access challenges could not be resolved by hiring or redesign. To monitor timeliness, VA created new metrics for FY 2013 to monitor new and established patient access to care, and is continuing site visits to collect information on access from the perspective of front line staff, Veterans, and mental health leadership.

• *Improving scheduling of mental health services*—Scheduling guidance is being rewritten to address the changes in the access metrics and education. The guidance requires schedulers to be audited regularly to ensure scheduling follows the directive. In addition, the ongoing site visits include interviews with scheduling staff to review compliance with the scheduling directive.

• *Increasing provision of required mental health services to CBOCs*—VA is expanding telehealth services to CBOCs in order to improve access to care. VA is also increasing the availability of specialty telemental health services.

Other areas that needed improvement at some sites, but were systemic strengths at other sites, include:

• *Integration of mental health services into primary care*—Research from VA's Mental Health—Quality Enhancement Research Initiative has demonstrated that facilitation helps clinical stakeholders implement or improve practices. Mental health has trained staff in this technology to implement evidence-based methods of consultation with facilities/Veterans Integrated Service Networks (VISN). This process bundles an integrated set of interventions to assist facilities through interactive problem solving. Intensive facilitation assistance is currently being rolled out to help facilities which request assistance with mental health in primary care. Additional assistance includes consultation with subject matter experts from the VA Center for Integrated Healthcare and the VA National Primary Care-Mental Health Program Office, monthly national training calls, educational materials available through a national SharePoint, and the creation of VISN-wide training in integrated care, as requested. Facilities identified as needing to grow integrated care programs through the site visit process are being monitored quarterly for their progress by VHA.

• *Care coordination across levels of care*—The site visits identified that many facilities faced challenges during transitions from one level of care to another (e.g., from inpatient to outpatient services, from outpatient to residential, etc.). Often times, this involved difficulty scheduling follow-up appointments when Veterans were discharged back to another VA or to a community resource. Individuals being seen for follow-up in contract or fee-basis care do not have visits which can be tracked in internal VA databases and local solutions for tracking follow-up for these Veterans must be employed. Currently, facilities with these challenges have developed improvement plans and are reporting to VA quarterly on their progress. Additionally, VHA is monitoring progress on nationally available data such as the 7-day follow up after an inpatient hospital stay to measure and assess progress.

• *Implementation of evidence-based treatment*—VA is now supporting facilities that desire more intensive assistance with evidence-based psychotherapy (EBP) implementation. VHA is initiating new EBP trainings for FY 2013 to increase the number of staff trained in these therapies. The implementation of EBP templates will also assist in ongoing monitoring of these efforts.

• *Implementation of recovery-oriented care*—Peer support services are part of a large expansion of recovery-oriented services. Consistent with the President's executive order, VHA is hiring 800 peer support specialists in 2013 to assist with this expansion. Additionally, the site visits identified the need to expand recovery-oriented services, especially on inpatient mental health units. VHA provided two training events on recovery care in the summer of 2012 to assist facilities transforming their inpatient units to become more recovery-oriented. Site visits will continue to require action plans to be submitted with quarterly updates on areas of concern related to recovery-oriented care at facilities.

Strong Practices

VHA has developed a Mental Health Strong Practice SharePoint site, which is an online repository of information about strong practices that were identified during the site visits. The SharePoint site provides contact information for all strong prac-

tices in order to foster communication across the VHA health care community. Some initial strong practices identified, at select sites, through the site visit process include:

• *Appointment Scheduling Program*—One facility created a small graphical user interface program that allows clinicians to quickly enter patient appointment information into the program with little typing. Once entered, the software places the appointment in the clinician's Outlook calendar with a numerical placeholder representing the patient. Clerical staff enters the appointment into VistA (VA's Electronic Health Record), the Veterans Health Information Systems and Technology Architecture, later the same day using automation. There is also an application for simple, rapid scheduling of mental health groups.

• *Dissemination of EBP via Telemental Health*—Clinicians who have completed training in an EBP are available at the main facility and at each of the CBOCs to offer EBPs across site. Each location has telehealth equipment readily available and all certified EBP clinicians are trained in the use of telemental health. This allows for EBPs to be offered across sites as needed, and provides for therapist gender preference flexibility and opportunities to improve access to care for a variety of Veterans.

• *Psychiatric Community Nursing Home Visits*—A VA psychiatrist travels to community-based, long-term, secured facilities to provide regular weekly psychiatric care, and to provide training to facility staff. This has facilitated increased communication between nursing facility staff and VA providers, and provides community nursing home residents with more frequent outpatient care. This practice has reduced emergency room visits and inpatient hospitalizations.

• *Time Limited Case Management for Chemical Abusing Mentally Ill (TLC-CAMI)*—The TLC-CAMI program seeks to improve continuity of care for Veterans with mental illness and co-morbid substance use disorders through a combination of case management, a harm reduction philosophy, and peer support designed to improve linkage to and sustained engagement in outpatient substance use disorder services.

Question 4. Based on the findings from the first round of site visit reviews of mental health services, how will VA ensure systematic surveillance efforts are carried out to better understand care trends, links between care processes and treatment outcomes, and facility-by-facility differences in performance?

Response. Systematic review of progress is part of each site visit. At the conclusion of each site visit, a report is issued outlining recommendations for responses from each facility. Facilities have an individualized follow-up call with VHA Central Office mental health and VISN leadership to discuss the recommendations and to develop specific strategic action plans. Facilities submit quarterly updates to document progress. Return visits to each facility will occur at least once every 3 years to monitor the Uniform Mental Health Services Handbook implementation. In addition, VHA will continue to analyze site visit findings, administrative data and other data sources to determine trends in care, barriers to implementation, and system-wide concerns.

Question 5. An important challenge for monitoring the outcome of evidence-based mental health treatments is the availability of good metrics to track the use of those treatments. VA's Office of Mental Health Services has previously committed to fully implementing psychotherapy session note templates by the end of FY 2013, which will help the agency to develop better metrics. Please provide the Committee with the status of the implementation of these session note templates.

Response. The information technology project to develop and implement psychotherapy session note templates in support of the EBP dissemination initiative is underway. Templates in support of the key psychotherapy protocols for the treatment of PTSD and depression are currently being piloted at four VAMCs. The templates are scheduled for national deployment during the fourth quarter of FY 2013.

Question 6. It is important to recognize that there should not be a "one-size fits all" approach to mental health treatment. What steps is VA taking to increase availability of alternatives for veterans, including complementary and alternative medicine? What has VA done to promote these care options?

Response. VHA's strategic priority is to provide personalized, proactive, patient-driven health care to our Veterans. Providing this care requires expanding health care options that are available to Veterans. To this end, VA is moving toward a model of care that is better aligned with integrative medicine principles, which include complementary and alternative medicine (CAM). Integrative medicine as defined by the Consortium of Academic Health Centers for Integrative Medicine is:

> "The practice of medicine that reaffirms the importance of the relationship between practitioner and patient, focuses on the whole person, is informed by evidence, and makes use of all appropriate therapeutic approaches, healthcare professionals and disciplines to achieve optimal health and healing."

The "practice" has the Veteran at the center of the health care team, and begins with *their* vision of health and their values and goals. It links the Veteran's personalized health plan to what matters to them in their lives, and it supports them in acquiring the skills and resources they need to succeed in making sustainable changes in their health and life. This approach, including the development of a personalized health plan, will improve identification of Veterans seeking CAM and better enable VA's ability to provide these services. This aligns with both the Recovery Model and the personalized, proactive, patient-driven approach, which is patient-centered care. VA mental health is seeking to transform care through the rational integration of CAM using this patient-centered care model.

Recognizing the alignment of integrative medicine and CAM and its critical role in meeting the VHA strategic priority for health care delivery transformation, the Office of Patient Centered Care and Cultural Transformation (OPCC&CT) has deployed a number of clinical, research, and education initiatives. These initiatives include clinical pilots, work within existing VA Centers of Innovations, work with VA Health Services Research and Development, as well as creating curricula and piloting education in these areas. In support of this effort, Mental Health Services is currently working collaboratively with OPCC&CT to develop an innovative approach to mental health care in VA for patient population groups at high risk for suicide. This initiative will focus on providing mental health care to these groups of patients based on how patients define their needs and include the use of both established evidence-based treatment and alternative and complementary strategies. This exciting campaign will involve both provider and patient education messaging as well as the development of new tools for providers to use to drive this use of alternative care strategies. We anticipate starting to roll out this initiative later this year.

Question 7. Families are an important source of support for veterans as they receive mental health treatment. What guidance has been provided to VA facilities on engaging families in veterans' mental health treatment?

Response. VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics, contains guidance for VA clinicians on family involvement in the Veteran's mental health treatment. VHA has developed a graduated continuum of services to meet the individual needs of Veterans and their family members. Public Law (P.L.) 110–387, Veterans' Mental Health and Other Care Improvement Act of 2008, added Marriage and Family Counseling to the list of available family services and removed limitations for non-service-connected Veterans (required hospitalization and identified need of family services for discharge). An Under Secretary for Health Information Letter was distributed to the field providing guidance on implementing this expansion for family services. The full continuum of family services ranges from family resiliency (currently in pilot phase) to family education, to family consultation, and then to more intense family psychoeducation and marriage and family counseling. VHA has created a Family Services SharePoint intranet site that is an internal resource for VHA staff and clinicians and conducts monthly educational conference calls to assist and educate VA clinicians.

This year's suicide prevention awareness campaign, "Stand By Them," is designed to encourage family members and friends to help their Veteran seek help. Across the country, Suicide Prevention Coordinators (SPC) is providing education and information about the warning signs and symptoms as well as how to get help by calling a local contact or the Veterans Crisis Line. Family members may also be experiencing difficulty themselves. Through a series of calls with Mental Health Liaisons, Local Recovery Coordinators, and OEF/OIF/OND Coordinators, VA staff around the country have been educated about the new provisions in Section 304 of the Caregiver Law, which authorizes VA to provide mental health care and readjustment counseling for families members of new Veterans for the first 3 years after their return from deployment. Brochures, Web announcements, and posters have been developed and are in different stages of distribution to encourage family members to seek services through their local VA facility or Vet Center.

Question 8. In the last year, how many veterans have received psychotherapy via telehealth? What processes, if any, does VA have in place to ensure that veterans are comfortable with receiving those services via telehealth as opposed to in-person?

Response. In FY 2012, VA provided telemental health consultations to 76,817 Veterans. VA does not have data currently available on the number of these Veterans who received psychotherapy via telehealth. VA does have data from FY 2006–2010

showing that between 57–62 percent of telemental health encounters were for psychotherapy. In FY 2012, VA provided 218,000 telemental health encounters to Veterans for all mental health conditions.

VA standard practice is to offer all Veterans appropriate for telemental health services the choice between traditional in-person visits and telemental health. VA conducts and documents in the patient record verbal informed consent for each Veteran choosing to commence telehealth services (to include telemental health services). VA conducts telehealth satisfaction surveys for Veterans choosing telehealth services. In FY 2012, clinical video telehealth (to include telemental health services) had a patient satisfaction score of 93 percent. VA is expanding teleconsultations into the home for mental health conditions with over 800 Veterans receiving these services in FY 2013. Further expansion of this care is planned and facilitated by technology innovations and VA's elimination of co-payments for video consultation into the home in FY 2012.

Question 9. Although the VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress cautions clinicians against prescribing sedatives for veterans with PTSD, there have been reports of high rates of such practices in VA. Please provide the number and percentage of veterans receiving treatment for PTSD through VA who were prescribed sedatives over the past year.

Response. In FY 2012, 28.1 percent of 502,546 (140,713) patients with PTSD were prescribed a benzodiazepine. Although benzodiazepines are the type of sedative that the PTSD clinical practice guideline recommends against prescribing in patients with PTSD, there are instances where a co-morbid diagnosis would have benzodiazepine as an appropriate treatment modality. Due to their lack of efficacy in the management of PTSD and their potential adverse effects, VHA is currently looking at benzodiazepine use in PTSD patients to ascertain whether or not such sedatives were appropriately prescribed.

(a) To address the issue of prescribing of benzodiazepines in PTSD patients, the National Center for PTSD has developed a number of products to inform providers on guideline-concordant practices. In addition to the peer reviewed articles listed in the recent PTSD Research Quarterly that focused on benzodiazepines in PTSD, The Role of Benzodiazepines in the Treatment of Posttraumatic Stress Disorder (PTSD) RQ Vol 23(4). 2013, disseminated to over 19,000 VA subscribers, there are numerous publications, lecture series, and educational materials that have been widely disseminated by VA. Specific examples include the Journal of Rehabilitation Research and Development Special Single-Topic Issue Related to PTSD Available Online; a Clinician's Guide to Medications on www.ptsd.va.gov that was visited over 47,000 times in 2012; 3 PTSD 101 Online Courses that provide recommendations about pharmacotherapy for PTSD and include cautions about the use of benzodiazepines that had a total of over 15,000 visits in 2012. There was also a kickoff presentation by Dr. Matthew Friedman in the 2013 PTSD Psychopharmacology Lecture Series in which a warning about the use of benzodiazepines was reiterated to over 350 VA clinicians. The June 2013 lecture topic is "Strategies to Decrease Benzodiazepine Use in PTSD" and will be given by Drs. Tasha Souter and Nancy Bernardy.

(b) The VA Academic Detailing Pilot Program, developed in VISNs 21 and 22, is a proactive outreach intervention aimed at improved patient care by promoting use of evidence-based treatments in Veterans with mental illness. The program uses clinical pharmacy specialists to meet face-to-face with VA prescribing clinicians to share educational program materials embedded with key messages and an informatics tool, the mental health dashboard, to provide desktop caseload information to target. Data collection for the dashboard includes 100 percent sampling of updated daily clinical information and allows clinicians to have a snapshot view of their patient panels to improve individual patient care. One of the areas that the academic detailers have targeted is PTSD and they have seen some positive effects through the pilot. These include increases in clinician use of the PTSD Checklist, increases in the use of prazosin to target PTSD-related nightmares, a practice recommended by the guideline, and decreases in the use of off-label atypical antipsychotic prescribing. Materials have been developed specifically to target benzodiazepine prescribing in PTSD patients by the academic detailing team and are now in use.

(c) The academic detailing work, outlined above, specifically targets prescribing clinicians through one-on-one intervention. Various research projects funded by VA to target benzodiazepine prescribing are also currently under development. Currently, there is not a decision support prompt nationally in the VA EHR that reminds prescribing clinicians of the guideline. VA does, however, have alerts that come up that caution prescribers about certain medications.

Question 10. What steps does VA take to inform veterans of complementary and alternative medicine options at VA facilities?

Response. Complementary and alternative medicine (CAM) options are currently provided within VA. There are currently several research and demonstration projects in progress that will be used to determine ongoing direction. In the meantime, Veterans are informed of CAM services as available at local VA facilities given the variability in options. Currently, a directive is being developed to help guide VA facilities in their implementation of these practices. The estimated time of completion for this directive is May 31, 2014.

Question 11. Please describe any recent and ongoing research that VA has on the use of complementary and alternative medicine for veterans.

Response. For PTSD and mental health conditions, VA research is determining the potential benefit of a variety of CAM approaches, several of which are highlighted here:

- Meditative techniques to improve PTSD symptoms, including mindfulness based stress reduction and mantram repetition are being examined in small clinical trials. The findings from these studies will be used to determine whether larger scale, more confirmative trials are needed to show whether there is sufficient evidence to support adopting these methodologies in clinical care.
- Several small pilot studies are underway to examine whether acupuncture improves symptoms related to PTSD or Traumatic Brain Injury.
- A study using bright light exposure in comparison to placebo is evaluating whether this treatment relieves symptoms of PTSD or other conditions.
- A study will evaluate use of service dogs for individuals diagnosed with PTSD. Objectives include: (1) to assess the impact service dogs have on the mental health and quality of life of Veterans; (2) to provide recommendations to VA to serve as guidance in providing service dogs to Veterans; and, (3) to determine cost associated with total health care utilization and mental health care utilization among Veterans with PTSD.

In 2011, VA research supported an analysis of the available research on CAM therapies for PTSD and concluded that there was a need to support rigorous clinical trials to evaluate the efficacy of these methods. In general, VA research has encouraged the exploration of CAM for conditions important to Veterans and has included CAM as a priority topic in clinical research.

Question 12. Although there may be limited evidence that wellness programs—when combined with more traditional therapies—can improve a veteran's quality of life, such programs may be a useful tool for veterans. Do you agree that wellness programs, such as yoga and meditation, have a place alongside VA's traditional mental health care services? If so, please describe the steps, if any, that VA is taking to promote wellness among veterans.

Response. Public Law 104–262, The Veterans' Healthcare Eligibility Reform Act of 1996, called for VA to provide needed hospital and medical services that will promote, preserve and restore health. Disease prevention and health promotion are cornerstones of VA's approach to care and VA strongly endorses the promotion of self-care and wellness activities that are focused on improving the general health and well-being of Veterans. Many Veterans, including those with chronic mental illness, are experiencing problems with overweight and obesity, which puts their health and quality of life at risk. VA has made a concerted effort to measure weight in mental health settings and offer the Managing Overweight/Obesity for Veterans Everywhere (MOVE!) Weight Management Program to foster lifestyle change that promotes maintaining a healthier weight. VHA has funded research efforts to examine whether MOVE! can be enhanced for patients with serious mental illness. VA has also implemented programs in stress management and problem-solving skill development to improve quality of life among Veterans.

There is increasing awareness within VA of the potential benefits of non-traditional methods in the management of chronic diseases including the management of mental health conditions. CAM practices, while lacking the evidence of efficacy to become standard of care as standalone therapies do show some promise as adjuncts to usual care. Studies have shown that therapies such as acupuncture, yoga, meditation, and tai chi may have beneficial effects and these effects may be useful in our approach to care of the Veteran with chronic health conditions. At the present time these CAM practices are not used in a systematic way across VA. However, efforts are ongoing to help improve our understanding of these modalities and how they may best benefit Veterans.

One approach VHA is undertaking to foster this education and understanding of the role of wellness in mental health treatment is through the sponsoring of demonstration projects. VHA's Mental Health Services is coordinating a series of dem-

onstration projects at local sites looking at the implementation of various types of meditation programs to treat Veterans with PTSD. The focus is on learning how best to introduce these modalities and integrate them into the Veteran's plan of care as interventions. In addition, VA wishes to learn how to support Veterans in sustaining these practices as well as measuring such variables such as patient satisfaction and symptom reduction. There are currently nine projects at eight different sites that will complete their implementation and first rounds of data collection by this summer. VA will then take the lessons learned to help implement more programs across the country.

Question 13. How is VA collecting and analyzing data from the Veterans Crisis Line and the Suicide Prevention Coordinators to ensure all facilities can benefit from lessons learned?

Response. When calls come into the Veterans Crisis Line (VCL) there is an internal referral mechanism via a secure web based program that allows the VCL staff to submit a referral to the local facility that they are required to respond to within 24 business hours. The VCL staff checks these daily to assure no one "slips through the cracks" and outcomes (admission, appointments, evaluations, etc.) are tracked. This and all VCL information regarding phone calls, chats initiated, and incoming texts are kept in a continual data system for VCL. Also, this information is provided to the field on a monthly basis.

VA collects data from the SPCs on a monthly basis and returns a monthly report to facilities including the numbers of suicide attempts, known suicides, outreach events, safety plans completed, etc., so facilities can track their progress and know how they compare within the system. Within the VISNs, SPCs meet to determine best practices and how to share ideas and interventions. There are monthly calls with all SPCs to review data and new policies and practices. There is also a suicide related analytic team that reviews all suicide related data on an ongoing basis and provides information back to the field in the form of memorandums or information sheets whenever specific information might be useful.

All of this information is also discussed during the monthly SPC calls to provide lessons learned about referrals and the Crisis Line processes to everyone.

Question 14. What practices does VA believe have been most effective in curbing suicides among veterans? Please also describe additional strategies that VA could take to further reduce the number of veteran suicides.

Response. VA believes that current programs (including the Veterans Crisis Line, SPCs, and the Suicide Prevention Enhanced Care program described further below) are effective.

The Veterans Crisis Line is a 24/7 call center that operates phone lines, a one-to-one chat service and a texting service to provide immediate mental health care and services to any Veteran, Servicemember, and family member who is in crisis or concerned about someone in crisis. Since its inception in 2007, over 800,000 calls, and 7,000 text messages have been received and responded to. There have been over 28,000 instances when emergency services were sent to someone in imminent danger.

SPCs and teams are at each VAMC and very large CBOC. These teams have the responsibility to monitor and assure care to high risk patients and respond to referrals from the Crisis Line and other sources. Their objective is to ensure that no patient slip through the cracks and that care is provided in a timely and individually appropriate manner. They also serve as both internal training and community education around suicide awareness, track events, participate in quality improvement programs and provide a resource to their facilities.

Each patient identified as being a high risk for suicide is enrolled in the Suicide Prevention Enhanced Care program. This involves having a chart notification flag placed on the medical record, receiving increased follow up for missed appointments, a development of a safety plan and mandated weekly follow-up visits. Through these efforts, VA has been able to decrease the number of suicide re-attempts.

If additional strategies become evident, VA will certainly implement them. Hopefully, ongoing research will soon provide additional intervention strategies, and continued outreach will result in more Veterans seeking care earlier. It is difficult to determine the direct effect that proactive outreach initiatives such as "Make the Connection" have on suicide rates.

Question 15. We understand that the nationwide shortage of mental health clinicians may present challenges to VA as the agency tries to hire additional clinicians to fill mental health vacancies. Please describe when VA facilities should coordinate with community providers to meet veterans' mental health needs and the extent to which VA has provided its facilities with guidance on this topic.

Response. VHA authorizes non-VA medical care when VA facilities or other government facilities are not capable of furnishing economical hospital care or medical services because of geographic inaccessibility or are not capable of furnishing care or services required. The ability to authorize non-VA medical care is legislated and subject to restrictions in how and when care may be authorized. In general, however, facilities have coordinated with community providers to support care for Veterans in the community as part of non-VA medical care. VA is developing additional guidance as part of the response to the President's executive order on Mental Health (Executive Order 13625). As part of the response to this executive order, the Department of Veterans Affairs (VA) has established pilot projects with 24 community-based mental health and substance abuse providers across nine states and seven Veterans Integrated Service Networks (VISNs). Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. As these pilot projects are evaluated, lessons learned will be compiled and shared with VA facilities nationwide.

Question 16. The most recent quarterly update from VA on the hiring of an additional 1,600 clinicians reflects that the Department hired just forty-seven clinicians in the last two months. During our hearing, Dr. Petzel indicated that VA is on track to hire the remaining 495 clinicians by June 30th of this year. Please provide information on the number of clinicians currently in the pipeline and VA's plan for completing the hiring process by the deadline.

Response. VA will continue to execute an aggressive recruitment campaign. As of June 30, 2013, 4,308 mental health professionals and administrative support have been hired and are providing services to Veterans since the start of VA's mental health hiring initiative in April 2012. VHA has 213 positions remaining to meet the goal. As of June 30, 2013, 42 job announcements were posted, 386 interviews and selections were pending, 204 tentative job offers and 99 firm job offers were made for a total of 731 potential hires in the pipeline. The number of clinical mental health professionals hired is 3,833 which includes the hiring efforts for existing VA positions and 1,669 new positions to meet the 1,600 position goal outlined in the August 2012 Executive Order. VA has also hired 304 administrative support personnel to meet the 300 position goal.

Question 17. How has VA supported the Army's efforts to improve the diagnosis and evaluation of behavioral health conditions? Please describe what VA has learned from the Army's efforts.

Response. In May 2012, the Secretary of the Army issued a directive to investigate and identify any systemic breakdowns or concerns in the Integrated Disability Evaluation System (IDES) as they affect the diagnosis and evaluation of behavioral health conditions. As a result of this directive, the Army Task Force on Behavioral Health was established. VA supported the Army's efforts to improve the diagnosis and evaluation of behavioral health conditions by having a senior mental health staff member serve as an active participant on this Task Force. From the Army's efforts, VA has learned that VA and the Army need to continue to engage in active communications regarding the IDES process. VA believes we are well positioned to have examiners evaluate behavioral health conditions in a timely fashion as part of the IDES process. VA will continue to support the Army and other branches of the Armed Forces in ensuring that individuals are evaluated for behavioral health conditions utilizing the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Executive Order 13625, regarding mental health services for veterans, recognized the importance of peer-to-peer counseling by directing the Department of Veterans Affairs (VA) to hire 800 of these counselors by December 31, 2013. Information supplied to the Committee by VA indicates that, as of March 5, 2013, VA has hired 149 peer-to-peer counselors.

a. How many of the 149, noted above, were hired after the Executive Order was signed on August 31, 2012?

Response. All of the 149 noted above were hired after the Executive Order was signed.

b. How many of the 800 peer-to-peer counselor positions will be new positions beyond those already employed by VA when the executive order was signed?

Response. All 800 peer counseling positions are new. To meet the requirements of Public Law 110–387, VA established a new, singular job classification for peer-

to-peer counselors that use the job titles of Peer Specialists, for those who are certified to provide peer support services, and Peer Support Apprentices, for those who are in training but not yet certified. This new job classification provides significant promotion possibilities for peers in demonstration of VHA's commitment to employing Veterans in meaningful jobs that have a career potential. All 800 peer counseling positions specified in the Executive Order are using the new job classification. Also, 275 VA employees have met the requirements to be converted to a peer specialist or peer support apprentice position, and 582 new employees have been hired, for a total of 857 new peer counselors.

c. What metrics will be used to determine which facilities will receive the new peer-to-peer counselors, and how many counselors will be needed at each facility?

Response. VA Mental Health Services has established a minimum standard of three peers counselors per VAMC and two peers counselors per very large CBOC. The majority of the 800 positions required by the Executive Order will be used to ensure that each facility meets at least the minimum standard. The remaining positions will be allocated to facilities based on projected outpatient mental health service demand and will be assigned to meet special needs as identified by the facilities.

d. Please describe, in detail, the training process and length of time training takes for new counselors.

Response. Peer counselors who have been hired but who are not yet certified are receiving certification training through contracts with community organizations. Training includes a week-long face-to-face workshop in addition to training delivered over the internet or a 2-week face-to-face course, covering such topics as communications skills, group facilitation, mental health first aid, crisis management, problem solving, the recovery process, understanding mental health conditions, the effects and side effects of medications, and working in a professional setting. Following the training activities, these peer support apprentices take an examination to receive their certification to provide peer counseling services.

Question 2. The Executive Order directed VA and HHS to develop 15 pilot projects, "whereby [VA] contracts or develops formal arrangements with community-based providers * * * to test the effectiveness of community partnerships in helping to meet the mental health needs of veterans in a timely way." According to information provided to the Committee, 11 pilot projects have been established with five more to be established by May 31, 2013.

a. Please describe, in detail, the metrics that went into deciding the locations of the pilot projects.

Response. VA has assessed recruitment success and difficulties, as well as access to care issues (performance measure information) such as wait times for appointments and geographic distances to VAMCs and/or CBOCs, to determine its top priorities for collaboration. These factors were used as VA developed its first round of pilot programs for community partnerships. Challenges in recruitment vary across VHA due to the differences between VHA facilities, patient need, and the local availability of mental health professionals. Additionally, the programs developed have considered community provider available capacity and wait times, community treatment methodologies available, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

b. In the past, VA medical centers (VAMC) have not referred veterans for care outside of VA on a consistent basis. How does VA intend to ensure that VAMC's, Clinics, and Vet Centers refer veterans for mental health care under these pilot projects?

Response. The first pilots initiated under the direction of the Executive Order were brought online during the last week of February 2013. There has been a positive response not only from the associated VAMC staff and the community partners, but among Veterans. VA leadership, from the Under Secretary for Health to the Network Directors to VAMC Directors, have made this a priority to implement and oversee these pilots. By early inclusion of both sides of the partnership in the planning and allowing the sites the leeway to define their programs based on local needs, we have achieved early buy-in from facilities and staff. To preserve the initial enthusiasm about these pilots, regular calls are conducted not only with each local site, but with the nationwide group to encourage information sharing and lessons learned. Veterans are encouraged to participate in a number of ways. The sites are using e-mail and local announcements to ensure staff are aware of the pilot program and the potential for inclusion of Veterans in the pilot. The Veteran's situation must be reviewed in order to ensure a good match for the treatment types and locations being offered through the pilots. VA staff contact the Veteran, explain the program, and offer the opportunity to participate. The key to a successful outcome and contin-

ued participation by all parties is coordinated communication among VA, the community partner, and the Veteran. Community partners are also reviewing their files for Veterans that may not be enrolled with VA and working with their pilot contacts at VAMCs to contact and enroll these Veterans.

c. Please provide the Committee with any directives, memoranda, or other communication to VAMC's, Clinics, and Vet Centers regarding the pilot projects.

Response. Each of the local VA sites will identify the best process for establishing a contract or other formal arrangement based on their unique local needs. There is no additional document that provides information on the pilot programs at this time. The VA pilot sites have been provided the Executive Order and a welcome letter from the Under Secretary of Health designating them as pilot locations. Routine conference calls are held to facilitate the process to determine status, identify any risks or issues, resolve or follow up on issues and questions, and provide lessons learned and best practices among the participating VAMCs. When establishing these pilots, VA is required to comply with regulatory and procedural policies that exist in the areas of procurement law, purchased care, and space utilization.

Question 3. Last April, VA announced the hiring of 1,600 mental health providers and 300 administrative staff. Please provide the Committee with the number of mental health providers and administrative staff hired. Please break this information out by provider type, by VISN and other offices, and by stage in the process (i.e. positions pending recruitment requests, positions pending draft announcement, number of positions advertised, positions with interviews pending, positions awaiting hiring manager decision, number of positions with a tentative job offer, number of positions with a firm job offer, and number of people hired and on board).

Response. As of June 30, 2013, VA hired a total of 1,669 mental health clinical providers and 304 nonclinical personnel to meet the goal of 1,600 new mental health professionals and 300 mental health administrative support staff. Attachment 1 provides information regarding the hired clinical providers and nonclinical staff by VISN.

ATTACHMENT 1

Clinical and Nonclinical Mental Health Hires as of June 30, 2013

By Network:

As of June 30, 2013	New MHC Hires			MHC Hires			Total Hires		
Network / Facility	Clinical	Non Clinical	Total New	Clinical	Non Clinical	Total MHC	Clinical	Non Clinical	Grand Total
VISN 1 Total	34	1	35	83	10	93	117	11	128
VISN 2 Total	10	1	11	41	3	44	51	4	55
VISN 3 Total	10	0	10	133	1	134	143	1	144
VISN 4 Total	203	41	244	81	1	82	284	42	326
VISN 5 Total	5	0	5	49	5	54	54	5	59
VISN 6 Total	55	15	70	78	18	96	133	33	166
VISN 7 Total	140	28	168	177	0	177	317	28	345
VISN 8 Total	198	47	245	145	4	149	343	51	394
VISN 9 Total	124	21	145	125	10	135	249	31	280
VISN 10 Total	24	3	27	88	6	94	112	9	121
VISN 11 Total	69	10	79	79	9	88	148	19	167
VISN 12 Total	46	9	55	117	16	133	163	25	188
VISN 15 Total	44	10	54	76	2	78	120	12	132
VISN 16 Total	177	40	217	142	16	158	319	56	375
VISN 17 Total	113	23	136	99	8	107	212	31	243
VISN 18 Total	47	8	55	102	10	112	149	18	167
VISN 19 Total	28	9	37	82	8	90	110	17	127
VISN 20 Total	23	2	25	148	26	174	171	28	199
VISN 21 Total	46	7	53	114	9	123	160	16	176
VISN 22 Total	98	18	116	111	5	116	209	23	232
VISN 23 Total	81	10	91	83	2	85	164	12	176
VCL Total	94	1	95	11	2	13	105	3	108
Grand Total	1669	304	1973	2164	171	2335	3833	475	4308

By State:

As of June 30, 2013	R19 Hires			MHC Hires			Total Hires		
State Facility	Clinical	Non Clinical	Total R19	Clinical	Non Clinical	Total MHC	Clinical	Non Clinical	Grand Total
AK Total	1	0	1	15	1	16	16	1	17
AL Total	52	8	60	91	0	91	143	8	151
AR Total	34	8	42	36	8	44	70	16	86
AZ Total	13	3	16	45	4	49	58	7	65
CA Total	106	19	125	184	13	197	290	32	322
CO Total	13	6	19	30	3	33	43	9	52
CT Total	2	0	2	16	1	17	18	1	19
DC Total	0	0	0	2	0	2	2	0	2
DE Total	33	5	38	4	0	4	37	5	42
FL Total	184	44	228	128	4	132	312	48	360
GA Total	45	10	55	53	0	53	98	10	108
HI Total	1	0	1	7	1	8	8	1	9
IA Total	18	2	20	25	1	26	43	3	46
ID Total	1	0	1	11	2	13	12	2	14
IL Total	44	7	51	88	7	95	132	14	146
IN Total	16	2	18	14	3	17	30	5	35
KS Total	20	4	24	37	2	39	57	6	63
KY Total	24	4	28	50	2	52	74	6	80
LA Total	30	7	37	32	5	37	62	12	74
MA Total	13	0	13	28	6	34	41	6	47
MD Total	3	0	3	28	3	31	31	3	34
ME Total	5	0	5	3	0	3	8	0	8
MI Total	45	8	53	55	8	63	100	16	116
MN Total	30	2	32	25	0	25	55	2	57
MO Total	18	3	21	30	0	30	48	3	51
MS Total	55	12	67	39	0	39	94	12	106
MT Total	7	2	9	10	0	10	17	2	19
NC Total	37	6	43	56	9	65	93	15	108
ND Total	4	1	5	8	0	8	12	1	13
NE Total	16	2	18	8	1	9	24	3	27
NH Total	5	1	6	11	0	11	16	1	17
NJ Total	5	0	5	52	0	52	57	0	57
NM Total	14	3	17	29	2	31	43	5	48
NV Total	37	6	43	34	0	34	71	6	77
NY Total	15	1	16	122	4	126	137	5	142
OH Total	24	3	27	88	6	94	112	9	121
OK Total	32	6	38	23	1	24	55	7	62
OR Total	5	1	6	70	10	80	75	11	86
PA Total	254	32	286	85	3	88	339	35	374
PR Total	14	3	17	17	0	17	31	3	34
RI Total	7	0	7	12	2	14	19	2	21
SC Total	43	10	53	33	0	33	76	10	86
SD Total	13	3	16	17	0	17	30	3	33

By State:

As of June 30, 2013		R19 Hires			MHC Hires			Total Hires		
State	Facility	Clinical	Non Clinical	Total R19	Clinical	Non Clinical	Total MHC	Clinical	Non Clinical	Grand Total
TN Total		90	14	104	69	7	76	159	21	180
TX Total		159	32	191	139	14	153	298	46	344
UT Total		3	1	4	21	1	22	24	2	26
VA Total		18	8	26	21	8	29	39	16	55
VT Total		2	0	2	13	1	14	15	1	16
WA Total		16	1	17	52	13	65	68	14	82
WI Total		16	5	21	48	7	55	64	12	76
WV Total		22	9	31	29	4	33	51	13	64
WY Total		5	0	5	21	4	25	26	4	30
Grand Total		1669	304	1973	2164	171	2335	3833	475	4308

STATE LOOKUP

Informal Name	State
Alaska Healthcare System	AK
Albany VAMC	NY
Alexandria VAMC	LA
Altoona VAMC	PA
Amarillo HCS	TX
Ann Arbor VAMC	MI
Asheville VAMC	NC
Atlanta VAMC	GA
Augusta VAMC	GA
Bath VAMC	NY
Battle Creek VAMC	MI
Bay Pines HCS	FL
Beckley VAMC	WV
Bedford VAMC	MA
Birmingham VAMC	AL
Black Hills HCS	SD
Boise VAMC	ID
Boston HCS	MA
Bronx VAMC	NY
Canandaigua VAMC	NY
Captain James A. Lovell FHCC	IL
Central AL HCS	AL
Central Arkansas HCS	AR
Central Iowa HCS	IA
Central Texas HCS	TX
Central Western MA HCS	MA
Charleston VAMC	SC
Cheyenne VAMC	WY
Chicago VAMC	IL
Chillicothe VAMC	OH
Cincinnati VAMC	OH
Clarksburg VAMC	WV
Cleveland VAMC	OH
Coatesville VAMC	PA
Columbia (MO) VAMC	MO
Columbia (SC) VAMC	SC
Columbus OPC	OH
Connecticut HCS	CT
Danville VAMC	IL
Dayton VAMC	OH
Detroit VAMC	MI
Dublin VAMC	GA
Durham VAMC	NC
Eastern CO HCS	CO
Eastern Kansas HCS	KS
El Paso HCS	TX

Informal Name	State
Erie VAMC	PA
Fargo HCS	ND
Fayetteville (NC) VAMC	NC
Fresno VAMC	CA
Grand Junction VAMC	CO
Greater Los Angeles HCS	CA
Gulf Coast Veterans HCS	MS
Hampton VAMC	VA
HCS of the Ozarks	AR
Hines VAMC	IL
Honolulu VAMC	HI
Houston VAMC	TX
Hudson Valley HCS	NY
Huntington VAMC	WV
Indianapolis VAMC	IN
Iowa City HCS	IA
Iron Mountain VAMC	MI
Jackson VAMC	MS
Kansas City VAMC	KS
Lebanon VAMC	PA
Lexington VAMC	KY
Loma Linda HCS	CA
Long Beach HCS	CA
Louisville VAMC	KY
Madison VAMC	WI
Manchester VAMC	NH
Marion VAMC	IL
Martinsburg VAMC	WV
Maryland HCS	MD
Memphis VAMC	TN
Miami HCS	FL
Milwaukee VAMC	WI
Minneapolis HCS	MN
Montana HCS	MT
Mountain Home VAMC	TN
Muskogee VAMC	OK
Nebraska-Western Iowa HCS	NE
New Jersey HCS	NJ
New Mexico HCS	NM
North Florida-South Georgia HCS	FL
North Texas HCS	TX
Northern AZ HCS	AZ
Northern California HCS	CA
Northern Indiana HCS	IN
Northport VAMC	NY
NY Harbor HCS	NY

STATE LOOKUP

Informal Name	State
Oklahoma City VAMC	OK
Orlando VAMC	FL
Palo Alto HCS	CA
Philadelphia VAMC	PA
Phoenix HCS	AZ
Pittsburgh HCS	PA
Poplar Bluff VAMC	MO
Portland VAMC	OR
Providence VAMC	RI
Puget Sound HCS	WA
Reno VAMC	NV
Richmond VAMC	VA
Roseburg HCS	OR
Saginaw VAMC	MI
Salem VAMC	VA
Salisbury VAMC	NC
Salt Lake City HCS	UT
San Diego HCS	CA
San Francisco VAMC	CA
San Juan HCS	PR
Sheridan VAMC	WY
Shreveport VAMC	LA
Sioux Falls HCS	SD
SORCC VAD White City	OR
South Texas HCS	TX
Southeast LA HCS	LA

Informal Name	State
Southern AZ HCS	AZ
Southern Nevada HCS	NV
Spokane VAMC	WA
St. Cloud HCS	MN
St. Louis VAMC	MO
Syracuse VAMC	NY
Tampa VAMC	FL
Texas Valley Coastal Bend HCS	TX
TN Valley HCS	TN
Togus VAMC	ME
Tomah VAMC	WI
Tuscaloosa VAMC	AL
VA Butler Healthcare	PA
VISN 2 Albany, NY	NY
VISN 7 Atlanta, GA	GA
VISN 9 Nashville, TN	TN
Walla Walla VAMC	WA
Washington VAMC	DC
West Palm Beach VAMC	FL
West Texas HCS	TX
Western NY HCS Buffalo	NY
White River Jct VAMC	VT
Wichita VAMC	KS
Wilkes-Barre VAMC	PA
Wilmington VAMC	DE

Question 4. At the hearing, VA testified that "* * * one of the takeaways from this hearing is to go out and * * * have a summit in the community of mental health providers," to work with community organizations in a more systematic way and "* * * stimulate our people to think about using the community in a larger sense." VA testified these mental health summits would be modeled after the homeless summits held by local VAMC's.

a. What directives will the Veterans Health Administration (VHA) provide to local VAMCs to ensure that facilities hold these mental health summits and follow through with the goal of involving the community in providing mental health care to veterans?

Response. These directives are in the process of being developed along with timelines and goals. We will share them as they are completed. VHA Mental Health Services will organize and support these summits and provide technical assistance to facilities to develop needed partnerships at the local community based level. Each VHA facility is required to complete their Mental Health Summit between July 1, 2013, and September 30, 2013.

b. How will the information gathered be translated into new partnerships within the community?

Response. This will be a locally driven endeavor but will be tracked centrally to assure participation and ongoing monitoring. Again, the plans for these are being developed now and will be shared as we move ahead.

c. Please provide a list of all VHA facilities that have held homeless summits since 2009 and any agenda or information that was developed for these homeless summits.

Response. Beginning in FY 2011, VA asked VAMCs to host Homeless Veteran Summits to synchronize Federal, state, and community resources in VA's efforts to end Veteran homelessness. As requested, please find below a list of all VAMCs that conducted a Homeless Summit in FY 2011 and FY 2012. VA is also providing a list of Homeless Summits already held in FY 2013 or planned for FY 2013.

HOMELESS SUMMIT INFORMATION
Fiscal Year 2011

VISN	Station Number	Medical Center	Date of Homeless Summit
1	402	Togus	1/28/2011
	405	WRJ	2/1/2011
	518	Bedford	2/4/2011
	523	Boston	1/28/2011
	608	Manchester	1/21/2011
	631	Northampton	1/26/2011
	650	Providence	1/28/2011
	689	West Haven	2/14/2011
2	528A6	Bath VAMC	1/27/2011
	528A8	Albany VAMC	1/31/2011
	528	Buffalo VAMC	2/1/2011
	528A5	Canandaigua VAMC	2/1/2011
	479	VISN Network Office	2/2/2011
	528A7	Syracuse VAMC	2/4/2011
3	620	VA Hudson Valley HCS	1/28/2011
	561	VA New Jersey HCS	2/3/2011
	632	Northport VAMC	2/4/2011
	526	Bronx VAMC	2/15/2011*
	630	VA NY Harbor HCS	2/15/2011*
			*Rescheduled due to inclement weather in NYC; originally scheduled for Feb. 2, 2011
4	503	Altoona	1/19/2011, 1/27/2011
	529	Butler	2/1/2011
	540	Clarksburg	1/13/2011
	542	Coatesville	1/20/2011
	562	Erie	1/13/2011
	595	Lebanon	1/21/11
	642	Philadelphia	1/27/2011
	646	Pittsburgh	1/31/2011
	693	Wilkes Barre	1/21/2011
	460	Wilmington	4/9/2010
5	688	Washington, DC	1/28/2011
	613	Martinsburg, WV	2/2/2011
	512	VA Maryland HCS	2/4/2011
6	517	Beckley VA Medical Center	1/31/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2011

VISN	Station Number	Medical Center	Date of Homeless Summit
	558	Durham VA Medical Center	2/2/2011
	565	Fayetteville VA Medical Ctr.	2/2/2011
	590	Hampton VA Medical Center	1/28/2011
	637	Charles George VA Medical Ctr. (Asheville, NC)	2/4/2011
	652	McGuire VA Medical Center (Richmond, VA)	2/3/2011
	658	Salem VA Medical Center	2/1/2011
	659	W.G. Bill Heffner VA Medical Center (Salisbury, NC)	2/3/2011
7	508	Atlanta	2/4/2011
2/28/2011	509	Augusta	2/4/2011
	521	Birmingham	2/3/2011
	534	Charleston	2/1/2011
	544	Columbia	2/1/2011
	619	CAVHCS	2/14/2011
	679	Tuscaloosa	2/1/2011
	557	Dublin	2/4/2011
8	516	Bay Pines VA HCS	2/3/2011
	546	Miami VA Heathcare System	2/3/2011
	573	North Florida South Georgia Veterans Health System	2/1/2011 2/2/2011
	548	West Palm Beach VA MC	2/4/2011
	672	VA Caribean HCS	1/27/2011
	673	James A. Haley Veterans Hospital	2/2/2011
	675	Orlando VA Medical Center	1/20/2011
9	581	Huntington	1/26/2011
	596	Lexington	1/31/2011
	603	Louisville	1/28/2011
	614	Memphis	2/1/2011
	621	Mountain Home	2/4/2011
	626	TVHS	2/2/2011
10	538	Chillicothe	1/25/2011
	539	Cincinnati	2/3/2011
	541	Cleveland	1/27/2011
	552	Dayton	2/3/2011
	757	Columbus	2/2/2011
11	506	Ann Arbor	2/25/2011
	506A	Toledo CBOC	2/14/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2011

VISN	Station Number	Medical Center	Date of Homeless Summit
	515	Battle Creek	2/22/2011
	550	Danville/Illiana	2/23/2011
	553	Detroit	11/16/2010
	583	Indianapolis	3/8/2011
	610	NIHCS	2/25/2011
	655	Saginaw	2/18/2011
12	676	Tomah VAMC	1/24/2011
	695	Clement Zabloki VAMC	1/28/2011
	585	Oscar Johnson VAMC	2/1/2011
	607	William Middleton VAMC	2/3/2011
	556	James Lovell FHCC	2/4/2011
	578	Edward Hines VAMC	2/9/2011
	537	Jesse Brown VAMC	2/9/2011
15	589a4	Columbia, MO	2/19/2011
	589	Kansas City, MO	2/3/2011
	589a5/a6	VA Eastern Kansas	1/28/2011
	657	St Louis	2/3/2011
	657a4	Poplar Bluff	2/3/2011
	589a7	Wichita	2/3/2011
	657a5	Marion, Ill	2/1/2011
16	502	Alexandria	1/31/2011
	520	Biloxi	2/1/2011
	564	Fayetteville	1/31/2011
	580	Houston	2/1/2011
	586	Jackson	2/1/2011
	598	Little Rock	1/31/2011
	623	Muskogee	1/27/2011
	629	New Orleans	2/3/2011
	635	Oklahoma City	2/3/2011
	667	Shreveport	2/11/2011
17	549	North Texas HCS	2/3/2011
	674	Central Texas HCS	2/1/2011
	671	South Texas HCS	1/27/2011
	740	Valley Coastal Bend HCS	January 28, 2011 at two sites in there area due to geographical dispersion

HOMELESS SUMMIT INFORMATION
Fiscal Year 2011

VISN	Station Number	Medical Center	Date of Homeless Summit
17	493	VISN 17 Network Office	February 3, 2011 with North Texas, February 4, 2011 and then held two conference calls, February 10 &11, 2011, with Federal and State partners due to inclemental weather which prevented face to face meetings.
18	644	Phoenix VA HCS	2/4/2011
	501	New Mexico VA HCS	1/31/2011
	649	NAVAHCS, Prescott, AZ	2/3/2011
	504	Amarillo VAHCS	1/27/2011
	678	Southern Az VAHCS	2/1/2011
	519	WTVAHCS	2/3/2011
	756	El Paso VA HCS	2/11/2011
19	554	Denver	2/7/2011
	666	Sheridan	2/1/2011
	660	Salt Lake City	2/9/2011
	436	Montana/Fort Harrison	2/16/2011
	442	Cheyenne	2/10/2011
	575	Grand Junction	2/4/2011
20	463	VA Alaska HCS	1/28/2011
	531	Boise VAMC	1/27/2011
	648	Portland VAMC	2/1/2011
	653	VA Roseburg HCS	2/3/2011
	663	VA Puget Sound HCS	1/18/2011
	668	Spokane VAMC	Coeur d'Alene: 1/18/11, Wenatachee 1/19/11, Spokane 2/4/11
	687	Walla Walla VAMC	La Grande 1/27/11 and Walla Walla 2/4/11
	692	VA SORCC	1/18/2011
21	570	Fresno	1/31/2011
	459	Honolulu	2/3/2011
	612	N. California	2/4/2011
	640	Palo Alto	1/20/11 1/26/11
	662	San Francisco	2/3/2011
	654	Sierra Nevada	1/25/2011
22	593	VA Southern NV HCS	2/3/2011
	600	VALBHS	1/31/2011
	605	Loma Linda HCS (SB County)	2/3/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2011

VISN	Station Number	Medical Center	Date of Homeless Summit
	664	San Diego	2/10/2011
	691	GLA- Los Angeles city/county	2/3/2011
23	636	Omaha	2/7/2011
	636	Lincoln CBOC	2/8/2011
	636	Grand Island CBOC	2/10/2011
	438	Sioux Falls	1/20/2011
	438	Sioux Falls: CBOC: Wagner	1/28/2011
	438	Sious Falls: CBOC: Watertown	2/3/2011
	438	Sioux Falls: CBOC: Spirit Lake	1/24/2011
	438	Sioux Falls: CBOC: Aberdeen	2/3/2011
	438	Sioux Falls: CBOC: Sioux City	1/26/2011
	618	Minneapolis VA HCS	2/8/2011
	437	Fargo	2/16/2011
	656	St. Cloud VA HCS	2/10/2011
	636A8	Iowa City CBOC: Davenport	1/24/2011
	636A8	Iowa City CBOC: Rock Island	1/12/11 2/16/11
	636A8	Iowa City CBOC: Macomb	2/10/2011
	636A8	Iowa City CBOC: Burlington	3/4/2011
	636A8	Iowa City CBOC: Ottumwa	3/2/2011
	636A8	Iowa City CBOC: Cedar Rapids	1/31/2011
	636A8	Iowa City	1/12/11 2/1/11
	636A8	Iowa City CBOC: Waterloo	2/28/2011
	636A8	Iowa City CBOC: Dubuque	2/8/2011
	636A6	Des Moines	2/2/2011
	568	BHHCS: Rapid City	1/21/2011
	568	BHHCS: Rapid City	1/28/2011
	568	BHHCS: Rapid City	2/10/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2012

VISN	Station Number	Medical Center	Summit Date
1			
	402	Togus	9/30/2011
	405	WRJ	11/7/2011
	518	Bedford	10/21/2011
	532	Boston	10/21/2011
	608	Manchester	10/21/2011
	631	Northampton	10/27/2011
	650	Providence	10/27/2011
	689	West Haven	10/27/2011
2			
	528A6	Bath VAMC	9/19/2011
	528A8	Albany VAMC	9/21/2011
	528	Buffalo VAMC	10/26/2011
	528A5	Canandaigua VAMC	10/12/2011
	528A7	Syracuse VAMC	11/4/2011
3			
	620	VA Hudson Valley HCS	10/13/2011
	561	VA New Jersey HCS	10/28/2011
	632	Northport VAMC	10/11/2011
	526	Bronx VAMC	11/2/2011
	630	VA NY Harbor HCS	11/4/2011
4			
	503	Altoona	11/7/2011
	529	Butler	11/10/2011
	540	Clarksburg	10/12/2011
	542	Coatesville	10/26/2011
	562	Erie	10/6/2011
	595	Lebanon	11/9/2011
	642	Philadelphia	10/24/2011
	646	Pittsburgh	10/25/2011
	693	Wilkes Barre	1/25/2012
	460	Wilmington	4/1/2012
5			
	688	Washington, DC	10/14/2011
	613	Martinsburg, WV	10/20/2011
	512	VA Maryland HCS	10/31/2011
6			
			8/9/11
	517	Beckley VA Medical Center	8/22/11
	558	Durham VA Medical Center	9/1/2011
	565	Fayetteville VA Medical Ctr.	9/1/2011
	590	Hampton VA Medical Center	10/27/2011
	637	Charles George VA Medical Ctr. (Asheville, NC)	9/1/2011
	652	McGuire VA Medical Center (Richmond, VA)	9/29/2011
	658	Salem VA Medical Center	11/1/2011
	659	W.G. Bill Heffner VA Medical Center (Salisbury, NC)	9/1/2011
7			
	508	Atlanta	11/3/2011
	509	Augusta	11/10/2011
	521	Birmingham	11/21/2011
	534	Charleston	11/10/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2012

VISN	Station Number	Medical Center	Summit Date
	544	Columbia	11/10/2011
	619	CAVHCS	11/9/2011
	679	Tuscaloosa	11/4/2011
	557	Dublin	11/7/2011
8			
	516	Bay Pines VA HCS	10/17/2011
	546	Miami VA Heathcare System	9/17/2011
	573	North Florida South Georgia Veterans Health System	10/27/2011 11/3/11
	548	West Palm Beach VA MC	11/1/2011
	672	VA Carribean HCS	10/20/2011
	673	James A. Haley Veterans Hospital	11/4/2011
	675	Orlando VA Medical Center	10/24/2011
9			
	581	Huntington	11/1/2011
	596	Lexington	10/31/2011
	603	Louisville	11/7/2011
	614	Memphis	10/20/2011
	621	Mountain Home	10/20/2011
	626	TVHS	11/2/2011
10			
	538	Chillicothe	10/5/2011
	539	Cincinnati	10/28/2011
	541	Cleveland	10/12/2011
	552	Dayton	11/4/2011
	757	Columbus	11/11/2011
11			
	506	Ann Arbor	1/15/2012
	515	Battle Creek	
	550	Danville/Illiana	
	553	Detroit	
	583	Indianapolis	11/29/2011
	610	NIHCS	
	655	Saginaw	
12			
	676	Tomah VAMC	10/26/2011
	695	Clement Zabloki VAMC	10/31/2011
	585	Oscar Johnson VAMC	10/26/2011
	607	William Middleton VAMC	10/4, 10/12, 10/24
	556	James Lovell FHCC	11/2/2011
	578	Edward Hines VAMC	10/12/2011
	537	Jesse Brown VAMC	10/12/2011
15			
	589a4	Columbia, MO	10/21/2011
	589	Kansas City, MO	11/8/2011
	589a5/a6	VA Eastern Kansas	10/26/2011
	657	St Louis	8/11/2011
	657a4	Poplar Bluff	11/3/2011
	589a7	Wichita	10/27/2011
	657a5	Marion, Ill	11/8/2011
16			
	502	Alexandria	10/26/2011
	520	Biloxi	11/1/2011
	564	Fayetteville	10/25/2011
	580	Houston	10/31/2011
	586	Jackson	11/1/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2012

VISN	Station Number	Medical Center	Summit Date
	598	Little Rock	10/26/2011
	623	Muskogee	10/10/2011
	629	New Orleans	10/22/2011
	635	Oklahoma City	11/3/2011
	667	Shreveport	10/6/2011
17			
	549	North Texas HCS	10/18/2011
	674	Central Texas HCS	10/7/2011
	671	South Texas HCS	11/3/2011
	740	Valley Coastal Bend HCS	11/4/2011
		Harlingen CBOC	10/24/2011
18			
	644	Phoenix VA HCS	10/17-18/11
	501	New Mexico VA HCS	10/19/2011
	649	NAVAHCS, Prescott, AZ	9/9/2011
	504	Amarillo VAHCS	10/5/2011
	678	Southern Az VAHCS	10/13/2011
	519	WTVAHCS	10/20/2011
	756	El Paso VA HCS	10/21/2011
19			
	554	Denver	10/14/2011
	666	Sheridan	11/10/2011
	660	Salt Lake City	9/28/2011
	436	Fort Harrison	11/1/2011
	442	Cheyenne	9/28/2011
	575	Grand Junction	10/21/2011
20			
	463	VA Alaska HCS	10/12/2011
	531	Boise VAMC	10/12/11 10/4, 10/18, 10/20
	648	Portland VAMC	10/17 -10/18
	653	VA Roseburg HCS	11/3/2011
	663	VA Puget Sound HCS	10/12-10/13
	668	Spokane VAMC	9/9/-11/5/2011
	687	Walla Walla VAMC	10/27/2011
	692	VA SORCC	11/9/2011
21			
	570	Fresno	11/1/2011
	459	Honolulu	10/18/2011
	612	N. California	10/28/2011
	640	Palo Alto	10/24/2011
	662	San Francisco	9/14/2011
	654	Sierra Nevada	11/10/2011
22			
	593	VA Southern NV HCS	11/2/11 or 11/3/11
	600	VALBHS	11/7/2011
	605	Loma Linda HCS	10/21/2011
	664	San Diego	10/27/2011
	691	Great Los Angeles	11/15/11 or 11/17/11
23			
	636	Omaha	10/12/2011
	438	Sioux Falls	10/29/2011
	618	Minneapolis VA HCS	11/10/2011
	437	Fargo	11/3/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2012

VISN	Station Number	Medical Center	Summit Date
	656	St. Cloud VA HCS	11/7/2011
	636A8	Iowa City	10/5/2011
	636A6	Des Moines	10/28/2011
	568	BHHCS: Rapid City	10/7/2011

HOMELESS SUMMIT INFORMATION
Fiscal Year 2013

VISN	Station Number	Medical Center	Summit Date
1			
	402	Togus	1/22/2013
	405	WRJ	3/19/2013
	518	Bedford	10/31/2013
	532	Boston	4/8/2013
	608	Manchester	11/30/2012 1/25/13 3/29/13
	631	Northampton	
	650	Providence	11/28/2012
	689	West Haven	10/11/2012
2			
	528A6	Bath VAMC	7/27/2012
	528A8	Albany VAMC	10/19/2012
	528	Buffalo VAMC	11/29/2012
	528A5	Canandaigua VAMC	3/6/2013
	528A7	Syracuse VAMC	3/15/2013
3			
	620	VA Hudson Valley HCS	TBD
	561	VA New Jersey HCS	TBD
	632	Northport VAMC	TBD
	526	Bronx VAMC	TBD
	630	VA NY Harbor HCS	TBD
4			
*	503	Altoona	8/15/2013
	529	Butler	8/1/2013
	540	Clarksburg	7/17/2013
	542	Coatesville	3/19/2013
	562	Erie	11/8/2012
	595	Lebanon	8/2/2013
	642	Philadelphia	12/13/2012 3/13/13
	646	Pittsburgh	2/26/2013
	693	Wilkes Barre	9/19/2013
	460	Wilmington	10/25/2012
5			
*	688	Washington, DC	11/8/2012
	613	Martinsburg, WV	10/18/2012
	512	VA Maryland HCS	11/9/2012 4/19/13
6			
*	517	Beckley VA Medical Center	TBD
	558	Durham VA Medical Center	TBD
	565	Fayetteville VA Medical Ctr.	TBD
	590	Hampton VA Medical Center	TBD
	637	Charles George VA Medical Ctr. (Asheville, NC)	TBD
	652	McGuire VA Medical Center (Richmond, VA)	TBD
	658	Salem VA Medical Center	TBD
	659	W.G. Bill Heffner VA Medical Center (Salisbury, NC)	TBD
7			
	508	Atlanta	12/11/2012

HOMELESS SUMMIT INFORMATION
Fiscal Year 2013

VISN	Station Number	Medical Center	Summit Date
	509	Augusta	11/27/2012
	521	Birmingham	2/14/2013
	534	Charleston	12/13/2012
	544	Columbia	12/13/2012
	619	CAVHCS	12/12/2012
	679	Tuscaloosa	4/26/2013
	557	Dublin	3/25/2013
8			
	516	Bay Pines VA HCS	TBD
	546	Miami VA Heathcare System	11/8/2012
	573	North Florida South Georgia Veterans Health System	2/28/2013
	548	West Palm Beach VA MC	TBD
	672	VA Carribean HCS	12/5/2012 2/14/13
	673	James A. Haley Veterans Hospital	TBD
	675	Orlando VA Medical Center	TBD
9			
*	581	Huntington	TBD
	596	Lexington	TBD
	603	Louisville	TBD
	614	Memphis	TBD
	621	Mountain Home	TBD
	626	TVHS	TBD
10			
	538	Chillicothe	4/23/2013
	539	Cincinnati	5/3/2013
	541	Cleveland	8/9/2013
	552	Dayton	6/21/2013
	757	Columbus	5/17/413
11			
	506	Ann Arbor	5/1/2013
	515	Battle Creek	TBD
	550	Danville/Illiana	4/30/2013
	553	Detroit	3/12/2013
	583	Indianapolis	12/12/2012
	610	NIHCS	TBD
	655	Saginaw	TBD
12			
	676	Tomah VAMC	TBD
	695	Clement Zabloki VAMC	10/29/2012
	585	Oscar Johnson VAMC	TBD
	607	William Middleton VAMC	TBD
	556	James Lovell FHCC	3/8/2013
	578	Edward Hines VAMC	TBD
	537	Jesse Brown VAMC	TBD
15			
	589a4	Columbia, MO	TBD
	589	Kansas City, MO	12/6/2012
	589a5/a6	VA Eastern Kansas	5/14/2013
	657	St Louis	8/9/2013
	657a4	Poplar Bluff	9/26/2013
	589a7	Wichita	TBD
	657a5	Marion, Ill	TBD
16			
	502	Alexandria	TBD
	520	Biloxi	TBD

HOMELESS SUMMIT INFORMATION
Fiscal Year 2013

VISN	Station Number	Medical Center	Summit Date
	564	Fayetteville	10/23/2012
	580	Houston	TBD
	586	Jackson	TBD
	598	Little Rock	TBD
	623	Muskogee	TBD
	629	New Orleans	TBD
	635	Oklahoma City	TBD
	667	Shreveport	TBD
17			
	549	North Texas HCS	TBD
	674	Central Texas HCS	TBD
	671	South Texas HCS	TBD
	740	Valley Coastal Bend HCS	TBD
		Harlingen CBOC	TBD
18			
	644	Phoenix VA HCS	10/16/2013
	501	New Mexico VA HCS	1/17/2013
	649	NAVAHCS, Prescott, AZ	11/8/2013
	504	Amarillo VAHCS	2/16/2013
	678	Southern Az VAHCS	TBD
	519	WTVAHCS	4/25/2013
	756	El Paso VA HCS	8/8/2013
19			
	554	Denver	12/4/2012
	666	Sheridan	3/19/2013
	660	Salt Lake City	11/8/2012
	436	Fort Harrison	9/9/2013
	442	Cheyenne	1/15/2013
	575	Grand Junction	2/12/2013
20			
	463	VA Alaska HCS	3/1/2013
	531	Boise VAMC	11/11/2013
	648	Portland VAMC	3/21/2013
	653	VA Roseburg HCS	TBD
	663	VA Puget Sound HCS	7/12/2013
	668	Spokane VAMC	TBD
	687	Walla Walla VAMC	3/28/2013
	692	VA SORCC	10/22/2013
21			
	570	Fresno	9/27/2012
	459	Honolulu	9/28/2012 1/29/13
	612	N. California	TBD
	640	Palo Alto	TBD
	662	San Francisco	TBD
	654	Sierra Nevada	9/28/2012
22			
	593	VA Southern NV HCS	TBD
	600	VALBHS	TBD
	605	Loma Linda HCS	TBD
	664	San Diego	TBD
	691	Great Los Angeles	TBD
23			
	636	Omaha	TBD
	438	Sioux Falls	TBD
	618	Minneapolis VA HCS	TBD
	437	Fargo	TBD

HOMELESS SUMMIT INFORMATION
Fiscal Year 2013

VISN	Station Number	Medical Center	Summit Date
	656	St. Cloud VA HCS	TBD
	636A8	Iowa City	TBD
	636A6	Des Moines	TBD
	568	BHHCS: Rapid City	TBD

* VISN's 4, 5, 6 and 9 are planning one, combined State-Wide Summit in West Virginia sometimes July, 2013.
** All dates in red text are planned Homeless Summits.

Question 5. During the hearing, Committee members discussed the use of alternative and complementary treatments for PTSD and TBI. It is important that treatment for mental health be tailored to specific veterans and their needs.

a. Please provide all complementary and alternative treatments (fishing, golfing, acupuncture, etc.) available for veterans with PTSD and other mental health diagnoses, and which VA medical facilities offer the treatment.

Response. It is difficult to capture CAM services provided to Veterans with mental health diagnosis. The boundaries between CAM and conventional medicine overlap and change with time. VA uses several types of administrative data that might capture evidence of CAM being provided in mental health encounters: Health Care Common Procedure Coding System (which includes Current Procedural Terminology (CPT) Codes), stop codes, International Classification of Diseases (ICD–9) procedure codes, and VA drug classes. While many Veterans use herbal or nutritional supplements on their own or through non-VA providers, Federal regulations prohibit VA from prescribing products that are not approved as treatments by the Food and Drug Administration. Both CPT codes and ICD–9 codes are set external to VA and have significant gaps in identifying CAM treatments.

The findings show that the availability of CAM, and/or use of procedure codes specific to CAM, is uneven across VA facilities. These interventions have mostly come into existence due to the dedication and persistence of staff who work in VA settings, and the desire to provide a wider range of care.

There is also a variety of research and demonstration projects across the country that will be useful to help determine CAM effectiveness and how best to implement programs more consistently and uniformly. Currently, a directive is being developed to help guide VA facilities in their implementation of these practices. According to a 2011 survey by VA's Healthcare Analysis and Information Group, 89 percent of VA facilities offered CAM treatments, an increase from 84 percent in 2002. The most common types of CAM provided are meditation (72 percent of VAMCs); stress management/relaxation therapy (66 percent); and, guided imagery (58 percent). Animal-assisted therapy is provided by 44 percent, acupuncture by 41 percent, and yoga by 44 percent. The most common uses of CAM are for stress management, anxiety disorder, PTSD, depression, back pain, and wellness-promotion (in order of frequency). Appendix A of the 2011 survey by VA's Healthcare Analysis and Information Group provides detailed information about CAM use at VA facilities.

APPENDIX A. EXCERPTS FROM HEALTH CARE ANALYSIS AND INFORMATION GROUP SURVEY, 2011

Department of Veterans Affairs
Veterans Health Administration
Office of the Assistant Deputy Under Secretary for
Health for Policy and Planning

2011

Complementary and Alternative Medicine

September 2011

E-2

2002 & 2011 COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) Modality Comparison

Provided at VA by VA staff or non-VA Staff

Mind-body Medicine

LOCATION	STATION NUMBER	Animal Assisted Therapy		Aromatherapy		Biofeedback		Guided Imagery		Hypnosis / Hypnotherapy		Meditation		Music Therapy		Non-Traditional Spiritual Practices		Progressive Muscle Relaxation		Stress Management, Relaxation Therapy		Yoga	
		02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11
VISN 7																							
Atlanta, GA	508						X		X														X
Augusta, GA	509					X	X		X		X		X	X	X				X		X		X
Birmingham, AL	521							X	X	X			X					X	X	X	X		
Charleston, SC	534						X		X			X	X	X				X	X	X	X		X
Columbia, SC	544						X																
Dublin, GA	557		X				X	X	X				X	X				X		X		X	
Tuscaloosa, AL	679							X		X				X	X			X		X	X		
VA Central Alabama HCS*	619				X		X		X		X		X				X		X		X		X
VISN 7 Totals		0	1	0	1	1	6	3	6	2	2	1	5	4	2	0	1	4	4	4	5	1	4
VISN 8																							
Bay Pines, FL	516	X	X	X	X		X	X	X	X		X		X	X			X	X	X	X	X	X
Miami, FL	546		X			X		X	X			X	X	X	X			X		X			X
Orlando, FL*	675																						
San Juan, PR	672		X				X				X	X		X	X			X		X	X		
Tampa, FL	673		X				X		X								X			X			X
West Palm Beach, FL	548	X				X		X		X		X						X		X			
VA N FL/S GA Veterans HCS	573		X			X	X	X	X			X	X					X	X	X	X		
VISN 8 Totals		2	5	1	1	3	4	4	4	2	1	5	2	3	3	0	1	5	2	6	3	1	3
VISN 9																							
Huntington, WV	581						X				X		X						X		X		
Louisville, KY*	603																						X
Lexington (Leestown), KY***	596																						
Lexington (Cooper Dr.), KY*	596A4																						
Memphis, TN	614		X			X		X	X				X	X				X	X	X	X		X
Mountain Home, TN	621					X		X	X				X						X	X	X		
VA Tennessee Valley HCS	626		X			X	X	X						X	X			X		X	X		
VISN 9 Totals		0	2	0	0	3	2	3	2	0	1	0	3	2	1	0	0	2	3	3	4	0	2
VISN 10																							
Chillicothe, OH	538		X			X			X				X		X				X		X		
Cincinnati, OH	539	X	X			X	X	X	X				X		X			X	X	X	X		X
Cleveland (Wade Park), OH*	541								X						X						X		
Cleveland (Brecksville), OH**	541A0					X				X								X		X			
Columbus, OH (OC)	757					X				X	X		X		X				X	X	X		X
Dayton, OH	552		X				X	X	X			X		X	X			X	X	X	X		
VISN 10 Totals		1	3	0	0	4	2	2	4	2	1	1	3	1	5	0	0	3	4	4	5	0	2
VISN 11																							
Battle Creek, MI	515		X				X	X	X		X		X	X	X			X		X	X		
Detroit, MI	553		X		X			X	X				X						X	X	X		
Indianapolis, IN	583							X				X						X		X			
Saginaw, MI*	655		X		X		X		X		X		X		X				X		X		X
VA Ann Arbor HCS	506		X					X	X	X			X						X		X		X
VA Illiana HCS	550	X	X			X	X		X		X		X	X	X				X		X		
VA Northern Indiana HCS	610		X			X		X					X		X			X		X			
VISN 11 Totals		1	6	0	2	2	3	5	5	1	3	1	6	2	4	0	0	3	4	4	5	0	2
VISN 12																							
Hines, IL	578		X					X	X	X		X	X		X			X		X	X		X
Iron Mountain, MI**	585																						
Madison, WI*	607						X		X				X						X		X		X
Milwaukee, WI	695		X		X	X	X		X	X	X		X	X	X				X		X		X
North Chicago, IL	556		X					X		X		X			X		X	X		X			
Tomah, WI	676		X		X		X		X					X	X		X		X	X	X		X
VA Chicago HCS	537		X			X	X	X	X	X	X		X	X	X		X		X	X			X
VISN 12 Totals		0	5	0	2	2	4	3	5	4	2	2	4	3	5	0	3	2	4	4	4	0	5
VISN 15																							
Columbia, MO*	589A4								X				X				X		X		X		
Kansas City, MO	589					X		X				X						X	X	X	X		
Marion, IL**	657A5					X		X		X		X						X					
Poplar Bluff, MO*	657A4												X										
St. Louis, MO*	657				X		X						X						X		X		
Wichita, KS	589A7						X						X								X		
VA Eastern Kansas HCS	589A5					X	X		X				X	X	X				X		X		
VISN 15 Totals		0	0	0	1	3	3	2	2	1	0	2	5	1	1	0	1	2	4	1	5	0	0

Biologically Based Practices / Manipulative and Body-based Practices / Energy Medicine

LOCATION	STATION NUMBER	Chelation		Diet-Alternative (02) Diet-Special; Diet Therapy (11)		Dietary / Nutritional Supplements		Herbal Medicines		Acupressure		Acupuncture		Massage Therapy		Movement Practices		Energy Healing		Tai Chi, Qigong	
		02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11
VISN 7																					
Atlanta, GA	508						X						X						X		
Augusta, GA	509											X	X								
Birmingham, AL	521											X									
Charleston, SC	534										X		X								
Columbia, SC	544														X						X
Dublin, GA	557																				
Tuscaloosa, AL	679																				
VA Central Alabama HCS*	619																		X		X
VISN 7 Totals		0	0	0	0	0	1	0	0	0	1	2	3	0	1	0	0	0	2	0	2
VISN 8																					
Bay Pines, FL	516									X			X	X	X			X		X	
Miami, FL	546					X					X		X		X		X				X
Orlando, FL*	675												X								
San Juan, PR	672												X		X						X
Tampa, FL	673				X	X	X					X					X		X		
West Palm Beach, FL	548					X				X		X	X								
VA N FL/S GA Veterans HCS	573			X		X						X		X						X	
VISN 8 Totals		0	0	1	1	4	1	0	0	2	1	3	5	2	3	0	2	1	1	2	2
VISN 9																					
Huntington, WV	581														X						
Louisville, KY*	603																				X
Lexington (Leestown), KY***	596																				
Lexington (Cooper Dr.), KY*	596A4												X								
Memphis, TN	614			X		X								X			X			X	X
Mountain Home, TN	621						X														
VA Tennessee Valley HCS	626				X		X						X		X						
VISN 9 Totals		0	0	1	1	1	2	0	0	0	0	0	2	1	2	0	1	0	0	1	2
VISN 10																					
Chillicothe, OH	538										X		X								
Cincinnati, OH	539						X			X	X	X	X	X	X				X		
Cleveland (Wade Park), OH*	541																		X		
Cleveland (Brecksville), OH**	541A0																				
Columbus, OH (OC)	757														X		X				
Dayton, OH	552						X						X								
VISN 10 Totals		0	0	0	0	0	2	0	0	1	2	1	3	1	2	0	1	0	2	0	0
VISN 11																					
Battle Creek, MI	515						X						X		X					X	X
Detroit, MI	553																		X		X
Indianapolis, IN	583																				
Saginaw, MI*	655				X		X								X						
VA Ann Arbor HCS	506								X					X	X		X				
VA Illiana HCS	550				X		X			X	X	X	X	X	X						
VA Northern Indiana HCS	610																				
VISN 11 Totals		0	0	0	2	0	3	0	1	1	1	1	2	2	4	0	1	0	1	1	2
VISN 12																					
Hines, IL	578																				
Iron Mountain, MI**	585																				
Madison, WI*	607												X								X
Milwaukee, WI	695						X		X			X	X		X				X		X
North Chicago, IL	556				X		X						X								
Tomah, WI	676				X	X	X								X				X		X
VA Chicago HCS	537				X		X						X						X		
VISN 12 Totals		0	0	0	3	1	4	0	1	0	0	1	4	0	2	0	0	0	3	0	3
VISN 15																					
Columbia, MO*	589A4																				
Kansas City, MO	589												X								
Marion, IL**	657A5																				
Poplar Bluff, MO*	657A4																				
St. Louis, MO*	657						X						X								
Wichita, KS	589A7						X					X	X								
VA Eastern Kansas HCS	589A5																				
VISN 15 Totals		0	0	0	0	0	2	0	0	0	0	1	3	0	0	0	0	0	0	0	0

Whole Medicine Systems / Other

LOCATION	STATION NUMBER	Ayurvedic		Homeopathy		Native American Healing Practices		Naturopathic Medicine		Other Indigenous Healing Performed by a Healer		Sweat Lodge		Traditional Chinese Medicine		Other	
		02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11
VISN 7																	
Atlanta, GA	508																
Augusta, GA	509																
Birmingham, AL	521																
Charleston, SC	534																X
Columbia, SC	544																
Dublin, GA	557					X											X
Tuscaloosa, AL	679																
VA Central Alabama HCS*	619																
VISN 7 Totals		0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
VISN 8																	
Bay Pines, FL	516																
Miami, FL	546															X	
Orlando, FL*	675																
San Juan, PR	672																X
Tampa, FL	673						X										
West Palm Beach, FL	548																
VA N FL/S GA Veterans HCS	573																
VISN 8 Totals		0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1
VISN 9																	
Huntington, WV	581																
Louisville, KY*	603																
Lexington (Leestown), KY***	596																
Lexington (Cooper Dr.), KY*	596A4																
Memphis, TN	614																
Mountain Home, TN	621																
VA Tennessee Valley HCS	626																
VISN 9 Totals		0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VISN 10																	
Chillicothe, OH	538																
Cincinnati, OH	539																
Cleveland (Wade Park), OH*	541																
Cleveland (Brecksville), OH**	541A0																
Columbus, OH (OC)	757																
Dayton, OH	552														X		X
VISN 10 Totals		0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
VISN 11																	
Battle Creek, MI	515																
Detroit, MI	553												X				
Indianapolis, IN	583																
Saginaw, MI*	655																
VA Ann Arbor HCS	506				X												
VA Illiana HCS	550																
VA Northern Indiana HCS	610															X	
VISN 11 Totals		0	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0
VISN 12																	
Hines, IL	578																X
Iron Mountain, MI**	585																
Madison, WI*	607																
Milwaukee, WI	695																
North Chicago, IL	556																
Tomah, WI	676						X										
VA Chicago HCS	537																X
VISN 12 Totals		0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
VISN 15																	
Columbia, MO*	589A4																
Kansas City, MO	589																
Marion, IL**	657A5																
Poplar Bluff, MO*	657A4																
St. Louis, MO*	657																
Wichita, KS	589A7												X				
VA Eastern Kansas HCS	589A5																
VISN 15 Totals		0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0

E-2

2002 & 2011 COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) Modality Comparison

Provided at VA by VA staff or non-VA Staff

LOCATION	STATION NUMBER	Mind-body Medicine																						Biologically Based Practices								Manipulative and Body-based Practices								Energy Medicine				Whole Medicine Systems															
		Animal Assisted Therapy		Aromatherapy		Biofeedback		Guided Imagery		Hypnosis / Hypnotherapy		Meditation		Music Therapy		Non-Traditional Spiritual Practices		Progressive Muscle Relaxation		Stress Management, Relaxation Therapy		Yoga		Chelation		Diet-Alternative (02) Diet-Special; Diet Therapy (11)		Dietary / Nutritional Supplements		Herbal Medicines		Acupressure		Acupuncture		Massage Therapy		Movement Practices		Energy Healing		Tai Chi, Qigong		Ayurvedic		Homeopathy		Native American Healing Practices		Naturopathic Medicine		Other Indigenous Healing Performed by a Healer		Sweat Lodge		Traditional Chinese Medicine		Other	
		02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11
VISN 7																																																											
Atlanta, GA	508						X		X														X						X						X						X																		
Augusta, GA	509					X	X		X		X		X	X	X				X		X		X											X	X																									
Birmingham, AL	521							X	X	X			X							X	X	X	X													X																									
Charleston, SC	534						X		X			X	X	X					X	X	X	X		X											X		X																								X
Columbia, SC	544						X																																X						X																
Dublin, GA	557		X				X	X	X				X	X				X		X		X																												X											X
Tuscaloosa, AL	679							X		X				X	X			X		X	X																																						
VA Central Alabama HCS*	619				X		X		X		X		X				X		X		X		X																		X		X																
VISN 7 Totals		0	1	0	1	1	6	3	6	2	2	1	5	4	2	0	1	4	4	4	5	1	4	0	0	0	0	0	1	0	0	0	1	2	3	0	1	0	0	0	2	0	2	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0	2
VISN 8																																																											
Bay Pines, FL	516	X	X	X	X		X	X	X	X		X		X	X			X	X	X	X	X	X									X			X	X	X			X		X																
Miami, FL	546		X			X		X	X			X	X	X	X			X		X			X					X					X		X		X		X			X															X	
Orlando, FL*	675																																		X																							
San Juan, PR	672		X				X				X	X		X	X			X		X	X														X		X						X																X
Tampa, FL	673		X				X		X								X			X			X				X	X	X					X					X		X										X										
West Palm Beach, FL	548	X				X		X		X		X						X		X								X				X		X	X																								
VA N FL/S GA Veterans HCS	573		X			X	X	X	X			X	X					X	X	X	X					X		X						X		X						X																	
VISN 8 Totals		2	5	1	1	3	4	4	4	2	1	5	2	3	3	0	1	5	2	6	3	1	3	0	0	1	1	4	1	0	0	2	1	3	5	2	3	0	2	1	1	2	2	0	0	0	0	0	1	0	0	0	0	0	0	0	0	1	1
VISN 9																																																											
Huntington, WV	581						X				X		X						X		X																	X																					
Louisville, KY*	603																						X																				X																
Lexington (Leestown), KY***	596																																																										
Lexington (Cooper Dr.), KY*	596A4																																		X																							
Memphis, TN	614		X			X		X	X				X	X				X	X	X	X		X			X		X								X			X			X	X																
Mountain Home, TN	621					X		X	X				X						X	X	X								X																														
VA Tennessee Valley HCS	626		X			X	X	X						X	X			X		X	X						X		X						X		X																						
VISN 9 Totals		0	2	0	0	3	2	3	2	0	1	0	3	2	1	0	0	2	3	3	4	0	2	0	0	1	1	1	2	0	0	0	0	0	2	1	2	0	1	0	0	1	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
VISN 10																																																											
Chillicothe, OH	536		X			X			X				X		X				X		X												X		X																								
Cincinnati, OH	539	X	X			X	X	X	X				X		X			X	X	X	X		X						X			X	X	X	X	X	X				X																		
Cleveland (Wade Park), OH*	541								X						X						X																				X																		
Cleveland (Brecksville), OH**	541A0					X				X								X		X																																							
Columbus, OH (OC)	757					X				X	X		X		X				X	X	X		X														X		X																				
Dayton, OH	552		X				X	X	X			X		X	X			X	X	X	X								X						X																							X		X
VISN 10 Totals		1	3	0	0	4	2	2	4	2	1	1	3	1	5	0	0	3	4	4	5	0	2	0	0	0	0	0	2	0	0	1	2	1	3	1	2	0	1	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	1
VISN 11																																																											
Battle Creek, MI	515		X				X	X	X		X		X	X	X			X		X	X								X						X		X					X	X																
Detroit, MI	553		X		X			X	X				X						X	X	X																					X		X												X				
Indianapolis, IN	583							X				X						X		X																																							
Saginaw, MI*	655		X		X		X		X		X		X		X				X		X		X				X		X								X																						
VA Ann Arbor HCS	506		X					X	X	X			X						X		X		X								X					X	X		X									X												
VA Illiana HCS	550	X	X			X	X		X		X		X	X	X				X		X						X		X			X	X	X	X	X	X																						
VA Northern Indiana HCS	610		X			X		X					X		X			X		X																																						X	
VISN 11 Totals		1	6	0	2	2	3	5	5	1	3	1	6	2	4	0	0	3	4	4	5	0	2	0	0	0	2	0	3	0	1	1	1	1	2	2	4	0	1	0	1	1	2	0	0	0	1	0	0	0	0	0	0	0	1	0	0	1	0
VISN 12																																																											
Hines, IL	578		X					X	X	X		X	X		X			X		X	X		X																																				X
Iron Mountain, MI**	585																																																										
Madison, WI*	607						X		X				X						X		X		X												X								X																
Milwaukee, WI	695		X		X	X	X		X	X	X		X	X	X				X		X		X						X		X			X	X		X				X		X																
North Chicago, IL	556		X					X		X		X			X		X	X		X								X		X						X																							
Tomah, WI	676		X		X		X		X					X	X		X		X	X	X		X				X	X	X								X				X		X							X									
VA Chicago HCS	537		X			X	X	X	X	X	X		X	X	X		X		X	X			X				X		X						X						X																		X
VISN 12 Totals		0	5	0	2	2	4	3	5	4	2	2	4	3	5	0	3	2	4	4	4	0	5	0	0	0	3	1	4	0	1	0	0	1	4	0	2	0	0	0	3	0	3	0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	2
VISN 15																																																											
Columbia, MO*	589A4								X				X				X		X		X																																						
Kansas City, MO	589					X		X				X						X	X	X	X														X																								
Marion, IL**	657A5					X		X		X		X						X																																									
Poplar Bluff, MO*	657A4												X																																												
St. Louis, MO*	657				X		X						X						X		X								X						X																								
Wichita, KS	589A7						X						X								X								X					X	X																				X				
VA Eastern Kansas HCS	589A5					X	X		X				X	X	X				X		X																																				
VISN 15 Totals		0	0	0	1	3	3	2	2	1	0	2	5	1	1	0	1	2	4	1	5	0	0	0	0	0	0	0	2	0	0	0	0	1	3	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	0	0	0	0

2002 & 2011 COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) Modality Comparison

Provided at VA by VA staff or non-VA Staff

		Mind-body Medicine																						Biologically Based Practices								Manipulative and Body-based Practices								Energy Medicine				Whole Medicine Systems															
LOCATION	STATION NUMBER	Animal Assisted Therapy		Aromatherapy		Biofeedback		Guided Imagery		Hypnosis / Hypnotherapy		Meditation		Music Therapy		Non-Traditional Spiritual Practices		Progressive Muscle Relaxation		Stress Management, Relaxation Therapy		Yoga		Chelation		Diet-Alternative (02) Diet-Special; Diet Therapy (11)		Dietary / Nutritional Supplements		Herbal Medicines		Acupressure		Acupuncture		Massage Therapy		Movement Practices		Energy Healing		Tai Chi, Qigong		Ayurvedic		Homeopathy		Native American Healing Practices		Naturopathic Medicine		Other Indigenous Healing Performed by a Healer		Sweat Lodge		Traditional Chinese Medicine		Other	
		02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11	02	11
VISN 16																																																											
Alexandria, LA	502					X	X		X	X	X		X		X			X	X	X	X																																						
Fayetteville, AR	564		X			X		X		X				X	X			X	X	X	X														X																							X	
Houston, TX	580					X	X		X	X	X		X						X	X	X													X																									X
Jackson, MS	586	X					X													X	X		X									X	X	X	X																								
Muskogee, OK	623					X	X	X		X								X		X															X	X					X																		
New Orleans, LA*	629						X		X		X		X						X		X		X												X		X																						
Oklahoma City, OK*	635		X														X				X												X		X				X		X		X																
Shreveport, LA	667	X				X			X	X	X		X					X	X	X	X											X				X																							
VA Central Arkansas HCS	598		X			X	X	X	X	X	X		X		X			X	X	X	X						X		X	X			X	X	X		X																						
VA Gulf Coast HCS*	520		X				X		X				X		X				X		X						X		X																														
VISN 16 Totals		2	4	0	0	6	7	3	6	6	5	0	6	1	4	0	1	5	7	7	9		2	0	0	0	2	0	2	1	0	2	3	3	6	2	2	0	1	0	2	0	1	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1	1
VISN 17																																																											
VA Central Texas HCS*	674		X						X										X		X														X								X																
Bonham, TX (VA North Texas HCS)**	549A4							X										X		X						X		X								X																							
Dallas, TX (VA North Texas HCS)	549		X		X	X	X	X	X				X		X		X	X	X	X	X		X			X		X	X						X	X																							
VA South Texas HCS	671		X		X		X		X		X		X		X				X		X		X											X		X							X																X
VISN 17 Totals		0	3	0	2	1	2	2	3	0	1	0	2	0	2	0	1	2	3	2	3	0	2	0	0	2	0	2	1	0	0	0	0	1	2	3	0	0	0	0	0	0	2	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	1
VISN 18																																																											
Phoenix, AZ	644		X			X	X	X	X						X					X	X																																						
El Paso VA HCS**	756					X												X		X								X																															
VA Amarillo HCS	504							X				X																												X																			
VA New Mexico HCS	501					X	X	X	X			X	X				X	X	X	X	X		X						X				X						X				X						X						X			2X	X
VA Northern Arizona HCS	649		X		X				X				X		X												X	X	X		X												X					X											
VA Southern Arizona HCS	678					X	X	X	X	X	X		X	X	X			X		X	X		X			X			X						X	X				X								X	X										
VA TX Valley Coastal Bend*	740								X				X						X		X								X																														
VA West Texas HCS*	519		X		X										X		X		X		X						X										X																						
VISN 18 Totals		0	3	0	2	4	3	4	5	1	1	2	4	1	4	0	2	3	3	4	5	0	2	0	0	1	2	2	4	0	1	0	1	0	1	1	1	0	1	2	0	0	2	0	0	0	0	2	2	0	0	0	0	0	1	0	0	2	1
VISN 19																																																											
Cheyenne, WY	442						X			X								X	X	X	X						X		X		X				X		X																					X	X
Grand Junction, CO*	575																						X						X						X		X		X																				
Sheridan, WY	666					X		X		X	X	X	X					X	X	X	X																X																						
VA Salt Lake City HCS	660						X	X	X	X	X	X	X				X	X	X	X	X	X	X			X	X		X	X			X	X	X		X		X			X	X					X	X						X		X		X
VA Southern Colorado HCS***	554GD																																																										
Denver, CO (VA Eastern Colorado HCS)	554	X	X			X	X	X	X	X	X	X	X				X	X	X	X	X		X									X				X				X																			
VA Montana HCS***	436																																																										
VISN 19 Totals		1	1	0	0	2	3	3	2	4	3	3	3	0	0	0	2	4	4	4	4	1	3	0	0	1	2	0	3	1	1	1	1	1	3	1	4	0	2	1	0	1	1	0	0	0	0	1	1	0	0	0	0	0	1	0	1	1	2
VISN 20																																																											
Boise, ID	531					X	X	X		X	X	X	X	X	X			X		X			X																									X	X						X				
Portland, OR	648		X			X		X								X		X	X	X	X		X				X		X						X	X	X					X																	
Spokane, WA***	668																																																									
Walla Walla, WA	687						X		X				X						X		X									X			X																										
White City, OR (Ind Dom)*	692		X				X		X				X		X								X																				X						X						X				
VA Alaska HCS*	463								X				X						X		X						X																																
VA Roseburg HCS	653					X		X		X			X	X			X										X	X	X																										X				
VA Puget Sound HCS	663					X		X	X	X	X	X	X					X		X											X			X		X	X			X																			
VISN 20 Totals		0	2	0	0	4	3	4	4	3	2	2	6	2	2	1	1	3	3	3	3		3	0	0	0	3	1	2	1	1	0	1	1	1	2	2	0	0	1	0	1	1	0	0	0	0	1	2	0	0	0	0	0	3	0	0	0	0
VISN 21																																																											
Honolulu, HI	459					X	X	X	X				X	X			X	X	X	X	X																				X		X																X
Manila, PI***	358																																																									
San Francisco, CA	662				X	X	X	X	X	X		X	X	X		X		X	X	X	X												X				X				X																	X	
VA Central California HCS	570		X		X		X			X					X											X	X	X	X																														
VA Northern California HCS	612					X	X	X	X	X	X		X					X	X	X	X	X	X				X		X		X		X	X	X				X				X																X
VA Sierra Nevada HCS	654	X	X		X	X	X	X	X	X	X	X	X		X			X	X	X	X		X					X				X		X															X										
Livermore, CA (VA Palo Alto HCS)**	640A4							X		X		X		X				X		X						X																																	
Palo Alto, CA (VA Palo Alto HCS)	640		X	X	X		X	X	X	X	X	X	X	X	X	X		X	X	X	X		X			X							X	X	X	X	X		X	X	X		X					X											X
VISN 21 Totals		1	3	1	4	4	6	6	5	6	3	4	5	4	3	2	1	6	5	6	5	1	3	0	0	3	2	2	2	0	1	1	3	3	2	1	2	0	2	1	3	0	3	0	0	0	0	1	1	0	0	0	0	0	0	0	0	1	3

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2002 & 2011 COMPLEMENTARY AND ALTERNATIVE MEDICINE (CAM) Modality Comparison

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Mind-body Medicine

LOCATION	STATION NUMBER	Animal Assisted Therapy 02	Animal Assisted Therapy 11	Aromatherapy 02	Aromatherapy 11	Biofeedback 02	Biofeedback 11	Guided Imagery 02	Guided Imagery 11	Hypnosis / Hypnotherapy 02	Hypnosis / Hypnotherapy 11	Meditation 02	Meditation 11	Music Therapy 02	Music Therapy 11	Non-Traditional Spiritual Practices 02	Non-Traditional Spiritual Practices 11	Progressive Muscle Relaxation 02	Progressive Muscle Relaxation 11	Stress Management, Relaxation Therapy 02	Stress Management, Relaxation Therapy 11	Yoga 02	Yoga 11
VISN 22																							
Loma Linda, CA	605		X			X	X		X		X		X					X	X	X	X		
VA San Diego HCS	664	X	X		X	X				X		X	X		X		X			X	X	X	X
VA Southern Nevada HCS	593					X														X	X		X
VA Greater Los Angeles HCS	691		X		X	X	X	X	X		X		X				X	X	X	X	X		X
VA Long Beach HCS*	600		X				X		X		X		X		X		X		X		X		X
VISN 22 Totals		1	4	0	2	4	3	1	3	1	3	1	4	0	2	0	3	2	3	4	5	1	4
VISN 23																							
Fargo, ND**	437					X				X													
Iowa City, IA	636A6												X										
Minneapolis, MN	618	X	X		X	X	X		X	X	X	X	X	X	X		X	X	X	X	X		X
Sioux Falls, SD**	438	X				X		X		X		X		X				X		X			
St. Cloud, MN	656		X				X		X						X				X		X		X
VA Black Hills HCS	568				X		X	X	X			X	X	X	X		X	X		X			
VA Central Iowa HCS	636A6		X		X	X		X	X	X		X	X	X	X			X	X	X	X		
VA Nebraska-W. Iowa HCS***	636																						
VISN 23 Totals		2	3	0	3	4	3	3	4	4	1	4	4	4	4	0	2	4	3	4	3	0	2
* No submission on the CAM modalities in 2002 ** No submission on the CAM modalities in 2011 *** No submission 2 on the CAM modalities in 2002 & 2011	Natl Totals	13	65	4	26	66	73	65	85	48	42	36	85	38	64	4	30	68	78	86	96	8	45

Biologically Based Practices / Manipulative and Body-based Practices / Energy Medicine

LOCATION	STATION NUMBER	Chelation 02	Chelation 11	Diet-Alternative (02) Diet-Special; Diet Therapy (11) 02	Diet-Alternative (02) Diet-Special; Diet Therapy (11) 11	Dietary / Nutritional Supplements 02	Dietary / Nutritional Supplements 11	Herbal Medicines 02	Herbal Medicines 11	Acupressure 02	Acupressure 11	Acupuncture 02	Acupuncture 11	Massage Therapy 02	Massage Therapy 11	Movement Practices 02	Movement Practices 11	Energy Healing 02	Energy Healing 11	Tai Chi, Qigong 02	Tai Chi, Qigong 11
VISN 22																					
Loma Linda, CA	605				X		X		X		X		X								X
VA San Diego HCS	664			X						X	X	X	X					X			
VA Southern Nevada HCS	593			X	X		X						X							X	X
VA Greater Los Angeles HCS	691					X							X							X	X
VA Long Beach HCS*	600										X		X		X						
VISN 22 Totals		0	0	2	2	1	2	0	1	1	3	1	5	0	1	0	0	1	0	2	3
VISN 23																					
Fargo, ND**	437			X		X															
Iowa City, IA	636A6				X		X						X								
Minneapolis, MN	618									X			X		X		X		X		X
Sioux Falls, SD**	438									X				X							
St. Cloud, MN	656				X				X												X
VA Black Hills HCS	568				X		X						X					X			
VA Central Iowa HCS	636A6				X		X					X	X				X				
VA Nebraska-W. Iowa HCS***	636																				
VISN 23 Totals		0	0	1	4	1	3	0	1	2	0	1	4	1	1	0	2	1	1	0	2
Natl Totals		0	1	13	34	18	47	4	9	13	25	32	61	23	39	0	19	10	19	14	33

Whole Medicine Systems / Other

LOCATION	STATION NUMBER	Ayurvedic 02	Ayurvedic 11	Homeopathy 02	Homeopathy 11	Native American Healing Practices 02	Native American Healing Practices 11	Naturopathic Medicine 02	Naturopathic Medicine 11	Other Indigenous Healing Performed by a Healer 02	Other Indigenous Healing Performed by a Healer 11	Sweat Lodge 02	Sweat Lodge 11	Traditional Chinese Medicine 02	Traditional Chinese Medicine 11	Other 02	Other 11
VISN 22																	
Loma Linda, CA	605																
VA San Diego HCS	664																
VA Southern Nevada HCS	593																
VA Greater Los Angeles HCS	691						X										
VA Long Beach HCS*	600																
VISN 22 Totals		0	0	0	0	0	1	0	0	0	0	0	0	0	0	0	0
VISN 23																	
Fargo, ND**	437																
Iowa City, IA	636A6																
Minneapolis, MN	618						X										X
Sioux Falls, SD**	438																
St. Cloud, MN	656												X				
VA Black Hills HCS	568					X							X				
VA Central Iowa HCS	636A6																
VA Nebraska-W. Iowa HCS***	636																
VISN 23 Totals		0	0	0	0	1	1	0	0	0	0	0	2	0	0	0	1
Natl Totals		0	0	0	1	7	12	0	0	0	1	0	10	0	2	6	18

2002 "Other" Provided Modalities		
VA Boston HCS	523	Thought Field Therapy
		Cognitive Behavior Therapy
		Eye Movement Desensitize & Reprocess
VA Connecticut HCS	689	Art Therapy
		Drama Therapy
Beckley, WV	517	Osteopathic Manipulation
Miami, FL	546	Recreational Therapy
Cincinnati, OH	539	Aquatic Therapy
VA Northern Indiana HCS	610A4	Pilates, Manual Therapy
		Craniosacral Therapy
Fayetteville, AR	564	Eye Movement Desensitize & Reprocess
VA New Mexico HCS	501	Art Therapy
		Self-Hypnosis
Cheyenne, WY	442	Eye Movement Desensitize & Reprocess
San Francisco, CA	662	Eye Movement Desensitize & Reprocess

2011 "Other" Provided Modalities		
Boston HCS	523	Biodynamic Craniosacral Therapy
Hudson Valley HCS	620	Creative Arts Therapy
Salisbury, NC	659	Art Therapy
		Horticulture
		Snoezelen Therapy
Charleston, SC	534	Dry Needling
Dublin, GA	557	Art Therapy
Caribbean HCS-San Juan	672	[illegible]
Dayton, OH	552	Dry Needling
Chicago HCS	537	Osteopathic Manipulation
Hines, IL	578	Art Therapy
		Horticulture
Houston, TX	580	Cranial Electrotherapy Stimulation
		Neurofeedback
South Texas HCS	671	Sensory Stimulation
New Mexico HCS	501	Visceral Manipulation
Cheyenne, WY	442	Osteopathic Manipulation
Salt Lake City HCS	660	Recreational Therapy
Northern California HCS	612	Laser Light Therapy
Pacific Islands HCS	459	Art Therapy
Palo Alto HCS	640	Art Therapy
		Expressive Arts Therapy
		Aquatic Therapy
Minneapolis, MN	618	Dance Therapy

As part of the national evaluation of Mental Health Residential Rehabilitation Treatment Programs (MH RRTP), programs are asked whether they offer any CAM interventions, and whether those interventions are delivered inside or outside of the RRTP programming itself. Out of 237 RRTP programs nationally, 65 percent offer at least one CAM intervention. Of those, 44 percent provide the CAM intervention directly within the RRTP program. The attachment below of the national evaluation of the programs report lists the locations of the programs that offer CAM services.

MH RRTP Treatment Process; Location and Types of Services Provided to Veterans by Site, VISN and Program for FY12

Scale: 0 - 3
0 = Service not Provided
1 = Service Provided Directly by MH RRTP Staff
2 = Service Provided Indirectly Outside MH RRTP
3 = Service Provided both Within and Outside MH RRTP

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
1	518	Bedford	CWT/TR	2
1	518	Bedford	DCHV	3
1	523	Boston	CWT/TR	2
1	523	Boston	SA RRTP	0
1	523W	Boston	CWT/TR	0
1	523a5	Brockton	PTSD RRTP	1
1	523a5	Brockton	CWT/TR	2
1	523a5	Brockton	DCHV	2
1	523a5	Brockton	SA RRTP	0
1	689a4	Newington	PTSD RRTP	3
1	631	Northampton	CWT/TR	2
1	689	West Haven	CWT/TR	2
1	689	West Haven	General RRTP	3
2	528a8	Albany	CWT/TR	2
2	528a8	Albany	SA RRTP	0
2	528a4	Batavia	PTSD RRTP	0
2	528a4W	Batavia	PTSD RRTP	0
2	528a6	Bath	General DOM	1
2	528	Buffalo	SA RRTP	0
2	528a5	Canandaigua	General DOM	2
2	528a5	Canandaigua	DCHV	2
2	528a5	Canandaigua	General RRTP	2
3	630a4	Brooklyn	DCHV	3
3	630a4	Brooklyn	General DOM	3
3	630a4	Brooklyn	SA DOM	3
3	561	East Orange	SA RRTP	3
3	561a4	Lyons	DCHV	3
3	561a4	Lyons	PTSD RRTP	2
3	561a4	Lyons	CWT/TR	2
3	561a4	Lyons	General RRTP	1
3	561a4W	Lyons	PTSD RRTP	2
3	620	Montrose	SA DOM	2
3	620	Montrose	PTSD DOM	0
3	620	Montrose	DCHV	0
3	632	Northport	PTSD RRTP	1
3	632	Northport	SA RRTP	1
4	529	Butler	CWT/TR	2
4	529	Butler	SA DOM	2
4	529	Butler	DCHV	2
4	540	Clarksburg	General RRTP	2

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
4	540	Clarksburg	PTSD RRTP	2
4	540	Clarksburg	SA RRTP	2
4	542	Coatesville	DCHV	0
4	542	Coatesville	PTSD DOM	1
4	542	Coatesville	SA DOM	0
4	595	Lebanon	CWT/TR	0
4	595	Lebanon	General RRTP	0
4	595	Lebanon	SA RRTP	0
4	646A4	Pittsbrgh-Heinz	General RRTP	0
4	646A4	Pittsbrgh-Heinz	SA DOM	2
4	646A4	Pittsbrgh-Heinz	DCHV	2
4	646A4	Pittsbrgh-Heinz	CWT/TR	2
4	693	Wilkes-Barre	SA RRTP	3
5	512	Baltimore	General RRTP	2
5	613	Martinsburg	SA DOM	0
5	613	Martinsburg	PTSD DOM	0
5	613	Martinsburg	General DOM	0
5	613	Martinsburg	DCHV	0
5	613	Martinsburg	CWT/TR	0
5	512a5	Perry Point	DCHV	2
5	512a5	Perry Point	CWT/TR	2
5	512a5	Perry Point	General RRTP	2
5	512a5	Perry Point	SA RRTP	2
5	688	Washington DC	CWT/TR	2
6	637	Asheville	SA RRTP	3
6	590	Hampton	General DOM	0
6	590	Hampton	PTSD DOM	0
6	590	Hampton	SA DOM	0
6	590	Hampton	CWT/TR	0
6	590	Hampton	DCHV	0
6	652	Richmond	SA RRTP	0
6	658	Salem	SA RRTP	0
6	659	Salisbury	SA RRTP	0
7	508	Atlanta	CWT/TR	2
7	509	Augusta	General DOM	2
7	521	Birmingham	CWT/TR	0
7	557	Dublin	DCHV	0
7	557	Dublin	PTSD DOM	0
7	557	Dublin	SA DOM	0
7	679	Tuscaloosa	SA RRTP	2
7	679	Tuscaloosa	PTSD RRTP	3
7	679	Tuscaloosa	CWT/TR	2
7	679	Tuscaloosa	DCHV	2
7	619a4	Tuskegee	CWT/TR	0
7	619a4	Tuskegee	DCHV	0
7	619a4	Tuskegee	General RRTP	0
8	516	Bay Pines	PTSD DOM	1

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
8	516	Bay Pines	DCHV	3
8	516	Bay Pines	General DOM	3
8	516	Bay Pines	SA RRTP	2
8	516	Bay Pines	PTSD RRTP	1
8	573	Gainesville	SA RRTP	1
8	573	Gainesville	CWT/TR	2
8	573	Gainesville	DCHV	3
8	573A4	Lake City	General RRTP	1
8	546	Miami	General RRTP	2
8	546	Miami	PTSD RRTP	2
8	546	Miami	SA RRTP	2
8	675	Orlando	DCHV	2
8	675	Orlando	General DOM	2
8	675	Orlando	SA DOM	2
8	673	Tampa	DCHV	0
9	596	Lexington	SA RRTP	1
9	596	Lexington	PTSD RRTP	2
9	603	Louisville	SA RRTP	2
9	614	Memphis	PTSD RRTP	2
9	614	Memphis	SA RRTP	3
9	621	Mountain Home	DCHV	0
9	621	Mountain Home	General DOM	0
10	538	Chillicothe	General DOM	2
10	538	Chillicothe	General RRTP	2
10	539	Cincinnati	SA RRTP	3
10	539	Cincinnati	PTSD RRTP	1
10	539	Cincinnati	DCHV	2
10	541	Cleveland	CWT/TR	0
10	541	Cleveland	SA DOM	0
10	541	Cleveland	PTSD DOM	3
10	541	Cleveland	DCHV	2
10	541	Cleveland	General RRTP	0
10	552	Dayton	DCHV	0
10	552	Dayton	PTSD DOM	0
10	552	Dayton	SA DOM	0
10	552	Dayton	General DOM	0
11	515	Battle Creek	General DOM	2
11	515	Battle Creek	SA RRTP	2
11	515	Battle Creek	PTSD RRTP	2
11	515	Battle Creek	CWT/TR	2
11	550	Danville	General RRTP	3
11	550	Danville	CWT/TR	2
11	553	Detroit	DCHV	0
11	583	Indianapolis	DCHV	3
11	610	Marion IN	SA RRTP	0
12	537	Chicago JB	SA RRTP	2
12	537	Chicago JB	General RRTP	2

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
12	578	Hines	SA RRTP	2
12	607	Madison	CWT/TR	3
12	607	Madison	SA RRTP	3
12	695	Milwaukee	General DOM	3
12	695	Milwaukee	DCHV	3
12	695	Milwaukee	CWT/TR	2
12	695	Milwaukee	PTSD DOM	1
12	695	Milwaukee	SA DOM	2
12	556	North Chicago	General DOM	0
12	556	North Chicago	CWT/TR	2
12	556	North Chicago	PTSD RRTP	3
12	556	North Chicago	DCHV	3
12	676	Tomah	PTSD RRTP	1
12	676	Tomah	CWT/TR	2
12	676	Tomah	SA RRTP	0
15	589a4	Columbia	CWT/TR	0
15	589	Kansas City	SA RRTP	0
15	589a6	Leavenworth	General DOM	1
15	589a6	Leavenworth	DCHV	1
15	657a5	Marion IL	General RRTP	0
15	657	St. Louis	SA RRTP	0
15	657	St. Louis	DCHV	0
15	589a5	Topeka	CWT/TR	0
16	520	Biloxi	PTSD RRTP	0
16	520	Biloxi	General RRTP	0
16	520	Biloxi	SA RRTP	0
16	580	Houston	DCHV	3
16	586	Jackson	SA RRTP	0
16	586	Jackson	PTSD RRTP	0
16	598	Little Rock	PTSD DOM	2
16	598	Little Rock	General DOM	2
16	598	Little Rock	DCHV	2
16	598	Little Rock	CWT/TR	2
16	635	Oklahoma City	CWT/TR	0
17	549a4	Bonham	CWT/TR	0
17	549a4	Bonham	SA DOM	0
17	549a4	Bonham	General DOM	0
17	549	Dallas	SA RRTP	2
17	549	Dallas	CWT/TR	0
17	549	Dallas	DCHV	2
17	671	San Antonio	SA RRTP	0
17	671	San Antonio	DCHV	0
17	674	Temple	CWT/TR	0
17	674	Temple	PTSD DOM	0
17	674	Temple	General DOM	0
17	674a4	Waco	General RRTP	2
17	674a4	Waco	PTSD RRTP	2

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
18	501	Albuquerque	SA RRTP	2
18	501	Albuquerque	General RRTP	2
18	501	Albuquerque	DCHV	2
18	501	Albuquerque	CWT/TR	2
18	519	Big Spring	General DOM	1
18	501GD	Gallup	General RRTP	2
18	644	Phoenix	SA RRTP	1
18	649	Prescott	General DOM	3
18	649	Prescott	DCHV	3
18	678	Tucson	SA RRTP	2
19	554	Denver	PTSD RRTP	1
19	436	Ft. Harrison	General RRTP	1
19	660	Salt Lake City	SA RRTP	3
19	666	Sheridan	PTSD DOM	2
19	666	Sheridan	DCHV	3
19	666	Sheridan	SA DOM	3
20	663a4	American Lake	SA DOM	3
20	663a4	American Lake	PTSD DOM	3
20	663a4	American Lake	DCHV	1
20	663a4	American Lake	CWT/TR	2
20	463	Anchorage	CWT/TR	2
20	463	Anchorage	DCHV	3
20	531	Boise	SA RRTP	1
20	648	Portland	DCHV	0
20	648	Portland	SA RRTP	0
20	653	Roseburg	PTSD DOM	0
20	653	Roseburg	SA DOM	0
20	687	Walla Walla	SA RRTP	3
20	692	White City	DCHV	1
20	692	White City	General DOM	1
21	459	Honolulu	PTSD RRTP	2
21	640	Palo Alto	DCHV	2
21	640	Palo Alto	SA RRTP	2
21	640	Palo Alto	PTSD RRTP	3
21	640	Palo Alto	CWT/TR	2
21	640	Palo Alto	SA DOM	2
21	640W	Palo Alto	PTSD RRTP	3
21	662	San Francisco	CWT/TR	2
22	691	West LA	SA DOM	1
22	691	West LA	General DOM	1
22	691	West LA	DCHV	1
23	636a6	Des Moines	DCHV	0
23	636a6	Des Moines	SA DOM	0
23	636a6	Des Moines	General DOM	0
23	636a6	Des Moines	PTSD DOM	2
23	568	Fort Meade	CWT/TR	0
23	636a4	Grand Island	SA RRTP	1

VISN	SITE CODE	SITE	MH RRTP Type	Complementary and Alternative Medicine (CAM)††
23	636a4	Grand Island	CWT/TR	0
23	568a4	Hot Springs	CWT/TR	0
23	568a4	Hot Springs	PTSD DOM	0
23	568a4	Hot Springs	General DOM	0
23	568a4	Hot Springs	DCHV	0
23	568PR	Hot Springs	CWT/TR	0
23	636	Omaha	SA RRTP	2
23	636	Omaha	General RRTP	1
23	656	St. Cloud	General DOM	1

† Includes services provided indirectly outside the MH RRTP as well as within the residence by MH RRTP staff.

†† Includes yoga, acupuncture etc.

6

A recent survey of specialized PTSD treatment programs found that 96 percent of all programs offer at least one type of CAM treatments to their patients with PTSD (Table 1); and, 88 percent offered at least one CAM intervention other than those that are commonly part of conventional PTSD treatments (guided imagery, progressive muscle relaxation, and stress management/relaxation therapies).

Table 1

Department of Veterans Affairs specialized posttraumatic stress disorder (PTSD) treatment programs offering complementary and alternative medicine (CAM) treatments, by program type

	All programs (N=125)		Outpatient programs (N=98)		Residential programs (N=19)		Inpatient programs (N=8)	
CAM treatment	N	%	N	%	N	%	N	%
Any CAM	120	96	94	96	18	95	8	100
Any CAM, modified[a]	110	88	84	86	18	95	8	100
Mindfulness	96	77	75	77	14	74	7	88
Stress management–relaxation therapy	90	72	74	76	11	58	5	63
Progressive muscle relaxation	83	66	67	68	10	53	6	75
Guided imagery	74	59	60	61	10	53	4	50
Art therapy	38	30	21	21	15	79	2	25
Yoga	36	29	26	27	5	26	5	63
Meditation	32	26	27	28	2	11	3	38
Spiritual practices or therapy	26	21	18	18	4	21	4	50
Tai chi	22	18	18	18	1	5	3	38
Biofeedback	17	14	14	14	3	16	0	—
Music therapy	16	13	7	7	7	37	2	25
Hypnosis or hypnotherapy	9	7	7	7	2	11	0	—
Native American healing practices	9	7	5	5	2	11	2	25
Qi gong	9	7	7	7	1	5	1	13
Acupuncture	8	6	6	6	2	11	0	—
Chiropractic or spinal manipulation	4	3	3	3	1	5	0	—
Emotional freedom technique	4	3	2	2	1	5	1	13
Acupressure	2	2	0	—	2	11	0	—
Dance therapy	2	2	0	—	2	11	0	—
Drama therapy	2	2	2	2	0	—	0	—
Energy healing	2	2	1	<1	0	—	1	13
Herbal medicines	2	2	1	<1	1	5	0	—
Massage or body work	2	2	1	<1	0	—	1	13
Sensorimotor psychotherapy	1	<1	1	<1	0	—	0	—

[a] Any CAM treatment except guided imagery, progressive muscle relaxation, and stress management–relaxation therapy, which are commonly part of conventional PTSD treatments

Question 6. In 2006, VA commissioned the RAND Corporation and Altarum to evaluate VA's mental health system. That evaluation, published in November 2011 in *Health Affairs*, found that there was a reliance on medication and that VA had a "low rate of delivery for some evidence-based practices." Similarly, an article published February 2013 in the *Journal of Traumatic Stress* found that, of the 38 residential treatment programs for Post-Traumatic Stress Disorder visited by the au-

thors, only 10 programs fully integrated Cognitive Processing Therapy and no program fully integrated Prolonged Exposure therapy.

a. When new evidence based practices are adopted how long does it typically take to fully integrate these practices into the clinical care setting?

Response. A variety of sources, including the New Freedom Commission on Mental Health, the Institute of Medicine, and the peer-reviewed scientific literature have documented the substantial delay in the adoption of EBPs in routine clinical care in both private and public health care settings. VHA has taken significant steps to expedite the process, including but not limited to, implementing national competency-based training programs in Cognitive Processing Therapy (CPT), Prolonged Exposure Therapy (PE), and other EBPs, and establishing national policy requiring the availability of these treatments. These efforts, which began in 2006, have significantly increased the availability of these therapies in VHA. In fact, all facilities have implemented CPT and/or PE, two of the most effective treatments for PTSD. More than 4,700 VA therapists have received training in one or both of these treatments through VHA's CPT and PE training programs.

Although implementation of CPT and/or PE has occurred at all sites, there is variability in the magnitude of EBP delivery across the system. Increasing the magnitude across sites is a major current focus. One initiative designed to promote the magnitude of EBP delivery is the implementation of CPT and PE through telemental health modalities. More than 100 staff have been hired or reassigned to focus on the delivery of CPT and/or PE telemental health services. In addition, three pilot regional CPT and PE telemental health clinics have been established to augment the local delivery of these therapies and expand their reach to more rural areas. Another mechanism to promote local implementation of these therapies is the issuance of VHA Handbook 1160.05, Local Implementation of Evidence-Based Psychotherapies for Mental and Behavioral Health Conditions. This Handbook specifies the requirements for fully implementing EBPs at the local level, including staffing needs, clinic and scheduling requirements, treatment planning and clinical implementation issues, and training needs. In addition, technical assistance and support on best practices for promoting local EBP implementation are being provided to sites. Furthermore, CPT and PE documentation templates to be released into VA's electronic medical record by fourth quarter of this fiscal year will allow for precise monitoring of the extent to which these therapies are being delivered at specific facilities. This is currently not possible through the use of current procedural terminology codes, which do not specify the type of psychotherapy provided.

VA also supports research to facilitate the adoption of EBP. For example, a new project—Collaborative Research to Enhance and Advance Transformation and Excellence (CREATE)—has the overall goal to improve Veteran access to and engagement in evidence-based PTSD treatments. This CREATE project includes complementary projects that together accomplish the following: (1) test Veteran- and family-directed outreach interventions to reduce delay in help seeking for PTSD; (2) test interventions to ensure that Veterans with PTSD seen in VA primary care clinics, including CBOCs receive evidenced-based treatment for PTSD; and (3) identify strategies to improve the reach of evidence-based treatment for PTSD among treatment-seeking Veterans.

b. Please provide the Committee with the number of veterans that have a mental health diagnoses who only receive medication, the number who only receive therapy, and the number of veterans who receive both medication and therapy?

Response. VA currently tracks initiation of new episodes of psychotherapy separately in specific subpopulations of mental health patients because the types of treatment and modes of delivery of psychotherapy that are evidence-based vary by mental health diagnosis. For this request, the response has combined these subpopulations, and provides the number of patients with (1) depression, (2) PTSD, (3) substance use disorders (SUD), or (4) serious mental illness who initiated a new episode of psychotherapy and/or received a VA prescription within the last 4 quarters. For comparison, we also include these rates for patients with serious mental illness (SMI), SUD, or PTSD, as these populations are more frequently treated in specialty mental health programs and accept and receive psychotherapy at somewhat higher rates.

Some Veterans will have mental health diagnoses that do not fall within any of these categories, and some Veterans will have mental health diagnoses within multiple categories. We note that only new episodes of psychotherapy are considered. Veterans receiving continuous monthly or bi-monthly psychotherapy with no breaks in care are not included in the psychotherapy counts. Additionally, we note that all prescriptions were counted, regardless of whether the medication is primarily used for treatment of psychiatric or medical problems. Because of high rates of medical

problems in VA patients with mental health diagnoses, we expect many of these patients to receive prescriptions for medical conditions.

Diagnostic subpopulation	Number (%) who initiated psychotherapy only	Number (%) who received a prescription only	Number (%) who initiated psychotherapy and received a prescription	Number who didn't initiate psychotherapy and didn't receive a prescription
SMI, SUD, PTSD, or Depression	26,530 (1.7%)	769,848 (49.7%)	698,930 (45.1%)	53,310 (3.4%)
SMI, SUD, or PTSD	19,394 (1.9%)	422,403 (42.4%)	527,777 (53.0%)	26,964 (2.7%)

Question 7. VA's testimony states that "a wide array of mobile applications to support the evidence-based mental and behavioral health care of Veterans will be rolled out over the course of 2013."

a. Please provide a list of all mobile applications that will be delivered during fiscal year 2013 and fiscal year 2014. In addition, please include the following information associated with each mobile application: when the application is expected to be delivered, any contracts associated with the development of the application, the length of time it took to develop the application, the development and sustainment cost associated with the application, and any performance measures associated with the application.

VA Response:

- *Stay Quit Coach.* Integrated Care for Smoking Cessation: Treatment for Veterans with PTSD.
  – iOS and Android versions are complete and are currently available internally for research and evaluation. Public release was in spring 2013 (iOS) and autumn 2013 (Android).
  – Contractor: Vertical Product Development. Development took 7 months for iOS and 4 months for Android (following completion of the iOS version).
  – Development costs: $38,500 for iOS and $50,000 for Android. Sustainment costs are $0.
  – Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *CBT-I Coach.* Cognitive Behavioral Therapy for Insomnia.
  – iOS version is complete and is currently available internally for research and evaluation. Public release was in spring 2013 (iOS). DOD has funded an Android version which was deployed autumn 2013.
  – Contractor for iOS: Vertical Product Development. Development took 7 months for iOS. Android version funding and development are with DOD.
  – Development costs: $30,000 for iOS. Sustainment costs are $0.
  – Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned. Pilot projects are underway. Two funded trials are beginning shortly.
- *Mindfulness Coach.* Mindfulness-Based Stress Reduction.
  – iOS version is complete and is currently available internally for research and evaluation. Public release is expected autumn 2013 (iOS).
  – Contractor for iOS: Vertical Product Development. Development took 5 months for iOS.
  – Development costs: $38,500 for iOS. Sustainment costs are $0.
  – Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *ACT Coach.* Acceptance and Commitment Therapy.
  – iOS version is complete and is currently available internally for research and evaluation. Public release is expected autumn 2013 (iOS).
  – Contractor for iOS: Vertical Product Development. Development took 8 months for iOS.
  – Development costs: $30,000 for iOS. Sustainment costs are $0.
  – Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *CPT Coach.* Cognitive Processing Therapy.

– iOS and Android versions are complete and are currently available internally for research and evaluation. Public release is expected autumn 2013 (iOS) and autumn 2013 (Android).
– Contractor for iOS: Vertical Product Development. Development took 7 months for iOS. Android development was funded and completed by DOD.
– Development costs: $30,000 for iOS. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.

- *Moving Forward.* Problem Solving Training.
– iOS version is complete and is currently available internally for research and evaluation. Public release is expected autumn 2013 (iOS).
– Contractor for iOS: Vertical Product Development. Development took 6 months for iOS.
– Development costs: $25,250 for iOS. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *Safety Plan.* Mobile version of VA safety planning for crisis management.
– iOS version is in development. Public release is expected autumn 2013 (iOS).
– Contractor for iOS: Vertical Product Development. Development has been going on for 4 months for iOS.
– Development costs: $40,000 for iOS. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *SPR Coach.* Skills for Psychological Recovery (secondary prevention for PTSD).
– iOS version is in development. Public release is expected winter 2013 (iOS).
– Contractor for iOS: Vertical Product Development. Development has been going on for 5 months.
– Development costs: $40,000 for iOS. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.

The following additional mobile applications are for self-management of concerns common to Veterans and their families:

- *Parenting2Go.* Parenting training for Veterans and Servicemembers.
– iOS version is in development. Public release is expected winter 2013 (iOS).
– Contractor for iOS: Vertical Product Development. Development has been going on for 4 months.
– Development costs: $25,250 for iOS. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *PTSD Family Coach.* Education and self-management for families of those with PTSD.
– Version 1.0 of this app for iOS and Android was completed in 2011. Version 1.1 for iOS and Android versions are in development. Public release is expected autumn 2013 (iOS) and autumn 2013 (Android).
– Contractor: Vertical Product Development. Development took 6 months for both iOS and Android.
– Development costs: $40,000 for updates to both iOS and Android. Completed version 1.0 cost $30,000 for iOS and $60,000 for Android. Sustainment costs are $0.
– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.
- *Concussion Coach (formerly TBI Coach).* Self-management for Veterans with mild Traumatic Brain Injuries.
– iOS version is complete and currently available internally for research and evaluation. Android version is in development. Public release is expected autumn 2013 (iOS) and winter 2013 (Android).
– Contractor: Vertical Product Development. Development took
– 4 months for iOS and has taken 2 months so far for Android (in process).
– Development costs: $40,000 for iOS and $60,000 for Android. Sustainment costs are $0.

– Performance measure: monthly download reports indicating number of users to begin upon public launch. Research on usability, clinical outcomes, and implementation is planned.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Do VA and DOD collaborate and coordinate on research initiatives regarding the treatment of PTSD and mental health issues? If so, what is the process, and how is it evaluated? If not, why not, and does it require legislation to establish such collaboration? (10P)

Response. VA and DOD collaborate and coordinate research initiatives regarding the treatment of PTSD and mental health issues, as well as other conditions affecting military Servicemembers and Veterans, and their families. The history of our collaboration is rich with examples of well-coordinated, highly integrated working relationships across research funding offices. Formal collaborations have been instituted to share mental health research portfolios based on a joint integrated research approach to present information systematically and consistently. We will plan our third annual portfolio review by the end of 2013. The portfolio reviews, as well as ongoing working relationships, enable agencies to identify research needs or gaps in real time, and determine the best way forward. Legislation is not required to establish collaboration or a process for collaboration, as each agency continues to operate within respective authorities for sponsored research.

Regarding collaborative initiatives, VA and DOD have determined that a major collaborative consortium effort focused on PTSD is a research need. Thus, a request for proposals was published in 2012 to solicit applications for a joint VA/DOD Consortium to Alleviate PTSD (CAP) award. The primary purpose of CAP is to improve the health and well-being of Servicemembers (active duty, National Guard, and Reservist) and Veterans, with the most effective diagnostics, prognostics, novel treatments, and rehabilitative strategies to treat acute PTSD and to prevent chronic PTSD. This Consortium is responsive to the findings of the Institute of Medicine report focused on "Treatment of PTSD in Military and Veteran Populations."

Key priorities of this Consortium are elucidation of factors that influence the different trajectories (onset/progression/duration) of PTSD and associated chronic mental and physical sequelae (including depression, anger/aggression, and substance use/abuse, etc.), and identification of measures for determining who is likely to go on to develop chronic PTSD. The Consortium will therefore work to improve prognostics, advance treatments, and mitigate negative long-term consequences associated with traumatic exposure.

Following scientific peer review, CAP was awarded in September 2013 to a collaboration involving the University of Texas Health Science Center at San Antonio and VA's National Center for PTSD, Boston VA Medical Center (www.ptsd.va.gov). They will attempt to develop the most effective diagnostic, prognostic, novel treatment, and rehabilitative strategies to treat and prevent PTSD.

Further, in August 2012, President Obama issued a Mental Health Executive Order (13625) requiring a National Research Action Plan that was submitted to the White House and released in July 2013. It further describes the extensive collaborations between VA and DOD, as well as other Federal research funding agencies, focused on PTSD and other mental health issues. The goals clearly describe the joint vision for this research focused on advancing treatment for Veterans, military Servicemembers, and their families.

Question 2. What is the most innovative and experimental research underway at DOD and at VA to develop innovative care and treatment for PTSD and mental health?

Response. "Innovative" and "experimental" describe the research VA sponsors to advance care and treatment for PTSD and mental health. Examples from the research portfolio that are focused on basic mechanisms underlying disorders will provide the platform for identifying possible biological targets for treatment development. One such example is a study examining the potential benefit of a novel medication, a corticotropin-releasing factor antagonist, for reducing PTSD symptoms. Other medication trials may develop from the recent *Federal Register* notice to develop public-private collaborations for new pharmacological treatments for PTSD, an experimental approach to identify potential treatment targets. Innovation is also underway in the form of multiple clinical trials focused on determining if there is a benefit to complementary and alternative medicine approaches such as meditation techniques for PTSD. VA is also supporting innovative ways to deliver treatments through technology based systems such as Internet, phone apps, and telehealth. Fu-

ture research efforts will continue to use an experimental approach to determine whether proposed innovation is beneficial for treating PTSD and mental health conditions in Veterans.

Question 3. How do VA and DOD review and evaluate outside research on PTSD and mental health treatments from the non-profit and private sector?

Response. VA uses a variety of strategies to review and evaluate research conducted outside of VA, some of which is conducted by VA scientists supported through non-VA funding sources such as non-profit or private sector mechanisms. In general, the scientific community and the respective research funding offices use multiple sources to remain current on outside research. Results from VA supported and non-VA supported work appear in the public domain through resources such as the National Library of Medicine's PubMed system. Clinicaltrials.gov is also a registry and results database of publicly and privately supported clinical studies of human participants conducted around the world utilized by researchers and funding offices. Such public domain information, including that posted to the National Institutes of Health RePORTER as is done by VA, increase the transparency and availability of research study information to evaluate efforts underway and results of scientific work. VA scientists, in making research applications for funding, must also describe ongoing work or impactful results, e.g., if a non-Veteran population showed beneficial effect of a treatment that might be beneficial to the Veteran population. Additionally, VA research conducts annual reviews of activities within the PTSD and other mental health conditions research portfolio with other agencies, allowing a systematic review and evaluation of ongoing and completed work.

The VA Evidence-Based Synthesis program was established to provide timely and accurate syntheses of research on targeted health care topics of particular importance to clinicians, managers, and policymakers. The program reviews research conducted within and outside VA to generate evidence syntheses on important clinical practice topics. Recent reports on mental health include: *Screening for Post-Traumatic Stress Disorder (PTSD) in Primary Care; Suicide Risk Factors and Risk Assessment Tools; Suicide Prevention Interventions and Referral/Follow-up Services; Family Involved Psychosocial Treatments for Adult Mental Health Conditions*; and, *Efficacy of Complementary and Alternative Medicine Therapies for Posttraumatic Stress Disorder*.

In addition, VA's National Center for PTSD (the Center) creates and disseminates research reviews using a range of formats. The *PTSD Research Quarterly* provides reviews and authoritative bibliographies on selected topics in trauma and PTSD; recent topics include: *The Role of Benzodiazepines in the treatment of PTSD; Complementary and Alternative Treatments for PTSD; and, PTSD Disability Assessment*. The Center also publishes the *Clinician's Trauma Update—Online*, a bi-monthly review of research on the clinical care of trauma-related problems in Veterans and Servicemembers. The Center also conducts two monthly online lecture series to provide syntheses of current evidence on a range of topics relevant to treatment of PTSD and related disorders in Veterans. All of these products are complemented by additional online research reviews disseminated as fact sheets through the Center's Web site, www.ptsd.va.gov.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. What plans are there to increase staffing to meet the following needs? I understand the Alaska VA did not request more MH positions, considering the problems with wait times, etc. will you be hiring more Mental Health personnel?

Response. The Alaska VA Healthcare System (AVAHCS) has 15 vacancies for mental health positions as of September 23, 2013. AVAHCS has plans that it is executing to recruit and hire mental health providers to fill these positions. AVAHCS is at various stages in the hiring process for these positions as indicated by the chart below:

Positions Beginning the Recruiting Process	Positions Pending Posting to USAJOBS	Positions Posted for Hire	Positions in the Interview Process	Positions with Candidates Selected & In Credentialing or Hiring Processes	TOTAL VACANCIES
1	2	4	4	4	15

These data include ongoing recruitment efforts for 15 mental health provider vacancies for the AVAHCS Domiciliary Care for Homeless Veterans (DCHV) Program.

In addition, AVAHCS has made progress in hiring six personnel for the Health Care for Homeless Veterans (HCHV) Program.

Question 1a. According to staff and veterans using the facilities: There is a need for additional therapists, especially dedicated to OIF/OEF veterans.

Response. As noted above, we do have mental health vacancies; however, all Patient Aligned Care Team (PACT) Social Work vacancies are currently filled. We have integrated OIF/OEF/OND case management into the PACT structure. This avoids fragmentation of care and is consistent with the Medical Home concept of the PACT.

Question 1b. There is a need for case managers who have time to keep track of veterans, their needs, to call them if they are not coming in, and refer them to appropriate services.

Response. As noted above, our OIF/OEF/OND case management activities are integrated into the PACT structure, which provides the benefit of Veterans having one identified case manager who is familiar with their needs and can coordinate services with both the Primary Care PACT and mental health services. They are clinically skilled and are able to provide the first line of behavioral health interventions as well. In addition to the OIF/OEF/OND case managers, we also have an OIF/OEF/OND Program Manager and a Transition Patient Advocate who ensure seamless transition from active duty/National Guard to VA services, assist with enrollment for health care and benefits, and provide linkages with community partners serving this population of Veterans.

Question 1c. There is a need for administrative support to help therapists and case managers.

Response. As of June 19, 2013, the Administrative Officer position to assist the therapists and case managers has been filled. Six of the seven identified Medical Support Assistant positions have also been filled. A vacancy announcement for the remaining position recently closed, and the list of candidates is being certified. When all positions are filled, adequate support should be in place for the therapists and case managers to be integrated into the PACTs. Specialty mental health providers currently have adequate administrative support.

Question 1d. Additional staff as listed above could help to reach out to rural Alaska; the VA has the technology to do so. What are the plans to use tele-health technology?

Response. AVAHCS is currently partnering with the State of Alaska on a Health Resources and Services Administration grant to increase enrollment and access for rural Veterans. VA mental health staff have provided training in Sitka, Juneau, Bethel, Barrow, and other sites to enhance the knowledge of Veteran issues and care among rural providers. As a part of this grant, VA clinicians will provide training in EBP that targets PTSD for providers in the Alaska Island Community Services in Southeast Alaska. As part of a VA Office of Rural Health grant, a partnership with the Southeast Alaska Regional Health Consortium (SEARHC) has been initiated to provide PTSD treatment by a VA psychologist using telemental health technology. The psychologist will partner with the SEARHC psychiatrist to provide a truly integrated service. These pilots are planned for replication at other rural sites. The clinical video teleconferencing to the home using secure software is currently being rolled out to Veterans in a variety of sites throughout the state. In addition, home telehealth monitoring is now available to address schizophrenia, bipolar disorder, and depression, PTSD, and substance use disorders. We are currently exploring use of telemental health at all AVAHCS sites to allow assistance from other facilities in our VISN.

Question 1e. There is a need for people with chronic pain management experience/expertise, also trained in non-traditional means to help vets cope with pain. Are there plans to hire more Physical and Occupational Therapists to help these vets?

Response. We currently have a chronic pain group clinic that provides opportunity for management and treatment of chronic pain issues. In addition, we also have physical and occupational therapy services available via referral. We have built a business case for hiring an additional physical therapist and physical therapy assistant to increase access to those services. We are actively recruiting for the physical therapist. The physical therapy assistant position is awaiting posting.

AVAHCS is a participant in the multi-site Office of Patient Centered Care grant for Healing Touch. Alaska received funding to begin training in Healing Touch as a shared best practice in the VA system.

Question 1f. Human Resources is still too slow to process advertisements, applicants etc; part of this is due their staffing, perhaps also the bureaucratic process.

Whatever the reasons, the process takes too long and we lose good applicants. What is the VA plan for expediting hiring?

Response. We have recently hired two human resource assistants to improve throughput in our hiring process. As evidenced by the hiring actions noted above, we are actively and aggressively recruiting, selecting, and bringing staff on board.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE HIRONO TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In working to meet Secretary Shinseki's goal of hiring 1,600 new mental health clinical providers and 300 administrative support staff, does VA have a goal to fill a percentage of these positions with veterans outside of peer specialists?

Response. There exists in VA a 40 percent Veteran hiring goal. Beyond that, many of the specialized disciplines will be difficult to fill with Veterans in that timeframe.

Question 2. In your testimony, you point to a widespread use of complementary and alternative medicine for treating mental health problems in the VA system, around 89%. What barriers remain to achieve universal access to this care for all our veterans and what steps is the VA taking toward this? Does VA have the ability to provide culturally appropriate care for example, traditional Hawaiian medicine and therapies in Hawaii for our Native Hawaiian veterans?

Response. There is increasing awareness within VA of the potential benefits of CAM practices in the management of mental health problems. Although the use of CAM in VA is widespread, the scope of CAM encompasses a broad range of treatments from whole systems of care (traditional medicine, Ayurveda, traditional Chinese medicine, homeopathy, naturopathy) to natural products (e.g., botanicals, probiotics) and mind-body practices to name a few.

The barriers to achieve universal access to CAM are complex and include internal and external factors including: synthesis of the rapidly growing scientific literature to determine efficacy and strategies to integrate into clinical practice; resources to build infrastructure and capacity to integrate CAM; lack of occupational series for CAM providers; provision of coverage of CAM services in the medical benefits package and gaps in Current Procedural Terminology—Relative Value Unit (CPT-RVU) modeling for CAM workload capture and tracking; and regulatory restrictions. For example, Federal regulations prohibit VA from prescribing products that are not approved as treatments by the Food and Drug Administration.

VA Mental Health Services is coordinating a series of demonstration projects, gathering lessons learned, and reviewing the scientific literature to guide future policy and program development. VA is committed to providing culturally relevant services to Veterans of all ethnic and cultural groups. The VA Office of Rural Health (ORH) and the Office of Tribal Government Relations support robust programs serving American Indian Veterans. ORH completed a survey in October 2012 identifying American Indian traditional practices (e.g., sweat lodge, drum ceremonies, traditional healers) in 19 of VA's 21 VISNs. The survey can be accessed on the ORH Native Domain Web site at: http://www.ruralhealth.va.gov/native/services.asp. A survey by VA's Chaplain Service, using different criteria from the ORH survey identified access to traditional healing services in all 21 VISNs. Because of the spiritual nature of American Indian healing practices, VA's Chaplain Service provides guidelines for traditional practitioners on these services and the processes for identifying and, through local American Indian tribes, verifying the competency of traditional healers. This guidance can be accessed through the National Chaplain Center Web site: www.va.gov/chaplain.

With regard to access of Native Hawaiian Veterans to traditional healing practices, the VA Pacific Islands Health Care System (VAPIHCS), like the rest of VA, is proud to offer a variety of state-of-the-art evidence-based mental health treatments to our Veterans, such as CPT and PE Therapy for PTSD. VA is able to offer these modalities to Veterans throughout their service area, including the neighboring islands of Guam, Saipan and American Samoa, either in-person or through telemental health. However, VAPIHCS recognizes that in a culturally diverse population, it must integrate a culturally sensitive approach to the holistic treatment of their Veterans. As such, VA staff work with members of the Veteran's cultural support network, which includes family, clergy, and other providers as requested by the Veteran, and certain aspects of evidence-based treatments have been modified to better fit the particulars of cultures represented by their patient population. VAPIHCS is a training site for the University of Hawaii Department of Psychiatry, which is home to the National Center on Indigenous Hawaiian Behavioral Health

(http://blog.hawaii.edu/dop/research/ncihbh/nhmhrdp/). Native Hawaiian Veterans are also eligible, as residents of the State of Hawaii, for culturally based services available through the State of Hawaii Adult Mental Health Division (AMHD), with whom VA has a collaborative relationship. For example, many Veterans at VAPIHCS receive mental health case management services through the AMHD in conjunction with VAPIHCS mental health services as part of their comprehensive mental health treatment plan.

Question 3. Marriage and family relationships play a major factor in veterans' mental health. Many in the Marriage and Family Therapist community in Hawaii nearly half of all MFTs do not have the opportunity to work for the VA due to VA's accreditation limitations. Hawaii does not have any COAMFTE accredited schools. To address the current limited access to practitioners that is encountered especially in rural areas, can the VA look at reevaluating its restrictive policy in this area and establish an alternative qualification?

Response. The VA qualification standard for Marriage and Family Therapists (MFT) was developed by a group of highly qualified subject matter experts (SME) and leadership within VHA Mental Health Services. The qualification standards require that a Marriage and Family Therapist have a degree from a program accredited by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE). This standard was developed to assure the provision of the highest quality of care to our Nation's Veterans. COAMFTE is a specialized accrediting body that accredits master's degree, doctoral degree, and post-graduate degree clinical training programs in Marriage and Family Therapy throughout the U.S. and Canada. Since 1978, it has been recognized by the U.S. Department of Education as the national accrediting body for the field of Marriage and Family Therapy. Having a COAMFTE accreditation ensures the program has undertaken an extensive external evaluation and meets the standards established by the profession. Requiring that a MFT possesses a COAMFTE accredited degree assures VA that the MFT has undertaken a superior course of professional preparation, and that the individual has been trained in the appropriate knowledge and skill areas required of the profession. If an individual has not graduated from a program that has been COAMFTE accredited, VA cannot be assured that the provider has graduated from a program that has met professional standards developed by a national consensus of professionals in the MFT field. Please note, all other mental health professions within VA must also be accredited by national accrediting bodies specific to their disciplines. Therefore, the standards for MFT graduate program accreditation are at the same high level as that required for other mental health professions in VA. For example, all Psychologists must have graduated from programs that have been accredited by the American Psychological Association and all Licensed Professional Mental Health Counselors must have graduated from programs that have been accredited by the Council on Accreditation of Counseling and Related Educational Programs. When developing the qualification standards, the SMEs reviewed documentation on current industry standards and practices and included consideration of all state requirements. While VA does not plan to change the MFT qualification standard, VA is supportive of increasing telemental health services to rural areas. These services may include services provided by MFTs.

Question 4. Kimberly Ruocco's testimony mentioned the experience of a surviving father who came to TAPS and was grieving the death of his veteran son by suicide and harmful effects that breaking of the bond with the counselor has on his healing. What is VA's current policy and practice on maintaining veteran-counselor relationship for the duration of therapy?

Response. VA recognizes the importance of a consistent therapeutic relationship and strives to sustain those relationships throughout treatment whenever practicable, taking into account the patient's preference as well as provider availability. However, there is no current, specific policy regarding the maintenance of the relationship between VA mental health providers and the patients for the duration of therapy. All providers are bound to operate within the ethical and practice standards of their professions, and to participate and communicate fully as a member of the Veteran's health care team.

Chairman SANDERS. Thank you very much, Dr. Petzel.
Colonel Porter.

STATEMENT OF COLONEL REBECCA PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, U.S. ARMY, DEPARTMENT OF DEFENSE

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 U.S. Army has fought for over 11 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 4, 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 information technology, or 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:]

STATEMENT BY COL. REBECCA I. PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, UNITED STATES ARMY

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.

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. The majority of our Soldiers have maintained resilience during this period. However, the stresses of increased operational tempo are evident in the increased demand for Behavioral Health Services.

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. Both the Ready and Resilient Campaign Plan and the Behavioral Health Service Line emphasize the shared responsibility amongst medical assets, commanders and leaders, and individual Soldiers and Family Members in optimizing the readiness and resiliency of our Force.

The Ready and Resilient Campaign Plan was mandated through a Directive issued on February 4, 2013. This campaign plan will create a holistic, collaborative and coherent enterprise to increase individual and unit readiness and resilience. 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. Several key programs and initiatives are nested under the Ready and Resilient Campaign Plan, including the Behavioral Health Service Line, the Army Suicide Prevention Program, The Performance Triad and Comprehensive Soldier and Family Fitness. These programs will teach Soldiers, Families, and DA Civilians coping skills for dealing with the stress of deployments and everyday life.

The Behavioral Health Service Line is the treatment component of the Ready and Resilient Campaign Plan, designed to provide consistent and ready access to integrated and evidence-based behavioral health services across the Soldier's Lifecycle, delivered by the most appropriately trained and credentialed providers and teams to meet the needs of the Army Family.

While 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 programs that put our behavioral health teams into the unit footprint, integrated behavioral health departments to simplify access for our beneficiaries and to integrate our services, child and family services, integrated behavioral health support in the Army's Patient Centered Medical Homes, and the Behavioral Health Data Portal, an IT capability that enables us to capture and share real time patient wellbeing status, risk assessment and treatment outcomes for the first time.

I want to highlight the demonstrated success of the Embedded Behavioral Health program, which provides multidisciplinary behavioral health teams to provide community behavioral healthcare 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: (1) inpatient behavioral health admissions; (2) off-post referrals; (3) high risk behaviors; and (4) 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 healthcare in the military setting. Currently, 26 Brigade Combat Teams and 8 other Brigade Sized Units are supported by Embedded Behavioral Health Teams. Expansion of Embedded Behavioral Health teams to all operational units is anticipated no later than FY16.

Our Tele-Behavioral Health (TBH) program increases access to specialty care in geographically isolated areas to include more than 60 sites in Afghanistan, 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. These Army Telehealth (TH) services are provided across 19 time zones in over 30 countries and territories at over 70 sites across all five RMCs and over 90 sites in the operational environment, a global net to extend capable accessible services wherever the Army goes.

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 via web application, enabling improved surveillance and assessment of program and treatment efficacy. It provides improved patient tracking within behavioral health clinics, provides real-time information regarding Soldier's behavioral health readiness status, and enhances provider communication with Commanders to ensure optimal, coordinated behavioral health

care. The Behavioral Health Data Portal was rapidly deployed and trained at 31 Military Treatment Facilities by the end of last year.

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 inTransition Program, which provides ready access to nationwide cadre of experienced and independent Behavioral Health professionals for Soldiers pending transition. These coaches teach life skills, provide guidance in obtaining long-term behavioral health assistance and resources, and provide current and relevant education on specific Behavioral Health conditions. We also utilize Military OneSource as an equivalent resource for Soldiers that are transitioning.

We are actively working with the VA to ensure continuity of care for Soldiers transitioning to leave military Service. For Soldiers with complex medical conditions, to include Behavioral Health, Warrior Transition Units ensure personal support, case management and a warm hand-off to the VA. We continue to collaborate with our DOD and VA partners to improve the Integrated Disability Evaluation System to ensure timely access to benefits that Soldiers have earned during their time on Active Duty Service and to ensure appropriate transfer of care to the VA. Army Medicine has increased IDES capacity by putting more resources (people) in place, reducing the number of days Servicemembers are in the process (and reducing the backlog), decreasing the amount of time spent on the Narrative Summary by accepting the proposed VA rating as the single rating, and conducting Army-wide training on customer service. VA Nurse Case Managers are assigned to Soldiers in the Integrated Disability Evaluation System to further support continuity of care upon separation from military service.

Behavioral Healthcare 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 a ready and resilient Army family. Thank you again for the opportunity to testify before the Committee and for your steadfast support to our Soldiers and Veterans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO COL REBECCA PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, U.S. ARMY

Question 1. The Army's Task Force on Behavioral Health recently completed a comprehensive report which contained a significant number of recommendations to improve both behavioral health care and the disability evaluation system Army-wide. Please describe how the Army plans to ensure these recommendations are implemented consistently across all installations.

Response. The Army Task Force on Behavioral Health made recommendations to many commands within the Army. The Army Medical Command (MEDCOM) has primary responsibility for 23 of the 47 recommendations and has assigned the oversight of its implementation to a team of personnel within its Operations section. MEDCOM has already begun to implement most of the recommendations and will report its progress to the Secretary of the Army on a quarterly basis.

Question 2. Given the expertise the Army has gained in the area of mental health, please provide information on how the Army is sharing lessons learned with the other uniformed services and the Department of Defense as a whole. Has the Army engaged DOD's Office of Warrior Care Policy in order to determine whether these recommendations could be utilized to strengthen behavioral health care and the Integrated Disability Evaluation System across the Services?

Response. The Army has shared the lessons it has learned in the area of mental health in many forums. Most recently the Army submitted documents describing over 20 key programs to DOD for consideration of possible dissemination to other services.

Question 3. Has VA supported the Army's efforts to improve the diagnosis and evaluation of behavioral health conditions?

Response. The Army has worked closely with the VA to improve the diagnosis and evaluation of Soldiers, especially during the IDES process. Specifically, Army and VA medical providers synchronize diagnostic conclusions before the Physical Evaluation Board reviews a Soldier's case.

Question 4. Why has the Army projected it will take several more years for Embedded Behavioral Health Teams to be expanded to all operational units?

Response. Establishing the Embedded Behavioral Health (EBH) model of outpatient care depends on several factors, including hiring and training adequate personnel and establishing new clinical facilities in each brigade's areas on the installations. The Army is accomplishing those tasks as quickly as possible and has established over 30 EBH teams to date on 18 installations.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO COL REBECCA PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, U.S. ARMY

Question 5. Do VA and DOD collaborate and coordinate on research initiatives regarding the treatment of PTSD and mental health issues? If so, what is the process, and how is it evaluated? If not, why not, and does it require legislation to establish such collaboration?

Response. Yes, Departments of Defense (DOD) and Veterans Affairs (VA) collaborate on Post-Traumatic Stress Disorder (PTSD) and mental health research initiatives. A variety of Federal agencies including the DOD, VA, National Institute of Drug Abuse (NIDA) and Department of Education each fund research programs devoted to scientific discovery to advance health. DOD and VA focus specifically on military/Veteran populations, whereas other agencies address health issues in the general population such as in minors or other subpopulations. Collectively, the agencies support research covering the broad spectrum of the human population that will lead to a better understanding, prevention, and treatment of the physical injuries and mental health and substance abuse problems related to stress and trauma experienced by servicemembers and Veterans.

DOD and VA held a combined research review addressing psychological health in Nov 2011. A similar review was held in Jan 2013 and this process is expected to continue on an annual basis. Together, DOD and VA developed a framework for research using a "Joint Integrated Research Continuum Approach" model that describes the entire research spectrum from foundational (basic) through prevention, treatment, follow-up care, and services research. The latter category addresses how care is delivered and issues associated with stigma regarding seeking mental health care and barriers to obtaining the desired services. This framework highlights the areas in which the two agencies are in a complementary manner seeking treatment solutions as well as elucidating areas where more research is needed.

In the past year, DOD provided more than $30.5 million to VA researchers for 351 projects. DOD currently funds VA scientists to investigate several high-priority topics, including: PTSD, alcohol abuse, resilience to mitigate combat stress and post-deployment reintegration problems, mental health of female Veterans (including military sexual trauma), treatment of Traumatic Brain Injury (TBI), treatment for amputations and improved prosthetics, rehabilitation, telemedicine, and illnesses in Veterans of Operation Iraqi Freedom and Operation Enduring Freedom. VA scientists frequently partner with DOD scientists, who serve in a supporting role as co-investigators. Approximately 80% of the Defense Health Program Research Development Test and Evaluation psychological health research efforts underway have VA involvement through investigator participation.

Recently initiated activities include two new joint DOD/VA consortium efforts to support PTSD and TBI biomarker studies (the Consortium to Alleviate PTSD [CAP] and the Chronic Effects of Neurotrauma Consortium [CENC]), new treatment studies to be generated from biomarker studies, and new treatment response studies to be incorporated into clinical trials.

Question 6. What is the most innovative and experimental research underway at DOD and at VA to develop innovative care and treatment for PTSD and mental health?

Response. Below are just a few examples of innovative research approaches in PTSD and Mental Health:

Combined Psychotherapy, Virtual Reality, and Cognitive Enhancers: This project addresses the use of Prolonged Exposure Psychotherapy, in combination with Virtual Reality techniques and the testing of a medication for "cognitive enhancement" that will augment the learning/memory aspects of the psychotherapeutic process. The research question to be answered is how much is the already evidence-based practice of prolonged exposure therapy further improved via the additions of virtual reality techniques and the cognitive enhancer when treating PTSD.

Transcranial Electro-magnetic Stimulation of the Brain: Cranial Stimulation applies the use of low voltage electrical stimulation in a non-invasive manner to speci-

fied exterior locations on the skull of PTSD patients. Pilot research has indicated that this technique demonstrates some potential for PTSD symptom relief.

Intranasal Administration of Thyroxin Releasing Hormone (TRH) to Offer Short-term Relief from Acute Suicidal Thinking: TRH has demonstrated properties that offer short-term relief from acute depression and associated suicidal ruminations. The challenge with administration of the compound is delivering an effective therapeutic dose in a manner that is not toxic while still crossing the blood brain barrier. This project seeks to develop an intranasal administration protocol as well as a device that will reliably provide only the prescribed dosage for short term use.

Development of Compressed Treatment Protocols for the Delivery of Evidence-Based Psychotherapies for PTSD: This research compares the standard delivery of psychotherapy that includes weekly or greater intervals between psychotherapy appointments, to the delivery of psychotherapy on a "compressed regimen" of daily session. This research has the potential to decrease the span of psychotherapy treatment for PTSD from a regimen that is several months or more long to one that consists of a period of three weeks or less. The goal of the research is to demonstrate comparability of the therapeutic result but within a much shorter treatment interval.

Mindfulness Training for Resilience: Several projects within this area of complementary and alternative medicine are evaluating the pre-deployment instruction and training of soldiers in mental resilience awareness, activities, and exercises that improve coping abilities for the psychological challenges typically associated with combat deployment.

Question 7. How do VA and DOD review and evaluate outside research on PTSD and mental health treatments from the non-profit and private sector?

Response. Generally, when DOD and the US Army Medical Research and Materiel Command's Military Operational Medicine Research Program (MOMRP) accept specific psychological health research requirements, a working group meeting is held that includes civilian researchers representing a variety of organizations (universities, private research foundations and enterprises) as well as leaders and experts within the VA and DOD research and provider communities. These meetings evaluate the current state of research in the designated areas and result in identification of future research needs. . Once research projects are selected and underway, we participate in periodic In Progress Reviews (IPRs) of funded projects. Reviewer participants on the panels include subject matter experts from a variety of domains, both military and civilian. These panels bring the expertise of cutting edge research in the field to MOMRP's research review meetings, which in turn serve as forums for both critical review, course correction, and the identification of future research needs. MOMRP annually conducts a number of IPRs for psychological health topics and working group meetings are typically held on an ad hoc basis.

Within specific research areas there are additional means of information sharing. One example is the Suicide Research Consortium (MSRC), which is charged with broadly monitoring civilian and military suicide research and ensuring that DOD/VA funded efforts reflect current research needs. The MSRC includes DOD, VA and civilian experts and researchers. Another example is the National Center for PTSD, operated through the VA, which includes a variety of civilian, VA, and DOD experts and researchers that track findings within the larger research community for PTSD and ensure that this information is widely disseminated for use in treatment policy development and planning as well as informing the future course of PTSD research. There are also several PTSD-specific research consortiums, including Strong Star and INTrUST, that also function in a manner loosely analogous to the MSRC.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE HIRONO TO COL REBECCA PORTER, CHIEF, BEHAVIORAL HEALTH DIVISION, OFFICE OF THE SURGEON GENERAL, U.S. ARMY

Question 8. What is your assessment of outreach to female soldiers to seek mental health services including for military sexual trauma?

Response. The Army is committed to ensuring its behavioral health (BH) programs and outreach services for victims of sexual assault are designed to support the needs of both male and female Soldiers.

Behavioral Health Care is an important factor in the readiness of the Army. The Army is committed to ensuring resources are available to address behavioral health needs of all Soldiers. We are embedding BH assets in unit areas and in the facility to reducing stigma associated with seeking behavioral health services. The Embedded Behavioral Health (EBH) Program provides multidisciplinary BH care located in the unit area to maximize coordination with unit leaders. This care model has demonstrated significant reductions in key behavioral health measures while knock-

ing down access barriers and reducing stigma associated with help seeking behaviors. Additionally, we have embedded BH assets into the primary care clinic in the Patient Centered Medical Home, providing increased access to behavioral health assets.

The recent professional credentialing of Sexual Assault Resource Coordinators (SARCs) and Victim Advocates (VA) provides a standard consistent pathway to direct both male and female Soldiers to the mental health resources. We are working to modify the periodic health assessment, pre- and post-deployment health reassessment forms to include specific sexual assault questions to support mental-health outreach efforts concerning sexual trauma.

Chairman SANDERS. Colonel, thank you very much.

Let me begin with Dr. Petzel. I mentioned in my opening remarks that as we have spent 10 years at war in Iraq and 11 in Afghanistan, the cost of war 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 talk about individuals suffering from Post Traumatic Stress Disorder and Traumatic Brain Injury, how many people are we talking about?

Dr. PETZEL. Thank you, Mr. Chairman. Right now, the VA is taking care of slightly over 500,000 people with Post Traumatic 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. OK.

Dr. PETZEL. We have about 119,000 people from the present conflicts that carry the diagnosis of Post Traumatic Stress Disorder.

Chairman SANDERS. OK. This is an issue. 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 wounds of these wars due to the incredible amount of explosions our soldiers were exposed to.

How many folks are we talking about who have the diagnosis of Traumatic Brain Injury?

Dr. PETZEL. We have tested since several years ago, more than 5 years 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 TBI. 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 an 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. OK. We are going to have a second round of questions but let me conclude my questions by asking Dr. Petzel one final question. You have engaged in a very ambitious effort to hire mental health clinicians. My understanding is that in order to reach your 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 clinicians?

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 that last year we lost more soldiers to suicide than to armed combat, and we are talking somewhere around 350 or so individuals.

Why is this number so incredibly high? Why is that occurring? And later on we will talk about what the Army is doing to address it.

I think the average American would be shocked that we are losing more people to suicide than to armed combat. But tell me, in your judgment, 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. OK. 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 of 1,600 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 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, 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, where it was, and correct it.

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 of. 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 that 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.

Second, 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 every one 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 are they 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 seen 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, 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 if you would provide 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 that you have addressed with the 1,600 people also created the Military and Veterans Mental Health Interagency Task Force; and it was directed to provide the President with recommendations to improve health and substance abuse services by February 2013.

Has 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 it is going through coordination and concurrences by a number of Federal departments and you will have it available to you as soon as it 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. OK. 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 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. I would love to have a discussion within the Committee about these reports once we get them if we have the 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 in defining rural.

Senator TESTER. Well, the reason I want to come to this is that we are hiring—we have got 1,300 and another 600 or so people you are hiring in the mental health profession.

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

But I am more concerned about rural where there are no resources. My question is, when you assign these folks, what is the priority you do it on? Is it based on where there are 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, MT, 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, in the 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 [continued]. 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 suicide is a huge issue and an incredible worry and something we have got to improve. Have you got any data on 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 declining suicide rate than those veterans who are not in contact with the VA, not getting care in our system.

Senator TESTER. Have you 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. 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. OK.

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.

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 servicemembers 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. I think that was a question I asked the gentleman from NAMI 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.

Dr. PETZEL. That is absolutely right.

Senator TESTER. OK. One last question. Oh good, I have more minutes than I thought. [Laughter.]

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

Colonel PORTER. I do not know that we finalized the number from last year.

Senator TESTER. Is it close?

Colonel PORTER. I think it is close, Senator.

Senator TESTER. OK. Is that all the branches of the military?

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

Senator TESTER. OK.

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 with you, we talked about the stigma attached. Is the military doing anything about that stigma because 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 that 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. OK. 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. OK. There is a huge problem here. This is the veterans Committee and we hold the VA accountable. But I think the Department of Defense has a responsibility here to train people of what they are going into 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—we heard about the community-based programs, we have heard about different things that seem to work.

You have got the classic therapy. One of our witnesses talked about an individual that was in Haiti helping other people and that seemed to help a lot. I heard about 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 Post Traumatic 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 to that. I think that we want to make sure that all veterans have access to our evidence-based psychotherapies and we want to make sure that they understand that treatment works because one of the biggest barriers for people coming into care is not knowing that there is something there that will help them.

But we also 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.

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 other programs.

My concern is, you know, in an effort—you guys work very, very hard to try to solve this problem. The trouble is that you are receiving the patient at the end stage. So, we are not addressing the cause of the problem.

So, you are having to deal with this 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 at overprescribing.

We are seeing this in the private sector, what has happened with pain management. They are consuming more opiates than all the rest of the world put 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 the sense that we need to look at the divorce rate in the military. You know, that is every bit as important because it all factors in.

We need to look at how our soldiers are doing financially, and also important is we almost need—maybe we have already—but we need to have a marital hotline at the bases, again to get our guys and girls in a situation where they are dealing with those problems while in the military for when they get out.

Also, the employment picture is so important; getting them hired where they can. What I see so often is with the multiple deployments you might not come back with PTSD, but I can tell you are probably coming back with family problems, particularly 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 a billion dollars to is going to go a long way toward 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, 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 like 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 issues.

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 [continued]. 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. In the meantime, let me bring some other issues and ask some questions.

I think it is fair to say that both VA and DOD, have a very good reputation for treating the wounds of war in terms of prosthetics, in terms of how we take care of amputees. There are probably no institutions in the world that do a better job than 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, hundreds 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. This is a mammoth issue, the number of veterans that are suffering.

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 about out-of-the-box therapies, talk a little bit about complementary medicine. There was a piece on CNN just the other day and they were talking about overmedication which is a very real issue.

In the story, some of the overmedicated individuals were moved toward acupuncture 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?

And the second issue, and Senator Boozman raised that as well what we are dealing with our real-life problems? Life is complicated; 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.

How we break through that old bureaucracy? Senator Boozman mentioned the idea of veterans playing golf. If four veterans spend an afternoon out playing golf and feeling good about each other and come back feeling a little bit better about themselves—or they go trout fishing or 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 works for them, understanding that we have to be careful when we make these recommendations 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 data as to what is working, you know.

Chairman SANDERS. Yes. OK. 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 golf tournament for the blind 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 of overmedication and 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 overmedication 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 the 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.

STATEMENT OF HON. RICHARD BLUMENTHAL, U.S. SENATOR FROM CONNECTICUT

Senator BLUMENTHAL. Thank you, Mr. Chairman.

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

Regarding the collection of data on the use of pain medications, many of us know that this issue has bedeviled our society. I know from my own experience as State attorney general how challenging it was when we were finally able to establish an electronic health records system that keeps track of who is prescribing and who is taking pain medications 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 that works seamlessly transfer to the VA? This system 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 with dancing it takes two.

Dr. PETZEL. Yes.

Senator BLUMENTHAL. And, the public announcement by Secretary Panetta and General Shinseki was certainly not encouraging. I have since heard conflicting reports and my concern is that this interoperable system may not be the same as a seamless, fully-integrated system that enables real-time 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, I'm 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. This is a thing that the VA particularly has been paying constant attention to. Our Secretary is absolutely relentless in pushing forward the need for having this integrated record.

Senator BLUMENTHAL. 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 commend fully and enthusiastically.

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

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

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.

During the proceedings I saw ESCAPE FIRE, the documentary that I think the Chairman mentioned earlier and I hope that more people have 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. So, I hope that 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, 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 of 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 overmedicate 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. Forty-five percent of people returning to this country after deployment complain about neck, arm, shoulder, and 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, OK, 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 Post Traumatic 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 physical pain.

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 that both DOD and VA are facing is extraordinary, and in many ways is unprecedented.

I appreciate 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.

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

A P P E N D I X

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

Chairman Sanders and Ranking Member Burr, Thank you for leadership for veterans, especially this hearing to focus on the importance of improving mental health care in VA.

The suicide rate among veterans is a sad, stunning alarm. Each individual case is a tragedy for families and the community. The invisible wounds for war are real and they deserve as much care and support as physical wounds.

This hearing is important because we start by hearing about the concerns our veterans and families have. I believe it is imperative for VA and the medical profession to reach out to care for our veterans with PTSD and mental health issues. It is good that both VA and DOD testified today. Both departments must find ways to coordinate care, transfer files and share practice and programs.

VA also needs to engage in bold research to find new and better ways to care for our veterans who are suffering because of their service. I am interested to know what the innovative treatments that VA researchers are studying as well as DOD researchers. The reoccurring theme of the testimonies seems to be that various care options are needed to meet the specific needs of individuals. I agree that "one size does not fit all." I want to know what new and promising research for mental health treatment exists. I believe that we need to follow the science to determine the promising treatments.

How are we using technology to meet the needs of our younger veterans and interact with them as they prefer, by technology?

Chairman Sanders and Ranking Member Burr, I stand ready to work with you to tackle this serious challenge of improving VA mental health and dealing with the stigma of mental health in our country.

PREPARED STATEMENT OF THE VETERANS AFFAIRS AND REHABILITATION COMMISSION, THE AMERICAN LEGION

A veteran in crisis, suffering from mental health problems, became so furious with the telephone delays he faced while trying to make a mental health appointment at the VA, assaulted his wife and dog after being repeatedly placed on hold. Veterans are struggling to access their mental healthcare across the country, and in Richmond, Virginia appointments for mental health (PTSD) issues are at least a six to eight month wait. Further, when calling for assistance, veterans are placed on hold before being asked whether the call is regarding an emergency, or whether the veteran is currently a danger to them self or to someone else.

On behalf of National Commander James Koutz and the 2.4 million veterans of The American Legion, we would like to thank this Committee for the opportunity to address this critical issue affecting veterans across the Nation.

The United States of America lost 22 veterans to suicide every day in 2010 according to the Department of Veterans Affairs (VA) study released earlier this month. According to the report's estimations, a veteran took his or her own life every 66 minutes.[1] With veteran suicide at an all time high, naturally we must question whether VA's mental health care system is equipped to meet the demands of the veteran population it was created to serve. The VA may offer veterans the best mental health care option available, but if we face difficult barriers to access that care, then veterans are not really being served.

Specifically, we will address the following five issues:

[1] "Suicide Data Report, 2012" Department of Veterans Affairs Mental Health Services Suicide Prevention Program, p 15.

1. Fulfilling the promise to hire additional mental health personnel and fill the large number of vacancies
2. Implementation of the E.O. to improve access to mental health care for veterans and their families
3. Addressing the recommendations in the IG and GAO report
4. Correcting lengthy wait times and misleading access measures, and cumbersome scheduling processes, and
5. Effective partnering with non-VA resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes

THE LARGE NUMBER OF EXISTING VACANCIES

During the past half decade, VA has nearly doubled their mental health care staff, jumping from just over 13,500 providers in 2005 to over 20,000 providers in 2011. However, during that time there has been a massive influx of veterans into the system, with a growing need for psychiatric services. With over 1.5 million veterans separating from service in the past decade, 690,844 have not utilized VA for treatment or evaluation. The American Legion is deeply concerned about nearly 700,000 veterans who are slipping through the cracks unable to access the health care system they have earned through their service.

On June 11, 2012, a VA Press Release outlined an aggressive recruitment effort to hire 1,600 mental health professionals and 300 support staff. The release stated that all of the positions would be filled by the 2nd Quarter of fiscal year (FY) 2013. Unfortunately, despite repeated requests for updates on the progress of the hiring, The American Legion had not received any numbers or date until a belated, eleventh hour press release from VA that was released just hours before this hearing.

In order to instill confidence in the veterans' mental health care stakeholders, VA must improve the transparency of their process and work to foster meaningful two-way communication. The veteran community wants to work with VA to ensure the needs of our veterans are being met, yet effective communication is impossible without open access to the information we need to discuss. The American Legion urges VA to provide more information on the status of hiring for these positions, throughout the entire process. If the concerned veterans' community only learns of unfilled positions after a deadline is missed, it will be too late for stakeholders and partners to work together to achieve meaningful solutions.

IMPLEMENTING THE EXECUTIVE ORDER ON IMPROVING ACCESS TO MENTAL HEALTH SERVICES FOR VETERANS, SERVICEMEMBERS AND MILITARY FAMILIES

The Executive Order on Improving Access to Mental Health Services for Veterans, Servicemembers and Military Families dealt with suicide prevention, enhancing partnerships between the VA and community providers, expanding VA mental health services staffing, improved research & development, and the creation of a Military and Veterans Mental Health Interagency Task Force.

After reviewing the Executive Order and examining the implementation, The American Legion has identified certain gaps that may need to be considered in the future development and implementation of this Executive Order.

The Executive Order Section 1: Policy order states that "as part of our ongoing efforts to improve all facets of military mental health, this order directs the Secretaries of Defense, Health and Human Services, Education, Veterans Affairs, and Homeland Security to expand suicide prevention strategies and take steps to meet the current and future demand for mental health and substance abuse treatment services for veterans, servicemembers and their families."

However, The American Legion is gravely concerned about the February 5, 2012 decision by VA and DOD to abandon efforts to create a single medical records system. Rather than supporting the vision of the Executive Order to work with multiple agencies, this decision can only lead to greater distance and fragmentation. With veterans waiting on average 374 days for Medical Evaluation Board (MEB)/ Physical Evaluation Board (PEB) claims and 257 days for a traditional VA claim, veterans need faster processing which will only come from a smooth transition of records. These records are needed for decisions and the lack of a shareable record is hurting veterans.

Suicide Prevention

According to the Executive Order, the Veterans Crisis Line was to be increased by 50 percent, which The American Legion applauds because it increases the capacity to serve veterans in a timely manner. It also called for the creation of a 12 month campaign, which began on September 1, 2012, which focuses on the positive benefits of seeking care and encourage veterans and servicemembers to proactively

reach out to support services. However, The American Legion is concerned this campaign does not adequately target families and community members. Because PTSD is comparable to other societal issues such as substance abuse, where the victim may not recognize their own problem, reaching out to the existing support structures around those victims is all the more critical. Veterans may have a lack of understanding or awareness of mental health care, and may not understand their conditions or may feel that their mental health conditions are not severe enough to warrant asking for help. Family and community members can help increase awareness and encourage the veteran to seek help.[2]

One of the impediments VA has faced has been with the collecting and tracking of accurate suicide data. In the Suicide report, it found that "as of November 2012, data had only been received from 34 states and data use agreements have been approved by an additional eight states." However, agreements are still under approval or development by other states which impacts VA's ability to accurately calculate the total number of veteran suicides. In order to improve the collection and reporting of suicide data, Congress should urge the states to share this information with VA. Without accurate suicide prevention and mortality data, the estimates that 18 to 21 veterans commit suicide are not truly accurate and these estimates in reality could be much higher or lower.

Enhanced Partnerships Between the VA and Community Providers

VA and Health & Human Services (HHS) were asked to establish at least 15 pilot programs with community providers in order to ensure that the needs of veterans are being met, by providing access to mental health services within 14 days of the patient's requested date.

While DOD has led the effort in utilizing pro-bono community provider programs to treat servicemembers for mental health conditions, including PTSD, testimony from a November 30th, 2011 Senate Veterans' Affairs Committee hearing[3] made it clear that VA was not working with non-profit organizations to minimize patient wait times for appointments, thus exacerbating the problem of the veteran's ability to receive care in a timely manner.

In a congressional hearing, "VA Fee Basis Care: Examining Solutions to a Flawed System," on September 14, 2012 The American Legion found many problems with VA's non-VA purchased care programs such as:

- need for VA to develop and implement fee-basis policies and procedures with a patient-centered strategy that takes veterans' interest and travel distance into account;
- lack of training and education programs for non-VA providers; lack of integration of VA's computer patient record system with non-VA providers which creates delay in contractors submitting appointment documentation;
- VA does not have a process to ensure all VA and non-VA purchased care contracts are inputted into a tracking system to ensure they do not lapse.

Without these VA reforms and improvements, VA cannot adequately leverage non-VA and community partnerships.

The American Legion demands that veterans have access to quality and timely mental health care, which should be based in an adequately funded budget for mental health. However, the VA should be leveraging community resources to help alleviate the issue associated with wait times whenever possible. In addition, it is crucial that the VA ensure that the community providers performing this important work are trained to provide the quality of care equal to what is delivered by VA providers. Ultimately, given the experience in dealing with military matters such as the unique complexities of PTSD, VA and DOD providers are, and should be, the gold standard of care, and VA planning should have the ultimate goal of fulfilling the needs of veterans within the VA system. While working to achieve that goal VA should ensure that no veterans slip through the cracks by leveraging all available community resources until the care can be completely met by VA resources.

It should be noted that the VA is working with community providers through the five-site, 3-year pilot program, Project Access Received Closer to Home (ARCH), which is administered through the Office of Rural Health. This program utilizes contracting and a fee-basis payment system to help meet the needs of rural veterans. The American Legion notes that processing the authorizations for certain services were concerns that were brought up in April 2012 during the evaluation of the Montana Project ARCH program. The 2012 System Worth Saving Task Force Report on Rural Health recognized that the ARCH project was a three year pilot,

[2] GAO Report *13–130, December 2012*.
[3] Testimony of Dr. Van Dahlen—11/30/11 Senate Veterans' Affairs Committee.

yet concerns existed regarding effective utilization of budget for patient care, a lack of outreach guidelines and communication, and the difference in structures between VA care and non-VA care.

While community providers are an option, The American Legion is concerned that a main issue associated with using community providers lies in the continuity of care. To address this concern, the VA is implementing a program that will address the lack of providers, while increasing the continuity of care, called; VA Specialty Care Access Networks—Extension for Community Healthcare Outcomes (SCAN-ECHO). This unique program utilizes primary care physicians to provide specialty care to veterans who choose to enroll in the program. The primary care physician presents the veteran's case to a panel of medical professionals, including specialists, who discuss diagnoses and treatments. By incorporating the primary care physician in the treatment, there is an increased level of continuity of care. Primary care physicians bring in a more holistic approach of the veteran that The American Legion believes will benefit the veteran patient.

Expanding VA Mental Health Services Staffing

The Executive Order also calls for the addition of 800 peer-to-peer counselors by December 2013, while providing hiring incentives and evaluating reporting requirements to reduce paperwork requirements to bring on new staff.

Peer-to-peer counseling has been used as an effective treatment to help veterans in the rehabilitation process, which is clearly exemplified by the Vet Center program implemented across the Nation. The American Legion advocates expanding the program of peer-to-peer support networks, and believes this would be very instrumental in moving from a treatment-based model to a recovery model.

The American Legion continues to encourage the Secretary of Veterans Affairs to utilize returning servicemembers for positions as peer support specialists in the effort to provide treatment, support services, and readjustment counseling for those veterans requiring these services. If appropriately skilled unemployed veterans can receive training to fulfill staffing needs in the mental health care system, VA will be solving multiple problems with a single, forward thinking solution. Robust recruitment and vocational training in this area should be a priority and The American feels so strongly about this issue that we passed a resolution during our National Convention last year specifically to call upon VA to institute a peer-to-peer outreach program.[4]

Hiring incentives may entice providers to apply to work for the VA over the private sector, and reducing the cumbersome process of credentialing and privileging to bring providers on board more quickly could help meet VA's needs, provided it is done in a manner that does not sacrifice quality and competency of care. VHA needs to conduct a staffing analysis to determine if psychiatrists or other mental health provider vacancies are systemic issues impending VHA's ability to meet mental health timeliness goals.[5] Many facilities visited through The American Legion's System Worth Saving program have demonstrated difficulties competing with the private sector, and complained that the Credentialing & Privileging process for physicians is too lengthy.

Improved Research & Development

The Executive Order called for the creation of a National Research Action Plan to be developed within 8 months by DOD, VA, HHS, and the Office of Science & Technology Policy (OSTP). This plan was supposed to develop better prevention, diagnosis, and treatment for PTSD, other mental health conditions, and Traumatic Brain Injury (TBI). Additionally it calls for DOD and HHS to engage in a comprehensive longitudinal health study on PTSD, TBI, and related injuries with minimum enrollment of 100,000 servicemembers.

The American Legion applauds this effort, because it is inclusive of TBI which has a high level of co-morbidity with PTSD. It also looks at long term effects of TBI, PTSD, and other mental health conditions, while focusing on the whole process of prevention, diagnosis, and treatment. The American Legion has long supported research efforts that address the signature wounds of the Iraq and Afghanistan conflicts and supports these efforts through a series of membership based resolutions that were passed during our National Convention last summer.[6]

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[4] American Legion Resolution No. 136: The Department of Veterans Affairs to Develop Outreach and Peer to Peer Programs for Rehabilitation.

[5] OIG Report *12–00900–168, April 23, 2012*.

[6] Resolution No. 108: Request Congress Provide the Department of Veterans Affairs Adequate Funding for Medical and Prosthetic Research; Resolution No. 285: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs.

In addition to traditional treatment measures currently in use through the VA and DOD health care systems, The American Legion urges Congress to provide oversight and funding to the DOD and VA for innovative TBI and PTSD research currently used in the private sector, such as Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy, as well as other non-pharmacological treatments. The American Legion also recommends the creation of a joint office for DOD & VA research in order to increase agency collaboration and communication. Finally, The American Legion finds it troubling that DOD and VA are not designated as the lead agencies for this effort, with HHS and OSTP providing advisory roles.

Military and Veterans Mental Health Interagency Task Force

The creation of a task force, which is designed to implement the Executive Order, met with all the stakeholders in January. The American Legion encourages the Task Force to continue to involve VSOs at all stages of their work.

ADDRESSING THE RECOMMENDATIONS IN RECENT VA INSPECTOR GENERAL (OIG) AND GOVERNMENT ACCOUNTABILITY OFFICE (GAO) REPORTS

Since 2005, multiple reports from the OIG have stated that the schedulers were entering incorrect desired appointment dates for veterans who were requesting mental health appointments. Recommendations have repeatedly directed VA to reassess their training, competency, and oversight methods to ensure reliable and accurate appointment data is captured.

The American Legion is extremely concerned that an overall lack of accountability will make this goal difficult to achieve. Much like the school system, the VA medical centers are trying to meet a standard they are mandated to achieve, and as in the case of the school systems, tests can be modified by the states to show success that is not occurring. The American Legion is further concerned that VHA statistics and data are being manipulated in order to show the desired results, and that this data is not accurately depicting the situation. Policies and measurements are created in order to monitor the information, but if individuals feel that their performance is based upon this measure, then the predilection to alter the data becomes problematic.

The American Legion also notes that the measurements are not always the issue. Staffing, technology, and veteran perceptions & circumstances also can play a big role in delaying treatment provided to veterans.

The VHA system has multiple issues with scheduling that could be alleviated with more funding.[7] Chief among these concerns are an outdated VistA Scheduling System, problems with scheduler turnover, and the ongoing provider staffing gaps. As the primary scheduling system, the outdated VistA can cause difficulties in scheduling due to a lack of multitasking ability inherent to the software. A more modern system could alleviate this, and will require funding to develop and implement. Consistency with staffing, not only of providers but also with schedulers, will ensure more consistency delivering appointments.

Although not mentioned in the report, the centralization of Informational Technology (IT) has created a shared pot where the different VA entities are now competing for the same technology storage space and resources. This creates an issue with updating programs such as the VistA Scheduling System or other IT solutions for scheduling. Facilities need to have flexibility in meeting their IT needs.

The more recent GAO report focuses on barriers faced and efforts to increase access.[8] The report mainly addresses the negative stigma, lack of understanding of mental health, logistical challenges, and concerns about the VA that may hinder veterans from accessing care.

Most notable in this report was the information regarding the values and priorities that veterans may have. For example, due to family, work, or schooling commitments, many veterans have concerns about scheduling VA appointments during traditional hours of operation.

VA attempted to address this issue with a Directive issued on September 5, 2012 developed by the VHA;[9] however, the Directive was rescinded less than a week later on September 11, 2012, through VHA Notice 2012–13, and the changes never took place. On January 9, 2013, VHA Directive 2013–001 was sent to the field to extend hours of access for veterans requiring primary care, including women's health and mental health services. Unfortunately, the implementation of this Directive is not

[7] GAO Report *13–130, December 2012*.
[8] Ibid.
[9] Directive 2012–023, "Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics."

expected until July 31, 2013 and they are only required to have one weekend shift that is limited to only two hours. In addition, extended hours are only required in VA medical centers and Community Based Outpatient Clinics with 10,000 unique patients or greater. The American Legion is concerned about the impact of this on veterans, particularly in rural areas.

CORRECTING LENGTHY WAIT TIMES, MISLEADING ACCESS MEASURES, AND CUMBERSOME SCHEDULING PROCESSES AND PROCEDURES.

Thus far, VA is taking a multipronged approach to address the scheduling issue, by looking at the issues associated with technology, access measures, training, and funding.

Technology

The VA announced in the *Federal Register* in October 2012 the opportunity for companies to provide adjustments to the open-source VistA electronic health system, and all submissions are due by June 2013. By creating the Medical Appointment Scheduling System (MASS) contest, the VA appears to be moving ahead on this issue.

Additionally, the GAO has determined that the VA telephone system is outdated.[10] The VHA directed all VISN directors to provide plans to assess their current phone system needs, and develop strategic improvements plans with a target completion of March 30, 2013, 6 weeks from now.

Because the correction of the substandard VistA system and phone systems is vital to helping alleviate some of the associated difficulties with access to mental health care, The American Legion urges Congress to ensure VA's budget receives adequate funding to address these issues.

Access Measures and Training

The VA is scheduled to have both the new measurements and the training package for schedulers by November 1, 2013. The American Legion would like the VA to be more transparent regarding the updates associated with any progress associated with scheduling procedures. Furthermore, as VA develops these methods, The American Legion encourages strong cooperation with veterans' groups and other stakeholders throughout the entire process.

Funding

In FY 2012 H.R. 2646 authorized the VA sufficient appropriations to continue to fund and operate leased facility projects that support our veterans all across the country. In November 2012 the FY 2013 appropriations for the same facilities was eliminated due to a "scoring change" initiated by the Congressional Budget Office (CBO). While the locations, projects, leases, and funding requirements did not change—the way in which CBO scored the projects did, which resulted in the appearance that the project would cost more than 10 times the actual needed revenue. According to VA, CBO refuses to share their evaluation process and will only issue the final score. As a result of CBO's adjustment in scoring, Congress refused to introduce the FY 2013 appropriations bill needed to keep these community-based centers open. As these leases now become due, there are 15 major medical facilities that will be forced to close unless Congress acts quickly to provide the appropriate funding to these centers.

If these centers are allowed to close due to insufficient funding, the impact on our veterans, and the VA would be devastating. Not only would the center employees have to either relocate within the VA or be terminated, the VA could be subject to legal action for prematurely defaulting on their leases. The veterans currently being served by these facilities would then have to either travel long distances to the nearest VA facility, or would have to find care at local hospital that the VA would be required to pay for, at a fee-for-services basis. This would ultimately cost the VA an estimated 4 times what the original appropriations would have cost for these shuttered facilities. The facilities currently in jeopardy are located in; Albuquerque, New Mexico, Brick, New Jersey, Charleston, South Carolina, Cobb County, Georgia, Honolulu, Hawaii, Lafayette, Louisiana, Lake Charles, Louisiana, New Port Richey, Florida, Ponce, Puerto Rico, San Antonio, Texas, West Haven, Connecticut, Worchester, Massachusetts, Johnson County, Kansas, San Diego, California, and Tyler, Texas.

The American Legion implores Congress to fund these centers as originally planned. The funds that these centers need have already been obligated, and refusal to fund these centers will cause a false perception of excess monies to exist within

[10] GAO Report *13–130, December 2012*.

the Federal budget, which The American Legion is afraid will be falsely reported as a money saving initiative.

EFFECTIVELY PARTNERING WITH NON-VA RESOURCES TO ADDRESS GAPS AND CREATE A MORE PATIENT-CENTRIC NETWORK OF CARE FOCUSED ON WELLNESS-BASED OUTCOMES

The Department of Veteran Affairs has not engaged The American Legion in the development of any of the 15 pilot programs that VA is engaging in, pursuant to the Presidential Executive Order. As such, we have concerns regarding the quality and viability of the non-VA resources. The American Legion has made clear that they would prefer to be one of the VA's primary resources for dealing with mental health care for veterans, for a variety of reasons which should be obvious.

The VA health care program is a holistic program as it takes into account all of the patient's doctors, to develop an approach that recognizes the interconnectivity of multiple or complicated disorders. Doctors in the VA system have access to all of a patient's records, which is helpful and relevant when dealing with disorders having co-morbid symptoms such as PTSD and TBI. Furthermore, VA mental health care providers are perhaps the most uniquely qualified practitioners available to address military related PTSD and other related emotional conditions. Civilian providers may lack the requisite experience and finite training to deal with these issues.

Because outside providers lack the sharing of information and military experience inherent to the VA system, the ideal solution is to ensure that veterans receive their care in the VA system. They have earned access to this system through their service, and deserve to be able to benefit from the VA's healthcare system, sans scheduling difficulties or unreasonable and potentially deadly delays. However, when that system proves unable to cope with the demand, outside help may be needed until the VA system can be adjusted to once again handle the scope and scale of the influx of veterans who need mental health care assistance.

The American public has expressed a tremendous outpouring of support for those who serve and there is a vast and growing assortment of community based groups who are eager to provide help to veterans who are suffering. Given this level of community support, veterans should be able to find the help they need within their communities. Understanding that the VA health care system is uniquely qualified to meet the needs of the veterans, and the ultimate goal should be to ensure that the system has the capacity to serve all veterans; local resources can and should be used to fill in the gaps until a suitable system is in place.

CONCLUSION

In conclusion, The American Legion is deeply concerned about the issues associated with the barriers to access, the timeliness, and quality of care available to our veterans, many of whom are suffering. The Legion urges VA to work with stakeholders, the Veterans Service Organizations, and Congress to develop a plan to increase transparency and address existing barriers to quality healthcare so we can all work together to ensure that veterans receive the timely and quality mental health services they deserve—especially for those veterans located in remote rural areas.

The American Legion recognizes that the VA is working hard to fulfill its mission; however, they will only be successful if they are able to enjoy the full support of Congress, the VSOs, and the community.

PREPARED STATEMENT OF JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS

Chairman Sanders, Ranking Member Burr, and Members of the Committee: Thank you for inviting DAV (Disabled American Veterans) to provide this statement for the record of today's important hearing assessing the mental health needs of veterans. We appreciate the opportunity to provide this information.

Mr. Chairman, each year DAV participates with our partner veterans organizations, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars of the United States, in presenting the *Independent Budget* to Congress, the Administration and the American people. It is a budget by veterans, for veterans. This statement is a synopsis of this year's Independent Budget report on mental health. For more in-depth information, we invite your professional staff to review the *Independent Budget* in its entirety, at www.independentbudget.org.

The Department of Veterans Affairs (VA) offers a wide array of mental health services that ranges from treating veterans with milder forms of depression and

anxiety in primary care settings, to intensive case management of veterans with serious chronic mental illness such as schizophrenia and bi-polar disorder. VA also offers specialized programs and treatments for veterans struggling with substance-use disorders and post-deployment mental health readjustment difficulties, including providing evidence-based treatments for Post Traumatic Stress Disorder (PTSD) for combat veterans and for veterans who have experienced military sexual trauma. VA has placed special emphasis on suicide prevention efforts, launched an aggressive anti-stigma and outreach campaign, and provided services for veterans involved in the criminal justice system. Peer-to-peer services, mental health consumer councils, and family and couples services have also been evolving and spreading throughout VA.

Over the past five years, the VA health care system has accommodated a 35 percent increase in the number of veterans receiving mental health services while absorbing a 41 percent increase in mental health staff. In fiscal year 2012, VA provided patient-centered specialty mental health services to 1.3 million veterans. These services were integrated in primary care.[1]

FUNDING IS KEY

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) in adequacy and availability of specialized mental health services. To address these concerns, over the past several budget cycles VA has provided facilities with targeted mental health funds to augment specialized mental health services. This funding was intended to address VA's recognized gaps in access to and availability of mental health and substance-use disorder services, to address the unique and growing needs of veterans who served in Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), and to create a comprehensive mental health and substance-use disorder system of care within VHA that is focused on recovery. Experts note that timely, early intervention services can improve veterans' quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of untreated mental health problems. Despite a 39 percent increase in resources since 2009, VA continues to struggle to meet demands and provide timely mental health services to many veterans.[2]

DAV is concerned about VA's apparent plan to cease separately accounting for mental health expenditures beginning this year, and instead to integrate all mental health funds in VA's global casemix-based allocation system. The unintended effects of this shift may diminish VA's intensity in providing for veterans' mental health and post-deployment readjustment services at a time when needs continue to rapidly escalate and program implementation is incomplete. It may also inadvertently increase the variation in veterans' access to mental health and substance-use disorder services. It is well accepted that setting strategic goals and objectives, allocating and tracking budget expenditures and measuring performance against those objectives result in demonstrable progress and improved health care quality. We recommend that the Veterans Health Administration (VHA) continue to utilize these principles in managing mental health and substance-use disorder programs. We intend to monitor this shift to determine its effects on veterans who need effective services, and we ask your Committee to provide oversight to ensure VA continues to meet its mental health mission.

CURRENT CHALLENGES

As a consequence of a July 2011 hearing by this Committee, and pressed to reconcile the disparity between VA policy and practice on waiting times, VA surveyed mental health providers across the system. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages and one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.[3] Based on the results of this internal

[1] Department of Veterans Affairs Press Release, "New VA Mental Health Outpatient Clinic to Open in Reno," August 10, 2012.

[2] Department of Veterans Affairs Press Release, "New VA Mental Health Outpatient Clinic to Open in Reno," August 10, 2012.

[3] Veterans Health Administration, *A Query of VA Mental Health Professionals: Executive Summary and Preliminary Analysis* (Washington DC: September 9, 2011).

VA survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall greatest on our newest war veterans, many of whom are in urgent need of services.

In October 2011, the Government Accountability Office (GAO) issued a report entitled *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, covering veterans who used VA from FY 2006 through FY 2010. Approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, the GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, and 88 percent (1,064,363) were veterans of earlier military service eras. The GAO noted that services for the OEF/OIF/OND group had caused growth of only two percent per year in VA's total mental health caseload since 2006. Given these findings, we believe there is a misperception that the majority of the recent mental health resources are needed for the OEF/OIF/OND population. We understand from VA officials that the overall improvements in VA mental health services over the past five years have benefited all eras of veterans—particularly older veterans and Vietnam era veterans—many of whom are accessing VA mental health services for the first time. Increased resources from Congress have been beneficial for all VA patients and should be sustained. One of the more obvious benefits is universal mental health screening in primary care with direct access to services within that care setting.

Additionally, RAND Corporation released a technical report in October 2011 entitled *Veterans Health Administration Mental Health Program Evaluation*, which identified 836,699 veterans in 2007 with at least one of five mental health diagnoses (schizophrenia, bipolar disorder, PTSD, major depression, and substance-use disorders). While this group represents only 15 percent of the VHA patient population, these veterans accounted for one-third of all VHA medical care costs because of their high rate and intensity of use of medical services. These high costs of mental health services may not be adequately recognized in VA's national allocation system. Interestingly, the majority of health care received by veterans with these diagnoses was for non-mental health conditions, reflecting the high degree to which veterans with mental health and substance-use conditions also face difficulties maintaining their general health.

The RAND research team concluded that the quality of VA mental health care is generally as good as, or better than, care delivered by private health plans, but that VA does not always meet its own explicit guidelines for local performance. One notable finding was that the documented treatment of veterans using evidence-based practices was well below the reported capacity of VA facilities to deliver this treatment. For example, only 20 percent of veterans with PTSD and 31 percent of those with major depression were reported to have received this type of treatment. The research team also found variances in quality of care across regions and populations; however, when most veterans were asked to express satisfaction with their care, 42 percent rated their care at 9 or 10 on a 10-point scale, but only 32 percent perceived improvement in their symptoms as an outcome of care.

VA indicates it is developing methods to improve access and address barriers; but veterans who seek VA assistance while struggling with mental health challenges too often face difficulty gaining timely appointments, despite VA official policies governing 24/7 access for emergency mental health care and scheduling of mental health specialty visits within 14 days of initial contact. In April 2012, the VA Secretary announced VA would add approximately 1,600 mental health clinicians and 300 support staff to its existing mental health staff of 20,590, in an effort to help VA facilities sustain these access goals.[4]

MENTAL HEALTH SERVICES FOR A NEW GENERATION OF WAR VETERANS

Mr. Chairman, eleven-plus years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD, and other combat- or stress-related mental health conditions are prevalent among veterans who have deployed to the wars in Iraq and Afghanistan and some of these veterans have been severely disabled. DAV believes that all enrolled veterans, and particularly servicemembers,

[4] Department of Veterans Affairs Press Release, "VA to Increase Mental Health Staff by 1,900," April 19, 2012, http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302.

National Guardsmen, and reservists returning from contingency operations overseas, should have maximal opportunities to recover and successfully readjust to civilian life. They must be able to gain "user-friendly" and timely access to VA mental health services that have been validated by research evidence to offer them the best opportunity for full recovery.

Regrettably, as was learned from experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are common and could even be called expected. Experts note that if not readily addressed, these problems can easily compound and become chronic. Over the long term, the costs mount due to impact on personal well-being, family relationships, educational and occupational performance, and social and community engagement of those who have served. Delays in addressing these problems can culminate in self-destructive behaviors, including substance-use disorders and suicide attempts, and can result in incarceration. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those diagnosed with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency of deployments, decreased time between deployments, intensity of exposure to combat, perception of danger, guerilla warfare in urban environments, and suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of post-deployment behavioral health problems experienced by returning veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of these wars is likely to grow over time for those who have deployed more than once, do not seek or receive needed services, or face increased stressors in their personal lives following deployments.[5]

Much debate has occurred about VA's ability to manage the new wartime population and provide timely access to the variety of VA's specialized mental health services. The primary question is whether VA should outsource or partner with community mental health sources to provide this care when local waiting times exceed VA's own policies. The VA has the authority to develop contracts for veterans to receive mental health services in the community if it cannot provide such care.

Clearly, nevertheless, VA employs the largest number of mental health providers with expertise in successfully treating post-deployment mental health conditions in veterans, such as PTSD. VA is also able to coordinate a comprehensive set of primary and specialty services for substance-use disorders, Traumatic Brain Injury (TBI) and other co-occurring disorders that are designed to meet veterans' complex needs.

VA should re-engineer its mental health service delivery system to maximize utilization of its integrated health care and delivery of high quality, accessible care to meet the dynamic needs of veterans. This may mean adoption of new systems of care and technology such as telemedicine and mobile applications for home care, as well as ensuring that it has expert mental health and substance-use disorder providers onboard. DAV prefers VA to be the provider of such services when possible, but access to care is a critical factor and must be maintained. We believe VA should make a determination for each patient based on the unique treatment needs presented, VA's ability to treat them, and then develop a treatment plan that meets those needs.

SUBSTANCE-USE DISORDERS

Misuse of alcohol and other substances including overuse of prescription drugs is a recognized problem for many veterans enrolled in VA care, including many OEF/OIF/OND veterans. VA reports that for FY 2011, 97 percent of VA patients were screened annually for at-risk drinking. The annual prevalence of substance-use disorder among all VA users was 8.5 percent (almost 500,000 veterans). VA offers these patients a wide variety of treatment options from motivational counseling in the primary care setting to more intensive inpatient and outpatient services. Unfortunately, there are a number of barriers to seeking or accessing treatment for sub-

[5] Brett T. Litz, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs, *The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq*, A National Center for PTSD Fact Sheet (January 2007).

stance-use disorder, including patients perceiving there is no need for treatment; believing treatment won't work; stigma of acknowledging substance use is a problem; and other family related concerns.[6] Experts note that an untreated substance-use disorder can result in emotional decompensation, an increase in health care and legal costs, additional stress on families, loss of employment, homelessness, and even suicide. Therefore, ready access to pharmacotherapy and psychosocial interventions are important treatment options for veterans with substance-use disorder.

The VA has acknowledged that it should focus on ways to enhance access to its substance-use disorder programs with a particular emphasis on the needs of OEF/OIF/OND populations as well as women, justice-involved, and homeless veterans. VA notes that the best resolution for substance-use disorder problems comes from early intervention. There is also a need to reduce stigma associated with seeking care for a substance-use disorder—and treatments for co-occurring conditions should be coordinated and done simultaneously. VA recommends that a community of substance-use disorder—PTSD specialists should be created and that family involvement can be very helpful in the treatment of both conditions. Additionally, VA indicates that the attractiveness of substance-use disorder services should be enhanced and that more computerized aids and the Internet should be used to provide or supplement substance-use disorder services. Most important, DAV believes that integration of services should be employed to address complex problems presented in patients with combinations of substance-use disorder and TBI, chronic pain, homelessness, nicotine dependence, and community/family readjustment deficits. VA reported that about two-thirds of patients with a substance-use disorder diagnosis are treated in a VA primary care or mental health clinic rather than in substance-use disorder specialty services.[7] The OMHS reports that a SUD-PTSD specialist has been funded for each VA medical center to promote integrated care but that currently there is no "Gold Standard" treatment developed for co-occurring SUD-PTSD.[8]

SUICIDE PREVENTION PROGRAM

VA reports that 18 veterans take their own lives each day, which translates into 6,750 suicides per year, or almost 75,000 in the 11 years since the conflicts in Afghanistan and Iraq began. VA estimates that on an annual basis, less than 25 percent of veteran suicides were enrollees receiving health care from VA.[9] In 2008, the last year when official data were used to identify veterans' suicide by matching suicides from the National Death Index with the roster of veterans in VA administrative data, the rate of suicide was 38 per 100,000 for OEF/OIF male and female veterans enrolled in VA health care. These data do not include unsuccessful suicide attempts.[10] As a comparison, the current Army suicide rate seven months into 2012 is 29 deaths per 100,000 soldiers. The veteran and active duty suicide rates greatly surpass the 2009 civilian rate—the latest available data—of 18.5 per 100,000.[11]

With news that suicide rates are ever increasing, in September 2012 a new national strategy for reducing the number of deaths by suicide by better identifying and reaching out to those at risk was released by the U.S. Surgeon General and the National Action Alliance for Suicide Prevention. The 2012 National Strategy for Suicide Prevention report includes community-based approaches to curbing the incidence of suicide, details new ways to identify people at risk for suicide and outlines national priorities for reducing the number of suicides over the next decade. In conjunction with the report, the Secretary of Health and Human Services announced $55.6 million in new grants for suicide prevention programs.[12] VA and DOD also

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[6] Daniel Kivlahan, Ph.D., Associate National Mental Health Program Director Addictive Disorders, Office of Mental Health Services, "VHA Evidenced Based Practices for Identification and Management of Substance Use Conditions in VHA," PowerPoint presentation, November 2011.

[7] John P. Allen, Ph.D., MPA, National Mental Health Program Director, Addictive Disorders, Department of Veterans Affairs, "Substance Use Disorder (SUD) Services for Veterans Having PTSD" (PowerPoint presentation to veterans service organizations, 2011).

[8] Dr. D. Kivlahan, Substance Use Disorder (PowerPoint, November 2011).

[9] Department of Veterans Affairs, Office of the Inspector General, *Combined Assessment Program Summary Report Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities* (March 22, 2011).

[10] Erin Bagalman, Analyst in Health Policy, Congressional Research Service, *Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures* (Washington, DC: July 18, 2011).

[11] Greg Zoroya, USA Today, "Army suicide rate in July hits highest one-month tally," August 16, 2012, http://usatoday30.usatoday.com/news/military/story/2012-08-09/army-suicides/57096238/1.

[12] Steve Vogel, The Washington Post, "National suicide prevention strategy released Monday," September 10, 2012, http://www.washingtonpost.com/blogs/Federal-eye/post/national-suicide-

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announced a new public awareness campaign, *Stand by Them: Help a Veteran*, as part of the national strategy on suicide prevention in the veteran and military populations. The campaign stresses the influence family members, friends, and colleagues can have in stopping suicide and aims to get those who know troubled servicemembers or veterans to call the Veterans Crisis Line, 1–800–273–TALK (8255), to obtain information and alert VA of the need for possible intervention.[13] We at DAV applaud these developments and urge their continuation and expansion.

RAND analysis suggests needed changes include making servicemembers aware of the advantages of using behavioral health care, ensuring that providers are delivering high-quality care, and ensuring that servicemembers can receive confidential help for their problems. Despite these efforts and progress made, this issue still remains a significant concern to DAV, and we urge Congress to provide clear oversight to ensure adequate focus and attention remains on this issue.[14]

VETERANS JUSTICE PROGRAM

VA also reports it is increasing its justice outreach efforts by working in collaboration with a number of state-based veterans' courts to assist in determining the appropriateness of diversion for treatment rather than incarceration as a consequence of veterans' behaviors. Likewise, VA reports it is participating in crisis intervention training with local police departments to help train and provide guidance to police officers on approaches to deal effectively with individuals who exhibit mental health problems (including veterans) in crisis situations. VA is working with veterans nearing release from prison and jail to ensure that needed health care and social support services are in place at the time of release. Finally, each VAMC has been asked to designate a facility-based Veterans' Justice Outreach Specialist, responsible for direct outreach, assessment, and case management for justice-involved veterans in local courts and jails, and in liaison with local justice system partners.

We salute VA mental health leaders for taking these proactive steps that not only can prevent recurrence of involvement with the justice system but are cost-saving to local and state governments and VA itself, and benefit society at large. Although this program is only in its beginning stages, it appears to have been beneficial for many veterans who have had the opportunity to get needed treatment for PTSD, TBI, depression and substance-use disorders rather than being punished by incarceration after committing wrongdoing against themselves, family, community, or society.

We also believe that DOD and VA should step up their primary and secondary prevention efforts and programs to promote coping and readjustment. These programs may reduce the likelihood that veterans will engage in risky or violent behavior that results in contact with the military or civilian justice systems.

WOMEN VETERANS: UNIQUE NEEDS IN VA'S POST-DEPLOYMENT MENTAL HEALTH SERVICES

The number of women serving in our military forces is unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, military police officers, civil affairs specialists, and in many other military occupational specialties that expose them to the risk of serious injury and death. To date, more than 150 women have been killed in action in the two current wars, and women servicemembers have suffered grievous injuries, with almost 950 wounded in action, including those with multiple amputations.[15] The current rate of enrollment of women veterans in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact, VA projects the number of women veterans coming to VA for health care services is expected to double in the next two to four years. According to VA, as of June 2012, 56.2 percent of female OEF/OIF/OND veterans have received VA health care. Of this group, 89.4 percent

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prevention-strategy-being-released-monday/2012/09/07/66102792-f92f-11e1-8b93-c4f4ab1c8d13_blog.html.

[13] Patricia Kime, Army Times, "DOD, VA roll out new suicide awareness effort," September 10, 2012 http://www.armytimes.com/news/2012/09/military-national-suicide-prevention-strategy-091012w/.

[14] RAND Corporation, News Release, "U.S. Military Should Improve Behavioral Health Programs in Response to Rising Number of Suicides Among Armed Forces" (February 17, 2011).

[15] Department of Defense Personnel, Defense Casualty Analysis System (Retrieved October 29, 2012). https://www.dmdc.osd.mil/dcas/pages/casualties.xhtml.

have used VA health care services more than once; 53.5 percent have used VA health care 11 or more times.[16]

Researchers have found that many women veterans need help reintegrating back into their prior lives after repatriating from war. Some women have reported feeling isolated, difficulties in communicating with family members and friends, and not getting enough time to readjust. Post-deployed women often complain of difficulties reestablishing bonds with their spouses and children and resuming their role as primary parent, caretaker of children and disciplinarian. Women reported feeling out of sync with their families and that they had missed a lot during their absences. Additionally, it appears that women are at higher risk for suicide. A National Institute of Mental Health five-year research study with the goal of identifying Army soldiers most at risk of suicide released findings in 2011 and noted that women soldiers' suicide rate triples in wartime from five per 100,000 to 15 per 100,000.[17]

For these reasons, it is vitally important that VA continue its outreach to women veterans and adopt and implement policy changes to help women veterans fully readjust. Public Law 111–163 includes provisions that require VA to conduct a pilot program of group counseling in retreat settings for women veterans newly separated from the Armed Forces. VA reports that a total of 67 women were served in fiscal year 2011 in three retreats and that three additional events were completed in 2012.[18] The VA's Readjustment Counseling Service (RCS) or "Vet Center" program, worked with the Women's Wilderness Institute to develop the locations and agenda for the retreats. We understand feedback from women veterans participating in the retreats thus far has been very positive and we expect the remaining retreats will be very successful. DAV recommends that an interim report be issued to Congress on the retreats to include the number of women served and overall satisfaction of women veterans with the retreats as well as any recommendations from the VA's RCS director on extension or expansion of the retreats.

Given the unique post-deployment challenges women veterans face, all of VA's specialized services and programs—including those for transitional services, substance-use disorders, domestic violence, and post-deployment readjustment counseling—should be evaluated to ensure women have equal access to services. Likewise, VA researchers should continue to study the impact of war and gender differences on post-deployment mental health care to determine the best models of care and rehabilitation, to address the unique needs of women veterans.

EXPANDING ACCESS THROUGH COMMUNITY MENTAL HEALTH PROVIDERS

Chairman Miller of the House Committee recently endorsed a VA-TRICARE outsourcing alliance to serve the mental health needs of newer veterans that VA is, admittedly, struggling to meet today. Having offered little to bolster the confidence of DAV's members and millions of other veterans and their families that mental health services are, in fact, being effectively provided by VA where and when a veteran might need such care, we urge the Committee to work with VA to ensure that, if mental health care is expanded using the existing TRICARE network or some other outside network, veterans must receive direct assistance by VA in coordinating such services, and the care veterans receive must reflect the integrated and holistic nature of VA mental health care.

When a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important for VA to determine the kind of mental health services needed and whether the most appropriate care would come from a VA provider or a community-based source. This type of triage is crucial, because effective mental health treatment is dependent upon a consistent, continuous-care relationship with a provider. Once a trusting therapeutic relationship is established between a veteran and a provider, that connection should not be disrupted because of a lack of VA resources, a local parochial decision, or for the convenience of the government.

Moreover, it is imperative that if a veteran is referred by VA to a community mental health resource, we would insist the care be coordinated with VA. Because of a high degree to which this particular patient population also has difficulties with physical functioning and general health, these patients will very likely need other health services VA is able to provide. A critical component of care coordination is health information sharing between VA and non-VA providers. Information flow in-

[16] Department of Veterans Affairs, Women Veterans Fact Sheet, August 2012 http://www.womenshealth.va.gov/WOMENSHEALTH/docs/WH_facts_FINAL.pdf.

[17] Gregg Zoroya, USA Today, "Female Soldiers' Suicide Rate Triples When at War" (March 18, 2011).

[18] Joan Mooney, "Update on Legislation Related to Women Veterans," PowerPoint presentation.

creases the availability of patient utilization and quality of care data and improves communication among providers inside and outside of VA. Not obtaining this kind of health information poses a barrier to implementing patient care strategies such as care coordination, disease management, prevention, and use of care protocols. These are some of the principal flaws of VA's current approach in fee-basis and contract care.

THE WAY FORWARD: GAPS MUST BE CLOSED

DAV agrees that VA must do a great deal more to meet veterans where they are, and must also improve access and timeliness of mental health care within VA facilities, reducing and hopefully eliminating gaps between national policies and variations in practice. To illustrate, in 2007, VA developed an important policy directive that identifies the wide range of mental health services that VA facilities should make available to all enrolled veterans who need them, no matter where they receive care.[19] But more than five years later VA has acknowledged in testimony based on external reviews that the directive is still not fully implemented.[20] However, we understand that VA is still conducting self-assessment surveys followed up with site visits from VA Central Office officials to verify progress and to help resolve any gaps in services, and in fiscal year 2012, all VAMCs were visited and that overall progress was observed. DAV recommends the Office of Mental Health Services brief Congress on these findings to continue fully funding VA mental health programs.

VA faces a particular challenge in providing rural veterans access to mental health care. Almost half of VA's rural facilities are small community-based outpatient clinics (CBOCs) that offer limited mental health services.[21] Access also remains a problem and geographic barriers are often the most prominent obstacle. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other types of health problems. The timeliness of treatment and the intensity of the services a veteran ultimately receives are affected by the geographic accessibility of that care.[22] VA policy directs that facilities contract for mental health services when they cannot provide the care directly, but some facilities have apparently made only very limited use of that authority. VA also must do more to adapt to the circumstances facing returning veterans who are often struggling to re-establish community, family, and occupational connections and associated challenges. These challenges may compound the difficulties of pursuing and sustaining mental health care.[23] VA has proven that PTSD and other war-related mental health problems can be successfully treated, but if returning rural veterans are to overcome combat-related mental health issues and begin to thrive, critical gaps in the VA mental health-care system must be closed.

SUMMARY

DAV applauds efforts made by VA and DOD to improve the safety, consistency, and effectiveness of mental health care programs for veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive package of services to meet the mental health needs of veterans, in particular veterans with wartime service and post-deployment readjustment needs. Yet we have concerns that these laudable goals may be frustrated unless proper oversight is provided and VA enforces mechanisms to ensure its policies at the top are reflected as results on the ground in VA facilities. Given the significant indications of rising self-medication, problem drinking and other substance-use disorder problems in the OEF/OIF/OND population, DAV urges VA to aggressively initiate early intervention programs to prevent chronic long-term substance-use disorder in this

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[19] Department of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics.

[20] Senate Committee on Veterans Affairs, Hearing, "Seamless Transition—Meeting the Needs of Service Members and Veterans," May 25, 2011. The link: http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=fa634e3e-df82-4e87-b305-f5356fec9779

[21] John R. Vaughn, Chad Colley, Patricia Pound, Victoria Ray Carlson, Robert R. Davila, Graham Hill, et al., *Invisible Wounds: Serving Servicemembers and Veterans with PTSD and TBI*. National Council on Disability, 4March 2009. (www.ncd.gov/newsroom/publications/2009/veterans.doc). Accessed 14 May 2009, 46.

[22] Benjamin Druss and Robert Rosenheck, *Use of Medical Services by Veterans with Mental Disorders*, Psychosomatics, 1997 Sep-Oct, Vol. 38 No. 5, pp. 451–8.

[23] C. R. Erbes, K. T. Curry, and J. Leskela, *Treatment Presentation and Adherence of Iraq/Afghanistan Era Veterans in Outpatient Care for Posttraumatic Stress Disorder*, Psychological Services 6(3): (2010) 175–183.

population. We are convinced that efforts expended early in this population can prevent and offset much larger costs to VA and American society in the future.

DAV also urges closer cooperation and coordination between VA and DOD and between VAMCs and Vet Centers within their areas of operations. We recognize that the Readjustment Counseling Service is independent from the VHA by statute and conducts its readjustment counseling programs outside the traditional medical model. We respect that division of activity, and it has proven itself to be highly effective for over 30 years. However, in addition to having concerns about VA's ability to coordinate with community providers in caring for veterans at VA expense, we believe veterans will be best served if better ties and at least some mutual goals govern the relationship of Vet Center counseling and VA medical center mental health programs.

DAV urges continued oversight by the Committees on Veterans' Affairs, Committees on Appropriations, as well as by the Secretary of Veterans Affairs, to ensure that VA's mental health programs and the reforms outlined in this discussion that we synopsized from *The Independent Budget*, meet their promise—not only for those returning home from war now, but for all veterans who need them.

Mr. Chairman, this concludes DAV's statement, and we appreciate the opportunity to provide it to the Committee.

PREPARED STATEMENT OF WOUNDED WARRIOR PROJECT

Chairman Sanders, Ranking Member Burr and Members of the Committee: We are grateful to you for conducting this hearing and for continuing oversight on mental health care. Thank you for inviting Wounded Warrior Project (WWP) to offer our perspective.

With WWP's mission to honor and empower wounded warriors, our vision is to foster the most successful, well-adjusted generation of veterans in our Nation's history. The mental health of our returning warriors is clearly a critical element. As has been well documented, PTSD and other invisible wounds can affect a warrior's readjustment in many ways—impairing health and well-being, compounding the challenges of obtaining employment, and limiting earning capacity. VA does provide benefits and services that are helping some of our warriors overcome such problems, but there is much more to do.

With the drawdown of forces in Afghanistan, more and more servicemembers will be transitioning to veteran status and the issues of engaging veterans and providing effective mental health care will continue to grow. We applaud the oversight and focus this Committee has provided, particularly regarding access to timely treatment. We also welcome such initial steps as VA's hiring additional mental health providers and its plans to contract with qualified providers across the country to provide Patient-Centered Community Care (PCCC), including mental health care. But these steps alone, even if fully realized, will not close all the gaps we see in VA's mental health system.

ENGAGEMENT IN TREATMENT AS A FIRST STEP

For example, we see evidence suggesting that veterans at many VA facilities may not be getting the kind of mental health care they need or the appropriate intensity of care. In a recent survey of over 13,000 WWP alumni, over a third of respondents reported difficulties in accessing effective mental health care. The identified reasons for not getting needed care were inconsistent treatment (e.g. canceled appointments, having to switch providers, lapses in between sessions, etc.) and not being comfortable with existing resources at the VA.[1] Some report that the VA is quick to provide medications,[2] and others identify the limited types of treatment available as potential barriers. VA is pressing clinicians to employ exposure-based therapies that—without adequate support—are too intense for some veterans, with the result that many drop out of treatment altogether. VA is also not reaching large numbers

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[1] Franklin, et al, 2012 Wounded Warrior Project Survey Report, ii (June 2012). WWP surveyed more than 13,300 warriors, and received responses from more than 5,600. (Hereinafter "WWP Survey").

[2] Id. at 105. Studies document widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, and the finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. D. Leslie, S. Mohamed, and R. Rosenheck, "Off-Label Use of Antipsychotic Medications in the Department of Veterans' Affairs Health Care System" 60(9) Psychiatric Services, 1175–1181 (2009); John Krystal, et al., "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service—Related PTSD: A Randomized Trial," 306(5) *JAMA* 493–502 (2011).

of returning veterans. As described by one of the leading mental health researchers on the mental health toll of the conflict in Afghanistan and Iraq, Dr. Charles W. Hoge, "* * * veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out * * *. With only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment.[3]

Without access or adequate care, one apparent consequence of only 1 out of 5 warriors getting sufficient treatment is a disturbing rise in the number of suicides. Recent data have only begun to describe the issue. Past research has shown that veterans were at an increased risk of suicide during the 5 years after leaving active duty.[4] There is an urgent need for intervention and an ongoing issue of identifying and tracking the scope of the problem. While access to care is the first step in preventing suicide, identifying the factors that lead warriors to drop out of therapy is a critical factor in reversing this troubling trend.

Another area of needed engagement is on mental health treatment for victims of military sexual trauma (MST). Victims' reluctance to report these traumatic incidents is well documented, but many also delay seeking treatment for conditions relating to that experience.[5] The VA reports that some 1 in 5 women and 1 in 100 men seen in its medical system responded "yes" when screened for MST.[6] While researchers cite the importance of screening for MST and associated referral for mental health care, many victims do not currently seek VA care. Indeed, researchers have noted frequent lack of knowledge on the part of women veterans regarding eligibility for and access to VA care, with many mistakenly believing eligibility is linked to establishing service-connection for a condition.[7] In-service sexual assaults have long-term health implications, including PTSD, increased suicide risk, major depression and alcohol or drug abuse and without outreach to engage victims of MST on needed care, the long-term impact may be intensified.[8]

With projections of only 1 in 5 veterans receiving adequate treatment, the importance of early intervention and consequences of delaying mental health care, and the rising rates of suicide and MST, we must heed growing evidence that a majority of soldiers deployed to Afghanistan or Iraq are not seeking needed mental health care.[9] While stigma and organizational barriers to care are cited as explanations for why only a small proportion of soldiers with psychological problems seek professional help, soldiers' negative perceptions about the utility of mental health care may be even stronger deterrents.[10] To reach these warriors, we see merit in a strategy of expanding the reach of treatment, to include greater engagement, understanding the reasons for negative perceptions of mental health care, and "meeting veterans where they are."[11]

Importantly, current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral health care.[12] Underscoring the benefit of warriors reaching out to other warriors, our recent survey found that nearly 30 percent identified talking with another Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veteran as the most effective resource in coping with stress.[13] Many of our warriors benefit greatly from the counseling and

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[3] Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," *JAMA*, 306(5): (August 3, 2011) 548.

[4] http://articles.washingtonpost.com/2013–02–01/national/36669331_1_afghanistan-war-veterans-suicide-rate-suicide-risk.

[5] Rachel Kimerling, et al., "Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning From Afghanistan and Iraq," 100(8) *Am. J. Public Health*, 1409–1412 (2010).

[6] U.S. Dept. of Veterans' Affairs and the National Center for PTSD Fact Sheet, "Military Sexual Trauma," available at http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp.

[7] See Donna Washington, et al., "Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care," 172(8) *Military Medicine* 812–817 (2007).

[8] M. Murdoch, et al., "Women and War: What Physicians Should Know," 21(S3) *J. of Gen. Internal Medicine* S5-S10 (2006).

[9] Paul Kim, et al. "Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care Among Soldiers," 23 *Military Psychology* 66 (2011).

[10] Id. at 78.

[11] Hoge, supra note 3.

[12] National Defense Authorization Act for Fiscal Year 2013, Public Law 112–239, § 730, (Jan. 2, 2013). Additionally, the President issued an Executive Order in August 2012 which included among new steps to improve warriors' access to mental health services, a commitment that VA would employ 800 peer-specialists to support the provision of mental health care. Exec. Order No. 13625 "Improving Access to Mental Health for Veterans, Servicemembers, and Military Families" (Aug. 31, 2012)

[13] WWP Survey, at 54.

peer-support provided at Vet Centers, but VA leaders are failing other warriors when they resist implementing a nearly two-year-old law that requires VA to provide peer-support to OEF/OIF veterans at VA medical facilities as well.[14]

Given research findings that high percentages of OEF/OIF veterans are not engaging in or are dropping out of mental health programs,[15] peer support has been identified as a critical element in reversing that trend. Last August's Executive Order on Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families was clear on improving care for the mental health needs of those who served in Iraq and Afghanistan. We applaud its directive that VA hire and train 800 peer counselors by the end of this calendar year. We are concerned, however, that VA's approach to the peer-support initiative in the Order is not focused or targeted to OEF/OIF veterans.

In addition to peer outreach, enlisting family members in mental health care helps foster recovery and facilitates warrior engagement. VA has lagged in addressing family issues and involving caregivers in mental health treatment.[16] Given the impact of family support and strain on warriors' resilience and recovery, more must be done to implement provisions of law to provide needed mental health care to veterans' family members.

The VA has certainly taken significant steps over the years to improve veterans' access to mental health care. But for all the positive action taken, too many warriors still have not received timely, effective treatment. In short, and as WWP has testified,[17] wide gaps remain between well-intentioned policies and on-the-ground practices.

NEED FOR OUTCOME MEASUREMENTS

Against the backdrop of this Committee's oversight highlighting long delays in scheduling veterans for mental health treatment, the VA last April released plans to hire an additional 1900 mental health staff.[18] While appreciative of VA's course-reversal, WWP has urged that other related critical problems also be remedied. It is not clear, for example, that VA medical facilities are sufficiently flexible in accommodating warriors. Access remains a problem, particularly for those living at a distance from VA facilities and for those whose work or school requirements make it difficult to meet current clinic schedules. Mental health care must also be effective, of course. As one provider explained,

> "Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment." [19]

Providing effective care requires building a relationship of trust between provider and patient—a bond that is not necessarily instantly established.[20] Accordingly, congressional testimony highlighting that many VA medical centers routinely place patients in group-therapy settings rather than provide needed individual therapy merits further scrutiny.[21] We have also urged more focus on the soundness and effectiveness of the VA's mental health performance measures; these track adherence to process requirements, but fail to assess whether veterans are actually improving.[22]

Unfortunately, the imperative of meeting performance requirements can create perverse incentives, at odds with good clinical care. As one provider explained, "Veterans face many obstacles to care that are designed to meet 'measures' rather than good clinical care, i.e. having to wait hours to be seen in walk-in clinic as the only

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[14] Sec. 304, Public Law 111–163.

[15] Hoge, supra note 3.

[16] Khaylis, A., et al. "Posttraumatic Stress, Family Adjustment, and Treatment Preferences Among National Guard Soldiers Deployed to OEF/OIF,"176 *Military Medicine* 126–131 (2011).

[17] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Ralph Ibson, National Policy Director, Wounded Warrior Project).

[18] Dept. of Veterans' Affairs Press Release, "VA to Increase Mental Health Staff by 1,900," (Apr. 19, 2012), available at: http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302.

[19] Id.

[20] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm, on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Nicole Sawyer, Psy.D., Licensed Clinical Psychologist).

[21] *VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans' Affairs*, 112th Cong. (Apr. 25, 2012) (Testimony of Nicholas Tolentino, OIF Veteran and former VA medical center administrative officer).

[22] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Ralph Ibson), supra note 21.

point of access, being forced to attend groups, etc."[23] Prior hearings also documented instances of such measures being "gamed."[24]

WWP has been encouraged by the VA's willingness to dedicate research resources and additional mental health providers to addressing gaps in veterans' mental health care. But it's not necessarily just about reaching particular funding or staffing levels. It's about outcomes—ultimately honoring and empowering warriors, and, in our view, about making this the most successful generation of veterans. It's not enough for VA administrators to set performance metrics for timeliness or other process-measures (especially when those metrics may not adequately reflect the true situation), they must establish performance measures that recognize and reward successful treatment outcomes.

Recent reports from VA Inspector General and Government Accountability Offices have highlighted the need for more effective measures to aid oversight.[25][26] WWP shares concerns about scheduling and wait times and urges VA to implement a reliable, accurate way to measure how long veterans are waiting for appointments in order to resolve problems effectively. Waiting too long during a time of intense need undermines a veteran's trust in the system.

The reports underscore concerns that VA is unable to measure a range of pertinent mental health matters, including timely access, patient outcomes, staffing needs, numbers needing or provided treatment, provider productivity, and treatment capacity. Greater VA transparency and continued oversight into VA's mental health care operations are starting points for closing those gaps.

NEED FOR CONTINUED CONGRESSIONAL OVERSIGHT

WWP has welcomed the Department's acknowledgment of a "need [for] improvement" in its mental health system.[27] While there has been movement in response to recent critical congressional oversight, the VA's actions have often lacked needed transparency. To illustrate, the VA testified to having conducted a "comprehensive first-hand assessment of the mental health program at every VA medical center,"[28] but it would not afford advocates the opportunity to participate in such visits (despite a request to do so) and has not disclosed its site-visit findings, the expectations for each such facility, or facility remediation plans. The VA also cited its adoption, on a pilot basis, of a prototype mental health staffing model, without meaningful explanation of the foundation or reliability of its model. VA Central Office recently also surveyed mental health field staff last September; but while its survey effort could represent a healthy step, officials have neither disclosed the survey findings nor indicated how the data might be used, if at all.

It bears emphasizing that PTSD and other war-related mental health conditions can be successfully treated—and in many cases, VA clinicians and Vet Center counselors are helping veterans recover and thrive. But these problems have their origin in service, and more can and must be done both to prevent and to treat behavioral health problems at the earliest point—during, rather than after, service. That will require not only overcoming negative perceptions among servicemembers about

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[23] WWP Survey of VA Mental Health Staff (2011).

[24] As one WWP-survey respondent explained in describing practices at a VA facility, "Unreasonable barriers have been created to limit access into Mental Health treatment, especially therapy. Vets must go to walk-in clinic so they are never given a scheduled initial appointment. Walk-in only provided medication management, but Vets who just want therapy must still go to walk-in. After initial intake, Vets are required to attend a group session, typically a month out. After completing the group session, Vets can be scheduled for individual therapy, typically another month out. Performance measures are gamed. When a consult is received, the Veteran is called and told to go to walk-in. The telephone call is not documented directly (that would activate a performance measure) * * *. Then the consult is completed without any services being provided to the Veteran. Vets often slip through the cracks since there is no follow-up to see if they actually went to walk-in. Focus of the Mental Health [sic] is to make it appear as if access is meeting measures. There is no measure for follow-up, so even if Vets get into the system in a reasonable time, the actual treatment is significantly delayed. Trauma work is almost impossible to do since appointments tend to be 6–8 weeks apart."

[25] U.S. General Accountability Office, "Reliability and Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement," GAO–13–130 (Dec 2012).

[26] VA Office of Inspector General, "Review of Veterans' Access to Mental Health Care" (Apr 2012).

[27] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Eric Shinseki, Secretary of the Dept. of Veterans' Affairs).

[28] Id.

mental health care, but affording them assurance of confidentiality.[29] Vet Centers—long a source of confidential, trusted care—can and should be a greater resource. Provisions of the National Defense Authorization Act for 2013 (NDAA) direct both DOD and the VA, respectively, to close critical gaps in their mental health systems, targeting particularly the importance of suicide prevention in the Armed Forces and the VA's need to provide wounded warriors timely, effective mental health care.[30] Among its provisions, the NDAA requires the VA—in consultation with an expert study committee under the auspices of the National Academy of Sciences (NAS)—to establish and implement both mental health staffing guidelines and comprehensive measures to assess the timeliness and effectiveness of its mental health care.[31] WWP urges VA to give high priority to entering into a contract with NAS as soon as possible—and bring some "sunshine" and outside expertise into what should be an important step toward improving VA behavioral health care.

Finally, it is important to consider the "culture" within which VA mental health care is provided. As one clinician described it succinctly in responding to a WWP survey,

> "The reality is that the VA is a top-down organization that wants strict obedience and does not want to hear about problems."

Mental health staff at some VA facilities have described a leadership climate that employs a command and control model that imposes administrative requirements which too often compromise providers' exercise of their own clinical judgment, and thus frustrate effective treatment.

Without answers to what Central Office has learned through its site visits or surveys about the extent to which clinicians have needed latitude to exercise their best clinical judgment, we are left to question whether morale or other problems compromise effective mental health care and whether remedial steps are being taken. We cannot answer such questions without greater VA transparency.

In the recent past, congressional oversight has been a critical catalyst in identifying the need for major system improvements in the provision of mental health care for wounded warriors and in effecting necessary reforms. Such vigilant oversight must continue in order to close remaining gaps in VA's mental health system. Among these, we urge that congressional oversight include focusing on the following:

- Given new statutory requirements to work with the NAS to establish new staffing guidelines and measures to assess timeliness and effectiveness of mental health care, the VA must give high priority to expeditiously contract with NAS to conduct the necessary assessments and establish the framework for reforms required by law;
- DOD and the VA must work collaboratively, not simply to improve access to mental health care, but to identify and further research the reasons for—and solutions to—warriors' resistance to seeking such care;
- As provided for in law and Executive Order, the VA in 2013 must carry out large-scale training and employment of at least 800 returning warriors (who have themselves experienced combat stress) to provide peer-outreach and peer-support services as part of VA's provision of mental health care to wounded warriors, and DOD must support that initiative by referring servicemembers to be considered for such employment;
- The VA should partner with and assist community entities or collaborative community programs in providing needed mental health services to wounded warriors, to include providing training to clinicians on military culture and the combat experience;

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[29] See Lt. Col. Paul Dean and Lt. Col. Jeffrey McNeil, "Breaking the Stigma of Behavioral Healthcare," U.S. Army John F. Kennedy Special Warfare Center and School, 25(2) Special Warfare (2012), available at: http://www.soc.mil/swcS/SWmag/archive/SW2502/SW2502BreakingTheStigmaOfBehavioralHealthcare.html.

[30] National Defense Authorization Act for Fiscal Year 2013, supra note 18, at §§ 580–583 and 723–730.

[31] Id. at § 726.

• The VA must implement provisions of law that require it to provide needed mental health services to immediate family members of veterans whose own war-related mental health issues may diminish their capacity to support those warriors;
• The VA should improve coordination between its medical facilities and Vet Centers, and increase both Vet Center staffing and the number of Vet Center sites, with emphasis on locating new ones near military facilities; and
• The VA should provide for Vet Center staff to participate in VSO-operated recreational programs that are designed to encourage veterans' readjustment, as provided for by law.

Thank you for consideration of WWP's views on this most important subject.