MENTAL HEALTH: BRIDGING THE GAP BETWEEN CARE AND COMPENSATION FOR VETERANS

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TUESDAY, JUNE 14, 2011

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
WASHINGTON, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Stearns, Lamborn, Bilirakis, Roe, Stutzman, Johnson, Runyan, Benishek, Buerkle, Huelskamp, Filner, Michaud, McNerney, Donnelly, Walz, and Barrow.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. Good morning. Thank you to our witnesses who are in attendance. Our hearing this morning is entitled, "Mental Health: Bridging the Gap Between Care and Compensation for Veterans."

On May 10th, the United States Court of Appeals in the Ninth Circuit issued a decision that was heavily critical of the care and compensation that the U.S. Department of Veterans Affairs (VA) provides to veterans with mental illness. The Court cited VA's "unchecked incompetence" and the "unnecessary grief and privation" that delays in treatment and benefits cause veterans and families.

I am not here this morning to judge the Court's decision, I will leave that to others. The heart of the Court's analysis of the issue is something with which all of us need to be concerned. Namely, is VA's system of care and benefits improving the health and wellness of the veterans that are suffering from mental illness?

On behalf of a grateful Nation, we have invested heavily in this system over the last decade to improve access and make treatment options that experts say are effective more readily available, but the question remains, are veterans, especially those returning from combat with the invisible wounds of war, on a road to recovery and able to live full and productive lives?

Recovery, restoration, and wellness; these should be overarching objectives of all of VA's programs, yet when I look at trends in disability ratings for veterans with mental illness, I see a very confusing picture.

On one hand we have a medical system that boasts of evidence-based therapies, improved access, and high quality of care, and on the other hand we have data from VA indicating that veterans with mental illness only get progressively worse.

These confounding facts raise the question, are VA's health and disability compensation programs oriented towards VA's mission of recovery and of wellness?

I am not the first who has noted this trend or suggested the need for closer integration of VA programs.

A 2005 report from the VA Office of Inspector General (OIG) concluded the following, and I quote, "Based on our review of post-traumatic stress disorder (PTSD) claims files, we observed that the rating evaluation level typically increased over time, indicating the veteran's PTSD condition had worsened. Generally, once a PTSD rating was assigned, it was increased over time until the veteran was paid at the 100 percent rate."

We also have a 2007 report from the Veterans' Disability Benefits Commission (VDBC), and we will hear from the Chair of that Commission on our second panel this morning, that recommended, quote, "A new holistic approach to PTSD should be considered. This approach should couple PTSD treatment, compensation, and vocational assessment."

Most recently, we have the Administration raising red flags. In its "Fiscal Year 2010 Performance and Accountability Report," VA commented on how well its Veterans Benefits Administration (VBA) collaborates with the Veterans Health Administration (VHA) when providing services to veterans with mental illness. The report suggested that with recovery as the essential goal to helping veterans with PTSD that perhaps VBA and VHA were working at cross purposes.

Let me quote from that report. "With the advent of the recovery model as central to the treatment of mental health and disorders, the current system fails to support and may even create disincentives to recovery."

Today, we are going to move beyond the numbers that simply tell us how many veterans use the system and get into the fundamental question of whether they are on the road to leading full and productive lives.

For veterans who don't seek VA care, we need to know why they are not seeking that care. We need to know if there are inherent disincentives to recovery. We need to know if the quality of treatment provided at VA is a reason to seek care elsewhere. And, we need to know what is effective and what is not effective.

Quoting from a recent policy paper from the Wounded Warrior Project, "VA's focus on the high percentage of veterans who have been treated begs such questions as, how effective was that treatment, and how many more need treatment but resist seeking it?" I couldn't agree more.

It is our duty at this Committee to ask these tough questions and the veterans for whom this system was created demand it of us.

We are fortunate to have with us on our first panel Mr. Daniel Hanson. Dan served in Iraq, then came home troubled in mind, trying to cope with the loss of so many of his fellow Marines. His is a story I hope everyone listens to closely today as a cautionary tale of where we may be inadvertently headed.

Looking back, Dan has some interesting thoughts of what it would have taken to get him into treatment sooner, and just as im-

portant, he has something to say about how he ultimately found help outside of VA's system.

On our second panel, we have Dr. Sally Satel, Resident Scholar at the American Enterprise Institute. Dr. Satel will share with us the principles surrounding what she believes would be a more effective system of care and compensation for veterans seeking mental health treatment.

As I mentioned, we also have the former Chairman of the Veterans' Disability Benefits Commission with us, General Terry Scott. We also have a VA clinician, Dr. Karen Seal, who will share with us her findings on health care utilization of Iraq and Afghanistan veterans.

And finally, on our third panel, we will hear from the Administration, and the views of two important veterans' organizations, AMVETS and the Wounded Warrior Project.

I want to thank everybody for coming, Members and those in the audience and those that are going to be testifying, and I now yield to the Ranking Member, Mr. Filner.

[The prepared statement of Chairman Miller appears on p. 59.]

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and thank you for taking the leadership on this subject.

Of course we have all raised serious concerns over many years about the backlog of claims and there are now a record number of servicemembers returning home with scars from the War. Now is simply not the time to delay their benefits.

The report you mentioned that was released last year by the VA Office of Inspector General (OIG) focusing on the delay of our servicemembers getting an appointment for a medical exam in order to process their claim for compensation is just one more example of how the VA seems to be failing our veterans.

That system has many obstacles for our warriors by putting them through numerous medical exams for each individual ailment for which they are filing a claim.

The VA could easily streamline this process and allow the veteran to receive one complete medical exam to expedite the claims process, alleviate the stress on our veterans, and save our veterans and taxpayers money.

You mentioned the recent decision by the Ninth Circuit Court of Appeals in *Veterans for Common Sense* v. *Shinseki.* That decision found that veterans have a property interest conferred upon them by the Constitution to both VA benefits and health care.

Ruling for the veteran plaintiffs, the Ninth Circuit went a step further to conclude that because there are property interests delaying access to health care or the adjudication of claims violates veterans due process rates guaranteed by the Fifth Amendment.

Unlike you, I don't want to take a judgment on that ruling. I fully support the ruling, and I am disappointed VA has not done more and more rapidly to fix the problem.

We know that every day 18 veterans of this Nation commit suicide. We also know that one in five servicemembers of our current conflicts will suffer from PTSD, and unfortunately the suicide rate

for these brave men and women is about one suicide every 36 hours.

Many of them as outlined by the recent Ninth Circuit Court ruling will be left undiagnosed, untreated, and uncompensated. This is a travesty and an outrage.

Last year, the VA Inspector General's Office made recommendations for the Veterans Health Administration and the Veterans Benefit Administration to collaborate more effectively and share information on issues affecting a timely delivery of exams.

I am disappointed, as you are, Mr. Chairman, that we are still discussing this issue 15 months after those findings and recommendations.

The VA is simply not committing sufficient resources to meet the demands of our warriors when they return home. I hope the VA will address these shortfalls and I expect them to come to the table with a plan to fix the problem.

Mr. Chairman, I look forward to this testimony.

[The prepared statement of Congressman Filner appears on p. 60.]

The CHAIRMAN. Thank you very much. I would like to call to the witness table Dan Hanson, if you will. He is joined by his wife Heather. Dan and Heather are from St. Paul, Minnesota. Dan joined the Marines in 2003.

We appreciate you being here to share your story. Thank you for your service to our country. You are recognized for your statement.

STATEMENT OF DANIEL J. HANSON, SOUTH ST. PAUL, MN (OPERATION IRAQI FREEDOM (OIF) VETERAN)

Mr. HANSON. Thank you, Mr. Chairman. I appreciate the opportunity to speak in front of the men and women that change our country, so thank you. I will get into why I am here with a brief testimony.

I grew up in South St. Paul, Minnesota, came from a large family, went through high school, eventually joined the Marine Corps after two of my brothers did before me. I actually thought about joining the Air Force, but they said they would break my arm, so I joined the Marine Corps in 2003 and shortly after I was deployed to Ar-Ramadi Iraq in 2004, and it was a deployment that started with one of our Marines shooting himself in the head.

I just kind of brushed that under the table, And then 34 Marines we lost throughout the deployment, had about 400, 450 Marines injured, came back and went on leave and that was that.

I started drinking pretty heavy, dealing with nightmares, dealing with things that I wasn't really prepared to deal with I would say, and I think one of the biggest reasons that I dealt with it myself was just because, I mean, I was in a battalion of 1,000 Marines and I don't think people wanted to hear, you know, my whining and complaining.

So then, shortly after we went on another deployment, non-combat, which just kept on drinking, kept on masking my issues with whatever would take away any of the pain.

I came back and then about 6 months later, my unit was deployed again to Iraq, this time I was in the remain behind element so I was kind of able to see the other side of things when we would

get the casualty reports, we would get the KIAs (killed in actions) in and have to notify and take, you know, be on that end of things as well.

I decided that I was going to get out of the Marine Corps, but I was persuaded by a good friend, Sergeant Major Ellis, to stay in, but on that deployment he ended up getting killed, and I went to his funeral over in Arlington National Cemetery.

Then about 2 weeks after that, a friend also in Second Battalion 4th Marines, John Shulzy, hung himself in the basement of his home and that kind of got me twirling out of control just before I was going to get out of the Marine Corps.

And then finally I got discharged in February 2007 and then on March 23rd, 2007, my brother, who was also in the Marine Corps, he hung himself in the basement of his home, and at that point I think I decided I was going to do everything to avoid pain, that I was going to do everything to deal with it myself as I had been doing for the last 3 or 4 years, and I got into drugs, I got into alcohol, I got into whatever it was that would mask the pain that day. Eventually I attempted to kill myself. I ended up in the St. Cloud VA Medical Center for about 48 hours in lock up and then I was released and off to do whatever it is that I wanted to do, which was go back to work, because that seemed like the normal thing to do after something like that.

And eventually I found myself in and out of jail. And I was getting treated on an outpatient basis for a while at the VA Medical Center, but when you were as messed up as I was it takes a lot more than one or two sessions a week to get through my issues, and so I eventually found my way into the Dual Diagnosis Program to get help. It was mostly to avoid a longer stint in jail for my DUIs (driving under the influence).

Eventually I got out after about 30 days. I think I started drinking the next day. About a year later I found myself in jail for I don't know the sixth or seventh time, and I decided for myself that I was done hurting myself, I was done hurting my family, I was done hurting my children, and I checked into a 13 to 15-month faith-based program. That was what changed my life.

About a week after jail I stopped going to work, stopped going to school, and I decided that I wasn't going to be very productive unless I got help, and that is what I did at Minnesota Teen Challenge. It was more of a holistic approach. I went to the VA once a week to get help on the combat and the military specific issues, and then I would stay there 7 days a week.

I wasn't able to get any funding through the VA because it was not a VA funded program, therefore, I got backed up on bills, I wasn't able to pay things, and eventually filed for bankruptcy.

So in my dealings with the VA Medical Center, I always felt like I was in control, I was running my own rehabilitation, although I couldn't even put my shoes and socks on correctly most days, I felt like it was whatever I wanted to do, Mr. Hanson, whatever I wanted to do that I thought was best for me.

Well, I thought what was best for me was to go and get drunk and get high and forget about all of my troubles and forget about all of my nightmares and pass out with a bottle in my hand, that

way I didn't have to deal with any of those issues that were affecting my life.

It was something I believe that could have been ended a lot shorter if I would have been able to be forced or somehow just—you know, I felt like the VA's role in my treatment over the last several years was more of a friend relationship instead of a parent relationship. Where it wasn't hey, you need to do this or else, it was, hey, you know, if something is wrong we have things that can help you, you seem like, you know, you have been through some things, so what can we do to help you?

So I appreciate the time and the honor to speak in front of you. Thank you, Mr. Chairman.

[The prepared statement of Mr. Hanson appears on p. 61.]

The CHAIRMAN. Thank you very much for your eloquence. You had a written statement and you didn't even look down at it. What you said obviously came from experience and from the heart.

Thank you for your service to our country and thank you for your service and your continued desire to not only seek help for yourself but your fellow veterans who are out there.

And I am interested in your written statement. You said, "I know that when I was discharged from the Marine Corps I was not a healthy individual, but I certainly would not have let anyone know that." Why do you think it was so hard for you to speak up about needing help, what can we do as Members of Congress to help improve the system? Is there a way to encourage people to seek the help that they need?

Mr. HANSON. Yes, Mr. Chairman. I knew I was very messed up when I got out of the Marine Corps, it was apparent, people told me you are not the same person, you are angry, and I was drinking and I was depressed, and it was apparent to me—and to go back a little bit in the Marine Corps my primary military occupational specialty was an 0151, which is administrative in nature, so I was attached to 2nd Battalion 4th Marines, a grunt unit sent to Iraq, so I immediately felt like I didn't deserve to get help because I wasn't 03, wasn't infantry by trade, so therefore, the things that I saw were things that are natural and therefore, you know, I just kind of need to suck it up.

So when I got out of the Marine Corps I started seeking treatment at the VA, and I just, I felt like I didn't get help because if I admitted that there was something wrong with me there was something wrong with me, and the VA though they were there and they were supportive they never really said, this is what is going to happen if you continue and you don't get help, you need to get help. Or if you don't get help, you are not going to get this disability check that, you know, you go and spend on the booze and strip clubs, to be very frank, and that is what I did.

And so I think the biggest reason I didn't get help is because I felt ashamed, I felt like I didn't—there was another bed for someone more deserving than myself, so that was the main reason, Mr. Chairman.

The CHAIRMAN. You raised two important issues in your testimony. First, you said that although you needed to get help you chose not to get it because, and these were your words," I was able

to afford not to." And I think it would be important for you to explain what you meant by that.

Also, how common do you think it is for individuals not to seek help because they have other avenues in which they could go?

How many out there who need help don't get it because they can "afford not to?" Do you think it is a large group?

Mr. HANSON. I do, Mr. Chairman, I obviously don't have an exact number, but I have plenty of friends that I feel, you know, you get the disability check and they are comfortable with it. They get it for whether it is a mental illness or a physical illness and a lot of the goal is to get it bumped up, and that way you don't have to—you know, it is $800, $1,000 that you don't necessarily have to—I shouldn't say work for, but it makes life easier.

And for me, as you said, I could afford not to because it was kind of supporting my alcohol problems, and I am not saying—I mean it has helped me tremendously, but when I was in my mix when I was unhealthy and making poor decisions, it was just a way for me to support my addiction essentially, and I know plenty of people that I was friends with and that I served with that, you know, it is kind of the same thing where it is a convenience thing, and it pays certain bills and it does certain things so why get help when that will take away from the money you are making every month essentially, money that goes in the bank.

The CHAIRMAN. Mr. Filner?

Mr. FILNER. Thank you, Mr. Hanson, I know it is not easy to talk about your own life here, but in your written testimony you do mention certain things you think the VA could do to serve you and your comrades better. Do you want to go over those ideas a little besides the one you just mentioned to the Chairman?

Mr. HANSON. Yes, sir. I felt that very often it was just kind of like I was another number in a revolving door, I never felt there was much of an actual care, whereas when I eventually did go to Minnesota Teen Challenge, I felt there was an actual effort for me to get help, to get better, not because it was their job, because it was something they were passionate about, and that was a big part of it for me.

And another big part of it for me was I was able to go to the VA Medical Center to get help once a week, but then I was removed. I didn't have to be the Marine, the combat veteran every time I went back to get help. I wasn't around a lot of veterans and I can understand that there is a certainly benefit to it, but there is also a benefit to not being with all the people that know what I went through. There was a certain part of it that being around people that didn't know what I went through was beneficial. I didn't have to put on this, you know, macho man, yeah, you know, I am this tough guy, which I am not, so it was a lot easier not to act most of the time, and I think that was a big part of it. A big part of it for me was being removed from a lot of the people that had been through the same things as I did myself.

And there is also certain other parts about the VA where I just don't feel they have any—at least for me I was able to go to a Dual Diagnosis Program, which is in St. Cloud VA Medical Center, which is 30 to 90 days. I mean after years and years of abuse and years and years of just masking my problems, I needed more than

30 to 90 days. I needed 13 to 15 months and that is what did it, and although it was painful at times and I hated it most of the time, there was a reason I did that. I wasn't able to get comfortable, I wasn't able to just pretend that everything was all right, because eventually things are going to come out and sometimes it takes time and that is what I needed.

The CHAIRMAN. Dr. Roe?

Mr. ROE. Thank you, Mr. Chairman, and thank you Mr. Hanson for being here today and giving some I think very tough testimony for what you have done. And how are things going now for you?

Mr. HANSON. Things are going great, sir. I am going to school full-time working on another Bachelor's degree. I am married, I have children. I serve people instead of taking away. I live a life to, you know, volunteer for veterans. I am a Veterans Affairs Liaison at Minnesota Teen Challenge. I am able to affect people in a positive way, and for all the years I took away give back, so I am very, very, very happy for the turn around in my life and so is my family.

Mr. ROE. It is great to hear that, and I know it is tough to lose friends, I certainly understand that as a veteran and having done the same thing myself it is very hard to talk about and you deal with it every day. I am sure you think about these men that you lost, friends that you knew every day. Do you feel any guilt for surviving and they didn't? Is that an issue with you, do you feel that?

Mr. HANSON. There was a particular incident in which yeah, there was a lot of survivor's guilt that I dealt with when I was supposed to go and inspected a VBIAD (Vehicle Born Improvised Explosive Device) and we got called off. Another unit came and they ended up losing seven Marines and I was the lead vehicle, and then as we pulled away, we got swore at and told that we should be the ones. And I don't want to bring stuff like that up, but yeah, there was a lot of survivor's guilt that I dealt with and that was, you know, what drove at times my drinking quit, you know, considerably.

Mr. ROE. I think that probably had something to do with a lot of folks.

I want to hear a little bit more about how you are faith based, how the program you felt was successful for you. I think that is really important, because obviously everybody is different, but this clearly worked with you and I think you had made your mind up too that you were going to change your life, I think it had a lot to do with you also.

Mr. HANSON. Yes, sir. I mean, I was at the point where it was either—I mean, I was on my knees in my jail cell praying, I said, you know, God, either use me or kill me, and I eventually went to Teen Challenge, and the reason I feel that was so effective was it was more of a holistic—I mean, I was such an immoral, I used to say social parasite, where I was a liar I was an alcoholic, I was a deadbeat dad essentially, and when I went into Minnesota Teen Challenge, I was able to deal with the moral and the—and not just the things that happened in combat, but going all the way back to childhood, you know, some of those issues and get to the heart. And for 13 to 15 months, you know, you are going to get through a lot of the issues.

I still have issues, but they are considerably less, and I mean it was physical healing, emotional healing, spiritual healing. It was, you know, a mental healing, and it was like I said more of a holistic approach of getting help for not just what happened when I was in the Marine Corps, but before and after and the damage I had done and the survivor's guilt and knowing that what happened happened. But I have a future and I have the chance to make the best out of it and that is what I intend on doing now.

Mr. ROE. Well, you have obviously done a great job with that, and a real asset not only as a soldier and a Marine, but as just a citizen of the country and as a father.

And again to the Chairman and Mr. Filner's question, how do you think the VA could have used some of the experiences you have had to make it better for other Marines or soldiers or airmen that have experienced the same thing?

Mr. HANSON. Well, I definitely feel that at times if I would have gotten the kick in the butt I needed to get into true rehab where the VA would have said look, either you go to rehab, you get better, or you know, you are not welcomed here. Basically, you know, if you don't want to use what we have set up for us then maybe you should use somewhere else.

Because if there are people that really want to get help, this place needs to be open for those individuals, and for years I had great opportunities to get help, but I didn't because I didn't want to.

And I think if the VA, you know, instead of a friendship role took that parent role where I know there are plenty of times when my dad made choices where I, you know, I hated him for it at the beginning, but I saw the absolute, you know, necessity of it, you know, years down the road, I appreciated it much more. Obviously instead of, you know, him not parenting me—and I am not—that is a weird analogy to use the VA as our parent, but I just think if the VA would be possibly more assertive in their treatment in saying, look you are obviously messed up, you have been through this, you have been through this, you have this police record, it is time to either get help or, you know, find somewhere else to try to get help.

Mr. ROE. Tough love.

Mr. HANSON. Tough love.

Mr. ROE. Again, thank you so much for your service to our country.

Mr. HANSON. Thank you, sir.

The CHAIRMAN. Mr. Michaud, you are recognized for 5 minutes.

Mr. MICHAUD. Thank you very much, Mr. Chairman, and I want to thank you, Mr. Hanson, for your service to this great Nation of ours and for coming here today, because I know as the others mentioned it cannot be easy for you to do that.

I have a couple of questions. First of all how did you find out about the Minnesota Teen Challenge program?

Mr. HANSON. I was actually in jail. I had gotten my 700th DUI it seemed like, and I made a phone call to tell my sister to pick up my son for a trip to Wisconsin Dells. I saw an advertisement on the wall, and then my brothers picked me up from jail and I heard an advertisement on the radio for Minnesota Teen Chal-

lenge, and said, okay, well, I think that is the sign. A week later I told work I got to go get better and I will be gone for a year. So that was how I heard about it.

My family had known about it because it is a faith-based program and my mom is a very religious person, and so she had mentioned it actually, previously, but I said, come on it is for 13 to 15 months and I have things to do, let us go here.

Mr. MICHAUD. Thank you.

Do you think that it would be more beneficial for those who are serving in the military today if actually before they are discharged that they actually are aware of different programs out there in trying to get some of those services while you are actually in the service versus once you are discharged from the military?

Mr. HANSON. Yes, sir, absolutely, 100 percent. I know when I was back from Iraq and I still had a couple years left in the Marine Corps and I had really no idea, you know, I could have spoken to the chaplain or went to the battalion aid station or something like that, but other than that, I really had no idea what I would do if I really wanted to get help.

So I wasn't really in the mindset of getting help. But I think if I would have been more aware and I would have been under the understanding that a lot of people did it, and I wouldn't have been the only one and that it wasn't weird or weak for me to that do that, I would have been much more apt to do it and get the help before I got discharged, and saved a lot of pain and suffering for my family, my children and my wife.

Mr. MICHAUD. And how do you think those services would be more beneficial?

For instance, I have been to Iraq and Afghanistan several times and every trip that I have been to Iraq and Afghanistan when I talk to the generals and ask them if they need help particularly with those who have traumatic brain injury (TBI) or severe post-traumatic stress disorder (PTSD) what do they need we get the same answer, well, they have the resources they need to take care of them, but the interesting thing is on one of those trips, I had someone with much lesser rank approach me, pulled me aside and said they need a lot more help, and one of the suggestions that they actually made was that I talk to the clergy.

And so since that trip to Iraq, every trip I have taken since then I did talk to the clergy, and the interesting thing is they were telling me that more and more of the soldiers are going to them because they are afraid to seek help from a doctor because they are afraid what other soldiers would say.

Do you find that true as well that they might be afraid to actually seek help while they are in the service because they might not get the promotion that they are looking for?

Mr. HANSON. Yes, sir, absolutely. I feel like it needs to start probably from the top on down, because when you were in a unit like that and you take the risk of asking for help—I mean you might be considered a broken Marine or you might be considered someone that isn't ready for the next promotion or isn't ready to lead Marines or be put in that billet in which you have a lot more responsibility— from then on out, I think if you were to do that I feel like, yeah, you would be putting yourself at risk because you

are basically looked as possibly like someone that is broken and that is no good to them or be given a job, you know, like cleaning toilets or something like that.

And that is probably not the case in every unit, but I know definitely in my unit, I would probably have been terrified to actually ask somebody for help and say, hey, I am having nightmares or I am having issues like that because I would have felt like that could have been the start of a domino effect of discussions about where I am headed, my next rank and my cutting score, and things like that, sir.

So, I definitely feel like there probably needs to be an atmosphere of, that is all right. But then, where do you draw the line? Is everyone going to be raising their hands? I am sure that is going to be the next question asked, but I think that definitely is where it starts is the top on down because I worked pretty closely with your RP and our chaplain and they had someone in there every single day. If you would have possibly asked a sergeant major or somebody else, they probably would have had no idea.

Mr. MICHAUD. My last question and everyone is different. You mentioned when you went to the VA that it was more of a friendship type of situation versus being a parent-type situation. And what is best when you are dealing with traumatic brain injury or post-traumatic stress, I think individuals react differently.

My next question is, and last question is, actually there was a report the Inspector General had done actually of a Marine that they investigated whether or not the VA provided this particular Marine the health care that he deserved, and actually it came out that in fact that was not the case, and primarily it probably was a different situation than yours where the VA actually was going to cut the disability benefits from this Marine, and it pretty much, I think, put the Marine over the edge as far as he has lost his benefits versus, you know, how can we better serve, you know, this particular individual.

So in your comments about you need that tough love, so to speak, do you think that would be the case in every situation or should the VA look more at the individual and more or less take down the silos between the benefits versus the VHA and the health care side? Do you think they should look differently at different situations versus saying, well, you have to show that tough love in all cases?

Mr. HANSON. Yes, sir, I definitely agree it is on a case to case basis, and for me I was financially secure enough where if they would have shown the tough love and said we are going to cut you off, I mean, I would have been able to survive and it would have angered me and I probably would have had some harsh words to say, but I would have been able to—I am sure it would have forced me into some sort of rehab and I think that would have helped.

But I definitely agree with you where there are some circumstances where people are not abusing that compensation and they do still need help, but I am sure there are other way to go about it than just cut compensation. But I think for some people like myself, it would have been beneficial to do so. But for some people, I agree that it is not the best route to go.

Mr. MICHAUD. Thank you. Thank you very much, Mr. Chairman.

The CHAIRMAN. Mr. Stutzman.

Mr. STUTZMAN. Thank you, Mr. Chairman, and thank you Mr. Hanson for being here, your testimony has just been—it is an amazing story and it is so good to see you here and taking the opportunity to share with us your experiences and what you have experienced not only in the military but also after the military and how you are a fighting success.

Also to your wife, I know she has been through a lot as well, I can tell she is very proud of you sitting back there.

My question is, is after you left the military, did the VA ever give you any direction on programs?

You mentioned that you heard about Teen Challenge on the radio and on an ad, and I am familiar with Teen Challenge, in fact a good friend of mine growing up, hit, you know, the bottom in his life and actually found a lot of success at Teen Challenge, so it is really encouraging to hear this.

But did they give you any direction of different programs, any ideas on where to find help, anything like that?

Mr. HANSON. When I did finally decide that I needed to get help, and you know, they were supportive in saying yeah, you should find a place, they offered VA treatments, which was the Dual Diagnosis Program in St. Cloud VA Medical Center that was 30 to 90 days. Then they offered an outpatient one at the Minneapolis VA Medical Center that was, I believe, it was 6 weeks. It was Monday through Friday something like 8 a.m. to 4 p.m..

But also at the Dual Diagnosis Program, I was able to leave on the weekends, so you know, I am there Monday through Friday, inpatient the whole week, but then on the weekend, I am able to get out and do whatever I really want to do.

So I think that was also a part of the reason I didn't gain as much success from that program, as well, because I was given that freedom. It is what I wanted, but freedom wasn't what I needed at the time. I needed a swift kick in the butt and some serious help.

So those were the two programs that they offered to me, they were both VA funded and through the VA.

Mr. STUTZMAN. And then so at Teen Challenge you were there 24/7 committed for about a year.

Mr. HANSON. Yes, sir, I lived there. There was special occasions where, you know, you can get a couple days where you go on a pass or something like that, but for the most part, you are there 24/7. You wake up, you get breakfast, I worked out and go to chapel. Then for the second half you are doing chores, you are doing all those things, but you are there every single day.

And like I said, it was nice because I was there. I was able to go to the VA for treatment and then come back to a safe place, a safe environment where I could be my own self, which wasn't, you know, Dan Hanson, Marine, combat veteran. I was just Dan, and I think that was a big part of it for me.

Mr. STUTZMAN. You mention in your testimony one of the biggest struggles that you dealt with was not having the funds to complete the program. What kind of cost did it take to attend the program for 1 year?

Mr. HANSON. For a full year it was about $850 to $860 a month, and so I had other priorities at the time that I was trying to pay

for and yeah, there were times I was behind in my payment to Minnesota Teen Challenge and I asked them several times to try to fund the program. They said that was not possible because that was a program that didn't fund. And then, I tried to do some other things, and eventually they bumped by service-connection after I was done with the program, but by that time. I was behind on all sorts of bills, and you know, it was a little bit of a disaster financially.

Mr. STUTZMAN. Did you meet any other veterans in the program by chance?

Mr. HANSON. Yes, I met some Vietnam veterans who were really struggling, that had been struggling for 30 years, I met Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans. Granted there wasn't a lot of them, but, there was a handful of them, and that is why I still do work with Teen Challenge to get veterans in there. I know that for the veterans that were in there and went through the program, it is a little bit easier because the structure is almost, you know, like the military where you wake up, you go to bed when they tell you, and there are strict rules. If you want to get in a fight, you are gone. There is nothing to talk about. And it was somewhere that I fit into very well because of the structure, and was able to excel.

Mr. STUTZMAN. Very good. So about $10,000 a year then for the program.

Mr. HANSON. Yes, sir.

Mr. STUTZMAN. Okay. All right. Thank you, Mr. Chair, and I will yield back.

The CHAIRMAN. Sergeant Major, Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman, and Mr. Hanson thank you as a fellow Minnesotan. Did you go to South St. Paul High?

Mr. HANSON. Yes, sir, I did.

Mr. WALZ. I coached football there many times for Mankato West, so we probably played against you at some point.

Mr. HANSON. Yeah, I believe we won most of the time.

Mr. WALZ. Yeah, I think so too. Thank you for adding that.

But again, thank you for your service and again, there are not words that we are going to share with you that are going to ease that pain other than for you to recognize that we take our responsibility very seriously here, so your coming here and your family, your wife coming is hugely important, and I am certainly not going to tell you that in 2003 and in the early stages of this current conflict we were ill prepared for the influx of veterans, we did not have that.

What I would say is, is this issue that I think we are getting at and I think it is very important, and with the next panel I will discuss some issues on the case for coercion versus autonomous care, but for you on this it obviously worked and that is what we want. One veteran that succeeds is what we are after.

My approach to this, and I see this and I take it very seriously as a senior non-commissioned officer (NCO), you are right, this culture of how you seek care and how you get your soldiers into that. This is—I think we need to keep in mind—this is a broader issue and Minnesota has a long legacy in this with former Senator or late Senator Wellstone and former Congressman Jim Ramstad on

this idea of mental health parity, something we fought for hard that this idea that you should be treated for mental health issues just as if you had lost a leg and those care.

And we are trying to get this right, we are trying to, and I think what is coming up and Mr. Michaud brought up, I think Mr. Stutzman talked a little bit about this individualized care, how do we get that right.

One of the things we have to be concerned with is evidence-based policy and those types of things.

Since you first testified over in the Senate side, have you used the VA for anything?

Mr. HANSON. Yes, sir, when I was in Minnesota Teen Challenge—oh, I apologize that was after—I have, very recently I met with a psychiatrist, Dr. Brown, who has seen me since I got out in 2007 and I have met with him and just kind of talked about things and then I have done physical therapy for my back and neck. But as far as mental health goes, I have pretty much done no follow up as far as that goes whatsoever.

Mr. WALZ. And I want to assure you and make sure you know as Minnesota's only Member of the delegation that is on this VA Committee, I spend a lot of time at those and 3 weeks ago, I was up at St. Cloud, I was in the in-treatment facility there and met with Dr. Ball and the administrator and talked a lot. I want you to know that I take the job very seriously of seeing what is working there and I think it is important to know that we are having successes there, which you have friends that have probably gone through there and we are having that.

I also want you to know any time there is a failure in any way, my job is to get to the end of it. And with Jonathan Shulzy I have spent, and my staff has spent, countless times understanding what happened there, where things went wrong, where we could have done better, what the outcome was. You need to know that you coming here and testifying gives us the motivation, if you will, makes it very clear to us what our job is to try and deliver.

And what we are trying to figure out is how do we best treat and care for folks like yourself? How do we do it in a way that respects your personal freedoms and your rights, but how do we make sure that you were given the opportunities to enter back into society?

And I think you keep bringing up a very good point, and I hope the Committee does, this holistic approach. I am very concerned with the employment issue. You know, this as well as anybody a good job is a good way to start getting better if you can get that and hold onto it in conjunction with therapy in conjunction with a family that is committed.

One of the problems we have is we have let some of those programs for hiring veterans lapse and we need to bring them back again. But you are working now, right?

Mr. HANSON. No, sir. Well, I do do some work, it is volunteering. Minnesota Teen Challenge has a Veterans Affairs Liaison, but I do go to school full-time at North Western College.

Mr. WALZ. Great. Using the GI Bill?

Mr. HANSON. Using the Post-9/11 GI Bill.

Mr. WALZ. It is working for you?

Mr. HANSON. It is working great for me, sir.

Mr. WALZ. So those benefits get you by, you are able to provide your wife and family, by the way of getting your education, provide your housing, food, and things like that.

Mr. HANSON. Yes, sir. I am sure I would have no problem getting a job right now, it is just I want to use the Post-911 GI Bill.

Mr. WALZ. What if those benefits were held back until you got treatment?

Mr. HANSON. That is a very good point, because all the way up until I went into Minnesota Teen Challenge, I was utilizing those. I was going to school full-time, and the biggest reason was that I did want more money and I was getting disability, but I was also, hey, I can go to school full-time and get this money. But if that was held back, I think that would have really done a good job of pointing me in the right direction saying, okay, they are serious now.

Mr. WALZ. So for you the holding it back would have motivated you to it?

Mr. HANSON. Absolutely. If they would have said you can't go to school and we are going to pay for it until you get help because you are clearly, if we look back in your history and in your doctor's appointments, you need help and here is your incentive, you want to go to school, go get help.

Mr. WALZ. So this is an issue I am very interested in and I have been spending a lot of time reading the literature on this to try and see overall how many times that works or what it does, so that is helpful to me.

Again, thank you for your service. I appreciate your courage in coming forward talking about these issues, and I assure you, I think we have learned during this conflict, at least I would like to believe this, I think especially as senior NCOs, we are getting better at seeing this issue of mental health parity and early treatment when the wounds are fresh is the best way to go instead of just sending you back to fend for yourself. So that is not the right way to do it.

So thank you for that and thanks to your family. I yield back.

Mr. HANSON. Thank you, sir.

The CHAIRMAN. Dr. Benishek, you are recognized.

Mr. BENISHEK. Thank you, Mr. Chairman.

Mr. Hanson, thank you so much. I want to commend you on your courage for being here today and providing us with that testimony, because I can tell it wouldn't be easy for me to give that story if it was me, so I really commend you and your wife for being here today and I appreciate the education.

I just have a couple simple questions. When you were discharged from the Marines, was there any sort of a mental health evaluation upon discharge or would you have been willing to, you know, talk about your problems upon discharge so you could get help?

I mean, I was curious about how you were reluctant to seek attention because you felt embarrassed about it. Tell me more about that discharge process.

Mr. HANSON. Yes, sir. There is the final physical in which you go through to make sure when you are discharged that you are 100 percent, you know, as when you joined the Marine Corps, and then if you are not, then you get hooked up with the VA.

But for me, I passed my final physical and they—you know, it was easy for me to say, yeah, I don't have nightmares, I don't have this, and that is what I did. You fill out a form and they ask are you going through any of these things, and you just circle no, and that is just really that, as far as that goes.

And then they have the Temp and TAP Program, which is about, I think, 4 days and that is about integrating back into society with civilians.

But for the final physical and Temp and TAP, it is really—you go through the physical part of it and then for the mental stuff, you fill out some paperwork. For me, I just pretty much X'd no on everything, and that was that. They didn't really ask me any follow-up questions. They didn't go any deeper into it, they just said, okay, it looks on the paper like you are doing pretty good.

Mr. BENISHEK. So you just basically didn't tell the truth in that.

Mr. HANSON. Yes, sir.

Mr. BENISHEK. Okay. And then no one really questioned you about it or you didn't have an evaluation with someone sitting down and talking about them.

Mr. HANSON. No, sir, they just basically had me fill out the paperwork and said, looks like you are doing well, and I said, yes, let's get out of the Marine Corps now.

Mr. BENISHEK. All right.

Another question I have is, tell me more about what you are doing with this group, this Teen Challenge group. What exactly are you doing for other Marines?

Mr. HANSON. With Teen Challenge basically I go to different—whether it is like VA, like the stand down, the VA stand down or I will go to any sort of veterans' event and I will have a table and I will just try to get the word out that, hey, this is a great place for veterans. It is a good option, it worked for me, here is my story. I would like to see more people going through that. So anywhere I can.

Like I am testifying at a court case on Friday about trying to get someone sent there instead of prison essentially. He is a combat veteran struggling with PTSD, and they want to send him to prison.

So any time I can speak about things like that, get a hold of someone that is a combat veteran or just a veteran—not just a veteran, but a veteran—and try to steer them into this long-term care, because I feel the key is, is the long-term care. For me, I put it off for as long as I could, but I know I would not be where I am today unless it was a year-long program, in which it was.

So that is essentially what I do for Teen Challenge. Just go to events, recruit any way I can, network and try to get a hold of veterans that are hurting and get them into the program.

Mr. BENISHEK. Thank you very much for your testimony, and I will yield back the remainder of my time.

Mr. HANSON. Thank you.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Daniel, I want to thank you like every Member of this panel for serving our country and for sharing your insights, and you are

sharing stuff with us that I haven't really heard before so it is useful.

I just want to talk a little bit about the Teen Challenge. It is obviously not aimed at veterans; is that correct?

Mr. HANSON. It is not, sir, it is for just normal non-veterans.

Mr. MCNERNEY. I am a little unclear about the relationship between the VA and the Teen Challenge. Were those two organizations able to work to make the program work for you or was it just something you had to fight through?

Mr. HANSON. It was more Minnesota Teen Challenge, working with the VA. The VA was open for me to do a program while I was in Teen Challenge, so essentially, I had to get it approved by Minnesota Teen Challenge because they have their rules and they have their Monday through Friday, everything planned out. But I was able to ask them, can I go to this, it was cognitive processing therapy, it was about 3 months, so 3 months out of the year that I was there, I was able to go to the VA, go meet with my psychologist, then I would go to a group meeting with some other veterans and then I would be sent back to the program.

So it wasn't really much of a working relationship, I would say it was Teen Challenge saying, yes, if you want to go there one day a week you can do that, and then the VA setting up a program for that.

Mr. MCNERNEY. So there could be better cooperation between the VA and some of those community-based operations.

Mr. HANSON. Yes, sir, absolutely, and that was something I struggled with and something I continue to try to help with when I graduated. The program was being more open to a program like this, because every time I try to talk to people, you know, someone at the VA about hey, this is a great program will you fund this, or you know, can I put up a sign for people. It was just they didn't want anything to do with it because it is not a government-funded program and that is understandable, but I feel it is a great program and hopefully some day there can be a better relationship there.

Mr. MCNERNEY. Well, I am sure my office would love to work with you on developing an idea on how to make that happen or anyone on this panel would I can guarantee you, so if you feel like you want to do that, any of our offices would be open, my office would specifically.

Now about Teen Challenge, were you compelled to stay there, did you have to stay there?

Mr. HANSON. No, sir, I did not have to stay there. I could have left. There are certain people that are, as I said to Dr. Benishek, that are required—they are court ordered there. But for myself, I checked myself in, therefore, I could leave at any time and there were plenty of times I thought I was going to leave, but I stuck through it and, you know, pushed through a lot of the pain.

Mr. MCNERNEY. So the interesting thinking is that you had decided that you wanted to go through the program, that you needed help, that you had reached rock bottom or whatever decision had come to you that you wanted to do this program.

Would there be any way to compel folks that didn't want to go through that program that needed help as you did to go through the program?

Mr. HANSON. Yes, sir, I believe so. There is a program that is part of Minnesota Teen Challenge, it is called Extended Care Program, that is a 30- to 90-day program. Then, if you feel like you are not where you need to be, then you can transition right over into the year-long program where those 90 days that you were already there count towards your year-long stay.

So you can get basically a small part of what the program is about through the 30- to 90-day program, see if it is a good fit for you. If it is not you, complete the shorter-term program and you can leave. But if you feel like this is what I need, I am getting the help I need here, then you just transition right over into the long-term program.

Mr. MCNERNEY. Well, I am really glad to hear about this. We just had a tragic case where a young man went through a program and he left and he walked in front of a train that afternoon a few hours after he was released, so clearly that wasn't giving him what he needed. He had been through several 2-week programs, it didn't help, so now I see the value of that.

So thank you for your testimony today.

Mr. HANSON. Thank you, sir.

The CHAIRMAN. Mr. Runyan.

Mr. RUNYAN. Thank you, Mr. Chairman, and thank you, Mr. Hanson, for your service to this country. I think many people a lot of times fail to recognize the sacrifice is lifelong and I think you are a prime example of that in dealing with this.

Another thing you touched on earlier and going back to the VA stuff, the lack of being a parent. I think sometimes here on the Hill we have the lack of ability to have adult conversations a lot of times, and I think you see that trickling down into the Administration throughout. You know, we are treating veterans, but we are not treating veterans. You know what I am saying?

Mr. HANSON. Yes, sir.

Mr. RUNYAN. We are not solving the problem.

Specifically to your situation as you said, you were in the program, and you were allowed to go home on the weekends. Obviously, we know the mental issues are underlying, but there is also a substance issue that was there also. Was that being addressed at all on say when you came in on a Monday morning, was that being addressed or were they just kind of saying, oh, whatever happened on the weekend happened?

Mr. HANSON. No, they would do urine tests when we would come back from the weekend and certain things like that—and we did, they had AA meetings at the program and things like that as well. But kind of like you said, I feel like it was a set up program, and while I was there it wasn't very structured to my individual needs.

You know, I agree with you there is an addiction problem 100 percent, but for me, I think it was much more emotional. I was a sensitive guy and I needed something to address that much more than I did my alcohol, and that I felt like solely it was either about the alcohol or it was either about the combat. It wasn't about some of the other issues like the guilt.

Sure that ties in with it, but specifically the guilt and the shame and the hate I had for myself, it was never really addressed whatsoever.

Mr. RUNYAN. And I know what you are saying, but sometimes I think most people agree with me. It is hard to get to the root of those issues until we get the chemicals out of the way.

Mr. HANSON. Absolutely.

Mr. RUNYAN. You know, there needs to be, as you say, specifically tailored to your issue. Obviously your issue kept ballooning and ballooning on the substance issue, we can't treat the mental issue until we get the drugs and the alcohol out of the way, and I think it was a shortcoming on the VA's program within itself there.

Mr. HANSON. Yes, sir. And going back to your question actually, you know, we would be released on Friday afternoon. Well, you can drink Friday night and Saturday night as long as you stay off the bottle on Sunday so when you come in, you will have a clear urinalysis test.

So absolutely, I agree with you where, you know, we are in there for a chemical addiction. Yet, we have an opportunity to drink for a couple of days, go back, look like it is all clear, not talk about it, pass the urinalysis test, and keep on going.

Mr. RUNYAN. I think that says it all, and with that I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Barrow. I thought you were leaning back, couldn't see you behind the sergeant major there, sir.

Mr. BARROW. I thank the Chairman, and with my thanks to the witness and all those that he represents I will defer to my colleagues.

The CHAIRMAN. Thank you.

Mr. Huelskamp.

Mr. HUELSKAMP. Thank you, Mr. Chairman, I additionally want to thank Mr. Hanson for his courage of being here and sharing his testimony. I think part of this is a faith testimony and I appreciate that. I come from a very rural district in western Kansas and this is a story that I have heard from a number of my constituents, as well as family members, so I believe your presence here today, I hope, will save lives and hopefully changes for the better at the VA.

And with that I yield back my time, Mr. Chairman.

The CHAIRMAN. Mr. Bilirakis.

Mr. BILIRAKIS. Thank you, Mr. Chairman, thank you for your service, sir. I appreciate it very much, and thank you for your testimony.

Just a couple quick questions. What is the greatest barrier you saw in getting treatment?

Mr. HANSON. Really just getting past myself. I knew the options were there, but I was working full-time, I was going to school full-time, I had a life. I wanted to party so it was getting past the inconvenience of having to get help, whether it be outpatient or inpatient, most certainly inpatient was out of the question. So that is why for some time I did outpatient care because there were times I felt like I would walk out of there feeling better. Certainly the biggest barrier was myself, getting past being able to control

whether I get help or not was the biggest thing, because I didn't want to be inconvenienced, because I knew what was right for me at the time.

Mr. BILIRAKIS. What can the VA do to further encourage treatment?

Mr. HANSON. Well, I think as I touched on a little bit earlier, I think just maybe being a little bit more forceful in their approach saying—not just saying we have these rehab programs, you are definitely a good candidate for them. But instead saying, we have these rehab programs and you need to get help, and you know, if you don't get help, there is going to be some sort of a consequence. I guess I don't know if it should be financial or you can't get help there, but I just feel like once a person—it is clear that they need help, possibly somehow it should be not just a good idea between myself and the psychiatrist or the psychologist I am talking to, it should be something where it is more assertive, more take charge, kind of you are messed up, we are going to get you into treatment one way or another. Not just giving me options as you are good candidate for help, you need help.

Mr. BILIRAKIS. Okay, thank you very much, appreciate it.

Mr. HANSON. Thank you, sir.

Mr. BILIRAKIS. I yield back.

The CHAIRMAN. Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman, and thank you for holding this hearing.

Let me again reiterate what my colleagues said, Mr. Hanson, we appreciate your service and your willingness to come here and to really be honest and candid with us.

When I read through your opening statement, you indicated that when you were discharged from the Marine Corps you knew you were not a healthy individual, but at the same time you did not tell anybody, and there was a feeling I guess in your own mind, mentioned in your opening statement, that you felt indestructible because you were in the Marine Corps and you had served, yet you were struggling.

You suggested that perhaps everyone should realize that they should get some help and perhaps as an incentive to have compensation withheld.

Let me ask you this, do you think if you, not talking about the VA, but about the military services, do you think the Marine Corps itself should have briefed you before you were discharged to say look, it is not being less of a Marine if you realize you need help and that somehow this feeling—not just in the Marine Corps, but all the military—that you are weak if you say I need help?

So, and I have been to these hearings before and generally I find that persons like yourself are courageous and are willing to give your life for your country, and so when it comes to signing on the dotted line that I am weak and I need help, people won't do it because they say it is a sign of weakness in America.

So had you ever thought, I know you suggested that as an incentive to withhold compensation, but is there a way through education perhaps that we could have you in the very beginning, either through the Marine Corps or the VA, through education?

Mr. HANSON. Yes, sir, I do believe so.

Like I said, when I got back from Iraq and was in the Marine Corps for a few years after, I was really not aware of any sort of program that I could do while I was a Marine. I really had no idea as far as that would look any ways, and there is definitely a certain amount of pride that goes along with admitting that you do have that problem.

So when you are coming to work every day with 1,000 other Marines, it is kind of like does he know, does he know? You know, you don't want to feel like the odd man out.

So, if there was much more openness at least when I was in the Marine Corps to get help, and to least talk about it or take the initial steps into at least realizing that there is help, you have a problem, and it is okay to get it, then just maybe having some sort of a more open communicationline between the top heavies and on down the chain to the the privates, PFCs, whatever, that it is okay to get help, and here is the way to do it, and you are not going to be looked down on if you do, we encourage it, it happens.

And I think it is pretty safe to say that if anybody goes to combat, they are changed for the rest of their life. So just sometimes there are more cases like myself that aren't quite able to take it as well.

So, it is definitely, based on the person. But I know if there were probably more of an open communicationline between myself and the higher ups, I would have been apt to get help sooner.

Mr. STEARNS. You indicated that everybody has changed in the military service, that is true, but it is also dependent upon the amount of stress and combat and what you see, and judging from what your opening statement, is you saw a lot, and all that impacted you in ways you didn't know until it was almost too late.

So in a way the VA has a responsibility, but in a way I think you are saying the Marine Corps, the Navy, the Air Force, the Merchant Marines, all have the responsibility to at least let the people in combat know that it is not a sign of weakness if you feel you are struggling.

Mr. HANSON. Yes, sir, absolutely.

Mr. STEARNS. And that before you discharge, this kind of message should be presented to the soldier so he or she knows it is not a sign of weakness, just realize that you have this option and so that everyone doesn't think it is a liability on your part.

Mr. HANSON. Absolutely, yes, sir.

And I feel like it would be just as important to get that communicated with the families of veterans of Marines coming back.

I mean, if I am not willing to get help, then the pressure from my family, once they know from the chain of command that there is an open forum, if they are having these issues, nightmares, if they are drinking a lot, talk to us and it is okay that they are all right, we are not going to look down upon them, we are not going to withhold a promotion. Talk to us, it is okay. He is a Marine, he has done this. But keeping that open line of communication between the military member and then their family as well—because if that person is not apt to go, their family is going to be the biggest reason that forces them into it. Because, oftentimes, I believe it is the family that gets them in and not the actual individual servicemember.

Mr. STEARNS. Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Buerkle.

Ms. BUERKLE. Thank you, Mr. Chairman, and thank you, Mr. Hanson. Thanks for your service to this Nation and for your courage to be here this morning.

I just have one question. You mention that the biggest obstacle that you had was getting past yourself and understanding and realizing that there is a need there for help.

Mr. HANSON. Yes, ma'am.

Ms. BUERKLE. Now something in Teen Challenge versus the VA system, there was a difference in those two programs. What was it with the Teen Challenge that let you get past yourself that was missing in the VA's approach to mental health?

Mr. HANSON. Well, ma'am, I believe it was really just—it was a couple things. One, the environment was where—which I mentioned earlier, it wasn't a bunch of combat veterans, it was people that are from all over the State and that had different experiences—but all had problems and we could talk about our issues and they were very different, but yet they were the same.

So there was yeah, a sense of—it was a lot easier for me, I feel, to let go and talk about my issues with people that didn't know exactly what I went through.

And I think also in my time at Minnesota Teen Challenge, I felt that it was much more—I wasn't just a number going through a revolving door. I felt like I was a person that they loved and that they cared about and they wanted regardless of what they got paid, regardless of what—they wanted to see me better and they wanted to see me better for my family, for my kids, and it was the faith-based part of it.

Once I was getting better, you know, ultimately hanging onto that religion, hanging onto God is—has a plan for me. God has a reason for me to live. Although I went through some of the things I went through, there is a reason for it, and I can be used and I can be loved and that was a big part of it as well, was the faith-based aspect that really led me to believe that you know what, even though everything that happened happened, I am loved and I have a future and there is a plan for me.

Ms. BUERKLE. Thank you very much, and I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Lamborn, any questions?

Mr. LAMBORN. My questions have basically already been asked and answered. I thank you for your service.

Mr. HANSON. Thank you, sir.

The CHAIRMAN. You said that Teen Challenge wanted you to be better.

Mr. HANSON. Yes, Mr. Chairman.

The CHAIRMAN. Do you think the VA wanted you to be better?

Mr. HANSON. I do absolutely, Mr. Chairman, I just feel that it was—I don't know if I want to say a generic sort of feeling better, if that even makes sense, but I feel like it was much more at Minnesota Teen Challenge it was much more——

The CHAIRMAN. Personal?

Mr. HANSON. Yes. Thank you. It was much more personal, yes, Mr. Chairman.

The CHAIRMAN. You said that even though VA screened you positive for PTSD, they never mentioned any option for immediate care and there was no immediate action on their part.

Mr. HANSON. No, Mr. Chairman, I actually was screened the first time and they said that I was fine. Then in a follow-up appointment, they just gave me a random survey in which I answered positively to on several questions on a scale of one to ten. Then they sent me a follow-up letter that said, you seem like you might have some PTSD issues so we would like to do a follow up.

Then I did a follow up and they suggested some outpatient things, but they didn't suggest anything really on a larger scale.

The CHAIRMAN. So again, we all have voiced our opinion. We thank you for your service to our country and your courage to testify before both the Senate and the House. We appreciate what you are doing. You are making a difference, and with that, we thank you for being with us today.

Mr. HANSON. Thank you. Thank you, Mr. Chairman. Thank you very much.

The CHAIRMAN. Now I ask the second panel if they want to begin making their way to the table. Dr. Karen Seal, a Clinician and Researcher at the San Francisco Department of Veterans Affairs Medical Center (VAMC); General Terry Scott, Former Chairman of the Veterans Disability Benefits Commission; and Dr. Sally Satel, Resident Scholar at the American Enterprise Institute. We thank you all for being here with us today.

Let us begin with Dr. Seal, you are recognized.

STATEMENTS OF KAREN H. SEAL, M.D., MPH, STAFF PHYSICIAN, MEDICAL SERVICE, SAN FRANCISCO DEPARTMENT OF VETERANS AFFAIRS MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, AND ASSOCIATE PROFESSOR IN RESIDENCE OF MEDICINE AND PSYCHIATRY, UNIVERSITY OF CALIFORNIA, SAN FRANCISCO; LIEUTENANT GENERAL JAMES TERRY SCOTT, USA (RET.), CHAIRMAN, ADVISORY COMMITTEE ON DISABILITY COMPENSATION; AND SALLY SATEL, M.D., RESIDENT SCHOLAR, AMERICAN ENTERPRISE INSTITUTE

STATEMENT OF KAREN H. SEAL, M.D., MPH

Dr. SEAL. First I just want to recognize Mr. Hanson for his bravery and courage coming forward to tell his story which, you know, as a clinician at the VA I hear weekly, and it motivates me to do the job that I do, it also motivates us at VA to figure out how we can better individualize treatment, so I just wanted to acknowledge that and thank him very much.

Good morning, Chairman Miller, Ranking Member Filner, and Members of the Committee, thank you for giving me this opportunity to testify today.

I will begin by placing my comments in context. I am a primary care internist based at one VA facility, the San Francisco VA Medical Center. In this capacity, I direct the integrated care clinic OEF/OIF veterans.

The clinic at the San Francisco VA Medical Center is novel in that it offers all new OEF/OIF veterans a one stop three-part ini-

tial visit with a primary care provider, a mental health clinician, and a social worker.

The integrated care clinic providers are all integrated and co-located within the primary care clinic and are trained to address post-deployment health concerns.

I am also an Associate Professor of Medicine and Psychiatry at the University of California, San Francisco and in this capacity, conduct clinical research that is focused on gaining a better understanding of the burden of mental illness in OEF/OIF veterans who use VA health care.

Based on my experience as a clinician and researcher, I offer my prospective first on the mental health problems of OEF/OIF veterans who use VA health care, second on utilization and barriers to VA mental health services, and third, current efforts by VA to overcome barriers to mental health care for OEF/OIF veterans.

I conclude with some thoughts about how VA might further meet the mental health needs of the several hundred thousand men and women who have served this country and deserve the best care possible.

Rates of mental illness, particularly rates of PTSD among OEF/OIF veterans enrolled in VA health care, have increased steadily since the conflicts began in 2001, closely followed by increasing rates of depression.

According to the most recent data released by VA in January 2011, over 300,000 OEF/OIF veterans, or 51 percent, or one in two veterans, has received one or more mental health diagnoses, and 27 percent, more than one in four veterans has received diagnoses of PTSD.

Our research indicates that not all veterans have been affected by war in the same way. Younger, active-duty veterans are at particularly high risk for PTSD and drug and alcohol abuse, whereas older National Guard Reserve veterans are at higher risk for PTSD and depression.

Rates of depression, anxiety, and even eating disorders are higher in women than in men. Female veterans who have experienced military sexual trauma are at four times the risk for developing PTSD as women who have not experienced military sexual trauma.

Appreciating these subgroup differences in OEF/OIF veterans seeking VA health care will help VA better implement more targeted interventions and treatments, as well as guide future research.

In 2007, the Institute of Medicine determined that only two therapies for PTSD Prolonged Exposure and Cognitive Processing Therapy, had sufficient evidence for the effective treatment of PTSD. Both therapies have been endorsed by VA and many VA mental health specialists have been trained to deliver these therapies to their patients in mental health clinics. These therapies require a minimum of nine or more sessions, ideally spaced at weekly intervals.

Our research showed that 80 percent of OEF/OIF veterans with new PTSD diagnoses attended at least one VA mental health follow-up visit in the first year of their PTSD diagnosis; however, unfortunately less than 10 percent of veterans with new PTSD diag-

noses attended a minimum number of sessions within the time frame required for evidence-based PTSD treatment.

We found that being young, less than age 25, and male, having received a mental health diagnosis from a non-mental health clinic, such as primary care, and living far from a VA facility, greater than 25 miles away, were all associated with failing to receive adequate PTSD treatment.

Because adequate, evidence-based PTSD treatment may prevent chronic PTSD, VA needs to focus on developing interventions designed not only to improve initial engagement in mental health treatment, but also retention in care.

Patient barriers to mental health care among OEF/OIF veterans include stigma, logistical barriers, and even the symptoms of the mental health disorders themselves, as you heard today. Avoidance in PTSD, apathy and depression, and denial and self-medication with drugs and alcohol may prevent veterans from seeking care.

The persistence of "Battle Mind" mentality, in other words continuing to think that symptoms like hypervigilance are as adaptive rather than problematic after returning home, has also prevented many veterans from seeking the care they need.

From a system standpoint, VA has not always been able to keep pace with the growing demand for specialty mental health services. System barriers include shortages of mental health personnel trained in these evidence-based mental health treatments. There is a lack of universal access to video teleconferencing, known as telemental health in which rural veterans can receive specialty mental health services at VA community-based clinics delivered by specialists based at VA medical centers.

In addition to the barriers we hear about frequently from veterans, difficulties navigating the VA system to make appointments, lack of extended hours, and drop in appointments, and lack of services for families and children, which tends to differentially impact women, there are some other potentially challenging barriers to mental health care.

For instance, while IT security is clearly important, excessive security concerns may be limiting the development and more novel Internet and telephone-based mental health treatment options that would expand access to VA mental health services and appeal to this younger generation of veterans.

In addition, privacy concerns about the Department of Defense's access to veterans' electronic medical records have discouraged some veterans from coming forward and disclosing more sensitive mental health symptoms, such as substance abuse and domestic violence.

In fact, in contrast to the under-utilization of mental health services, OEF/OIF veterans with mental health disorders disproportionately use VA primary care medical services. Capitalizing on this trend, VA might consider a further restructuring of VA services such that more specialty mental health providers trained in evidence-based mental health treatments are embedded within VA primary care. This may even involve infrastructure changes to existing medical clinics to accommodate the co-location of more specialty mental health providers in primary care. These structural changes could literally break down the walls that exist between

medical and mental health services, overcome stigma, and narrow the gap between primary care and mental health.

For instance, pre-scheduling mental health visits to occur at the same time as a veteran's primary care visit, as we do in our one-stop integrated care clinic at the San Francisco VA Medical Center, could make it more likely that patients will attend and be retained in mental health care.

In addition, new clinical resources available through the VA Medical Home Patient Aligned Care Teams (PACT) in VA primary care, such as nurse care managers, could be leveraged to facilitate engagement of veterans in mental health treatment. For instance, PACT nurses could act as "motivational coaches" to remind or encourage veterans to attend mental health appointments while at the same time working with veterans on behavioral concerns or physical complaints that often accompany the mental health problems.

PACT nurses could also provide veterans access to new technologies such as the VA Internet site My Health*e*Vet or smart phone applications, such as PTSD Coach, to enhance access to online mental health treatment or treatment adjuncts. Finally, there is a need for more research to develop and test modified evidence-based treatments for PTSD that are better suited to primary care settings.

In summary, OEF/OIF veterans have extremely high rates of accruing combat-related mental health problems. Despite this large burden of mental illness, many OEF/OIF veterans do not access of receive an adequate course of mental health treatment. Veterans with mental health problems disproportionately use VA primary care medical services. The VA has already made advances through the VA primary care mental health integration initiative, and more recently the VA Medical Home Patient Aligned Care Team model. Thus, VA is now well-positioned to take the next step to address many of the remaining barriers to mental health care by incorporating more specialty mental health services within VA primary care settings. In this way, VA can continue to work to meet the growing mental health needs of this current generation of men and women returning from war.

Thank you.

[The prepared statement of Dr. Seal appears on p. 63.]

The CHAIRMAN. Thank you, Doctor.

General, it is good to see you again, and you are recognized.

STATEMENT OF LIEUTENANT GENERAL JAMES TERRY SCOTT, USA (RET.)

General SCOTT. Well, thank you Chairman Miller and Members of the Committee, it is a pleasure to be with you today.

My oral remarks will be brief. I hope that my complete written statement can be included in the record of the hearing.

The CHAIRMAN. Without objection.

General SCOTT. I am presently the Chair of the Advisory Committee on Disability Compensation chartered by the Secretary and in compliance with the Public Law 110–389, and this Committee has forwarded reports to the Secretary that has addressed our efforts.

Our focus has been on disability compensation on the revision of the VA Schedule for Rating Disabilities (VASRD), on procedures for servicemembers transitioning to veteran status with special emphasis on the seriously ill or wounded, and on disability compensation for non-economic loss, sometimes referred to as quality of life.

Recently we have added a review of individual unemployment, a review of the methodology for determining presumptions, and a review of the appeals process and its effect on disability compensation.

My discussions with your Committee staff included a request that I review the pertinent findings and recommendations of the Veterans Disability Benefits Commission that met from 2004 to 2007 and made 113 recommendations covering a wide range of veterans disability issues.

Specifically, I was asked to discuss the VDBC recommendation to integrate compensation, treatment, vocational assessment or training, and follow-up examination for veterans suffering from mental disability to include PTSD.

The VDBC invested significant time and effort in analyzing the then current methods of diagnosing, evaluating, and adjudicating the claims of veterans suffering from mental illness, including PTSD.

The principal source documents that we used in the analysis were those you mentioned, Mr. Chairman, at the outset of the hearing, a 2005 report by the VA Office of the Inspector General and an Institute of Medicine study completed in 2006 entitled, "Post-Traumatic Stress Disorder Diagnosis and Assessment."

These studies, and the testimony of veterans, family members, medical professionals, and VA subject experts provided the basis for such recommendations that the VDBC offered. The complete recommendations and accompanying explanations are in my written statement.

The key recommendation of the VDBC was to change the VA approach to diagnosing, evaluating, adjudicating, and treating mental disability by establishing linkage among compensation, treatment, vocational assessment and rehabilitation, and follow-up examinations.

The purpose of the follow-up examination would be to determine the efficacy of the treatment that is being undergone.

The benefits of linking these factors might very well enable us to reduce homelessness, suicide, and substance abuse, as well as to evaluate the effectiveness of various treatment programs.

Most importantly, it greatly improves the opportunity for a veteran suffering from a mental disability to maximize his or her future contributions to society, which is what we should all be about.

Now, I understand that this recommendation is somewhat controversial in many circles. For one thing, it dramatically changes the role of the Department in evaluating and treating mental disability.

The principal arguments against the linkage are that it will be viewed by some stakeholders as a mechanism to reduce disability payments and that it differs from how the Department addresses physical disabilities, vis-à-vis, mental disabilities. Both of these ar-

guments can be addressed with carefully written and explained regulations and policy directives.

The VDBC offered a recommendation that offered an approach to compensation that recognizes the relapsing and remitting nature of these illnesses.

Regarding the differences in approach, the physical versus mental disabilities, there is significant evidence that individuals with mental disabilities are less likely to seek and maintain a treatment regimen than those with physical disabilities.

There is of course a resource bill that accompanies an expanded treatment mandate and the Committee was aware of that and as I am sure most of you are; however, the VDBC recommendation to link compensation, treatment, vocational assessment and training, and periodic reevaluation offering an opportunity to reduce homelessness, suicide, and substance abuse among the veterans. Such an approach should offer some long-term help for mentally disabled veterans and improve their chances for integration into society.

I would like to thank you, Mr. Chairman, and Members of the Committee for the opportunity to present to you today. I will be happy to respond to any questions you may have now or as the hearing goes forward.

Thank you.

[The prepared statement of General Scott appears on p. 72.]

The CHAIRMAN. Thank you very much, General.

Dr. Satel.

STATEMENT OF SALLY SATEL, M.D.

Dr. SATEL. Thank you, Mr. Chairman and Committee for the invitation to be here.

My name is Sally Satel, I am a psychiatrist who formerly worked at VA in West Haven Connecticut and now I am a Resident Scholar at the American Enterprise Institute.

In the current system as we have seen and as we have been discussing, a veteran can receive disability compensation for a psychiatric condition that has never been treated.

A straightforward approach to bridging this gap, and the kind that General Scott has been focusing on, is an urge of course to integrate VBA and VHA so that claimants are referred for treatment. I am certainty not the first to suggest this.

But integrating compensation and care while a definite advantage over current practice, does not address the timing issue. That is whether veterans necessarily benefit when the disability claims process can proceed care and that is what I want to focus on now.

We have to consider the fact that compensation before care, that kind of a sequence of granting disability claims before a veteran has been treated, can sometimes have significant draw backs.

For one thing, it is very difficult for a compensation manager to make an accurate assessment of a veterans future function, that is whether or not he or she will continue to be disabled in a way that impairs employability before treatment and rehabilitation has taken place.

As clinicians know, not everyone in pain with symptoms or a diagnosable mental health disorder is going to be disabled, that is impaired in terms of future workplace function.

Beyond the matter of accurately judging functional impairment, which I have been saying is kind of hard to do as a compensation and pension (C&P) manager without the person being in treatment and rehabilitation first, there is the possibility that with our current sequence of being allowed to receive and file disability claims before treatment, that despite the best intentions of this system awarding disability status prematurely, especially at levels that indicate unemployability can actually complicate the veterans path to recovery.

Now consider the example below based on an actual case. This is a young soldier, we will call him Joe, who was wounded in Afghanistan. He has classic PTSD, noises make him jump out of his skin, he is flooded with bloody memories and nightmares, he can barely concentrate, and he feels emotionally detached from everything and everybody. He is 23 years old, about to be discharged from the military. He is afraid he will never hold a job, he will never integrate fully and function fully in society, and he applies for total disability compensation from the VA.

And on its face, this seems quite logical and granting those benefits seem quite humane. But in reality, this is probably the last thing that this young soldier turning veteran needs. And what I mean by that is that compensation at a high level can confirm the fears that in fact he will remain deeply impaired for years, if not for life.

Now that is a sad verdict for anyone, but it is especially tragic for someone who is only 23.

You know, imagine telling someone with a spinal injury they will never walk again before he has even had surgery or physical therapy.

Now a rush to judgment as well meaning as it is about the prognosis of psychic injuries can carry significant long-term consequences insofar as a veteran who is unwittingly encouraged to see himself as seriously and chronically disabled, risks fulfilling that prophesy. Why should he even bother with treatment he might think, which of course is a terrible mistake, because this period soon after separation as a veteran as quite as young is when mental wounds are most fresh and when they are most responsive to therapeutic intervention.

But Joe is told he is disabled and he and his family may assume, typically incorrectly, that he will never be able to work, he will no longer be able to work. This becomes a self-fulfilling prophesy in many cases and ending up depriving the veteran of work itself, which has enormous therapeutic value. It is also quite demoralizing, and once a patient is caught in a downward spiral of invalidism, it can be very hard to throttle back out.

For example, even if he wants to work very much he understandably fears losing that financial safety net if he were to get off the disability roles.

Now of course this suggests, everything I have just said so far suggests, a sequence that would begin with treatment and move to rehabilitation. And then if necessary, the veteran would go on to become assessed for disability, if he was not improving, but this can't be all.

Any person who is too fragile for employment while he is in treatment will need to receive a living stipend. A treatment first approach could not work without some sort of living stipend for the veteran and his family.

Now in closing, however, this gap between care and compensation is to be closed, there are at least four important things to remember.

First, there has to be sufficient information for the C&P examiner. He needs to make a good determination about ongoing employability, and without a course of quality treatment and rehab, there is often not enough information to make judgments about disability.

Two, except for total and permanent disability and Individual Unemployability (IU) status, reevaluations every 2 to 5 years are vital and also communicate the expectation of improvement.

Three, while a veteran is getting care neither he, she, nor the family should suffer economically.

And four, we should try as best as we can to avoid premature labeling of disability that down plays the recovery prospects.

It is reasonable and important to instill the expectation that most veterans will get better, they are changed by their wartime experience naturally, but that they will find a comfortable and productive place in the community and their family.

Finally, conferring a high-level disability status upon a veteran and the chronicity of dysfunction that that implies before his prospects for recovery are known, can make the long journey home even harder than it is.

Thank you very much.

[The prepared statement of Dr. Satel appears on p. 74.]

The CHAIRMAN. Thank you very much.

Dr. Satel, you raised the issue of prematurely granting disability compensation and caution against the perverse incentives that such a designation may have.

How can we balance the need to encourage early and effective treatment with the financial reality that many young servicemembers have when they return from combat and are experiencing mental health problems?

I think you may have addressed it from the fact that you said a treatment with some type of a stipend, but could you elaborate a little further?

Dr. SATEL. Well, that is the basic idea, that there would have to be some sort of living stipend. The important thing in my view is to not call it disability. It could be as generous, it could be more generous even than his disability rank might have been if he were assessed for a claim right out of, you know, right off the bat without first getting treatment. That is not my concern.

My concern is that the family and he not worry about their support, that will impair his ability to get better, of course just that financial security is so anxiety provoking I don't see how anyone could get better, and the family shouldn't suffer at all either, but call it a wellness stipend, call it a treatment scholarship, call it something. But I personally prefer not—the word disability has so frayed it now frankly in the—well, I work in a clinic because I have

seen this in Social Security and also in the VA, that I feel the language here is important as well.

The CHAIRMAN. General, your Commission recommended periodic reevaluation of PTSD every 2 to 3 years to gauge the treatment and effectiveness and to encourage wellness. Did the recommendation extend to veterans of all eras?

General SCOTT. Yes, sir, I would say that it does. I would say that we have an opportunity here with this young group of veterans to start the process that we have not chosen to begin in the past, but I would say that it probably should apply to all.

You know, I would be the first to say and I am certainly not a clinician or a medical doctor, that every case is different, and the clinician should be the person who decides it every 2 years, 3 years, 5 years, or whatever.

So it is probably not a cookie cutter approach, but it is something that I believe could be decided inside the treatment part of VHA.

The CHAIRMAN. And Dr. Seal, in your testimony you said despite the initial use of VA mental health services among OEF/OIF veterans retention in VA mental health services appears less robust. You also noted that compared to studies of civilians retention in VA mental health treatment appears inferior. How do we improve it?

Dr. SEAL. Well, I think I laid out in my oral testimony some ideas for how to improve it. We know that OEF/OIF veterans are coming into primary care. They are coming into primary care for physical complaints. Often pain and other physical complains do keep company with PTSD and depression, so they come to primary care. We are trying to meet veterans where they are, at least in our clinic.

I think we run into difficulties when we separate mental health from primary care and we don't adopt a more holistic approach.

It is very difficult sometimes for veterans to come into primary care, seek care for their physical complaints, then have a separate appointment at a separate time in a separate building for their mental health complaints.

I think if we can bring the two together more holistically I think veterans would be more likely to stay in care.

I also think that sometimes it is difficult to come to the VA at all. People have jobs, they go to school, and I think we really have to be open to more innovative approaches to deliver specialty mental health care, and that is why I brought up the use of the Internet, the use of the telephone, and even iPhone applications that can serve as mental health treatment adjuncts.

I think we need to broaden the way in which we deliver specialty medical health care.

The CHAIRMAN. Thank you.

Mr. Filner.

Mr. FILNER. Thank you for your testimony.

Dr. Seal, I appreciate your specific recommendations from my own experience and I think they have a lot of merit.

There is so much of the testimony that we get from people who have had problems. Mr. Hanson, who was on the panel before you was turned away by the VA. I don't know if you saw his written testimony. Each of the suicide cases that occurred in the United

States was preceded by attempts to go to the VA for help. Mr. Hanson used the phrase turned away. Our veterans have to almost fight to get care.

I just had a constituent who was fighting for months for VA to take him seriously, and nothing occurred, he then committed suicide.

So once you get in, your reforms make sense. What is going on with the testimony that we get from our veterans? Is it subjective or is it their impression? If it is their perception, it is obviously meaningful. Why do so many veterans feel they can't get the help that they need when they go to the VA? It seems that all of the cases that we hear about involve that in some way.

Dr. SEAL. Well, I think you raise a very, very important concern.

I do meet veterans who come into my clinic who say that it was hard for them to figure out how to come into our clinic, and yet there are other veterans who walk into the building, go to the combat case manager, are literally escorted upstairs, an appointment is made, and in many cases, they are seen the same day.

So I think there is a wide variation of experience, which isn't to say that it isn't tragic when one person is not able to get services and commits suicide, obviously that——

Mr. FILNER. By the way, why is there such variation in the national system that we have? That is, don't we have common policies and supposedly common sense training?

Dr. SEAL. I think there are common policies and I think there are common standards, but I think there really are regional differences.

We have VA medical centers, we have VA community-based outpatient clinics (CBOC), and we have other types of VA facilities that don't even fall under that description, and I think some VA facilities are not sufficiently resourced with outreach workers, and with administrative staff to handle the influx of veterans that are coming in. I actually think we could use more combat case managers.

In fact, at our VA Medical Center, I just learned that they are no longer called OEF/OIF combat case managers, they are now in some more generic social service role, and I think that it is exceedingly important that we maintain that particular position at all VA facilities, so that we have VA outreach to communities, and when veterans come into VA, they are met with somebody that knows exactly what they need and can literally escort them through the process of enrolling in VA through member services in order to receive care.

Mr. FILNER. You might supplement your written recommendations with looking at that aspect too for us, that would be great.

We have had hearings in this room recently and we will have more on employment and on PTSD. You know, we have 20, 25 percent unemployment with OEF/OIF veterans, surely they could help our veterans. We ought to be hiring them. They could get training in this area. And help brothers and sisters who are coming in and they could help guide them.

Do you think there is a bigger role for our veterans and that you could work with them and get them at least some of the training they might need——

Dr. SEAL. I think that is an excellent idea.

Mr. FILNER. I think we each have a responsibility to these kids to do that.

Dr. SEAL. But I think again we have to look at resources, and at our VA there is a hiring freeze, so I don't know—I am not exactly——

Mr. FILNER. I don't mean to interrupt you. Mr. Chairman, I have heard this in several places that there is a hiring freeze.

We have the biggest problem we have ever had, we have given the VA more money than they have ever had and we keep hearing about a hiring freeze. What is going on here? We are under resourced, you say?

We have increased the VA budget every year, as long as we have been here it is 60, 70 percent higher than it was just 5 years ago. What is going on? Do you have any sense of that from where you are?

Dr. SEAL. Well, I mean, I think it is important to look at where I am. I am a primary care clinician and I am a researcher, so I don't know that I can answer for VA.

Mr. FILNER. I keep hearing this and yet from our perspective we keep pouring in money and then we hear there is a hiring freeze.

Dr. SEAL. Well, it depends where you want to spend the money. The money has been spent to greatly expand the capacity of mental health services.

So we are hiring psychologists, we are hiring psychiatrists, but what you were talking about is different, you were talking about an outreach worker which is——

Mr. FILNER. I wasn't talking about the hiring freeze but you brought it up. You said you have a hiring freeze, so for what jobs do you have a hiring freeze?

Dr. SEAL. Well, I don't know if there is a hiring freeze on everybody at the San Francisco VA. I know for clinicians there is right now because we have greatly expanded our mental health services capacity. That may not apply to outreach workers, I actually don't know.

Mr. FILNER. By the way, you have joint employment with the university and with the——

Dr. SEAL. Yes.

Mr. FILNER. What percentage do you have with each?

Dr. SEAL. I am five-eighths VA and three-eighths university employment.

Mr. FILNER. I know hospitals where the employees are one-eighth VA, seven-eighths university, and yet we say we have eight psychiatrists on staff when there is only one. I never underrate the importance of research and you know the daily needs, and also your own integrated life, but with all the clinical needs it seems that we shouldn't be putting people on seven-eighth time. If they want to do research let them do it, but let us get full-time clinicians in there.

Dr. SEAL. So just to clarify I am based 100 percent at the VA, so I am partially supported by the university through my own grant funding, but I am based 100-percent of the time at the VA.

Mr. FILNER. Okay.

Dr. SEAL. And interestingly, all of my research involves access to mental health care for OEF/OIF veterans.

Mr. FILNER. I understand. I know universities where it is the other way around, they are mainly at the University.

Mr. Chairman, it seems that we have the heart of the problem where we keep thinking we are giving the resources, but then we hear from the field and from people like Mr. Hanson that we just don't have the resources to do the job, so we have to figure this out.

The CHAIRMAN. Well, we did hear yesterday in our sexual assault hearing where we thought dollars were being spent for security we are now finding out that some of those dollars are being redirected and not going where they need to be. Obviously this is outside your lane, but it is an issue that this Committee needs to address.

And thank you, Mr. Filner.

Mr. Bilirakis.

Mr. BILIRAKIS. Thank you very much, Mr. Chairman.

Dr. Satel, with regard to your proposal, are you saying the veteran will not seek treatment, because he or she has financial obligations and also possibly because of a stigma?

And then I want to also—well, why don't you answer that question first.

Dr. SATEL. Well, the reason for the financial stipend would be because if we expect people to be in treatment, and even if the possibility was endorsed of actually requiring it, and I know that is very controversial, meaning requiring it as a condition of being considered for disability, we certainly can't expect someone to be in treatment intensive care before—intensive care that either takes up a lot of their time where they would otherwise be working, or that they are simply not fit to work. You can't expect that of them without providing income support. That is what I mean.

Mr. BILIRAKIS. Yeah, and we definitely have to have this stipend if we go forward with this.

The other question is how long, what kind of a time frame are you talking about as far as determining a person's disability rating? If you can answer that question as well. I guess does it depend on an individual case?

Dr. SATEL. Definitely. Definitely.

Mr. BILIRAKIS. Okay. But can you give me maybe a time frame, approximate time frame?

Dr. SATEL. You know, for some individuals who are very impaired at the time, it could take up to a year. For others, it could take a few months.

Mr. BILIRAKIS. Thank you.

Could I ask the panel if they wanted to give their opinion whether this proposal has any merit? You are welcome to respond if you would like.

Dr. SEAL. I think it is an interesting proposal. Immediately I think I was struck with something that I know clinically; that is, I know that when a veteran is ready to come forward for treatment is probably the best time to treat them, and I am a little concerned about the potential for coercion or the sense that well, now it is time to get treatment and we will pay you to do it and they are not truly ready or receptive for treatment.

I was struck with our previous testimony that when he was ready for treatment he, Mr. Hanson, found the right treatment and he responded to it, and I see that over and over again.

I don't think that people all develop PTSD symptoms at the same time after leaving the service. I think there is a natural history of PTSD. I think some people develop it immediately. In some people it can take years to develop. People are ready for treatment at different times. Often you hear a "hitting-bottom" phenomenon, so I worry about the institutionalization of treatment; or a semi-coercion or payment for treatment, just some concerns.

I am not saying that it is a bad idea across the board, but I think we would have to give it a lot of thought to how it was implemented.

Mr. BILIRAKIS. Okay. General, would you like to speak on that?

General SCOTT. Well, I think we would have to very carefully lay out exactly how we were going to balance compensation and treatment.

Certainly the individual who is clearly disabled, and I believe the Secretary has the authority to grant disability on pretty short order on a temporary basis and I believe he could do that. Certainly a stipend for someone who is significantly disabled while undergoing treatment is required as was pointed out.

I think you have to be careful about forcing people into treatment who are not ready. But on the other hand, I think we have an obligation to try to be sure that all the people who are ready are enrolled and getting the treatment, back to Mr. Filner's comment earlier about people who commit suicide or do things and then they say well, we couldn't get treatment.

So I think this is a complicated issue and there is no one solution fits all, but I do believe that a relationship between treatment and compensation and an assessment, which gets at Dr. Seal's question, and some follow-up evaluations can be worked out in such a way that it is beneficial.

Mr. BILIRAKIS. Thank you very much.

And thank you, I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Michaud?

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. Seal, in your testimony you pointed out that older National Guard and Reserve veterans are at higher risk for PTSD and depression. Can you speak to why members of the Guard and Reserves face these unique mental health challenges?

Mr. HANSON. Well, I think part of it is the discrepancy of taking an older Guard or Reserve member who is established in their community or their job and there may not be as much training for them. You put them in a war zone, and they may be less well-equipped to be in that war zone than active-duty personnel. Then they come back and are expected to reintegrate into their jobs, their communities, their families, and I think the disparity between those two worlds sometimes can be truly overwhelming. I think that is why we tend to see that in older Guard and Reserve members as compared to younger Guard and Reserve members who may be a little less established already in jobs, communities, et cetera.

Mr. MICHAUD. Thank you.

Dr. Satel, when we talk about PTSD, a lot of the focus over a number of years has been—the last few years anyway—has been on OEF/OIF veterans. You know, that being said that that there is definitely a significant number of Vietnam veterans with PTSD from the Vietnam War.

In your work, have you seen any unique needs for us addressing the Vietnam veterans as it relates to PTSD compared to the OEF/OIF veterans?

Dr. SATEL. Well, one thing that is very relevant it seems to me to people who are from the Vietnam era is that from a developmental standpoint they are now entering the retirement phase of life and that is when a lot of folks, not just veterans, but a lot of people feel when they finally retire it is—they are sometimes very excited about it, but it also can be a very stressful dislocating milestone in one's life. It is also coincident with aging and illnesses and your spouse getting sick, and that is a time where veterans can be vulnerable to a recurrence of symptoms that have been dormant for decades often. And as I said, we often see that with regular civilians where people get kind of, you know, go through a period of depression and it acts as that kind of a dislocation at that time.

In the case of veterans who had PTSD symptoms at one time, this is the period where they should be alert for reemergence of symptoms.

It is treatable in almost all cases and people do regain their footing, but it is a period that can be fragile and we should be aware of that.

Mr. MICHAUD. In order to address that issue, specifically with the Vietnam veterans, what do you think the VA should be doing as far as should be doing different type of programs or to address that concern that you just raised?

Dr. SATEL. No. Again, it depends on what the person presents with. If they present with a severe major depression or a full-blown recurrence of symptoms, we would sort of symptomatically treat them of course. But then it is more a—but for many people it is a kind of—it is a kind of psychological process where they come to terms with—they have to figure out really how to start the second or third, you know, part of their life. And again, that is just sort of regrouping and rethinking that that many people go through, and those strategies are again highly individual and you treat everyone, you know, with their own situation and you would want to know what their interests were, you know, how people again find themselves as they mature.

Just frankly, a competent clinician, open minded, should be able to navigate someone through that phase.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

The CHAIRMAN. Would it surprise any of you at the panel, I was just looking over some numbers from 2001 Vietnam-era PTSD claims, or benefits I guess, 106,801 is the number, the base number. In 2010, the number now is 269,000. Does that seem inordinate to you? I am sorry, any of you?

General SCOTT. I think there are a couple of factors that were looked at by the VDBC and others, and one of them was the recognition of PTSD as a disability.

Ten to 15 years ago there was a significant number of people in and out of the military, in and out of the veterans' community who really thought that PTSD was somewhat of an imaginary disease, that it wasn't there, and I think that over this period of time between 2001 and the present, it has become certainly more widely recognized. This is not to say that there was never recognition during that period of time, because the clinicians and others there were a lot of books written and understanding, but for the average person, veteran or non-veteran, knowledge and understanding of PTSD is a fairly recent phenomena, so that would be point one on the increase.

People suddenly realized, well, I have some of these symptoms, or they would say my husband has some of these symptoms, I am going to get him in and get him checked out or whatever. So I think that was a part of it.

Also the opportunity to receive treatment inside the VA, you know, in my judgment, increased dramatically over that period of time.

And so whereas in 2000 and 2001, if a person had presented and said, you know, I have this, I have that, this is wrong, that is wrong, it probably would not have been sort of categorized as saying, okay, well, these are symptoms of a PTSD, some of them, so we are going to get him into a treatment program that the VA now has, which was not present in the past. So that is two of them.

There has also been, and I say this somewhat advisedly, some amount of people who as they reached a retirement age were looking for perhaps some other, you know, they went through a crisis and they realized they had a problem and they presented themselves to the VA or to medical authorities and said, well, you know, I am really doing poorly here.

So I think those are three aspects of it, but probably not the only three, and I defer to these two clinicians here to either amplify that or to refute it.

Dr. SATEL. It sounds right.

The CHAIRMAN. Very good.

Colonel Johnson.

Mr. JOHNSON. Well, thank you, Mr. Chairman, I thank the panel for being here today.

As a veteran myself I have great concern about our young men and women that are coming back today experiencing PTSD. I have long maintained that there is one segment of our society here in America that we owe entitlement to and that is our veterans.

It is vitally important when they come back, I mean they are coming back today with experiences that most of us cannot imagine. They have seen their friends killed, they have seen their friends dismembered, disfigured, maybe even they have suffered that themselves, and yet we continue to debate as the Chairman and the Ranking Member have said, we continue to have these questions over and over and over again about the adequacy of the care.

You know, the veterans, one of the things that help them most when they get back is family support.

Dr. Seal, are there specific programs that reach out to the families of the veterans that have PTSD to help them understand how to deal with their loved one who is suffering?

Dr. SEAL. Well, I am most informed about our own VA Medical Center.

I do know that nationwide, VA is putting a great emphasis on the family, on support of families, and trying to educate families as to how they can help detect symptoms of PTSD and other mental health problems and how they can help their loved one access care.

Very recently there is a lot of emphasis being directed at the family from VA nationwide.

At our VA, we have a very robust family counseling program. I am very happy and pleased to say that when a veteran comes to see me and expresses marital problems, problems with parenting, or domestic violence issues, that I do have a specific place to refer them and I know that they are going to be taken well care of. It is not just for the veteran, but it is also for the veteran's spouse and/or the children as well. I don't know how unique that is, but I know at our VA, it is there and it is a very robust program, and I do know that there is a lot of attention now in VA nationwide being paid to family support and the importance of the family.

Mr. JOHNSON. General Scott, did your commission look into the family aspects in terms of your study?

General SCOTT. We looked into the family aspects of veterans disability at large. We looked at some of the issues surrounding the quality of life of the veterans who had returned and the impact of their quality of life or lack thereof on the families.

We made some recommendations regarding family care. I suppose some of the things we did may have been spade work for the Family Care Act that was passed here in the last Congress, I would hope so.

But in terms of looking specifically at the impact of family members on PTSD or the impact of family members when a member of the family suffering from PTSD, we did not look into it directly.

Mr. JOHNSON. Okay. I will just submit that these veterans they go into the—they volunteer, it is a family commitment, it is not just a veteran commitment, and I think we need to look deeper at the involvement of the family in their rehabilitation and their treatment.

Just a quick question. I heard, you know, nightmares, flashbacks. To put these folks on a track to recovery and get them ready to go back into the workforce they have to be able to work, which means they have to be able to sleep.

Do you have any idea, are there numbers out there that reflect how many of veterans with PTSD suffer from sleep apnea or anything like that?

Dr. SEAL. Well, did you want to make a comment?

Dr. SATEL. I would say that sleep disturbance is one of the most common symptoms. So you may well have actual epidemiological data on it, but impressionistically and clinically, the vast majority I think have sleep problems.

Dr. SEAL. It is part of the hyper-arousal symptom cluster that you see with PTSD, so it is almost hallmark for most veterans who

suffer from PTSD, and sometimes if we can actually address their individual symptoms, particularly in primary care, such as sleep, we can help them be more amenable to core PTSD therapy by specialty mental health clinicians.

So it is extremely important that we focus on individual symptoms that are treatable.

Mr. JOHNSON. Okay, thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Dr. Seal, I appreciate your evidence-based approach to this whole subject. It is important that we have a basis for what we expend our resources on in treating veterans, so thank you for that hard work.

What are your specific recommendations for improved retention in the mental health programs of some of these veterans? You gave some statistics, you didn't say the dropouts, but people that stayed in and people that didn't, what can the VA do to help retain people in these programs?

Dr. SEAL. Well, I think I made some comments earlier about embedding more of the treatment where the veterans present, which is primary care, but I would also say that VA has done a lot to invest in the VA Medical Home and our PACT teams, which are Patient Aligned Care Team nurse care managers who could actually be leveraged to make reminder phone calls, conduct a therapy called motivational interviewing over the telephone, send secure e-mail messages to veterans to remind them of appointments, and do even more than that over the phone, which would be trying to figure out what the barriers are to staying in care.

It is very difficult for veterans to stay in mental health treatment, because honestly, these evidence-based treatments, particularly at the beginning are not pleasant. It is not pleasant to go over and over your trauma many times, and we tend to lose veterans at the second or third sessions where they just can't take it anymore, and it is in really important that we try to retain them in treatment, because once they get over the hump, recovery is definitely possible.

But we need to really leverage the staff that we have at VA, such as our nurses, our outreach workers to help veterans stay in treatment, wherever they are, whether it is primary care or specialty mental health treatment.

Mr. MCNERNEY. Would you say that threatening to withhold disability payments would be an effective tool?

Dr. SEAL. I think that would be highly coercive.

Mr. MCNERNEY. Yes, yes, thank you.

Dr. SEAL. And I should add unethical, really.

Mr. MCNERNEY. Good.

Dr. Satel, one of the things you said that compensation before care can or may complicate treatment and recovery.

I am glad that you used that in your statement, because every individual is going to be different. Sometimes it might help as in the case of Daniel Hanson who thought that might have been helpful in his case, but I have heard that some of the housing programs that require veterans to be in treatment and be clean is also a

problem because it is a catch-22. If they are out on the street, they can't clean up, so it would be helpful for a lot of them to have housing provided even if they are using.

And so, I think it is very important to keep that in mind, how individual this is rather than trying to say well, geeze, we need to withhold treatment or we need to withhold payments or anything like that, because that would be I think counter-productive in most cases or a lot of cases.

Dr. SATEL. Oh, yes, I mean that sounds punitive and that certainly is not the intent, in fact someone earlier I believe it was Congressman Bilirakis said something about forcing people into treatment. Actually what came to mind as the others were answering that question is that it seems to me if a veteran felt in enough distress to want to come forward and file a claim, then there was enough distress and pain to desire treatment. But, as Dr. Seal said, a patient might be ready to go through desensitization and reexperiencing therapy, or not be ready to talk about his or her traumatic experience, which parenthetically I might say sometimes I think we impose these kinds of reexperiencing therapies too aggressively, but the point is he is in distress. There is usually almost always a way to engage someone who is in distress and through all kinds of things. How are things at home? What is it like being with your children again? The simplest things like that. What is your day like? You know, that is the kind of approach one might take.

We are not talking about forcing someone to go through therapies that they find distressing, I wouldn't even suggest that to someone who was a complete volunteer patient. We are not going to have you confront or participate in a kind of intervention that we felt was against your best interest in the short term.

Mr. MCNERNEY. Good. I mean what we are seeing here even with our first witness this morning was that treatment is most effective when the patient is ready to accept that treatment, so it might be best for us to find a way to encourage the patient to get to that point and to make sure that treatment is available for anyone who is at that point.

Dr. SATEL. Definitely. We want to engage.

Actually, Mr. Hanson said so many interesting things. He mentioned the holistic approach, which gets to the family situation, that was earlier mentioned, as opposed to a constant drum beat of emphasis on the military experience.

Some patients like that sense of being back in a cohort of fellows, and some don't. And again, I guess if there is one theme that is emerging from this is that there is so much individual variation and that is always hard for policy makers to reconcile because they obviously have to come up with a more generic kind of approach, but there are ways to build room into the system.

Mr. MCNERNEY. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Buerkle.

Ms. BUERKLE. Thank you, Mr. Chairman, and thank you to our panels this morning.

This issue of veterans being ready or someone coming out of the military being ready concerns me, because I think if contact is made, if someone calls a clinic or shows up in an emergency room

or talks to their primary care physician about symptoms, I think that the presumption on the part of the VA should be he is ready. I don't think we should wait for him to bottom out. And I am concerned with what I am hearing is that the VA doesn't create that culture, that environment where there are degrees of readiness, but we are ready right at the beginning to address this issue, and the presumption should be that everyone coming home is going to suffer some variation of PTSD, that is just the reality of what they are going through, and it seems to me that the VA should be prepared for that.

The military state of mind that I am tough, I can deal with that, we all know that is the culture of the military, but the VA should be ready to address that and be able to get around it, and I am concerned that based on what we heard from Mr. Hanson that maybe that is not the case.

Dr. Satel, do you want to comment on that?

Dr. SATEL. You know, when I was listening to Mr. Hanson, I was thinking there were so many other opportunities to essentially in his case impose the kind of structure that he needed earlier than he got it, and what I am referring to is the fact that unfortunately he was arrested he said a number of times.

The criminal justice system, there are veterans mental health courts, there are ways to take folks who are within the criminal justice system, because that is where there is leverage. I do a lot of work with drug addicted people, so that is an actual entry point into treatment, and he could have been essentially diverted to a drug treatment program. I mean thank goodness he didn't leave Teen Challenge, but under some of these diversion programs, you know, there are significant consequences for leaving and significant rewards in addition to recovery and reintegration into society, but another reward is that your charges are dropped when you complete them. So that was one way for him to come in.

Another possible way, you know, in retrospect this all looks neat, I realize this at the time, it is very difficult, but sometimes people who are incredibly out of control can be civilly committed by their families. That is difficult, but that can happen as well, and it is very hard and families are reluctant. I understand that, it is easy for me to say, but I mean there are—those kinds of mechanisms are already used in the mental health system.

Ms. BUERKLE. It seems to me the VA should be far more prepared and way out in front of all of this because of what we are seeing and the evidence is there.

Go ahead, Dr. Seal, then I have another question.

Dr. SEAL. I just really appreciated your comment. I think what you are saying is you want VA to be proactive and even more aggressive in terms of trying to detect a mental health problem if it exists.

And I mean again, I go back to our model, which is really almost—I don't mean to use the word passive as opposed to being aggressive, but it is passive in the sense that all new OEF/OIF veterans who come into primary care see a primary care clinician for 50 minutes. Then we literally walk them over to the mental health clinician who is actually a PTSD psychologist. They then see that

PTSD psychologist for 50 minutes whether or not they have screened positive for PTSD depression or alcohol use.

We just assume that if you have been to a war zone, you may have something to talk about. And if you don't have anything to talk about, at least you can hear about services that may be available to you when you are ready to talk. And then they see the social worker to discuss any benefits that they may be due.

So that is a program that is in place so that there is no question well, do I need this, do I not need that. They just get it when they come in.

Ms. BUERKLE. But if we listened to what Mr. Hanson said, he filled out a form and based on that initial interview, that form seems pretty, you know, black and white, and may depend on his outlook that day, and I think there is a bigger picture for these vets coming home that it may not just be as simple as ten questions on a scale of one to ten. It seems like the scope and the examination should go far beyond that.

And as you mentioned earlier, perhaps more holistic. Why are we separating mental health from the physical health? It seems to me we need to look at the entire health of that veteran and it all works together that he is healthy.

Just briefly, you heard Mr. Hanson talk about how he felt that the VA system was not as personal. He felt that the staff maybe didn't quite care as much as he found in Teen Challenge. He felt that there was no accountability. That concerns me.

I don't know if we have time to get that question answered, but perhaps if you would like to comment on that very briefly I would appreciate it.

Dr. SEAL. Again, I can only really comment from my own experience, and I feel like we—I can't speak for every clinician and every nurse and every clerk at VA, but I think we go the extra mile to try to reach out to veterans that are coming in. We know that for every veteran who comes in, that it wasn't easy for them to get there, that it took a lot of courage to come to VA, that it is not always a pleasant experience, and so we welcome them when they get there. We acknowledge their military service, and we give them contact information. I give them my card, I give them my e-mail. I know that I am technically not supposed to e-mail with my veteran patients because of VA policy, but if that is the only way they can reach me, that is how they reach me. And I have a pretty close personal connection with most of the veterans who come and see me. That is really all I can speak about, but I know that my colleagues in our clinics share that same approach, and I have met clinicians from all over the country who are dedicated to serving these veterans.

So it is very tricky, because PTSD by its very nature, and some of these other mental health problems, result in avoidance of care. It is one of the symptoms of PTSD, and so there is a bit of a dance between the patient seeking care and the providers wanting to deliver that care, and sometimes it takes a while before we can meet people where they are. A lot of the motivational work that we can do over the phone with veterans or a lot of the education, the psycho education we can give veterans, can be very, very helpful in preparing them to accept treatment.

Ms. BUERKLE. Thank you. I yield back, Mr. Chairman, thank you.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Well, thank you, Mr. Chairman.

Again, many of you in this room have heard me say often that I am the staunchest supporter of the VA system and the harshest critic, and that it is a zero sum game, that if one veteran falls through the crack that is one too many.

I also though am pleased to hear people talking about evidence-based policy and practice. Anecdotal evidence is no way to drive policy.

I would also tell, if I could, to the Ranking Member, I would say what is past is prologue. Our leadership of this Nation told us that the conflict that Mr. Hanson was involved in would be weeks, not months and that is how we prepared for it, and so the influx of veterans coming afterwards is a result of not preparing for that. We have been behind the eight ball for years and we are trying to get there.

With that being said, I certainly want to see us using the best policy, the best practices to get the best treatment for all these veterans.

I would tell my colleague from New York I live a few hours from the clinic that is being discussed here at St. Paul or in Minneapolis and in St. Cloud. The St. Cloud clinic treats 1,100 inpatients per year, they have a 90 percent completion rate. We have data that the evidence is driven. Again, if it failed for Mr. Hanson, that is a failure we can't live with. We have to be better.

My point in this hearing is, for us to focus on where the VA does well, strengthen those, some suggestions that come up to me, pre-deployment and post-deployment assessments to get a better baseline of where we are going. Some smart things like that.

I also would ask Dr. Seal, the VA medical center and I attend these monthly every month in one of them unannounced, go in and talks to folks.

In Minneapolis, for example, they have a geriatric psychiatric team that for 65 and older with complex age-related medicals, the team provides outpatient mental health services, they bring a multidisciplinary staff of psychiatrists, advanced practice nurse specialists and all of that. We are approaching this aren't we in some cases from holistic? Do you have that in San Francisco?

Dr. SEAL. Yes, we have a geriatrics clinic.

Mr. WALZ. Okay. How do you measure your success in your programs?

Dr. SEAL. How do we measure success? Not always at the end of treatment. A lot of the work that I do involves large national VA databases where we look at diagnoses. We aren't always able to see when a diagnosis remits.

Mr. WALZ. Would it be safe to say that the VA probably has as extensive data on practices and treatments and outcomes as any place in the world? Would that be safe to say?

Dr. SEAL. I don't know.

Mr. WALZ. Would you think it would be better than Teen Challenge's research?

Dr. SEAL. I think that——

Mr. WALZ. An outcome? Should we not be measuring these things? I say that because I know it was successful for Mr. Hanson.

Dr. SEAL. We should definitely be measuring these things, and I think individual clinicians within their individual therapies do measure PTSD symptoms at the start, in the middle, and at the end of treatment.

Mr. WALZ. Okay.

Dr. SEAL. Do I have access to all of that data? Not necessarily, because it is confidential patient data, but I think individual clinicians in VA are trained in evidence-based methods, which do involve assessment pre- and post-treatment.

Mr. WALZ. So we would have a pretty good idea if I said that the Minneapolis VA treated 15,185 could I have an idea of how many of those patients received at least some form of help and we could measure it in terms of getting back to work, personal measurements of life satisfaction, and those type of things? We could gather that data couldn't we?

Dr. SEAL. You could.

Mr. WALZ. And should we be basing our decisions on how we expand programs, work on programs, change programs based on that type of data?

Dr. SEAL. I think you should definitely look at the data before you decide to make changes.

Mr. WALZ. Okay. Dr. Satel, thank you for joining us again, I have become very familiar with your work over the years.

The case for coercion, tell me just briefly, you have worked on that, and I am glad it got brought up. I am very I would say concerned would be the right word from a medical ethic standpoint, from a human right standpoint, I have read your work on medical ethics too and the lack of need to have those in large. Am I mischaracterizing that?

Dr. SATEL. Yes, sir.

Mr. WALZ. You said did not have them in large hospitals?

Dr. SATEL. Oh, no, no, no, with all due respect I——

Mr. WALZ. Okay. Explain to me though the case for coercion.

Dr. SATEL. Okay.

Mr. WALZ. Research based case for coercion.

Dr. SATEL. Yeah, that was written, that was a monograph I wrote a while ago and it had to do with addiction and that was the context I mentioned earlier.

So we are talking about people who have basically violated the law, so it is a different population.

Mr. WALZ. Are you applying this to this though, this idea you did put out the idea of possibly withholding benefits as use in some ways? Is this not coercion? Is your policy, what you are asking for on how we get people into this, is it not coercion? Am I mischaracterizing that?

Dr. SATEL. You know, I am actually setting forth various kinds of options. One could be that before we call someone disabled, before we call them disabled, they have to experience some good quality treatment and there is a whole lecture on what good quality treatment is. It sounds like you are doing a great job, but I am talking about at the point in which we call someone disabled. That is very different from not giving someone the kind of financial as-

sistance they need and provide, you know, making the kind of help that they need available to him.

So we are not withholding. Really almost just changing the conceptualization of when a disability claim itself, when the whole identity of being a disabled person would kick in.

Mr. WALZ. You know we deal with slippery slope issues here all the time. What would stop this from crossing over into the physical issue?

Because the issue we are discussing here is mental health parity, and I would argue with the Chairman's point, we have increased, we had to bring the VA in here and tell them they could advertise mental health parity has now been incorporated into law and those types of things.

How would we not slip into this and say, you know, that we are going to wait and see first if you can go back to work before we help you with that limp you got from being shot in the leg? Is that not a slippery slope you think this would take us on?

Dr. SATEL. I think the principals apply across the board. No one is talking about withholding help or withholding financial care. Again, it is the point at which we consider disabled, that is all.

Mr. WALZ. And you think we do that too much, am I right? And that isn't how the helping culture is eroding self-reliance?

Dr. SATEL. Sometimes we do, and sometimes we don't do it fast enough. You can see for every over diagnosis there is an under diagnosis and a missed diagnosis. All these things occur.

Mr. WALZ. How would you rate the VA if you could overall how they care for mental health patients?

Dr. SATEL. I think the VA's associated with major universities that have high standards and I think they have learned a lot of lessons from the way they approached the Vietnam era, which again was with the best of intentions, but there were things that we learned that I think we don't do now as much which is to say now, well, things are so different also.

A lot of those men, well some women, but mostly men, you know, we didn't recognize that psychiatry—didn't recognize it until 1980 and then the first Center of Excellence I believe didn't start until 1987, so by the time people showed up, they had been sick for so long, and often in what—there is a term for it, I am not making this term up, it is called malignant PTSD that some of them had because of the years of substance abuse and years of criminalization.

So by the time someone appears, then it is so hard to treat them, but we have a chance, and we are taking it now, with this new generation stepping in, you know.

Mr. WALZ. Well, I appreciate that, and I think we concur on that that the earlier before these things take hold the better, and it is also holistic in terms of physical, but I would argue it is also the employment issue.

Dr. SATEL. Definitely.

Mr. WALZ. And everything else. So thank you for that.

Thank you, Mr. Chairman, for the extra time.

The CHAIRMAN. Thank you very much. Thank you very much for being here today, we appreciate your comments. There may be some additional questions that will be asked for the record, we

would ask that you would respond, if in fact, some come your way. Thank you very much.

I ask the third panel to make their way forward. Ralph Ibson, Executive Director of Wounded Warrior Project (WWP); Christina Roof, National Acting Legislative Director for AMVETS; and Dr. Antonette Zeiss, Acting Deputy Patient Care Services Officer for Mental Health for the Veterans Health Administration.

We thank you all for being here today.

Mr. Ibson, you are recognized.

STATEMENTS OF RALPH IBSON, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT; CHRISTINA M. ROOF, NATIONAL ACTING LEGISLATIVE DIRECTOR, AMERICAN VETERANS (AMVETS); AND ANTONETTE ZEISS, PH.D., ACTING DEPUTY PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MATTHEW J. FRIEDMAN, M.D., PH.D., EXECUTIVE DIRECTOR, NATIONAL CENTER FOR PTSD, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; MARY SCHOHN, PH.D., ACTING DIRECTOR, OFFICE OF MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND TOM MURPHY, DIRECTOR, COMPENSATION SERVICE, VETERANS BENEFITS ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF RALPH IBSON

Mr. IBSON. Chairman Miller, Ranking Member Filner, and Members of the Committee, thank you for inviting Wounded Warrior Project to testify this afternoon.

WWP's vision is that this will be the most successful, well-adjusted generation of veterans in history, but critical gaps in VA's mental health system are compromising that vision in our view.

The first large gap, and Ms. Buerkle made reference to it, is lack of effective outreach. Given the prevalence of PTSD among returning warriors and the risk that lack of treatment will result in severe chronic disability, it is concerning to us that VA is reaching only about one of every two returning veterans.

In our view VA should approach this issue as more of a public health issue.

In 2008, VA telephoned the approximately half million OEF/OIF veterans who at that time had not enrolled for VA health care and it encouraged them to do so. This was apt recognition, in our view, that we must be concerned with the entire OEF/OIF veteran population. But a single telephone contact is hardly an effective outreach campaign.

Compounding lack of aggressive outreach, we see Dr. Seal's data as very, very powerful and very disturbing. It tells us that enrolling for VA care and being seen for a war-related mental health problem does not assure that a returning veteran will complete a course of treatment or even return for a follow-up visit.

Also troubling is that VA has set a very low performance bar for reversing this trend.

Certainly I think, as evidenced by Dr. Seal's testimony and what she described at VA's Medical Center in San Francisco, veterans are getting good mental health care at many places in VA, but it is worth acknowledging that VA really operates two mental health systems, a nationwide network of medical centers and outpatient clinics and a much smaller readjustment counseling program operating out of community-based Vet Centers.

In our view, the differences between these two systems help explain why greater numbers of returning warriors do not pursue VA treatment and why many of them discontinue treatment.

The warriors with whom we work consistently report high satisfaction with the Vet Center experience. In essence, the strengths of the Vet Center program highlight the limitations of the larger system for many of these warriors.

As Dr. Seal indicated, VA medical centers passively wait for veterans to pursue mental health care rather than aggressively reaching out to them in their communities on a one-on-one basis.

The larger system gives insufficient attention, in our view, to ensuring that those who begin treatment actually continue and thrive.

No doubt it emphasizes, as was discussed, training clinicians in evidence-based therapies, but it does much less to ensure that those clinicians really understand warriors' military culture and the combat experiences they have been through.

And unlike Vet Centers and unlike what Dr. Seal described at VAMC San Francisco, most VA medical centers fail to provide family members needed mental health services, often resulting in those warriors struggling without a healthy support system.

In 2007, VA developed an important policy directive that identifies what mental health services should be available to all enrolled veterans no matter where they live, but as VA has acknowledged this directive is still not fully implemented. Access remains a problem, as many small VA clinics have at best limited mental health staff. VA policy directs that facilities contract for mental health services where necessary to provide that care, but those facilities have generally made only very limited use of that authority.

PTSD and war-related mental health problems can be successfully treated, as you have heard this morning, and in many cases VA clinicians in Vet Centers are helping veterans recover, but we urge that VA focus on closing what we see as serious gaps.

We look to the experience that veterans like Mr. Hanson have had. Mr. Hanson is the kind of veteran who could do extraordinary work in his community and other communities in Minnesota reaching out and working one-on-one with other veterans and bringing them into treatment. If he had had a successful experience with VA, he would be an extraordinary salesperson, unfortunately he didn't have that positive experience.

Likewise in terms of sustaining veterans in treatment, in terms of dealing with that retention issue that Dr. Seal discussed, a veteran like Mr. Hanson would be a wonderful adjunct to a clinical team to work directly with warriors having the unique warrior-to-warrior connection that he has.

Secondly, we would urge VA to launch education and training programs for its staff on military culture and the combat experi-

ence so that the connection is a closer one so that it is not a distant or simply "friendly" clinician-patient relationship as Mr. Hanson described it.

We would urge that VA provide needed mental health services to family members whose own war-related mental health issues may diminish their capacity to provide support.

And we would urge that VA expand the number of its Vet Center sites and locate new ones near military facilities.

We recognize the importance of robustly addressing the full range of issues facing returning warriors so that they can thrive physically, psychologically, economically.

Compensation for service-connected disability is certainly an earned benefit and critically important to most veterans' reintegration and economic empowerment, yet data from recent surveys we have conducted underscore that much more work needs to be done at the most basic level to achieve better coordination and unity of focus between VHA and VBA.

For example, notwithstanding guidance suggesting that compensation and pension (C&P) exams may need to be as long as 3 hours to fully develop a PTSD claim, one out of every five of the warriors who responded to our survey indicated they were seen for 30 minutes or less.

This Committee has emphasized this morning the goal of a wellness-focused VA response to mental illness. One step in that direction, in our view, would address a problem identified by the Disability Commission regarding VA's IU benefit. We concur with their recommendation and that of the Institute of Medicine that the Individual Unemployability benefit should be restructured to encourage its veterans to reenter the workforce.

In closing, Mr. Chairman, while we recognize that VA has some excellent mental health treatment programs, our work with warriors highlights the gaps plaguing the system, gaps in a largely passive approach to outreach, gaps in access to mental health care, gaps in sustaining veterans in mental health treatment, gaps in clinicians understanding of military culture and combat experience, gaps in family support, and gaps in coordination with the benefit system.

We look forward to working with this Committee to help close those gaps.

Thank you.

[The prepared statement of Mr. Ibson appears on p. 78.]

Ms. BUERKLE. [Presiding.] Thank you, Mr. Ibson.

Ms. Roof.

STATEMENT OF CHRISTINA M. ROOF

Ms. ROOF. Madam Chair, Ranking Member Filner, and distinguished Members of the Committee, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to share with you our view and recommendations at today's hearing regarding VA's system of mental health care and benefits.

You have my complete statement for the record so today I will briefly discuss two areas of concern to AMVETS.

Sadly suicide has become a too familiar casualty of war. Suicide among veterans and servicemembers seems to become an epidemic

with no end in sight. The rate at which veterans and active duty military personnel are taking their own lives has surpassed that of the non-veteran population for the first time in our Nation's history.

According to numerous studies performed by the National Institutes of Health (NIH), VA, and the U.S. Department of Defense (DoD), upwards of 43 percent of veterans having served in the recent conflicts will have experienced traumatic events resulting in PTSD or other invisible wounds such as depression. Left untreated, these invisible wounds have a devastating impact on the lives of those veterans and servicemembers who suffer in silence, as well as their families.

AMVETS believes one of the hardest and most humbling decisions a veteran can make is to seek care for their invisible wounds of war. However, often when these men and women reach out to VA for help, they are met with broken policies, lengthy procedures, as well as an overall lack of communication between VHA and VBA.

Moreover, these veterans who are brave enough to ask for mental health care are encountering a confusing and frustrating claims system entrenched in bureaucracy.

Many of these veterans find VA to be more of a hindrance than helpful to their overall well-being and thus choose to forego the care and benefits they critically need.

One of the initial experiences a veteran will have within the VA system is with the claims examiner, thus the response from VA to a veteran seeking care for their invisible wounds is a PTSD claims evaluation without a concurrent offer for treatment. Now a potentially fragile situation is made even worse.

VA agency affiliation of the examining claims representative may not be clear to a newly enrolled veteran filing their first mental health claim.

Qualitative data suggests veterans who undergo compensation examinations report not understanding the distinction between an evaluative claims examination with that of a mental health care treatment examination.

Many veterans do not make the distinction between the VHA staff who conduct examinations and provide care to that of the VBA staff who decide claims and dispense benefits. To many veterans they are both simply "VA staff."

For example, a claims examination focuses on data collection rather than addressing a veteran's distress. The compensation examiner may have to collect information about traumatic issues that the veteran is unprepared to address, even in a therapeutic setting.

In addition, a compensation interview often has more time constraints and the veteran may feel rushed, coupled with the frustrations felt towards the claim examiner who must consider not only the veteran's perspective, but also the alternative sources of data and may ask questions that challenge the veteran's version of events.

AMVETS urges VHA and VBA to immediately address the current confusion between clinical VHA functions and that of forensic VBA functions. The lack of education being provided to our vet-

erans is causing too many veterans in need to turn away from the life-sustaining care and benefits VA has to offer.

AMVETS second area of concern is with the non-compliance of numerous Veterans Integrated Services Networks (VISNs) to current VHA directives, policies, and procedures addressing mental health care. More specifically VHA Handbook 1160.01.

In September 2008, VA issued VHA Handbook 1160.01 defining the clear minimum clinical requirements of mental health services throughout the entire VA health care system. The handbook outlines policies and procedures related to suicide prevention, specialized PTSD services, 24/7 emergency mental health care, and over 100 other issues directly related to the treatment and programs of mental health care.

VHA 1160.01 also clearly outlined the requirement that every VAMC and community-based outpatient clinic was to have these programs and policies in place no later than the last working day of September 2009 unless granted written permission by the Secretary.

Immediately following this deadline, as required by the Military Constructions Veterans Affairs and Related Agency Appropriations Bill of 2009, the Office of Inspector General (OIG) conducted a review of VHA's progress and the implementation of the requirements.

In 2010, OIG's findings on VA's progress were released and raised several serious concerns for AMVETS.

AMVETS found VA's failure to implement numerous critical parts of the handbook directly related to suicide prevention and mental health care to be unacceptable.

AMVETS is especially concerned over the following OIG findings:

One, the lack of access to timely treatment within all VISNs regarding specialized PTSD residential care program. The current wait time for many veterans living in rural or remote areas is 6 to 8 weeks.

Two, VHA's lack of trained personnel to provide intensive outpatient services for the treatment of substance abuse. As we have seen today, substance abuse can lead to things such as homelessness and/or aggravate symptoms of the invisible wounds for veterans not receiving the care they have earned through their service.

Three, VA's limited availability of 23-hour observation beds for patients at risk of harming themselves or others.

And finally, VA's failure to have the presence of at least one full-time psychologist to provide clinical services to veterans in VA community living centers with at least 100 residents.

These are only a few of the numerous problems OIG outlined in their report. AMVETS finds it to be inexcusable and irresponsible that numerous VAMCs and CBOCs are still, in 2011, being allowed to operate in a state of non-compliance to the VHA Handbook 1160.01.

In closing, AMVETS believes VA must hold these non-compliant VAMCs and CBOCs accountable and start taking a more proactive approach to insuring our veterans are receiving only the highest quality of mental health care they can provide.

AMVETS further urges Congress to step up the oversight as it relates to the full implementation of the VHA Handbook 1160.01 and mental health care as a whole within the VA health care system.

Until we stop taking a reactionary approach to VA's system of mental health care, we are destined to be playing catch up and meeting the needs of today's returning war fighters.

Chairman and distinguished Members of the Committee, this concludes my testimony, and I stand ready to answer any questions you may have for me.

Thank you for allowing me to go over my time.

[The prepared statement of Ms. Roof appears on p. 86.]

Ms. BUERKLE. Thank you very much for your testimony.

Dr. Zeiss.

STATEMENT OF ANTONETTE ZEISS, PH.D.

Ms. ZEISS. Thank you, and I am here accompanied by Dr. Matt Friedman, the Director of the National Center for PTSD, Dr. Mary Schohn who is the acting lead for the new Office of Mental Operations who will have significant responsibility for implementation and ensuring that policies are fully implemented, and Mr. Tom Murphy from the Veterans Benefits Administration. And many issues have been raised.

I am going to actually do a very abbreviated oral testimony, because I think you all have questions and I want to address many of the things that have come up.

Let me focus the testimony first on comments on a couple of earlier things and then on the call for evidence-based policy and care within VA.

I guess I would say first in terms of Mr. Hanson's testimony that the most moving thing to me and something that Dr. Seal addressed, but I also want to address, is his sense of not feeling a personal connection at VA.

My own experience of working for VA for almost 30 years now is that this is the most passionate and dedicated group of professionals I can imagine working with, and I have worked in academic settings and other settings as well, and I would love to talk more with Mr. Hanson about his experience and think together about how to make sure that the passion we all feel for the work we do and for caring for veterans is being communicated directly.

I also want to say that I agree enormously with Dr. Seal's comments. In fact, most of the things she was recommending are in fact national VA programs. She was talking about them within the context of the San Francisco VA, but most of them are mentioned in the Uniform Mental Health Services Handbook, and in fact, the integrated clinic for returning OEF/OIF veterans is present throughout the system led by Dr. Stephen Hunt and is staffed with mental health professionals throughout the system. I think it is an excellent way to specifically meet the initial needs of a number of returning veterans. And then we have to stand ready to deliver in many ways beyond just that initial care.

I would say and I am happy to talk with you, the OIG has closed all of its recommendations from the report that you describe as we have reported on further progress and implementation and they

have agreed that those recommendations have been met and that there is still work to do. We are still not at 100-percent implementation. We can talk about that how we are absolutely committed to that work, but we are well beyond what was in that set of recommendations. We shared the same concern you did about making sure that things happened and things changed.

A couple of other things to comment on that have come up during the discussion. We have hired since fiscal year 2005, 7,500 full-time mental health staff, that is mental health professionals, psychologists, psychiatrists, nurses, and social workers, but also addiction techs, outreach workers, support staff of a variety, and the number of veterans who are seen for mental health care has increased quite commensurately going up from in the less than a million around 800,000 to over 1.2 million if we look only at specialty mental health care, and up to 1.8 million if we are thinking about people who are also being seen in integrated care, primary care settings.

So we are very much expanding care, and we are working as Dr. Seal talked about to deliver the most effective evidence-based care.

We agree that we need to continue to lay the groundwork and ensure that more veterans receive those full courses of care, but we do have some evidence that people may not have been captured in the early time period her study covered up to 2008, but in fact just as with substance abuse treatment people often drop out several times before they then engage with a full course of treatment, and we are seeing some of those same patterns in VA.

We are also developing increased tools to link people to care such as the mobile app for a PTSD coach that Dr. Seal mentioned, which after 2 months has been downloaded as a free app by over 10,000 people in 37 countries and has the highest possible ratings.

And finally in closing, I would encourage you to look at a report that has been submitted to Congress, the "Government Performance and Results Act Review" that VA participated in from fiscal year 2006 through fiscal year 2010, to look at the transformation of the VA system for mental health care in that time and point out that it concludes that VA mental health care was superior to other mental health care offered in the United States on most all dimensions surveyed.

These data speak to the great strides VA has made in mental health care. Clearly we have more to do. We share concerns about many of the issues that have been raised. We are happy to talk about what are the next steps, what are ways in which we can continue to act on our passion to serve veterans fully.

Thank you.

[The prepared statement of Dr. Zeiss appears on p. 94.]

Ms. BUERKLE. Thank you all very much, I will yield myself 5 minutes at that time for questions.

Mr. Ibson, in your opening statement you mentioned that there were gaps. Could you perhaps in order of priority mention the most glaring gaps and the ones that need the attention, you know, our most immediate attention?

Mr. IBSON. It's difficult to prioritize, but I think you put your finger on a powerful point, which is that we should assume that all returning veterans are at risk of PTSD, and the fact that untreated

PTSD can be such a pernicious, disabling condition argues that a VA health care system not passively rely on notices on its Web site, but that it actually engage veterans in their communities and attempt to bring them into treatment through more aggressive outreach. That is we urge VA to view this as really a public health problem, not simply a matter of providing treatment when veterans walk through the door.

And I think secondly the concern with retention, asking the question why are veterans not staying in the system, and exploring in a more wholehearted way efforts to sustain veterans in treatment.

I think Dr. Seal spoke to a number of ideas. Our suggestion, which is actually reflected in Section 304 of the Caregiver Law of last year calls on VA to employ returning veterans to do peer-outreach and provide peer-support services. We think there is an important role for returning veterans who have experienced mental health problems and benefited from the excellent treatment that can be available to work with their peers who may be on the fence, who may be hesitant, who may be quick to drop out. I would say those are two of the more compelling ways in which we see gaps and would urge that they be closed.

Ms. BUERKLE. Thank you.

Dr. Zeiss yesterday we had a hearing and the Chairman alluded to the hearing regarding sexual assaults, and one of the most compelling pieces of information that came out from that and you get a sense of it this morning is that we can't count on every VA facility to be consistent, and so I would like you to speak to that a little bit.

You mention about the staff that you are involved with, and I know Dr. Seal earlier mentioned her facility, but how can we ensure that the same environment is being created across the VA system? It seems to me that needs to be a priority so we can ensure it isn't dependent on the facility, it is dependent on the VA system as a whole and they are giving our vets what they need.

Ms. ZEISS. Well, I think that is a splendid question. It is one of the things that has consumed my energy since coming to Central Office, because I completely agree with you that we can set important policies based on data, evidence, and what we know about gaps and then we have to be sure that they are very consistently carried out.

And I would like to turn to Dr. Schohn, because one of the things that has happened just in the last few months is that VHA has reorganized to create this Office of Mental Health Operations that will be able to interact much more directly with VISN directors, with facilities, and really tackle some of those issues very directly.

Dr. SCHOHN. Yes, just in the last few months, VHA has reorganized, and part of the reorganization has been to build in a clinical presence in operations so the office that I am with, the Mental Health Operations Office, is really charged with overseeing compliance of things like the handbook. So my first job essentially is really to ensure that that has been implemented enough in all facilities.

As Dr. Zeiss mentioned, we are aware that it has not been fully implemented. We are concerned about that, and we are directly working with the field in terms of identifying what are the various

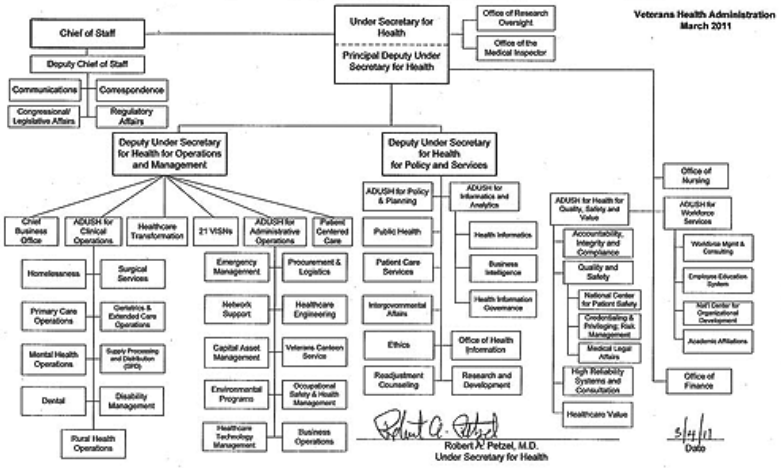
implementations, what needs to be done, do we need to provide education, do we need to provide staff training, you know, what do we need to do in order to make sure that those programs are implemented as written?

As well we will be looking at other areas of concern, things that arise in reports like what you saw yesterday. So how do we collect that data and then ensure that the field actually implements the changes that we are advocating?

Ms. BUERKLE. Thank you. Would it be possible to get that reorganization plan to the Committee?

Ms. ZEISS. Certainly. We can take care of that when we get back.

[The VA subsequently provided the following information:]



Ms. BUERKLE. Thank you very much, I would appreciate that.

I now yield 5 minutes to the Ranking Member of the Health Subcommittee, Mr. Michaud.

Mr. MICHAUD. Thank you very much, and I want to thank the panel as well for testifying today and have heard, you know, Mr. Hanson and I heard Dr. Zeiss talk about, yeah, the employees really do give that care, in reality you don't hear that throughout the country quite frankly. There are VA employees who do a really good job and there are those that are there and just can't wait to get rid of this paperwork and there is no consistency among the VA.

I heard Ms. Roof talk about the fact that the VA employees aren't even following the handbook that they are supposed to follow, which is a concern about some of the problems that we are seeing and the non-compliance among different VISNs and as far as how they move forward on these particular cases and the problems that it is causing veterans as far as getting services, whether it is dealing with female veterans issues as we heard yesterday when we look at sexual assault and rape. And the fact that the VA has not done a very good job in that regard, when you look at Mr. Hanson this morning talk about how he felt that he didn't get the

service within the VA, and I have heard that complaint as well from a lot of veterans throughout the country.

And I guess my question, particularly when you look at mental health type issues for the doctor, actually Mr. Ibson mentioned this morning about in his testimony that when the VA goes through their evaluation exams, that it is extremely brief and superficial.

How can the VA actually address these issues so that they are not brief or superficial and they really give the care that the veterans really need so they will not get frustrated and try to go elsewhere? Because that is the problem I see as veterans getting frustrated and not seeking the care among the VA. I mean where is the accountability within the VA system?

Ms. ZEISS. Well, several things in what you said so let me address what I can and then come back to others as needed.

First of all, in fact we set a standard that veterans who are newly referred for mental health care need to be seen. They need a 24-hour triage call and diversion to urgent care if it is needed, but the main standard is within 14 days then that they will have a full diagnosis and beginning of treatment plan, and we meet that standard by well over 95 percent. And part of what contributes to not meeting the standard is veterans who decline to get an appointment within that 2-week window.

Now in a system as huge as ours with over 1.8 million veterans being seen for mental health care, there could be in that 5 percent that are not meeting that a number of people that you hear about and that we are concerned about and that we believe we need to be better on. We would like to continue to do far better and we want to hear when there are instances where people have not gotten the care that the system is set up to deliver.

In terms of the claims interviews, which is I believe what Mr. Ibson was talking about when he talked about the brief, what I can say is that we have very recently had a study completed on PTSD interviews for C&P claims, we will be hearing about the outcome of that research very shortly.

I will ask Dr. Friedman to say just a bit more about that, because he has been involved with it, and we will certainly be very happy to share with you when that evidence is complete what the evidence is actually showing about what is required for a full, effective, accurate, and valid PTSD interview and what policies we will set and how we will work with mental health operations to ensure that they are met.

Mr. MICHAUD. Before you answer my concern is, that there appears to be a lot of studies and evaluations going on and this issue is not new. It has been going on for quite some time and it is getting really frustrating because the other big issue that we hear, particularly coming from rural States such as Maine, is access issues.

When Congress adopted the Office of Rural Health, we provided funding for the Office of Rural Health to really focus on the fact that about 40 percent of the veterans live in rural areas, that that office is supposed to focus on Office of Rural Health. However, when the GAO did their study to see how effective the Office of Rural Health has been, the VA can't account for over 51 percent of the spending that has occurred in the Office of Rural Health.

How many veterans that the office is supposed to take care of been treated? They can't account for that.

So the accountability issue is a big concern that I have, because these are individuals lives, they are families, and I am just tired of just study after study without really, really focusing on the problem.

And the other issue that is a big concern is the fact that when you look at the studies that do occur within the VA system that they don't include individuals such as the veterans service organizations (VSOs), individuals who are really affected by it as part of that collaborative effort, and that is a huge concern, because if you have VA management that is going to comprise the Committee that is going to study, you have the same individuals and they are going to go in there and try and collaborate and what have you, and that is a big concern that I have is we are not really focusing on the veterans who really need the help.

As we heard this morning in the different panels, VA, don't get me wrong, I think VA does a good job by and large, but there is a lot of room for improvement, and when I get, whether it is a Inspector General report or a GAO report saying the VA can't account for the money that we are giving them and that the effect that it is having, I mean that is really concerning.

When I hear from veterans who are frustrated with a system and they go elsewhere for the help because VA is not providing that help, that is concerning to me as a Member of Congress, and I hope, Doctor, that you take this hearing very seriously and you really start focusing on getting results versus doing another study and reporting back to Congress. Because all too often what happens is after the hearing is done unless we do have an aggressive oversight hearing, you know, you get that report done, it sits on the shelf and that is the end of it until we hear another outrage among the veterans community.

So I am just getting frustrated with what I see happening and hopefully we can do a better job than what we currently have had over the past few years.

Ms. ZEISS. Well, certainly I am trying to convey that in fact we are not just studying, we are doing. We have increased the number of veterans we are seeing for mental health. We have increased the number of mental health staff, we have increased the effectiveness of the interventions, and we are putting our passions into trying to make the kinds of changes in the VA system that you are frustrated about and that we want to see those changes too, and we welcome hearing when, you know, what are the places where we have not made the progress that you would like to see. And it sounds like right now one of those is in doing the C&P exams, and I would really love to let Dr. Friedman, who is really our expert on PTSD speak to that.

Dr. FRIEDMAN. Well, thank you.

A number of years ago, there was a meeting between VHA and VBA people to see how could we develop a standard that would establish a floor so that every C&P exam would meet a minimum standard. One of the bases for that was this initiative in research and also in clinical evaluation. For years now, we have developed a number of excellent assessment tools, some wonderful diagnostic

scales and other symptom severity scales that are not just used in VA, but which are used universally, internationally. It seemed to us that we had an evidence base for assessment that could very well inform the C&P progress. And based on that meeting, a study, which as Dr. Zeiss mentioned a few minutes ago, is nearing completion, was set in motion with examiners at different VA regional offices throughout the country comparing a standard C&P exam with a C&P exam that used such an approach—specifically we used the clinician administered PTSD scale (CAPS), which is considered the gold standard for PTSD assessment and the World Health Organization Disability Assessment scale, the WHODAS, which again is internationally accepted as the best approach for assessing functional status regarded. And so, we have basically C&P as usual compared with an evidence-based standardized assessment utilizing both the CAPS and WHODAS. Those encounters are being videotaped. They are being assessed at the National Center for PTSD, and, stay tuned, we will have the results as soon as we can get them written up.

Ms. ZEISS. Let me just add finally if I can keep my voice—you probably know we do have a mental health rural project going on in Maine in VISN 1 as well as in VISN 20, and 19, the most rural VISNs that we have, and we are finding that there are some very effective things we can do in partnering with communities and making sure that we are getting care more broadly into your system and we will learn from that to be able to spread to other parts of the system as well.

We agree with you, it is really crucial. And the Office of Rural Health has supported us in doing that, but it is our Office of Mental Health Service that the really focusing that project in VISN 1.

Ms. BUERKLE. Thank you, Mr. Michaud.

At this time first of all I want to just reiterate and emphasize what my colleague and the Ranking Member has talked about, and that is the sense of urgency that lives are being lost and people are slipping through the cracks who need our help, and they are men and women who have sacrificed so much for this country. So our duty is even greater.

So I would really encourage the Veterans Affairs to work hard and diligently and give us an action plan as to how we are going to address these issues. The gaps that Mr. Ibson talked about, that we talked about earlier that shows that the VA is getting out in front of this. We are not just going to be reactionary, we understand, we appreciate the fact how these young men and women are suffering overseas as they protect our Nation, and what you are going to do to get out in front of this to help them. So I can't emphasize that enough, time is of the essence.

At this time I want to take a moment to recognize the presence of Andrea Sawyer. Andrea is the spouse of an OIF veteran who has 100-percent service-connected rating for PTSD.

Andrea has been kind enough to submit testimony for the record outlining her observations of the VA mental health care system, and in short she has made the following suggestions.

Treatment must be timely and available. Treatment must be appropriately timed and tailored to address the severity of the symptoms. Treatment must be practical. Treatment must be culturally

competent. Community options should be available. And communication between the VBA and the VHA need to improve.

I would encourage all of my colleagues to read Andrea's very compelling testimony, and I want to thank Andrea for being here and for providing us with that testimony. Thank you very much.

[The prepared statement of Ms. Sawyer appears on p. 63.]

Ms. BUERKLE. Are there any other questions? At this time I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material for the record on today's hearing. Hearing no objection so ordered.

This hearing is now adjourned.

[Whereupon, at 1:07 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman, Full Committee on Veterans' Affairs

Good morning. Thank you to our witnesses in attendance, and welcome to the Committee on Veterans' Affairs hearing entitled, "Mental Health: Bridging the Gap Between Care and Compensation for Veterans."

On May 10, the United States Court of Appeals for the Ninth Circuit issued a decision that was heavily critical of the care and compensation VA provides to veterans with mental illness. The Court cited VA's "unchecked incompetence" and the "unnecessary grief and privation" that delays in treatment and benefits cause veterans and families.

I am not here this morning to judge the Court's decision . . . I'll leave that to others. But the heart of the Court's analysis of the issue is something with which all of us need to be concerned. Namely, is VA's system of care and benefits improving the health and wellness of veterans suffering from mental illness?

On behalf of a grateful Nation, we've invested heavily in this system over the last decade to improve access and make treatment options that experts say are effective more readily available. But the question remains, are veterans—especially those returning from combat with the invisible wounds of war—on a road to recovery and able to live full, productive lives?

Recovery, restoration, and wellness . . . these should be overarching objectives of all VA's programs. Yet when I look at trends in disability ratings for veterans with mental illness I see a confusing picture.

On one hand we have a medical system that boasts of evidence-based therapies, improved access, and high quality of care. On the other we have data from VA indicating that veterans with mental illness only get progressively worse. These confounding facts raise the question: Are VA's health and disability compensation programs oriented towards VA's mission of recovery and wellness?

I am not the first who has noted this trend or suggested the need for closer integration of VA programs.

A 2005 report from the VA Inspector General concluded the following: "Based on our review of PTSD claims files, we observed that the rating evaluation level typically increased over time, indicating the veteran's PTSD condition had worsened. Generally, once a PTSD rating was assigned, it was increased over time until the veteran was paid at the 100 percent rate."

We have a 2007 report from the Veterans' Disability Benefits Commission—and we'll hear from the Chair of that Commission on our second panel—which recommended that "a new, holistic approach to PTSD should be considered. This approach should couple PTSD treatment, compensation, and vocational assessment."

Most recently, we have the Administration raising red flags. In its Fiscal Year 2010 Performance and Accountability Report VA commented on how well its Veterans' Benefits Administration collaborates with the Veterans Health Administration when providing services to veterans with mental illness.

The report suggested that with recovery as the essential goal to helping veterans with PTSD, that perhaps VBA and VHA were working at cross purposes. Let me quote from that report: "With the advent of the Recovery Model as central to the treatment of mental health disorders, the current system fails to support *and may even create disincentives to recovery.*"

Today, we will move beyond numbers that simply tell us how many veterans use the system and get at the fundamental question of whether they are on a road to leading full, productive lives.

For veterans who don't seek VA care, we need to know why. We need to know if there are inherent disincentives to recovery. We need to know if the quality of treatment provided at VA is a reason many seek care elsewhere. We need to know what is effective and what isn't.

Quoting from a recent policy paper from the Wounded Warrior Project, "VA's focus on the high percentage of veterans who have been treated begs such questions as, how effective was that treatment, and how many more need treatment but resist seeking it?" I couldn't agree more.

It is our duty at this Committee to ask these tough questions. The veterans for whom this system was created demand it of us.

We are fortunate to have with us on our first panel Mr. Daniel Hanson. Dan served in Iraq, then came home troubled in mind, trying to cope with the loss of so many of his fellow Marines. His is a story I hope everyone listens closely to as a cautionary tale of where we may be inadvertently headed. Looking back, Dan has some interesting thoughts of what it would have taken to get him into treatment sooner. And, just as important, he's got something to say about how he ultimately found help outside of VA's system.

On our second panel we have Dr. Sally Satel, resident scholar at the American Enterprise Institute. Dr. Satel will share with us the principles surrounding what she believes would be a more effective system of care and compensation for veterans seeking mental health treatment. As I mentioned we also have the former Chairman of the Veterans' Disability Benefits Commission with us, General Terry Scott. We also have a VA clinician, Dr. Karen Seal, who will share with us her findings on health care utilization of Iraq and Afghanistan veterans.

Finally, on our third panel, we will hear the administration's views, and the views of two important veterans' organizations, AMVETS and the Wounded Warrior Project.

Again, I thank everyone for being here today. I now yield to the Ranking Member, Mr. Filner.

Prepared Statement of Hon. Bob Filner, Ranking Democratic Member, Full Committee on Veterans' Affairs

Thank you, Mr. Chairman, for holding this very important hearing today.

Over the last 4 years, I have raised serious concerns with the backlog of claims for our veterans. There are a record number of our servicemen and women returning home with scars from the war and now is not the time to delay their benefits.

The report released last year by the VA Inspector General focusing on the delay of our servicemembers getting an appointment for a medical exam in order to process their claim for compensation is just another example of how the VA is failing our veterans.

The VA system has many obstacles for our warriors by putting them through numerous medical exams for each individual ailment for which they are filing a claim. The VA could easily streamline this process and allow the veteran to receive one complete medical exam to expedite the claims process, alleviate the stress on our veterans, and save our veterans and taxpayers money.

The recent decision issued by the 9th Circuit Court of Appeals in *Veterans for Common Sense and Veterans United for Truth* v. *Shinseki* found that veterans have a property interest conferred upon them by the Constitution to both VA benefits and health care.

Ruling for the veteran plaintiffs, the 9th Circuit went a step further to conclude that because these are property interests, delaying access to health care or the adjudication of claims, violates veterans' due process rights guaranteed by the Fifth Amendment.

I agree with this ruling wholeheartedly and am disappointed that the VA has not done more to fix the problem.

We know that on average, every day, 18 veterans commit suicide in this country. We also know that 1 in 5 servicemembers of our current conflicts will suffer from PTSD and, unfortunately, the suicide rate for these brave men and women is about 1 suicide every 36 hours. Many of them, as outlined in the ruling, will be left undiagnosed, untreated and uncompensated. This is a travesty and an outrage.

Last year, the VA Inspector General's office made recommendations for the Veterans Health Administration and the Veterans Benefits Administration to collaborate more effectively and share information on issues affecting the timely delivery of exams. I am disappointed that we are still discussing this issue 15 months after the findings and recommendations.

The VA is not committing sufficient resources to meet the demands of our warriors when they return home. I hope that VA will address these shortfalls and I expect them to come to the table with a plan to fix the problem.

Mr. Chairman, I look forward to the testimony this morning.

Prepared Statement of Hon. John Barrow

Thank you Chairman Miller and Ranking Member Filner for holding this hearing on mental health treatment.

It is our duty and obligation to ensure that when our troops come home we provide them the mental health services they not only need, but the services they have earned. Unfortunately, we have failed to provide adequate mental health treatment. Too often our veterans afflicted with mental illness go undiagnosed and untreated.

One group of veterans we have failed to provide for adequately are those in rural areas. Veterans living in rural areas face all the same challenges that veterans in urban areas face with the added stress of long travel to receive care. For example, if a veteran in Statesboro, GA needs routine mental health treatment, he would be forced to travel over an hour and a half to get to the closest VA health facility. That is too far to travel for routine mental health treatment. A veteran in Statesboro should be able to travel a short and convenient distance for routine mental health treatment.

I look forward to hearing ways we can more effectively provide mental health to our veterans, and I look forward to working with this Committee to provide more effective mental health treatment. We need to be certain that VA is providing high quality mental health treatment, while ensuring that veterans can conveniently and quickly use VA's health services.

Prepared Statement of Daniel J. Hanson, South St. Paul, MI (OIF Veteran)

My name is Daniel Joseph Hanson and I am 27 years old. I joined the United States Marine Corps in January 2003. I was eventually assigned to 2d Battalion, 4th Marines and in February 2004 was deployed to Ar-Ramadi Iraq. The deployment started with one of our Marines shooting himself in the head and killing himself. It was not long before we started losing men and funerals seemed to become a regular thing. It was hard to know that you had just talked to someone the day before and now you were saluting an empty pair of combat boots, an upside down M–16 and a pair of dog tags. When it was all over in October 2004 we lost a total of 35 Marines.

On our 'cool down' period before returning we had a few classes discussing what each person had seen and how they were dealing with it. For me it was very difficult to talk about anything that bothered me because I was not an infantryman and felt as if I did not have the right to raise my hand because of it. I felt as if I was subpar because the other people in my battalion had been through much worse and I was weak if I couldn't handle the things that I went through. After a few classes we all returned from the deployment and shortly after went on leave. That is all that we went through in regards to post deployment, a few classes to make sure that if we had any traumatic events we made sure we let somebody know.

I was deployed a second time to Okinawa, Japan in 2005. At this point I was married and had a child on the way. Upon returning from Okinawa, I had my son and began preparations to get out of the Marine Corps. I was drinking almost every single day, getting in fights and was very depressed. I got out of the Marine Corps in January 2007 and decided I was out of control and needed to get help.

Before I was released from active duty, a friend and fellow Marine hanged himself in the basement of his home with an electrical wire. He had gone to the Saint Cloud VA Medical Center seeking help, but was turned away. A couple weeks later (February 7th, 2007) my good friend and father figure Sergeant Major J.J. Ellis was killed in combat. His funeral at Arlington National Cemetery got me to start drinking just a few short weeks after I was trying to get things together again. Then on March 23, 2007, my brother and best friend, who was also a Marine, hanged himself in the basement of his home. Travis was working with the VA Medical Center, but was not willing to open up to them about his internal struggles.

At that point I really went off the deep end. I started working with the VA Medical Center on an outpatient basis. I struggled with anxiety and depression which eventually led to a lot of destruction. In August of 2007 I separated from my wife and eventually got divorced, after I got another woman pregnant while I was still married. I started racking up DUI after DUI and spent some time in jail. I went to the Saint Cloud VA Medical Center and went through the Dual Diagnosis Program. There was good content and it was very informative. However, it lacked any sort of discipline and there was a gentleman that was smoking meth in the stairwell

at one point in time. It seemed more like something that would effectively be able to teach people about what drugs and alcohol can do to a person, but there was not a whole lot of real life application. Also, there was no aftercare so once I was cut loose I was pretty much on my own. I still did followup at the Minneapolis VA Medical Center, but I was so far gone outpatient would not suffice.

About a month after I completed the Dual Diagnosis Program, I attempted to kill myself by swallowing a large amount of prescribed pills. I woke up in the Saint Cloud VA Medical Center and was put up in the psych ward. I was put on a 72-hour hold and then released. There was almost no followup after my departure from my 72-hour hold and then I was just thrown back into my life again. I continued to drink, cheat, and live a life of anger. I started using drugs again because the alcohol was not doing enough to help me cope during the day. I got another DUI and found myself in jail yet again. A week after my last DUI, I found myself looking at a lot of jail time. I was scared, broken and wanted to die yet again. One week later, I checked myself into Minnesota Teen Challenge, which is a 13–15 month faith based program.

The Minneapolis VA Medical Center does not offer anything close to a 13–15 month long inpatient treatment program. I was walking around wanting to die every single day, month after month, and no 30-, 60-, or 90-day program would have been able to get me to where I needed to be. A year removed from the world that had just become too much for me and that I hated seemed like way too much to commit to, but it has saved my life. Minnesota Teen Challenge changed me more than I ever thought possible. I have completely changed my thoughts, actions, and attitude over the last year. It was a struggle and I considered leaving many times, but that is because I have always been a person that always took the easy way out. I now want to live and I want to live a successful life free of any chemicals.

While at Minnesota Teen Challenge, one of the biggest struggles that I dealt with was not having the funds to complete the program. I was not able to get the VA to fund the program while I was attending so I put in a claim to have my disability raised. I fell behind in child support, bills and eventually my payments to Minnesota Teen Challenge. It made things very difficult in the midst of me trying to get my life straightened out. I finally got my claim completed one day after my graduation and up until then I thought I was going to have to sleep in my car to come out to Washington, D.C. to testify on March 3rd of last year.

There are a lot of things that the Department of Veterans Affairs does well, but there are several I believe that they could do much better. First, they do not provide any long term care at all. The longest program that I know about is the Dual Diagnosis Program at the Saint Cloud VA Medical Center and I believe that it is only 90 days at the most. The problems that I picked up over the years of bad living were not going to go away in a matter of months. There are a lot of veterans I know that walk around in constant pain and depression because they have never been able to overcome the root of their problems. A program that lasts for a year or more is much more likely to help a person, and help them not just cope with their problems, but get rid of them all together. Minnesota Teen Challenge has changed my life from wanting to die every day to wanting to get up every day because I finally have a passion to live. Second, there was never any accountability in my experiences with the VA system. If I missed appointments or just stopped calling all together it did not seem to really matter to anyone. I felt like I was just another number going through the revolving door of head doctors that had to talk to me. I had the opportunity to work with a lot of great VA employees over my time there, but I never really felt connected. Never thought anyone really cared. Third, there are a lot of great organizations that are not connected to the Government, but are not being utilized because it may be more expensive. The VA cannot possibly take care of all the hurting veterans on their own and I believe that being able to utilize the resources of organizations not connected to the VA is necessary to help all of them.

I know that when I was discharged from the Marine Corps I was not a healthy individual, but I certainly would have not let anyone know that. I began getting treatment at the Minneapolis VA Medical Center, but I was holding back considerably. If I was forced to go into treatment I am sure that I would have saved myself and most importantly my family a lot of pain and hurt. For me it was a way to get a pay check without having to do anything for it in return.

I believe that it would be in the best interest of veterans that are struggling to have compensation withheld if they are not willing to get some sort of help. If the Government was able to set up some sort of incentive based program to encourage hurting veterans to take the time and make the effort to get help. I know that if I would have gotten that kick in the butt I needed I would have been much more receptive to getting help. As a veteran that used to be struggling with addiction and mental disorders I can honestly say that getting help was never really something

I took seriously. But why would I take it seriously? I thought that I was able to get through anything on my own and I was pretty much indestructible. It didn't matter what was going wrong in my life because I could always find a way to blame it on someone else or to find an excuse that got me through from a day-to-day basis. I needed someone to tell me that it was not alright and if I didn't get help there was going to be some serious consequences for my actions. I was, at the time, a grown adult capable of making 'grown up' decisions, but to be honest I was not very 'in touch' with reality. A good example of this was my financial decisions during this time. The amount of money that I wasted is astronomical and yet the amount of debt I still racked up is even more unbelievable. I was often times using my compensation money to fuel my drinking and carousing, but when that ran out I started using credit cards. I mention this because it is just an example of the many reasons that I needed to get help, but I chose not to because I was able to afford not to.

Another issue I believe needs to be addressed is rehab and counseling that is strictly with other veterans. I went through Minnesota Teen Challenge which is a 13–15 month rehabilitation program that is set up primarily for nonveterans. I was able to work on myself at Minnesota Teen Challenge and then once a week go to the Minneapolis VA Medical Center to work on my service-related problems. In my personal opinion that is a big reason for my success throughout the program as well as my continued success today. It was important for me to get my service-related issues dealt with, but for me to be able to go back to a program that didn't solely concentrate on these issues was crucial. It was much easier for me to blend in and not feel like I always had to talk about my service-related issues, instead I was able to take a much more in depth look at where a lot of my issues started.

I would not be where I am now without the help from the Department of Veterans Affairs, but I could have gotten here a lot sooner. I have watched my friends and family who are veterans suffer through many invisible wounds, and there is no reason for it. I appreciate your time and the opportunity to share my testimony.

Prepared Statement of Karen H. Seal, M.D., MPH, Staff Physician, Medical Service, San Francisco Department of Veterans Affairs Medical Center, Veterans Health Administration, U.S. Department of Veterans Affairs, and Associate Professor in Residence of Medicine and Psychiatry, University of California, San Francisco

Executive Summary

Mental Health Problems in OEF/OIF Veterans in VA Health Care

PTSD rates in OEF/OIF Veterans in VA health care have increased steadily since the conflicts began, followed by increasing rates of depression. ***Younger active duty Veterans*** appear to be at particularly high risk for PTSD; ***older National Guard and Reserve Veterans*** are at higher risk for PTSD and depression. Rates of depression, anxiety, and eating disorders are higher in women than men; female Veterans who experienced military sexual trauma are at heightened risk for developing PTSD. Appreciating subgroup differences in the prevalence and types of mental health disorders can help guide more targeted interventions and treatments, as well as future research efforts.

Mental Health Services Utilization in OEF/OIF Veterans

The majority (80 percent) of OEF/OIF Veterans that received new PTSD diagnoses attended at least one VA mental health follow-up visit in the first year of diagnosis. However, less than 10 percent with new PTSD diagnoses attended a minimum number of mental health sessions within a time frame required for evidence-based PTSD treatment. Being young (under age 25) and male, having received a mental health diagnosis from a non-mental health clinic (i.e., primary care), and living far from a VA facility (>25 miles) were associated with failing to receive adequate PTSD treatment. Because adequate evidence-based PTSD treatment may prevent chronic PTSD, VA must continue to develop interventions designed to improve ***retention*** in mental health treatment. In contrast, despite underutilization of mental health services, those with mental health disorders disproportionately used VA primary care medical services. Thus, models that integrate primary care and mental health services may improve engagement in mental health treatment, and, at the same time, address co-occurring physical complaints.

Barriers to VA Mental Health Care

Patient barriers to mental health care among OEF/OIF Veterans include stigma, logistical barriers, and even the symptoms of the mental health disorders themselves. Avoidance in PTSD, apathy in depression, and denial and self-medication with drugs and alcohol may prevent Veterans from seeking care. In addition, VA has not always been able to keep pace with the demand for mental health services. System barriers include shortages of mental health personnel trained in evidence-based treatments and lack of universal access to telemental health care, particularly in rural VA facilities. While information technology security is important, excessive concerns may be impeding the development of more novel Internet and telephone-based mental health treatment options. Privacy concerns about the Department of Defense's access to Veterans' electronic medical records have discouraged some Veterans from coming forward and disclosing symptoms.

Improving Access to and Retention in Mental Health Treatment for OEF/OIF Veterans

Capitalizing on the propensity for OEF/OIF Veterans with mental health problems to receive care in VA primary care settings, VA might consider further restructuring VA services such that more specialty mental health providers trained in evidence-based mental health treatments are embedded within primary care. In addition, new clinical resources available through Patient Aligned Care Teams (PACT) in VA primary care (i.e., Nurse Care Managers) could be leveraged to facilitate enhanced engagement of Veterans in mental health treatment. For instance, PACT nurses could act as motivational coaches or could help provide Veterans access to new technologies such as the VA Internet site, "My Health*e*Vet" or smart phone applications such as "PTSD Coach" to enhance access to online mental health treatments or treatment adjuncts. There is also a need for more research to develop and test modified evidence-based treatments for PTSD and other mental health problems that are better suited to primary care settings.

Conclusions

OEF/OIF Veterans have extremely high rates of accruing military service-related mental health problems. Despite this large burden of mental illness, many OEF/OIF Veterans do not access or receive an adequate course of mental health treatment. Veterans with mental health disorders disproportionately use VA primary care medical services. Recognizing the advances that VA has already made in VA Primary Care-Mental Health Integration, and more recently, the Patient-Aligned Care Team (PACT) model, VA is poised to address many of the remaining system barriers to mental health care for OEF/OIF Veterans by incorporating *more* specialty mental health care within VA primary care to meet the growing needs of this current generation of men and women returning from war.

It has been nearly 10 years since the current conflicts began and over 2.1 million servicemembers have served in OEF and OIF. Of these, over 1.2 million have separated from active duty service and have become eligible for VA services. Many soldiers have endured multiple tours of duty and most have experienced combat. Making the transition from war zone to home has been challenging, especially for veterans who have sustained physical injuries, as well as for those who have developed mental health problems. Based on prior DoD, VA, and nationally representative samples of OEF/OIF Veterans, the prevalence of mental health disorders has steadily increased: between 19 percent and 42 percent of OEF/OIF veterans have been estimated to suffer from deployment-related mental health problems (Milliken et al., 2007; Tanielian & Jaycox, 2008). The most recent data released from the VA Environmental Epidemiology Service (January 18, 2011) indicate that 331,514 (51 percent) of 654,348 VA-enrolled Veterans have received mental health diagnoses and 177,149 (27 percent) have received post-traumatic stress (PTSD) diagnoses. These data confirm that the burden of mental health diagnoses has continued to increase since the conflicts began in 2001.

The mental health prevalence estimates our research group provides are based on data our group has acquired from VA national administrative databases which contain mental health diagnostic codes associated with VA clinical visits. The use of diagnostic codes has been shown to be a valid proxy for estimating disease prevalence, but is subject to reporting biases and some misclassification errors. Our findings are based on the entire population of OEF/OIF veterans who sought VA health

care nationwide and thus are not based on a nationally representative sample of OEF/OIF Veterans. Of note, our findings have been consistent with other published studies of nationally representative samples of OEF/OIF Veterans.

In one of our earlier studies (Seal et. al, 2009), of 289,328 Iraq and Afghanistan Veterans who were first-time users of VA health care after separation from OEF and/or OIF military service, we found that new mental health diagnoses increased 6-fold from 6 percent in April 2002 to 37 percent by March 31, 2008. Thus, by 2008 over 1 of every 3 Veterans had received one or more mental health diagnoses. Moreover, with each additional year of follow-up, we observed the accrual of additional mental health diagnoses in individual Veterans. Similarly, Milliken and colleagues demonstrated increases in mental health problems among OEF/OIF soldiers who were screened again several months after returning home compared to rates immediately after returning (Miliken et al., 2007). There are several factors that contribute to delayed onset of mental health diagnoses. There may be stigma leading to reluctance to disclose mental health problems until those problems interfere with functioning (Hoge et al., 2004). Some military service-related mental health problems only appear months to years after combat (Solomon et al., 2006) and somatization or co-morbidity often confound accurate mental health diagnosis (Kessler et al., 1995). The VA policy change that extended free VA military service-related health care to 5 years from 2 years post-discharge has likely increased our ability to detect mental illness in OEF/OIF Veterans. Now our challenge is to engage Veterans with mental health problems in care.

Several other key findings regarding the prevalence of mental health disorders have emerged from our recently published studies (Seal et al., 2009; Maguen et al., 2010; Seal et al., 2011):

- Among the 106,726 OEF/OIF Veterans with mental health diagnoses, by study end (2008), two thirds had more than one co-occurring mental health diagnosis: approximately one-third had two mental health diagnoses and another third had 3 or more different mental health diagnoses, increasing diagnostic complexity and complicating treatment.
- Overall, from 2002 to 2008, the rate of PTSD had increased from 0.2 percent to 22 percent (62,929); with a rapid increase in PTSD in the first quarter of 2003 following the invasion of Iraq. Greater combat exposure was associated with higher risk for PTSD in active duty Veterans.
- Age and component type mattered: ***Active duty*** Veterans ***less than age 25*** years had 2 to 5 times higher rates of PTSD, alcohol and drug use disorder diagnoses compared to active duty Veterans ***over age 40.*** In contrast, among ***National Guard/Reserve*** Veterans, risk for PTSD and depression were significantly higher in Veterans ***over age 40*** compared to their younger counterparts ***less than age 25.***
- Rates of depression diagnoses in OEF/OIF Veterans paralleled increases in PTSD with 50,432 (17 percent) Veterans diagnosed with depression by 2008. PTSD and depression were highly comorbid with as many as 70 percent of Veterans suffering from both conditions.
- Women OEF/OIF Veterans were at significantly higher risk for depression than men; women Veterans were also at significantly higher risk for anxiety disorders and eating disorders than their male counterparts.
- Thirty-one percent of women with PTSD compared with 1 percent of men with PTSD screened positive for a history of military sexual trauma (MST). Women Veterans with MST were over four times more likely to develop PTSD than OEF/OIF female Veterans without MST.
- Overall, over 11 percent of OEF/OIF Veterans received substance use disorder diagnoses. Male Veterans had over twice the risk for substance use disorders as female Veterans. Among Veterans with substance use disorders, 55–75 percent had comorbid PTSD or depression.

In summary, PTSD rates in treatment-seeking Veterans in VA health care have increased steadily since the conflicts began, closely followed by increasing rates of depression diagnoses. Particular subgroups of OEF/OIF Veterans appear at higher risk for mental health diagnoses. Younger active duty Veterans appear to be at particularly high risk for PTSD likely due to higher combat exposure. Older National Guard and Reserve Veterans were at higher risk for PTSD and depression than younger National Guard/Reserve Veterans. Further investigation of the causes of mental health diagnoses in older Guard/Reserve Veterans is warranted because measures of greater combat exposure were not consistently associated with mental health diagnoses. One explanation is that when called to arms, older Guard/Reserve members are more established in civilian life and may be less well prepared for combat, making their transition to war zone and home again more stressful. Regard-

ing the relatively low prevalence rates of drug use disorders in OEF/OIF Veterans in our sample, stigma, fear of negative repercussions, and lack of universal screening for illicit substances in VA may have reduced the number of drug use disorders reported and detected. Finally, there are pronounced gender differences in military service-related mental health disorders: Rates of depression, anxiety and eating disorders were elevated in women compared to men; female Veterans who experienced MST were at extremely high risk for developing PTSD. Appreciating subgroup differences in the prevalences and types of mental health disorders can help guide more targeted interventions and treatments, as well as future research efforts.

Mental Health Services Utilization in OEF/OIF Veterans

Overview

The Department of Veterans Affairs (VA) health care system is the single largest provider of health care for OEF/OIF Veterans with over 50 percent of all returned combat Veterans enrolled. This is historically high for VA; only 10 percent of Vietnam Veterans enrolled in VA health care (Kulka et al., 1990). Since 2001, the VA had provided OEF/OIF Veterans 2 years of free military service-related health care from the time of service separation, a benefit which was extended to 5 years in 2008 ("National Defense Authorization Act of 2008"). Most of the over 150 VA medical centers in the United States offer a complete spectrum of mental health services, including over 140 PTSD specialty clinics. For rural Veterans living far from a VA medical center, over 900 VA community-based outpatient clinics offer basic health care and some offer basic mental health services. After the 5-year period of combat-related health coverage, OEF/OIF Veterans are eligible to continue to use VA health care services without charge (if service-connected) or are assessed a nominal co-pay scaled to income. Of note, OEF/OIF Veterans who have health insurance through employment, school or otherwise, may seek non-VA health care services in their communities, and VA data systems do not capture non-VA health care utilization.

Early, adequate evidence-based mental health treatment has been shown to prevent mental health disorders, such as PTSD, from becoming chronic (Bryant et al., 2003). Multiple studies of Veterans and civilians reveal however that a substantial proportion of those suffering from mental health problems either do not access, delay, or fail to complete an adequate course of specialty mental health treatment (Hoge et al., 2004; Tanielian & Jaycox, 2008; Wang et al., 2005). Studies have shown that mental health disorders other than PTSD, such as depression and substance use disorders may be managed in primary care as opposed to specialty mental health (Batten & Pollack, 2008). Some specific symptoms of PTSD, such as insomnia, may be managed by primary care clinicians in primary care. However, consistent with the Institute of Medicine's finding that only two mental health therapies have demonstrated efficacy for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, the VA recommends that Veterans with a PTSD diagnosis receive definitive treatment by mental health providers trained in these evidence-based therapies, which usually occurs in mental health clinics (Institute of Medicine's Committee on Treatment of Posttraumatic Stress Disorder, 2007). Evidence-based PTSD treatments typically require a minimum of 9 or more sessions, ideally spaced at weekly intervals (Foa et al., 2007; Monson et al., 2006).

Mental Health Services Utilization in OEF/OIF Veterans using VA health care (2002–2008)

Of nearly 50,000 OEF/OIF Veterans with newly diagnosed PTSD, 80 percent compared to 49 percent of Veterans receiving mental health diagnoses other than PTSD had at least one VA mental health visit in the first year of diagnosis. Nevertheless, only 9.5 percent with new PTSD diagnoses attended 9 or more follow-up sessions in 15 weeks or less after receiving their diagnosis. When the follow-up period was extended to 1 year, a larger proportion, 27 percent, attended 9 or more mental health sessions. Among OEF/OIF Veterans receiving mental health diagnoses other than PTSD (e.g., depression), only 4 percent attended 9 or more follow-up sessions in 15 weeks or less and slightly more, 9 percent, attended 9 or more sessions when the follow-up period was extended to 1 year. Our study was limited in that we lacked information about non-VA mental health treatment utilization and the specific type of mental health treatment received. Thus, we can draw no firm conclusions about the adequacy and intensity of mental health care for OEF/OIF Veterans since we lack data on care received outside the VA system. Nevertheless, VA is currently the single largest provider of health care for OEF/OIF Veterans and, of those with new PTSD diagnoses, in the first year of diagnosis, under 10 percent appear

to have received what would approximate evidence-based mental health treatment for PTSD at a VA facility, and those with other mental health diagnoses received an even lower intensity of VA care.

Our study revealed that factors such as being young (under age 25) and male, factors linked to a greater likelihood of receiving a PTSD diagnosis, were also associated with a failure to receive minimally adequate PTSD treatment. These findings may reflect the symptoms of PTSD itself, including avoidance, denial and comorbid disorders such as depression and substance abuse. In young male Veterans, stigma likely also plays a major role (Hoge et al., 2004). In addition, we found that having received a mental health diagnosis from a non-mental health clinic (i.e., primary care) and living far from a VA facility (>25 miles) were associated with failing to receive adequate PTSD treatment. Veterans who receive PTSD diagnoses from VA primary care may be less symptomatic than those receiving diagnoses from mental health clinics and less in need of specialty mental health treatment or prefer primary care-based treatments. Indeed, many mental health problems of OEF/OIF Veterans other than PTSD, such as depression, may be effectively managed in primary care. In fact, we found that among OEF/OIF Veterans receiving mental health diagnoses other than PTSD, more than 85 percent had attended at least one primary care visit in the year following diagnosis, the majority of which were coded to indicate that a mental health concern had been discussed. It is also possible that Veterans who receive PTSD diagnoses from non-mental health clinics or who live far from VA services fall through the cracks in the referral for specialty mental health care. In sum, our research findings support ongoing implementation efforts by VA leadership to promote expanded access and adherence to specialty mental health care, especially for rural Veterans (Zeiss & Karlin, 2008).

Our results suggest that OEF/OIF Veterans may, in fact, be more likely than Vietnam-era Veterans to have had ***at least one*** initial VA mental health follow-up visit after receiving a new mental health diagnosis. In the National Vietnam Veterans Readjustment Study (NVVRS), a nationally representative sample of Vietnam-era Veterans, a much lower proportion of Vietnam Veterans (30 percent) reported having sought any mental health treatment and only 7.5 percent used VA mental health services (Kulka et al., 1990). A more recent study demonstrated that after adjustments for potential confounding, variables such as age and the complexity of mental health disorders were more important predictors of whether Veterans received mental health treatment, as opposed to which era they served (Harpaz-Rotem & Rosenheck, 2011).

It stands to reason that OEF/OIF Veterans would be more likely than prior-era veterans to have had at least an ***initial*** mental health visit. In comparison to Vietnam-era Veterans, a higher proportion of OEF/OIF Veterans has experienced "frontline" combat exposure and has survived their injuries (Gawande, 2004), which has been associated with the development of mental health disorders and increased need for mental health services (Hoge et al., 2007). Unlike in prior eras, Congress extended health coverage for OEF/OIF veterans to 55 years after service separation. Many newly returned OEF/OIF veterans facing economic hardship have taken advantage of blanket VA health care coverage and have used VA services. Also, different from prior eras, the Department of Defense, in an effort to reduce stigma, now openly discusses combat-related stress with active duty servicemembers. Similarly, widespread media attention focused on mental health disorders in Iraq and Afghanistan Veterans has lowered the threshold for recently returned Veterans to seek care. Finally, both the VA and the military have implemented population-based post-deployment mental health screening programs and routinely refer Veterans who screen positive for further mental health assessment and/or treatment (Hoge et al., 2006; Seal et al., 2008), all factors which support initial VA mental health services utilization.

Nevertheless, despite ***initial*** use of VA mental health services among OEF/OIF Veterans, ***retention*** in VA mental health services appears less robust. The strongest predictor of retention in VA mental health treatment services in our study, as in others, was "need" for mental health treatment (Spoont et al., 2010). Veterans receiving PTSD diagnoses (as opposed to other mental health diagnoses) and those receiving additional comorbid mental health diagnoses in conjunction with PTSD were more likely to remain in care and receive minimally adequate PTSD treatment. Unfortunately, compared to studies of civilians however, retention in VA mental health treatment appears inferior. For instance, the National Comorbidity Survey Replication Study, a population-based survey of 9,282 U.S. civilian adults, found that 48 percent of patients with any mental disorder (including PTSD) reported having received at least "minimally adequate therapy," defined by evidence-based national mental health treatment guidelines, within the first year of diagnosis (Wang et al., 2005). In contrast, similar to our findings, a RAND Corporation study re-

ported that a much lower proportion, 25 percent of a nationally representative sample of OEF/OIF Veterans with PTSD and depression, received "minimally adequate therapy" within the first year of diagnosis (Tanielian & Jaycox, 2008).

In summary, we found that the majority of OEF/OIF Veterans that received new mental health diagnoses, including PTSD, attended at least one mental health follow-up visit in the year after mental health diagnosis. However, the vast majority of OEF/OIF Veterans with new PTSD diagnoses failed to attend a minimum number of mental health sessions within a recommended time frame required for evidence-based PTSD treatment. Because early, evidence-based PTSD treatment may prevent chronic PTSD, it will be important that the VA, in its mission to provide the best care for returning combat Veterans, continue to develop and implement interventions to improve retention in mental health treatment, with particular attention to the needs of more vulnerable OEF/OIF Veterans.

Utilization of VA Primary Care in OEF/OIF Veterans with Mental Health Problems

Despite underutilization of mental health services, those with mental health disorders disproportionately use VA primary care medical services compared to OEF/OIF Veterans without mental health problems. Frayne et al. examined non-mental health medical care among 90,558 Veterans from 2005 through 2006 and found that those with a diagnosis of PTSD had more medical diagnoses and greater primary care service utilization than those without a mental health diagnosis (Frayne et al., 2010). Another article published by Cohen et al. in our group, found an increased prevalence of cardiovascular risk factors (i.e. hypertension, high cholesterol, smoking, and obesity) in OEF/OIF Veterans with PTSD compared to Veterans with mental health conditions other than PTSD, or no mental health conditions (Cohen et al., 2010). In a related study, Cohen et al. reported that Veterans with PTSD consumed almost twice as much primary medical care as those without a mental health diagnosis (Cohen et al., 2010). There are several possible explanations for these findings: The traumatic events that caused PTSD might have also caused physical injury requiring medical attention; somatic symptoms and stigma associated with PTSD may have motivated Veterans to seek VA primary care; PTSD may be associated with high-risk behaviors (e.g. alcohol abuse) leading to physical health problems, and finally, increased contact with the medical system through PTSD treatment, may have led to increased detection of other physical problems. To the extent that we fail to retain Veterans in an adequate course of mental health treatment, we may continue to grapple with pervasive and chronic comorbid physical and behavioral problems in VA primary care clinics. Because most individuals with PTSD, including OEF/OIF Veterans, pursue medical treatment in primary care, models that integrate primary care and mental health treatment may improve both engagement and retention of patients in mental health care, while simultaneously addressing co-occurring physical complaints.

Barriers to VA Mental Health Care

Patient Barriers

There have been numerous reports of barriers to mental health care for OEF/OIF Veterans. Our data and the work of others indicate that while there are indeed barriers to access and initiation of mental health treatment, longer-term retention in mental health treatment is far more problematic (Seal et al., 2010; Seal et al., 2011, in press; Spoont et al., 2011; Harpaz-Rotem & Rosenheck, 2011). Barriers to engagement in mental health treatment have generally been categorized into patient-related barriers and system barriers. Patient barriers have been well-described and include: (1) Stigma regarding mental illness-concerns about being perceived as weak by family, friends, colleagues, or within one's culture for coming forward with mental health problems, (2) "Battlemind"—not recognizing or believing that behaviors such as hypervigilance that were adaptive in the war zone are now maladaptive in civilian life, and thus not seeking or accepting mental health treatment, (3) Beliefs and attitudes that mental health treatment, including psychoactive medication, is not effective or even dangerous, (4) Logistical barriers such as job, school, family obligations, geographical distance, and lack of transportation, (5) Symptoms of mental health disorders themselves, such as avoidance in PTSD, apathy in depression, and denial in drug and alcohol abuse, and (6) Self-medication with drugs and alcohol that may temporarily mask symptoms.

VA System Barriers

The Institute of Medicine (IOM) identified six aims for improvement of the quality of mental health care. These included safety, effectiveness, patient-centeredness, timeliness, efficiency, and equity (Institute of Medicine, 2006). Consistent with these aims, the VA has made numerous strides toward improving the delivery of mental health treatment for OEF/OIF Veterans by greatly increasing mental health capacity and services. For instance, in order to improve identification and treatment of Veterans with mental health disorders, since 2004, the VA has conducted universal post-deployment mental health screening of OEF/OIF Veterans who receive care at VA facilities (Seal et al., 2008) In addition, in 2007, the VA initiated an expansion of mental health services capacity, which included an increase in the number of mental health staff assigned to more rural VA clinics, an increase in the use of video-teleconferencing services ("telemental health") to increase access to specialty mental health care for rural Veterans, and the implementation of the Primary Care Mental Health Integration initiative to co-locate mental health providers in primary care settings (Zeiss & Karlin, 2008). Indeed, the new VA primary care Patient Aligned Care Team (PACT) model is consistent with IOM principals to improve the quality of mental health care by identifying a mental health provider that is associated with each of the primary care PACT teams to provide timely and efficient mental health care to Veterans within primary care.

Nevertheless, with ever-increasing numbers of OEF/OIF Veterans presenting with mental health problems, VA has not always been able to keep pace with the demand for services, particularly in more rural VA facilities. From my perspective, there are several VA system barriers which are remediable and require our attention:

- There are shortages of mental health staff (psychologists and social workers) who are trained in evidence-based therapies for PTSD, particularly in more rural VA community-based outpatient clinics.
- There is a lack of universal access to telemental health services for Veterans receiving care at more rural VA community-based outpatient clinics to provide access to specialty mental health clinicians based at VA medical centers.
- Information technology (IT) security is important, yet excessive concerns about IT security may be slowing the development and use of more novel Internet and telephone-based mental health treatment options that may appeal to younger Veterans.
- Veterans continue to complain about difficulties navigating the VA system to schedule appointments, long wait times for appointments, and shortages of drop-in appointments, which limit access to care.
- Limited mental health treatment resources for families and children of Veterans, as well as the lack of childcare limits mental health treatment options for Veterans and their families; particularly affecting Women Veterans.
- In an effort to enhance information exchange between the Department of Defense (DoD) and the VA, there is concern that Veterans' confidential electronic medical records will be viewed by DoD, causing some Veterans to be reticent about disclosing sensitive mental health concerns such as substance abuse issues, interpersonal violence, and sexual identity issues, which limits their ability to receive treatment for these problems at VA.

Enhancing Access to and Retention in Mental Health Treatment for OEF/OIF Veterans

Capitalizing on the propensity for OEF/OIF Veterans to receive care in VA primary care settings, one strategy to further enhance engagement in mental health services is to further co-locate and integrate specialty mental health services, such as evidence-based PTSD treatment, within primary care. Despite the VA Primary Care Mental Health Integration initiative, even in model programs, these embedded mental health providers (many of whom are social workers) typically provide further assessment of positive mental health screens, specialty mental health referrals, medication management, and brief supportive therapies, but rarely provide evidence-based mental health treatments (Possemato et al., 2011). Use of specialty mental health services has been associated with greater retention in mental health treatment, and in turn, improved clinical outcomes (Wang et al., 2005). There are several ways to provide greater access to specialty mental health treatment through primary care. Below are a few possible suggestions:

- *Restructure VA services such that specialty mental health providers trained in evidence-based mental health treatments are co-located and fully integrated within primary care.* This requires a new holistic paradigm for VA primary

care that views mental health care as part of primary care. This may even involve infrastructure changes to existing medical clinics to accommodate the co-location of more mental health providers in primary care. These structural changes could literally "break down walls" that exist between medical and mental health services, overcome stigma, and narrow the gap between primary care and mental health. For instance, pre-scheduling mental health visits to occur at the same time as primary care visits, as we do in our one-stop Integrated Care Clinic at the San Francisco VA Medical Center, will make it more likely that patients will attend and be retained in mental health.

- *Leverage new clinical resources available through Patient Aligned Care Teams (PACT) in VA primary care.* Nurse Care Managers in primary care PACT teams are currently being trained nationwide through the VA National Center for Prevention to conduct motivational coaching through a new VA program called "TEACH" (**T**uning in, **E**valuation, **A**ssessment, **C**ommunication and **H**onoring the patient). Primary care PACT nurses could conceivably conduct brief telephone motivational coaching sessions to remind and motivate Veterans to attend their mental health appointments. As an alternative to the telephone, nurses could use the new VA Internet application, "My Health***e***Vet" to securely e-mail Veterans about upcoming mental health visits, a communication modality that particularly appeals to younger Veterans. In addition, consistent with the evidence-based collaborative care model for depression treatment, nurses could feed back relevant clinical information from patients to mental health and primary care providers to promote more efficient, coordinated, and effective care.
- *Exploit new technologies to deliver mental health treatment through VA primary care in rural settings where there are limited or no specialty mental health services.* For instance, PACT nurses could coordinate telemental health visits at VA community-based outpatient clinics with specialty mental health providers based at VA medical centers. For patients who need care, but are unable to travel to any VA facility, VA might give serious consideration to newer technologies that bring mental health care into patients' homes. Examples include the delivery of evidence-based mental health treatments over the telephone or through "Skype," the use of smart phone applications such as "PTSD Coach" as an adjunct to mental health treatment, and the use of the Internet to deliver mental health treatments through VA sites such as "My Health***e***Vet" or other state-of-the-art DoD-sponsored Web sites such as www.afterdeployment.org, which provides online evidence-based mental health treatment. These Internet-based treatments could be facilitated by VA therapists who could conduct regular telephone check-ins with patients. These innovations will require re-visiting some of VA's current IT security policies.
- *Support further research to develop and test the implementation of modified evidence-based treatments for PTSD and other mental health problems in primary care.* There is a need to develop and test PTSD treatments that are briefer and better suited for primary care. In addition, there is a need to develop and test integrated treatments for PTSD that simultaneously address substance abuse or other behavioral (e.g. smoking) or physical health problems (e,g, chronic pain) in the context of PTSD treatment, since PTSD is highly comorbid with other mental and physical health problems. In this vein, the incorporation of complementary and alternative modalities in the treatment of PTSD, such as exercise, yoga, and acupuncture can be used to help motivate engagement in mental health treatment and may help to improve symptoms and overall physical and emotional well-being of Veterans suffering with mental illness.

Conclusion

In summary, OEF/OIF Veterans have extremely high rates of accruing military service-related mental health problems. Despite this large burden of mental illness, because of patient and system barriers to VA mental health care, many OEF/OIF Veterans do not access or receive an adequate course of mental health treatment. In contrast, despite underutilization of mental health services, combat Veterans with mental health disorders disproportionately use VA primary care medical services. Recognizing the advances that VA has already made in VA Primary Care-Mental Health Integration, and more recently, the Patient-Aligned Care Team (PACT) model, VA is poised to address many of the remaining system barriers to mental health care for OEF/OIF Veterans by incorporating *more* specialty mental health care within VA primary care. VA has been a pioneer in our national health care system, learning and growing through vast clinical experience and the enterprise of

VA health services research. Given the current epidemic of mental health problems in OEF/OIF Veterans, coupled with budgetary constraints, we will again need to challenge ourselves to "think outside of the box" to develop and implement new systems of care, new technologies, and new services to meet the needs of this current generation of men and women who have served our Country.

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Prepared Statement of Lieutenant General James Terry Scott, USA (Ret.), Chairman, Advisory Committee on Disability Compensation

Chairman Miller, Ranking Member Filner, and Members of the Committee: It is my pleasure to appear before you today representing the Advisory Committee on Disability Compensation. The Committee is chartered by the Secretary of Veterans Affairs under the provisions of 38 U.S.C. in compliance with P.L. 110–389 to advise the Secretary with respect to the maintenance and periodic readjustment of the VA Schedule for Rating Disabilities. Our charter is to "(A)ssemble and review relevant information relating to the needs of veterans with disabilities; provide information relating to the character of disabilities arising from service in the Armed Forces; provide an ongoing assessment of the effectiveness of the VA's Schedule for Rating Disabilities; an provide on going advice on the most appropriate means of responding to the needs of veterans relating to disability compensation in the future".

The Committee has met twenty nine times and has forwarded two reports to the Secretary that addressed our efforts as of September 30, 2010 and fulfilled the statutory requirement to submit a report by October 31, 2010. (Copies of these reports were furnished to majority and minority staff in both Houses of Congress.) The Secretary of Veterans Affairs responded to the interim report on February 23, 2010. (Copies provided for the Record).

Our focus has been in three areas of disability compensation: Requirements and methodology for reviewing and updating the VASRD; adequacy and sequencing of transition compensation and procedures for servicemembers transitioning to veteran status with special emphasis on seriously ill or wounded servicemembers; and disability compensation for non-economic loss (often referred to as quality of life).

After coordination with the Secretary's office and senior VA staff, we have added review of individual unemployment and the review of the methodology for determining presumptions to our agenda. Recently, we were asked to review the appeals process as it pertains to the timely and accurate award of disability compensation.

Your letter of invitation asked me to "(P)resent the views of the Department on the serious questions that have been raised about the VA mental health care system and the Department's ability to provide timely, effective and accessible care and benefits to veterans struggling with mental illness". I believe that the representatives of the Department are more current and better qualified to present the view of the Department. I am offering my views based on the analysis, findings, and recommendations of the Veterans Disability Benefits Commission (VDBC) that I had the privilege of chairing from 2004–2007.

Discussions with the Committee staff included a request that I review the pertinent findings and recommendations of the Veterans Disability Benefits Commission (VDBC) that met from 2004–2007 and made 113 recommendations covering a wide range of Veterans disability issues. Specifically, I was asked to discuss the VDBC work on the topic of integration among compensation, treatment, vocational assess-

ment and training, and follow *up* examination for Veterans suffering from mental disability, to include PTSD.

It is important to acknowledge the significant progress that VA has made in adopting and implementing many of the VDBC recommendations and many of the recommendations of the Advisory Committee.

A master plan for reviewing and updating the entire VASRD body system by body system is published. A dedicated staff is working on this important project and making significant progress. A draft of the revised mental health body system is prepared and under review. Significant progress is underway on four other body systems with initial conferences set for October 2011 to begin review of three more body systems.

Disability Benefits Questionnaires are being developed and tested that simplify the process of evaluating conditions.

Additional adjudicators are being hired and trained.

VA and DoD have established working groups at all levels of the organizations to ensure improved transition from soldier to veteran.

Pertinent to today's hearing, the VDBC invested significant time and effort analyzing the then current methods of diagnosing, evaluating, and adjudicating the claims of veterans suffering from mental illness including PTSD. Principal source documents used in the analysis were a 2005 report by the VA Office of the Inspector General that summarized the trends in PTSD claims and compensation from FY 1999–2004 and an Institute of Medicine study competed in 2006 titled "Posttraumatic Stress Disorder: Diagnosis and Assessment". These studies and the testimony of veterans, family members, medical professionals, and VA subject experts provided the basis for the six recommendations the VDBC offered. They are;

Recommendation 5.28

VA should develop and implement new criteria specific to post-traumatic stress disorder in the VA Schedule for Rating Disabilities. Base those criteria on the Diagnostic and Statistical Manual of Mental Disorders and consider a multidimensional framework for characterizing disability caused by post-traumatic stress disorder. (This recommendation is addressed by the revision of the pertinent VASRD section).

Recommendation 5.29

VA should consider a baseline level of benefits described by the Institute of Medicine to include health care as an incentive for recovery for post-traumatic stress disorder as it relapses and remits. (This recommendation is yet to be addressed and will likely be addressed as part of the comprehensive approach described in Recommendation 5.30)

Recommendation 5.30

VA should establish a holistic approach that couples post-traumatic stress disorder treatment, compensation, and vocational assessment. Reevaluation should occur every 2–3 years to gauge treatment effectiveness and encourage wellness. (This recommendation is the central issue in recasting VA approach to all mental illness including PTSD)

Recommendation 5.31

The post-traumatic stress disorder examination process: Psychological testing should be conducted at the discretion of the examining clinician. VA should identify and implement an appropriate replacement for the Global Assessment of Functioning. Post-traumatic stress disorder data collection and research:

VA should conduct more detailed research on military sexual assault and post-traumatic stress disorder and develop and disseminate reference materials for raters.

Recommendation 5.32

A national standardized training program should be developed for VA and VA-contracted clinicians who conduct compensation and pension psychiatric evaluations. This training program should emphasize diagnostic criteria for post-traumatic stress disorder and comorbid conditions with overlapping symptoms, as set for the Diagnostic and Statistical Manual of Mental Disorders. (Implementing this recommendation will address the reported inconsistencies in diagnosis and evaluation of veterans claiming mental illness).

Recommendation 5.33

VA should establish a certification program for raters who deal with claims for post-traumatic stress disorder (PTSD), as well as provide training to support the

certification program and periodic recertification. PTSD certification requirements should be regularly reviewed and updated to include medical advances and to reflect lessons learned. The program should provide specialized training on the psychological and medical issues (including comorbidities) that characterize the claimant population, and give guidance on how to appropriately manage commonly encountered rating problems. (Implementing this recommendation will also help address the reported inconsistencies in diagnosis and evaluation of veteran claiming mental illness. Consolidating the adjudicating of mental illness claims in a few centers of excellence may also assist in the timely, accurate and consistent award of mental disabilities).

The key recommendation of the VDBC regarding significant change to the VA approach to diagnosing, evaluating, adjudicating and treating mental disability is to create a linkage among compensation, treatment, vocational assessment/rehabilitation, and follow up examinations to determine efficacy of treatment. The benefits of linking treatment, compensation, vocational assessment, and periodic reevaluation include the potential to reduce homelessness and suicide as well as evaluate the effectiveness of treatment programs. Most importantly, it greatly improves the opportunity for a veteran suffering from mental disability to maximize his/her future contributions to society.

This is a controversial recommendation in the sense that it dramatically changes the role of the Department in evaluating and treating mental disability. The principal arguments against the linkage are that it will be viewed by some stakeholders as a mechanism to reduce disability payments and that it differs from how the Department addresses physical disabilities. Both of these arguments can be addressed with carefully written and explained regulation and/or policy directives. Recommendation 5.29 offers an approach to compensation that recognizes the relapsing and remitting nature of mental illness. Regarding the differences in approach to physical versus mental disabilities, there is significant evidence that individuals with mental disabilities are less likely to seek and maintain a treatment regimen than those with physical disabilities.

The VDBC recommendation to link compensation, treatment, vocational assessment/training, and periodic reevaluations offers an opportunity to reduce homelessness, suicide and substance abuse among veterans suffering from mental disabilities, particularly PTSD. Such an approach should offer long term help for mentally disabled veterans and improve their chances for maximum integration into society.

Thank you for the opportunity to present this recommendation to you and for your consideration and attention.

Prepared Statement of Sally Satel, M.D.,
Resident Scholar, American Enterprise Institute

Chairman Miller, Ranking Member Filner, and Members of the Committee, thank you for the invitation to appear before the Committee. My name is Sally Satel. I am a psychiatrist who formerly worked with disabled Vietnam veterans at the West Haven VA Medical Center in Connecticut from 1988–1993. Currently, I am a resident scholar at the American Enterprise Institute (and work, part-time, at a local methadone clinic). I have been interested in applying the lessons we learned in treating Vietnam veterans to the new generation of service personnel returning from Iraq and Afghanistan.

At issue is the relationship between mental health treatment and compensation benefits. I have been asked to discuss the implications of granting disability status and benefits to veterans with psychiatric diagnoses before they have been treated for their mental health problems.

The Problem: Disabled yet Untreated

Much has been said about the different goals of two agencies within the Department of Veterans' Affairs: The Veterans' Health Administration, which provides treatment for veterans, and the Veterans' Benefits Administration, which adjudicates disability claims. In theory (and reality) veterans can apply for and receive disability entitlements for a psychiatric condition for which they never receive treatment. Yet treatment and rehabilitation could reasonably resolve or improve the suffering that prompted the veteran to seek compensation in the first place.

How many veterans fall through the gap between care and compensation is a question that the Committee is investigating. The scope is important, but there is little question that the problem exists.

At best, the missions of the two agencies can be integrated to enhance the welfare of veterans. Yet as policymakers consider the optimal administrative arrangement, it will be important to bear in mind the potential for inadvertent consequences—namely, that prematurely granting disability compensation may, in some cases, derail rather than speed veterans on their path to recovery.

Goals of Disability Benefits

Before considering the interaction between treatment and compensation—how they work in concert for the benefit of the veteran or at cross purposes to his or her detriment—a brief overview of disability compensation is in order.

According to the 2007 VA Benefits Commission the goal of disability benefits "should be rehabilitation and reintegration into civilian life to the maximum extent possible" and "should be provided [to] compensate for the consequences of service-connected disability on earnings capacity, the ability to engage in usual life activities, and quality of life."[1]

At this time, the DVA is formulating a rating schedule for mental disorders. According to the Office of Mental Health Services, Department of Veterans, the new version will "shift the emphasis from disabling symptoms to a functional impairment model that focuses on work and income."[2]

According to the current rating system, an individual with a service-connected rating of 100 percent is unemployable and highly symptomatic; a 50 percent rating corresponds to "occupational and social impairment with reduced reliability and productivity due to such symptoms [of PTSD, depression, anxiety]; difficulty in establishing and maintaining effective work and social relationships." A 30 percent rating reflects "occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks."

Thus, both the current and future metrics emphasize diminished function as a core feature of what it means to be disabled. This, in turn, underscores the value of compensation as a mechanism for enabling and enhancing patient social function—and a key facet of function is work, as I will discuss.

Benefits and Treatment Integration

The standard rating assessment by VBA benefit examiners relies upon clinical "comp and pension" (C and P) exams conducted by VHA psychiatrists and psychologists. These clinician-examiners, acting strictly in an evaluative rather than a therapeutic role, base their conclusions about diagnosis, functional impairment, and relationship of impairment to military service, upon existing military, medical, psychiatric records. They also meet with applicants for face to face interviews. Typically, treatment is not discussed; it is simply not part of the C and P encounter.

To remedy this situation, veterans who have received a C and P evaluation for mental health disability, whether or not they go on to receive a compensation award, should receive care for that problem. Failure to direct the veteran to care is akin to diagnosing someone with a broken leg and then not setting it. Given that C and P examinations are a common point of contact with the VA for veterans, they afford optimal opportunities (or more strongly, the imperative) for the clinician-evaluators to encourage veterans to obtain care.[3]

Benefits and Treatment at Cross Purposes

The importance of linking treatment with benefits is a point of general consensus among those who have reviewed the topic of mental health and compensation (e.g., VA Benefits Commission, Institute of Medicine.) There is less agreement, however, surrounding the thorny questions raised by the process of disability assessment itself.

First, how competently can comp and pension examiners assess a veteran's functional impairment and potential for recovery if he or she has not yet undergone a course of treatment and rehabilitation? This is a complicated matter. After all, gauging mental injury in the wake of war is not as straightforward as assessing, say, a lost limb or other physical wound. At what point, for example, do normal, if pain-

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[1] Veterans' Disability Benefits Commission. *Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century,* Oct. 2007 p. 3.

[2] Testimony of A. Zeiss, Dept. Veterans' Affairs, June 14, 2011 (Bridging the Gap Between Care and Compensation for Veterans, House Veterans' Affairs Committee).

[3] Rosen MI, Compensation examinations for PTSD—An opportunity for treatment? *J Res Rehab Devel* (2010) vol 47, no. 5: xv-xxii at *www.rehab.research.va.gov/jour/10/475/pdf/rosen.pdf*.

ful, readjustment difficulties become so troubling as to qualify as a mental illness? How can clinicians predict which patients will recover when the odds of success depend so greatly on nonmedical factors, including the veteran's own expectations for recovery; availability of social support; and the intimate meaning the patient makes of his or her distress, wartime hardships and sacrifice?

Second, at what point after a soldier is discharged from the military should the VA try to determine his or her potential for recovery and employability. what is the optimal timing of treatment relative to claims-filing?

Paradox of Compensation: Granting disability benefits prematurely—especially at the level of unemployability (e.g., 100 percent, Individual Unemployability)—may not always in the best interest of the veteran and the veteran's family. Consider the example below, based on an actual case.

A young soldier, let's call him Joe, was wounded in Afghanistan. His physical injuries heal, but his mind remains tormented. Sudden noises make him jump out of his skin. He is flooded with memories of a bloody firefight, tormented by nightmares, can barely concentrate, and feels emotionally detached from everything and everybody. At 23 years old, the soldier is about to be discharged from the military. Fearing he'll never be able to hold a job or fully function in society he applies for "total" disability (the maximum designation, which provides roughly $2,300 per month) compensation for PTSD from the DVA. This soldier has resigned himself to a life of chronic mental illness. On its face, this seems only logical, and granting the benefits seems humane. But in reality it is probably the last thing the young soldier-turning-veteran needs—because compensation will confirm his fears that he is indeed beyond recovery.

While a sad verdict for anyone, it is especially tragic for someone only in his twenties. Injured soldiers can apply for and receive VA disability benefits even before they have been discharged from the military—and, remarkably, before they have even been given the psychiatric treatment that could help them considerably. Imagine telling someone with a spinal injury that he'll never walk again—before he has had surgery and physical therapy. A rush to judgment about the prognosis of psychic injuries carries serious long-term consequences insofar as a veteran who is unwittingly encouraged to see himself as beyond repair risks fulfilling that prophecy. "Why should I bother with treatment?" he might think. A terrible mistake, of course, as the period after separation from the service is when mental wounds are fresh and thus most responsive to therapeutic intervention, including medication.

Told he is disabled, the veteran and his family may assume—often incorrectly—that he is no longer able to work. At home on disability, he risks adopting a "sick role" that ends up depriving him of the estimable therapeutic value of work. Lost are the sense of purpose work gives (or at least the distraction from depressive rumination it provides), the daily structure it affords, and the opportunity for socializing and cultivating friendships. The longer he is unemployed, the more his confidence in his ability and motivation to work erodes and his skills atrophy.

Once a patient is caught in such a downward spiral of invalidism, it can be hard to throttle back out. What's more, compensation contingent upon being sick often creates a perverse incentive to remain sick. For example, even if a veteran wants very much to work, he understandably fears losing the financial safety net if he leaves the disability rolls to take a job that ends up proving too much for him. This is how full disability status can undermine the possibility of recovery.

Without question, some veterans will remain so irretrievably damaged by their war experience that they cannot participate in the competitive workplace. But the system, well-intentioned though it surely is, must, at the same time, adequately protect young veterans from a premature verdict of invalidism.

Implications for timing: To the extent that granting disability may inadvertently undermine reintegration, a treatment first approach is logical. This sequence would begin with treatment, moves to rehabilitation, and then—if necessary—goes on to assessment for disability status.

The transition between military and civilian life is a critical juncture marked by acute feelings of flux and dislocation. Young men and women who are suffering from military-related mental illness will benefit most when they pursue treatment with the goal of recovery before labeling themselves beyond hope of improvement—and thus a candidate for high level or full service-connected disability status. Judging an individual disabled by a mental illness—worse, doomed to a life of invalidism in instances of unemployability determinations—before he or she has even had a course of therapy and rehabilitation is drastically premature.

Trauma-related distress and disorders should be treated *early* when symptoms are most responsive to treatment. There are excellent treatments for the component parts of PTSD (e.g., the phobias, anxiety, depression, existential dislocation). Treatments include desensitization protocols (such as Virtual Iraq), cognitive-behavioral

therapy, psychotherapy, and medication. There is often a period in which treatment and rehabilitation overlap.

In general, clinical optimism is warranted and must be communicated to patients. While demoralization is not a formal diagnosis, in my experience, it can be the difference between someone who throws in the towel and someone who prevails.

In addition to the importance of a forward-looking stance is the extent to which problems of reintegration are managed. This is why quality rehabilitation addresses marital discord, readjustment to civilian life as well as to being a parent, vocational training, and financial concerns. Some veterans will need help with skills in relating to family, friends, neighbors, colleagues, and bosses. When day to day hassles are made more manageable, the patient feels more in control. Not only can he or she tolerate some symptoms better (e.g., sleep problems, distressing memories), those symptoms will likely fade faster. The veteran will be less likely to ascribe morbid interpretations to symptoms and to less apt to feel discouraged.

Does Compensation Discourage Treatment Participation? A 2007 report on PTSD compensation by the Institute of Medicine concluded that disability benefits for combat-related PTSD do not pose a disincentive to Vietnam veterans' participation in treatment or their treatment outcomes.[4] Notably, an analysis by the DVA Inspector General found a large drop off in treatment use once 100 percent disability status was attained. But the other studies surveyed by the IOM found little or no difference in treatment engagement and symptom change between compensation-seeking/compensation-granted Vietnam veterans and non-compensation seeking veterans.

The striking aspect of these studies, in my view, is how little they revealed about the subjects' real-world functioning. (Moreover, the study subjects were Vietnam veterans with chronic PTSD, a group that might not be readily comparable to younger cohorts). Granted, attendance at treatment sessions and measurable reductions in symptoms is encouraging, but this is only a part of the picture. Without some kind of productive work, the goals of compensation as set forth by the Commission and the VA (fostering reintegration, rehabilitation, and quality of life) are not likely to be achieved.

Options

Treatment entry facilitated at point of compensation evaluation—This represents a straight-forward mechanism for leveraging a major goal of disability compensation: rehabilitation. A critical feature of this arrangement would be periodic re-evaluations at 2–5 year intervals to assess progress and continued applicability of disability status.

Treatment First—As discussed, making a determination about a veteran's future functional capacity—that is, the degree of ongoing disability—before he or she has had the opportunity for care is difficult, if not impossible.

For patients needing intensive treatment who are too fragile for employment, the VA should consider a living stipend for the veteran and his or her family during the course of care. In addition to providing income support, the stipend would allay the stress of financial insecurity that would surely undermine the veteran's clinical progress. If meaningful functional deficits persist following a substantial course of treatment and rehabilitation, the veteran would then file a disability claim.

Conclusion

Returning from war is a major existential project. Imparting meaning to one's wartime experience, reconfiguring personal identity, and reimagining one's future take time. Sometimes the emotional intensity can be overwhelming—especially when coupled with nightmares and high anxiety or depression—and even warrants professional help. When this happens, veterans, like Joe, should receive a message of promise and hope. This means a prescription for quality treatment and rehabilitation—ideally before the patient applies for disability status.

Everyone who fights in a war is changed by it, but few are irreparably damaged. For those who never regain their civilian footing despite the best treatment, full and generous disability compensation is their due. Otherwise, it is reckless to allow a young veteran to surrender to his psychological wounds without first urging him to pursue recovery. Conferring disability status upon a veteran before his prospects for recovery are known can make the long journey home harder than it already is.

[4] *PTSD Compensation and Military Service,* 2007 The National Academies Press, Washington D.C., Chapter 6.

Prepared Statement of Ralph Ibson, National Policy Director, Wounded Warrior Project

Chairman Miller, Ranking Member Filner and Members of the Committee:

Thank you for inviting Wounded Warrior Project (WWP) to testify this morning.

With WWP's mission of honoring and empowering those wounded in Afghanistan and Iraq, 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 among our very highest priorities.

Given that priority, we are greatly concerned that there are critical gaps in VA's approach to meeting the mental health needs of returning veterans, and no apparent plans for closing those gaps. So we particularly welcome this hearing.

The U.S. Court of Appeals for the Ninth Circuit recently characterized the VA's mental health care system as beset by "egregious problems" and "unchecked incompetence," leading the court to conclude that veterans are denied rights relating to timely mental health care. That characterization unfairly characterizes thousands of dedicated VA health care professionals and tends to undermine confidence in a system that has a vital role to play. But there are problems beyond the capability of individual VA clinicians to remedy. Judicial resolution of the points of law raised in the Ninth Circuit case are not likely to remedy the more wide-ranging problems in VA's mental health system.

Despite the goal of intervening early, VA is failing to reach most returning veterans:

VA reports that nearly 600 thousand, or 49 percent of all, OEF/OIF veterans have been evaluated and seen as outpatients in its health care facilities, and reports further that approximately one in four showed signs of PTSD.[1] But more than half of all OIF/OEF veterans have not enrolled for VA care. Unique aspects of this war—including the frequency and intensity of exposure to combat experiences; guerilla warfare in urban environments; and the risks of suffering or witnessing violence—are strongly associated with a risk of chronic post-traumatic stress disorder.[2] The lasting mental health toll of the wars in Iraq and Afghanistan are likely to increase over time for those who deploy more than once, do not get needed services, or face increased demands and stressors following deployment.[3] Chronic post-service mental health problems like PTSD are pernicious, disabling, and represent a significant public health problem. Indeed mental health is integral to overall health. So it is vitally important to intervene early to reduce the risk of chronicity.

In 2008, VA instituted an initiative to call the approximately half million OEF/OIF veterans who had not enrolled for VA health care and encourage them to do so. This unprecedented initiative was apt recognition that we must be concerned not just about those returning veterans who come to VA's doors, but about the entire OIF/OEF population. But a single telephone contact is hardly enough of an outreach campaign.

VA has not been successful in retaining veterans in treatment:

Until recently, little had been known about OEF/OIF veterans' actual utilization of VA mental health care. The first comprehensive study of VA mental health services' use in that population found that of nearly 50,000 OEF/OIF veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received evidence-based mental health treatment for PTSD (that is, attending 9 or more mental health treatment sessions in 15 weeks) at a VA facility; 20 percent of those veterans did not have a single mental health follow up visit in the first year after diagnosis.[4]

These data raise a disturbing concern. They show that enrolling for VA care and being seen for a war-related mental health problem does not assure that a returning veteran will complete a course of treatment or that treatment will necessarily be successful.

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[1] VA Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans," October 2010.

[2] National Center for PTSD. "National Center for PTSD FactSheet." Brett T. Litz, "The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq," January 2007 http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf (accessed 10 June 2011).

[3] *Ibid*.

[4] Karen Seal, Shira Maguen, Beth Cohen, Kristian Gima, Thomas Metzler, Li Ren, Daniel Bertenthal, and Charles Marmar, "VA Mental Health Service Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses," *Journal of Traumatic Stress,* 2010.

Even more disturbing, VA has set a very low bar for reversing this trend. Consider performance measures reported in VA budget submissions. One measure calls for tracking the percentage of OEF/OIF veterans with a primary diagnosis of PTSD who receive a minimum of 8 psychotherapy sessions within a 14-week period. The FY 2010 performance goal for that measure was only 20 percent.[5] In other words, having only one in five veterans attend about half of a recommended number of treatment sessions constituted "success." This year's budget submission shows that actual performance fell short of even that very modest goal, with only 11 percent of PTSD patients receiving that minimum.[6] In contrast, VA is meeting its performance target that 97 percent of veterans are screened for PTSD.[7] This wide gap between VA's high rate of identifying veterans who have PTSD and its low targets for successful treatment is very troubling.

Two VA "Mental Health" Systems

VA, of course, operates a vast health care system, and there are surely pockets of excellence—just as it employs many excellent, dedicated clinicians. It is somewhat misleading, however, to speak of "the VA mental health system," because not only is there wide variability across VA, but in some respects VA can be said to operate two mental health systems. First, VA provides a full range of mental health services through its nationwide network of medical centers and outpatient clinics. That system has increasingly emphasized the provision of "evidence-based-," recovery-oriented care. VA's much smaller Readjustment Counseling program—operating out of community-based "Vet Centers" across the country—provides individual and group counseling (including family counseling) to assist veterans to readjust from service in a combat theater. In some areas, these two "systems" work closely together; in others, there is relatively little coordination between them.

The differences between these two systems may help explain why greater numbers of veterans do not pursue VA treatment, and why those who do often discontinue.

In our daily, close work with warriors and their families, WWP staff consistently hear of high levels of satisfaction with their Vet Center experience. Warriors struggling with combat stress or PTSD typically laud Vet Center staff, who are often combat veterans themselves and who convey understanding and acceptance of warriors' problems.

In contrast with the relative informality of Vet Centers, young warriors experience VA treatment facilities as unwelcoming, geared to a much older population, and as rigid, difficult settings to navigate. Warriors have characterized clinical staff as too quick to rely on drugs, and as often lacking in understanding of military culture and combat. Medical center and clinic staff sometimes have more experience treating individuals who have PTSD related to an auto accident or domestic abuse than to combat. VA treatment facilities have had little or nothing to offer family members. Unlike Vet Centers that have an outreach mission, VA treatment facilities conduct little or no direct outreach—placing the burden on the veteran to seek treatment.

In essence, the strengths of the Readjustment Counseling program highlight the limitations and weaknesses that afflict the larger system. Too often, that larger system——

- Passively waits for veterans to pursue mental health care, rather than aggressively seeking out warriors one-on-one who may be at-risk;
- Gives insufficient attention to ensuring that those who begin treatment continue and thrive;
- Emphasizes training clinicians in so-called evidence-based therapies but fails to ensure that they have real understanding of, and relate effectively to, OEF/OIF veterans' military culture and combat experiences;
- Fails to provide family members needed mental health services, often resulting in warriors struggling without a healthy support system;
- Largely fails to establish effective linkages and partnerships with the communities where warriors live and work, and where reintegration ultimately must occur.

Perhaps the most disturbing perception warriors have expressed regarding their experiences with VA mental health treatment is that VA officials operate in a way that too often seems aimed at serving the VA rather than the veteran.

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[5] Department of Veterans Affairs, FY 2011 Budget Submission, Vol. 2, p. 1J–5.
[6] Department of Veterans Affairs, FY 2011 Budget Submission, Vol. 2, p. 1G–7.
[7] Ibid.

Richmond: A Case Study

In describing what it termed its "FY 11–13 Transformational Plan to Improve Veterans' Mental Health," VA emphasizes its core reliance on providing evidence-based, recovery-oriented, veteran-centric care. But when those three concepts are not in alignment, experience now suggests that the veteran's voice may go unheard.

Consider VA's handling of PTSD support groups at the Hunter Homes McGuire Department of Veterans Affairs Medical Center in Richmond, VA (Richmond VA). Last year, officials at the Richmond VA advised its PTSD therapy groups of its intention to phase out and, effective January 2011, terminate those PTSD therapy groups. Richmond VA had run several such groups which had met weekly since 2005. One of those groups (the "Young Guns") included veterans who served in Iraq and Afghanistan and were struggling with often-severe mental health conditions.

The Young Guns group was disturbed by these plans and petitioned the medical center director to reinstate the group. The petition, which was signed by 27 members of the group, explained both the importance to the members of the group therapy and expressed their strong view that VA's alternative—for the group to operate as a community-based peer group—was not an effective substitute.[8] While WWP also urged the Medical Center Director to reinstate the group at the medical center, the director's reply stated that "while these . . . PTSD groups have proven effective in providing environments of social support . . . , they are not classified as active treatment for PTSD symptoms." The upshot of the medical center director's ignoring the veterans' strong views and proceeding with the plans was that only 7 members of the Young Guns group attended the initial "community-based" group meeting (which was neither adequately staffed or facilitated). Most have dropped out altogether—having lost trust, feeling "discarded", or in some instances—because it is no longer a "VA group"—they could no longer get approval to take time off from jobs.

Veterans too often confront a gap between well-intentioned VA policy and real-world practice. In this instance, the applicable VA policy (set forth in a handbook setting minimal clinical requirements for mental health care) is clear and on point:

> The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. **No longstanding supportive groups are to be discontinued without consideration of patient preference**, planning for further treatment, and the need for an adequate process of termination or transfer. (Emphasis added.)

Throughout our efforts to advocate for these warriors—writing to the Medical Center Director, meeting with VA Central Office officials, meeting with the Medical Center Director, and finally writing to the Secretary—VA's position at every level remained inflexible. Honoring the veterans' wishes was simply not considered a VA option and while numerous "alternatives" were listed, few took into consideration the sensitivities of these particular patients.

The Richmond matter is stunning in several respects. While a recently conducted WWP survey indicated that as many as 15 other VA medical centers have terminated PTSD support groups, the Richmond VA case appears unique in its utter disregard for the veterans' wishes, and in Central Office's acquiescence in that medical center's position. Secondly, VA did not terminate an ineffective program at Richmond VA. Medical Center officials even acknowledged that it was helping the veterans. VA's cavalier insistence on the appropriateness of transferring responsibility for a therapeutically-beneficial modality from VA to an inexperienced community entity appears altogether unprecedented.

VA Mental Health Care Policy: Still in Transition, Ignoring Gaps

This hearing asks in part whether VA is able to provide timely, effective, and accessible care to veterans struggling with mental illness. VA has certainly instituted policies that are designed to achieve those goals. But as the above-cited situation at the Richmond VA illustrates, the gap between VA mental-health policy and practice can be wide.

In 2007, VA developed an important detailed policy directive that identifies what mental health policies should be available to all enrolled veterans who need them, no matter where they receive care, and sets certain timeliness standards for sched-

[8] WWP would be pleased to provide, at the Committee's request, a copy of the petition and subsequent WWP correspondence on the issue with VA officials.

uling treatment.[9] But as VA acknowledged in testifying before the Senate Veterans Affairs Committee on May 25th, those directives are still not fully implemented. Funding is not the problem, VA testified.

The fact that a policy aimed at setting basic standards of access and timeliness in VA mental health care has yet to be fully implemented—4 years after the policy is set—has profound ramifications for warriors struggling with war-related mental health problems, and who face barriers to needed VA treatment. Of VA's many "top priorities", the mental health of this generation of warriors should be of utmost importance as it will directly impact other areas of concern such as physical wellness, success in employment and education, and homelessness.

Geographic barriers are often the most prominent obstacle to health care access, and can have serious repercussions on the veteran's overall health. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other health problems and that critical aspects of a veteran's mental health treatment (including timeliness of treatment and the intensity of the services the veteran ultimately receives) are affected by how geographically accessible the care is.[10]

VA faces a particular challenge in providing rural veterans access to mental health care. VA has stated that of all veterans who use VA health care, roughly 39 percent reside in rural areas and an additional 2 percent reside in highly rural areas;[11] over 92 percent of enrollees reside within 1 hour of a VA facility, and 98.5 percent are within 90 minutes.[12] But many of these VA facilities are small community-based outpatient clinics (CBOC's) that offer very limited or no mental health services.[13] Overall, CBOC's are limited in their capacity to provide specialized or even routine mental health care. Indeed, under current VHA policy, large CBOC's (those serving 5,000 or more unique veterans each year), mid-sized CBOC's (serving between 1,500 and 5,000 unique veterans annually), and smaller CBOC's (serving fewer than 1,500 veterans annually) have the option to meet their mental health provision requirements by referring patients to "geographically accessible" VA medical centers.[14] CBOC's are only required to offer mental health services to rural veterans in the absence of a "geographically accessible" medical center.[15] Notably, current policy does not define what constitutes "geographic inaccessibility." Moreover, in those instances in which small and mid-sized CBOC's do have mental health staff, VA does not require the CBOC to provide any evening or weekend hours to accommodate veterans who work and cannot easily take time off for treatment sessions.

Since long-distance travel to VA facilities represents a formidable barrier to veterans' availing themselves of mental health treatment, it is important that VA provide community-based options for veterans who would otherwise face such barriers. VA policy—as reflected in the uniform services handbook—calls for ensuring the availability of needed mental health services, to include providing such services through contracts, fee-basis non-VA care, or sharing agreements, when VA facilities cannot provide the care directly.[16] But VA officials have informally admitted that, despite the policy, VA facilities have generally made only very limited use of this new authority—often leaving veterans without good options.

Yet there is evidence that this rural access problem could be overcome if there were the will to meet it. In Montana, for example, the VA Montana Health Care System has been contracting for mental health services since 2001. According to a report by the VA Office of Inspector General (OIG), more than 2,000 Montana veterans were treated under contracts with community mental health centers in FY 2007, and more than 250 were treated under fee-basis arrangements with 27 private

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[9] Department of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

[10] Benjamin Druss and Robert Rosenheck, "Use of Medical Services by Veterans with Mental Disorders," *Psychosomatics* 38(1997) 454.

[11] *Testimony of Gerald Cross, Acting Principal Deputy Undersecretary for Health Department of Veterans' Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Health,* (Washington DC:April 18, 2007), http://www.va.gov/OCA/testimony/hvac/sh/070418GC.asp.

[12] Ibid.

[13] 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,* 4 March 2009, National Council on Disability, [www.ncd.gov/newsroom/publications/2009/veterans.doc], Accessed 14 May 2009, 46.

[14] *VHA Handbook 1160.01,* 8.

[15] Ibid., 18.

[16] *VHA Handbook 1160.01,* paragraphs 13.i.; 13.k.; 23.f.(1)(c); 23.h.(2)(b); 28.d.(1).

therapists.[17] The OIG report also indicates that the VA Montana Health Care System has sponsored trainings for contract and fee-basis providers in evidence-based treatments.[18]

It is not enough for VA simply to promulgate policies and directives on access-to-care and timeliness. Surely we owe those suffering from war-related mental health conditions real access to timely, effective care, not the hollow promise of a policy that is still not fully implemented 4 years later.

Finally, a 4-year-old policy must itself be open to re-assessment. VA must continue to adapt to the needs of younger veterans whose obligations to employers, school, or young children may compound the challenge of pursuing mental health care. To illustrate, a recent WWP survey found that among veterans who are currently participating in VA medical center and Vet Center support groups, 29 percent said they are considering no longer attending due to the location of the group being far from their place of work or home. Another 39 percent of respondents indicated they are considering no longer attending because groups are held at a time that interferes with their work schedule.

Needed: A Veteran-Centered Approach to the Mental Health of OEF/OIF Veterans

PTSD and other war-related mental health problems can be successfully treated—and in many cases, VA clinicians and Vet Center counselors are helping veterans recover. But, as discussed above, VA is not reaching enough of our warriors, and is not giving sufficient priority to keeping veterans in treatment long enough to gain its benefits. What can VA do, beyond fully implementing its policies and commitments? What should it do? We've asked our own warriors these questions, as well as consulted with experts. Our recommendations follow:

Outreach: WWP recommends that VA adopt and implement an aggressive outreach campaign through its medical centers, employing OEF/OIF warriors—who have dealt with combat stress themselves—to conduct direct, one-on-one peer-outreach. Current approaches simply fail to reach many veterans. For example, post-deployment briefings that encourage veterans to enroll for VA care tend to be ill-timed, or too general and impersonal to address the warriors' issues. An outreach strategy must also take account of many warriors' reluctance to pursue treatment. An approach that reaches out to engage the veteran in his or her community, and provides support, encouragement, and helpful information for navigating that system can be impactful. VA leaders for too long have limited such outreach efforts to Vet Centers. Given what amounts to a public health challenge with regard to warriors at risk of PTSD, there is a profound need for a broad VA effort to conduct one-on-one peer outreach to engage warriors and family in their communities.

Cultural competence education: WWP urges that VA mount major education and training efforts to assure that its mental health clinicians understand the experience of combat and the warrior culture, and can relate effectively to these young veterans. Health care providers, to be effective, must be "culturally competent"—that is, must understand and be responsive to the diverse cultures they serve. WWP often hears from warriors of frustration with VA clinicians and staff who, in contrast to what many have experienced in Vet Centers, did not appear to understand PTSD, the experience of combat, or the warrior culture. Rather than winning trust and engaging warriors in treatment, clinical staff are often perceived as ignorant of military culture or even as dismissive. Warriors reported frustration with clinicians who in some instances do not appear to understand combat-related PTSD, or who pathologize them or characterized PTSD as a psychological "disorder" rather than an expected reaction to combat.[19] Dramatically improving the cultural competence of clinical AND administrative staff who serve OEF/OIF veterans through training, standard-setting, etc.—and markedly improving patient-education—must be high priorities.

Peer-to-peer support: WWP recommends that VA employ and train peers (combat veterans who have themselves experienced post-traumatic stress). In describing highly positive experiences at Vet Centers, warriors emphasized the importance of being helped by peers on the Vet Center staff—combat veterans who themselves have experienced combat stress and who (in their words) "get it." Given the inherent challenges facing a patient in a medical setting and data showing high percentages discontinuing treatment, it is important to have the support of a peer who, as a

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[17] VA Office of Inspector General, *Access to VA Mental Health Care for Montana Veterans,* (March 31, 2009), 4–5.

[18] Ibid., 63.

[19] Id, 9, 51.

member of the treatment team, can be both an advocate and support. Public Law 111–163 requires VA within 180 days of enactment to provide peer-outreach and peer-support services to OEF/OIF veterans along with mental health services, and to contract with a national nonprofit mental health organization to train OEF/OIF veterans to provide such services. It is critical that the Department design and establish a national peer-support program, initiate recruitment of OEF/OIF veterans for a system-wide cohort of peer-support-specialists and institute the required training at the earliest possible date.

Provide family mental health services: One of the strongest factors that help warriors in their recovery is the level of support from loved ones.[20] Yet the impact of lengthy, multiple deployments on family may diminish their capacity to provide the depth of support the veteran needs. One survey of Army spouses found that nearly 20 percent had significant symptoms of depression or anxiety.[21] While Vet Centers have provided counseling and group therapy to family members, VA medical facilities have offered little more than "patient education" despite statutory authority to provide mental health services. It took VA nearly 2 years to implement a legislative requirement to provide marriage and family counseling.[22] Section 304 of Public Law 111–163 directs VA to go further and provide needed mental health services to immediate family of veterans to assist in readjustment, or in the veteran's recovery from injury or illness. This provision—covering the 3-year period beginning on return from deployment—must be rapidly implemented, particularly given its time-limit on this needed help.

Expand the reach and impact of VA Vet Centers: Although many OEF/OIF veterans have been reluctant to pursue mental health treatment at VA medical centers, Vet Centers have had success with outreach and working with this population. Given that one in two OEF/OIF veterans have not enrolled for VA care and many are likely to be experiencing combat-stress problems, WWP recommends that VA increase the number of Vet Center locations, and give priority to locating new centers in close proximity to military facilities. As Congress recognized in Public Law 111–163, Vet Centers—in addition to their work with veterans—can be an important asset in helping active duty, guard, and reserve servicemembers deal with post-traumatic stress. Vet Centers can serve as an important asset to VA medical centers as well, and we urge greater coordination and referral between the two.

Foster community-reintegration: VA mental health care can play an important role in early identification and treatment of mental health conditions. Yet success in addressing combat-related PTSD is not simply a matter of a veteran's getting professional help, but of learning to navigate the transition from combat to home.[23] In addition to coping with the often disabling symptoms, many OEF/OIF veterans with PTSD, and wounded warriors generally, are likely also struggling to readjust to a "new normal," and to uncertainties about finances, employment, education, career and their place in the community. While some find their way to VA programs, no single VA program necessarily addresses the range of issues these young veterans face, and few, if any, of those programs are embedded in the veteran's community. VA and community each has a distinct role to play. The path of a veteran's transition, and successful community-reintegration, must ultimately occur in that community. For some veterans that success may require a community—the collective efforts of local community partners—businesses, a community college, the faith community, veterans' service organizations, and agencies of local government—all playing a role. Yet there are relatively few communities dedicated, and effectively organized, to help returning veterans and their families reintegrate successfully, and other instances where VA and veterans' communities are not closely aligned. The experience of still other communities, however, suggests that linking critical VA programs with committed community engagement can make a marked difference to warriors' realizing successful reintegration. With relatively few communities organized to support and assist wounded warriors, WWP urges the establishment of a grant program to provide seed money to encourage local entities to mobilize key community sectors to work as partners in support of veterans' reintegration. In short, a grant to a community leadership entity (which, in any given community, might be a non-profit agency, the mayor's office, a community college, etc.) could be the focal point for mounting a community group to work with a VA medical center or Vet Center to support veterans and their families on their path to community

[20] C.W. Hoge, *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home,* (Globe Pequot Press, 2010), 28.

[21] Ibid, 259.

[22] Veterans Health Administration, IL 10–2010–013, "Expansion of Authority to Provide Mental Health and Other Services to Families of Veterans," August 30, 2010.

[23] Hoge; *Once a Warrior Always a Warrior.*

reintegration. There is ample precedent for use of modest grants to stimulate the development of community-based coalitions working in concert with government to provide successful wraparound services.[24]

We have offered most of these recommendations to VA officials, and have urged them to implement section 304 of Public Law 111–163. The response was little different from the responses we received in advocating on behalf of the veterans in Richmond. In essence, the message seems to be, "No thank you, we'll do it our way, and we'll do it when we get to it."

But the stakes are high! With a generation of combat warriors at risk of chronic health problems associated with combat stress, VA and Congress can have few higher priorities, in our view, than to institute such recommendations. *To that end, WWP expects to provide the Committee draft legislation to incorporate these recommendations later this month.*

Coordination with the Veterans Benefits Administration

WWP recognizes the importance of robustly addressing the full range of issues facing returning warriors so that they can thrive—physically, psychologically and economically. Compensation for service-connected disability is not only an earned benefit, it is critically important to most veterans' reintegration and economic empowerment.

As recognized by this Committee, VA has yet to achieve the goal of being a department that provides "wraparound" services that seamlessly and effectively integrate Veterans Health Administration (VHA) services and Veterans Benefits Administration (VBA). A panel of the National Academy of Public Administration addressed that important goal. It reported that care and benefits to veterans could be improved if VA management, organization, coordination, and business practices were transformed with the aim of improving outcomes for veterans, rather than simply aiming to improve operational processes.[25] That National Academy panel provided VA detailed recommendations constituting a comprehensive blueprint for such a transformation.[26] At its core was an emphasis on the importance of leadership commitment to creating and maintaining veteran-centered systems, including a "no wrong door" policy to ensure receipt of appropriate guidance regardless of point of contact. The Academy provided VA a vision, strategy and detailed recommendations for organizing and delivering veteran-centered services.

Data from a very recent WWP survey of wounded warriors regarding their experience with VA adjudication of original claims for service-connection for PTSD underscores the point that much more work remains to be done to achieve better coordination and unity of focus between VHA and VBA. More than one in five survey respondents indicated that the compensation and pension (C&P) examination associated with the adjudication of that claim was 30 minutes or less in duration. Prior testimony before this Committee regarding an Institute of Medicine study on PTSD compensation reflected keen concern that VA mental health professionals often fail to adhere to recommended examination protocols:

> "Testimony presented to our Committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD Compensation and Pension ("C&P") examination—sometimes as little as 20 minutes—even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete."[27]

Hurried, or less than comprehensive, C&P examinations heighten the risk of adverse outcomes, additional appeals, and long delays in affording veterans the benefits to which they are entitled. VHA and VBA must do more to actively address the concerns the IOM panel voiced.

Our survey also addressed a related issue in asking warriors, "have you been diagnosed and treated for PTSD at a VA medical center or clinic since deployment to Iraq or Afghanistan, but—despite that VA treatment—been denied service-con-

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[24] M. Libby, M. Austin. "Building a Coalition of Non-Profit Agencies to Collaborate with a County Health and Human Services Agency." *Administration in Social Work.* 26,4(2002): 81–99.

[25] National Academy of Public Administration, "*After Yellow Ribbons: Providing Veteran-Centered Services,*" October 2008, p. ix.

[26] Ibids.

[27] Dean G. Kilpatrick, Ph.D., Committee on Veterans' Compensation for Posttraumatic Stress Disorder, Institute of Medicine, Testimony before House Veterans' Affairs Committee Hearing on "The U.S. Department of Veterans Affairs Schedule for Rating Disabilities" Feb. 6, 2008, accessed at: http://veterans.house.gov/hearings/Testimony.aspx?TID=638&Newsid=2075&Name=%20Dean%20G.%20Kilpatrick,%20Ph.D.

nection for PTSD?" Approximately one in four respondents answered in the affirmative. These data suggest a profound disconnect between the two administrations—inexplicable to warriors and, we trust, to the Committee as well.

This Committee has emphasized the goal of a wellness-focused VA response to mental illness. One important step in that direction, in our view, would address a problem—rooted in the regulations governing VA's compensation program—that impedes numbers of wounded warriors from overcoming disability and regaining productive life. VA regulations have long provided a mechanism to address the situation where the rating schedule would assign a less than a 100 percent rating but the veteran is nevertheless unable to work because of that service-connected condition. Accordingly, in instances where a veteran has a disability rating of 60 percent of higher, or multiple disabilities with a combined total rating, VA may grant a 100 percent disability rating when it determines the veteran is "unable to follow a substantially gainful occupation as a result of service-connected disabilities." This Individual Unemployability (IU) rating results in a very substantial increase in the veteran's compensation. But while veterans receiving IU are compensated at the same monetary level as those who receive a 100 percent rating, the implications for employment drastically differ. A veteran who receives a schedular rating of 100 percent is not precluded from gainful employment. But for veterans receiving IU, a return to the workforce for longer than 12 months or at an income level that exceeds the Federal poverty line can result in a loss of the IU benefit, and a subsequent reduction in financial compensation. For some veterans, this can spell a sudden loss of as much as $1700 in monthly income. Both the Institute of Medicine (IOM) and Veterans' Disability Benefits Commission have recognized this decrease as a "cash-cliff" that may deter some veterans from attempting to re-enter the workforce.[28]

We concur with the recommendations of the IOM and VA Disability Commission that the IU benefit should be restructured to encourage veterans to reenter the workforce. The experience of the Social Security Administration (SSA)—which has had success piloting a gradual, step down approach to reducing benefits for beneficiaries who return to employment—offers a helpful model. SSA's experience has shown that, for those reentering the workplace, a gradual rather than sudden reduction in disability benefits not only allowed participants to minimize the financial risk of returning to work, but over time participants actually increased their earning levels above what they would have received in disability payments.[29] Inherent in this approach is the underlying assumption that individuals with disabilities can and will re-enter the workforce if benefits are structured to encourage that opportunity. Recognizing that employment often acts as a powerful tool in recovery and is an important aspect of community reintegration for this young generation of warriors, WWP recommends that VA revise the IU benefit accordingly.

Summary

In closing, let us emphasize that VA can have few higher goals than to help veterans who bear the psychic scars of combat regain mental health and thrive. But a Department of Veterans Affairs that comes before this Committee—as it too often does—with only a list of pertinent mental-health "programs" and "initiatives"—is a Department destined to fail many of these warriors, as it failed warriors at the Richmond VA. Regrettably, there are wide gaps between those programs and initiatives, and our warriors' needs.

While we recognize and acknowledge that VA conducts some quality programs and laudable initiatives, our work with warriors struggling with mental health issues reminds us daily of the gaps plaguing the system: gaps arising from VA's largely- passive approach to outreach; gaps in access to mental health care in a system still marked by wide variability; gaps in sustaining veterans in mental health care; gaps in clinicians' understanding of military culture and the combat experience; gaps in family support; and gaps in coordination with the benefits system. We look forward to working with this Committee to close these gaps and to witness the development of a truly transformative veteran-centered approach to VA mental health care and benefits.

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[28] Institute of Medicine. *A 21st Century System for Evaluating Veterans for Disability Benefits.* Committee on Medical Evaluation of Veterans for Disability Compensation, National Academies Press, 2007, 250, and Veterans' Disability Benefits Commission, *Honoring the Call to Duty: Veterans Disability Benefits in the 21st Century, October 2007, 243.*

[29] Social Security Administration. "Benefit Offset Pilot Demonstration—Connecticut Final Report." September 2009, Accessed at: http://www.ssa.gov/disabilityresearch/offsetpilot.htm.

Prepared Statement of Christina M. Roof, National Acting Legislative Director, American Veterans (AMVETS)

Chairman Miller, Ranking Member Filner and distinguished Members of the Committee, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations at today's hearing regarding "Mental Health: Bridging the Gap Between Care and Compensation for Veterans."

AMVETS feels privileged in having been a leader, since 1944, in helping to preserve the freedoms secured by America's Armed Forces. Today our organization prides itself on the continuation of this tradition, as well as our undaunted dedication to ensuring that every past and present member of the Armed Forces receives all of their due entitlements. These individuals, who have devoted their entire lives to upholding our values and freedoms, deserve nothing but the highest quality of care we, as a Nation, have to offer.

As we are all aware the suicide rates among veterans and servicemembers has become a sort of "epidemic" and the rates at which these men and women are taking their own lives has surpassed that of their non-veteran population counterparts for the first time in recorded history. Unfortunately, due to the methods the Department of Veterans Affairs' (VA) utilizes in tracking suicide rates, AMVETS fears the rate is actually much higher than VA reports. The Department of Defense's (DoD) rates tend to be more accurate given the daily oversight they have over their personnel. However, AMVETS also believes DoD's reported number to be lower than the actual number due to the discrepancies in the reported causes of death. Regardless of the exact number, AMVETS believes that even one veterans or servicemember life lost to suicide is one too many.

As of December 2009, approximately 1.1 million OIF/OEF veterans, of the 1.7 million who have served or are serving in these conflicts, had transitioned out of active duty out service.[1] According to multiple studies performed by the National Institute of Health, Department of Veterans Affairs (VA) and Department of Defense (DoD) upwards of 43 percent of veterans having served in Operations Enduring Freedom, Iraqi Freedom and New Dawn, as well as the war in Afghanistan, will have experienced traumatic events causing Post-Traumatic Stress Disorder (PTSD) or other psychological disorders such as depression. Left untreated, these invisible wounds can have a devastating impact on the lives of those veterans and servicemembers who suffer in silence. Unfortunately, even though there has been an effort to remove the stigmas associated with psychological wounds in recent years by VA and DoD leadership, their message has failed to reach the everyday servicemember and veteran. Theses stigmas still seem to be ever so present and seeking assistance is often viewed as a sign of weakness or lack of resiliency among those who have been trained to be strong and fearless. We must step up our efforts in removing stigmas and immediately develop and implement newer, more confidential ways of offering assistance to those who need it most if we wish to end the cycle of preventable suicides plaguing today's veteran and military communities. Moreover, there needs to be numerous changes and corrections in the policies and procedures within the Veterans Health Administration (VHA) and the Veterans benefit Administration (VBA).

One of the hardest and most humbling decisions a veteran can make in their life, is to seek care and assistance for their invisible wounds of war. However, given the broken policies and lengthy procedures, as well as an overall lack of communication between VHA and VBA, veterans seeking care and assistance are often met with a confusing and frustrating claims system entrenched in bureaucracy. Many of these veterans find VA to be more of a hindrance, than helpful, to their overall wellbeing and thus chose to stop receiving the care and benefits they critically need. One of the initial experiences a newly enrolled veteran will have within the VA system is with a claims examiner. Thus, the response to a PTSD claim is an evaluation without a concurrent offer of treatment has now potentially caused adversarial situation to be made worse.

In 2010 changes were made to the VA regulation governing PTSD disability claims. The regulation, 38 CFR 3.304(f)(3), allows for the veteran's lay statement to satisfy the establishment of an "occurrence" under specific criteria. Title 38 requires the occurrence must be "related to fear of hostile military or terrorist activity and a VA psychiatrist or psychologist, or contract equivalent, confirms that the claimed stressor is adequate to support a diagnosis of PTSD and the veteran's symptoms are related to the claimed stressor." While this change was for the better and

[1] VHA Office of Public Health and Environmental Hazards. Washington (DC): Department of Veterans Affairs; 2009. Analysis of VA health care utilization among U.S. Global War of Terrorism (GWOT) veterans [Internet] [cited 2010 Apr 28].

seems relatively straightforward, it is yet to be seen as to how well the VA is implementing the criteria and if the claims process will be improved. Furthermore, the process may prove more lengthy due to the fact VA has implemented a case-by-case review of the facts surrounding each claim. The VA claims representative will need to verify that the facts given by the veteran are true, including duty locations and service or campaign medals, prior to the veteran being scheduled for an exam. Thus, certain medals are now sufficient to schedule a PTSD examination. For example, VA Compensation has concluded that a veteran's receipt of the Vietnam Service Medal or Vietnam Campaign Medal is sufficient proof that the veteran service in a hostile military environment. This also includes veterans aboard ships in "blue water". Therefore, veterans with either of these medals should be able to pass the first threshold of proving the occurrence. Once the claim is verified, an examination should be immediately scheduled.

However, veterans filing new claims know they will have to wait in a very long, continuously growing, pending claims line. They will stand behind a quarter of a million men and women waiting over 125 days, many of which, about 43 percent, will just to be told if their claim is not approved. PTSD claims alone have increased 125 percent over the past few years according to VA.

The compensation examiner has a responsibility to VBA to obtain information to adjudicate a claim, and as such, the examination serves a societal need rather than a treatment need. In fulfilling this societal need, compensation examiners are put into an evaluative role that can alienate the veteran being evaluated.[2] For example, the compensation examiner may have to collect information about traumatic issues that the veteran is unprepared to address therapeutically. A compensation examination focuses on data collection rather than addressing veteran distress. In addition, a compensation interview often has more time constraints than multisession clinical treatment, and the veteran may feel rushed. Limited time is available to focus on helping the veteran process his or her subjective experience. An examiner must consider not only the veteran's perspective but also alternative sources of data and may ask questions that challenge the veteran's version of events.[3]

Based on the number of compensation claims that have been filed for recent conflicts and the number filed in past wars, a conservative estimate is that 50 percent of OIF/OEF veterans will apply for some service-connected compensation, which is only slightly higher than the 44 percent of Gulf War veterans who applied. It is likely that a majority of those who apply are actually those who are at least partially disabled. In studies describing pre-OIF/OEF cohorts, award rates ranging from 33 to 72 percent for PTSD have been reported. More recently, a review of 2,400 PTSD claims decided during 2007 and 2008 indicated 42.5 percent were denied and an additional 2.9 percent were rated at 0 percent (veterans had the diagnosis but were not disabled by it); 1.54 percent were rated at 100 percent and the rest fell in between as shown in the **Figure**.[4]

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[2] Strasburger LH, Gutheil TG, Brodsky A. On wearing two hats: Role conflict in serving as both psychotherapist and expert witness. Am J Psychiatry. 1997;154(4):448–56. [PMID: 9090330].

[3] (Rosen MI. Compensation examinations for PTSD–An opportunity for treatment? J Rehabil Res Dev. 2010; 47(5):xv-xxii.

[4] *Marc I. Rosen (Department of Psychiatry, VA Connecticut Health Care System, West Haven, CT 2010 Mar 18.*

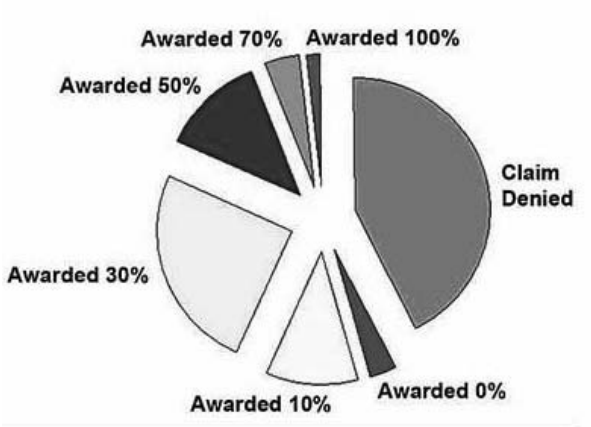

Figure.
Service-connected compensation awards from sample of post-traumatic stress disorder claims, 2007 to 2008 (*N = 2,400).*

Considerable public pressure exists to improve the process of evaluating compensation claims and engaging veterans in treatment. AMVETS believes as a direct result of the pressure to adjudicate claims, partnered with limited initial and continuing education of VBA personnel is resulting in unwanted and avoidable circumstances for veterans seeking VA care and benefits.

At present, VA compensation examiners complete online training to become credentialed to conduct compensation examinations. In this training video, the compensation examiner explains to a veteran that the purpose of the examination is not to conduct counseling but to "document your experiences." VA regulations further reinforce this boundary between the evaluator and the clinician by noting that the evaluation should be conducted by someone who is not providing clinical care to the claimant. The Automated Medical Information Exchange (AMIE) worksheets for conducting the compensation examination require a directive interview to elicit the plethora of specific information that is required to process a claim, yet there is no recommendation in the AMIE that treatment be offered to the veteran who has just been asked to relive traumas from their past service.

These procedures are consistent with the tradition in psychiatry that "clinical" and "forensic" functions be performed by separate clinicians, and disability evaluations have been considered to be a particular type of forensic evaluation. The American Academy of Psychiatry and the Law Ethics Guidelines recommend this explicitly: "At the beginning of a forensic evaluation, care should be taken to explicitly inform the evaluee that the psychiatrist is not the evaluee's 'doctor.'" Acknowledging the fact that evaluees may fall into the patient role anyway because of setting, wish, and having vented, the guidelines continue, "Psychiatrists have a continuing obligation to be sensitive to the fact that although a warning has been given, the evaluee may develop the belief that there is a treatment relationship". This also shows to be the case when examining the relationship between the veteran, claims examiner and physician.

The VA agency affiliation of the examining clinician may not be clear to veterans filing claims. Qualitative data suggests that veterans who undergo compensation examinations report not understanding the distinction between an evaluative examination and a treatment examination-after all, both are conducted by mental health professionals. Veterans may not make the distinction between the VHA staff who conduct examinations and the VBA staff who decide claims and dispense benefits. Both are "VA staff." This is a problem that must immediately be addressed by VHA and VBA. Veterans need to fully understand the different roles VHA and VBA have in their treatment and care. AMVETS believes too many veterans forego VHA care simply because of a bad experience with VBA.

A recent VA OIG investigation revealed a high number of errors being made on disability claims evaluations filed by veterans suffering from Traumatic Brain Injuries (TBI) and Post-Traumatic Stress Disorder (PTSD). There was an overall 23 percent error rate in all the OIG-reviewed cases. Most of these errors had a direct impact on the veteran's disability rating and benefits.

OIG also examined 16,000 disability files based solely on PTSD claims. OIG found there was no way the claims processors could be accurate with the limited training and experience they possessed. VA noted the largest number of mistakes were made verifying specific events qualifying for PTSD benefits. OIG found inexperienced and undertrained processors caused most problematic errors in TBI and PTSD claims. The errors themselves ranged in cause, and retraining should be completed by the end of June according to VA officials AMVETS spoke with. AMVETS hopes this Committee will have the strictest of oversight in ensuring all VBA staff receive the training necessary to avoid incidents such as this in the future. It is important to remember these are not simply statics and errors rates, but rather real life veterans who are struggling and depend on VHA and VBA to sustain their quality of life.

Compensation and pension (C&P) examination reports are available to VA clinicians but are located in a different portion of the VA's electronic medical record than most other clinical information and, are infrequently consulted by clinicians. Compensation examiners have access to clinical records for the period preceding the examination and are expected to dictate a report soon after interviewing the veteran. AMVETS has serious concerns as to whether or not claims examiners are properly trained to read the medical diagnosis and background information contained within the veteran's record. Medical appointments made or kept after the interview are not typically part of the examiner's report and attendance at subsequent treatment might be an issue if the veteran's claim is denied. A recent VA Compensation Service Bulletin, released in April 2011, sought to eliminate processing ambiguity relating to PTSD claims. Regional Offices nationwide have been largely critiqued because of erratic application of rating criteria. The current bulletins are intended in part to decrease the overall 23 percent of improper claims processing. AMVETS is eager to see if these new practices will actually improve the processing of mental health related claims.

Finally, when discussing the claims process as it related to benefits and care for psychological wounds, AMVETS strongly recommends a focus on quality instead of quantity when processing claims. AMVETS believes this must start with the Rater Veteran Service Representative's (RVSR) initial training. AMVETS recommends extending the initial training RVSRs' receive, regularly have current RVSRs' participate in continuing education and that all training take place at an offsite location. RVSRs must have access to uniform, high quality and in depth training regardless of what location they will be assigned to perform their job. Off site training will eliminate new trainers from being taught incorrect or bias practices that are often picked up when training occurs on site. Furthermore, AMVETS recommends current RVSRs be mandated to participate in regular continuing education classes so that they may stay up to date on any and all changes to current laws and regulations. AMVETS also recommends stronger enforcement of annual reviews in order to identify the strengths and weakness of every individual rater. The only way the backlog of mental health claims can be decreased is through educating the RVSRs in order to have all claims rated correctly the first time.

AMVETS second area of concern is the noncompliance of numerous VISNs to current VHA directives, policies and procedures addressing mental health. In 2003 the President of the United States formed a commission to investigate the United States mental health care system. This Committee issued "The 2003 President's New Freedom Commission Report," which identified 6 goals and made 19 broad recommendations for transforming the delivery of mental health services in the U.S.

In 2004 VHA developed its 5 year "Mental Health Strategic Plan," (MHSP) that included over 200 initiatives to improve mental heath care within VA. Since the MHSP was organized by goals and recommendations made by the Commission's 2003 report, rather than by a mental health program or operational focus, many of the MHSP initiatives did not make clear what specific actions should take place to achieve their goals. Therefore, many of the initiatives set forth by the MHSP are not measureable.

With Congressional approval of the VHA Comprehensive Mental Health Strategic Plan in 2004, it received additional funding in 2005 through the Mental Health Enhancement Initiative. In June 2008 VHA Handbook was issued outlining the specific goals and established what are to be the minimum clinical requirements for all VHA Mental Health Services. It delineates the essential components of the mental health program that is to be implemented nationally. However, many felt that the handbook was still to broad, so in Sept. 2008 VHA re-issued VHA Handbook 1160.01 defining more clearly the minimum clinical requirements of mental health services. Another important fact is the handbook also specifies that all parts of the handbook must be provided to each VA Medical Facility (VAMC) and Community-Based Outpatient Clinic (CBOC) and that all VA medical facilities and CBOC's are to have these requirements in place no later than the last working day of September 2009,

unless otherwise written granted permission by the Secretary of VA. VHA ensured congress that the distribution of this handbook would be followed by the distribution of the metrics that would be used to ensure the implementation of all of its requirements, and when fully implemented the handbook's requirements will complete the patient care recommendations of the Mental Health Strategic Plan, and its vision of a system providing ready access to comprehensive, evidence-based care would be realized. The opening statements published in VHA Handbook 1160.01, VHA states *"VHA employees are encouraged to become familiar with the statutory and regulatory eligibility and enrollment criteria for each of the programs discussed in this handbook, and to consult their respective VHA program office or business office as needed."*

VHA states that because they are responsible for mental health care to a defined population, that it is their responsibility to ensure ready access to care for new patients, as well as for the continuity and quality of care for established ones. They continue by adding *"At a time when large numbers of veterans are returning from deployment and combat, ensuring access to care for patients in need must be considered VA's highest priority."* Finally VHA affirms that *"Every program element described in this handbook must be understood as an integrated component of overall health care."* The hand book also states "*Each Veterans Integrated Service Network (VISN) must request approval from the Deputy Under Secretary for Operations and Management for modifications and exceptions for requirements that cannot be met in FY 2009 with available and projected resources."*

The following is a short list of specific services and programs in the VHA 1160.01 Handbook:

- Suicide Prevention
- Specialized PTSD Services
- Gender-Specific Care and Military Sexual Trauma
- 24/7 Emergency Mental Health Care
- Seriously Mentally Ill and Rehabilitation/Recovery Services
- Inpatient Care
- Care Transitions (discharge from medical care with instructions)
- Substance Abuse Disorders
- Homeless Programs
- Incarcerated Veterans Programs
- Elder Care (integration of mental health into medical care)
- Access to Trained Mental Health Staff

As required by the Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009 (FY 09'), the VA Office of Inspector General (OIG) conducted a review of VHA's progress in implementing the recommendations of the Mental Health Strategic Plan as outlined by VHA 1160.01. AMVETS found OIG's findings released in 2010 quite troubling at best. Given the fact VHA was given over 5 years and upwards of $38 billion to develop and implement the critical issues addressed in VHA 1160.01, AMVETS finds it to be inexcusable and irresponsible that numerous VAMCs and CBOCs are still, in 2011, being allowed to operate in a state of noncompliance.

OIG's findings on the progress of VHA 1160.01 implementation raised several concerns for AMVETS. The following is a list of OIG findings AMVETS believes must be corrected immediately:

- Accessing timely treatment within all VISNs regarding specialized post-traumatic stress disorder (PTSD) residential program. The current wait time for many veterans living in rural and remote areas of the country is 6 to 8 weeks.
- VHA's lack of ability and trained personnel in providing Intensive Outpatient Services (at least 3 hours per day at least 3 days per week) for the treatment of substance use disorders. As we have seen substance abuse can lead to homelessness and many other problems for veterans not receiving the care they need and are entitled to through their service.
- The limited availability of 23-hour observation beds for patients at risk of harming themselves or others.
- The limited and sometimes non-existent availability of substitution therapy for narcotic dependence to veterans seeking care.
- The failure of numerous VAMCs in providing a Psychosocial Rehabilitation and Recovery Center Program at facilities with more than 1,500 Serious Mental Illness or Impairment (SMI) patients. This includes, but is not limited to schizophrenia, bi-polar mania, sociopathic or homicidal tendencies and suicidal behaviors.

- The failure to have the presence of at least one full-time psychologist to provide clinical services to veterans in VA community living centers (formerly nursing home care units) with at least 100 residents.
- VHA 1160.01 also specifies that all VAMCs and VL CBOCs must have: specialized outpatient PTSD programs and the ability to provide care and support for veterans with PTSD and either a PTSD clinical team (PCT) or PTSD specialists. Overall the data indicates the presence of specialized PTSD or clinical teams (the Handbook requirement) at 79 percent of sites and 49 percent of VAMC's had actual PTSD clinics. Very important is the fact that PCT are responsible for training all onsite staff on how to properly treat and interact with veterans suffering PTSD.
- Finally, the Handbook (VHA 1160.01) states that medical centers with 1,500 or more current patients included on the National Psychosis Registry (NPR) must have an outpatient psychosocial rehabilitation recovery center (PRRC). PRRC programs treat patients with serious mental illness (primarily schizophrenia and other psychosis) following stabilization of an acute phase of illness. OIG found that best case scenario was 33 percent of facilities with 1,500 or more *"seriously mentally-ill patients"* (SMI) were compliant. Furthermore, OIG explained they encountered such extreme difficulties regarding this section of the handbook outlining treatment and policies for VA's largest facilities treating 1,500 or more patients diagnosed as severely mentally ill, their only recommendation is as follows:

  "We cannot distinguish which other psychosocial rehabilitation programs are functionally non-approved PRRCs and which other psychosocial rehabilitation programs have not progressed toward functioning as PRRCs. Administrative data support provision of either an approved PRRC or other psychosocial rehabilitation program at 33–55 percent of all VAMCs with more than 1,500 SMI patients during October 2009. As this represents a best case scenario, more work needs to be done to achieve system-wide implementation of PRRC programs at sites with more than 1,500 SMI patients."

From OIG's findings it appears to AMVETS that VA does not currently utilize a system to reliably track their own provisions and utilization of these therapies and policies on the national level. This is very disturbing given the fact that the number of patients seeking care from VA who served in OEF/OIF/OND has risen to over 25 percent of the initially projected totals and the fact that veteran suicide rates continue to rise. Furthermore, VA/VHA set their own objectives and expectations for the implementation timeline of the handbook and yet to date has failed to meet said deadlines according to OIG. VHA 1160.01 outlines uniform policies and procedures for the treatment of some of the most prevalent health conditions afflicting today's returning troops and provides numerous improvements upon current care models for veterans of all eras.

While AMVETS understands what a daunting undertaking the handbook posed itself to be, again VA was given over 5 years and appropriated billions of dollars to implement the required changes, as well as multiple opportunities to express concerns or problems they were encountering to Congress. Numerous hearings and OIG reports measuring the implementation of the handbook clearly illustrated the troubles VA was experiencing implementing the handbook and many of the OIG reports showed VA to be behind schedule in their 'implementation processes,' however VA officials repeatedly told Congress they would meet the September 30, 2009 deadline. To date the handbook remains partially implemented. AMVETS believes VA and Congress must start taking a more proactive approach in ensuring our veterans are receiving all the necessary mental health care. Until we stop taking a "reactionary" approach to bettering the VA system of mental health we are destined to be playing "catch up" in meeting the needs of today's returning war fighters.

AMVETS must stress the urgency of the handbook's implementation. According to VA, the needs of OIF/OEF/OND veterans for mental health services are even greater, with almost 45 percent having been evaluated for, or having received, a possible diagnosis of a mental health disorder. Another recent study by the American Council on Disabilities found that 30 to 45 percent of all servicemembers returning from Iraq and Afghanistan have been clinically diagnosed with PTSD, depression, TBI and/or dual diagnoses of these illnesses and injuries. AMVETS notes that there are still many of returning servicemembers who have not yet sought treatment for their psychological wounds, skewing the aforesaid numbers. AMVETS also stresses the urgency of plan completion by recommending a more attentive oversight process, and an empowered organizational structure to inform that oversight accountability.

Another important part of bridging the gap within VA's mental health care that needs to be addressed involves the services available to members of the National Guard and Reserve. The suicide rates among this population continue to rise at a rate this country has never seen. AMVETS believes this can be partially attributed to the lack of services available to this group of servicemembers. On June 6, 2010 the Walter Reed Army Institute of Research released the findings of their first study. The study focused on the mental health and functional impairments of returning National Guardsmen and the progression of symptoms over time. The study outlined statistics on PTSD, depression and other psychiatric, and some physical, diagnoses. It is important to note that this study was conducted through self reporting and two mailed surveys. These surveys were distributed to 18,305, composed of Iraq war veterans from four different units and two National Guard infantry brigade combat teams. Part of this study reported up to 14 percent of returning servicemembers suffer at least one symptom of PTSD. The symptoms studied ranged from nightmares to physical violence. The study went on to explain the strictest definition, defined as high incidence rates and serious impairment of normal functioning, found a PTSD rate of between 5.6 percent and 11.3 percent, with depression ranging from 5 to 8.5 percent. Those numbers affirm many past studies on PTSD and depression prevalence among returning servicemembers. We all agree that mending our servicemembers' psychological wounds is just as important as mending the physical ones. In contrast we obviously do not all agree on the most effective and responsible way of reporting and educating the public and the DoD communities.

The Army National Guard had the highest rate of suicide among the service branches in 2010.

Using the National Guard as an operational force in the Global War on Terror will require a more accessible mental health program for servicemembers, veterans and their families post deployment in order both to provide the care they deserve as veterans and to maintain the necessary medical readiness required by current deployment cycles. Members of the National Guard, Reserve and their families rely heavily on VA for mental health care services and resources post deployment. In 2009, Congress recognized this need through the passing of "The Caregivers and Veterans Omnibus Health Services Act of 2009," now known as *Public Law* 111–163, enacted May 6, 2010. P.L. 111–163 requires VA to provide enhanced mental health services to veterans and their immediate family members. Unfortunately, distressing developments have emerged since the passage of P.L. 111–163. One of these developments is VA's failure to implement Section 304 of P.L. 111–163. Section 304 requires VA, no later than 180 days after its passage or by November 6, 2010, to establish a program that provides mental health services to the Guard and Reserve members under VA care, as well as to the immediate family members of veterans of Operation Enduring Freedom and Operation Iraqi Freedom. To date VA has failed to implement the program as required by P.L. 111–163. AMVETS and other member organizations within the VSO/MSO community fear VA has no intention to implement P.L. 111–163, Section 304, beyond allowing the Vet Centers to continue to provide counseling to families of qualified veterans. Unfortunately, Vet Center counseling, even though very good, does not provide the full range of mental health services veterans or their immediate family members may need.

Furthermore, VA is required by P.L. 111–163, Section 304 to contract out with private entities in rural communities to bridge the geographical barriers preventing many of our veterans and their families from receiving mental health treatment and care. AMVETS requests this Committee to closely monitor the implementation of Section 304,[5] which to date has not occurred. It has been clearly illustrated through

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[5] **P.L. 111–163, SEC. 304. PROGRAM ON READJUSTMENT AND MENTAL HEALTH CARE SERVICES FOR VETERANS WHO SERVED IN OPERATION ENDURING FREEDOM AND OPERATION IRAQI FREEDOM.**

(a) Program Required—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall establish a program to provide—

(1) to veterans of Operation Enduring Freedom and Operation Iraqi Freedom, particularly veterans who served in such operations while in the National Guard and the Reserves—

(A) peer outreach services;
(B) peer support services;
(C) readjustment counseling and services described in section 1712(A) of title 38, United States Code; and
(D) mental health services; and

(2) to members of the immediate family of veterans described in paragraph (1), during the 3-year period beginning on the date of the return of such veterans from deploy-

VA's numerous actions, and lack thereof, that only the strictest of oversight by Congress will ensure the proper and timely implementation of P.L. 111–163.

Our National Guard and Reserve veterans of OIF/OEF/OND for the most part are still serving with their units and are still subject to deployment. It is historical anomaly for VA to be caring for veterans still subject to redeployment. To create a seamless medical transition from active duty to VA and then back to active duty will require improved medical screenings of these men and women before their initial release from DoD. AMVETS believes it will be essential for DoD and VA to have a clearer system of communication if they wish to properly identify the medical issues requiring care and to avoid redeploying servicemembers who should stay stateside for treatment of psychological wounds. AMVETS believes DoD needs to responsibly share the cost with VA in funding mental health care for our National Guard and Reserve members between deployments, which to date remains an unmet readiness need.

It is imperative for DoD to ensure at the end of every deployment all returning servicemembers be examined confidentially at their home station or base by a qualified mental health care provider. This would help correct the underreporting of psychological health symptoms on "Post Deployment Health Assessment" (PDHA) forms, which are currently being processed either in theater or at demobilization sites which in most cases are far removed from home. The PDHA is a self assessment questionnaire given to returning servicemembers and is subject to the instruction that reporting a serious medical condition may result in the servicemember

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ment in Operation Enduring Freedom or Operation Iraqi Freedom, education, support, counseling, and mental health services to assist in—

(A) the readjustment of such veterans to civilian life;
(B) in the case such veterans have an injury or illness incurred during such deployment, the recovery of such veterans from such injury or illness; and
(C) the readjustment of the family following the return of such veterans.

(b) Contracts With Community Mental Health Centers and Other Qualified Entities—In carrying out the program required by subsection (a), the Secretary may contract with community mental health centers and other qualified entities to provide the services required by such subsection only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. Such contracts shall require each contracting community health center or entity—

(1) to the extent practicable, to use telehealth services for the delivery of services required by subsection (a);
(2) to the extent practicable, to employ veterans trained under subsection (c) in the provision of services covered by that subsection;
(3) to participate in the training program conducted in accordance with subsection (d);
(4) to comply with applicable protocols of the Department before incurring any liability on behalf of the Department for the provision of services required by subsection (a);
(5) for each veteran for whom a community mental health center or other qualified entity provides mental health services under such contract, to provide the Department with such clinical summary information as the Secretary shall require;
(6) to submit annual reports to the Secretary containing, with respect to the program required by subsection (a) and for the last full calendar year ending before the submittal of such report—

(A) the number of the veterans served, veterans diagnosed, and courses of treatment provided to veterans as part of the program required by subsection (a); and
(B) demographic information for such services, diagnoses, and courses of treatment; and

(7) to meet such other requirements as the Secretary shall require.

(c) Training of Veterans for Provision of Peer-outreach and Peer-support Services—In carrying out the program required by subsection (a), the Secretary shall contract with a national not-for-profit mental health organization to carry out a national program of training for veterans described in subsection (a) to provide the services described in subparagraphs (A) and (B) of paragraph (1) of such subsection.

(d) Training of Clinicians for Provision of Services—The Secretary shall conduct a training program for clinicians of community mental health centers or entities that have contracts with the Secretary under subsection (b) to ensure that such clinicians can provide the services required by subsection (a) in a manner that—

(1) recognizes factors that are unique to the experience of veterans who served on active duty in Operation Enduring Freedom or Operation Iraqi Freedom (including their combat and military training experiences); and
(2) uses best practices and technologies.

(e) Vet Center Defined—In this section, the term 'vet center' means a center for readjustment counseling and related mental health services for veterans under section 1712A of title 38, United States Code.

being medically held on active duty at the demobilization site far from home or medically discharged. These brave men and women would rather suppress any psychological wound before they ever let their units deploy without them. Moreover, rather than risk being retained on active duty and further separated from their families, many members of the Guard and Reserve are not reporting or are underreporting their psychological wounds on the PDHA in order to return home as soon as possible and to avoid being medically discharged. As a consequence, unreported psychological health symptoms that are best treated expeditiously are going untreated because they are not being captured at this earliest post deployment opportunity. This underreporting of service-connected injuries not only delays VA treatment but could also prejudice later VA disability claims filed by transitioning servicemembers. Prior inconsistent medical statements can have a very negative impact on subsequent VA disability claims as well. Furthermore, AMVETS believes VA must implement a stronger mental health screening process for all newly enrolled veterans. This will assist VA in identifying veterans with mental health issues that may have slipped through the cracks at DoD. AMVETS also strongly recommends immediate, joint VA and DoD, development and implementation of stronger post deployment and transition mental health assessments in order to identify and treat these wounds at their start, rather than later when these untreated wounds have been amplified by more deployments or simply by being allowed to fester over time without the necessary medical treatment. If VA and DoD want to stop the avoidable trend of increased suicides among those under their care they need to take a more proactive approach to treatment. As the increasing suicide rates among our veteran and military communities have shown us, "reactionary" care models do not work.

At all stages of PTSD and depression, treatment is time sensitive but this is particularly so after onset as the illness could persist for a lifetime if not promptly and adequately treated and could render the member permanently disabled. The effects of this permanent disability on the member's entire family can be devastating. AMVETS believes it is absolutely imperative that all servicemembers returning from deployment be screened with full confidentiality, while still on active duty by trained and qualified mental health care providers from VA staff and/or qualified health care providers from the civilian community when the demand exceeds the resources DoD and VA can provide. Prompt diagnosis and treatment will help to mitigate the lasting effects of these psychological wounds. Furthermore, AMVETS believes DoD and VA must do a better job in removing the fear and stigmas associated with seeking care for mental health issues. AMVETS believes admitting you need assistance and actively seeking out the necessary resources shows a person to have great resiliency, strength and determination in wanting to better their life.

AMVETS believes inadequate medical screenings of our servicemembers before they are released from active duty is unacceptable for a group that has selflessly sacrificed for our country. This is just as true for those seeking the care and resources of VA after their release from DoD. Given the enormous number of this Nation's returning war fighters who have sustained a psychological wound during their service, AMVETS believes it is time to stop this vicious cycle of reactionary care that has caused us to have to bury veterans who suffered in silence for so long they felt the only way out was to take their own life since they wholeheartedly believed they were an unnecessary burden to their families or communities any longer. AMVETS strongly believes that the men and women who have selflessly sacrificed to serve this Nation deserve much more than we are currently offering.

Chairman Miller, Ranking Member Filner and distinguished Members of the Committee, AMVETS again thanks you for inviting us to share our concerns and recommendations regarding this critical issue. This concludes my testimony and I stand ready to address any questions you may have for me.

Prepared Statement of Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Chairman Miller, Ranking Member Filner, and Members of the Committee: Thank you for the opportunity to appear and discuss the Department of Veterans Affairs' (VA) response to the mental health needs of America's Veterans. I am accompanied today by my colleagues, Dr. Matthew Friedman, Executive Director of VA's National Center for PTSD, Veterans Health Administration (VHA); Dr. Mary Schohn, Acting Director of the Office of Mental Health Operations in VHA, and Mr. Tom Murphy, Veterans Benefits Administration (VBA) Director of Compensation Service.

VA has responded aggressively since fiscal year (FY) 2005 to address previously identified gaps in mental health care by expanding our mental health budgets significantly. In FY 2011, VA's budget for mental health services, not including Vet Centers, pharmacy, and primary care, reached over $5.7 billion, while the amount included in the President's budget for FY 2012 is $6.15 billion. Both of these figures represent dramatic increases from the $2.4 billion obligated in FY 2005.

This funding has been used to greatly enhance mental health services for eligible Veterans. VA has increased the number of mental health staff in its system by more than 7,500 full time employees since FY 2005. During the past 3 years, VA has trained over 4,000 staff members to provide psychotherapies with the strongest evidence for successful outcomes for post-traumatic stress disorder (PTSD), depression, and other conditions. Furthermore, we require that all facilities make these therapies available to any eligible Veteran who may benefit. We also have expanded inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care. These expansions also have increased the numbers of Veterans receiving mental health care in VA. In FY 2010, VA treated more than 1.25 million unique Veterans in a VA specialty mental health program within medical centers, clinics, inpatient settings, and residential rehabilitation programs; this was an increase from 905,684 treated in FY 2005. If including care delivered when mental health is an associated diagnosis in integrated care settings, such as primary care, VA treated almost 1.9 million Veterans in FY 2010, an increase of almost a half a million Veterans since FY 2005.

According to VHA guidelines, all new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days. These guidelines help support VA's Suicide Prevention Program which is based on the concept of ready access to high quality mental health care and other services, and is discussed in more detail later in this testimony. Data closely monitored by VA confirm that our established standards for access to mental health care are met. Over 95 percent of all Veterans referred for new mental health care receive an appointment leading to diagnosis, and when warranted a full treatment plan, within 14 days. Similarly, data confirm that over 95 percent of established mental health patients also receive appointments for continuing care within 14 days of the preferred date, based on the treatment plan. VA also participated from FY 2006 through FY 2010 in a Government Performance and Results Act review, which was recently submitted to Congress. That review, conducted by RAND/Altarum, concluded that VA mental health care was superior to other mental health care offered in the United States on almost all dimensions surveyed. These data speak to the great strides made in the mental health care VA provides since implementation of the Comprehensive Mental Health Strategic Plan began in FY 2005, culminating with the Uniform Mental Health Services Handbook that was disseminated at the end of FY 2008 as VA policy for comprehensive mental health services to be offered throughout our health care system.

In this testimony, I will begin by describing PTSD and associated scientific evidence, with particular focus on two important findings from research: that recovery from PTSD is complicated by co-occurring disorders, and that even the most effective treatments do not guarantee recovery. I will then explain VBA's role in providing support and compensation to affected Veterans. Finally, I will review some highlights of VA's mental health care program, including a general description of the services and care provided, the recovery-oriented nature of our programs, our suicide prevention and crisis line, VA's Readjustment Counseling Service and Vet Centers, and PTSD-specific care.

Explanation of PTSD and Scientific Evidence on PTSD

All VA clinicians, including those responsible for completing Compensation and Pension (C&P) evaluations, adhere to the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders Volume IV Text Revision (DSM–IV–TR), recognized as the authoritative source for mental health conditions. According to the DSM–IV–TR clinical criteria, PTSD can follow exposure to a severely traumatic stressor that involves personal experience of an event involving actual or threatened death or serious injury. It can also be triggered by witnessing an event that involves death, injury, or a threat to the physical integrity of another. The person's response to the event must involve intense fear, helplessness or horror. The symptoms characteristic of PTSD include persistent re-experiencing of the traumatic event, persistent avoidance of stimuli associated with the trauma, numbing of general responsiveness, and persistent symptoms of increased arousal. No single individual displays all these symptoms, and a diagnosis requires a combination of a suf-

ficient number of symptoms, while recognizing that individual patterns will vary. PTSD can be experienced in many ways. Symptoms must last for more than 1 month and the disturbance must cause clinically significant distress or impairment in social, occupational or other important areas of functioning. Military combat certainly creates situations that fit the DSM–IV–TR description of a severe stressor event that can result in PTSD. The likelihood of developing PTSD is known to increase as the proximity to, intensity of, and number of exposures to such stressors increases.

PTSD is associated with increased rates of other mental health conditions, including Major Depressive Disorder, Substance-Related Disorders, Generalized Anxiety Disorder, and others. PTSD can directly or indirectly contribute to other medical conditions. Duration and intensity of symptoms can vary across individuals and within individuals over time. Symptoms may be brief or persistent; the course of PTSD may ebb and return over time, and PTSD can have delayed onset. Clinicians use these criteria and discussions with patients to identify cases of PTSD, sometimes in combination with additional psychological testing. VA adheres to the guidance of the DSM–IV–TR when it states, "Specific assessments of the traumatic experience and concomitant symptoms are needed for such individuals." VA seeks to ensure we offer the right diagnosis in all clinical settings, whether for C&P examinations or as part of a standard mental health assessment for clinical treatment planning.

VA recognizes that many individuals with symptoms of combat stress or PTSD find it difficult to discuss the details of their experiences, although they can more easily describe their symptoms and level of distress. However, without their disclosing the source of the stress, it is impossible for a clinician to diagnose patients with PTSD according to the clinical criteria of the DSM–IV–TR. Clinicians must develop a sense of safety and trust with patients in order to make them feel comfortable enough to share their trauma in the clinical interview. The expertise and sensitivity required for such clinical evaluation is one of the reasons why only doctoral level psychiatry and psychology providers are allowed to conduct initial C&P exams for service-connected PTSD.

The following evidence provides a brief overview of current scientific understanding of PTSD, particularly those findings related to VA decisions on care for Veterans with PTSD and determination of service-connected disability for PTSD. Research demonstrates that PTSD prevalence is directly related to the likelihood of traumatic exposure and is therefore greatest among individuals who are most likely to face life-threatening situations such as military personnel, police, firefighters, and emergency medical practitioners. Among deployed Servicemembers, PTSD prevalence varies with each different military engagement. Among Operation Enduring Freedom, Operation Iraqi Freedom, Operation New Dawn (OEF/OIF/OND) personnel, PTSD is estimated to affect approximately 15 percent of deployed Servicemembers. Data from a number of sources has shown increasing rates of PTSD with increasing numbers of deployments. Given the reality of PTSD as a diagnosis that has greater prevalence among Veterans, the following discussion offers some perspective on the challenges faced by those with a PTSD diagnosis and the challenges in conceptualizing and providing the most effective treatments.

OEF/OIF/OND Veterans with PTSD exhibit significantly more problems with post-deployment readjustment, including homelessness, marital instability and divorce, family problems such as parenting, and poor occupational functioning. PTSD is associated with unemployment for Veterans of all eras. Data from the Bureau of Labor Statistics for 2008 shows that unemployment for OEF/OIF-era Veterans was 7.3 percent as compared with the overall jobless rate of 4.6 percent for Veterans of all eras, and 5.6 percent for non-Veterans. A number of studies have documented more functional impairment and role limitations at work due to PTSD, more sick calls and missed days of work, more depression, poorer physical functioning, more divorce, poorer relationship functioning and more psychosocial difficulties.[1] Veterans who screened positive for PTSD were more than four times as likely to indicate suicidal thoughts as Veterans without PTSD. This rate increases to 5.7 times more likely if there are two or more comorbid disorders associated with PTSD.

Recovery From PTSD Is Complicated by Co-Occurring Disorders

Recovery from PTSD is usually complicated by co-occurring disorders, since most Veterans with PTSD have at least one additional diagnosis such as traumatic brain

[1] *See, e.g.,* Paula P. Schnurr, et al., *Posttraumatic Stress Disorder and Quality of Life: Extension of Findings to Veterans of the Wars in Iraq and Afghanistan,* 29 CLINICAL PSYCHOLOGY REVIEW, 727 (2009).

injury (TBI), depression, substance use disorder (SUD), chronic pain, problems with aggression, insomnia and other medical problems. Treating Veterans with multiple conditions cannot be restricted to PTSD but must address the other problems concurrently. For example, a Veteran with PTSD and chronic pain as a result of his or her injuries will experience the pain as a traumatic trigger that will reactivate other reactions such as PTSD nightmares, avoidant symptoms, and hyperarousal. The pain must be treated along with the PTSD if clinical improvement can be expected realistically. Unfortunately, although VA has excellent treatments for PTSD alone, the development of evidence-based treatments for concurrent PTSD and chronic pain is still at an early stage.

Even the Most Effective Treatments Do Not Guarantee Recovery

Not everyone with PTSD who receives evidence-based treatment is likely to have a favorable response. For example, a recent analysis (submitted for publication) of data from VA's large Cooperative Study (CSP#494) on prolonged exposure to the stress factors associated with and contributing to PTSD symptoms among female Veterans and active duty Servicewomen identified those factors that predict poor treatment outcome. This is the largest randomized clinical trial of Prolonged Exposure (PE) ever conducted, with 284 participants, and the first one focusing solely on Veterans and military personnel. While the results (overall) clearly showed the efficacy of PE treatment for women with a military history who have PTSD, our analysis shows that Veterans with the most severe PTSD are least likely to benefit from a standard course of treatment. Other factors that predicted poor response were unemployment, comorbid mood disorder, and lower education. In other words, those with the worst PTSD are least likely to achieve remission, as is true with any other medical problem.

Even when Veterans are able to begin and sustain participation in treatment, timing, parenting, social, and community functions all matter a great deal. Treatment, especially treatment of severe PTSD, may take a long time. During this period, disabled Veterans with PTSD are at risk for many severe problems including family problems, parenting, inability to hold a job, inability to stay in school, social and community function. Further, evidence also shows that whereas a positive response to treatment may reduce symptom severity and increase functional status among severely affected Veterans, the magnitude of improvement may not always be enough to achieve clinical remissions or terminate disability. This is no different than what is found with other severe and chronic medical disorders (such as diabetes or heart disease) where effective treatment may make a difference in quality of life without eradicating the disease itself.

Compensation for PTSD

VBA has taken a number of steps to improve the effectiveness, timeliness, and consistency of the PTSD claims adjudication process. These improvements have occurred within the general framework of PTSD regulations and the medical examination process. In October 2008, VA amended its regulations to relax the stressor verification requirements where PTSD is diagnosed while a member is on active duty. In July 2010, VA again amended its regulations to relax stressor verification requirements where the claimed stressor is related to fear of hostile military or terrorist activity and the stressor is consistent with the places, types, and circumstances of service. The adjudication process involves making a determination as to: (1) whether current symptoms are connected to service and, if so, (2) what level of compensation is appropriate.

Service-Connection

Service-connection for PTSD is governed by 38 CFR § 3.304(f) and requires:

- Medical evidence diagnosing the condition in accordance with the American Psychiatric Association's DSM–IV [Diagnostic and Statistical Manual of Mental Disorders];
- A link, established by medical evidence, between current symptoms and an in-service stressor; and
- Credible supporting evidence that the claimed in-service stressor occurred.

The regulation draws a distinction between different types of stressors and the evidence required to substantiate them. If the stressor relates to an in-service diagnosis of PTSD, participation in combat with the enemy, or being held as a prisoner of war, the Veteran's lay statement alone may be sufficient to establish occurrence

of the stressor. For all other stressor types, except the new type described below, VBA must substantiate occurrence of the stressor with credible supporting evidence.

As the wars in Iraq and Afghanistan progressed and Veterans returning from those areas of conflict filed more claims for PTSD, it became apparent that a modification to the PTSD regulations was necessary to facilitate a more effective adjudication process. Many claims were filed by Veterans who were not involved with direct combat, but who experienced stressors related to their war-zone service. In these cases, the Veteran's lay statement was not sufficient to establish occurrence of the stressor, and obtaining credible documentation of the stressor was difficult and time consuming. As a result, VBA modified the PTSD regulations to add section 3.304(f)(3) in July 2010. This section provides that the Veteran's lay testimony alone may establish occurrence of the claimed in-service stressor if:

- The Veteran's stressor is related to fear of hostile military or terrorist activity;
- A VA psychiatrist or psychologist (or contract equivalent) confirms the claimed stressor is adequate to support a diagnosis of PTSD and symptoms are related to the stressor;
- There is no clear and convincing evidence to the contrary; and
- The claimed stressor is consistent with places, types, and circumstances of service.

This regulation change has allowed VBA to schedule a PTSD examination in "fearbased" stressor claims without the need to objectively document the occurrence of the stressor, as long as the Veteran served in an area of potential hostile military or terrorist activity. When the stressor is accepted by the medical examiner and associated with current PTSD symptoms, the occurrence of the stressor is established. This has improved effectiveness by reducing evidence-development time and promoting an equitable and consistent approach to evaluating PTSD claims where stressor evidence is difficult to obtain.

Military sexual trauma (MST) claims fall under the PTSD regulatory heading of personal assault, at section 3.304(f)(5). These claims receive special treatment because of the sensitive nature of the stressor and the difficulty with obtaining evidence to support its occurrence. Evidence is sought from multiple sources in addition to military records, and any evidence of the Veteran's behavioral change is among the different types of evidence that may provide credible evidence of the stressor. The examiner's assessment of the evidence may then lead to a finding of occurrence of the stressor. Because of an emerging focus on these MST claims, VBA recently incorporated tracking mechanisms into the computer programs used to produce and store adjudication decisions. This will allow VBA to monitor statistics on these cases and determine how to further improve processing effectiveness.

Compensation

Once service-connection is established in a PTSD claim, a determination of the rate of disability compensation payable must be made. This involves comparing the medical evidence describing symptom severity with the rating criteria in the VA Schedule for Rating Disabilities, contained in 38 CFR Part 4. PTSD, along with all other mental disorders, is evaluated under a section that assigns various degrees of disability, in percentages ranging from 0 to 100 percent, to various levels of occupational and social functioning, from no impairment to total occupational and social impairment. The rate of compensation paid correlates to the degree of disability assigned. VBA employees who adjudicate these claims must often exercise a measure of judgment when medical evidence is less than consistent. As a means to improve effectiveness and reduce judgmental variation, VBA, in conjunction with the Veterans Health Administration (VHA), developed a revised worksheet for the PTSD examiners to use. This serves as the basis for the final examination report, which is reviewed by VBA adjudicators when making their decisions. The revised worksheet prompts the examiner to choose one of a range of options that most closely describes the scope of the Veteran's symptom severity. The wording of the options is consistent with the wording of symptom gradations described in the actual mental-disorder rating schedule. This provides adjudicators with a statement from a medical authority that matches the rating schedule and thereby provides the basis for more accurate and consistent ratings.

To devise a more comprehensive means to improve effectiveness and consistency in PTSD and other mental-disorder claims adjudication, VBA and VHA are developing an entirely new rating schedule for mental disorders. This evolved from a national mental health conference in January 2010 and an acknowledged need to update the rating schedule in order to conform to current medical practice. This new

version has not been finalized, but will shift the emphasis from disabling symptoms to a functional impairment model that focuses on work and income-related outcomes. When the final version of this new rating schedule is adopted, it will further the goal of increased effectiveness and consistency in PTSD rating decisions. The proposed revision has been drafted and is in concurrence. We anticipate publishing the final rule by December 2012.

VA currently does everything possible to support Veterans with PTSD and offer care and benefits that will enable them to begin a course of effective treatment through its excellent mental health services. We understand that some Veterans advocates have recommended a program that would offer Veterans financial incentives to seek treatment and delay applications for compensation and pension. VA believes delaying compensation to severely affected Veterans until they have had a full course of treatment will leave them vulnerable and at risk of the consequences of PTSD, such as suicide, homelessness, incarceration, marital/family disruption and unemployment. In addition, because avoidance of stressful situations, especially those that may remind the person with PTSD of the original traumatizing experience, is inherent in the diagnosis of PTSD, many severely affected Veterans will be challenged in seeking VA exposure-based treatment or maintaining participation in such treatment, once started. Handling this issue is the essence of successful care for PTSD: trauma survivors are best treated by re-experiencing of the original situation, in a safe and supportive environment with clinical relearning opportunities; however, the nature of the disorder makes this intrinsically difficult. Forcing individuals to enter treatment before they are ready and have developed trust of their therapist and the clinical environment could not only lead to treatment failure but also to retraumatization.

VA Mental Health Services

In addition to our compensation and pension programs, VA offers mental health services to eligible Veterans through medical facilities, community-based outpatient clinics (CBOC), and in VA's Vet Centers. As noted above, VA has been making significant advances in its mental health services since 2005, beginning with implementation of the VA Comprehensive Mental Health Strategic Plan utilizing special purpose funds available through the Mental Health Enhancement Initiative. In 2008 implementation of the strategic plan culminated in development of the VHA *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics,* which defines what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care. Current efforts focus on fully implementing the Handbook, and continuing progress made, emphasizing additional areas for development, and sustaining the enhancements made to date.

VA's enhanced mental health activities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide. VA has a full range of sites of care, including inpatient acute mental health units, extended care Residential Rehabilitation Treatment Programs, outpatient specialty mental health care, mental health care in integrated physical health/mental health settings such as the Patient Aligned Care Team (PACT), geriatrics and extended care settings, and Home-Based Primary Care, which delivers mental health services to eligible home-bound Veterans and their caregivers in their own homes.

For Veterans seen in VA, identifying and treating patients with PTSD and other mental health conditions is paramount. VA's efforts to facilitate treatment while removing the stigma associated with seeking mental health care are yielding valuable results. VA screens any patient seen in our facilities for depression, PTSD, problem drinking, and a history of military sexual trauma. Any positive screen must be followed by a full diagnostic evaluation; if the screening is positive for PTSD or depression, an additional suicide risk assessment is conducted. This screening and treatment have been incorporated into primary care settings, resulting in the identification of many Veterans who benefit from early treatment, before they may have reached the point of initiating discussion of mental health difficulties they are facing.

VA also offers a full continuum of care, including our array of inpatient, residential rehabilitation, and outpatient services for Veterans with one or more of the following conditions (this list is illustrative, not exhaustive): serious mental illness (such as schizophrenia), PTSD, alcohol and substance abuse disorders, depression, and anxiety disorders. Special programs are offered for Veterans at risk of suicide, Veterans who are homeless, and Veterans who have experienced military sexual trauma with resulting development or exacerbation of mental health problems.

VA ensures that treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions, with emphasis on all relevant, evidence-based modalities, including psychopharmacological care, psychotherapy, peer support, vocational rehabilitation, and crisis intervention. VA is focused on providing patient-centered, effective care by ensuring that when there is evidence for the effectiveness of a number of different treatment strategies, the choice of treatment should be based on the Veteran's values and preferences, in conjunction with the clinical judgment of the provider.

To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions, when appropriate. Mental health services are incorporated in the evolution of VA primary care to PACT, an interdisciplinary model to organize a site for holistic care of the Veteran in a single primary health care location. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery.

Recovery-Oriented Care

With the publication and dissemination of VHA Directive 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics* in September 2008, VHA required that all mental health services must be recovery-oriented, with special emphasis on those services provided to Veterans with serious mental illness. VA has adopted the definition of recovery as developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which states: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." It is important to note that this definition does not refer to the individual being "cured" of mental illness. Rather, it is a functional definition that describes an improved quality of life—often while managing ongoing symptoms of mental illness—as a result of engaging in recovery-oriented services.

Recovery-oriented services are strengths-based, individualized, and person-centered. These services strive to help the Veteran feel empowered to realize his or her goals and to engender hope that symptoms of mental illness can be managed and integration into the community can be achieved. They rely on support for the Veteran from clinical staff, family, and friends and allow the Veteran to take responsibility for directing his or her own treatment, within the range of viable, evidence-based approaches to care.

Although reducing the symptoms of mental illness that the Veteran is experiencing is important, the goal of recovery-oriented treatment services does not focus solely on symptom reduction, as symptoms may wax and wane over the course of the individual's life. While reducing the symptoms of mental illness the Veteran is experiencing is important, the reduction of symptoms alone does not mean that the Veteran has the skills necessary to lead a meaningful life. The goal of recovery is to help Veterans with mental illness achieve personal life goals that will result in improved functioning, while managing the symptoms they experience to the extent possible. For some Veterans, recovery could mean that they are able to live independently and that they have meaningful interpersonal relationships. For others, it could mean that they are able to return to school or achieve meaningful employment. VA believes that all Veterans should be afforded the opportunity to work, and offers the Supported Employment program to Veterans whose mental health problems interfere with obtaining or sustaining employment. This program has been implemented as an important recovery-oriented tool to assist those Veterans with serious mental illness in gaining competitive employment and providing continuing coaching and other services to increase the chances of success at work.

It is important to emphasize that the path to recovery is not necessarily linear. Periods of significant growth, improvement, and stability in functioning are sometimes interrupted by periods of increased difficulty that may be accompanied by a worsening of symptoms or other setbacks. Such setbacks may have a significant effect on Veterans' ability to reach their goals. Many Veterans, for example, value work and understand its importance in improving their self-esteem and helping their integration into the community. Advancing in employment to the degree the Veteran could have expected without a mental health problem is often difficult or impossible, however, given the impact of remaining symptoms. The other major concern for Veterans in a recovery-focused course of treatment is that maintaining employment may be difficult if the Veteran has to take time away from the job due to a worsening of symptoms. Veterans with serious mental illness often become con-

cerned that they will lose their jobs and will not be able to provide for themselves or their family during times of such relapse. In addition, while life events or environmental stressors might cause a relapse, there are many times when there is no identifiable cause. Because experiencing a relapse can be significantly disruptive, and because relapses are often unpredictable, Veterans with serious mental illness are sometimes hesitant to engage in recovery-oriented activities without assurance that their basic needs can be met during times when they are unable to work.

Suicide Prevention/Veterans Crisis Line

As mentioned earlier in the testimony, the VA Suicide Prevention Program is based on the concept of ready access to high quality mental health care and other services. VHA has added Suicide Prevention Coordinators (SPCs) at every facility and large CBOC; these are an important component of our mental health staffing. The SPCs ensure local planning and coordination of mental health care of support Veterans who are high risk for suicide, they provide education and training for VA staff, they do outreach in the community to educate Veterans and health care groups about suicide risk and VA care, and they provide direct clinical care for Veterans at increased risk for suicide. One of the main mechanisms to access enhanced care provided to high risk patients is through the Veterans Crisis Line, and the linkages between the Crisis Line and the local SPCs. The Crisis Line is located in Canandaigua, New York, and partners with the Substance Abuse and Mental Health Services Administration National Suicide Prevention Lifeline. All calls from Veterans, Servicemembers, families and friends calling about Veterans or Servicemembers are routed to the Veterans Crisis Line. The Crisis Line started in July 2007, and the Veterans Chat Service was started in July 2009. To date the Crisis Line has:

- Received over 400,000 calls;
- Initiated over 15,000 rescues;
- Referred over 55,000 Veterans to local VA SPCs, who are available in every VA facility and many large CBOCs, for same day or next day services;
- Answered calls from over 5,000 Active Duty Servicemembers; and
- Responded to over 16,000 chats.

VA also has put in place sensitive procedures to enhance care for Veterans who are known to be at high risk for suicide. Whenever Veterans are identified as surviving an attempt or is otherwise identified as being at high risk, they are placed on the facility high-risk list and their chart is flagged such that local providers are alerted to the suicide risk for this Veteran. In addition, the SPC will contact the Veteran's primary care and mental health provider to ensure that all components of an enhanced care mental health package are implemented. These include a review of the current care plan, addition of possible treatment elements known to reduce suicide risk, ongoing monitoring and specific processes of follow-up for missed appointments, individualized discussion about means reduction, identification of a family member or friend (either to be involved in care or to be contacted, if necessary), and collaborative development with the Veteran of a written safety plan to be included in the medical record and provided to the Veteran. In addition, pursuant to VA policy, SPCs are responsible for, among other things, training of all VA Staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with veterans, so they know how to get immediate help when veterans express any suicide plan or intent.

All VA Suicide Prevention Program elements are shared regularly with the Department of Defense (DoD), and a joint conference is held annually to encourage use of all effective strategies across both Departments, including educational products and materials.

Readjustment Counseling Service: Vet Centers

Vet Centers provide community outreach, professional readjustment counseling for war-related readjustment problems, and case management referrals for combat Veterans. Vet Centers also provide bereavement counseling for families of Servicemembers who died while on Active Duty. Through March 31, 2011, Vet Centers have cumulatively provided face-to-face readjustment services to more than 525,000 OEF/OIF/OND Veterans and their families. As required by Section 401 of Public Law 111–163, VA is currently drafting regulations to expand Vet Center eligibility to include members of the Active Duty Armed Forces who served in OEF/OIF/OND (including Members of the National Guard and Reserve who are on Active Duty).

In addition to the 300 Vet Centers that will be operational by the end of 2011, the Readjustment Counseling Service program will also have 70 Mobile Vet Centers operational by the end of 2011 to provide outreach services to separating Servicemembers and Veterans in rural areas. The Mobile Vet Centers provide outreach and direct readjustment counseling at active military, Reserve, and National Guard demobilization activities. To better serve eligible Veterans with military-related family problems, VA is adding licensed family counselors to over 200 Vet Center sites that do not currently have a family counselor on staff.

PTSD Care in VA

VA is nationally recognized for its outstanding PTSD treatment and research programs, and the quality of VA health care in this area also is outstanding, with continual enhancements as more is learned. For example, VA's National Center for PTSD advances the clinical care and social welfare of Veterans through research, education and training on PTSD and stress-related disorders. They also lead a national mentoring program throughout the VA system that provides continuous training to guide programs to consistently delivering recommended care based on Clinical Practice Guidelines and recognized best practices. They recently added a clinical consultation program to supplement the ongoing mentoring educational offerings. Their advances are used to guide clinical program policy development and implementation.

In FY 2010, VA treated more than 408,000 unique Veterans for PTSD in VA *specialty* mental health programs within medical centers, clinics, inpatient settings, and residential rehabilitation programs; this was an increase from 235,639 treated in FY 2005. If we include care delivered in *integrated care* settings, such as primary care, VA treated a cumulative total of more than 438,000 in FY 2010, an increase from approximately 250,000 in FY 2005. Given the increasing numbers of Veterans seeking VA care for PTSD, VA is monitoring parameters to ensure prompt and efficient services for PTSD and other mental disorders, using indicators such as "time to first appointment" for Veterans of all service eras who present with new mental health problems.

It is essential that mental health professionals across our system provide the most effective treatment for PTSD, once the diagnosis has been identified. In addition to use of effective psychoactive medications, VA supports use of evidence-based psychotherapies. VA has conducted national training initiatives to educate therapists in two particular exposure-based psychotherapies for PTSD that have especially strong research support, as confirmed by the Institute of Medicine in their 2008 report, *Treatment of Posttraumatic Stress Disorder:* Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE). To date, VA has trained over 3,400 VA clinicians in the use of CPT and PE. For both of these psychotherapies, following didactic training, clinicians participate in clinical consultations to attain full competency in the therapy. VA is also using new CPT and PE treatment manuals developed for VA, with inclusion of material on the treatment of unique issues arising from combat trauma during military service.

Conclusion

Thank you again for this opportunity to speak about VA's diagnosis and treatment of mental health concerns of eligible Veterans who use VA's health care system, with particular emphasis on PTSD. PTSD is a diagnosis of central importance in our work with Veterans, both in providing health care and when Veterans submit mental health service-connection claims to VBA. It is imperative that VA provide a system of mental health care and benefits that is driven by evidence and is fully responsive to the mental health challenges that Veterans face. My colleagues and I are prepared to answer any questions you may have.

Joint Statement of American Association for Marriage and Family Therapy, National Board for Certified Counselors, California Association of Marriage and Family Therapists, American Counseling Association, and American Mental Health Counselors Association

Chairman Miller, Ranking Member Filner, and Members of the Committee, our groups represent more than 160,000 Professional Counselors and Marriage and Family Therapists (MFTs), who are licensed in every State to provide behavioral-health services such as psychotherapy.

This Committee is well aware of the large and rapidly growing number of veterans with long-term behavioral health needs, as current conflicts have produced "signature wounds" of Post-Traumatic Stress Disorder as well as Traumatic Brain Injury, which also has major behavioral symptoms. Repeated deployments, including of Guard and Reserve forces, also have increased the prevalence of separation anxiety and depression. Several hearing witnesses have detailed the extent and severity of these needs.

Indeed, in 2006, Congress enacted Public Law 109–461 establishing 38 U.S.C. § 7401(3) to permit VA to hire MFTs and Counselors to help address veterans' mental-health needs. It took until September 30, 2010 for the VA to issue Counselor and MFT Job Specifications (VA Handbook 5005/41 for MFTs and 5005/42 for Counselors) implementing the law.

Meanwhile, on May 10, 2011, the 9th Circuit Court of Appeals (*Veterans for Common Sense* v. *Shinseki) ruled that "unchecked incompetence" by the VA has led to inadequate mental health care. According to the panel, "(M)any veterans with severe depression or post-traumatic stress disorder are forced to wait weeks for mental health referrals and are given no opportunity to request or demonstrate their need for expedited care . . . . The delays have worsened in recent years, as the influx of injured troops . . . has placed an unprecedented strain on the VA, and has overwhelmed the system that it employs to provide medical care to veterans . . ."*

While we are pleased that the VA is finally taking steps to implement the 2006 statute, we are concerned with the pace and extent of implementation. We understand that most VA postings for MFTs and Counselors are for Readjustment Counseling Center ("Vet Center") jobs, rather than at clinical facilities. We appreciate the integration of our professions into these facilities, but do not believe that they reflect the full intent of the law, which was to employ MFTs and Counselors throughout the health system. The nominal employment opportunities for MFTs and Counselors in the medical facilities since the release of the Standards, while hundreds of Social Work positions are advertised, shows a systemic failure to implement.

As an example of the problem, the VA's testimony at this hearing stated "VA is adding licensed family counselors to over 200 Vet Centers that do not currently have a family counselor on staff." The fact that the VA incorrectly characterized these professionals as "family counselors," thereby combining the two distinct professions into one inaccurate title, does not inspire confidence that the VA understands how either MFTs or Professional Counselors can aid its mission. Further, the VA only references the use of these professionals in Vet Centers, reinforcing our concerns that they are not considered for positions throughout the system. This language demonstrates a lack of understanding about who these professions are and why Congress passed the law. It is clear that more education needs to be done at all levels of the VA and a proactive integration plan needs to be developed. The VA national office needs to spearhead this effort and ensure that it is adopted by local facilities. We urge Congress to recommend such action.

In addition to our concerns with the pace and extent of implementation, we have concerns with the rigidity of the eligibility criteria. Specifically, the fact that the new Qualification Standards for both professions exclude a significant portion of qualified MFTs and Professional Counselors from VA employment. While we appreciate the need for high standards, the lack of flexibility in the standards restrict access to many MFTs and Counselors who have been practicing effectively for decades. We estimate that roughly 80,000 Counselors and MFTs nationwide, including up to 95 percent of California MFTs, are barred from VA jobs by these requirements. We believe this severely undermines the VA's ability to hire qualified behavioral-health personnel.

These requirements provide that job candidates must hold an advanced degree awarded by an academic program that, *when the degree was granted,* was accredited by a specialty accrediting body. (For Counselors, this is the Council for Accreditation of Counseling and Related Educational Programs, and for MFTs, it is the Commission on Accreditation for Marriage and Family Therapy Education.) This fails to recognize that there was a time when accreditation by these specialized bodies was not a widespread practice, even though the degree-granting institutions themselves were accredited by a Regional accrediting body. There are some professionals who may have graduated prior to the creation of these accrediting bodies and many who may have had limited or no accessible accredited programs. These MFTs and Counselors have been practicing for many years and should not be excluded from employment by the VA.

In response to this concern, we formally requested that the VA establish an alternate means to recognize qualified MFTs and Counselors with strong credentials and significant clinical experience who may not otherwise meet the Qualification Standards. The VA denied this request to Counselors and a response is pending for MFTs.

We believe that this flexibility will increase the number of qualified professionals available to serve our veterans and help address the access problems identified by the 9th Circuit Court of Appeals. We ask Congress to urge the VA to develop alternatives to the existing standards that allow for employment of experienced and qualified MFTs and Counselors.

Finally, we agree with several hearing witnesses that the Committee should question why VA has not implemented Public Law 111–163, Section 304, regarding mental-health and support services for OEF/OIF veterans and their families.

We would be pleased to work with this Committee and VA to address these challenges, and to respond to any questions this Committee may have.

Statement of the California Association of Marriage and Family Therapists

Mr. Chairman, Members of the Committee, the California Association of Marriage and Family Therapists (CAMFT), with over 29,000 members, is an independent professional organization representing the interests of licensed marriage and family therapists (MFTs) in the State of California. With its membership, CAMFT represents more than half of the 54,000 licensed MFTs in the United States. CAMFT is dedicated to advancing the profession as an art and a science, to maintaining high standards of professional ethics, to upholding the qualifications for the profession, and to expanding the recognition and awareness of the profession.

We are all painfully aware of the multitude of mental health problems that a number of veterans are dealing with today. The Congress has recognized that part of the solution to dealing with this problem is to make more mental health professionals available to treat these conditions being experienced by our veterans. With the passage of the Veterans Benefits, Health Care, and Information Technology Act of 2006, P.L. 109–461 and the Veterans' Mental Health and Other Care Improvements Act of 2008, P.L. 110–387, Marriage and Family Therapists are now recognized by the Department of Veterans Affairs as a provider of mental health services to both veterans and their family members. In order to implement the law, the Department of Veterans Affairs (VA) had to create employment standards by which their individual facilities could hire qualified MFTs. (Copy attached as Appendix A) From the outset, we believe that the VA has been seriously misinformed about how MFTs practice. Consequently, the qualification standard needs to be significantly reworked to reflect the actual way MFTs practice throughout the United States.

Education Requirements

Standard 2(b) sets forth the education requirement for MFTs who wish to work for the VA. This standard requires MFTs to have graduated from master's programs approved by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE), or programs accredited by a "nationally accredited program conferring a comparable mental health degree as specified in the qualification standard of those disciplines (Social Work, Psychiatric Nursing, Psychology, and Psychiatry)." CAMFT believes that these requirements are much too limiting. (Additionally, we are informed that MFTs in other States such as New York, Florida, and Texas as well are graduates of non-COAMFTE approved schools.) In actuality, very few MFT programs are approved by COAMFTE or accredited by national organizations. It is anticipated that 90 percent of California MFT graduates are from programs that are **NOT** COAMFTE accredited. Further, COAMFTE accredits only those degree programs that are already accredited by a regionally accepted accrediting body. Given that there are 99 Veteran's Facilities in California, eliminating 90 percent of the pool of potential VA MFTs, who are licensed by the State of California in the profession, is a disservice to our veterans. Moreover, we are puzzled by the naming of the other disciplines (Social Work, Psychiatric Nursing, Psychology, and Psychiatry) for comparison purposes. MFTs are a separate and distinct discipline licensed to provide mental health services for individuals, adults, couples, '!,'; families, children, and adolescents, and groups. In California, MFTs may have master's or doctoral degrees in marriage and family therapy; marriage and family child counseling; 'psychology; counseling psychology; or, counseling with an emphasis in' marriage, faruily, and child counseling. The education of MFTs is comparable to what is required for licensed professional counselors with additional content required to work with couples, families, and children. In California, an MFT can earn the underlying master's or doctor's degree from a school, college, or university that is accredited by a *regional* accrediting agency recognized by the United States Depart-

ment of Education, or by a school, college, or university approved by the Bureau of Private Post Secondary Education (see California Business & Professions Code § 4980.37(b), Copy attached as Appendix B). CAMFT believes that ***regional*** accreditation should be the standard required by the VA.

Ability to Diagnose and Treat

Standard 2 (c) sets forth the licensure requirement for MFTs who wish to work for the VA. This section needs to recognize that MFTs do diagnose and treat individuals with mental illness. In California, by law, the master's or doctor's program leading to licensure as an MFT must train students to diagnose, assess, and treat mental disorders (see California Business & Professions Code § 4980.37 (e)(1), Copy attached as Appendix C).

Moreover, MFTs diagnose and treat mental disorders in government agencies, nonprofit counseling agencies, and private practices. And, MFTs are reimbursed by public mental health programs, TRICARE, and private insurance companies for providing such work. MFTs, like other mental health professionals, diagnose and treat mental disorders. They are trained to do such work; they are tested by licensing boards on their ability to do such work; and, they get paid by public and private sources to do such work. CAMFT believes that this reality needs to be reflected by the VA in the MFT qualification standard.

Every week a new study or report emphasizes the growing mental health needs of our veterans and the. shortage of mental health providers to minister to them. The members of CAMFT are anxious and willing to be added to the staff of VA facilities to provide for the needs of this patient population. Unless the standards are changed, a vast resource of mental health professionals in California and other parts of the country will be unavailable to care for our veterans. Thank you.

APPENDIX A

VA Transmittal Sheet

Department of Veterans Affairs
Handbook 5005/
Washington, DC 20420

STAFFING

1. **REASON FOR ISSUE:** To establish a Department of Veterans Affairs (VA) qualification standard for Marriage and Family Therapist, GS–I0l, appointed under 38 U.S.C. § 7401(3).
2. **SUMMARY OF CONTENTS/MAJOR CHANGES:** This handbook contains mandatory procedures on staffing. This revision establishes the Marriage and Family Therapist occupation under VA's Title 38 Hybrid excepted service employment system in accordance with the "Veterans Benefits, Health Care, and Information Technology Act of 2006" (Public. Law 109–461). Authority is given to the Secretary of the VA under 38 U.S.C. § 7402 to prescribe qualifications for occupations identified in 38 U.S.C. § 7401(3). The pages in this policy are to be inserted in part II of VA Handbook 5005. This new qualification standard will be incorporated into the electronic version of VA Handbook 5005 that is maintained on the Office of Human Resources Management
3. **RESPONSIBLE OFFICE:** The Recruitment and Placement Policy Service. (059), Office of the Deputy Assistant Secretary for Human Resources Management.
4. **RELATED DIRECTIVE:** VA Directive 5005, Staffing.
5. **RESCISSIONS:** None.

CERTIFIED BY:

Roger W. Baker
Assistant Secretary for
Information and Technology

BY DIRECTION OF THE SECRETARY OF VETERANS AFFAIRS:

John U. Sepulveda
Assistant Secretary for
Human Resources and Administration

CONTENTS—CONTINUED

CONTENTS—CONTINUED—Continued

CONTENTS—CONTINUED—Continued

*Use in conjunction with the OPM Standard.

VA HANDBOOK 5005/
PART II
APPENDIX G42

[APPENDIX G42. MARRIAGE AND FAMILY THERAPIST QUALIFICATION STANDARD]
GS–101
Veterans Health Administration

1. **COVERAGE.** The following are requirements for appointment as a Marriage and Family Therapist (MFT) in the Veterans Health Administration (VHA). These requirements apply to all VHA MFTs in the GS–l0 I series, including those assigned to VA Medical Centers, Community-Based Outpatient Clinics (CBOCs), Vet Centers, Veterans Integrated Service Network (VISN) offices, and VHA Central Office.
2. **BASIC REQUIREMENTS.** The basic requirements for employment as a VHA MFT are prescribed by statute in 38 U.S.C. 7402(b)(10), as amended by section 201 of Public Law 109–461, enacted December 22, 2006. To qualify for appointment as an MFT in VHA, all applicants must:

a. **Citizenship.** Be a citizen of the United States. (Non-citizens may be appointed when it is not possible to recruit qualified citizens in accordance with chapter 3, section A, paragraph 3g, this part.)

b. **Education.** Hold a master's degree in marriage and family therapy from a program approved by the Commission on Accreditation for Marriage and Family Therapy Education (COAMFTE) or have graduated from a nationally accredited program conferring a comparable mental health degree as . . . specified in the qualification standards of those disciplines (Social Work, Psychiatric Nursing, Psychology, and Psychiatry). All additional course work taken to be accepted for MFT licensure must come from a nationally accredited program in one of the above areas.

NOTE: *.A doctoral degree in marriage and family therapy from a COAMFTE approved program is considered to be a comparable mental health degree.*

c. **Licensure.** Persons hired or reassigned to MFT positions in the GS–l0 I series in VHA must hold a full, current, and unrestricted license to independently practice marriage and family therapy in a State.

(1) **Exception.** The appointing official may waive the licensure requirement for persons who are otherwise qualified, pending completion of state prerequisites for licensure examinations for a period not to exceed 2 years from the date of employment on the condition that MFTs appointed on this basis provide care only under the supervision of a fully licensed MFT. Non-licensed MFTs who otherwise meet the eligibility requirements may be given a temporary appointment as a graduate MFT under the authority of 38 U.S.C. 74057405(c)(2)(B) This exception only applies at the entry level (GS–9). For grades at or above the full performance level, the candidate must be licensed.

(2) **Failure to Obtain License.** In all cases, unlicensed MFTs must actively pursue meeting State prerequisites for licensure starting from the date of their temporary appointment. At the time of appointment, the supervisor will provide the unlicensed MFT with the written requirements for licensure, the time frame by which the license must be obtained, and the consequences for not becoming licensed by the deadline. Failure to obtain a license within the prescribed amount of time will result in removal from the GS–101 MFT series and may result in termination of employment.

(3) **Loss of Licensure.** Once licensed, MFTs must maintain a full, valid and unrestricted license to remain qualified for employment. Loss of licensure will re-

sult in removal from the GS–101 MFT series and may result in termination of employment.

d. **Physical Requirements.** See VA Directive and Handbook 5019.

e. **English Language Proficiency.** MFTs must be proficient in spoken and written English in accordance with VA Handbook 5005, part II, chapter 3, section A, paragraph 3j.

3. GRADE REQUIREMENTS

a. **Creditable Experience**

(1) **Knowledge of Current Professional Marriage and Family Therapy Practices.** To be creditable, the experience must have required the use of knowledge, skills, and abilities associated with current professional marriage and family therapy practice. The experience must be post-master's degree or above. Experience satisfying this requirement must be active professional practice, which is paid/non-paid employment as a professional MFT, as defined by the appropriate State licensing board.

(2) **Quality of Experience.** Experience is only creditable if it is obtained following graduation with a master's degree in marriage and family therapy or comparable degree in mental health (Social Work, Psychiatric Nursing, Psychology, and Psychiatry) from an accredited training program and includes: work as a professional MFT directly related to the position to be filled. Qualifying experience must also be at a level comparable to. marriage and family therapy experience at the next lower grade level. For all assignments above the full performance level, the higher level duties must consist of significant scope, administrative:independence, complexity (difficulty) and range of variety as described in this standard at the specified grade level and be performed by the incumbent at least 25 percent of the time.

(3) **Part-Time Experience.** Part-time experience as a professional MFT is creditable according to its relationship to the full-time work week. For example, an MFT employed 20 hours a week, or on a ½ time basis, would receive 1 full-time work week of credit for each 2 weeks of service.

(4) **Fellowships or Post-Graduate Training.** Fellowship and post-graduate training programs are typically in a specialized area of clinical practice, e.g., group or family practice. Training as a fellow or post-graduate may be substituted for creditable experience on a year-for-year basis.

(5) **Practicum in a VA Setting.** A VHA practicum experience may not be substituted for experience, as the practicum (field placement) is completed prior to graduation with a master's degree in marriage and family therapy or comparable mental health degree.

b. **Grade Determinations.** In addition to the basic requirements for employment, the following criteria must be met when determining the grade of candidates.

(1) **GS–9 Marriage and Family Therapist (Entry Level)**

(a) **Experience, Education and Licensure.** GS–9 is the entry level grade for the GS–101 Marriage and Family Therapist series and is used for licensed MFTs with less than 1 year of experience (postmaster's degree) or for MFTs (master's or doctoral level) who are graduates not yet licensed at the independent practice level. Unlicensed MFTs at the GS–9 level have completed the required education listed in paragraph 2b above, and are working toward completion of prerequisites for licensure. In addition, the candidates must demonstrate the KSAs in subparagraph (b) below.

(b) **Demonstrated** Knowledge, Skills, **and** Abilities

1. Basic knowledge of human development throughout the lifespan, including interventions based on research and theory, family and system interaction formal diagnostic criteria, risk assessment, evidence-based practice and assessment tools.

2. Ability to assess, with supervision, the psychosocial functioning and needs of patients and their family members, and the knowledge to formulate, implement, and re-evaluate a treatment plan through continuous assessment identifying the patient's problems, strengths, readiness to change, external influences and current events surrounding the origins and maintenance of the presenting issue, and interactional patterns within the client system. This includes the utilization of testing measures where appropriate.

3. Ability to provide counseling and/or psychotherapy services to individuals, groups, couples and families in a culturally competent manner that facilitates change through restructuring and reorganizing of the client system with supervision.
4. Ability to establish and maintain effective working relationships with clients, colleagues, and other professionals, with supervisory guidance as needed. This includes the ability to communicate effectively, both orally and in writing, with people from varied backgrounds, and to communicate the MFT perspective in interdisciplinary staff meetings while respecting the roles and responsibilities of other professionals.
5. Basic knowledge and understanding of existing relevant statutes, case law, ethical codes, and regulations affecting professional practice of marriage and family therapy. This includes the ability, under close supervision, to assist clients in making informed decisions relevant to treatment, including limits of confidentiality.
6. Ability to organize work, set personal priorities and meet multiple deadlines as assigned by the supervisor.
7. Ability to use computer software applications for drafting documents, data management, maintaining accurate, timely and thorough clinical documentation, and tracking quality improvements.

(c) **Assignments.** Individuals assigned, as GS–9 MFTs are considered to be at the entry level and are closely supervised, as they are not yet functioning at the independent practice level conferred by independent licensure. MFTs at the GS–9 entry level are typically assigned to VHA program areas that do not require specialized knowledge or experience. Since these MFTs are not practicing at an independent level, they should not be assigned to program areas where independent practice is required, such as in a CBOC, unless there is a licensed MFT in the program area who can provide supervision for practice. GS–9 MFTs provide mental health services under close supervision and within the ethics and guidelines of the professional standards set by AAMFT.

(2) **GS–11 Marriage and Family Therapist (Full Performance Level)**

(a) **Experience, Education and Licensure.** In addition to the basic requirements, the GS–11 full performance level requires completion of a minimum of 1 year of post-master' s degree experience in the field of health care marriage and family therapy work (VA or non-VA experience) and licensure in a state at the independent practice level. In addition, the candidate must be licensed to practice at the independent practice level and must demonstrate the KSAs in subparagraph (b) below.

OR,

A doctoral degree in marriage and family therapy or comparable degree in mental health from an accredited training program (see page 2.b. NOTE above) may be substituted for the required 1 year of professional marriage and family therapy experience in a clinical setting. In addition, the candidate must be licensed to practice at the independent practice level and must demonstrate the KSAs in subparagraph (b) below.

(b) **Demonstrated Knowledge, Skills, and Abilities**

1. Knowledge of human development throughout the lifespan, interventions based on research and theory, family and system interaction, formal diagnostic criteria, risk assessment, evidence-based practice and assessment tools.
2. Ability to independently assess the psychosocial functioning and needs of patients and their family members, and the knowledge to formulate, implement, and re-evaluate a treatment plan through continuous assessment identifying the patient's problems, strengths, readiness to change, external influences and current events surrounding the origins and maintenance of the presenting issue, and interactional patterns within the client system. This includes the utilization of testing measures where appropriate.
3. Ability to provide counseling and/or psychotherapy services to individuals, groups, couples and families in a culturally competent manner that facilitates change through restructuring and reorganizing of the client system.
4. Ability to establish and maintain effective working relationships with clients, colleagues, and other professionals in collaboration throughout treatment regarding clinical, ethical and legal issues and concerns. This includes the ability to represent and educate others regarding the MFT perspective in interdiscipli-

nary staff meetings while respecting the roles and responsibilities of other professionals working with the client.
5. Knowledge and understanding of existing relevant statutes, case law, ethical codes, and regulations affecting professional practice of marriage and family therapy. This includes the ability to assist clients in making informed decisions relevant to treatment to include limits of confidentiality.
6. Ability to provide orientation, training and consultation to new MFTs including clinical oversight of MFT graduate students, and/or provide supervision to prelicensure MFTs.
7. Skill in the use of computer software applications for drafting documents, data management, maintaining accurate, timely and thorough clinical documentation, and tracking quality improvements.

(c) **Assignments.** This is the full performance level for MFTs. GS–11 MFTs are licensed to independently practice marriage and family therapy and to provide other mental health services within the ethics and guidelines of the professional standards set by AAMFT. They may be assigned to all program areas that provide mental health services. MFTs at this level may also be involved in program evaluation and/or research activities.

(3) **GS–12 Marriage and Family Therapist Supervisor**

(a) **Experience, Education, and Licensure.** In addition to the basic requirements, completion of 1 year of progressively responsible assignments and experience equivalent to the GS 11–level, which demonstrates knowledge, skills, and abilities that are directly related to the specific assignment. In addition, the candidate must demonstrate the professional KSAs in subparagraph (b) below.

(b) **Demonstrated Knowledge, Skills, and Abilities**

1. Ability to assess qualifications and abilities of current and prospective employees to include staff performance evaluation.
2. Ability to identify professional development needs of other MFTs and guide them in current practice guidelines.
3. Ability to collaborate with members of other disciplines and supervisors and to represent the profession both in and outside of VHA. This includes knowledge of the roles, contributions, and interrelationships with other disciplines.
4. Ability to administratively supervise in areas related to the provision of marital and family services. This includes knowledge of VA policy and procedures as well as fair, principled, and decisive leadership practices.
5. Ability to clinically supervise in areas related to the provision of marital and family therapy services to accomplish organizational goals and objectives.

(c) **Assignment.** MFT Supervisors typically supervise MFT professional staff, which may include experienced MFTs, and program coordinators. Supervisory MFTs at this level may be assigned to any program area and may be involved in program evaluation and/or research activities. Supervisory MFTs are licensed to independently provide marital and family therapy services, which may include coordinator responsibilities and to supervise for licensure other MFTs within the ethics and guidelines of the professional standards set by AAMFT.

(4) **GS–12 Marriage and Family Therapist Program Coordinator**

(a) **Experience, Education, and Licensure.** In addition to the basic requirements, completion of 1 year of progressively responsible assignments and experience equivalent to the GS–11 level, which demonstrates knowledge, skills, and abilities that are directly related to the specific assignment. In addition, the candidate must demonstrate the professional KSAs in subparagraph (b) below.

(b) **Demonstrated Knowledge, Skills, and Abilities**

1. Ability to organize work, set priorities, meet multiple deadlines, delegate tasks and facilitate team building.
2. Ability to manage and direct the work of others to accomplish program goals and objectives.
3. Ability to devise innovative ways to adapt work operations to new and changing programs, to develop staffing and budget requirements, and to translate management goals and objectives into well coordinated and controlled work operations and ensure compliance with pertinent VHA policies.

4. Ability to establish and monitor production and performance priorities and standards and program evaluation criteria.

(c) **Assignment.** MFT Program Coordinators are administratively responsible for a clinical program providing treatment to patients in a major specialty such as, but not limited to homeless veterans program, and mental health intensive case management (MHICM). They may be the sole mental health practitioner in this specialty at the facility and typically provide direct patient care services in the program area. They manage the daily operations of the program, develop policies and procedures for program operation and prepare reports and statistics for facility, VISN and national use. They may be responsible for the program's budget. At this level, GS–12 MFTs are licensed to independently provide mental health services and to supervise for licensure other MFTs within the ethics and guidelines of the professional standards set by AAMFT. Other assignments of equal complexity and responsibility may be approved on an individual basis where warranted.

(5) **GS–13 Marriage and Family Therapist Program Manager**

(a) **Experience, Education, and Licensure.** In addition to the basic requirements, completion of 1 year of progressively responsible assignments and experience equivalent to that obtained at the GS–12 level, which demonstrates knowledge, skills, and abilities that are directly related to the specific assignment.

(b) **Demonstrated Knowledge, Skills, and Abilities**

1. Skill in assessing qualifications and abilities of current and prospective employees to include staff performance evaluation.
2. Ability to facilitate professional development of other MFTs and guide them in current practice guidelines.
3. Ability to contribute to professional development of staff members across a variety of disciplines within program specific area.
4. Ability to collaborate with leaders of other disciplines within facilities, the community, VISN, and VACO.
5. Skill in managing and directing the work of others to accomplish program goals and objectives, reporting requirements and ability to devise ways to adapt work operations to new and changing programs, staffing and budget requirements. This includes knowledge of VA policy and procedures as well as fair, principled and decisive leadership practices.
6. Ability to analyze organizational and operational problems and to develop and implement solutions that result in sound operation of the program.
7. Ability to clinically supervise in areas related to the provision of marital and family therapy services to accomplish organizational goals and objectives.
8. Knowledge of the roles, contributions and interrelationships of other disciplines within the program.

(c) **Assignment**

1. MFT Program Managers have broad program management responsibilities, which include the operation and management of key clinical, training, or administrative programs. Responsibilities include development and implementation of programs, policies and procedures; oversight of administrative and programmatic resources; and monitoring of outcomes using a data driven quality assurance process. Decisions made affect staff and other resources associated with the programs managed and are made while exercising wide latitude and independent judgment. Such programs deliver specialized, complex, highly professional services that are important program components and significantly impact the health care provided to Veterans. They have responsibility for staffing, work assignments, budget, clinical services provided and admission criteria for the program, day-to-day program operations and all reporting requirements. Additionally, program managers at this grade generally have collateral assignments determined by the needs of the local facility, the VISN, and/or VACO.
2. Managers may also have full responsibility for oversight of the professional practice of MFTs to assure the highest quality of mental health care provided to veterans throughout the facility and affiliated clinics. This responsibility also includes insuring that all MFTs in the facility and its affiliated clinics meet the requirements of this qualification standard. At this advanced performance level, GS–13 MFTs are licensed to independently provide marital and family therapy services with program management responsibilities.

(6) **GS–14 Marriage and Family Therapist Program Manager Leadership Assignments (Care Line Manager/VISN/National)**

(a) **Experience, Education, and Licensure.** In addition to the basic requirements, completion of I year of progressively responsible assignments and experience at the GS–13 level, which demonstrates knowledge, skills, and abilities that are directly related to the specific assignment.

(b) **Demonstrated Knowledge, Skills, and Abilities.** In addition to meeting the KSAs for GS–13 level, the candidate must demonstrate the KSAs below:

1. Advanced knowledge and skill in management/administration of multidisciplinary mental health programs at complex facilities and/or across multiple sites, which includes supervision, consultation, negotiation, and monitoring.
2. Demonstrated global knowledge of mental health counseling practice to develop, maintain, and oversee programs in all settings.
3. Ability to provide consultation on policy implementation, qualification standards, counseling practice, and competency with medical center director, VISN, or national program managers that are consistent with organizational goals and objectives.
4. Advanced knowledge of evidence-based practices and mental health practice guidelines in multiple professional areas, and the ability to use these resources to guide the program staff in providing appropriate treatment interventions.
5. Ability to influence high level officials in adoption of, and conformance to, performance measures, monitors, and other policy guidelines.

(c) **Assignment.** Typical assignments include serving at a facility as a care line manager or at the VISN/VACO level. A care line manager is assigned to manage, direct, and oversee complex treatment programs within the medical center. Supervisory responsibilities cover multiple disciplines that may be separated geographically or in multi-division facilities. They have responsibility for staffing, work assignments, budget, clinical services provided and admission criteria for the program, day-to-day program operation, and all reporting requirements. Leadership positions at the VISN or national level are characterized by their scope, level of complexity, significant impact on VHA mission, significant importance to the VISN, etc. They direct a mental health, behavioral science, other patient care program component at the VISN or national level or direct organizational development at the national level. Duties are exercised with wide latitude, autonomy, and independence. They have delegated authority to determine long range work plans and assure that implementation of the goals and objectives are carried out. They may serve as consultants to other management officials in the field, VISN, or national level.

4. DEVIATIONS

a. The appointing official may, under unusual circumstances, approve reasonable deviations to the grade determination requirements for MFTs in VHA whose composite record of accomplishments, performance, and qualifications, as well as current assignments, warrant such action based on demonstrated competence to meet the requirements of the proposed grade.
b. Under no circumstances will the educational or licensure requirements be waived for grade levels GS–11 or above.
c. The placement of individuals in grade levels not described in this standard must be approved by the Under Secretary for Health, or designee, in VHA Central Office.

Authority 38 U.S.C. 7402, 7403

Appendix B

4980.37.

(b) To qualify for a license or registration, applicants shall possess a doctor's or master's degree in **marriage, family**, and child counseling, **marriage** and **family** therapy, psychology, clinical psychology, counseling psychology, or counseling with an emphasis in either marriage, family, and child counseling or **marriage** and **family** therapy, obtained from a school, college, or university accredited by a regional accrediting agency recognized by the United States Department of Education or approved by the Bureau for Pri-

vate Postsecondary and Vocational Education. The board has the authority to make the final determination as to whether a degree meets all requirements, including, but not limited to, course requirements, regardless of accreditation or approval. In order to qualify for licensure pursuant to this section, a doctor's or master's degree program shall be a single, integrated program primarily designed to train **marriage** and **family therapists** and shall contain no less than 48 semester or 72 quarter units of instruction. This instruction shall include no less than 12 semester units or 18 quarter units of coursework in the areas of **marriage**, **family**, and child counseling, and marital and **family** systems approaches to treatment. The coursework shall include all of the following areas:

(1) The salient theories of a variety of psychotherapeutic orientations directly related to **marriage** and **family** therapy, and marital and **family** systems approaches to treatment.
(2) Theories of **marriage** and **family** therapy and how they can be utilized in order to intervene therapeutically with couples, families, adults, children, and groups.
(3) Developmental issues and life events from infancy to old age and their effect on individuals, couples, and **family** relationships. This may include coursework that focuses on specific **family** life events and the psychological, psychotherapeutic, and health implications that arise within couples and families, including, but not limited to, childbirth, child rearing, childhood, adolescence, adulthood, marriage, divorce, blended families, stepparenting, abuse and neglect of older and dependent adults, and geropsychology.
(4) A variety of approaches to the treatment of children.

The board shall, by regulation, set forth the subjects of instruction required in this subdivision.

Appendix C

(e) In order to provide an integrated course of study and appropriate professional training, while allowing for innovation and individuality in the education of **marriage and family therapists,** a degree program that meets the educational qualifications for licensure or registration under this section shall do all of the following:

(1) Provide an integrated course of study that trains students generally in the diagnosis, assessment, prognosis, and treatment of mental disorders.
(2) Prepare students to be familiar with the broad range of matters that may arise within **marriage and family** relationships.
(3) Train students specifically in the application of **marriage** and **family** relationship counseling principles and methods.
(4) Encourage students to develop those personal qualities that are intimately related to the counseling situation such as integrity, sensitivity, flexibility, insight, compassion, and personal presence.
(5) Teach students a variety of effective psychotherapeutic techniques and modalities that may be utilized to improve, restore, or maintain healthy individual, couple, and **family** relationships.
(6) Permit an emphasis or specialization that may address any one or more of the unique and complex array of human problems, symptoms, and needs of Californians served by **marriage and family therapists.**
(7) Prepare students to be familiar with cross cultural mores and values, including a familiarity with the wide range of racial and ethnic backgrounds common among California's population, including, but not limited to, Blacks, Hispanics, Asians, and Native Americans.

Prepared Statement of Hon. Russ Carnahan, a Representative in Congress from the State of Missouri

Chairman Miller, Ranking Member Filner, and Members of the Committee, thank you for hosting this hearing to discuss mental health care issues in the Department of Veterans Affairs. Mental health is crucial to being a productive member of society. Unfortunately, many of our veterans struggle upon their return home. Today's hearing provides a conversation between Congress and those with knowledge of what needs to be done to ensure our Nation's heroes are successful and healthy.

Our veterans returning from Operation Iraqi Freedom and Operation Enduring Freedom are suffering a lasting mental health toll. They have witnessed urban guerilla warfare and have intimately experienced the stress of combat. Many have seen their friends lost. They then return home to begin the difficult reintegration into civilian life. According to the VA, only half of OIF and OEF veterans have been evaluated and seen as outpatients in health care facilities. Of those, one out of four veterans demonstrates Post-Traumatic Stress Disorder (PTSD).

PTSD is a disabling mental health epidemic among veterans. It impedes all aspects of a veteran's life, from employment to social wellbeing and family relationships. It is staggering that over half of OIF and OEF veterans have not been seen in health care facilities. How can these men and women begin to cope if they have not received the proper mental health evaluation? In 2008, the VA began efforts to call all veterans who had not yet enrolled in a VA health clinic to encourage them to seek care. These are the kinds of concerted efforts we must continue to employ. If our veterans are to thrive, we have to actively close the gaps that hinder their recuperation.

PTSD rates have been steadily growing since the overseas conflicts began. Depression diagnoses are up particularly among younger active duty veterans who have higher combat exposure. We need greater community outreach efforts to help these heroes. By connecting with veterans in their own communities, we can provide the necessary support and encouragement for recovery. Many veterans find it personally difficult to seek care, but we can't allow these men and women to fall through the cracks. We must expand the scope of VA Vet Centers to ensure that servicemembers make a smooth transition.

I look forward to hearing from our witnesses on ways we can guarantee successful community reintegration and mental health services for all veterans.

Prepared Statement of Andrea B. Sawyer, Colonial Heights, VA
(Spouse of Sergeant Loyd Sawyer, USA (Ret.))

Mr. Chairman, Ranking Member Filner, thank you having this hearing today and for allowing me to submit my testimony for the record.

My name is Andrea Sawyer, caregiver and spouse of U.S. Army Sergeant Loyd Sawyer, retired. While I understand that this Committee does not have jurisdiction over the Department of Defense, it is important that you understand my husband's whole story to understand why we are so frustrated with his care.

Loyd was a civilian funeral director and embalmer before joining the Army Mortuary Affairs team. As a mortuary affairs soldier, Loyd did a tour at Dover Port Mortuary where all deceased servicemembers returning from Iraq and Afghanistan re-enter the United States, and Loyd worked in the Army uniform shop (where paperwork is processed and final uniforms prepared for deceased servicemembers) and embalmed on the days he was not in the uniform shop. Loyd then served a tour in Iraq, first in Talil and then the Balaad mortuaries where he processed countless deceased civilians and servicemembers. While there, he began exhibiting signs of mental distress such as anger, hypervigilance, insomnia, etc.

Upon his return home, I attempted to get him help for 11 months. There was a delay in getting help because we had only one psychiatrist on base and then the help he received was ineffective. Ultimately I sat in a room with an Army psychiatrist and my husband and watched Loyd pull a knife out of his pocket and describe his plan of slitting his throat. It was apparent that he was delusional and in great psychiatric distress. On December 19, 2007, Loyd was admitted to Portsmouth Naval Medical Center (PNMC). What followed was an initial crisis hospitalization of 5 weeks (3 exclusively inpatient and 2 intensive outpatient), a separate 1 week crisis hospitalization for homicidal ideations, 8 months in an Army Warrior Transition Unit (WTU), appointments 3 days a week at PNMC 2 hours away from our home Army base of Fort Lee, a medical and physical evaluation (MEB/PEB) process that resulted in a 70 percent permanent Department of Defense (DoD) retirement from active duty for post-traumatic stress disorder and a secondary diagnosis of major depressive disorder, and medical paperwork that said, "The degree of industrial and military impairment is severe. The degree of civilian performance impairment is severe at present, though over time—likely measured in years (emphasis added)—with intensive psychotherapy augmented by pharmacotherapy to control his anxiety and depressive symptoms—his prognosis MAY improve." In July 2008 while still on Active Duty, but with retirement paperwork in hand, we enrolled Loyd at our local VA, the Richmond polytrauma center, better known as Hunter Holmes McGuire VA Medical Center (HHM VAMC), for medical services in the Veterans

Health Administration (VHA). In October, with help from Wounded Warrior Project (WWP), Loyd's VA disability claim declared him 100 percent permanent and totally disabled (this claim is done through Veterans Benefits Administration), thus giving him the highest priority status for VA care.

Knowing that Loyd needed extensive help quickly, we tried getting him into the PTSD clinic immediately which was not available. The first available appointment was almost a 2-month wait. When the appointment came, Loyd presented his history, including that he had been seen two to three times weekly at PNMC for the last 8 months of active duty, that he remained suicidal, and that he needed intensive therapy. What was available at the VA in the PTSD clinic for him was a once every quarter medicine management appointment and a once a month to once every 6 weeks 1-hour therapy appointment. Knowing that this was leading to spiraling depression and an unchecked increase in his PTSD symptoms, we used our TRICARE and began treatment with a local civilian counselor who was trained at the VA's National Center for PTSD. The counselor was able to see Loyd once or twice a week depending on the severity of the symptoms. Throughout the winter of 2008 and the spring of 2009, I became increasingly concerned at the out of control depression I was witnessing and feared that suicide was an imminent possibility. After getting little response from VA mental health, his TRICARE counselor and I discussed sending him to a long-term inpatient treatment program for PTSD through the VA. I contacted Loyd's Federal Recovery Coordinator (FRC) for help in finding a program. We did eventually do phone interviews, made a site visit, and enrolled him in a PTSD program at the VA facility in Martinsburg, WV. I got little to no help from our local VA hospital in finding this program, but I received invaluable help from Loyd's Federal Recovery Coordinator.

The hospitalization was a nightmare. The program delivered on none of its promises. His doctors there never coordinated with his local VA mental health clinician, his civilian counselor, or his FRC. At one point, his civilian counselor, his FRC, and I were calling the facility daily because we were concerned the medication change they had made was making him physically and verbally aggressive. Even more concerning was that this was a medicine that he had been removed from while on active duty for the same reasons. In 90 days of inpatient treatment at the VA facility, he received fewer than five individual therapy sessions. Upon his completion of the program, which I truly believe was just about marking time, he was released and told to follow up with his local VAMC. For my husband, who had already expressed suicidal ideations, there was no coordination or communication between any of his treatment providers. He came home and promptly discontinued ALL of his medication because he did not like the way it made him feel. (It is important to note that for the year and a half prior to this hospitalization at Martinsburg, he had been completely compliant with his medication plan.)

I immediately called the Richmond PTSD clinic as soon as I realized that he had stopped taking his medication. I was told that it would be 4 weeks before they could see him to re-evaluate his medications. I had the FRC try to intervene with the primary care provider (PCM), hoping the PCM could speed up the process, but he simply told me, "I was wasting his time." Eventually with the help of the FRC, I was able to get him an appointment within the week with a VA psychiatrist in general psychiatry. This psychiatrist has done his medication management since then, as she very clearly listened to what symptoms needed to be controlled, and, even more importantly, listened to what he needed and wanted as a patient. At that time, we agreed with her, that for counseling Loyd was better off continuing with the civilian counselor because he could be seen once/twice a week and with her for medication. By involving Loyd, she made it much more likely that he would continue with his pharmacotherapy regimen. She also asked that neuropsych testing be redone and suggested that Loyd try the PTSD "Young Guns" therapy group that met with a clinician in the Richmond PTSD clinic weekly.

Loyd's repeat neuropysch testing in January 2010 showed that his PTSD symptoms were still severe. On the DAPS (a psychiatric scale test for symptoms of PTSD used frequently by the VA), Loyd scored all 20 out of 20 on all the indicators except for suicidality for which he scored a 16, meaning he still fell into the extremely high risk category and was actively suicidal. His authenticity score was a five which is as high as you can score. So after more than a year in the VA, a 90-day hospitalization, weekly therapy, Loyd was not really improving. Feeling rather hopeless, Loyd did decide to try the Young Guns group. He found great solace in this group in being able to relate with others who experienced the same symptoms but also because he saw people in different stages of recovery who, led by a clinician, were able to analyze their behaviors and suggest multiple positive coping strategies that they each found successful. Unfortunately, 4 months into the group and without consultation with the patients, it was announced that the VAMC was changing its treatment

model and was disbanding the group by year's end. For those who wished to continue in a group setting, the VA would be turning them over to a yet untested regional division of a new community-based program which had only two employees for a twenty-three county region, neither of whom was trained in counseling. I immediately contacted the Wounded Warrior Project (WWP), and the resulting year long saga of trying to keep the group on campus with a clinician is in their testimony. Suffice it to say, despite all requests from the veterans in the group in a petition signed by 27 of them, and an on campus successful attendance of 40 members regularly, the VAMC moved the group off campus, renamed it a support group, but has yet to pull the clinician because the community organization has failed to show up for a single off campus meeting of the group. Attendance has fallen sharply (averaging 7–10 individuals) as working veterans can no longer leave work to go to a "support group" like they could leave work to go to therapy appointment. In addition, by moving the group off campus, the VA is no longer able to reimburse for mileage—a significant problem in today's economy.

So my question to you, the Committee is this:

> *My husband is a veteran with well-documented severe chronic PTSD who uses one of the major VA polytrauma centers as his VAMC. We have all the advantages that should guarantee him good treatment—an excellent, caring Federal Recovery Coordinator, a 100 percent service-connected disability rating, a polytrauma case manager, and a super VSO. Yet, he has had a difficult time accessing appropriate mental health treatment in this VISN and in the inpatient treatment program at which he received care that was in another VISN. If that is the case for him, how can any vet just enrolling without any of these advantages be expected to get quality and accessible care?*

That question being asked, as a spouse who has been involved with this system for some time and after having spoken to a number of other wounded warriors and spouses in similar situations, I would like to make to following suggestions to encourage those with mental health issues to seek and continue with treatment:

1. Treatment must be timely and available.

The new treatment model suggests that veterans should be seen/complete a minimum of nine visits to VA PTSD clinicians for either group or individual therapy in 15 weeks. I do not see how this is even a realistic model. Currently in VA's all over the country, veterans are waiting months in between appointments and drive hours to these appointments.

According to a caregiver of a South Dakota OIF veteran:

> *Hubby went to the group meeting last night for their final session with the VA provider. She told them during the meeting that the VA is hiring a new provider who will continue with the group in July or possibly the end of June. I'm skeptical that it will actually happen as we are still waiting for a full-time psychiatrist at our CBOC that was promised a year ago after they let the contract provider go. I'm afraid it's another story to keep everyone happy.*

A caregiver for an OIF Marine veteran from Washington State wrote:

> *We have an AWESOME psychiatrist at the VA, and I am terrified he will retire. . .The only bad thing is that he is more popular than a single sat [satellite] phone in a deployed battalion. He is about 2 hours away and about once every other month or so we get into see him.*

Another caregiver wrote:

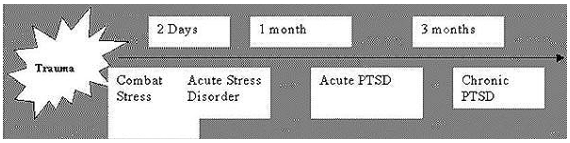
> *My husband has PTSD also, he was not considered a priority for care for his PTSD by the VA and they said he only needed to be seen every 6 months. Then he had an episode and was tazed 6 times by police and sent to civilian psych hospital where he was not given his meds, they tried to treat him like a schizophrenic and wanted to have him committed. Luckily I was able to talk to an intern who had half a brain who went to bat for my husband to get him released to my care. Now that my husband has been hospitalized in a mental hospital the VA suddenly thinks oh, well lets see him once every 2–3 months. Not to mention that when he goes in to see his psychiatrist he doesn't tell him everything and tries to make everything look great. I have to e-mail his psychiatrist just to keep him properly updated on my husband's status. Then there is also the issue of availability of appointments if something sooner is needed. If you have an emergency or feel your husband needs to be seen sooner they never have anything available.*

The mom of a Kentucky vet wrote:

One of the biggest problems I have noticed is simply not being able to get an appointment. Call for help. . .wait 6 weeks to get in to talk to someone.

While I understand that there is a shortage of mental health providers in this country, that does not mean that we can set unrealistic standards for treatment and then wonder why no one is completing said treatment. If there is a shortage of providers, we must use all means necessary to ensure timely, quality care and use mechanisms such as fee-basis more often to accommodate the needs of this growing population.

2. Treatment must be an appropriately time focused intervention and needs to address severity, chronicity, and provide multiple ongoing treatment options.



(From VA/DoD CLINICAL PRACTICE GUIDELINE FOR THE MANAGEMENT OF POST-TRAUMATIC STRESS)

The clinical practice guidelines are joint guidelines between DoD and VA and deal with the range of diagnoses involving trauma exposure. The guidelines' beginning focuses on EARLY intervention, literally starting assessment and treatment within minutes of experiencing or witnessing the trauma. For VA, this is not even a remote possibility. VAMC's access to veterans is limited to their time of enrollment being in most cases months to years after the witnessing of the trauma. Because of this, veterans who enter VA have chronic PTSD which is defined as anyone experiencing clinically significant symptoms 6 months after the trauma. (ptsd—full core page 10). This just by nature of the delay in treatment suggests that more time than nine visits will be necessary. VA needs to ensure that guidelines it is following are appropriate to the diagnosis of the individual.

The treatment modules, which are located within the clinical guidelines, includes the recovery model which focuses on mild to moderate PTSD. Veterans with severe PTSD need different options than veterans with mild post-traumatic stress. The recovery model as it is being implemented at our VAMC, at least, puts too much emphasis on addressing mild-to-moderate PTSD, and not addressing severe PTSD. This leaves veterans with severe PTSD feeling not understood. By doing away with long-term therapy groups on campus, it leaves little option for continuing therapy except individual therapy which as discussed above is not available, plus it pits vets with long-term chronic issues needing continual individual therapy against vets just entering the system needing to begin therapy. VA must ensure that a wide variety of treatment options for the veteran population with a wide degree in severity and chronicity of their PTSD exists.

3. Treatment must be practical.

One focus of VA has been veteran unemployment. Currently the new VA Mental Health (MH) guidelines are not at all conducive to employment. Consider this scenario: VA wants a veteran to attend nine treatment sessions in a 15-week period. A veteran as illustrated in the examples above may have to drive hours away to get treatment, but we will use for purposes of our example an hour drive. So a veteran must tell his employer that he will miss 9½ days of work at his job within the first 15 weeks of work. Then if the veteran were at the Richmond VAMC PTSD clinic and probably others, he may be channeled into 10-week recovery group, 6 week mindfulness coping skills group, 6-week anger management coping skills group, and more individual therapy, IF he needed all parts of the new recovery model. Literally that would require that a veteran miss a 1/2 day of work once a week for the first 6 months of a job, ONLY for mental health treatment purposes, that disregards any other physical health issue for which a veteran may need treatment. Few employers would hire or retain that individual. It is not practical. Eventually a veteran would have to choose between his job and his care. That is not a choice a veteran should have to make.

To complicate matters, veterans nationwide are not allowed to choose their appointment times, leading to inconvenient and missed appointments and constant rescheduling requirements. Currently, the VA sets the appointment time, and veterans are simply expected to show up regardless of other obligations. This obviously

prevents a veteran from scheduling appointments around employment needs or scheduling multiple appointments on the same day.

In light of the intensive requirements of the MH guidelines and out of respect for the time of individual veterans, the VA needs to allow veterans to make their own appointments and have limited evening and weekend hours to accommodate working veterans with families. Currently our VA is saying it will implement evening hours, but I have little faith in that as I have heard the same statement for the entire 3 years we have been in the VA.

4. Treatment must be tailored to the individual and not a series of a completion of cookie cutter modules.

Too often in VA, patients are channeled into programs where every veteran is given the same program regardless of their needs. For example, every veteran in the clinician led group therapy session was moved into the community-based group without individual evaluation of the veteran's preparedness for the move. The new model lends itself to the same thing happening. A veteran would simply be channeled into a series of cookie-cutter modules explaining what PTSD is, what changes it creates in the chemicals of the body, what changes it creates in thinking patterns, and then a series of modules on teaching coping skills. It lends itself to shuffling them through the modules without the quality assessment to see if veterans have mastered the skills. Once a module is completed it is checked off whether or not the veteran feels he has mastered the skill. Where is his remedy in this situation? Individual therapy? He will have to wait months for that appointment where he will probably be told he has already had that class. A veteran does not need to be told by PowerPoint or workbook what all his symptoms are or should be; he lives them daily. While some education is good, this model makes me fear that it is simply check the block and veterans will be pushed through or simply quit because they do not see it as quality, individually tailored, or making a difference, not to mention the time it takes away from the occupational arena.

Along the same lines, what happens to a veteran who has had all of these modules while still on active duty? Will he be funneled through them again on the VA side of treatment? Loyd had all these modules over his 8 months of treatment at PNMC on active duty. He got them again during his 90-day hospitalization and he was frustrated at having to retake them because that was all that was available. He wanted something that he had not tried. Who is going to check to see that people are not being forced to repeat things just for the sake of checking the block for treatment? A repeat of a previous therapy is another reason people do not continue with treatment.

To encourage a veteran to seek and complete treatment, VA must ensure that each individual veteran is not lost in a maze of completing treatment that is not relevant to him as an individual patient. PTSD veterans like all other veterans with health conditions needs to be seen as patients first and diagnoses second. The patient's individual symptoms should determine his type of treatment, not a predetermined course of treatment that does not account for individual variances.

5. Treatment must be culturally competent.

Some, not all, VA clinicians seem out of touch with combat PTSD. Most of them seem familiar with PTSD as a clinical diagnosis, but many do not seem to understand the difference veterans experience with combat PTSD verses military sexual trauma (MST) verses a routine car accident. Veterans routinely get frustrated having to stop and explain language/command structure/nature of combat jobs/even basic military language to clinicians. In one instance with my husband as he was explaining damage done to a body by an IED, the clinician got a very puzzled look on her face and asked how a contraceptive device could have caused limbs to be blown off. We had to explain the difference between an IED—improvised explosive device—and an IUD—a female contraceptive device—to her. At that point, that clinician had lost all credibility. Therapy was over for the day, and we never saw her again.

In another instance, a female veteran whose PTSD rating is in part due to an MST and who still experiences horrific flashbacks, was placed in an all-male PTSD coping skills group. She was in with older men, mostly Vietnam era, who had little respect for females who had served, and certainly no understanding of MST. Eventually she stopped going to the group as it caused her more trauma listening to the comments of her fellow group participants than the symptoms she already experienced.

The VA should engage in a program a program similar to the Navy's Civilian Familiarization for all employees. This program allows members of the public to experience a small taste of a sailor's occupation. Also a continuing education class in

military terms is necessary. This could be easily added to the required continuing education classes that already exist in the VA.

6. Community-based partnerships for treatment should be available options for veterans to seek treatment, but they should not be the only option.

There is a trend in VA to form community partnerships for purposes of offering wider support for veterans and for expanding options for veterans. While I think this may be a good idea, when it comes to dissolving existing therapy groups to hand over to community groups to become support groups, it is necessary for there to be some kind of oversight process if compensation is going to be tied to therapy. In the case of Richmond changing the therapy groups to support groups and moving them off campus, the community group that the VA said was going to facilitate the group has never shown up. Even if it had shown up, the community group does not have the trained staff to lead a group. Also, in the instance of Richmond, veterans were not consulted about the change, it was simply dictated, without evaluation to ensure that each individual was ready for leaving a clinical therapeutic setting and transitioning to a non-clinical supportive setting.

For purposes of treatment and compensation, administrative data collection to support the evidence that treatment is being provided must be worked out in advance. Support groups do not normally keep attendance records, so it would be difficult to prove that a veteran had been to treatment at a support group. Also, using community settings whether support groups or community clinicians, needs to be evidence-based treatment. It is not fair to do away with a treatment at the VA because it is not evidence-based only to send veterans out into the community to receive other non-evidence based treatments while leaving them no options at the VA.

VA should use MOA's with community partners and fee-basis providers to ensure that veterans with PTSD may have the option, at the veteran's discretion, of receiving evidence-based treatment in their home communities. This scenario would make treatment for veterans more accessible geographically, more time sensitive to the onset of the symptoms, and more practical from a standpoint of the availability of evening and weekend hours. Using MOA's would allow VA to ensure that all treatment remains evidence-based and set a clear expectation about the administrative practices it requires to document a veteran's treatment regimen for purposes of compensation.

7. Communication between DoD and VA, in addition to communication between VHA and VBA, and intraVHA needs to be improved.

A model that would tie an incentive to receive and complete treatment for PTSD rests heavily on communication between all elements of inter DoD/VA and intra VA (VHA and VBA.)

In the matter of tying compensation to treatment, a vet would need DoD to clearly communicate what treatment for PTSD had been received on active duty and determine whether or not there was a prognosis for improvement. If a veteran has received DoD treatment, then VA and DoD must communicate whether or not the veteran has shown improvement or has a prognosis that suggests improvement. If there is a prognosis to suggest that treatment will improve the quality of life and decrease the functional impairment caused by PTSD, then a veteran should be incentivized to seek all treatment available to improve functionality, but that treatment should NOT be a repeat of what was done already on active duty or with a civilian provider outside of DoD and VA.

The point of incentivizing treatment is where I need to clearly see details worked out. I see this as being a bureaucratic nightmare. VHA and VBA need to agree on what the severity of a veteran's PTSD was and what treatment is necessary. Currently these two systems do not interact which constantly leads to one system giving one diagnosis for compensation and the other system giving a different diagnosis for treatment purposes. In addition, once VBA assigned a temporary rating, and then presumably VHA would assign a treatment plan, who researches whether that treatment plan is feasible for the veteran, which upon completion would go back to VBA for a final rating? Assigning a working vet to 6 months of weekly therapy modules would not work. It would lead to the vet not completing treatment and then not receiving compensation for a condition which he has due to service but for which VA cannot accommodate his real life needs of working and treatment. Not to mention, the therapy has to be geographically available which in ever increasing instances it is not. The amount of appointments necessary would have to be available clinically. I worry that VBA would set a timeline for treatment that is unreasonable because the VHA clinic appointments are not available due to staff shortages at clinics. The only person who would be penalized is the vet.

In Loyd's case, before even leaving DoD, he had done all of the treatment that has been offered at VA. There was simply no point, other than going for symptom maintenance, for him to even go to the VA for mental health treatment. He has gone over the last 3 years, but it has been an exercise in futility and frustration which at times has increased the depression. Despite the fact that he has repeatedly indicated that he thinks of suicide three to four times a week, we have never been contacted by the suicide prevention person, and at this point, it is mute. People with Loyd's severity and chronicity should not necessarily be incentivized as through 4 years of treatment, one DoD and three VA, there has been little improvement as was the prediction of DoD.

In other cases, where there has been no treatment for a veteran with PTSD, certainly incentives should be tied to treatment. That treatment should be relevant to the health needs of that particular veteran and accessible to the veteran as determined by the VETERAN and his clinician, not just a clinician. Simply assigning a rating without any treatment is a situation that says to a veteran that his case is hopeless. The incentive to receive that treatment, a stipend that allows a veteran to go to treatment, must be appropriate to address the financial concerns that will arise while treatment is obtained. Simply giving a veteran $100 a month will not cover the cost of travel, missed work for appointments, or emotional distress that will be increased at the beginning phase of treatment.

DoD and VA must communicate to ensure relevant treatment is obtained and not duplicated. VHA must communicate internally to see that treatment is relevant and appropriate, grouping together all elements of a veterans mental health team—counselor, psychiatrist, neuropsychiatrist, etc. VHA and VBA must develop a plan to address timeliness of treatment, what is appropriate treatment to incentivize a veteran to seek treatment, and that treatment required is actually available to a veteran (meaning that staff, location, and particular treatment model are at a location where a veteran has access.) I fear that this may become a plan where VBA sets a particular timeframe for treatment only for VHA not to have the treatment available in a location accessible or a timeframe accessible to the veteran in that frame of time—for example that VBA will set a stipend limitation of 6 months to do all eight visit, but a veteran's CBOC will only have one appointment a month available. I think that is an extremely realistic concern.

In conclusion, I understand that some of these matters are questions that are theoretical, however, I think in this matter, it is necessary for Congress to have answers to these questions and a practical model BEFORE any changes are made. Too often, laws are made, then policies are implemented that do not agree with the spirit of the law, and it takes years to address and fix the issues. In this case, changing the treatment and compensation models as they exist without these questions being firmly answered with a practical working plan may cost lives. Today there are almost 400,000 veterans receiving compensation for PTSD with numbers predicted to increase rapidly with the influx of veterans from OIF/OEF into the VA system. Veterans are dying from suicide at a rate of 18 a day. If we want veterans to feel that VA truly understands them and wants them to successfully seek treatment and lead mentally healthy lives, Congress must show veterans that legislators and the VA understand the true barriers to seeking VA mental health care and remove them so that our veteran population can continue to be strong and productive for years to come.

Summary: I believe that every veteran who suffers from post-traumatic stress would gladly give up any compensation check if they could get quality, timely, relevant treatment to end the daily nightmare that they live. While I think in theory the idea of tying compensation to receiving treatment is logical, I have grave concerns about the VA being able to do this correctly. I think this matter of tying compensation to continuous treatment that needs to be treated cautiously and needs to consider several matters concerning existing treatment need to be addressed. I have asked to be able to present my testimony to raise the concerns that I have.

Main Points:

1. Treatment must be timely and available.
2. Treatment must be an appropriately time focused intervention and needs to address severity, chronicity, and provide multiple ongoing treatment options.
3. Treatment must be practical.
4. Treatment must be tailored to the individual veterans needs and symptoms not be a series of cookie-cutter modules.
5. Treatment must be culturally competent.
6. Community based partnerships for treatment should be available options for veterans to seek treatment, but they should not be the only option.

7. Communication between DoD and VA, in addition to communication between VHA and VBA, and intraVHA needs to be improved.

Conclusion:

I understand that some of these matters are questions that are theoretical; however, I think in this matter, it is necessary for Congress to have answers to these questions and a practical model BEFORE any changes are made. Too often, laws are made, then policies are implemented that do not agree with the spirit of the law, and it takes years to address and fix the issues. In this case, changing the treatment and compensation models as they exist without these questions being firmly answered with a practical working plan may cost lives. Today there are almost 400,000 veterans receiving compensation for PTSD with numbers predicted to increase rapidly with the influx of veterans from OIF/OEF into the VA system. Veterans are dying from suicide at a rate of 18 a day. If we want veterans to feel that VA truly understands them, wants them to successfully seek treatment, and wants them lead mentally healthy lives, Congress must show veterans that legislators and the VA understand the true barriers to seeking VA mental health care and remove them so that our veteran population can continue to be strong and productive for years to come.

MATERIAL SUBMITTED FOR THE RECORD

Pre-Hearing Questions for the Record for House Veterans' Affairs Committee Chairman Miller

Question 1: Please outline the growth in the budget for VA mental health care programs from 2002 to the present. Please outline what those resources have been used for, i.e., staffing increases, rural initiatives, etc.

Response:
Information included in the annual President's Budget submissions related to the growth in the VA mental health care program budget is shown in the table below. Major expenses within the categories shown are mental health staffing, training for mental health staff, and environmental improvement costs (including, for example, provision of telemental health equipment in both medical facilities and outpatient clinics).

History of Mental Health in the President's Budget ($Millions)												
	Actual Obligations									Current Estimate		
	FY 2002	FY 2003	FY 2004	FY 2005	FY 2006	FY 2007	FY 2008	FY 2009	FY 2010	FY 2011	FY 2012	FY 2013
Seriously Mentally Ill	$2,282	$2,393	$2,137									
PTSD	$138	$154	$160									
Substance Abuse	$426	$459	$353									
Psychiatric Inpatient				$1,022	$965	$973	$1,228	$1,323	$1,449	$1,575	$1,679	$1,770
Psychiatric Outpatient				$1,238	$1,265	$1,421	$2,052	$2,445	$2,932	$3,295	$3,606	$3,778
Psychiatric RRT*				$170	$185	$196	$246	$264	$240	$250	$261	$272
Domiciliary RRT*						$334	$353	$415	$540	$583	$607	$630
Mental Health Initiative						$326						
Total Mental Health	$2,846	$3,006	$2,650	$2,430	$2,415	$3,250	$3,879	$4,447	$5,161	$5,703	$6,153	$6,450

*Residential Rehabilitation Treatment

Question 2: How many veterans in receipt of compensation for mental illness utilize VA mental health care services? Please break the data down by war cohort.

Response: The following data are based on interpretation of the request above, as follows:

- Compensation for mental illness, as well as treatment for mental illness, is provided to a larger population of veterans than that limited to PTSD, anxiety disorder, or depression. For the purposes of this query we are responding to these three diagnoses because they are specifically mentioned in the request and they are the three diagnoses provided to the Veterans Health Administration (VHA) by the Veterans Benefits Administration (VBA), based on most recent complete VBA rolls (through May 2011). For all veterans with a compensable, service-connected mental health condition, these are the three most prevalent mental health diagnoses.
- VBA provided data on service era for all compensated veterans based on Congressionally-defined war cohorts.
- When reviewing the veteran population considered to be "diagnosed" with any of the mental illnesses included, VA usually includes a veteran in the population based on at least two outpatient encounters or one inpatient admission for that mental illness. This is done because mental illness diagnoses are often coded on encounters where the visit is intended to assess veterans for the disorder, and such patients may or may not be meet criteria for a confirmed mental illness diagnosis. However, for the purposes of this report, VA included in the population all veterans with a coded entry of the mental illness for which they have received service-connection, regardless of the number of visits in the record. This more inclusive methodology may result in a higher number of mental illness diagnoses than in other reports.

A total of 648,118 veterans are receiving compensation for PTSD, anxiety, or major depression and are service-connected as of May 2011. This includes veterans rated 0 percent for these conditions, but receiving compensation for other conditions; veterans rated zero percent for these conditions are not included in these counts unless they are receiving compensation for another disability. Of these, 554,469 received some health care in VA and 381,334 received specialty mental health services in VA between April 1, 2010, and March 31, 2011. Thus 59 percent of all veterans receiving compensation for PTSD, anxiety, or major depression received specialty mental health treatment in VA during this time period and 69 percent of those receiving compensation for PTSD, anxiety, or major depression received some VA health care services during this time period, not limited to specialty mental health treatment. These data are broken out into populations defined by service era (war cohort).

Period of Service (war cohort) •	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received any VA health care in Q3FY10–Q2FY11 ••	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received specialty mental health services in Q3FY10–Q2FY11 ••	Percent of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received specialty mental health services in Q3FY10–Q2FY11 ••	Percent of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received any VA health care in Q3FY10–Q2FY11 ••
Gulf War*	228,727	181,485	134,922	59%	74%
Peacetime Era	40,720	35,239	25,871	64%	73%

Period of Service (war cohort) •	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received any VA health care in Q3FY10–Q2FY11 ••	Number of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received specialty mental health services in Q3FY10–Q2FY11 ••	Percent of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received specialty mental health services in Q3FY10–Q2FY11 ••	Percent of veterans receiving compensation and service-connected for PTSD, anxiety or major depression who received any VA health care in Q3FY10–Q2FY11 ••
Vietnam Era	325,476	295,195	202,689	62%	69%
Korean Conflict	17,888	15,624	8,278	46%	53%
WWII	35,307	26,926	9,584	27%	36%
Total	648,118	554,469	381,344	59%	69%

•Gulf War population is composed of both Pre- and Post-9/11 veterans. VA did not break out veterans of OEF/OIF vs. non-OEF/OIF because this is not an official war era in VBA records, and the veteran population included in this analysis was supplied by VBA.

••In order to investigate recent VA specialty mental health service use in this population, we matched this cohort of compensated veterans with VA patients seen in the most recent 4 quarters (Q3FY10–Q2FY11). This time period was chosen to match a fiscal year in length, but provide the most updated information possible. FY 2010 was not used because it may not have included veterans added to VBA rolls between October 2010 and May 2011 who subsequently received VHA services.

Question 3: How many veterans have completed the recommended, evidence-based treatments (EBT) VA acknowledges as effective? Please break down the data by war cohort.

Response: VA is strongly committed to developing IT capabilities that will enable VA Central Office to track how many veterans have received evidence-based mental health treatments. Currently this information resides in the field. Described below are the processes we are putting in place to ensure needed data can be captured, as well as relevant data currently available on some specific populations being treated.

Evidence Based Psychotherapies (EBP)

Current Procedural Terminology codes used for tracking health care services do not allow distinction of different types of psychotherapy, nor do they provide information about an individual's level of participation, such as the number of therapy sessions received as compared to the number recommended within a given therapy protocol. The VA Office of Mental Health Services has developed documentation templates for each of the EPBs being nationally disseminated; these templates will become part of the VA's electronic medical record. These templates will allow for precise tracking of EBP delivery and treatment completion, as well as facilitate documentation of session activity, promote fidelity to therapy protocols, and capture data elements to help track more detailed information about participation in EBP activities than is available through the standard encounter form data currently in use. The templates have been piloted at several facilities and are scheduled for national system deployment in fiscal year 2012.

Pending these new informatics processes, VA has conducted surveys of the field to obtain information on the extent to which OEF/OIF/OND veterans with PTSD have been offered and provided Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) Therapy—two evidence-based psychotherapies for PTSD—as well as the extent to which the veterans participating in these therapies have completed a full course of at least one of these treatments. Responses to this survey indicate that all facilities are providing either CP Therapy or PE Therapy, as required by VHA

Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics,* and all but two facilities reported providing *both* CPT and PE Therapy. Further, the survey results reveal that, between October 1, 2009 and May 31, 2010, 8,484 OEF/OIF veterans initiated CPT or PE Therapy, and 4,314 of these veterans completed a full course of at least one of these therapies.

It is important to note that these survey data are approximations reported by facilities based on locally available data collected by facility staff, since centralized administrative data for tracking specific types of psychotherapy are not available at this time. Furthermore, these data represent a subset of the total number of veterans who have received and completed a full course of EBPs for PTSD, as these data refer only to OEF/OIF/OND veterans. These therapies have also been implemented and shown to be effective with veterans of other service eras, including Vietnam veterans. Moreover, these data relate only to EBPs for PTSD. In addition to these therapies, VHA has been nationally implementing EBPs for depression, serious mental illness, relationship distress, insomnia, and other conditions.

In addition to the survey data noted above, VA collects data on the number of veterans who have received a full course of EBP as participants in the VA national EBP training programs, which include as a core component of competency-based training, intensive, weekly consultation on actual cases with an expert in the EBP. As part of these centralized EBP training processes, approximately 2,500 additional veterans have completed a full course of EBP. Thus, to date we can verify that 6,814 veterans have completed a course of EBP (4,314 + 2,500), but we are certain this is a subset of a larger group of veterans who have received treatment. When the treatment templates are in use throughout the system, we will be able to identify from that point forward, the entire population of veterans who have received EBP.

Program evaluation data are also obtained on a subset of the 2,500 veterans who have received EBP as participants in the training of VA mental health staff. These data indicate that the implementation of the EBPs has resulted in statistically significant positive treatment outcomes for many patients. Patient outcomes associated with VA's EBP training programs in CPT or PE Therapy for PTSD and Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression are summarized below:

1. Both the PE Therapy Training Program and the CPT Training programs collected clinical outcome data regarding pre- and post-treatment PTSD scores using the PTSD Checklist (PCL) and pre- and post-treatment depression scores using the Beck Depression Inventory (BDI). PCL scores can range from 17 to 85 and a score of 50 or greater is suggestive of PTSD. BDI scores can range from 0 to 63 and scores in the 20 to 28 range are considered suggestive of moderately severe depression.
    a. Prolonged Exposure Therapy Results: Veterans who completed PE therapy decreased from an average pre-treatment PCL score of 62.1 to an average post-treatment PCL of 42.1. This reduction is statistically significant and indicates a 32 percent drop in self-reported PTSD symptoms. Improvement as a result of treatment was similar across veteran cohorts. The average pre-treatment BDI–2 score was 28.0, and the average post-treatment BDI–2 was 17.3. This reduction is statistically significant and indicates a 38 percent drop in self-reported symptoms of depression.
    b. CPT Results: Veterans who completed CPT decreased from an average pre-treatment PCL score of 63.8 to an average post-treatment PCL of 45.5. This reduction is statistically significant and indicates a 29 percent drop in self-reported PTSD symptoms. Treatment gains were similar across veteran cohorts. The average pre-treatment BDI–2 score was 30.4, and the average post-treatment BDI–2 was 19.2. This reduction is statistically significant and indicates a 37 percent drop in self-reported symptoms of depression.
2. The Cognitive Behavioral Therapy for Depression (CBT–D) and Acceptance and Commitment Therapy for Depression (ACT–D) training programs have collected clinical outcome data regarding pre- and post-treatment depression scores using the Beck Depression Inventory—Version 2 (BDI–2).
    a. CBT–D Results: Veterans who completed CBT–D decreased from an average pre-treatment BDI–2 score of 27.5 to an average post-treatment BDI–2 of 17.0. This reduction is statistically significant and indicates a 38 percent drop in self-reported symptoms of depression.
    b. ACT–D Results: Veterans who completed ACT–D decreased from an average pre-treatment BDI–2 score of 29.8 to an average post-treatment BDI–

2 of 18.7. This reduction is statistically significant and indicates a 37 percent drop in self-reported symptoms of depression.

Evidence Based Pharmacotherapy

Evidence-based pharmacotherapy cannot be tracked with current information systems to determine who has received a full course. Evidence-based psychopharmacotherapy consists of guideline concordant medication treatment for a particular condition. VA can determine which veterans have received a prescription for a particular psychoactive medication, but cannot currently determine whether a full course of the treatment was completed.

The first-line (Grade A) pharmacotherapy recommendation for PTSD in the new VA/DoD Clinical Practice Guideline for PTSD (released in 2010) is the use of selective serotonin reuptake inhibitors (SSRI) or selective norepinephrine uptake inhibitors (SNRI). Data from a VA-sponsored research project examining the use of evidence-based medication practices for PTSD indicate that in fiscal year (FY) 2009, 59 percent of all patients with a PTSD diagnosis received a SSRI or SNRI. This is up from 50 percent of veterans with a PTSD diagnosis in 1999. Moreover, more than 80 percent of veterans with PTSD who received any psychotropic medication received a SSRI or SNRI. Medication use includes having at least one outpatient prescription fill of any quantity, day's supply, or dosage from within the selected therapeutic classes. These data do not allow VA to draw a conclusion as to whether a veteran completed a full course of prescribed treatment, but they do provide verification that a veteran presented for and received treatment at some point during the year.

To promote best practices in pharmacological management of PTSD, the VA National Center for PTSD, in the Office of Mental Health Services developed a monthly telephone-based lecture series in the fall of 2008, which was widely promoted and has been well-received by VA providers. In this series, an expert discusses various aspects of pharmacotherapy for PTSD, reviews the research evidence and recommendations in the VA/DoD Clinical Practice Guideline for PTSD, and answers commonly posed questions. The series includes an overview presentation on PTSD pharmacotherapy and presentations on specific issues, including issues around prescribing in veterans with mild TBI or those who are aging. Moreover, a fact sheet for providers was developed and revised in 2011 to provide information to the field on recommendations for good prescribing practice and management of PTSD and is available on the National Center for PTSD's Web site. Educational products and lectures have also been developed, and are available on the Web site that allow clinicians to earn CEU's and CME's to learn these best practices.

Likewise, Opioid Agonist therapy is considered first-line therapy for treatment of opioid dependence based on the 2009 VA/DoD Clinical Practice Guideline for Management of Substance Use Disorder. Opioid Agonist Treatment (OAT) is a highly effective, evidence-based treatment for opioid dependence, and opioid dependent patients receiving OAT are more likely to achieve and maintain illicit opioid abstinence, and less likely to contract infectious diseases such as HIV and engage in criminal activities. VHA has mandated that OAT be available to opioid dependent patients at all VA facilities either as 1) care in a licensed VA OAT clinic with methadone or buprenorphine, 2) office-based OAT with buprenorphine, or 3) OAT by contract with a community provider or clinic. VA continues to undertake initiatives to increase availability and improve quality of OAT delivery in VA, including development of a mentoring network, a clinical help-line, monthly newsletters with practice tips and summaries of new literature, and monitoring and feedback on performance. In FY 2010, VA treated 11,919 (33.4 percent) of the 35,713 patients diagnosed with opioid dependence with clinic, office, or contracted OAT, up from 7,724 (27.8 percent) of 27,840 patients in FY 2002.

Question 4: How many veterans who have received a diagnosis of mental illness (PTSD, anxiety disorder, or major depression) from VHA are *not* receiving compensation for that diagnosed condition? Please break the data down by war cohort.

Response: The following data are based on interpretation of the request above, as follows:

Compensation for mental illness, as well as treatment for mental illness, is provided to a larger population of veterans than that limited to PTSD, anxiety disorder, or depression. For the purposes of this query we are responding to these three diagnoses because they are specifically mentioned in the request and they are the three diagnoses provided to VHA by VBA, based on most recent complete VBA rolls (through May 2011). For all veterans with a compensable, service-connected mental health condition, these are the three most prevalent mental health diagnoses.

A total of 891,362 VA patients seen between April 1, 2010 and March 31, 2011 were diagnosed with PTSD, anxiety disorder, or major depression. (Note: VHA data represents ICD9 codes. PTSD patients were included if PTSD was a "possible" diagnosis.) Of these patients 57 percent or 510,345 were **not** receiving compensation for these diagnoses. VA patients diagnosed with these disorders who were veterans of the OIF/OEF conflicts were more likely to be receiving compensation for these diagnoses than those from other combat eras (55 percent OIF/OEF veterans receiving compensation versus 41 percent of non-OIF/OEF veterans receiving compensation). These numbers do not account for veterans with pending claims.

Period of Service	Number of VA patients with a diagnosis of PTSD, anxiety disorder, or depression in Q3FY10–Q2FY11	Number of VA patients with a diagnosis of PTSD, anxiety, or depression in Q3FY10–Q2FY2011 who are not receiving compensation for PTSD, anxiety, or depression	Percent of VA patients with a diagnosis of PTSD, anxiety, or depression in Q3FY10–Q2FY2011 who are not receiving compensation for PTSD, anxiety, or depression
All VA Patients	891,362	510,345	57%
OIF/OEF VA Patients	135,918	61,638	45%
Non-OIF/OEF VA Patients	755,444	448,707	59%

The majority of VA patients who were recently seen in VA for PTSD, anxiety, or depression and receive compensation for these disorders are veterans of the Gulf war era (including OEF/OIF) or the Vietnam war era. These numbers do not account for veterans with pending claims.

Period of Service	Number of VA patients with a diagnosis of PTSD, anxiety, or depression in Q3FY10–Q2FY2011 who are receiving compensation and are service-connected for PTSD, anxiety, or depression
Gulf War	123,288
Peacetime Era	20,840
Vietnam Era	215,845
Korean Conflict	9,100
WWII	11,944
Total	381,017

Question 5: How many veterans in receipt of compensation for mental illness utilize non-VA mental health care services? Please break the data down by war cohort.

Response: Based on VA's response to Question 2 where a full count of who is service-connected for mental health is not implied by those numbers, a total of 648,118 veterans were receiving compensation for PTSD, anxiety, or major depression and are service-connected as of May 2011. This includes veterans rated 0 percent for these conditions, but receiving compensation for other conditions; veterans rated zero percent for these conditions are not included in these counts unless they are receiving compensation for another disability. Of these veterans, 381,344 received specialty mental health services in VA between April 1, 2010, and March 31, 2011. Thus 59 percent of all veterans receiving compensation for PTSD, anxiety, or major depression received specialty mental health treatment in VA during this time period. We are not able to determine the number of these veterans who may have received this care in primary care or in general mental health.

VA does not collect data on veterans who choose to utilize non-VA mental health care or receive mental health care in VHA non-specialty Clinics. Of the approximately 41 percent remaining veterans that receive compensation for PTSD, anxiety, or major depression, they either receive mental health care within VHA in non-specialty care, from non-VA providers, **or** are not receiving mental health treatment at all.

Question 6: What measure exists to demonstrate that veterans who utilize VA mental health care services are on the road to recovery?

Response: This is a complex question, since the mental health Recovery model relates to functioning at the highest possible level for an individual, despite a chronic illness, and recovery is not equivalent to "cure" nor is it equivalent to reaching a state where there is no disability, as discussed in VA's Testimony for this Hearing. Thus, being on the "road to recovery" is a multifaceted state and requires a battery of measures, not any single measure.

One component is improvement in the presence or severity of symptoms leading to a mental health diagnosis; this is probably the easiest component to measure. For PTSD, for example, VA has evidence-based psychotherapy protocols in place that incorporate weekly symptom monitoring with the PTSD Checklist (PCL) plus a single item on the impact of symptoms on level of function. In addition, current standards require the administration of the PCL (plus the item on personal function) every 90 days for all OEF/OIF veterans in active treatment for PTSD, as defined by at least 2 visits to an outpatient mental health clinic within the previous 6 months. Data on the PCL (plus the item on personal function) have recently been extracted into a national data base allowing for total population sampling for clinical review and aggregate analyses. Outcome measures for evaluation of symptom level during the course of treatment for substance abuse and depression are under development and will be available, dependent on availability of informatics tools, which are scheduled for deployment in FY 2012.

A measure of veterans' self-reported perceptions of their recovery and current functional status versus their desired status is in development. While symptom monitoring is an important element in measuring treatment effectiveness, broader, systematic outcome evaluation of functioning and meeting personal life goals is also critical for evaluating program effectiveness.

Question 7: Does VA have baseline measures to determine the status of a veteran's mental illness prior to treatment and after treatment?

Response: Baseline, ongoing, and post-treatment administration of established symptom measures (e.g., PCL, Beck Depression Inventory-2) are routinely conducted as part of EBP protocols for PTSD, depression, and other mental health conditions implemented in VHA. Additional measures of well-being and the treatment process are also often administered during the course of these therapies. In addition, as noted in #6 above, current standards require the administration of the PCL plus a single item on the impact of symptoms on level of function every 90 days for all OEF/OIF veterans in any active treatment for PTSD, as defined by at least 2 visits to an outpatient mental health clinic within the previous 6 months. This will automatically ensure measurement at the end of treatment. Outcome measures for evaluation of symptom level during the course of treatment for substance abuse and depression are under development and will be available, dependent on availability of informatics tools which are scheduled for deployment in FY 2012.

Question 8: Please provide data to the Committee on the following:

Question 8(a): For each of the last 10 years, the net number of veterans who have a disability rating, broken down by war era, for PTSD, depression, or anxiety disorder.

Response: Please see Enclosure 1 for the breakdown by period of service for veterans service-connected for PTSD, depression, or anxiety disorder and in receipt of disability compensation at the end of the past 10 fiscal years. Veterans rated zero percent for these conditions are not included in these counts unless they are receiving compensation for another disability.

Question 8(b): For each of the last 10 years, the average disability rating for veterans (broken down by war era) with a mental illness (PTSD, depression, or anxiety disorder). Please make the average rating exclusive to the mental health conditions, e.g., exclude ratings associated with physical ailments and other non-mental health service-connected disabilities.

Response: Please see Enclosure 1 for the average ratings exclusively for PTSD, depression, and anxiety disorder at the end of the past 10 fiscal years by period of service.

Question 8(c): For Gulf War II veterans, please break out the distribution of ratings among those in receipt of compensation for mental health conditions over the last 10 years. For example, the number of Gulf War II veterans who have a disability rating. Veterans rated zero percent for these conditions are not included in these counts. Also, veterans that are service-connected for these conditions are not necessarily receiving compensation due to these conditions.

Response: Please see Enclosure 2 for the breakout of Post-9/11 veterans service-connected for PTSD, depression, or anxiety disorder and in receipt of disability compensation at the end of the past 10 fiscal years by disability rating. These veterans are included as Gulf War era veterans in Enclosure 1.

Question 9: For every veteran with a service-connected mental illness VA has the name, address, and specific condition for which the veteran is receiving compensation. After disability is established, what effort is made to proactively link those individuals to effective treatment?

Response: VHA does not receive notification when a veteran is awarded compensation and/or pension for a mental health diagnosis. Lacking this notification, there is no current trigger that would alert VHA to conduct outreach following the C&P decision. C&P examiners are required to review medical records to assess what diagnoses have been made and any treatments received. C&P examiners often do encourage veterans to seek treatment at VA, or in some other site of their choosing, if a diagnosis is confirmed in the C&P interview and it does not appear that treatment is being received, but we do not have formal data on how frequently this occurs. There are no protocols that require C&P examiners to encourage veterans who are examined for service-connection to engage in treatment. However, VHA and VBA are increasingly working on projects together, and will consider how best to ensure that all veterans with service-connected diagnoses are encouraged to enter treatment, with VA proactively engaged in reaching out to these veterans to offer and facilitate needed health care services.

For all veterans there are a number of outreach functions where VA collaborates with DoD, e.g., the Yellow Ribbon Program and PHDRA events. Each medical center also provides at least one outreach function each year.

U.S. Department of Veterans Affairs
Enclosure 1

2001							
	9400 Anxiety Disorder		9411 PTSD		9434 Major Depressive Disorder		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	2,277	22	7,479	42	7,287	33	17,043
Korean Conflict	6,822	30	6,524	50	219	53	13,565
Peacetime Era	6,580	27	5,626	51	3,526	45	15,732
Vietnam Era	16,779	27	106,801	59	2,268	51	125,848
World War II	48,978	26	18,095	44	421	50	67,494

2001							
	9400 Anxiety Disorder		9411 PTSD		9434 Major Depressive Disorder		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Grand Total	**81,436**	**26**	**144,525**	**44**	**13,721**	**50**	**239,682**

2002							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	2,563	23	8,833	44	9,540	34	20,936
Korean Conflict	6,438	31	7,682	51	291	52	14,411
Peacetime Era	6,482	28	6,429	52	4,600	45	17,511
Vietnam Era	16,504	28	121,863	60	3,283	50	141,650
World War II	44,074	26	20,684	46	506	50	65,264
Grand Total	**76,061**	**27**	**165,491**	**57**	**18,220**	**40**	**259,772**

2003							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	3,020	24	10,942	46	12,602	34	26,564
Korean Conflict	6,130	31	8,994	52	368	51	15,492
Peacetime Era	6,342	29	7,390	54	5,986	46	19,718
Vietnam Era	16,275	29	142,865	61	4,781	50	163,921
World War II	39,577	26	23,187	47	611	50	63,375
Grand Total	**71,344**	**28**	**193,378**	**57**	**24,348**	**41**	**289,070**

2004							
	9400		9411		9434		
Period Of Service	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Total
Gulf War	3,569	25	13,524	47	15,882	35	32,975
Korean Con-flict	5,758	32	10,016	53	442	51	16,216
Peace-time Era	6,236	31	8,261	56	7,302	46	21,799
Vietnam Era	16,025	30	161,023	61	6,256	49	183,304
World War II	35,375	27	24,590	48	705	50	60,670
Grand Total	**66,963**	**28**	**217,414**	**58**	**30,587**	**41**	**314,964**

2005							
	9400		9411		9434		
Period Of Service	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Total
Gulf War	4,371	26	19,358	47	20,214	36	43,943
Korean Con-flict	5,422	32	10,944	53	531	51	16,897
Peace-time Era	6,173	32	9,088	57	8,522	47	23,783
Vietnam Era	15,773	31	179,735	61	7,756	49	203,264
World War II	31,364	27	25,281	49	784	49	57,429
Grand Total	**63,103**	**29**	**244,406**	**58**	**37,807**	**41**	**345,316**

2006							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	5,291	26	28,392	45	25,035	36	58,718
Korean Conflict	5,128	33	11,423	53	594	50	17,145
Peacetime Era	6,071	32	9,796	57	9,582	47	25,449
Vietnam Era	15,571	32	194,438	61	9,224	49	219,233
World War II	27,809	28	24,902	49	801	49	53,512
Grand Total	**59,870**	**29**	**268,951**	**58**	**45,236**	**41**	**374,057**

2007							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	6,600	26	44,445	44	30,629	36	81,674
Korean Conflict	4,849	33	11,940	52	665	49	17,454
Peacetime Era	6,005	33	10,586	58	10,727	47	27,318
Vietnam Era	15,390	33	210,432	61	10,759	49	236,581
World War II	24,561	28	24,219	49	803	49	49,583
Grand Total	**57,405**	**30**	**301,622**	**57**	**53,583**	**41**	**412,610**

2008							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	8,425	25	66,073	44	38,128	35	112,626
Korean Conflict	4,564	33	12,288	52	720	48	17,572
Peacetime Era	6,018	33	11,639	58	12,367	47	30,024
Vietnam Era	15,150	33	228,538	60	12,238	47	255,926
World War II	21,223	28	23,373	49	814	48	45,410
Grand Total	**55,380**	**30**	**341,911**	**56**	**64,267**	**40**	**461,558**

2009							
	9400		9411		9434		
Period Of Service	Cnt	Average Disability %	Cnt	Average Disability %	Cnt	Average Disability %	Total
Gulf War	10,412	25	91,648	44	46,168	36	148,228
Korean Conflict	4,267	33	12,360	52	800	48	17,427
Peacetime Era	6,013	34	12,869	59	14,304	47	33,186
Vietnam Era	14,987	33	247,426	60	13,971	47	276,384
World War II	18,106	28	22,110	49	799	47	41,015
Grand Total	**53,785**	**30**	**386,413**	**55**	**76,042**	**40**	**516,240**

2010							
	9400		9411		9434		
Period Of Service	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Cnt	Average Dis-ability %	Total
Gulf War	12,598	26	120,449	45	54,609	37	187,656
Korean Con-flict	3,984	33	12,518	52	839	48	17,341
Peace-time Era	6,025	34	14,578	59	16,580	48	37,183
Vietnam Era	14,940	34	268,849	59	16,028	47	299,817
World War II	15,274	28	20,534	49	788	47	36,596
Grand Total	**52,821**	**30**	**436,928**	**55**	**88,844**	**41**	**578,593**

Enclosure 2

2001											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	3	29		19		5		1		1	58
9411	5	29		63		36		20		2	155
9434	24	138	1	135		70		21		14	403
Grand Total	**32**	**196**	**1**	**217**		**111**		**42**		**17**	**616**

2002											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	27	169		117		25		8		4	350
9411	19	178		440		262		130		62	1,091
9434	98	782	2	803	1	362		131		61	2,240
Grand Total	**144**	**1,129**	**2**	**1,360**	**1**	**649**		**269**		**127**	**3,681**

2003											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	59	361	1	260		59		27		6	773
9411	36	379	2	931		597		360		200	2,505
9434	183	1,589	3	1,729	1	762		293		138	4,698
Grand Total	**278**	**2,329**	**6**	**2,920**	**1**	**1,418**		**680**		**344**	**7,976**

2004											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	88	563	1	456		121		39		14	1,282
9411	49	573	4	1,643	3	1,111	1	669		410	4,463
9434	242	2,338	7	2,784	2	1,218	1	528		233	7,353
Grand Total	**379**	**3,474**	**12**	**4,883**	**5**	**2,450**	**2**	**1,236**		**657**	**13,098**

2005											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	105	865	4	753		201		64		21	2,013
9411	91	1,193	7	3,666	5	2,382	2	1,357		776	9,479
9434	333	3,321	14	4,293	7	1,871	2	825		361	11,027
GrandTotal	**529**	**5,379**	**25**	**8,712**	**12**	**4,454**	**4**	**2,246**		**1,158**	**22,519**

2006											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	181	1,237	3	1,076		277		92		32	2,898
9411	195	2,352	8	7,386	9	4,486	2	2,211		1,169	17,818
9434	439	4,435	15	6,059	6	2,544	6	1,158		505	15,167
Grand Total	**815**	**8,024**	**26**	**14,521**	**15**	**7,307**	**8**	**3,461**		**1,706**	**35,883**

2007											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	305	1,673	7	1,595		407	1	132		51	4,171
9411	397	4,220	12	14,081	9	8,369	5	3,861		2,004	32,958
9434	639	5,679	23	8,137	9	3,429	8	1,564		671	20,159
Grand Total	**1,341**	**11,572**	**42**	**23,813**	**18**	**12,205**	**14**	**5,557**		**2,726**	**57,288**

2008											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	529	2,372	8	2,157	1	589	2	194		65	5,917
9411	680	6,646	14	21,942	11	14,064	11	6,557		3,395	53,320
9434	1,073	7,320	34	10,605	10	4,565	4	2,148		937	26,696
Grand Total	**2,282**	**16,338**	**56**	**34,704**	**22**	**19,218**	**17**	**8,899**		**4,397**	**85,933**

2009											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	704	2,954	14	2,964	3	799	2	269		91	7,800
9411	865	8,548	16	31,143	18	21,107	9	10,412		4,959	77,077
9434	1,337	8,849	48	13,307	19	5,968	5	2,922		1,224	33,679
Grand Total	**2,906**	**20,351**	**78**	**47,414**	**40**	**27,874**	**16**	**13,603**		**6,274**	**118,556**

2010											
	PERCENTAGE										
DIAGNOSIS	**0**	**10**	**20**	**30**	**40**	**50**	**60**	**70**	**80**	**100**	**Grand Total**
9400	903	3,467	14	3,903	3	1,092	2	401		117	9,902
9411	1,072	10,243	23	40,926	21	29,020	11	15,838		6,689	103,843
9434	1,530	9,916	47	16,256	26	7,741	8	3,899		1,563	40,986
Grand Total	**3,505**	**23,626**	**84**	**61,085**	**50**	**37,853**	**21**	**20,138**		**8,369**	**154,731**

Committee on Veterans' Affairs
U.S. House of Representatives
Post-Hearing Questions for Karen H. Seal, M.D., MPH
From the Honorable Bob Filner
Mental Health: Bridging the Gap between Care and Compensation for Veterans
June 14, 2011

1. One of your recommendations is to provide greater access to specialty mental health treatment through primary care which includes restructuring VA services such that specialty mental health providers are collocated and fully integrated within primary care. Can you describe how this differs from the current configuration of providing mental health services in the primary care setting?
2. One of the key findings of your study regarding the prevalence of mental health disorders is that age and component type mattered. Active duty veterans less than age 25 years had 2 to 5 times higher rates of PTSD, alcohol and drug use disorder diagnoses compared to active duty veterans over age 40. In contrast, among National Guard/Reserve veterans, risk for PTSD and depression were significantly higher in veterans over age 40 compared to their younger counterparts less than age 25. What is your professional opinion on this finding and do you have any recommendations to address this issue?
3. How are OEF/OIF veterans different from older cohorts of veterans in terms of their mental health needs and the involvement of their families in their care?
4. In your testimony, you point out that older National Guard and Reserve Veterans are at higher risk for PTSD and depression.
   - Can you speak to why members of the Guard and Reserve face unique mental health challenges?
   - What support and services do you feel the VA could better provide to older veterans from OEF/OIF/OND as well as older cohorts of veterans, such as Vietnam Veterans?
5. Do you have any specific recommendations to improve retention in mental health treatment?
6. How well prepared do you feel that VA medical facilities are in providing for the growing mental health needs of veterans?
7. With respect to the privacy concerns regarding Department of Defense's access to veterans' electronic medical records and how this has discouraged some veterans from coming forward and disclosing information about substance abuse, interpersonal violence, and sexual identity issues—How do you suggest VA best address these concerns?
8. Your testimony points to a need for more research to develop and test modified evidence-based treatments for PTSD and other mental health problems.
   - What specific areas should the VA invest research resources in order to close some of these research gaps on effective treatments for PTSD?
   - How can the VA work with other Federal research organizations such as the National Institutes of Health (NIH) to advance this area of research?

U.S. Department of Veterans Affairs
San Francisco, CA.
August 5, 2011, 2010

Chairman Bob Filner
Committee on Veterans' Affairs
U.S. House of Representatives
One Hundred Eleventh Congress
335 Cannon House Office Building
Washington, DC 20515

Dear Chairman Filner:

Below please find my responses to the post-hearing questions following the June 14, 2011 Full Committee Hearing entitled, "Mental Health: Bridging the Gap between Care and Compensation for Veterans". Questions are paraphrased, followed by my responses.

1. ***How does the recommendation to restructure VA primary care services to collocate and more fully integrate specialty mental health providers***

in primary care differ from the current system of providing mental health services within VA primary care?

Currently, even in model VA primary care clinics, embedded mental health providers (many of whom are social workers) typically provide very basic, time-limited mental health services such as further assessment of positive mental health screens, mental health referrals, medication management, and brief supportive therapies, but rarely provide evidence-based mental health treatments (Possemato et al., 2011). In some cases, brief, time-limited treatment may be sufficient for conditions such as mild depression or re-adjustment stress. The majority of OEF/OIF veterans who present to VA, present with more complex mental health conditions however. The most common mental health condition in OEF/OIF veterans is PTSD, which is highly comorbid with depression and substance use disorders. Comorbid PTSD is most effectively treated with evidence-based trauma-focused therapies that are delivered by trained mental health professionals. Currently, in the majority of VA facilities across the country, this requires a referral to a specialty mental health clinic. Unfortunately, due to a myriad of barriers, many veterans fail to follow-up with specialty mental health referrals and thus fail to engage in and complete an adequate course of therapy. Thus, in order to enhance engagement in specialty mental health treatment, it may be prudent to restructure VA primary care such that specialty mental health providers, trained in evidence-based therapies, are available to meet patients where they present, i.e. in primary care (Hoge, 2011). Moreover, with the new Patient Aligned Care Team (PACT) model in VA primary care, PACT primary care nurses are also available to support patient adherence to and retention in specialty mental health services, especially if these services are delivered within primary care.

2. ***Why, in your study, do you think that you found that mental health disorders were more prevalent in older National Guard and Reserve veterans (> age 40) compared to their younger counterparts (< 25 years)?***

One explanation is that when called to arms, older Guard/Reserve members are more established in civilian life—are married, have children, jobs and community ties, and may be less well prepared for combat, making their transition to war zone and home again more stressful, mostly because of the disparity between their civilian life and life as a soldier. In addition, relatively older National Guard and Reserve veterans may return to family responsibilities, relationship and/or parenting stress, job pressures, or in this economy, unemployment, which may compound post-deployment stress. Thus, they may be more vulnerable to PTSD or other mental health problems after deployment. It is therefore important to carefully assess older National Guard and Reserve veterans for potential mental health problems after war and to provide targeted counseling services both in VA and in their communities.

Younger veterans often access the GI Bill after returning home, attend school, and defer financial pressures, but older veterans must often return to work immediately after returning from war. Perhaps, some time-limited financial support for older National Guard and Reserve veterans who are not accessing the GI Bill could alleviate some financial pressure and allow them to de-compress for a couple of months after returning home. Unlike active duty military personnel who return home to a military base with other military personnel and their families, older National Guard and Reserve members may find themselves relatively isolated in their communities. Education and support for families of National Guard and Reserve veterans regarding the unique stressors older veterans face upon their return home may prove helpful. Adding a component of professional or peer support during National Guard and Reserve monthly trainings could also be very useful for some.

3. ***How are OEF/OIF veterans different from other era-veterans in terms of their mental health needs and the involvement of their families in their care?***

I would argue that OEF/OIF veterans are not significantly different from other era-veterans in terms of their mental health concerns and needs and the importance of family in their care. I think the main difference between this generation of veterans and prior generations is that we now have a substantial body of literature and clinical experience to guide us in the care of these veterans. We know substantially more than we did when Vietnam veterans returned home about the diagnosis of PTSD and prevention of chronic PTSD. For instance, evidence-based treatments for PTSD have been developed, tested, and have been proven effective. We now face different challenges than before in that we know how to diagnose PTSD and have effective therapies, but we are still struggling to figure out how to get these thera-

pies to the veterans who most need them. Here, family education and support are invaluable in that family members are often the ones who rally around the veteran to help them access and stay in treatment.

4. *Why do National Guard and Reserve members face unique challenges on returning home and what support services would be beneficial to this group and to Vietnam-era veterans?*

The answer to this question is largely addressed in my response to question 2 above. Vietnam veterans can indirectly benefit from increased VA mental health and support services for OEF/OIF veterans because in VA, these enhanced services are generally not limited to OEF/OIF veterans. Indeed, OEF/OIF veterans often comment that they appreciate the participation of Vietnam veterans in their treatment programs because these older veterans provide peer support for younger veterans. Being able to reach out and help the younger veterans is also proving therapeutic for many older Vietnam veterans.

5. *What are some specific recommendations to improve retention in mental health service?*

As mentioned in response to question 1 above, providing specialty mental health care in primary care could improve retention in mental health treatment. Our own data show that OEF/OIF veterans with mental health problems are significantly more likely to utilize primary care medical services than OEF/OIF veterans without mental health problems. Moreover, those with mental health problems are also more likely to utilize primary care more frequently. Thus, in the spirit of meeting veterans where they are, we believe that these veterans would be more likely to be retained in mental health treatment if these services were provided in the context of primary care. In addition, many of the medical problems (e.g. alcohol abuse, smoking, obesity, hypertension etc . . .) seen in OEF/OIF veterans are associated with mental health problems as demonstrated by our research. Addressing these related physical and mental health problems together in a coordinated and collaborative fashion, which would occur if specialty mental health providers practiced along side primary care colleagues, would likely reinforce retention in both mental health and primary care, as well as lead to improved behavioral health outcomes.

There is no reason why primary care and mental health appointments could not be scheduled as sequential appointments on the same day, as we already do in our OEF/OIF Integrated Care Clinic at the San Francisco VA Medical Center. This is more convenient for patients, especially patients who live at a distance, increasing the likelihood that they will attend their mental health visit when they come for their primary care visit. Same-day, sequential visits also promote greater coordination and collaboration between primary care and mental health providers in delivering integrated care. Other recommendations to improve engagement and retention in mental health services involve the use of primary care nurses to call patients to remind and motivate them to follow-up with their primary care-mental health appointments, as well as increased use of the telephone and Internet to deliver mental health treatments to those patients who live too far to come to a VA facility for weekly treatment.

6. *How well prepared are VA medical facilities in providing for the growing mental health needs of veterans?*

In my position as a researcher at one VA medical center, it is difficult for me to make generalizations about the adequacy of mental health treatment at all VA facilities across the country. I suspect that there is likely wide geographic variation. Our study on mental health utilization in OEF/OIF veterans based on national VA administrative data revealed that 50 percent or more of returning combat veterans with a new mental health diagnosis have attended at least one mental health session. Nevertheless, only a minority (10 percent or less) of these veterans went on to complete what would be considered an adequate amount of therapy for most mental health disorders. As was discussed in this session, there are numerous barriers to veterans staying in and completing a course of mental health therapy, both patient-level barriers as well as VA system-level barriers. VA is working on several innovative solutions, such as telemental health, in an attempt to overcome system-level barriers to mental health treatment, but more work in this area is clearly needed.

7. *The DoD may access veterans electronic medical records and this may inhibit some veterans from coming forward to disclose sensitive concerns to their VA medical providers. How should VA address these privacy concerns?*

There is potentially a great advantage to bi-directional sharing of de-identified data across the VA and DoD systems for research. Nevertheless, while there may be an advantage to the VA's being able to access prior medical information about a veteran from their military service in order to provide the best medical care in the post-deployment period, there may be risks to the DoD being able to access veterans' medical records without a patient's consent once they have sought care at VA. Most veterans who seek care at VA have separated from active duty military service, and while some may remain in inactive status, most consider returning to military service a remote possibility. A notable exception are National Guard and Reserve veterans who are eligible to obtain VA health care services after each deployment and they may be re-deployed in the future.

Most veterans who come to VA desire treatment for one or more medical or mental health conditions. Many of the conditions for which veterans seek care could potentially render them ineligible to pursue a career in the military, such as drug or alcohol dependence, illegal drug use, and severe mental health conditions. It is devastating to think that veterans would not disclose important, but sensitive medical and mental health concerns to their VA providers out of concern that the DoD might obtain access to these records without their consent. This may prohibit some veterans with serious problems from getting the help they need at VA facilities. Thus, while VA may have some of the best care available for combat-related conditions such as PTSD, some veterans may chose to receive their care elsewhere from less well-trained community providers because DoD would not be able to have access or their medical records. This may very well represent a significant barrier to accessing care at VA for many veterans. Prior to making decisions about VA–DoD information sharing however, it is essential that this matter be evaluated more thoroughly and systematically.

8. *Your testimony points to a need for more research to develop and test modified PTSD treatments. In what specific areas should the VA invest research resources and how can the VA work with other federally-funded research organizations, such as the NIH, to advance this area of research?*

There is a need to develop and test PTSD treatments that are briefer and better suited for primary care settings. It is important to implement these treatments directly within primary care settings to better understand the specific barriers and facilitators to their effective delivery. Since PTSD is highly comorbid with other mental and physical health problems, there is a need to develop and test integrated treatments for PTSD that simultaneously address substance abuse or other behavioral (e.g., smoking) or physical health problems (e.g., chronic pain) in the context of PTSD treatment. It is also important to test novel delivery techniques for PTSD treatment especially designed to meet the needs of rural or remote veterans, such as the use of the telephone or the Internet to deliver these treatments. VA facilities and clinics often represent the best and most natural settings in which to conduct this research.

VA, in its historical affiliation with universities and academic medical centers, has a long-standing tradition of excellence in research. Nevertheless, VA cannot be expected to fund all research studies that occur in VA settings, especially when the research findings could easily generalize to other health care systems. It is hoped that NIH will consider funding more research that is based at VA because veterans' concerns are important to American public health, VA provides ideal clinical settings in which to conduct research, and information gleaned from these studies may inform needed improvements in other health care systems in the United States.

Thank you for giving me the opportunity to respond to these follow-up questions. Should additional questions arise, or you would like additional clarification about any of my responses, please feel free to contact me at 415–732–9131 or via email karen.seal@va.gov or karen.seal@ucsf.edu.

Sincerely,

Karen Seal, MD, MPH
Associate Professor of Medicine and Psychiatry
University of California, San Francisco
Co-Director, OEF/OIF Integrated Care Clinic
San Francisco VA Medical Center

Committee on Veterans' Affairs
Washington, DC.
June 23, 2011

LTG James Terry Scott, USA (Ret.)
Chairman
Advisory Committee on Disability Compensation
P.O. Box 893
Coleman, TX 76834

Dear General Scott:

In reference to our full Committee hearing entitled "Mental Health: Bridging the Gap between Care and Compensation for Veterans," that took place on June 14, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 5, 2011.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by faxing your responses to Debbie at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

Prepared Statement of LTG James Terry Scott, USA (Ret.)
Chairman, Advisory Committee on Disability Compensation
P.O. Box 893
Coleman, TX 76834

August 10, 2011

Committee on Veterans' Affairs
U.S. House of Representatives
Post-Hearing Questions for LTG James Terry Scott, USA (Ret.)
From the Honorable Bob Filner

Subject: Mental Health: Bridging the Gap between Care and Compensation for Veterans held on June 14, 2011.

I am honored to respond to the questions and more than willing to elaborate subsequently if useful.

Question 1: What do you think is the most important change the Department of Veterans Affairs can make to help bridge the gap between compensation and care for veterans?

Answer: A significant component of the gap between compensation and care for veterans is division of responsibilities between VHA and VBA. VBA is focused on claims adjudication and VHA on patient care. Neither has any real responsibility for maximizing the disabled veteran's ability to function as a contributing member of society through follow up assessment and vocational rehabilitation. The argument can be made that we "pay them to go away". The magnitude of the case load and case backlog make it difficult to focus on follow up treatment and vocational rehabilitation. An argument can be made that to the extent that resources are a shortfall, VA should focus on the disabled veteran. It may be that we are asking VA (VHA) to treat more categories of patients than the resources allow. In a time of budget tightening, priorities may require a more focused approach.

Question 2: The arguments against creating the linkage among compensation, treatment, vocational assessment/rehabilitation, and follow up examinations to determine efficacy of treatment include it could be used as a mechanism to reduce disability benefits. Do you agree with that argument?

Answer: The perception is widely held among veterans and veterans' advocates, that linking compensation, treatment, vocational assessment/rehabilitation, and fol-

low up examinations places disability benefits at risk. A program that creates the linkage must protect the participant from arbitrary and dramatic reductions in compensation. Perhaps a pilot program combining a temporary disability rating and the previously mentioned linkages could be instituted. Current VA policy is to wait until the mentally disabled veteran presents himself/herself for treatment rather than requiring or rewarding veterans for seeking treatment.

Question 3: Do you believe that mental disabilities should be addressed differently than physical disabilities by the Department of Veterans Affairs?

Answer: Yes, for the reasons elaborated on in question 4. In particular, the reluctance of individuals with mental disabilities to seek treatment and the self destructive behavior that often accompanies the disability differentiate between physical and mental disabilities.

Question 4: In your testimony you state there is significant evidence that individuals with mental disabilities are less likely to seek and maintain a treatment regimen than those with physical disabilities. What do you attribute that to?

Answer: Individuals with a physical disability historically seek treatment and medical care in an attempt to be sure they are taking advantage of advances in medical science that may alleviate their pain, injuries, or disability. Among veterans with physical disabilities, there is little perceived risk of losing disability benefits because the nature of physical disabilities and the permanence associated with them. Physical disabilities tend to become more debilitating with age and virtually all physically disabled veterans want to maintain as high a level of functioning as possible for as long as possible.

The literature available indicates that many individuals with mental disabilities, whether veterans or not, do not perceive themselves as needing or benefitting from treatment and therefore do not seek treatment or follow unsupervised treatment regimens. Lack of treatment may include manifestations of self destructive behavior such as substance or alcohol abuse, homelessness, and suicidal risk. The untreated mentally disabled veteran may be a risk to himself/herself, the family and/or society. At best, the opportunities for maximum improvement and integration into society are foregone.

James Terry Scott
Chairman
Advisory Committee on Disability Compensation

Committee on Veterans' Affairs
Washington, DC.
June 23, 2011

Sally Satel, M.D.
Resident Scholar
American Enterprise Institute
1150 Seventeenth Street, N.W.
Washington, DC 20036

Dear Sally:

In reference to our full Committee hearing entitled "Mental Health: Bridging the Gap between Care and Compensation for Veterans," that took place on June 14, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 5, 2011.

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Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

August 5, 2011
Responses to Post-Hearing Questions
from the Honorable Bob Filner regarding
Mental Health: Bridging the Gap Between Care and Compensation for Veterans (June 14, 2011)
Sally Satel, M.D.

Question 1: You recommended a living stipend for the veteran or his family during the course of care; can you explain how it would work?

Response: My recommendation assumes what one might call a "treatment first" approach. That approach is warranted, in my view, because VA psychiatrists and psychologists are not able to render an assessment of a veteran's potential for work in a 90-minute comp-and-pension exam. The information derived from serious course of treatment/rehabilitation is essential to making an intelligent determination of disability status.

The basic idea of a "stipend" is that veterans who are too mentally impaired to work would be offered financial support to sustain them and their families while they are undergoing care for war-related depression, anxiety, or PTSD within a number of different treatment settings: inpatient hospitalization, residential care facility, intensive outpatient treatment, and/or intensive rehabilitation.[1] Given that veterans would have no earning power during the time-limited and intensive treatment phase, the amount of temporary financial support offered could logically equal the "full disability" amount otherwise available to totally disabled veterans.

These funds provided to veterans during the treatment-rehab phase could be considered a living stipend, a wellness benefit, or a treatment benefit. Other labels may be appropriate as long as the word "disability" is not part of them. This is because the prognosis regarding a veteran's capacity to join the workforce is yet to be determined—and also because of the unfortunate consequence of prematurely labeling someone disabled.

Consider this general outline:

> Veterans, mostly OIF/OIE veterans, who are not already receiving disability payments from VBA, would present to the VA for care, just as he or she does now. An assessment of clinical need would be made, just as it is now. There would be no special "program" for anyone. Veterans who are judged to require intensive treatment and rehabilitation will receive it, as is done now. The differences from the status quo are (1) there would be no opportunity to apply for disability prior to treatment for PTSD, anxiety, or depression; (2) veterans referred to intensive care—their precise treatment regimen to be determined by clinicians on a case by case basis—would meet with a VA social worker to discuss the patients' need for financial support for themselves and their families while they are unable to work.

Ideally, of course, veterans who receive excellent treatment/rehab will no longer be mentally impaired or believe they are unfit for the workplace. But, doubtless, some veterans will remain partially disabled—and a much smaller number will be totally and permanently incapable of competitive employment. If after a year or so of quality treatment, the VBA deems such veterans disabled, he or she would receive a standard rating and corresponding benefits and a reassessment of disability status within 3 to 5 years.

At bottom: the VA should support veterans while they recover and ready themselves to enter the workforce. Meaningful disability assessments cannot be made by VBA unless the veteran first receives quality treatment/rehab first. (see C. W. Hoge editorial on Interventions for War-Related Posttraumatic Stress Disorder in Aug.3, 2011 *JAMA*)

Question 2: How do we change the stigma behind compensation suggesting that a veteran is beyond recovery?

Response: One answer is to help veterans get better so that they do not need to apply for disability compensation in the first place—see answer to question #1 above. Another is to set an expectation for recovery by re-assessing veterans who are receiving disability every 1 to 3 years (the frequency might depend upon the severity of rating.)

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[1] The same general principles could apply to veterans with bipolar illness and schizophrenia taking into account that (1) these conditions, while service-connected (that is, they were temporally associated with service in a war-zone but not *caused* by the stress of serving) and (2) the high likelihood of chronicity of schizophrenia.

Sadly, too many veterans are given the message that they are beyond recovery. Partly, this reflects the low expectations for improvement that many clinicians still harbor (i.e., based on a misimpression of what the diagnosis itself means). Failure to rejoin the workforce can also be attributed to the perverse incentives that accompany disability payments themselves. For example, even if a veteran wants very much to work, he understandably fears losing his financial safety net if he leaves the disability rolls to take a job that ends up proving too much for him. A practice of gradually decreasing benefits over a year or more as the veteran acclimates to the workforce is something to consider.

Accordingly, the VA should emphasize some kind of productivity even if it is not in the competitive workforce. One strategy is to deploy more compensated work therapy programs for disabled veterans through the VA (see http://www.cwt.va.gov/veterans.asp) and to allow the VA to use financial incentives to as a contingency management strategy to combat co-morbid substance abuse (see http://www.mirecc.va.gov/visn1/brief/brief__money.asp but substitute VA compensation for SSI compensation).

At bottom: The best way to alter impressions is to change the reality behind them. The foregoing are some suggestions to weaken the existing link between veterans' compensation and the all-too-common failure to recover or at least to assume productivity of some kind.

Question 3: How can VA do a better job at integrating occupational therapists into treatment teams?

Response: This is an important logistical question that is best addressed by someone who works daily at a VA and understands the organization of specialty care there. My fellow panelist, Karen Seal, MD, for example, would be in a good position to answer.

Thank you very much for your interest in my June 14, 2011 testimony.

Committee on Veterans' Affairs
Washington, DC.
June 23, 2011

Ralph Ibson
National Policy Director
Wounded Warrior Project
1120 G Street, NW, Suite 700
Washington, DC 20005

Dear Ralph:

In reference to our full Committee hearing entitled "Mental Health: Bridging the Gap between Care and Compensation for Veterans," that took place on June 14, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 5, 2011.

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Due to the delay in receiving mail, please provide your response to Debbie Smith by faxing your responses to Debbie at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

HVAC: Questions for the Record
Ranking Member Filner
June 14, 2011—Mental Health: Bridging the Gap between Care and Compensation
Ralph Ibson, Wounded Warrior Project

Question 1: Of the pieces not yet fully implemented in VA Mental Health Strategic Plan, what piece would be considered WWP's priority?

Answer: VA's Mental Health Strategic Plan recognizes the importance of early detection and early intervention of war-related mental health conditions, but it has only partially realized that critical goal. While VA has established a system for routine screening of OEF/OIF veterans for PTSD, it has no mechanism to assess veterans who do not seek VA care but may be at risk of PTSD. For those veterans who are deemed to need further evaluation and treatment for possible PTSD, VA has had only mixed success at sustaining those veterans in treatment and achieving positive outcomes. A system that sets its own performance goal at only 20 percent evidence based treatment completion, and then fails that standard by almost half, can hardly be considered successful in supporting veterans' treatment goals. As discussed in our testimony, there are many dimensions to that problem associated with gaps in VA mental health care. Of those, the Mental Health Strategic Plan discusses the importance of "community mental health"—outreach to OEF/OIF veterans in the community and coordination and partnership with mental health services that already exist in that space. This aspect of the strategic plan remains largely unrealized.

Question 2: Do you have any ideas about how VA can be more effective in providing reintegration services for veterans and their families?

Answer: Successful community reintegration is of the utmost importance to this generation of young veterans. Many return home eager to pursue civilian employment, begin their education, and resume family life, yet still need assistance in making a successful transition into the civilian world. VA offers an array of benefits and services that can be helpful in that process, but it lacks a holistic coordinated approach that could make a profound difference in a veteran and family's efforts to reintegrate. The Department should be moving toward the goal of "One VA" that provides "wraparound" services that seamlessly and effectively integrate Veterans Health Administration (VHA) services and Veterans Benefits Administration (VBA) benefits, as proposed by a panel of the National Academy of Public Administration.[1] As emphasized in our testimony, recognizing and meeting warriors' mental health needs is an important aspect of successful reintegration. But VA must work to close the formidable gaps cited in our testimony if it is to be more effective in reintegrating veterans with war-related mental health problems, and their families.

In that regard, we believe it is important for VA to harness the power of peer-networking to engage OEF/OIF veterans who may be at risk of war-related mental health issues. One important step would involve implementing section 301 of the Caregivers and Veterans Omnibus Health Act of 2010, which requires VA to conduct a peer-outreach program through VA medical centers as it pertains to OEF/OIF mental health. As demonstrated by the success of the Vet Centers' approach, peers can draw veterans into the system and connect them to resources, as well as keeping them engaged in services and their treatment when things are difficult.

VA must also work to improve access to effective mental health care. A system that can offer only one mental health appointment every 6 weeks for a veteran in severe psychological distress is not structured to meet the reintegration needs of this generation of warriors. While VA has increased mental health staffing over the past few years, there are still inadequate human resources in many communities to meet the demand for mental health services. Another concern is that VA facilities do not effectively accommodate the needs of a young, working population. Veterans must be able to access services at times and locations that allow them to continue with other activities of daily living—their jobs, schooling, and family responsibilities. Where VA facilities are unable to provide needed services like mental health treatment, they must partner with community entities to provide timely, needed services. In many instances, successful reintegration will require the collective efforts of the VA medical center, Vet Centers and local community partners—all playing a coordinated role. VA must take a more proactive role in fostering VA-community partnerships, given that there are relatively few communities that are effectively organized and have existing partnerships with VA to assist in this process of community reintegration.

Question 3: How great is the need for family access to VA mental health care?

Answer: WWP staff who work with warriors and families have used terms like "huge" to describe the need for mental health services for family members. Another estimated that "70 percent of the warriors that I have counseled have expressed the need for access to mental health care for their families." Recent work done by RAND confirms our staff's experience. RAND has documented, for example, that children

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[1] National Academy of Public Administration, *"After Yellow Ribbons: Providing Veteran-Centered Services,"* October 2008.

of deployed parents experience behavioral and emotional difficulties at rates above national averages, with anxiety being a specific problem.[2] These issues seldom dissipate upon the servicemember's return or after separation from service.

Question 4: Do you have any recommendations about what types of mental health services for families that VA might provide?

Answer: Given the experience of coping with multiple deployments, separation, fears of death or injury of a loved one, and subsequent readjustment challenges, it is not surprising to find that family members can experience a range of different mental health problems of varying severity. One would expect that needed interventions might range from individual or group counseling to more intense psychotherapy and/or psychopharmacotherapy to family-focused mental health services. In some instances, particularly where children might need mental health care, such services would best be furnished through fee-basis or other community-based arrangements.

Question 5: You indicate that VA compensation exams for PTSD are "brief" and "superficial." How can VA improve on these exams to ensure that veterans are properly rated for PTSD?

Answer: A recent WWP survey of wounded warriors found that some 20 percent of these exams are 30 minutes or less in duration. Prior testimony before this Committee regarding an Institute of Medicine study on PTSD compensation underscored the gravity of this concern:

> "Testimony presented to our Committee indicated that clinicians often feel pressured to severely constrain the time that they devote to conducting a PTSD Compensation and Pension ("C&P") examination—sometimes as little as 20 minutes—even though the protocol suggested in a best practice manual developed by the VA National Center for PTSD can take 3 hours or more to properly complete."[3]

VA can take many steps to improve this process. It can require as a matter of standard practice that the examiners be provided the hours of time needed to conduct a thorough examination consistent with the protocol suggested in the best-practice manual. It can require examiners to review the veteran's medical treatment records prior to an exam or obtain information from the veteran's treating psychologist or psychiatrist. It can institute a policy that recognizes that a veteran with a mental health condition often will have difficulty in discussing sensitive or difficult psychiatric or psychological issues with a stranger, that is, with a C&P examiner. As such, a C&P examination is often the least revealing and least reliable source on which to base VA decisions regarding service-connection for a mental health condition. VA policy should be revised to give greater weight to the findings of clinicians who have or are treating the veteran and are necessarily far more knowledgeable about his or her circumstances. To the extent that VA must still rely on C&P exams, measures should be instituted to achieve more thorough exams. For example, cases are sometimes remanded because of inadequate examinations. Such remands are costly to the veteran and to the VA; VA could certainly take steps to hold the examiner (or contractors) responsible and institute appropriate disciplinary measure or penalties.

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[2] James Hosek, "How Is Deployment to Iraq and Afghanistan Affecting U.S. Servicemembers and Their Families?," RAND (2011), accessed at http://www.rand.org/pubs/occasional_papers/OP316.html.

[3] Dean G. Kilpatrick, Ph.D., Committee on Veterans' Compensation for Posttraumatic Stress Disorder, Institute of Medicine, Testimony before House Veterans' Affairs Committee Hearing on "The U.S. Department of Veterans Affairs Schedule for Rating Disabilities," Feb. 6, 2008, accessed at: http://veterans.house.gov/hearings/Testimony.aspx?TID=638&Newsid=2075&Name=%20Dean%20G.%20Kilpatrick,%20Ph.D.

Committee on Veterans' Affairs
Washington, DC.
June 23, 2011

Christina Roof
National Acting Legislative Director
AMVETS
4647 Forbes Blvd.
Lanham, MD 20706–4380

Dear Christina:

In reference to our Full Committee hearing entitled "Mental Health: Bridging the Gap between Care and Compensation for Veterans," that took place on June 14, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 5, 2011.

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Due to the delay in receiving mail, please provide your response to Debbie Smith by faxing your responses to Debbie at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

Committee on Veterans' Affairs
U.S. House of Representatives
Post-Hearing Questions for Christina M. Roof
From the Honorable Bob Filner
Mental Health: Bridging the Gap between Care and Compensation for Veterans
June 14, 2011

Question 1: Do you have any ideas about how the VA can be more effective in providing re-integration services for veterans and their families?

Answer: AMVETS believes in order to provide a successful transition and re-integration for a servicemember/veteran VA must have a stronger presence in TAP classes and a greater presence on DoD installations. Transitioning servicemembers and eligible family members must be armed with the understanding of all of the post-service resources VA has to offer. By taking a more "pro-active" approach to re-integration, AMVETS believes many of the issues and/or problems many veterans and their families face can be avoided all together. DoD and VA must build upon their relationship if we are to truly offer a seamless transition to all of today's returning war fighters and their families.

Question 2: Do you have any recommendations about what types of mental health services for families that VA might provide?

Answer: In order to provide the highest quality of mental health care available to our veterans community we must start treating the entire veteran, including support for their families, instead of the reactionary approach of treating individual symptoms and illnesses as if they are exclusive of one another. VA has several programs aimed at providing mental health resources to the families of veterans, such as VetCenters counseling programs. However, AMVETS believes these programs are not often offered to family members and that the programs are too widespread to be utilized by the number of families that actually need them. It is going to be critical to the treatment and care of today's veterans to remember that mental health issues not only affect the veteran, but can also affect, and have devastating impacts if incorrectly treated, on the veteran's spouse, children and/or other immediate family members. Often we see a large disconnect between the families of veterans and veterans themselves. Often families are not aware of the possibility that the person that may have left for war, just may not be the same person that returns. This is not say that the person will never return to their pre-deployment self, but the odds are very slim. We need to provide support services to the families of veterans and

servicemembers to help better educate them on what to expect when their loved one returns and/or what to expect and how to cope with a loved one who may need mental health care when they return. VA and DoD both need to provide strong pre- and post-deployment mental health services to the entire family. The way a child will react to a parent suffering from a mental health disorder, compared to that of a spouse will be very different. VA and DoD mental health services need to be designed to address this fact. Recovery from either physical or mental wounds is a process the entire family will endure and until we start addressing this issue we will not be able to offer the best care and services available to all veterans seeking VA care.

Question 3: How great of a need is there amongst your members for family access to VA mental health care?

Answer: Given the fact that AMVETS membership is composed of veterans, active duty military personnel, as well as members of the National Guard and Reserve, there is a very large need for improved availability and care for mental health care among our membership's families.

Question 4: You indicate that the VA compensation exams for PTSD are "brief" and "superficial." How can VA improve upon these exams to ensure that veterans are properly rated for PTSD?

Answer: When discussing the claims process as it related to benefits and care for psychological wounds, AMVETS strongly recommends a focus on quality instead of quantity when processing claims. This is especially true for mental health claims, such as those for PTSD. AMVETS believes that the Rater Veteran Service Representative's (RVSR) must be better trained in mental health care issues. For example, a rater may need to address issues that the veteran is not even prepared to address in a therapeutic setting, let alone a claims review. This means the veteran will most likely internally shut themselves down and provide little to no assistance to the RVSR. This is not a good outcome for any party involved. What will occur is that the rater will deny the claim due to lack of information and the veteran will then be left with a negative opinion of VA and will most likely appeal their denial, thus putting the claim into the growing claims appeals system. If we were to better educate the veteran on what to expect and better train the raters on the same, we will start seeing better outcomes and claims processed correctly the first time.

Question 5: In what ways might the implementation of the Uniform Mental Health Services Handbook contribute to reducing the barrier that stigma plays in keeping veterans from seeking mental health and substance use services?

Answer: AMVETS cannot speculate on how the proper implementation of VHA Handbook 1160.01 would reduce the stigmas attached to mental health care, however AMVETS strongly believes that the handbooks full implementation, as required by law, full would help ensure uniform care and availability resources for veterans in the areas of:

- Suicide Prevention
- Specialized PTSD Services
- Gender-Specific Care and Military Sexual Trauma
- 24/7 Emergency Mental Health Care
- Seriously Mentally Ill and Rehabilitation/Recovery Services
- Inpatient Care
- Care Transitions (discharge from medical care with instructions)
- Substance Abuse Disorders
- Homeless Programs
- Incarcerated Veterans Programs
- Elder Care (integration of mental health into medical care)
- Access to Trained Mental Health Staff

As well as in several other key areas directly relating to mental health care and treatments.

Question 6: In terms of the initiatives set forth in the Mental Health Strategic Plan, which action item is of top priority for AMVETS?

Answer: AMVETS believes that every initiative, policy and procedure laid out by VHA 1160.01 are equally important in ensuring our veterans receive only the highest quality of care and availability of resources VA has to offer.

Question 7: What can VA do to provide better outreach to OEF/OIF veterans regarding the availability of PTSD treatment?

Answer: AMVETS believes VA must start taking a more proactive approach in ensuring our veterans are receiving all the necessary mental health care. Until we stop taking a "reactionary" approach to bettering the VA system of mental health we are destined to be playing "catch up" in meeting the needs of today's returning war fighters. Veterans and their families must be educated on all of the resources available to them. This should be done through more affective outreach campaigns on television, through social media and through education provided to veterans and their families by VA personnel.

Committee on Veterans' Affairs
Washington, DC.
June 23, 2011

The Honorable Eric K. Shinseki
The Secretary
U.S. Department of Veterans' Affairs
810 Vermont Ave., NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our full Committee hearing entitled "Mental Health: Bridging the Gap between Care and Compensation for Veterans," that took place on June 14, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on August 5, 2011.

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Sincerely,

BOB FILNER
Ranking Democratic Member

CW:ds

Committee on Veterans' Affairs
U.S. House of Representatives
Post-Hearing Questions for Antonette Zeiss, Ph.D.
From the Honorable Bob Filner
Mental Health: Bridging the Gap between Care and Compensation for Veterans
June 14, 2011

Question 1: Can any veteran who needs VA care for acute PTSD receive that care immediately? Can you give the Committee staff an update on the average waiting time for starting specialized therapy or counseling once it is requested?

Response: According to Veterans Health Administration (VHA) guidelines, all patients newly requesting or referred for mental health services must receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The rationale for initial evaluation within 24 hours of first contact with a Veteran is to identify urgent care needs and to initiate treatment in a timely manner. Over 95 percent of all Veterans referred for new mental health care receive an appointment leading to diagnosis, and when warranted a full treatment plan, within 14 days. Similarly, data confirm that over 95 percent of established mental health patients also receive appointments for continuing care within 14 days of the preferred date, based on the treatment plan. The average wait times for Veterans needing specialized outpatient PTSD care are 0 to 5.9 days from their desired date, depending on the clinic.

Question 2: In regards to Mr. Hanson's testimony, what are the follow-up procedures after a veteran is released from psychiatric treatment?

Response: VHA Mental Health services are provided in inpatient, residential rehabilitation treatment, and outpatient settings. During his testimony, Mr. Hanson

indicated that he received VHA inpatient psychiatric care, residential care, and outpatient follow-up. We are not sure what you are referencing in regard to "released from psychiatric treatment", but will assume that you are referring to discharge from acute inpatient care.

All VHA facilities are required to ensure that there is continuity of care during transitions from acute inpatient mental health care to outpatient or residential care. VHA has a monitor that requires that Veterans being discharged from an inpatient mental health program must be followed-up by an outpatient treatment program within 7 days of the date of discharge. This initial contact can be face-to-face, telephonic, or using telemental health services. If the contact is telephonic, a face-to-face appointment must take place within 14 days of the date of discharge from the inpatient program. Based on VHA data, in May 2011, 66 percent of Veterans discharged from inpatient psychiatric care received an outpatient mental health follow up within 7 days (the target for this measure is 75 percent of Veterans in FY13). While data indicate that in May 2011, 66 percent of Veterans received mental health follow-up within 7 days, this does not imply that the other 34 percent of Veterans have not received mental health follow-up. Many Veterans choose not to receive mental health follow-up care during the first 7 days after discharge despite medical recommendations. VHA providers continue to attempt to engage these Veterans in treatment after the initial 7-day period after discharge. Specifically, Veterans who are released from inpatient hospitalizations and are considered to be at high risk for suicide receive regular follow-up from the Suicide Prevention program. All Veterans who are discharged from inpatient psychiatry are given information about how to access emergency mental health treatment and provided with the VA Crisis line telephone number.

Question 3: Does the VA offer inpatient treatment programs spanning more than 90 days?

Response: VA offers a full continuum of mental health care and programs, including inpatient mental health services and residential rehabilitation treatment programs. Both inpatient mental health services and residential rehabilitation treatment programs serve Veterans whose length of stay is greater than 90 days. The decision regarding length of stay is based on clinical need. Inpatient services are provided for patients with acute mental health problems, such as suicidality; behavior due to mental illness that can put the Veteran or others in danger; severe symptoms of depression, post-traumatic stress disorder, bipolar disorder or psychosis; or other symptoms requiring close monitoring and stabilization. Given the focus on stabilization of acute symptoms, the average length of stay in an inpatient setting is 11.1 days, though patients may remain in the hospital for longer periods of time when clinically indicated. Once stabilized, patients are discharged to a lower level of care, depending on their clinical needs. As examples, patients may be discharged home or to transitional housing through the Homeless Program, with follow-up outpatient mental health care including possible participation in a Psychosocial Rehabilitation and Recovery Center (PRRC), or to a Mental Health Residential Rehabilitation and Treatment Program (MHRRTP).

MHRRTPs provide residential rehabilitative and clinical care to eligible Veterans who have a wide range of problems, illnesses, or rehabilitative care needs which can be mental health, substance use, homelessness, vocational, educational, or social; Veterans also may have comorbid medical problems. The programs provide a 24-hours-per-day, 7 days-per-week ($^{24}/_{7}$) structured and supportive residential environment as a part of the rehabilitative treatment regime. In addition to specialized treatment for mental health, substance use and co-morbid medical conditions, MHRRTPs provide a strong emphasis on psychosocial rehabilitation and recovery services that instill personal responsibility to achieve an optimal level of independence upon discharge to independent or supportive community living. In fiscal year (FY) 2010, the average length of stay in an MHRRTP was 62.8 days, although there is significant variation around that average.

In FY 2010 there were 62 Substance Abuse Residential Rehabilitation and Treatment Programs (SARRTP) and Domiciliary Substance Abuse (DOM–SA) programs in VA. These programs provide initial specialized Substance Use Disorder (SUD) services to Veterans in a residential setting. Average length of stay in the SARRTP and DOMSA programs was 36.4 days, with significant variation around that average. VHA policy does not provide a specific length of stay recommendation for SARRTP and DOM–SA programs. Rather, policy (VHA Handbook 1162.02) requires that length of stay should be individualized based on the needs of the Veteran, as outlined in the treatment plan, with evolving attention to the length of time required to meet the Veteran's identified treatment goals and objectives. While participating in the initial specialized SUD care in the SARRTP or DOM–SA program, the

Veteran's discharge planning is based on continued engagement in recovery services. Based on individual need, the Veteran may transition to additional levels of residential care, transitional, or permanent housing with continued engagement in community and VA outpatient treatment supports following discharge. Current VHA policy and treatment approaches are consistent with the available literature which demonstrates that a longer length of stay is not associated with better treatment outcomes.[1]

Question 4: Are there mechanisms to track when veterans miss appointments or just stopped calling all together and if so, what steps does the VA take to reengage these veterans?

Response: Local VA facilities are required to make at least three attempts to contact Veterans who miss mental health treatment appointments after any missed appointment. Contacts are typically made by telephone, and the goals of these contacts are to determine if the Veteran is in need of urgent care and to address any concerns the Veterans may have about their condition or the quality of care they have been receiving. The results of these attempts are documented in the Veteran's medical record.

In addition, the Office of Mental Health Services (OMHS) is implementing a program designed to locate and re-engage in treatment any Veterans with serious mental illness who have been lost to follow-up care. This program is based on a project conducted by the Office of the Medical Inspector (OMI), which found that re-engaging Veterans with serious mental illness in treatment could significantly decrease the mortality rate of this population of Veterans. Using lists provided by the Serious Mental Illness Treatment Resource and Evaluation Center, the Local Recovery Coordinators at each facility attempt to locate these Veterans, assess their need for health care services, and re-engage them in treatment. This program is currently being piloted at five VA medical centers and will be implemented nationally during the fourth quarter of FY 2011.

Question 5: What are the VA's views on Mr. Hanson's suggestions to withhold compensation until treatment is complete as an incentive for veterans to seek care?

Response: VHA and the Veterans Benefits Administration (VBA) are working very closely to facilitate appropriate treatment and disability compensation. Both parts of the organization have the goal of facilitating independence and the best possible health. For many Veterans, this is achieved through appropriate health care and treatment.

However, VA does not support this suggestion to link benefits and treatment for the following reasons. Congress has mandated in 38 U.S.C. §§ 1110 and 1131 that VA pay compensation to Veterans discharged or released under conditions other than dishonorable for disability resulting from personal injury or disease incurred or aggravated in line of duty. This requirement to pay compensation is mandatory and is not predicated upon any requirement that the Veteran undergo medical treatment as a condition of receiving compensation. The statutory and regulatory framework for rating disabilities is based on the premise that payments for service-connected disability are intended to compensate Veterans for "reductions in earning capacity" resulting from injury or disease.

VA's statutes and regulatory scheme are clear that compensation payments are intended to make up for loss of earnings incurred throughout the course of a disability, including those periods while the disability is at its most severe, prior to completion of any necessary treatment, and when it has stabilized. Withholding compensation from Veterans with the most severe disabilities until all treatment modalities are completed would cause great harm to these Veterans and their families at a time when compensation is most needed, when the reduction in earning capacity is at its highest level.

Question 6: Does VA have enough resources to admit veterans to treatment at the point of compensation evaluation?

Response: VA currently has sufficient resources to engage eligible Veterans who desire or need mental health treatment at the point of their compensation evaluation as evidenced by current VHA data. VHA data from May 2011, indicates that 95 percent of new mental health patients are seen for a mental health evaluation within 14 days following their first mental health encounter and that 96 percent of established mental health patients are seen for a follow-up mental health appoint-

[1] Harris, A. H. S., Kivlahan, D., Barnett, P. G., & Finney, J. W. (2011). *Longer Length of Stay is Not Associated with Better Outcomes in VHA's Substance Abuse Residential Treatment Programs,* Manuscript submitted for publication.

ment within 30 days (if a follow-up mental health appointment is required/desired). Thus Veterans have been able to access both initial and follow-up mental health care.

VHA and VBA are currently collaborating to determine the best processes to provide targeted mental health outreach to those Veterans who receive new service-connected status for a mental health disability and who are not currently accessing VHA mental health care. VA has the capacity to provide such services, so only the administrative actions to ensure information flow from VBA to VHA are needed to accomplish this goal.

Question 6(b): Does VA have the resources to conduct periodic re-evaluations at 2 to 5 year intervals to assess progress and continued applicability of disability status, as discussed by the American Enterprise Institute?

Response: VA regulations provide that, generally, a reexamination is required if it is likely that a disability has improved or if evidence indicates a material change in a disability or that the current rating may be incorrect. VA's current policy is to conduct routine reexaminations at 5 year intervals unless a different interval is required by regulation. According to 38 CFR § 3.327(b), VA rating boards may schedule, when necessary, reexaminations after 2 years but no later than 5 years, unless another time period is elsewhere specified. VA does not schedule reexaminations when, among other things, the disability is determined to be static, has persisted without improvement for over 5 years, or is permanent and not likely to improve or in Veterans over 55 years of age.

Question 7: What are the VA's views on providing treatment to a veteran before making a determination about their future functional capacity?

Response: The question has two relevant contexts. The first relates to how clinicians evaluate and plan for treatment of Veterans who are using VHA health care. The second relates to policies that VA has been encouraged to consider regarding requiring a course of treatment for a mental illness prior to being considered for compensation due to a mental illness. VA can respond to the first based on clinical experiences and policies, and that information follows (No. 1 below). The second issue depends in many ways on the first, but also involves additional policy issues as discussed below, in No. 2.

1. Clinician evaluation and planning for treatment of Veterans: Clinical determination of future functional capacity cannot be established without full assessment and engagement of the Veteran in treatment. When a Veteran is referred for or requests mental health treatment, immediate needs are first evaluated and addressed. Subsequently, the Veteran works with his or her treatment team to set goals designed to maximize recovery and help the Veteran meaningfully integrate into the community. Only after the Veteran has begun to achieve his or her treatment plan goals can a reliable assessment of future functional capacity be conducted. Any clinical determination of future functional capacity must take into account that individuals in the process of recovery from mental illness sometimes encounter setbacks that affect the course of their recovery. Throughout these processes, OMHS is committed to providing Veteran-centered, recovery-oriented mental health service, as codified in a variety of Directives and memoranda to the field (e.g., VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*).
2. Requiring a course of treatment for a mental illness prior to being considered for compensation: As noted above, it is never clear when first beginning to treat a Veteran what the response to treatment will be and over what time course that response will occur. Thus, requiring treatment before a claim can be submitted leaves the Veteran in an uncertain status for a potentially lengthy period. Such uncertainty is especially difficult for those with a mental illness to tolerate and this added stress may, in fact, reduce the likelihood that treatment will be successful.

As noted in our testimony, there are other concerns about establishing such a requirement. These are the relevant sections of the Testimony, prepared specifically to provide background information regarding the suggestion that treatment should precede claim submission (pages 5–7 of submitted Testimony). While these sections specifically focus on PTSD, the issues are very similar for other mental illnesses:

"Recovery from PTSD Is Complicated By Co-Occurring Disorders

Recovery from PTSD is usually complicated by co-occurring disorders, since most Veterans with PTSD have at least one additional diagnosis such as trau-

matic brain injury (TBI), depression, substance use disorder (SUD), chronic pain, problems with aggression, insomnia and other medical problems. Treating Veterans with multiple conditions cannot be restricted to PTSD but must address the other problems concurrently. For example, a Veteran with PTSD and chronic pain as a result of his or her injuries will experience the pain as a traumatic trigger that will reactivate other reactions such as PTSD nightmares, avoidant symptoms, and hyperarousal. The pain must be treated along with the PTSD if clinical improvement can be expected realistically. Unfortunately, although VA has excellent treatments for PTSD alone, the development of evidence-based treatments for concurrent PTSD and chronic pain is still at an early stage.

Even the Most Effective Treatments Do Not Guarantee Recovery

Not everyone with PTSD who receives evidence-based treatment is likely to have a favorable response. For example, a recent analysis (submitted for publication) of data from VA's large Cooperative Study (CSP#494) on prolonged exposure to the stress factors associated with and contributing to PTSD symptoms among female Veterans and active duty Servicewomen identified those factors that predict poor treatment outcome. This is the largest randomized clinical trial of Prolonged Exposure (PE) ever conducted, with 284 participants, and the first one focusing solely on Veterans and military personnel. While the results (overall) clearly showed the efficacy of PE treatment for women with a military history who have PTSD, our analysis shows that Veterans with the most severe PTSD are least likely to benefit from a standard course of treatment. Other factors that predicted poor response were unemployment, comorbid mood disorder, and lower education. In other words, those with the worst PTSD are least likely to achieve remission, as is true with any other medical problem.

Even when Veterans are able to begin and sustain participation in treatment, timing, parenting, social, and community functions all matter a great deal. Treatment, especially treatment of severe PTSD, may take a long time. During this period, disabled Veterans with PTSD are at risk for many severe problems including family problems, parenting, inability to hold a job, inability to stay in school, social and community function. Further, evidence also shows that whereas a positive response to treatment may reduce symptom severity and increase functional status among severely affected Veterans, the magnitude of improvement may not always be enough to achieve clinical remissions or terminate disability. This is no different than what is found with other severe and chronic medical disorders (such as diabetes or heart disease) where effective treatment may make a difference in quality of life without eradicating the disease itself."

In summary, VA does not support the concept that treatment should be required before a Veteran may submit a claim for compensation due to a mental illness incurred or aggravated as a consequence of military service. Placing such a restriction on Veterans is inconsistent with the mandate in 38 U.S.C. §§ 1110 and 1131. This requirement to pay compensation is mandatory and is not predicated upon any requirement that the Veteran undergo medical treatment as a condition of receiving compensation. In addition, the added stress of uncertainty and concern about every setback in treatment, and how that may prolong the course of improvement in treatment—thus prolonging the period before a claim can be submitted, may in fact render treatments that could be very effective much less successful. That would be the greatest tragedy for Veterans.

VA needs to consider changes in its current system of disability evaluation and determination of level of service-connected disability for those with a substantiated service-connected mental illness diagnosis. Those efforts are underway.

Question 8: Currently, are Rater Veteran Service Representatives (RVSRs) required to train regularly on changes to current laws and regulations?

Response: All Rating Veterans Service Representatives are required to undergo 85 hours of annual training. Technical training makes up 80 hours of the annual requirement and topics involve policy, regulations and procedures. The training topics are reviewed throughout the year to ensure that current lessons are available on all emerging issues as well as refresher training on established topics.

Question 9: Is there a shortage of trained staff to provide Intensive Outpatient Services for the treatment of substance use disorders?

Response: At the national and regional level, VHA has adequate numbers of trained staff to provide intensive outpatient services for substance use disorders (SUD). Specifically, all VISNs have licensed psychologists or social workers assigned

to provide specialty intensive outpatient treatment for SUD as well as physicians and/or advanced practice nurses to provide pharmacotherapies for SUD. All VISNs provide intensive SUD treatment to VA patients with SUD diagnoses who would benefit from such intensive services. All VISNs also provide pharmacotherapy for SUD, opioid agonist treatment and pharmacotherapy as a component of treatment for problem use of alcohol. We are confident that staff are trained to provide intensive outpatient services across all VISNs.

To further ensure competence to deliver a full range of services in Intensive Outpatient Programs (IOP) for Substance Use Disorder, during FY 2011, OMHS also conducted trainings for leaders of all active IOP programs to promote standardization of this level of care and implementation of evidence-based recommendations from the VA/DoD Clinical Practice Guideline on Management of Substance Use Disorders, including addiction focused pharmacotherapy and encouraging abstinence in early recovery through systematic use of motivational incentives. Ongoing follow-up consultation and monitoring is supporting implementation of this initiative to assure adequate training of staff in this level of care.

At the facility level, because of variation in the structure of mental health and substance use disorder treatment programming, determining whether an optimal level of trained staff are available is more complex. Intensive outpatient services are provided to patients with SUDs within a variety of staffing structures at VA facilities. Some facilities have a single set of staff that provide intensive services to residential and outpatient patients with SUDs; others structure their outpatient programs such that staffs provide both intensive treatment and less intensive after care to patients with SUD. Thus, it is impossible to break out "staff that provide intensive outpatient services" from other specialty SUD treatment providers, as the same staff member may provide different levels of service to various patients in their care. Moreover, at some facilities, prescribing staff, such as MDs and advance practice nurses, may be shared between specialty SUD programs and general mental health programs, which can be beneficial for integrating pharmacotherapy for the majority of patients with SUD who have co-occurring mental health conditions. Using as a guide staffing recommendations contained in a June 11, 2008 memorandum by the Deputy Under Secretary for Health Operations and Management when establishing 28 new IOPs, all 92 stand-alone specialty SUD outpatient programs offering intensive services have a sufficiently large total number of clinical staff. Nevertheless, 6 of these 92 programs have fewer clinical psychologists or social workers and 22 have fewer prescribers assigned directly to them than recommended in the new program staffing memo. We are following these programs to 1) ensure that they are not providing intensive SUD treatment at lower rates than other programs, and 2) to determine if they are using more integrated mental health programming structures to deliver effective care to patients with SUD.

Question 10: Is there a shortage of 23-hour observation beds for patients at risk for harming themselves or others?

Response: There is not a shortage of beds for the purpose stated in the question. Veterans who are a danger to themselves or others (as indicated in this question) should not be assigned to 23-hour observation beds; they require immediate admission to an acute inpatient psychiatry unit. Per the Mental Health Handbook, "Inpatient care must be available to all Veterans who require hospital admissions for a mental disorder, either in the VA medical center where they are treated, a nearby facility, or by contract, sharing agreement, or non-VA fee basis referral to a community facility." All sites in the VA system report meeting this standard.

There are appropriate uses for such 23-hour observation beds. All medical centers with emergency departments must have resources to allow extended observations for up to 23 hours when clinically indicated. This is often used for patients presenting in states of intoxication to allow effective determination of the required level of care for ongoing treatment. Per the survey results of June 2010, 79 percent of facilities with emergency rooms had implemented this requirement. VA is conducting a follow up survey to determine the current level of compliance with this requirement. However, this requirement is often met through an admission to the inpatient psychiatry unit when an observation bed is unavailable and admission is indicated, leading to an even greater availability of appropriate resources. The Mental Health Operations Office will monitor availability to ensure adequate resources are available.

Question 11: What sorts of substitution therapies are available for veterans with narcotic dependence?

Response: Methadone and buprenorphine are the only FDA approved agonist (i.e., "substitution") therapies for opioid addiction and there are no FDA approved

agonist therapies for other drugs classified by statute as narcotics (e.g., cocaine). Methadone can be used to treat addiction only in the setting of federally regulated Opioid Treatment Programs (OTP) that may also make buprenorphine available under the same regulations. Buprenorphine can also be used by specially qualified providers in regular office-based practice outside of OTPs, making opioid replacement therapy much more accessible.

- **Are these substitution therapies treatment offered at all VA medical facilities?**

Response: Opioid Agonist Treatment can be delivered in either or both of the following settings:

1. OTP. This setting of care involves a formally-approved and regulated opioid substitution clinic within which patients receive opioid agonist maintenance treatment using methadone or buprenorphine.
2. Office-based Buprenorphine Treatment. Buprenorphine can be prescribed as office-based treatment in non-specialty settings (e.g., primary care), but only by a "waivered" physician. Administration and prescription of buprenorphine are not subject to all of the regulations required in officially identified OTPs, but buprenorphine must be delivered in a manner consistent with treatment guidelines and Pharmacy Benefits Management criteria for use.

OTPs are established on-site at 32 medical centers, largely in urban settings where there is a "critical mass" of opioid dependent Veterans to warrant these complex programs. An additional 22 facilities arrange methadone treatment via contract or on a fee basis with a community provider. Buprenorphine is offered at 116 facilities as well as at a number of community-based outpatient clinics for a total of 239 distinct points of service. Nineteen facilities have yet to establish capacity for providing opioid agonist treatment on-site or in the community. Since the VHA Handbook on Uniform Mental Health Services requires that pharmacotherapy with approved, appropriately-regulated opioid agonists (e.g., buprenorphine or methadone) must be available to all patients diagnosed with opioid dependence for whom it is indicated and for whom it is not medically contraindicated, this is a continuing source of implementation effort through monitoring and consultation.

- **If a substitution therapy is needed but is not offered at a particular facility, is it possible for a veteran to get the needed services from another VA medical facility? If so, what is the process for doing so?**

Response: Opioid agonist treatment initiation involves frequent visits early in recovery and long-term maintenance visits; thus arranging time-limited care at remote facilities is not indicated clinically. However, some VA facilities lacking internal opioid agonist treatment capacity are located within reasonable driving distance from other VA facilities and referral to these nearby VA medical facilities is an option. In these cases, referral is typically made via clinical coordination between providers within the two VA facilities.

Question 12: Does VA have a system to reliably track your own provisions and utilization of mental health therapies and policies?

Response: VA has multiple processes to track provision and utilization of mental health therapies and policies. Some major components of this system include:

- To track compliance with the Uniform Mental Health Services in VA Medical Centers and Clinics, VISNs (to include all medical centers and associated CBOCs) are required to report on the presence/absence of required services twice a year. This requirement has recently been increased to require reporting four times per year.
- The Mental Health Program Evaluation Centers: Northeast Program Evaluation Center (NEPEC), Program Evaluation and Resource Center (PERC), and Serious Mental Illness Treatment Resource Evaluation Center (SMITREC) expand on this basic dataset by analyzing VA administrative data sets to both validate and quantify the self-report data.
- VA offices outside of mental health, such as Systems Redesign, and the Office of Quality and Performance (OQP), are responsible for collecting data on mental health processes such as screening requirements and compliance with timeliness standards.
- VA also participates actively in reviews of compliance conducted by the IG, GAO, and other oversight bodies. VA has monitored compliance with the Mental Health Residential Rehabilitation and Treatment Programs (MHRRTP) through both VISN self-report and through a contracted review of

all programs by Mathematica. Sites that have been found to have serious deficiencies are required to submit action plans and are subject to more intensive follow-up until the program comes into compliance. All MH programs are also monitored by the Joint Commission.

Question 13: One issue that is particularly important is care for veterans of the Guard and Reserve. An issue that they face is that they go back and forth between the DoD and VA health care systems sometime making 'seamless transition' a less-than-seamless process. This can be particularly concerning for veterans as the continuity of their care, particularly mental health care, may be compromised.

Response: VA partners with DoD through multiple programs to foster optimal transitions between their health care systems for Guard and Reserve component veterans, as well as other servicemembers. VA's Liaisons for Health Care are Masters Prepared Social Workers (MSWs) or Registered Nurses (RNs) who serve as essential resources for transitioning injured and ill OEF/OIF/OND veterans and servicemembers. VA now has 33 VA Liaisons for health care stationed at 18 military treatment facilities (MTF) to transition ill and injured Servicemembers from DoD to VA Medical Centers that have specialized services that their medical condition requires or that may be closer to that Servicemember's home. VA Liaisons for Health Care are co-located with DoD Case Managers at MTFs and provide onsite consultation and collaboration regarding VA resources and treatment options. They educate Servicemembers and their families about VA's system of care, coordinate the Servicemember's initial registration with VA, and secure outpatient appointments or inpatient transfer to a VA health care facility as appropriate. VA Liaisons for Health Care make early connections with Servicemembers and families to begin building a positive relationship with VA. VA Liaisons coordinated 7,150 referrals for health care and over 26,825 professional consultations in fiscal year (FY) 2010. In fiscal year 2011, VA Liaisons coordinated 4,686 transitions for health care through June 2011.

Continuity of care is also provided through the DoD *InTransition* program, which provides support and coaching as Servicemembers transition between health care systems or providers, including those who are transferring their care to the VA system. This program empowers Servicemembers to improve their psychological and overall wellness, promotes and encourages Servicemembers to consider healthy choices, and models positive coping and adapting strategies. *InTransition* Support Coaches answer questions about mental health treatment modalities and techniques and use motivational interviewing techniques to maintain the Servicemember's engagement in treatment and followup.

Question 14: From your experience, do you have any examples of how this 'back and forth' has been a problem for veterans and their families?

Response: The major potential concerns about the 'back and forth' between the DoD and VA health care systems for National Guard and Reservists who return from deployment are access to high quality care, continuity of care, and confidentiality. We are aware of anecdotal incidents where these issues have been of concern and are making every effort to address them, both as they occur individually as well as proactively addressing them on a national level.

National Guard and Reservists often return to their home community and do not remain at their post or installation where support and medical care may be more readily available. Many return to rural community settings where there may only be distant access to DoD health care resources or tertiary VA medical centers. Through the network of VHA's Community Based Outpatient Clinics (CBOCs) and Vet Centers, including mobile Vet Center capability, VA continues efforts to improve access to high quality mental health care for these Veterans and their family members who live and work in rural communities. In addition, VA continues to implement telehealth strategies to improve access to care for Veterans in rural settings.

Active Duty Servicemembers receive care from both DoD and VA sequentially, the usual pattern; or concurrently, for those who are seen at VA facilities while still on active duty; or—especially for Guard and Reserve—in an alternating pattern, with care from DoD while activated and from VA when between periods of activation. The VA/DoD Bi-directional Health Information Exchange was initiated in 2008 and is designed to ensure that providers from both systems have access to information related to current treatments, which aims to improve continuity of care for the Servicemember or Veteran.

This bidirectional record system supports continuity of care, but can raise concerns about confidentiality. A joint DoD/VA task group is currently examining policies for health information sharing between DoD and VA in order to provide continuity and coordination of care while allowing Veterans and Servicemembers some

measure of control over whether, how, and with whom their information will be shared. This is particularly relevant for National Guard and Reservists, for whom medical records serve not only the purpose of clinical care but also the purpose of determining fitness for duty.

Question 15: Is VA currently able to work with DoD in any way to maintain some continuity of care for Guard and Reserve members?

Response: There are several ways in which VA and DoD work together to maintain continuity of care for Guard and Reserve members. For example, a 2005 Memorandum of Agreement between the National Guard Bureau and VA helps provide assistance to National Guard and Reserve Members. In 2006, the National Guard placed 62 Transition Assistance Advisors (TAAs) in all 50 States, the District of Columbia, and the territories of Guam, Puerto Rico, and the Virgin Islands. VA staff provided in depth training for the initial TAAs and continues to provide updates via monthly conference calls. The TAAs serve as the statewide point of contact and coordinator to facilitate access to VA health care and benefits and to provide assistance in accessing the Military Health System (TRICARE). TAAs assist National Guard with access to care and enrollment at local VA health care facilities. While the program was set up primarily to take care of Guard members and their families, TAAs provide critical support and facilitate the delivery of VA and community services to all members of the active and reserve components.

The DoD *inTransition* mental health coaching and support program provides counselors who are trained to assist and support Servicemembers making transitions from one location to another within DoD, as well as those who are transitioning from the DoD health care system to VA. Through telephone assistance, the Servicemember and family members work with a personal coach who provides advice, information about mental health care, location of resources, and assistance in connecting with new providers. The *inTransition* program operates 24-hours-a-day, 7-days-a-week, 365 days-a-year.

The needs of the most severely injured Servicemembers and Veterans are also met through the Federal Recovery Coordination (FRC) Program. FRCs serve to ensure that severely injured Veterans and Servicemembers receive access to the benefits and care they need to recover. Since its creation in 2008, the FRC Program has helped Servicemembers and Veterans access Federal, State, and local programs, benefits and services, while supporting the families of these heroes through their recovery, rehabilitation, and reintegration into the community. Currently, 556 clients are enrolled and another 31 individuals are being evaluated for enrollment; an additional 497 have received assistance through FRC.

Each VA medical center has an Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Care Management team in place to coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits from the moment they begin receiving care in VA. Members of the OEF/OIF/OND Care Management team include a Program Manager, Clinical Case Managers, and a Transition Patient Advocate (TPA). The Program Manager, who is either a registered nurse or licensed social worker, has overall administrative and clinical responsibility for the team and ensure that all OEF/OIF/OND Servicemembers/Veterans are screened for case management. Those severely ill and/or injured are provided with a case manager and other OEF/OIF/OND Servicemembers and Veterans are assigned a case manager as indicated by a positive screening assessment or upon request. Clinical Case Managers, who are either registered nurses or licensed social workers, coordinate all patient care activities, using an integrated approach across all systems of care. The TPA helps the Veteran and family navigate VA's system by acting as a communicator, facilitator, and problem-solver.

OEF/OIF/OND Care Management team members actively support outreach events in the community, such as annual 'Welcome Home' events. OEF/OIF/OND team members also participate in the demobilization process, the Yellow Ribbon Reintegration Program events, Post-Deployment Health Reassessment events, and Individual Ready Reserve musters. Local VAMC OEF/OIF/OND staff regularly make presentations to community partners, Veterans Service Organizations, colleges, employment agencies, and others to collaborate in providing services and connecting with returning Servicemembers and Veterans.

Since many returning OEF/OIF/OND Veterans are connected to more than one specialty case manager, VA introduced a new concept of a "lead" case manager. The lead case manager now serves as a central communication point for the patient and his or her family. Case managers maintain regular contact with Veterans and their families to provide support and assistance to address any health care and psychosocial needs that may arise. The OEF/OIF/OND Care Management program now

serves almost 54,000 Servicemembers and Veterans, including 6,400 who are severely injured.

Question 16: The mission of the National Center for PTSD is to advance the clinical care and social welfare of America's Veterans through research, education, and training in the science, diagnosis, and treatment of PTSD and stress-related disorders. What are VA's future research priorities as they relate to the treatment of PTSD?

Response: A major goal of all National Center for PTSD (NCPTSD) research is to develop and test the most effective treatments for PTSD. In order to design the best treatments, it is essential to conduct a broad array of research that advances the scientific understanding of PTSD. NCPTSD investigators also seek to improve accuracy and efficiency in the assessment and diagnosis of PTSD through development of the best assessment instruments. Finally, ongoing collaborations with the military seek to understand basic mechanisms underlying resilience in order to develop effective preventive strategies. Here is a list of the National Center's research priorities in these areas.

- **Advancing knowledge concerning evidence-based treatments through multi-site and single-site trials of psychotherapy, pharmacotherapy and the combination.** Utilizing VA's Cooperative Studies Program, NCPTSD has carried out large-scale multisite clinical trials testing: Prolonged Exposure Therapy (PE), group therapy, and risperidone augmentation of first line (selective serotonin reuptake inhibitor, SSRI) pharmacotherapy. A recent multisite trial also tested delivery of PTSD treatment in primary care settings. Smaller, no less rigorous, single-site trials have tested cognitive processing therapy (CPT), telehealth delivery of evidence-based psychotherapy, complementary and alternative medicine (CAM) trials such as mindfulness and yoga, telephone-based care monitoring, and Internet-based treatment and self-management regimens for Veterans and military personnel. Since PTSD is often accompanied by at least one other co-occurring disorder, NCPTSD research has focused on clinical trials for various comorbid conditions: PTSD and substance use disorders (SUD), PTSD and traumatic brain injury (TBI), and PTSD and pain.
- **Advancing our scientific understanding of the causes and biobehavioral abnormalities associated with PTSD.** Such research has included structural and functional brain imaging to understand abnormalities in neurocircuitry associated with PTSD. Genetic research has focused on identification of genes that confer either vulnerability or resilience among Veterans with PTSD. Molecular research investigates PTSD-related alterations in neuronal function and how they promote hormonal and physiological abnormalities associated with the disorder. Psychological and behavioral research focuses on how veterans with PTSD change their appraisals of environmental stimuli and how such misperceptions affect behavior and functional capacity. Finally, research on cognitive deficits associated with PTSD is not only important in its own right, but also helps to understand how the combination of PTSD and TBI might affect intellectual performance and memory.
- **Developing reliable and valid assessment tools for assessing PTSD diagnosis, symptom severity and response to treatment as well as measurement of functional status**. Such tools are intended for use in clinical settings, research and for evidence-based compensation and disability assessment. NCPTSD has developed some of the major instruments currently used in PTSD diagnosis, treatment and research such as the Clinician Administered PTSD Scale (CAPS), generally acknowledged as the gold standard in the field), the PTSD Checklist (PCL used widely in VA and DoD clinical and research settings) and the Primary Care PTSD Scale (PC–PTSD) used in all VA (and many DoD) primary care settings. Currently, NCPTSD is involved in a multisite trial to see whether utilization of the CAPS for Compensation and Pension exams will improve the quality of such exams. Preliminary efforts are underway to modify current instruments in order to incorporate revisions in the PTSD diagnostic criteria that will go into effect in 2013 when the American Psychiatric Association releases a new revision of the Diagnostic and Statistical Manual of Mental Disorders (DSM–5).
- **The above research activities are currently being extended to understand how gender, ethnocultural differences, and advancing age might affect post-traumatic reactions as well as influencing the validity of assessment and the response to different treatments.**

- **In collaboration with military colleagues, ongoing research is leading to a better understanding of resilience at both the molecular and behavioral level**. For example, NCPTSD investigators have identified two molecules, produced by the brain (Neuropeptide Y) and adrenal cortex (dehydroepiandosterone, DHEA), respectively, which improve performance under stress and appear to be related to resilience.
- **Finally, NCPTSD research is exploring the relationship between PTSD and medical illnesses.** Although not directly related to PTSD treatment, per se, such research is directly relevant to growing evidence that PTSD is an important risk factor for medical illnesses. Conclusive findings, in this regard, would have a major impact on strategies to screen and treat Veterans with PTSD in the primary care setting where a holistic approach to treatment is often most beneficial.

Question 17: What progress has the VA made in implementing the Mental Health Strategic Plan (MHSP)?

- **VSOs note that all action items have not been implemented. What is the VA's response to these concerns?**
- **How does the VA know that MHSP was a success and helped to improve mental health care for our veterans?**

Response: The Mental Health Strategic Plan is no longer an active document. It was originally developed in FY 2004, approved in FY 2005, and implemented from FY 2005 to FY 2008. By the end of FY 2008, implementation on the Mental Health Strategic Plan was complete and lessons learned in that process were incorporated into the development of VHA Handbook 1160.01—Uniform Mental Health Services inn VA Medical Centers and Clinics, which was released in 2008 and defined minimum clinical requirements for VHA Mental Health Services throughout the VA health care system. VA has made steady progress in implementation of the Uniform Mental Health Services Handbook. Specifically, implementation rates of the Handbook have increased 5.8 percent between August 2009 and June 2010. The current rate of implementation of the VHA Uniform Mental Health Services Handbook across networks is 92 percent.

You indicate that VSOs have noted that not all action items in the Mental Health Strategic Plan have been implemented, but that is not the case—the plan was fully implemented. We assume you mean that VSOs note that not all components of the Uniform Mental Health Services Handbook have been implemented, which is correct. To address this issue, the OMHS and the Office of Mental Health Operations are providing technical assistance to assure that all networks achieve at least 95 percent implementation by second quarter, fiscal year 2012. Currently, two VISNS have > 95 percent implementation, 16 VISNS are between 89–95 percent implementation, and three VISNs are between 83–89 percent.

While VA is still in the process of working towards 95 percent implementation in 100 percent of VISNs, VA believes that the Uniform Mental Health Services Handbook has been an effective document, as the increasing rates of implementation have translated to additional mental health services being offered to Veterans and more Veterans accessing these services. Some specific examples that demonstrate the increase of access to services are:

1. The number of Veterans with a confirmed mental illness who utilized VHA health services increased by 17.1 percent between 2008 and 2010;
2. The proportion of Veterans with a confirmed mental illness who received mental health services in any specialty mental setting increased by 1.2 percent between 2008 and 2010;
3. The number of unique veterans treated in an outpatient mental health setting increased by 17.6 percent between 2008 and 2010; and
4. The number of mental health outpatient encounters increased by 25.7 percent between 2008 and 2010.

Question 18: There have been concerns raised here today and recently with the Subcommittee on Health concerning the ongoing cost of implementation of the Uniformed Services Handbook.

- **What roles do you anticipate VA's stakeholders (e.g. veterans themselves, Veterans Service Organization, and mental health professional associations) to play in the final implementation stages of the plan?**

Response: VA has been working with stakeholders as part of the implementation of the Uniform Services Handbook. The Handbook requires that each VISN and facility appoint mental health staff to liaise with various levels of governmental and non-profit service agencies, to establish and work with Veteran Consumer Councils,

Veteran Service Organizations, and other agencies who work with Veterans or provide care for mental illness. The purpose of this requirement is to ensure that each VA facility is an integral part of its surrounding communities in planning, developing, and providing service delivery for mental health. Since many Veterans do not seek care with VA, VA also works with groups outside of VA to serve either as referral sources or to provide education about Veterans' mental health needs, thus expanding the reach of VA. OMHS has implemented regular meetings with representatives from Veterans Service Organizations (VSOs); mental health agencies including the National Alliance on Mental Illness (NAMI), the Depression and Bipolar Support Alliance (DBSA), and Mental Heath American (MHA)-; and mental health professional agencies such as the American Psychiatric Association, the American Psychological Association, the American Association of Marriage and Family Therapists, the National Board for Certified Counselors and the National Association of Social Workers. The purpose of the meetings is to exchange information between OMHS and the stakeholder groups and to encourage continued positive relations with those groups.

In addition, Veteran Mental Health Councils (VMHC), also known as Consumer Councils, are strongly encouraged in the Handbook. The purpose of a council is to provide input regarding local mental health structures and operations and to share information with veterans, family members, and community representatives about local VA mental health programs and initiatives. Councils also promote the understanding and use of VA mental health services by all Veterans and their families. The councils are encouraged to be established and run by Veterans, and members may include Veterans, family members and community and VSO representatives. Although councils are independent of VA management, a VA staff liaison to the council facilitates communication with mental health and medical center leadership, VMHCs and the local VA work in partnership with each other to the benefit of both. Currently, there are 93 facility level VMHCs.

- **Can VA quantify the resource levels needed to fully implement the outstanding action items?**

Response: VA currently cannot quantify the exact resource requirements to fully implement the Uniform Mental Health Services Handbook, since resources are organized at the VISN level and there is no national roll-up. However, VA has estimated that, given the extensive mental health enhancements in staff already completed prior to adoption of the Handbook, that resources generally should already be available in the field for implementation. As part of the recent VA reorganization, the Office of Mental Health Operations was developed. This Office (in conjunction with OMHS) will be actively working with the VISNs on monitoring compliance and actively working to remove barriers and to facilitate implementation. The Mental Health Operations office oversees the MH Program Evaluation Centers, which are in the process of developing a comprehensive monitoring system to bring together in one place much of the previously reported information as well as to expand on the depth of the information to evaluate progress of implementation. Mental Health Operations will be developing interventions to assist in ensuring field compliance. In this process, information may be obtained about additional resources needed, but full implementation also will include needs for basic education about program development in transformational areas. We have started to work with the VISNs on getting better information about the barriers to implementation that can inform any needs for additional resources or redistribution of available resources.

- **Have equipment, space, and personnel office needs of the outstanding action items been recalculated in terms of budget? Have VISN and local authorities allocated those resources?**

Response: Equipment, space, and office needs were addressed extensively during the period of implementation of the Mental Health Strategic Plan, when staff were most rapidly being added to enhance mental health services. At this time, we expect that the issues are less about new resource needs of these kinds, and more about most effective utilization of available resources.

- **Will other sources of funding be required at the VISN, medical center and local levels to fully implement the plan? If so, how much will be required? Is the funding set-aside through the Mental Health Enhancement Initiative sufficient?**

Response: At present, we do not have enough information, as mentioned above, to specify what additional funding will be required, though we do not expect that to be the major obstacle. If funding is needed, there are no longer Mental Health Enhancement Initiative set aside funds, except for some designated to sustain na-

tional training programs and other national level efforts. Since FY 2010, funding from the VA mental health budget is sent directly to VISNs/facilities proportionately as a component of the Veterans Equitable Resource Allocation (VERA) process, without specific designation for mental health funds, and these funds are not currently tracked separately. Current monitoring efforts, as noted in several places, track functional measures, not dollars per se: resource availability, such as staff; service delivery to Veterans; and increasingly, tracking of outcomes for those receiving mental health services

Question 19: How many VA mental health providers have been trained to provide evidence-based PTSD treatments? What is the average timeline for completing staff training nationally, and what are its elements?

Response: As part of its effort to nationally disseminate and implement evidence-based psychotherapies (EBPs) for PTSD, VA has developed and actively implemented national programs to train VA staff in the delivery of Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) for PTSD. CPT and PE are recommended in the VA/Department of Defense (DoD) Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." Moreover, in 2007, the Institute of Medicine (IOM) conducted a review of the literature on pharmacological and psychological treatments for PTSD and concluded in its report, *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence,* that there was sufficient evidence to support the efficacy of these therapies. As of July 1, 2011, VA has provided training to over 3,500 VA staff in the delivery of CPT or PE, and many of these staff have been trained in both therapies.

VA's CPT and PE training programs are competency-based training programs that involve intensive, highly experiential learning. The training model for these initiatives involves two key components designed to build skill mastery and promote successful implementation and sustainability: (1) participation in an in-person, experientially-based, workshop, followed by (2) ongoing telephone-based clinical consultation on actual therapy cases with a training program consultant who is an expert in the psychotherapy, lasting approximately 6 months. The average timeline for completion of the overall training is 7–9 months.

The CPT and PE training workshops provide didactic and experiential training on the theoretical basis of PTSD, the specific therapy, assessment of PTSD and trauma-related symptoms prior to and during treatment, implementation of therapy components and processes (e.g., imaginal and in-vivo exposure for PE, cognitive restructuring for CPT), session structure, and logistical and practical implementation issues. The consultation phase that follows the training workshop provides in-depth training and experience on the application of the therapy with actual therapy cases with an expert in the treatment who serves as a training consultant. The consultation further provides an opportunity for training participants to receive extensive feedback on their implementation of the therapy. The consultation has been shown to be a critical component to this competency-based training. Initial program evaluation results indicate that the CPT and PE training and implementation of the therapies has resulted in significant positive outcomes for both therapists and patients (Karlin et al., 2010).