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HEARING ON MENTAL HEALTH CARE AND SUICIDE PREVENTION FOR VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

ONE HUNDRED ELEVENTH CONGRESS

SECOND SESSION

MARCH 3, 2010

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HEARING ON MENTAL HEALTH CARE AND SUICIDE PREVENTION FOR VETERANS

WEDNESDAY, MARCH 3, 2010

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

The Committee met, pursuant to notice, at 9:32 a.m., in room 418, Russell Senate Office Building, Hon. Daniel K. Akaka, Chairman of the Committee, presiding.

Present: Senators Akaka, Murray, Brown, Begich, Burris, Burr, Isakson, and Johanns.

OPENING STATEMENT OF HON. DANIEL K. AKAKA, CHAIRMAN, U.S. SENATOR FROM HAWAII

Chairman AKAKA. The Senate Committee on Veterans' Affairs will come to order.

I want to say aloha and welcome to our panelists as well as other who are here and, of course, our Members and staff who have been working hard to prepare for this hearing. Today, we will address mental health issues confronting veterans with a particular emphasis on the risk of suicide.

These are grave and troubling matters that I fear are becoming more prevalent as we send servicemembers into combat zones on repeated occasions. When we send men and women in uniform into battle, we seek to provide them with equipment to protect them from physical dangers. Too often, however, we do not provide sufficient protection and preparation for the equally serious mental dangers they will face.

Mental illness is prevalent among today's veterans, which include PTSD, depression, and substance use disorders. Unfortunately, many of those suffering from such disorders do not seek proper help. The rising rate of suicide among these men and women is especially heartbreaking.

The best information available suggests that about 18 veterans kill themselves every day. In December 2009, the Army reported 17 suicides of active duty members. In January, the Army reported 27 confirmed or suspected suicides. These are very troubling and sobering numbers.

I mention these statistics to open a broader discourse on mental health care issues affecting veterans and the need for focused and increased attention to effectively address these matters. As a Nation at war, it is our responsibility to fully explore ways to help those suffering from mental health disorders and to develop preventive measures to safeguard against the risks of suicide.

We have made a promise to care for the invisible wounds of veterans and we must be vigilant ensuring we keep that promise. This obligation is not limited just to the time after a veteran separates from service. We must ensure we prepare deploying servicemembers for what they might experience and make sure that resource are available during deployment to help them cope with it.

We must ensure that returning servicemembers are screened carefully, that those who need assistance are provided appropriate mental health care, and that all those leaving the military have a seamless transition to VA. It is also vitally important that family members be involved throughout these same stages.

As a Senior Member of the Armed Services Committee and as Chairman of this Committee, I know that VA is a leader in providing mental health care and suicide prevention services. It is my strong hope that VA and DOD will work together to provide the best care to those in need.

I continue to believe that it is very difficult to provide effective mental health care to someone still in active service. For that reason, I encourage VA and DOD to increase cooperation so that resources are used to their fullest potential and no veterans or servicemembers are overlooked or ignored.

We had a productive hearing on mental health issues in April 2007. That hearing contributed to the passage of mental health care legislation dedicated to Justin Bailey, a veteran who overdosed while receiving treatment from VA for PTSD and substance use disorder. I hope to learn about how VA is implementing the provisions of the Bailey bill.

VA has made great strides in improving the care and services available to veterans, but there is always more that can be done. I hope that our witnesses today can help us have a constructive discussion on what VA is currently doing, what VA can do better, and what VA needs to start doing. I look forward to hearing more about what the latest research is telling us and how we can implement these findings to keep VA on the cutting edge of mental health care delivery. While it is never possible to prevent all suicides in all cases, that must not stop us from trying.

I thank the witnesses for being here this morning and look forward to hearing your testimony.

May I now call on Senator Isakson for his statement.

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

Senator ISAKSON. Aloha, Mr. Chairman.

Chairman AKAKA. Aloha.

Senator ISAKSON. Thank you very much for calling this hearing today. I was there 2 years ago at our first hearing, because we had a rapid spike in suicides in the First Blended Air Force Wing stationed at Warner Robins, GA, where I will be this coming Saturday. It was an alarming statistic. It was an alarming occasion, and I took an interest in mental health in all of our military personnel.

I think it should be noted that following that hearing in 2007, the implementation of the Warrior Transition Centers was expedited. I have toured the one at Fort Stewart, GA, which is the DOD's attempt to have these transition centers ready for

diagnosiswhen our soldiers are coming back, both for wounds that you can see as well as those that you cannot see. I think we are making progress, but there is a long way for us to go.

I also want to thank the Chairman for referencing the seamless transition from DOD to Veterans health care. That is a significant area where we need improvement. The Uptown VA in Augusta and the Eisenhower Medical Center at Fort Gordon have developed a great seamless transition where the veterans don't end up falling in this black hole when they leave active duty and go into veteran status. I think it is an example of what can be done in our medical centers to see to it that our veterans have that continuum of contact with mental health and with physicians to help us reduce this problem of a high rate of suicide.

So, your hearing 2 years ago has paid a dividend in a higher level of attention, and from what I have been able to see in my State, both at Fort Gordon as well as Fort Stewart, the military is addressing it quickly and decisively. Hopefully, with our continued pressure, we can get help to those that need it and we can get diagnosis of those that have not been diagnosed so they can get help before it is too late.

So I want to thank the Chairman for his calling of this hearing today, but in particular note the success that has taken place since the 2007 hearing. Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Isakson.

Senator Johanns, your statement, please.

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

Senator JOHANNS. Mr. Chairman, let me just say thank you for holding this hearing today on what all of us regard as an enormously important topic.

I certainly know that mental health and suicide are challenges that servicemembers and veterans are struggling with very intensely. If my numbers are correct here, last year, the active Army alone reported 160 actual and suspected suicides for 2009, and it is my understanding that that is the worst year on record. It is enormously troubling. I know that the DOD and the VA are making an effort to stem this tide, but we all hope that more can be done and sooner.

There are a couple of pieces of legislation that I just want to mention that I was proud to be a part of, which I hope will help. The first, with Senators Baucus and Tester, increased PTSD screening before and after deployments. The other, with Senator Shaheen, expanded Yellow Ribbon suicide prevention efforts for Guard and Reserve servicemembers.

We do have a responsibility to care for our servicemembers not only while they are in the military, but also when they leave. That responsibility begins with oversight and making the efforts that I hope will bear some fruit.

Now, I want to acknowledge that I am very aware that the VA is working on a solution, as Dr. Cross notes in his testimony. VA is allocating more financial and staff resources toward mental health in fiscal year 2011. That is a good step. Solving the problem probably, though, needs more than just additional brute force, if

you will. Some of the nongovernmental people and organizations here today are doing groundbreaking work in helping loved ones support veterans with mental health disorders.

On Friday, I was here for a hearing on the budget. I was very impressed by Secretary Shinseki's promotion of innovative pilot projects to reduce the disability claims backlog. My hope is that that kind of spirit of outside-the-box thinking will be applied to dealing with mental health disorders.

So I look forward to the testimony today. I applaud the efforts, but I think we all have to acknowledge it is just such a heartbreaking problem. My hope is that we will continue to find ways forward to deal with this very important issue.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Johanns.

Senator Brown?

STATEMENT OF HON. SHERROD BROWN, U.S. SENATOR FROM OHIO

Senator BROWN. Aloha, Mr. Chairman——

Chairman AKAKA. Aloha.

Senator BROWN [continuing]. And thank you for holding this important hearing. I appreciate your leadership. And I want to thank even more than normal the witnesses for coming in. These are hard issues to discuss and thank you for joining us and applaud your willingness to talk about this.

I am reminded that we have such a stigma attached to suicide. The President historically—Presidents of both parties, have typically not sent letters as they do when servicemen and women are killed. They have not sent letters out to families when someone commits suicide and that is a, if not a policy, a practice that clearly needs to change.

Several veterans every day kill themselves. We know that. The rate of young veterans committing suicide continues to rise at alarming rates. We know that when young veterans return, when young soldiers, marines, sailors, airmen and women return from Iraq or Afghanistan or from the service and go back to Coshocton, St. Clairesville, Finley, or Dayton, OH, that so often the veterans service organization doesn't even know that young returning soldier or airwoman is even in town and then is less likely to get the counseling, the testing, the screening for PTSD, the support groups from peers and all that so often can save that young man or woman from continuing persistent and worse behavior later in their lives. That is why it is so important that we are here.

The VA's residential PTSD program at Cincinnati Medical Center is an example of the extraordinary work VA is doing, not only treating PTSD, but helping veterans suffering from all kinds of mental illness and how important that is. My office is inundated with casework-related PTSD claims by Vietnam-era veterans. The question becomes, what can we do to help older veterans? What can we do to help younger veterans just returning?

The Cincinnati VA is leading the Nation in providing vital and cutting-edge services in mental health, yet we have so much more to do.

I am also concerned, Mr. Chairman, with veterans and military personnel self-medicating with drugs or alcohol. I hear from so many veterans' advocates who tell stories of veterans seeking help, but since they were discharged from the military on drug or alcohol abuse or some other manifestation of mental illness, rather than for the service-connected mental illness, they are essentially shut out of care from the VA. That is inhumane. It is bad public policy. It is morally wrong.

I have introduced legislation and offered amendments to previous Defense Authorization bills to put important safeguards in place so that servicemembers can understand the ramifications of accepting a discharge that could prohibit them from receiving VA benefits later on.

And last, I want to commend Secretary Shinseki, who was at the Vet Center, the Chillicothe Medical Center, 2 weeks ago. They are a national leader in treatment and care for homeless veterans. I want to commend him and the VA for their bold homelessness initiative. We have much to do.

I want to thank those, again, who are testifying today.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator.

Now, we will receive the opening statement of our Ranking Member, Senator Burr.

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

Senator BURR. Aloha, Mr. Chairman. My apologies for my tardiness. I am going to ask unanimous consent that my opening statement be a part of the record, and I would like to specifically welcome Mr. Hanson and Mr. Jordan. I thank both of you for your willingness to share your experiences with us, many of which I know are painful to recount. This country owes both of you a debt of gratitude for your service and your continued service.

Mr. Chairman, 3 years ago, this Committee held a hearing to examine VA's efforts to address the mental health needs of our veterans. At that hearing, we heard from family members of veterans and servicemembers who had taken their own lives following combat service. Only days after that hearing, a National Guard unit headquartered in Boone, NC, returned home from Iraq. Within 18 months of their return, four of the unit's 175 soldiers had taken their own lives. This problem is real.

With that said, Mr. Chairman, VA cannot be expected to do this alone. The Department of Defense has a critical role to play, but so do community organizations, veterans groups, nonprofits, churches, and others. This has to be an effort where we use every available source to help us end this quest. And I thank the Chair.

[The prepared statement of Senator Burr follows:]

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

Good morning, Mr. Chairman, and a warm welcome to our panelists today, particularly you, Mr. Hanson and Mr. Jordan.

We are truly grateful for your willingness to share your experiences with us, many of which are no doubt painful for you to recount. This country owes you both a debt of gratitude for your sacrifice and continued service to the Nation.

Three years ago, the Committee held a hearing to examine VA's efforts to address the mental health needs of veterans. At that hearing, we heard from family members of veterans and servicemembers who had taken their own lives following combat service. They told us of a mental health care system that was too reactive, often only making services available when it was too late to be effective.

Only days after that hearing, a National Guard unit headquartered in Boone, North Carolina, returned home from Iraq. Within 18 months of their return, four of the unit's 175 soldiers had taken their own lives.

I hope to hear today that we have, in fact, put more emphasis on outreach, early intervention, and prevention. Legislation was enacted out of this Committee giving VA the authority it needs to do this; I'm anxious to hear about the progress being made, although the statistics we do have remain sobering.

According to Congressional Quarterly, more American servicemembers took their own lives in 2009 than were killed in the wars in Afghanistan and Iraq combined. With that said, VA can't be expected to do it alone. The Department of Defense has a critical role to play, but so do community organizations, veterans' groups, nonprofits, churches and others.

The reasons which lead a young man or woman to contemplate ending their life are complex. So, too, are the solutions to prevent that from happening. We must continue to reach out on a general level to provide help for veterans with PTSD, depression, anxiety disorder, and other mental illness.

The goal is to be sure that those with mental illness can return to live, work, learn, and participate fully in their communities.

That means we must identify unmet needs and barriers to services. We must identify innovative treatments and services that are demonstrably effective. We must improve coordination among case managers and providers.

These are tough goals, and they require that we ask tough questions. Questions such as whether our servicemembers are prepared to manage the stresses of combat before they set foot on the battlefield, and whether we are setting appropriate benchmarks to evaluate the effectiveness of prescribed treatment.

As I said, these remain difficult questions. But the price of not addressing them is too high.

Thank you, Mr. Chairman, and thank you to all of our witnesses.

Chairman AKAKA. Thank you very much, Senator Burr. Your full opening statement will be included in the record, without objection.

The Senator from Alaska, Senator Begich.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Thank you very much, Mr. Chairman. I will be very brief. I have a meeting in Commerce at 10:15 for a budget presentation, but I am going to first say I appreciate you all being here. I am anxious for your comments.

I have a series of questions which I am going to submit for the record to have you respond to of which some are very parochial. Alaska is a very rural State and how we deliver services and so forth; some commentary from that perspective and your thoughts in that arena; how do we use telemedicine; how do we use other avenues?

But again, for this panel as well as the second panel who might be in the audience, I have a series of questions, Mr. Chairman, that I will just submit to the Committee, if that is OK, for response. I apologize for having to leave early, but I do want to hear the first panel's commentary. Thank you.

Chairman AKAKA. Thank you very much, Senator Begich.

I want to welcome the witnesses on our first panel, all of whom bring a different perspective to this issue which will help to broaden our dialog of mental health care and suicide prevention for veterans. We have Daniel J. Hanson, an Operation Iraqi Freedom veteran; David Rudd, Dr. David Rudd, Dean of the College of Social

and Behavioral Science at the University of Utah; and last, Clarence Jordan, a member of the National Board of Directors of the National Alliance on Mental Illness.

I thank you all for being here this morning. Your testimony will appear in the record.

Mr. Hanson, will you please begin with your testimony.

STATEMENT OF DANIEL J. HANSON, VETERAN, OPERATION IRAQI FREEDOM

Mr. HANSON. Good morning. My name is Daniel Hanson and I am 27 years old. I joined the U.S. Marine Corps in 2003. Shortly after, I was assigned to Second Battalion, Fourth Marines, and we were deployed to Ar-Ramadi, Iraq. It was a deployment that started out with one of our Marines committing suicide. Shortly after, the funerals seemed to become a regular thing. It was pretty difficult to know that you had just talked to someone the day before and now you are saluting a pair of empty boots and an upside down M–16 and a set of dog tags. We lost 35 total.

After we got back from the deployment, we had a few classes and then we went on leave and that was that. Shortly after, 6 months later, we deployed to Okinawa, Japan. After Okinawa, I got out of the Marine Corps, and just before getting out, I had a good friend, also a Marine, who went to the VA to get services, but they were booked at the time and he ended up hanging himself the next day, and that was hard for me. I was trying to get things back—my life was getting a little out of control—so I was trying to get things back in order.

Shortly after, I lost another friend. He was killed in combat, buried at Arlington Cemetery here, and it kind of got me sliding again, as well. On March 23, 2007, my best friend and my brother was—he hung himself—he was also a Marine—in the basement of his home. After that day, I pretty much lost it. I was drinking every day, doing drugs, anything I could do to get away from the pain.

I worked with the VA medical center. They were helpful. I did therapy and things like that. Eventually, I started getting DUIs and I went to the Dual Diagnosis Program at the St. Paul VA medical center. I did 30 days of treatment. I got out, and though it was informative, it wasn't something very applicable to my life. I kind of felt like just a number going through a revolving door. I have had doctors kind of deal, just do their things.

About a month after I got out of the program, I attempted suicide. I woke up at the St. Cloud VA medical center on a 72-hour lock-up. After that, I was released back to work. I think I got a phone call or two to make sure I was all right, to make sure that I had my life together. I was pretty much a monster. I was drinking all the time. I was lying all the time. I thought about dying every day. I got a divorce. I also just left my kids aside. I didn't want to live every day. I thought, I have got to kill myself before my kids know what a loser their dad is. I didn't know what to do.

Eventually, after my last DUI, I just gave up and I knew I was either going to kill myself or I was going to do something for myself, for my kids. So, finally I had enough—I don't know what it was. I just gave up and I went to a program called Minnesota Teen Challenge. It is a 13- to 15-month faith-based rehabilitation pro-

gram. I graduated a week ago, actually. For once in my life, I have a purpose. I don't wake up every day wanting to kill myself.

I know if I did a 3-month program, a 6-month program, a 9-month program, I would still be in the same boat I was. But 13 to 15 months is what I needed to be able to get through, not just scratch the surface, but get down to the deep, the root issues that I was dealing with. And I know that going on an outpatient or going on a 30-, 60-, 90-day inpatient program wasn't going to do it. I needed much more, and I would be dead or in prison right now if I hadn't gone to Minnesota Teen Challenge. I mean, the problems I picked up over the years weren't going to go away in just a matter of months.

I know a lot of veterans still that need it. They are kind of going through the outpatient program. I have friends that still just don't know what to do. Their everyday, once-a-week counseling isn't doing anything for them. They are going out drinking 10 minutes after they leave.

For me, if I could suggest anything, it would be that there is more long-term care. I know in Minnesota the only thing that they really offer is the Dual Diagnosis Program, and I believe there is one at the Minneapolis VA, but it is outpatient only and I believe it is 5 or 6 weeks. For someone like me who hated myself, hated everything, wanted to die every day, I just needed way more. I was sick and nothing else was going to do it except for getting away from that environment for a long, long period of time.

And the second, I would say there was really no accountability. I mean, it wasn't too long after I attempted a suicide and I was doing a once-a-week thing at the VA medical center where it was, you know, like everything was all right, but it wasn't all right. Sure, it was my part, too. I didn't want to—I was embarrassed. I thought, what kind of loser would kill himself? There is no reason for it. But there was never a feeling that someone really cared for me, really cared what happened to me when I left out that door. Maybe that hour we were together, but after that, it was done. There was no connection. There was no feeling that I needed—that they cared about me, that there was something, that if I died that day, that someone would care. And that is part of the reason why I was angry for so long.

And then, also, I would suggest that—I think the VA has great programs, but programs like Minnesota Teen Challenge that can offer a 13- to 15-month stay and have been doing it for a long time would be great organizations to have relationships with, not just keep it internal in the VA, but be able to branch out to some of the nonprofit organizations, branch out to some of the non-government places to help these veterans so nobody is left behind and so that nobody commits suicide, because I have seen too many great men take their own life and I just would do anything to prevent it—anything. Anything.

And that is all I have. Thank you very much for letting me share.

[The prepared statement of Mr. Hanson follows:]

PREPARED STATEMENT OF DANIEL J. HANSON, OPERATION IRAQ FREEDOM 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 was 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 SgtMaj 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 lead to a lot of destruction. In August 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 be 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 follow up 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 am 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 follow up 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 MnTC. 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.

In my working with the VA the three biggest things that I noticed was through my experiences at the VA Medical Center. 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 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 of invisible wounds and there is no reason for it. Being able to get outside programs funded, keeping accountability of veterans and opening up to long term rehabilitation programs will save lives. I appreciate your time and the opportunity to share my testimony.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO DANIEL J. HANSON, OPERATION IRAQI FREEDOM VETERAN

First, I want to thank you for your compelling testimony. Sharing your difficulties has to be hard, but it is brave of you to speak out about what you think needs to change to help other veterans. I understand your points about the need for a longer program—over 90 days—and the importance of follow up.

Question. What do you think about a mandatory training course or mental health program for all veterans as a way to eliminate the stigma? Do you think this would be helpful? How long should such course be?

Response. I think that is a great idea and the more training the better, but I just feel it is of the utmost importance to have the right people in charge of a program like that. I also think that it would be a great idea for some of the non VA programs to get training for how to handle veterans with problems. A program that would really be able to help, in my opinion, would be a lot more beneficial if it was at least a few months long.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO DANIEL HANSON, OPERATION IRAQI FREEDOM VETERAN

Question 1. Long term care, was it available for you?

Response. None. The longest care that I was offered was the Dual Diagnosis Program and that is 90 days at the most. I went through the program in 30 days and was no better than the day I started. There is not even an inpatient program offered in Minneapolis.

Question 2. What type of follow-up aftercare by the VA was available for you?

Response. I did weekly 1 hour therapy sessions and the occasional group therapy through the VA, but it was very hands off.

Question 3. Did the VA give you a choice of outside treatment facilities and Faith-Based programs?

Response. No. I had to pay for Minnesota Teen Challenge out of my own pocket and was told the VA would not pay for the program. That made things much more difficult for me and for trying to support my children.

Question 4. What type outreach and follow-up did you receive from the VA?

Response. Weekly counseling sessions. The occasional phone call was all I received even after I attempted suicide.

Chairman AKAKA. Thank you very much, Mr. Hanson.

Dr. David Rudd?

STATEMENT OF M. DAVID RUDD, Ph.D., ABPP, DEAN, COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCE, UNIVERSITY OF UTAH

Mr. RUDD. Mr. Chairman, Mr. Ranking Member, and Members of the Committee, as a veteran and a psychologist, I appreciate the opportunity to appear today and discuss the Department of Veterans Affairs efforts to address the mental health needs of America's veterans. I would like to thank Mr. Hanson for his testimony. It is the kind of strength and courage that he demonstrates that is exactly what we need: for people to step forward, talk about their experiences, and offer unique insight and input into the process.

There is no disagreement that the mental health demands on the VA will continue to grow over the course of the next decade. Given the duration of Operation Enduring Freedom and Operation Iraqi Freedom, current mental health demands are unprecedented. In addition to grappling with anticipated problems like depression, Post Traumatic Stress Disorder, and substance abuse, the VA is struggling to address the tragic loss of veterans to suicide. I have absolutely no hesitation to endorse the recent efforts of the VA, but will certainly encourage the VA to explore non-traditional approaches and public-private partnerships in an effort to undermine the devastating impact of stigma, an issue that oftentimes gets very little discussion and debate.

As you will hear from other witnesses, the VA has implemented a range of programs and initiatives all geared toward meeting the growing mental health demands of today's veterans. With respect to suicide, the VA has launched an intensive suicide prevention program, one that includes an innovative Suicide Prevention Hotline, an Internet chat line—and let me say, these two programs are cutting edge. They are unlike any that have ever been implemented and they are having great success, and I would certainly applaud those efforts.

As you know, there are 18 deaths per day due to suicide among American veterans with approximately five per day among those in active treatment. The numbers are nothing short of heartbreaking. These numbers reveal several challenges, including the simple reality that the majority of veterans are not accessing much-needed care during moments of crisis. I think that is the critical point—that we are not reaching the veterans that are at highest risk, and that is the primary concern that I personally have.

Data is emerging to suggest that recent changes in the VA delivery system are proving more effective with OEF and OIF veterans, with a reduction in soldier risk for those in active treatment. We have good treatments today for suicidality. There are a number of treatments that are effective and can be effective in a number of

settings. They are not difficult to implement. The problem is getting people to actually access the treatment, and getting people to stay in treatment once they start.

Scientifically, we know that there are a number of treatments and inventions that prove effective. The effective elements of these treatments are simple and straightforward, they are very concrete, and they result in hope, which is what we need to help overcome the issue of suicidality. Despite the availability of effective treatments, it is important to remember that not only will many of our veterans face acute problems, but just as Mr. Hanson has demonstrated, they will continue to face chronic problems. This is an issue that is not going to go away. Part of my concern personally and scientifically is that this is going to require long-term care, far more than short-term care that we have conceptualized to this point.

In addition to what the VA is currently doing, efforts that certainly should be applauded, I would like to emphasize the need for the VA to think outside of the box, to experiment with non-traditional approaches and consider that the existing data point to the undeniable truth that we simply are not reaching the larger portion of veterans in need. This is a problem for both the VA and the Department of Defense.

I would suggest to you that stigma and the nature of the military culture are at the heart of the problem. The military culture is one that appropriately is dedicated to developing warriors, a culture that treasures strength, courage, and sacrifice, all admirable qualities.

As OEF and OIF have demonstrated, psychiatric casualties are much larger than originally anticipated. Prolonged and repeated exposure to combat takes a considerable psychological toll. Our soldiers and veterans struggle to understand their health—they continue to struggle to understand the health consequences of killing, the exposure to combat, what it means to be in combat, and what the normal trajectory of response to combat is. It is an issue that we need to think very seriously about and we need to look beyond traditional mental health approaches when we are doing that.

Traditional mental health approaches talk almost exclusively in the language of illness, contrary to the very core of what we know about a warrior mentality. For many of our veterans, the notion of illness and disorder is synonymous with personal failing and weakness, and it only serves to compound the existing shame and guilt that they experience. We need to move away from this traditional language of pathology and talk about the issues of optimal performance and resilience. We need to do this early in the experience of training soldiers. We need to look at unique programs and alternatives for helping soldiers understand early in the process about potential problems in terms of adjustment to combat.

It is critical for the Department of Defense and the VA to reach veterans by normalizing the combat experience and subsequent adjustment. This can take a number of forms, but it is essential that early in training, all soldiers be exposed to training targeting the consequences of killing, talking in specific terms about post-combat adjustment.

It is important for the VA to recognize that they fight a long-standing image as an inflexible and unresponsive bureaucracy. There is a need to stretch existing boundaries and explore public-private partnerships that provide new experience and alternatives for our veterans.

As an example, given an estimated 500,000 veterans will transition to college campuses over the course of the next decade, I would strongly encourage the VA to look at partnering with university campuses. They need to go where the veterans are, and a large portion of those veterans are going to be on our college campuses. We need to look at partnering in very specific ways. I can tell you, we would welcome the opportunity to partner with the VA system in terms of providing care and assessing and responding to veterans on campuses.

The problems experienced by today's veterans demonstrate an undeniable truth. Traditional approaches do not reach those in greatest need. We need to think outside of the box, experiment with non-traditional approaches, set aside the language of mental illness and pathology, and put our veterans first.

Thank you very much. I would welcome the opportunity to answer questions.

[The prepared statement of Mr. Rudd follows:]

PREPARED STATEMENT OF M. DAVID RUDD, PH.D., ABPP, DEAN, COLLEGE OF SOCIAL & BEHAVIORAL SCIENCE, UNIVERSITY OF UTAH; SCIENTIFIC DIRECTOR, NATIONAL CENTER FOR VETERANS STUDIES, UNIVERSITY OF UTAH

Mr. Chairman, Mr. Ranking Member, and Members of the Committee, I appreciate the opportunity to appear today to discuss the Department of Veterans' Affairs (VA) efforts to address the mental health needs of America's Veterans.

There is no disagreement that the mental health demands on the VA will continue to grow over the course of the next decade. Given the duration of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) current mental health demands are unprecedented. In addition to grappling with anticipated problems like depression, Post Traumatic Stress Disorder, and substance abuse, the VA is struggling to address the tragic loss of veterans' to suicide. I have no hesitation to endorse the recent efforts of the VA, but will offer encouragement for the VA to explore non-traditional approaches and public-private partnerships in an effort to undermine the devastating impact of stigma.

As you will hear from other witnesses, the VA has implemented a range of programs and initiatives, all geared toward meeting the growing mental health demands of today's Veterans. With respect to suicide, the VA has launched an intensive suicide prevention program, one that includes an innovative suicide prevention hotline and Internet chat line. As you know, there are eighteen deaths per day due to suicide among America's Veterans, with approximately five per day among those in active treatment with the VA. These numbers are nothing short of heartbreaking.

These numbers reveal several challenges, including the simple reality that the majority of Veterans' in need are not accessing much needed services at moments of crisis. Data is emerging to suggest that recent changes in the VA delivery system are proving more effective with OEF and OIF Veterans', with a reduction in suicide risk for those in active treatment. Scientifically we know that there are a number of treatments and interventions proven effective for suicidality. The effective elements of these treatments are simple and straightforward, inspiring hope and recovery in concrete fashion. Despite the availability of effective treatment, it is important to remember that not only will many of our Veterans face acute problems a large percentage will struggle for many years requiring intensive and enduring care. This is not a short-term issue.

In addition to what the VA is currently doing, efforts that certainly should be applauded, I would like to emphasize the need for the VA to think outside of the box, to experiment with non-traditional approaches and consider that the existing data point to one undeniable truth, we simply are not reaching the larger portion of those in need. This is a problem for both the VA and the Department of Defense. Stigma and the military culture are at the heart of the problem.

The military culture is one appropriately dedicated to developing warriors, one that treasures strength, courage and sacrifice. As OEF/OIF have demonstrated, psychiatric casualties are much larger than originally anticipated. Prolonged and repeated exposure to combat takes a considerable psychological toll. Our soldiers and Veterans struggle to understand their experiences and the consequences of killing. Traditional mental health approaches are simply not effective at reaching our soldiers and Veterans, an outcome that is not particularly surprising. Traditional mental health approaches talk almost exclusively in the language of illness, contrary to the very core of military training. For many of our Veterans the notion of illness and disorder is synonymous with personal failing and weakness, only serving to compound existing shame and guilt. We need to move away from the traditional language of pathology and talk about the issue of optimal performance and resilience.

It is critical for both the Department of Defense (DOD) and VA to reach Veterans by "normalizing" the combat experience and subsequent adjustment. This can take many forms, but it is essential that early in training all soldiers be exposed to training targeting the consequences of killing, talking in specific terms about post-combat adjustment. Not a single soldier comes out of combat the way that they went in; combat is a life altering experience. We can do a better job of helping our warriors understand the normal adjustment problems experienced following combat, eliminating the possibility that subsequent psychological problems will be attributed to personal failings and weakness. As the Air Force Suicide Prevention Program demonstrated, the impact of high-ranking leaders cannot be underestimated. Nothing is more powerful to a struggling enlisted man or woman, hesitant to seek care, than to see a commander talk openly and honestly about his or her own difficulties following combat.

Similarly, it is important for the VA to recognize that they fight a longstanding image as an inflexible and unresponsive bureaucracy. There is a need to stretch existing boundaries and explore public-private partnerships that provide new service alternatives for our Veterans. As an example, given that an estimated 500,000 Veterans will make their way to college and university campuses over the next decade, the VA should consider the placement of providers on campuses around the country. The VA will need to go to where the Veterans are in order to reach the seventy percent hesitant to seek care. We would certainly welcome such a partnership. Similarly, expansion of the existing VA system may not be the most effective expenditure of available funds. As is well known among suicide researchers, a large percentage of those that take their own lives see primary care providers in the month prior to their death. Although the VA has improved training for primary care providers within their system, why not explore other potential partnerships with private medical centers?

The problems experienced by today's Veterans demonstrate an undeniable truth, traditional approaches do not reach those in greatest need. We need to think outside of the box, experiment with non-traditional approaches, set aside the language of mental illness and pathology, and put our Veterans first.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO M. DAVID RUDD, PH.D., ABPP, DEAN, COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCE, UNIVERSITY OF UTAH

Question 1. Especially in terms of research and emerging opinions on most effective treatment methods, what was not discussed in the hearing that needs to be?

Response. It should be mentioned that, according to the empirical literature, there are only two effective treatments for PTSD, including cognitive processing therapy and prolonged exposure therapy. There needs to be more effort to make sure that these are the psychotherapeutic treatments offered to veterans, including the necessary clinical training for VA providers.

With respect to suicidality, there are only a handful of effective treatments. As with PTSD, it is important for the VA system to offer these psychotherapeutic options and make sure their providers are appropriately trained.

The VA system should also be making a concerted effort to implement interventions in Emergency Departments that work to do two things: 1) reduce the rates of ED presentations for suicide attempts and 2) facilitate transition into treatment and improved compliance with ongoing treatment.

Question 2. We recently heard from veterans in Hawaii that they do not want to utilize tele-mental health options, whereas many younger veterans like this form of care delivery. What studies have been done to compare needs and preferences of the different generations with respect to delivery or type of care? How should that be integrated into VA's care delivery?

Response. There are a number of options for integrating online treatment options. The majority view online options as adjunctive in nature, i.e. used as a resource to traditional approaches. In net gain is a reduction in demand for face-to-face sessions, something particularly important for veterans in rural areas with limited access to major medical centers and clinics. We are in the process of testing an online "toolkit" for suicidal veterans with the goal of reducing the need for face to face contact. The most effective tele-mental health/online options utilize a combination of online and face to face contact.

Question 3. In addition to veterans severely injured and those returning from combat zones, do any of you have any recommendations for identifying less obvious groups of veterans who might be at an increased risk for suicide?

Response. The VA and DOD have both launched fairly extensive efforts to identify high-risk veterans struggling with mental health problems. I would suggest (and empirical data supports the idea) that there is far greater need to identify at risk veterans in primary care settings (i.e. family medicine, internal medicine). A considerable number of high risk patients appear in primary care and refuse mental health care. They can more effectively be identified, treated and maintained in primary care settings.

Question 4. We know that the stigma associated with mental health problems is a serious barrier to veterans seeking treatment. What else, in addition to VA's current efforts to overcome stigma, would be beneficial?

Response. Far greater coordination is needed between DOD and the VA. The problem with stigma is generated while on active duty. If greater steps are not taken by DOD the problem will persist. We need those in the upper echelon of command (both officers and NCO's) to openly discuss mental health problems and talk about the effectiveness of their own treatment, all the while emphasizing that it has not limited their careers. Additionally, more attention needs to be focused on the transition from active duty status, particularly for National Guard and Reserves. These two groups in particular need to be the target of stigma reductions campaigns.

Question 5. Have male and female veterans differed much in their treatment outcomes for various models of mental health services? If so, how well do you believe VA has factored such differences into its treatment programs?

Response. There are not particular differences in response rates to care. However, there are differences in the types of trauma that precipitate care. For example, sexual assault among female veterans has not received the attention it deserves. The same can be said for vicarious trauma, i.e. among health care providers (e.g. nurses) in combat zones.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO M. DAVID RUDD, PH.D., ABPP, DEAN, COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCE, UNIVERSITY OF UTAH

Question 1. In your testimony, you mention the need to change traditional language about mental health for the military and veterans. Can you explain that idea in more detail?

Response. DOD and the VA can do a better job "normalizing" post traumatic stress by "relabeling" the problem. We need to talk about how to effectively adjust to post combat environment. As long as we continue to use diagnostic labels like depression, PTSD, and substance abuse we'll see a large percentage of soldiers unwilling to receive care. If we talk about building and maintaining "resilience" and "optimal performance", something that should be started in basic training, we'll have more soldiers involved. We'll also have to go to the soldiers and stop asking them to come to clinics and hospitals for care. The facilities themselves stop soldiers from accessing care since they don't want to be "seen" in those settings.

Question 2. You mention partnerships with other health providers, but how would this work with your other idea of changing the traditional language about mental health for the military?

Response. We should partner with primary care providers. The integration of mental health professionals in primary care settings carries far less stigma. Soldiers are willing to willing to be seen for "medical" problems and related injuries. Providing mental health care in that context helps get around the traditional problem of going to a specialty mental health clinic.

Question 3. How could we educate or make the entire private sector sensitive to this issue?

Response. I believe we have to start talking in consistent fashion about the emotional and psychological consequences of combat, normalizing the experience. Not

one single soldier goes to war and returns home without having to address emotional or psychological issues in some form or fashion, whether it's grieving the loss of friends or more complex issues. The issue of the Purple Heart is a great example. We honor those with physical wounds but not those with psychological ones. Until we are willing to take on that problem, psychological problems following combat will continue to be viewed as "weakness" and "failure."

Chairman AKAKA. Thank you very much, Dr. Rudd.

Mr. Clarence Jordan, your statement, please.

STATEMENT OF CLARENCE JORDAN, MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS

Mr. JORDAN. Thank you. Chairman Akaka, Ranking Member burr, and Members of the Committee, on behalf of the National Alliance on Mental Illness, NAMI, thank you for inviting me today to share my views.

I am privileged to serve on the National Board of Directors of NAMI, the Nation's largest grassroots mental health consumer organization. We are dedicated to improving the lives of individuals and families affected by mental health in adults and in children.

Mr. Chairman, NAMI is deeply concerned about the newest generation of repatriated war veterans, whether they remain on active duty, serve in the Guard and Reserve, or return to civilian life following service. We want to see the VA take a more relating posture in coordinating both intergovernmental and public-private arrangements that would do a better job at outreach, screening, education, counseling, and care of veterans who fought and are still fighting these wars and to help their families recover from these experiences.

NAMI is very proud that the VA in 2008 recognized that we can play an important role within the VA in helping families of veterans cope with and recover from mental illness. NAMI's signature program, Family-to-Family, is dedicated and designed to meet the needs of family members who have questions relative to whether or not their loved one, the veteran home from deployment and war, is experiencing not only from the standpoint of what the illness is, but the treatment, the various medications, the prognosis, and what they can expect in supporting and caring for those loved ones and gaining the ultimate goal of recovery.

Mr. Chairman, I am a 15-year veteran of the world's finest Navy. I know how combat situations and military life in general put unique stresses on these individuals. In my case, while the signs and symptoms of a problem were there and more than one person tried to point them out to me, I completely denied the problem at the time. I mean, after all, an individual with mental illness isn't sent to the Naval War College or given a scholarship to Naval Post-Graduate School in Monterey.

With the clarity of hindsight now, I can say that I struggled for years with mental illness, and when I was on active duty, I know that I was not alone. Following the Navy, I wandered literally in the wilderness for nearly two decades. This lifestyle ultimately led to getting me into deep kimchi. I owe a debt of gratitude to the judge who gave me a choice of going to treatment or going to jail. I chose treatment. It was the push that I needed to start turning my life around.

I stayed in treatment at a local community mental health center for 12 months and I continue to be a consumer today. I believe I have achieved recovery to enable me to live a better life. I am living proof that a mental illness does not mean that one cannot live happy, productive lives. Since leaving that initial treatment, I have not only held responsible jobs, but I have become actively involved in NAMI, where I train others to do advocacy work and to help others achieve their ultimate goal of recovery.

It is important for people, veterans and non-veterans, to realize that there are different types and levels of mental illness and that, most importantly, the things they can do to stop forward is to talk to mental health professionals to find out the essence of their problems.

When I served in the Navy, I had no basis of experience or knowledge about mental illness that would have led me to believe I had a problem. Furthermore, my personal image of someone with a mental illness when I was in the Navy was definitely not me. I knew next to nothing about the VA and its mental health programs. I believe I share this experience with thousands of military servicemembers, veterans who could benefit from VA services but may not be getting them. I believe that the VA must do a better job of reaching out and making its services known to larger shares of the veterans' population who serve.

Given our experience to date in the wars in Afghanistan and Iraq, plus the overlay of combat experience of prior generations of veterans, more veterans need readjustment and mental health counseling and other mental health services than those who are appearing at the VA facilities to seek these services. I believe much insight about veterans who do not use VA health care should be obtained from serving those veterans who have called 273-TALK, the National Suicide Prevention Hotline, and I would urge this Committee to consider requiring such a study to determine how much VA is aiding these callers.

Make no mistake, NAMI deeply appreciates the existence of 273-TALK. We have committed and commended to VA's Office of Mental Health Services for having established this vital link to VA counseling and who have saved the lives of thousands of veterans, but we believe a large group of veterans still are in need and are not being reached. We are proud that our members, despite these problems, actively participate in consumer counsels and our Family-to-Family education programs in VA facilities.

The VA and NAMI executed an important Memorandum of Understanding in 2007 formally committing to our signature Family-to-Family education program within the VA facilities. At 100 VA medical centers, Family-to-Family is a formal 12-week NAMI education program. It enables families living with mental illness to learn how to cope and better understand it. Also, Family-to-Family focuses on care for caregivers and how caregivers can cope with worry, stress, and the emotional overload that attends mental illness in families. Based on the success of Family-to-Family, we have a goal of introducing more NAMI signature programs, such as Peer-to-Peer and NAMI Connection program within the VA mental health care.

Mr. Chairman, our Grade the States Report last year revealed that very few States offered mental health or readjustment programs for returning members of the National Guard and Reserve from Iraq and Afghanistan. However, we learned that States like Massachusetts and Vermont are good models of programs that provide peer outreach and direct delivery of services to their Guardsmen.

We call your attention also to similar efforts in California, Connecticut, Maine, Maryland, New Hampshire, and New Jersey, New Mexico, New York, and North and South Carolina. Of special note, the State of Montana launched an ambitious program of post-deployment screening and referrals for Montana National Guardsmen home from Afghanistan and Iraq.

NAMI is committed to recovery. In the case of our professional military service, we want to ensure that those serving in these regular forces are well cared for by the DOD when they return from active duty; by both DOD and the VA for those in the National Guard and Reserve components when they return to their garrisons. NAMI believes that many tailored approaches need to be made for those new veterans, that all civilian efforts should be led by VA in coordination with agencies, including DOD, SAMHSA, the Public Health Services, Indian Health Services, the National Guard Bureau, the State Guard leadership, and leaders of State public mental health agencies, as appropriate as needed. In some cases, private mental health providers should be enlisted and coordinated by VA to ensure they can provide the quality of care veterans may need.

NAMI also urges this Committee to expand the establishment of diversionary courts for veterans. I mentioned my personal experience with that judge in Nashville who gave me an opportunity to turn my life around, and I believe that many military experiences like mine can be helped if provided an opportunity.

NAMI urges the Committee to support the development of diversionary courts for veterans, especially combat veterans, to make sure that the VA reaches out and coordinates with existing court systems in cities and States to ensure post-deployment veterans receive the most timely and effective care possible rather than allowing sick and disabled veterans suffering with mental illnesses consequences to their war service to be convicted and sent to jail.

Finally, NAMI endorses the organization of the *Independent Budget* for fiscal year 2011. In that budget and policy statement, AMVETS, Disabled Veterans, Paralyzed Veterans, and American Veterans of Foreign Wars in the United States recommend a series of good ideas that would further improve VA's mental health programs. I ask the Committee to consider these recommendations and to ensure, either through oversight or legislation, the Department of Defense carries out these intents and the spirits of these recommendations.

This concludes my testimony, Mr. Chairman.

[The prepared statement of Mr. Jordan follows:]

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

Chairman Akaka, Ranking Member Burr, and Members of the Committee: On behalf of the National Alliance on Mental Illness (NAMI), please accept NAMI's collec-

tive thanks for this opportunity to provide testimony at today's oversight hearing to assess the Department of Veterans Affairs' (VA) mental health programs.

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

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

As a case in point, I am a 15-year veteran of U.S. Navy aviation. I know how combat situations, as well as other more basic tenets of military life, put unique stressors on those of us who have served, as well as on our families. In my case, while the signs of a problem were there, and more than one person tried to point them out to me, I completely denied the problem at that time. With the clarity of hindsight now, I can say that I struggled for years with mental illness when I was on active duty in the United States Navy. I know now that I was not alone.

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

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

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

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

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

other mental health services than those who are appearing at VA facilities to seek these services.

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

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

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

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

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

Mr. Chairman, in March of last year NAMI issued its biennial Grade the States report, an effort to survey state mental health program directors on the types and scope of mental health programs available within their states for all residents.

I hope the Committee's professional staff will take the opportunity to review the results. NAMI found that while 14 States had improved their grades since NAMI's

2006 survey, 12 fell backwards, and that the national average grade for state-sponsored public mental health programs still remained unchanged, a grade of "D." You can see the full Grade the States report at www.nami.org/grades09.

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

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

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

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

deployment veterans receive the most timely and effective care possible, rather than allowing sick and disabled veterans suffering with mental illnesses consequent to their war service to be convicted and sent to jail or prison.

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

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

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

Attachment

ATTACHMENT TO TESTIMONY OF CLARENCE JORDAN

Recommendations in VA Mental Health

Fiscal Year 2011 *Independent Budget*

VA should provide frequent periodic reports that include facility-level accounting of the use of mental health enhancement funds, and an accounting of overall mental health staffing, the filling of vacancies in core positions, and total mental health expenditures, to Congressional staff, veterans service organizations, and to the VA Advisory Committee on the Care of Veterans with Serious Mental Illness and its Consumer Liaison Council.

Consistent with strong Congressional oversight, the Under Secretary for Health should appoint a mental health management work group to study the funding of VA mental health programs and make appropriate recommendations to the Under Secretary to ensure that VHA's allocation system sustains adequate funding for the full continuum of services mandated by the Mental Health Enhancement Initiative and UMHS handbook and remains in full commitment to recovery as the driving force of VA mental health programs.

VA must increase access to veteran and family-centered mental health-care programs, including family therapy and marriage counseling. These programs should be available at all VA health-care facilities and in sufficient numbers to meet the need.

Veterans and family consumer councils should become routine standing committees at all VA medical centers. These councils should include the active participation of VA providers, veteran health-care consumers, their families, and their representatives.

VA and the DOD must ensure that veterans and servicemembers receive adequate screening for their mental health needs. When problems are identified through screening, providers should use nonstigmatizing approaches to enroll them in early treatment in order to mitigate the development of chronic illness and disability.

VA and the DOD should track and publicly report performance measures relevant to their mental health and substance-use disorder programs. VA should focus intensive efforts to improve and increase early intervention and the prevention of substance-use disorder in the veteran population.

VA should invest in research on effective stigma reduction, readjustment, prevention, and treatment of acute Post Traumatic Stress Disorder (PTSD) in combat veterans, increase its funding for evidence-based PTSD treatment programs, and con-

duct translational research on how best to disseminate this state-of-the-art care across the system.

VA should conduct an assessment of the current availability of evidence-based care, including for PTSD, identify shortfalls by the site of care, and allocate the resources necessary to provide universal access to evidence-based care. VA should conduct a rigorous study of the intensity of mental health care to determine if it has been reduced for older generations of veterans in order to generate the capacity to absorb newer arrivals (primarily veterans of Operations Enduring and Iraqi Freedom) with more acute needs. If the study finds results in the affirmative, VA should begin to address that trend.

A task force—composed of experts from the Veterans Benefits Administration, Veterans Health Administration mental health staff, veterans service organizations, and disabled veterans—should be assembled to explore potential barriers and disincentives to recovery from mental health disabilities that may be created or influenced by VA's disability compensation system.

VA should immediately correct case management program deficiencies and begin to treat psychological injury and mental illness in veterans with the same intensity that it treats serious physical injuries. VA and the DOD should move rapidly to develop health policy and research inquiries that are responsive to the recommendations published in the 2007 IOM report, *Gulf War and Health: Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress*.

VA needs to improve its succession planning in mental health to address the professional field shortages, recruitment, and retention challenges noted in this *Independent Budget*. VA should ensure that qualified women mental health counselors with expertise in military sexual trauma are available in all Vet Centers and that all professional staff are provided training on the current roles of women returning from combat theaters and their unique post-deployment mental health challenges.

The VA Advisory Committee on the Care of Veterans with Serious Mental Illness should be replaced by a secretarial-level committee on mental health, armed with significant resources and independent reporting responsibility to Congress.

Congress should ensure that the new mandatory, face-to-face mental health screening process for post-deployed combat servicemembers (including National Guard and Reserves) required by the National Defense Authorization Act of 2010 is conducted by personnel who are effectively trained to identify these hidden service-incurred wounds, and to treat them when found. This responsibility should be jointly embraced by both DOD and VA mental health-care programs in a shared effort under the authority of Public Law 97–174, "VA/DOD Health Resources Sharing and Emergency Operations Act."

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO CLARENCE JORDAN, MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS

Question 1. What are the members of NAMI's Veterans' Council finding are the most serious roadblocks to veterans or family members receiving the necessary care and services, and do you have any recommendations to remove those roadblocks?

Response. Of primary concern is stigma, which continues to exert a tremendous amount of force on those in need of care. Ignorance and confusion over signs and symptoms are baffling resulting in prolonged periods of rationalization and denial. The resulting effect is individuals who present late in the disease state at which time any number of co-morbid conditions become apparent. Another critical roadblock for many is accessibility and an attending social and cultural norm that results in the prospective recipient of care isolating and resulting in self destructive behaviors.

There is any number of roadblocks and depending upon the resilient nature of the veteran and/or family member, presenting lesser or greater degree of difficulty in overcoming them to include:

- Dual diagnosis of mental health and primary care have been co-located but not with substance abuse.
- Women's issues are still huge, with concerns over inconsistencies in care and apparent confusion over a no-fault process for obtaining gender preference therapists for military sexual trauma treatment. In previous generations we did not talk about military sexual trauma, and some women veterans going back as far as Vietnam and Korea are just beginning to tell their stories. There are no verifying records because there were no mechanisms to deal with the issue at that time.
- Treatment for PTSD claims for veterans who have either had no symptoms for years and are experiencing symptoms re-emerging or that were never addressed.

• Cultural competency on the part of health care providers is extremely problematic; veterans have expressed numerous concerns over the lack of a shared set of values and beliefs with their VA caregivers.

• Outreach to families including children (of deployed, returning troops) is still a great concern, despite recent reported improvement in the numbers over the past several months.

• Lack of a person-centered family first approach to care. In VA there is this "assembly line" approach; get them in, and get them out. Individual needs preference, hopes and aspirations are seldom heard resulting in a feeling of not being heard. There is not a sense of hope or expectation of recovery at the service level.

On the plus side of the equation the VA Secretary has listed both substance abuse and homelessness as high priorities. As mentioned previously there is more family involvement than a year ago, but not enough. I do not think that the VA will go full bore on children's services, but a family therapy approach that includes the children both as a support system to a returning parent and for their own stability is needed. Maybe this could be a contract issue with children's or family services in the community.

Secretary Shinseki in my opinion is really doing a good job. His T—21 Initiatives that include strategies to improve community partnerships, outreach and education and addition to supportive services, are strategies for the 21st century. His style as well as his content are highly respected but he alone cannot do it all. A collaborative approach with private and public service centers and support facilities could go a long way to dealing with many of the issues raised above. Employing the principles espoused in the SAMHSA Consensus Statement on recovery combined with the Secretary's T–21 Initiative would help immensely. Borrowing from lessons learned in the public sector VA should use more web-based resources to provide 24-hour a day, seven days a week access to user information and connection to others through social networking. Also VA should use trained consumer experts in recovery to help shape and guide recovery services employed at higher levels within the VA system for greater continuity and oversight of recovery efforts and programs. Finally, the VA needs to find an innovative solution to engage over time with this latest cohort of returning veterans and family members that circumvents existing stigma and is designed to assist those less likely to ask for assistance in current traditional outreach ways. Mr. Chairman, a life filled with hope, pride of service and support of a grateful nation and community should be the end game for our returning warriors.

Question 2. During your 12-month inpatient treatment, what do you believe was the most effective component of the program that motivated you to become more proactive in your own treatment and adhere to your program?

Response. In a word, CONTACT; the development of an interpersonal relationship with a person who self disclosed they had a mental illness just like me. Gentlemen, we should never underestimate the power that stigma holds sway over the sufferer. In my case I was affected in three ways: self stigma, label avoidance and public stigma. My sense of self worth and self efficacy was all but eliminated. To avoid being labeled as someone with a mental illness I would rather had been labeled as an addict, alcoholic and yes, even as homeless, with all its connotations. For decades I wore a mask, too afraid of what I might really see if ever I took a good look in a mirror. Estranged from family and friends and everything that ever meant anything to me, I existed in a world of aberrant behavior whereas to hide my own bizarre behaviors. I paid tithes to the church of shame and despair, attending every sermon hoping and praying that one day I would be delivered from this hellish no-man's land of the self-exiled. This once proud Naval Officer willingly embraced all the negative stereotypes of what it meant to live on the fringes of society.

Even after the diagnosis, or shall I say diagnoses, I believed that one day I would just be over it like a common cold.

Like my descent, my rise from the depths of my despair took a slow, often fatuous journey of having to re-learn the simplest of executive functioning skills. I found the road of treatment to be fraught with disempowering practices and low expectations.

Peer support for me was more than mentorship through a twelve-step process; it was about vicariously learning how to deal with decisions involving emotions and a fragile belief system. The weeks and months of treatment that preceded the acquisition of peer services could only do so much; I had learned that medication could have positive effects, I had learned the importance of journaling as a means of mood check; I had arrived at a state of enactive attainment. I was at a point persuasion, still being seduced by my illness, and my peer specialist provided the physical arousal needed to move beyond the symbiotic nature of our relationship and posed for a renewed self-efficacy. It was at this point that I appreciated all the more the values and beliefs I had learned in the Navy.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO CLARENCE JORDAN, MEMBER, NATIONAL BOARD OF DIRECTORS, NATIONAL ALLIANCE ON MENTAL ILLNESS

Thank you for your testimony and the commitment of NAMI to the Family to Family program for education and support. I hope you will continue to work on this until every VAMC has a group.

Question. Can you also share your thoughts on a mandatory training course or mental health program for all veterans as a way to eliminate the stigma? Do you think this would be helpful? How should such a course be structured?

Response. Programs like the Illinois Warrior Assistance Program and the Real Warriors Campaign are very valuable. The developer and staff of these great efforts deserve to be commended; their scope is very comprehensive, offering a full array of social networking, information and referrals. They are packaged in very patriotic and eye popping web designs, and unique and return visitor numbers are very impressive. They, like our own NAMI web resources and so many other tremendous resources, depend on a "pull" methodology; they are built to bring those in who are seeking help and are willing to receive the much needed support.

The real or more pressing question at hand is what programs exist for the more than two thirds of those eligible who are in need but do not seek help. And unless I miss my guess, there may be significant underserved segments of our Veterans population that have not yet come to rely upon the internet for their information.

The warrior ethos, good order and discipline along with a sense of esprit-de corps goes to the heart of our military culture and structure on which Army, Navy, Air Force, Marine Corps and Coast Guard depend. Military culture is sometimes maligned as too rigid and involving too much discipline that nevertheless colors the environment in which the sailor, soldier, airman and marine must step forward and admit to an illness that for some invokes feelings of weakness and perhaps laziness or just being a plain slacker. Promoting and rewarding (at a minimum, not penalizing) help-seeking behavior is at odds with the public stigma both within military and civilian (for Guard and Reservists) worlds these service personnel compete and live in, and that is the dilemma. Some programs use a reverse logic approach depicting help-seeking behavior as consistent with a sense of operational readiness; some use an avoidance approach whereby mental illness and/or its many symptoms are simply looked upon as a natural consequence of military life. Research certainly suggests that education in and of itself, whether conducted at the unit or brigade level, whether single or multiple presenters, produces limited effects with most participants returning to their base line within a week. Public stigma and negative stereotypes return leaving those who responded to the affirmative without much support and worse yet, they may encounter outright discrimination.

An approach that is designed to resemble more of a push or "mandatory approach," could speak to that. By its very nature a push approach wherein everyone participates could go a long way in avoiding personal stigma associated with help-seeking behaviors. Such an approach would also have a higher probability of neutralizing public stigma.

A combination push/pull approach could increase significantly the number of veterans receiving care provided there is some incentive for individuals to participate fully and with anonymity. The use of technology that is not only personal but also employed to reach the masses with simultaneous messaging could be used to produce the desired push for participation. Innovative use of screening and incentives could enhance more timely and effective interactive between military servicemember and helpers. ValueOptions® has designed an innovative solution that, in my opinion, addresses these cultural challenges inherent in asking for help and garnering access to care to existing programs.

One other barrier exists that is directly associated with the stigma of label avoidance. Personnel policies and procedures exist which serve as a barrier to military servicemember participation in operational readiness programs, and must be silent on matters of servicemember's successful treatment. Stigma will be more difficult to battle as long as policies remain that penalize or limit future options or opportunities as a consequence of seeking behavioral health assistance. While there has been progress in this area, there is much work to be done before eliminating rational reasons for not seeking care. Additionally, the Uniform Code of Military Justice (UCMJ) can, by individual commanders, be misused to exorcise personnel deemed to be "odd balls" or different following deployments and exposure to war. Such practices must be closely monitored.

Chairman AKAKA. Thank you very much, Mr. Jordan.

My first question is to Mr. Hanson, and I want to thank you for sharing your story with us. We heard from Dr. Rudd that a large number of veterans will contend with mental health difficulties over the long term and may require treatment for years. Your experience seems to support that. Do you believe the VA program you completed was helpful as a stepping stone to your final recovery, or do we need to significantly revise the VA program?

Mr. HANSON. Well, Mr. Chairman, I believe that the program I did was beneficial and that I was able to see what the drugs and alcohol were doing, that I did have a problem; but as far as treating my issues, I believe that it was little to no benefit for me. I mean, I drank the day after I got out of the program and I pretty much wasn't changed. It was something that I had to do because I knew I eventually had a court case coming up and I thought that treatment might look good, because it was a licensed program, to be honest with you, Mr. Chairman. As far as changing me the way I needed change, it did absolutely nothing, to be honest with you. Having no disrespect to the Department of Veterans Affairs, but I felt like it wasn't beneficial at all.

Chairman AKAKA. Mr. Jordan, I believe that involving family members in care is critical to a successful outcome and to getting a veteran seen in the first place. What lessons should VA take from NAMI's Family-to-Family program that would make mental health care more successful?

Mr. JORDAN. Thank you, Mr. Chairman. Several things. One, that recovery is possible.

Number 2, that recovery is a process; it is not linear. That setbacks, such as those described by Mr. Hanson, do occur, and that love and support more than anything else is the key to supporting that member's recovery.

Chairman AKAKA. For all of our witnesses, significant resources have been allocated through VA over the last couple years for the purpose of improving mental health care. If you were to rate VA's progress over the past 8 years on a scale of one to ten, what score would you give VA's mental health services? Mr. Hanson?

Mr. HANSON. I only have been really working with the VA for the last 3 years, Mr. Chairman. I would have to give it around a six, just because I feel, kind of like Mr. Jordan said, there is not a feeling of a lot of care or love and I think that is what I need. I understand that it is a professional environment, but there are a lot of times I felt like I was just another number and it left me feeling, you know, put off by it, really, to be honest, Mr. Chairman. So I would say a six. Thank you.

Chairman AKAKA. Thank you very much.

Mr. Jordan?

Mr. JORDAN. I would agree, a five or a six. I mentioned the 273-TALK. I think that is an excellent program. I think that there is a lot of research regarding peer-to-peer-type services, mutual support groups, that have not benefited the vast majority of individuals in care. There seems to be an absence of outreach and education that I think is very vital to a member obtaining full recovery.

Chairman AKAKA. Thank you.

Dr. Rudd?

Mr. RUDD. Well, I probably would rate it a little higher. I would say a seven or an eight. I think that they have been innovative, that they have tried some new things. There is evidence that some of these new things are working. Certainly, the hotline and Internet chat line are unique and there is evidence of success there. They are having much greater success in terms of reduction of suicide risk for those in active treatment.

I think at the heart of the problem, though, that they face and that many other clinicians face is the difficulty of getting a certain portion of the high-risk population actually in for care, and that is where you have to think outside of the mental health scope, that perhaps there are other kinds of partnerships within primary care and other alternatives that we can look at to get that portion of the population to agree to come in for treatment.

Chairman AKAKA. Thank you. Thank you very much.

Let me call on our Ranking Member for his questions.

Senator BURR. Thank you, Mr. Chairman.

Dean Rudd, I am sorry I overlooked your military service. Thank you for that.

Dean, let me ask you, you expressed the importance for the VA to think outside the box to treat mental illness by experimenting with non-traditional approaches. The Department of Defense funds the Complementary and Alternative Medicine Research for Military Operations and Health Care Program, which does research non-traditional treatments, such as manipulation, bio-electromagnetic devices, and acupuncture. Are these examples of non-traditional approaches that you would recommend the VA take a look at or use?

Mr. RUDD. Not necessarily. I think that when I talk about non-traditional, I am thinking more about how we reach out to veterans, and rather than identifying the presence or absence of a mental illness, telling someone that they have a mental illness is not necessarily a compelling reason for them to get care when they have been raised in a culture in which that mental illness is seen as a weakness. It is almost an affirmation of their failure——

Senator BURR. Let me ask you——

Mr. RUDD [continuing]. To say, you have PTSD. You need treatment.

Senator BURR. Let me ask you from the standpoint of your professional experience, how important is it when we identify a servicemember who has been discharged and we think there is a likelihood of a mental health challenge there, that we immediately get them in treatment and keep them in treatment versus to wait a year for something to manifest itself to a different point?

Mr. RUDD. I think, actually, Mr. Hanson's story kind of tells the tale. I think we need to get them in treatment, recognize and understand what the barriers are to keeping them in treatment, and then facilitate ongoing care; because once they step out of treatment, the problem becomes far more complex. And as he demonstrated, it goes from a difficulty of perhaps a post-traumatic stress problem to depression to substance abuse, a lot of comorbidity, a lot of clinical complexity, where it is very difficult to keep people in care at that point.

I, frankly, think we need to do far more on the very front end when we bring people into basic training and start to talk to them

about resilience and about how they can perform at their best and recognize when they are having difficulty to relabel, reframe that to a large degree to make it acceptable and understandable.

I can tell you the most compelling thing I have ever seen, I was on a panel on Veterans Day and there was a one-star general, a Brigadier General. He spoke at that panel about his difficulty with PTSD after his experience in Iraq. After that panel, there was a cohort of young soldiers that came up to him to talk about that experience because he essentially said it is acceptable, it is OK, it is understandable that you are going to have these difficulties.

I think we just—we need to think differently and not necessarily in terms of the clinical end, because we know what works clinically, but how do we convince people, how do we talk to people about the problem.

Senator BURR. Mr. Hanson, as you know, the primary screening tool for returning combat servicemembers is the completion of a Post-Deployment Health Assessment, and then we do a Post-Deployment Reassessment several months after the separation. What is your view on the adequacy of those screening procedures?

Mr. HANSON. Senator, kind of like what Dr. Rudd said, it was something where it is considered a weakness. Essentially, I recall ours was in a large setting. They said, if you have any problems, raise your hand or something like that. And, I mean, you know, no one is going to raise their hand. For me, it was a weakness kind of deal, especially for me. My primary MOS was in infantry, so I felt like, these guys aren't raising their hand. I have got absolutely no right to raise my hand, whether I saw something or not. So for me, it is just if it can be maybe on a more one-on-one basis where it is more personal, it would probably be a lot more effective, I would think.

Senator BURR. Had yours been one-on-one, would you have raised your hand?

Mr. HANSON. I definitely would have opened up, Senator, that is for sure. A little bit more, anyway. But it is hard to say, because I definitely thought I was a big, bad Marine, so I didn't really want to talk about anything.

Senator BURR. And had you opened up and had the VA set out a treatment regime for you, would you have gone?

Mr. HANSON. I highly doubt it.

Senator BURR. So what would it take for you to have participated? I am asking more about the challenges you had in life that were competing with, should I take the time to go to this treatment.

Mr. HANSON. I think for me, if they would have made it clear that, essentially, I have to. I mean, if I said that I had an issue and it had to be addressed, then maybe it would be something with my veterans' benefits, with a disability check. You are not going to get any—you have to go to this or there is going to be stuff held back, essentially. You have an issue. You need readjusting. You are not man enough to do it.

Senator BURR. Daniel, at what point after you got back did the alcohol and drugs begin to play a role?

Mr. HANSON. As soon as I went on leave, pretty much, Senator. Right away. I mean, the drinking was progressive, where I was on

leave and I was drinking, and then slowly it got to where when I was happy I was drinking. Then when I was sad I was drinking. When I was bored I was drinking. So essentially it was to drink to celebrate and it was to drink when I was depressed and it just kind of slowly evolved into an everyday thing where I was abusing and I was neglecting my family and friends.

Senator BURR. And the length of that time between your disengagement with the military and finding the program in Minnesota was what length of time?

Mr. HANSON. It was about 2 years.

Senator BURR. About 2 years? During that 2-year period, did you visit a VA facility?

Mr. HANSON. Yes, sir, I did. I was doing outpatient therapy for some time. Also, I did the Dual Diagnosis Program.

Senator BURR. So did you share with them your level of alcohol consumption and drug consumption?

Mr. HANSON. Yes, I did.

Senator BURR. And what was their course of treatment relative to that?

Mr. HANSON. I mean, they knew that I—they told me that I had a problem, that I shouldn't be drinking, that I was depressed, and I was put on medication, and a follow-up where it was once-a-week therapy. Once I completed that program, I was told to take the anti-depressant, come in once a week, and keep your head up.

Senator BURR. From the start of your association with VA or at any point while you exercised services from the VA, did you understand the full scope of benefits that were offered?

Mr. HANSON. For me, I did. When I—a couple months after I got out of the Marine Corps, I worked for the Veterans' Benefits Administration, so I was familiar with what was offered. So, I knew on the grand scale of things what was offered, that is, as far as the benefits go. But as far as the VA hospital, there were a lot of things I wasn't aware of as part of——

Senator BURR. Well, my next question was, did you understand the full array of services, as well.

Mr. HANSON. No, sir.

Senator BURR. At any point, did you look at the VA doctor that was treating you and say, what else can we do? Or were you just feeling OK that you had gone occasionally?

Mr. HANSON. I mean, I work with a lot of really good doctors over there and they—I mean, there was definitely benefit there, but yes, Senator, I—we had a lot of conversations where I just said, I don't know what to do anymore, you know. Well, maybe you should do this other program. Well, do you feel like killing yourself? Yes, I kind of do. Well, do you have a plan to do it? No, not right now, I don't have a plan to do it. Well, you know, here is a card if you need it. You call this number if you are going to do that. OK, you know. And I said, I just can't get this thing right, and they made a lot of good suggestions. You can do this program and this program. But at 4, it was leaving time and, you know, you want to look at somebody in the eye when they are going to their vehicle kind of deal. So it was—I had some great conversations, but in the long run, it was kind of—I know they have got a lot of people, and I understand, but I just kind of felt like——

Senator BURR. You needed the boot in the butt to get you in it?

Mr. HANSON. Yes, sir. I did need the boot in the butt.

Senator BURR. Good. Good. Thank you.

Thank you, Mr. Chairman.

Chairman AKAKA. Thank you very much, Senator Burr, for your questions.

I want to thank the panel for your testimony and also your responses to our questions. This is an issue and an area where we want to spend time in trying to help as much as we can, and you have been helpful this morning and you will be very helpful in what we are planning to do. So I want to thank you very much for coming and participating in this hearing. Thank you.

Let me now introduce the second panel. I would like to welcome the witnesses of our second panel, Dr. Gerald Cross, Acting Principal Deputy Under Secretary for Health. Dr. Cross, welcome back to the Committee. He is accompanied by Dr. Janet Kemp, VA National Suicide Prevention Coordinator; Dr. Caitlin Thompson, Clinical Care Coordinator; Dr. Antonette Zeiss, Associate Deputy Chief Consultant and Chief Psychologist of the Office of Mental Health Services; Dr. Theresa Gleason, Deputy Chief of Mental Health Services at the Office of Research and Development; and Dr. Alfonso Batres, Director for Readjustment Counseling for Vet Centers.

I want to thank you for being here. Your full testimony will appear in the record. Dr. Cross, will you please begin. I understand that Dr. Thompson will be making some remarks, as well. Thank you.

STATEMENT OF GERALD CROSS, M.D., ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JANET KEMP, R.N., Ph.D., VA NATIONAL SUICIDE PREVENTION COORDINATOR; CAITLIN THOMPSON, Ph.D., CLINICAL CARE COORDINATOR; ANTONETTE ZEISS, Ph.D., ASSOCIATE DEPUTY CHIEF CONSULTANT AND CHIEF PSYCHOLOGIST, OFFICE OF MENTAL HEALTH SERVICES; THERESA GLEASON, Ph.D., DEPUTY CHIEF, MENTAL HEALTH SERVICES, OFFICE OF RESEARCH AND DEVELOPMENT; AND ALFONSO BATRES, Ph.D., MSSW, DIRECTOR FOR READJUSTMENT COUNSELING FOR VET CENTERS

Dr. CROSS. Chairman Akaka, Ranking Member Burr, and distinguished Members of the Committee, thank you for the opportunity to appear here today to discuss VA's response to the mental health care needs of America's veterans.

I want to digress for a moment and say thank you to the previous panel. I listened closely and I found the stories compelling. That means a great deal to us. Particularly, I was compelled by the alternative court mechanism, an innovative approach that we are very interested in, as well, and we can talk more about that perhaps later.

Thank you for the introductions of my team. I want to mention that Dr. Thompson, sitting next to me, is one of the counselors at our Suicide Prevention Hotline. She is on the front lines every day,

and her work as well as that of Dr. Kemp and the other counselors on the hotline have saved countless lives of veterans and we deeply appreciate her time and thank her for her service to America's veterans.

My written testimony provides greater detail about our mental health programs and policies. Right now, I want to make three points.

First, VA's clinical programs are improving the lives and well-being of veterans with mental health conditions. I can point to several objective outcome measurements that support this claim. To begin with, the number of homeless veterans continues to decline. These data are gathered annually and show that those veterans most in need are receiving the care and services necessary to reestablish their lives.

Another outcome measure is that veterans with serious mental illness who use VA services do not have the more challenging gap that is present elsewhere. In this and in other countries, individuals with serious mental illness have an average life expectancy of approximately 20 years less than those without mental illness. However, in VA, that has virtually disappeared. It is less than 2 years' difference. That is an 18-year benefit, approximately, to the veterans being treated for serious mental illness in VA.

Yet another outcome measure is the soldier rate among veterans receiving VA care. It continues to drop. And as you can see on the chart, there has been a decline since 2001 resulting in about 250 fewer suicides per year. This decrease was especially observed in our youngest veterans, those age 18 to 24.

Data obtained from the CDC confirms that young veterans receiving VA care are significantly less likely to commit suicide than those not receiving VA care. And based on these findings, we know that our programs are working and we will continue to improve them because we believe that we have much more that needs to be done. Any suicide of a veteran is an absolute tragedy, in my belief.

To continue achieving these results, we need to bring more veterans into our facilities to deliver the care they need. We have a variety of outreach initiatives because we understand not all veterans are the same and there is no such thing as too much communication when it comes to letting veterans know that we are there for them.

So my first main point was better mental health outcomes at the VA. My second main point is that VA is committed to a robust research program that identifies the causes and effective treatments for mental health conditions. Our current budget for this research portfolio is about $100 million, and we are using these resources to determine biologic and genetic factors that may increase a person's risk for developing mental health problems.

We are also researching the best treatment protocols and we are using these results to improve care. For example, VA research has determined that it is imperative we closely monitor patients immediately following their inpatient stay, and so more and more we are requiring closer follow-up, weekly follow-ups, more periodic follow-ups, as necessary, after inpatient care is completed.

The National Academy of Sciences Institute of Medicine found that VA-sponsored research provided sufficient evidence for pro-

longed exposure and cognitive processing therapy as key treatments for PTSD, and we have actively implemented those findings, those research findings, to guide our care for veterans with PTSD.

My third point is that our suicide prevention efforts are having a real impact and saving lives every day. It is no exaggeration, sir, to say that our Suicide Prevention Hotline is one of the most successful programs we have ever implemented. In 2009 alone, we intervened to save more than 3,300 veterans from suicide. Our hotline operators, like Dr. Caitlin Thompson right next to me, and suicide prevention coordinators have compelling stories to share with you about those encounters with veterans and how they bring them back from the very edge.

Mr. Chairman and Ranking Member, this is work we can all be proud of and we thank you for your support of these initiatives and helping to make them possible.

In conclusion, VA has aggressively increased the resources available to address the mental health needs of our veterans. We are working closely with our partners at DOD to improve the quality of care for veterans and for servicemembers alike. Since October, we have held two major conferences related to mental health care needs of veterans and servicemembers with DOD.

We were also able to provide direct support to our colleagues at DOD within hours of the shootings at Fort Hood. We deployed staff, including four Mobile Vet Centers, to the Fort Hood community. They provided readjustment counseling services to more than 6,600 veterans, active duty servicemembers, and families.

This concludes, sir, my prepared statement. Thank you again for the opportunity to appear, and sir, my colleagues and I are prepared to answer any questions.

[The prepared statement of Dr. Cross follows:]

PREPARED STATEMENT OF GERALD M. CROSS, MD, FAAFP, ACTING PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Mr. Chairman, Mr. Ranking Member, and Members of the Committee: Thank you for the opportunity to appear today to 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. Antonette Zeiss, Deputy Chief Consultant and Chief Psychologist, Office of Mental Health Services, Office of Patient Care Services, Veterans Health Administration (VHA); Dr. Theresa Gleason, Mental Health Research Portfolio Manager, Office of Research and Development, VHA; Dr. Alfonso Batres, Chief Readjustment Counseling Officer; and Dr. Janet Kemp, VA National Suicide Prevention Coordinator.

VA has responded aggressively to address previously identified gaps in mental health care by expanding our mental health budgets significantly. In fiscal year (FY) 2010, VA's budget for mental health services reached $4.8 billion, while the amount included in the President's budget for FY 2011 is $5.2 billion. Both of these figures represent dramatic increases from the $2.0 billion obligated in FY 2001. VA also has increased the number of mental health staff in its system by more than 5,000 over the last 3 years. During the past 2 years, VA trained over 2,500 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. In FY 2010 and FY 2011, we will continue to expand inpatient, residential, and outpatient mental health programs with an emphasis on integrating mental health services with primary and specialty care.

VA is working closely with our colleagues at the Department of Defense (DOD) to improve the quality of care for Veterans and servicemembers alike. Since October 2009, VA and DOD have held two major conferences related to the mental health needs of Veterans and servicemembers.

My testimony today will make three points: first, it will describe VA's approach to treating mental health conditions. It is our belief that treatment options should be widely available and uniquely tailored to the individual needs of each Veteran. Second, it will detail VA's policy and guidance to the field, as specifically identified in the Uniform Mental Health Services in VA medical centers and Clinics Handbook. This Handbook is being implemented across the VA health care system to expand access to necessary mental health services for Veterans. Finally, my testimony will conclude by providing evidence VA has gathered that our programs are successful and based upon the best available scientific basis; it will also detail the research VA conducts in this area. In sum, our programs are saving lives and improving the quality of life for Veterans with mental illness.

VA'S APPROACH TO MENTAL HEALTH CARE

With its emphasis on providing care management for depression and making evidence-based psychotherapy available for all Veterans who need it, VA is ensuring that planning for treatment of mental health conditions includes attention to the benefits as well as the risks of the full range of effective interventions. Making these treatments available responds to the principle that when there is evidence for the effectiveness of a number of different treatment strategies that can be effective, the choice of treatment should be based on the Veteran's values and preferences, as well as the clinical judgment of the provider.

VA has been making significant enhancements to its mental health services since 2005, through the VA Comprehensive Mental Health Strategic Plan and special purpose funds available through the Mental Health Enhancement Initiative. 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. 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. 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.

The focus on recovery for those with serious mental illnesses reflects major scientific advances in treatment and rehabilitation. Although it is still not possible to offer definitive cures for all patients with serious mental illness, it is realistic to offer the expectation of recovery. Veterans, often with their families, should collaborate with their providers in planning treatments, where the goals are to help the Veteran live the kind of life he or she chooses, in spite of any residual signs or symptoms of mental illness. To achieve this vision, VA has hired staff to provide peer support, trained clinicians in evidence-based strategies for treatment and rehabilitation, enhanced the care in residential treatment settings, and strengthened programs that involve families.

In addition to the care offered in medical facilities and clinics, VA's Vet Centers provide outreach and readjustment counseling services to returning war Veterans of all eras. By the end of the current fiscal year, we anticipate having 299 Vet Centers in operation. It is well-established that rehabilitation for war-related PTSD, Substance Use Disorder, and other military-related readjustment problems, along with the treatment of the physical wounds of war, is central to VA's continuum of health care programs specific to the needs of war Veterans. The Vet Center service mission goes beyond medical care in providing a holistic mix of services designed to treat the Veteran as a whole person in his or her community setting. Vet Centers provide an alternative to traditional mental health care that helps many combat Veterans overcome the stigma and fear related to accessing professional assistance for military-related problems. Vet Centers are staffed by interdisciplinary teams that include psychologists, nurses and social workers, many of whom are Veteran peers.

Vet Centers provide professional readjustment counseling for war-related psychological readjustment problems, including PTSD counseling. Other readjustment problems may include family relationship problems, lack of adequate employment, lack of educational achievement, social alienation and lack of career goals, homelessness and lack of adequate resources, and other psychological problems such as Depression and/or Substance Use Disorder. Vet Centers also provide military-related sexual trauma counseling, bereavement counseling, employment counseling and job referrals, preventive health care information, and referrals to other VA and non-VA medical and benefits facilities.

To promote suicide prevention, VA established a strong partnership with the Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) to operate a Veterans Call Center as part of the National Suicide Prevention Lifeline (1–800–273-TALK). VA also has appointed suicide prevention coordinators and care managers at each VAMC and the largest community-based outpatient clinics. Altogether, VA employs over 400 staff members who focus specifically on suicide prevention. My colleague, Dr. Janet Kemp, discusses these programs in greater detail in her testimony.

VA POLICY AND REQUIREMENTS

In 2009, VA approved the Handbook on Uniform Mental Health Services in VA medical centers and Clinics to define what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care, and to sustain the enhancements made in recent years. One important set of requirements in the Handbook was to ensure that evidence-based psychotherapies are available for Veterans who could benefit from them and that meaningful choices between effective alternative treatments are available.

Also, based on its Comprehensive Mental Health Strategic Plan, VA has enhanced access to mental health services by requiring that mental health services must be integrated into primary care services. To ensure Veterans are monitored appropriately while they are receiving mental health services, including treatment with psychotherapeutic medications, VA requires that these integrated care programs include evidence-based care management.

Care management for depression includes repeated contacts with patients to educate them about depression, medications, and other treatment, as well as to provide evaluations of both therapeutic outcomes and adverse effects. The benefits of the frequent contact program relate to increased patient-engagement in care. Also, information from patient monitoring is translated into decision-support for providers about when they should modify treatment. Two programs that are used frequently in VA primary care settings are Translating Initiatives in Depression into Effective Solutions (TIDES) and the Behavioral Health Laboratory (BHL), both of which are evidence-based interventions supported by extensive research. Studies on care management for depression in primary care settings have demonstrated that these interventions can decrease both depression and suicidal ideation in older adults. This led to recognition of care management for late life depression as a best practice for suicide prevention.

For several years, VA has provided training to clinical mental health staff to ensure that there are therapists in each facility who are able to provide evidence-based psychotherapies for the treatment of depression and PTSD as alternatives to pharmacological treatment or as a course of combined treatment. The initiative to make these psychotherapies broadly available within VA is relevant to concerns about medication safety, but the program was not developed as a result of those concerns. VA implemented the broad use of evidence-based psychotherapies in response to evidence that for many patients, specific forms of psychotherapy are the most effective and evidence-based of all treatments. Specifically, the Institute of Medicine report on treatment for PTSD emphasized findings that exposure-based psychotherapies, including Prolonged Exposure Therapy and Cognitive Processing Therapy, were the best-established of all treatments for PTSD. Other specific psychotherapies included in VA's programs include Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression and Skills Training and Family Psycho-Education for schizophrenia. VA is adding other treatments such as Problem Solving for Depression, Cognitive Behavioral Therapy and Contingency Management for Substance Use Disorder, and behavioral strategies for managing both pain and insomnia.

VA'S ACCOMPLISHMENTS

As stewards of the public interest and bearing the responsibility for caring for America's Veterans, VA conducts ongoing analyses of its programs and continually asks itself how they can be improved. VA's mental health enhancements were designed to implement evidence-based practices. Evidence led VA to adopt specific requirements for follow-up care after hospital discharge, and to require depression care management. Most generally, the findings support the conclusion that high quality mental health care can prevent suicide. The suicide rate for all Veterans who used VA health care declined significantly from FY 2001 to FY 2007, as the attached chart indicates.

Mental illnesses are among the most prevalent conditions affecting Veterans of all generations, wars or conflicts. VA research continues its commitment to defining the

most effective mental health treatments. VA investigators have generated many major findings related to behavioral and psychiatric disorders such as schizophrenia, depression, substance use (including alcohol, illicit drugs, and nicotine), suicide prevention, and PTSD. From conducting large clinical trials to supporting center-based research programs to improving care delivery, mental health research continues to be a major priority for the VA research program.

In one line of research, VA scientists are investigating factors related to improving adherence and compliance. This includes studies on anti-depressant adherence among older Veterans, reducing the impact of drug side effects, and a patient-centered approach to improve screening for side effects of second-generation antipsychotics. Efforts to improve the quality of care for persons with severe mental illness have focused on the inclusion of family members as active participants in the patient's treatment. VA researchers are also evaluating how to best implement an integrated health care approach for Veterans with serious mental illness. Combined with a number of other behavioral and psychological intervention studies, VA has been at the forefront of mental health research that seeks to improve treatment options for clinicians and patients dealing with mental health care needs.

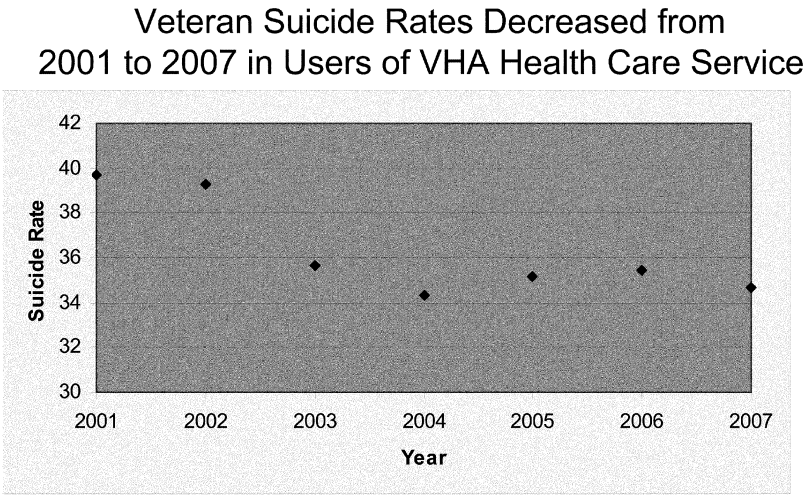
VA research is also striving to identify critical risk factors for major mental health disorders. One unique study is looking at Veterans who were deployed to Iraq as active duty Army, National Guard, or Reservists who had baseline physical and mental health assessments before deployment. Planned follow up studies will determine the effect of the combat experience on mental health, emotions, reactions, and cognition—shortly after return from Iraq as well as over ensuing years. Research is also changing how care is provided to individuals with less access to treatment facilities or providers. VA investigators successfully adapted a collaborative/team care approach to treat depression in older Veterans using telemedicine to address rural health disparities. Subsequently, this study provided the support for implementing telemedicine-based collaborative care in hundreds of small rural CBOCs that do not have on-site mental health specialists.

Moreover, VA is working to better understand risk factors associated with suicide and the optimal means to prevent suicide. VA investigators focused on suicide prevention recently reported a correlation between chronic pain and suicide suggesting an important risk factor and highlighting a potentially at-risk group. Additional research is ongoing to evaluate the effectiveness of suicide hotline interventions, firearm safety, and how to care for Veterans receiving treatment for substance use disorder and depression who express suicidal thoughts.

CONCLUSION

VA as a system is committed to improving the quality and availability of mental health care to Veterans. VA's mental health enhancements have included major initiatives—far too many to itemize completely, but including effective efforts to increase access to mental health care, increase the use of evidence-based psychotherapy for the treatment of PTSD and depression, enhance the safe use of psychotherapeutic medications, provide effective suicide prevention interventions, fully utilize psychosocial rehabilitation and recovery-oriented services, and ensure the appropriate level of trained staff are available to provide needed services. VA firmly believes that each Veteran has earned an individual determination of the best treatment and routine follow up for his or her specific condition, and its clinical guidelines support this endeavor. Thank you again for the opportunity to appear, and my colleagues and I are available to address any questions from the Committee.

THE CHART REFERENCED DURING THE HEARING



• Suicide rates are in deaths per 100,000 individuals per year
• Rates are calculated using causes of death from the National Death Index and VA administrative data.
• From a statistical perspective, the 12.8% decline in rates between 2001 and 2007 is significant with $p < 0.001$.
• From a public health perspective, the decline in rates is significant, corresponding to about 250 fewer lives lost through suicide.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO DR. GERALD CROSS, ACTING PRINCIPAL DEPUTY UNDERSECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. How is implementation of the Uniform Mental Health Services package progressing? Are mental health clinics with weekend and evening hours widely available across the system? What are the barriers to full implementation?

Response. We have surveyed the field twice about the status of their efforts to implement the requirements of the Uniform Mental Health Services Handbook. The most recently completed survey reflects the status of implementation as of the end of December 2009. At that time, facilities reported implementing approximately 90 percent of more than 200 requirements. A recent draft Office of Inspector General (OIG) study indicated the same conclusion.

The draft OIG report specifically looked at the availability of weekend and evening hours. They reported that these hours were available in 94 percent of 139 VA medical centers, and in 43 percent of the 49 very large Community Based Outpatient Clinics (CBOCs).

Some barriers to full implementation include: space limitation for new staff programs as well as difficulties recruiting and hiring the needed staff. Additionally, there are barriers with some of the complex programs, such as Residential Rehabilitation and Recovery Centers, which require a cultural shift as well as establishing new staff and programming. The ultimate requirement also includes receiving Commission on Accreditation of Rehabilitation Facilities (CARF) accreditation. The Office of Mental Health Services (OMHS) works closely with the field to accomplish this innovative implementation and sites are making excellent progress; however, full implementation will take additional time.

Question 2. What type of coordination is occurring between DOD and VA to transition a demobilizing or separating servicemember to VA care, or to refer a currently serving servicemember to VA care? How effectively is data, such as PDHRA information, being communicated between the Departments?

Response. Of the 1,094,502 servicemembers eligible for VA care who have served in Afghanistan or Iraq since FY 2002 through the fourth quarter of FY 2009, 46 percent have come to VA for health care which is a significantly large number compared to other service eras. This is due in part to the efforts of both the Department of Defense (DOD) and VA to inform separating servicemembers of their health care and other benefits to which they are entitled by virtue of their service to our Nation in time of war. VA's outreach efforts to separating servicemembers are multiple. Every eligible Veteran receives a letter from the Secretary of Veterans Affairs informing them of their health care benefits and follow-up letters are sent to those who have not come to VA for care. Staff from Vet Centers, VA Regional Offices, and medical centers attend Post-Deployment Health Reassessment (PDHRA) administrations, National Guard and Reserve Yellow Ribbon events and welcome home events at VA medical centers (VAMCs). These events provide opportunities to share information about VA health care and other benefits such as those involving education and home loans. Specifically, DOD provides PDHRA records to VA on those Veterans who are referred to VA for care. VA tracks the clinical services provided to Veterans referred from DOD for care. DOD has systems in place to follow-up on referred Veterans.

The Federal Partners Work Group on Reintegration of Returning Servicemembers and their Families is an interagency group co-chaired by Dr. Antonette Zeiss, Deputy Chief Consultant for Mental Health of VA and Brigadier General Loree Sutton, Director of the Defense Center of Excellence on Psychological Health and Traumatic Brain Injury. The work group promotes collaborative actions across agencies and with community providers. It has subgroups that focus on strategic collaborations between VA, DOD and other Federal and state entities, services for families, tracking of Veterans, destigmatization approaches and Veteran employment issues.

For servicemembers who are ill or injured, VA and DOD have complementary and integrated team activities including:

- DOD and VA Federal Recovery Coordinators (FRCs) are assigned to severely injured servicemembers/Veterans and families. The FRCs work to coordinate VA and community benefits and services and provide an integrated approach to coordinate medical, social and community resources;
- VA Liaisons at military treatment facilities (MTFs) who transition injured Veterans to VA;
- Coordination of lodging in Fisher Houses for family members of Veterans in extended rehabilitation for war injuries;
- Transition Patient Advocates (TPAs) as navigators or advocates for Veterans and family member at VAMCs;
- Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Care Management teams that serve as an initial point of contact for Veterans and family members and Military Liaisons at VA medical centers (e.g. Army Wounded Warrior (AW2) staff);
- VA mental health clinicians support the mental health needs of wounded Veterans being treated in Polytrauma rehabilitation settings.

Also, based on the October 2009 VA/DOD Mental Health Summit, VA and DOD are collaborating on projects designed to support separating servicemembers. This includes the DOD-sponsored "In Transition" project that provides trained mental health coaches to support continuity of care for servicemembers and Veterans who are transitioning from mental health care in DOD to VA.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO DR. GERALD CROSS, ACTING PRINCIPAL DEPUTY UNDERSECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Cross, while it is good news that VA's new efforts are reducing suicide among veterans in active treatment. If the statistics of 18 veterans committing suicide and only 5 are known to VA, there are 13 veterans not in care. What are the VA's ideas for how to find and reach more veterans that need this assistance?

Response. We will continue to reach out to these Veterans through the Hotline, media campaigns and outreach events as well as continue to develop relationships with community organizations and individuals who may be in a position to make referrals and provide assistance to Veterans needing help. We have partnered with organizations such as the Student Veterans of America and the American Legion to assist us to reach out to Veterans in crisis. We have developed collaborative agreements with the IHS and the Department of Health and Human Services' Sub-

stance Abuse and Health Services Administration (SAMHSA) to assist us to reach Veterans in the community who are in crisis.

Question 2. Dr. Cross, given all the new GI bill students on campuses, what is VA doing to help their readjustment from Iraq and Afghanistan with combat and IEDs to the new life of a college campus?

Response. VA has created an Internet page that targets college and university counseling center staff to provide them with information about common adjustment and mental health issues faced by Veteran students. A resource page for Veteran students is also included. The page can be accessed at: http://www.mentalhealth.va.gov/College/index.asp.

Information about this resource has been broadly disseminated throughout VA, in partnership with Veteran Service Organizations, and through the National Academic Advisors Association Military Interest Subgroup.

Additionally, VA has established a working relationship with the Student Veterans of America, to facilitate development of resources for student Veterans. One shared project involves suicide prevention efforts. Locally, Suicide Prevention Coordinators, based at each VA medical center, include college campuses in their outreach efforts and are providing Operation SAVE training to college students.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO DR. GERALD CROSS, ACTING PRINCIPAL DEPUTY UNDERSECRETARY FOR HEALTH, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. How are the Veterans' Affairs Regional offices preparing for the surge of Veterans returning in 2010 and 2011 with mental health, TBI and PTSD problems?

Response. By hiring and training additional employees, VA will have a stronger and more productive workforce to offset the impact of the expected workload increases over the next two fiscal years. We are actively exploring process and policy simplification, short-term technology enablers, as well as the traditional approach of hiring additional employees to address the continued growth of all categories of claims.

Question 2. Alaska's Veterans need additional mental health services. The Alaska VA system's participation in the Alaska Psychiatry Residency would improve access to mental health care for Alaska's Veterans. What financial and political support is necessary for the Alaska VA system to be able to participate in the Alaska Psychiatry Residency?

Response. VA is eager to enhance mental health services for all Veterans, including those in Alaska. Clinical education programs have been shown to be an important source for producing a pipeline of health care professionals in a particular geographic area, and should be encouraged in under-served areas.

The Alaska VA Healthcare System (HCS) is actively exploring the possibility of participating in a psychiatry residency program. In general, the requirements for such participation are as follows:

- An Accreditation Council for Graduate Medical Education (ACGME) accredited psychiatry residency program is willing to associate with the Alaska VA HCS.
- The Alaska VA HCS is found to be a good learning site with experienced psychiatrists who are willing to teach.
- Educational resources for trainees are available; these include space, technology, and information resources to support the training program.

The Office of Academic Affiliations could support trainees in a psychiatry training providing the above minimum standards are met. The financial considerations should not be considered a major barrier in this endeavor.

Recently, VA opened a Psychology Internship Program at the Alaska VA HCS. This is currently the only psychology internship program in Alaska, and is also a potential program for expansion to meet the mental health needs of the Alaskan Veterans.

Question 3. Rural Veterans are a major concern in my state and across the country. What are your plans to coordinate with the Indian Health Service (IHS) and Community Health Centers in rural areas to provide "seamless" services for rural vets? For example, the vet should be able to go to the clinic in their village and not have to worry about paperwork or denials or to travel over 500 miles for an appointment.

Response. Since the signing of a Memorandum of Understanding (MOU) between VA and IHS in 2003, there have been and continue to be a number of cooperative arrangements and agreements. For example, tele-psychiatry clinical demonstration

pilots are currently serving Native Americans on rural reservations in eight sites covering 13 tribes in four western states. In Alaska, a similar initiative is located at the Yukon-Kuskokwim Regional Hospital in Bethel. The same initiative is under negotiation at the Kotzebue Regional Medical Center. The Care Coordination Store and Forward (CCSF) project, in Kenai, Alaska includes tele-retinal imaging to screen for diabetic retinopathy, tele-dermatology and tele-pathology. VHA has also initiated a project to expand fee-based authority for primary and mental health care serving Native Alaskans in the highly rural areas, a project with potential national implications.

VA and IHS are partnering to allow IHS staff to view (read-only) VA's electronic medical record on the Rosebud Reservation in South Dakota. A project at the VA Outreach Clinic in Saipan, Commonwealth of the Northern Mariana Islands includes the use of contracted part-time providers, with on-island tele-health capability, negating the need for Veterans to travel to more distant locations for routine examinations. In collaboration with VA, IHS has developed a patch for Bar Code Medication Administration, which has been tested at Fort Defiance, AZ and connectivity has been established with the Tucson VA Centralized Mail Out Pharmacy (CMOP).

In addition to supporting one another in the shared delivery of care to rural Veterans who are located on Native lands, VA and IHS have embarked on an ambitious cooperative educational program. In FY 2009, VA provided 133 training episodes to tribal health care and IHS providers. In the first quarter of FY 2010, VA has already provided 80 training programs. These educational sessions are conducted through satellite, video teleconferencing and web-based technologies strengthening our shared use of technology, and are highly valued by both tribal and IHS providers.

In closing, the Under Secretary for Health and the Chief Medical Officer for IHS agreed in January 2010 to update the 2003 MOU between VA and IHS.

Question 4. In states, such as Alaska, where Psychological Health, TBI, and Suicide resources are low and the workforce is underdeveloped, is there a mechanism to encourage VA to work with state/community leaders that are working hard to develop the same care in the civilian sector and having similar workforce, access, or outreach/identification challenges. How will (or can) telemedicine be used to increase access to Psychological Health, TBI and suicide services and supports?

Response. VA actively engages the public and private sector to identify, coordinate, and utilize providers and facilities within the catchment areas of VA facilities to provide services that meet the needs of Veterans. Such collaborations have been successful in complementing VA care. For example, in FY 2009, over 3,800 Veterans with TBI received inpatient and outpatient hospital care and medical services from public and private entities, with a total disbursement of $21,375,168.

VA uses Telehealth to provide medical care services and support to more than 260,000 Veteran patients, including Veterans in Alaska and in rural locations in other states. VHA Telehealth has increased access to VA medical center service and support to 500 CBOCs and to 41,000 Veteran patients at home. VHA plans to increase Telehealth activity by 30 percent in FY 2010.

Increasingly, tele-mental health provides a mechanism for specialist care within VA to diagnose, treat and prevent depression with expanded accessibility to patients locally using health information and telecommunication technologies. There is good evidence to show that these telehealth interventions are effective and comparable to face-to-face delivery of services. Over 30 peer-reviewed scientific articles have substantiated the role for tele-mental health in expanding access to care.

Telehealth services are an important element of VA's Uniform Mental Health Services. The most common clinical videoconferencing Telehealth application in VHA is tele-mental health used to link Veteran patients at the CBOC with their mental health provider at the VAMC. In FY 2009, VHA provided tele-mental health services to almost 40,000 Veteran patients during more than 128,000 encounters.

The Alaska VA HCS has established a Tribal Veterans Representative Program that uses local community volunteers to help VA in reaching out to Alaska native Veterans. Alaska VA HCS has made special efforts to reach out to Alaska Native Tribal Health Consortium organizations. A group of VA staff has traveled to rural areas to provide education on PTSD, TBI, and suicide awareness and prevention. Further, Alaska VA HCS has signed an MOU with Alaska's Department of Military and Veterans Affairs that outlines a partnership to work together to meet the needs of returning soldiers.

Alaska is served by four Vet Centers located in Anchorage, Fairbanks, Kenai and Wasilla. An American Indian counselor on staff at Anchorage provides outreach services to Veterans in remote American Indian and Native Alaskan villages, many not accessible by roads. On a biannual basis, remote villages are visited by the coun-

selor traveling via bush plane and/or the Alaska National Guard. Remote villages are contacted by radio transmission beforehand to announce the date of arrival. The visiting Vet Center counselor provides informational VA brochures, briefings, and some counseling to Veterans and family members.

Staff from VISN 20 in Alaska participate in the Alaska Brain Injury Network, a non-profit organization created by the Alaska mental health trust to provide resources to Alaska residents with TBI and integrate and share services from different sectors (Federal, state, Native, private) for individuals with TBI. Telehealth is used to provide follow-up comprehensive TBI evaluations from a VA medical center provider to Veteran patients at rural clinics. Such a Telehealth link has been established with the CBOC in Fairbanks, with plans for the Kenai and Juneau CBOCs. This practice, also used in the VHA Eastern Colorado Health Care System, continues to expand.

VHA is also in the final acceptance testing phase of a Home Telehealth Disease Management Protocol (DMP) for mild TBI that will be deployed throughout VA to eligible Veteran patients on home Telehealth devices.

Regarding suicide prevention efforts relevant to rural Veterans, OMHS has established mechanisms for access to care for those Veterans in crisis through the use of the Hotline and Chat Service. VA Suicide Prevention Coordinators have been conducting outreach programs in all communities included in their respective catchment areas to involve community organizations in the referral process. There is a pilot project in Oregon that educates community health care personnel to do suicide prevention outreach to Veterans, and provide initial services and facilitate on-going care with VA using tele-mental health.

Finally, the VHA Polytrauma Telehealth Network established in 2006, links the four VA Polytrauma Rehabilitation Centers and 17 VA Polytrauma Network Sites from across the Nation (including the San Juan VAMC). All of these sites are part of VHA's larger Clinical Videoconferencing Network that currently reaches 500 CBOCs. VHA is defining patient criteria and clinical pathways to enable CBOCs to link appropriate patients into care via the polytrauma Telehealth network.

Question 5. Are there telemedicine options for specialty therapies for TBI, such as physical therapy, speech therapy, occupational therapy or counseling?

Response. Yes, currently, there are 60 VA sites providing rehabilitation using Telehealth with planned expansions in FY 2010 in the areas of speech pathology, mild TBI home Telehealth, Spinal Cord Injury (SCI), and post-amputation medical services and support.

In 2009, 17 of 21 VISNs provided some form of tele-rehabilitation with an overall increase in workload of 31 percent from the previous year. Speech therapy accounted for 72 percent of this workload, and Telehealth was also used to provide physical therapy and occupational therapy services. New initiatives are underway to utilize telehealth for audiology services

Question 6. Will case management be utilized? Why?

Response. Polytrauma/TBI specialty case managers are part of the interdisciplinary rehabilitation teams that care for Veterans and servicemembers with polytrauma and TBI. They participate in the development of the individualized rehabilitation and re-integration care plans, and oversee the implementation of the plan, including securing the necessary resources to assist Veterans, servicemembers and families through recovery, rehabilitation, and re-integration into the community.

The Polytrauma Telehealth Network is utilized by these specialty case managers to assess the psychosocial needs of the patient and the family, help coordinate the necessary services to address those needs, and to coordinate rehabilitation care including outreach to community resources.

Case management is a core component in the provision of care and services to help OEF/OIF servicemembers and Veterans restore or maintain their functioning within the context of their family relationships and community re-integration post-deployment. Case managers for patients with complex, multiple injuries, including TBI, amputation and psychological trauma require specialized knowledge and skills. Patients and families need long-term case management services to ensure coordination of services, evaluation of ongoing rehabilitation needs, and supportive services to assist with successful community reintegration. In rural or underserved areas of the country, case managers assist Veterans and their families to identify and access community, state and local resources close to the Veteran's home. Services are provided across a continuum of care that may include inpatient and outpatient rehabilitation, long-term care, transitional living, community re-integration programs, and vocational rehabilitation and employment services.

Each VA medical center has a Case Management team consisting of both a clinical component (registered nurses and social workers) that includes the OEF/OIF

Program Manager and OEF/OIF case managers and a non-clinical component led by Transition Patient Advocates (many of whom are OEF/OIF Veterans). The Program Manager coordinates clinical care and oversees the transition and care for this population. OEF/OIF case managers coordinate patient care activities and ensure that all clinicians providing care to the patient are doing so in a cohesive and integrated manner. Transition Patient Advocates help Veterans navigate the VA system and Veterans Benefits Administration (VBA) team members assist Veterans with the benefit application process and provide education about VA benefits.

All severely ill and injured OEF/OIF servicemembers and Veterans receiving care at VA are provided a case manager. All others are screened for case management needs and, based upon the assessment a case manager is assigned as indicated. The patient and family serve as integral partners in the assessment and treatment care plan. Our 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.

Question 7. What are you doing to ensure that Veterans are being provided the best possible psychiatric care? Statistics show that 40% of those servicemembers who die by suicide had previously been seen at Behavioral health. Are the treatments effective? Do we have appropriate, timely, cultural and effective treatments available?

Response. We know that a little less than 50 percent of VHA Veterans who died by suicide had a mental health diagnosis. We believe this is due to VA's ongoing efforts to provide quality mental health services to all Veterans. There is an "enhanced care package" for Veterans who have been identified as high risk for suicide. It includes suicide-specific interventions such as safety planning and engagement into evidence-based psychotherapies. We will continue to enhance our mental health services as more information on the effectiveness of our programs becomes available.

Question 8. What are you doing to reach out to families, especially parents, to provide education on emergency mental health issues, how to identify them and what to do about it?

Response. VHA Handbook 1160.01 identifies family involvement and family services, when appropriate and in connection with the treatment of the Veteran, as an essential component of the mental health program. To facilitate this patient—centered, family focused transformation in services, the Handbook requires that the clinical provider discuss with the Veteran the need and the benefits of family involvement in their care annually and at the time of discharge if there has been an inpatient stay. As part of this process, the provider must seek the consent of Veterans to contact family as necessary in connection with Veterans' treatment. Additionally, every medical center will provide a continuum of family services within existing statutory and regulatory authority either on site, by tele-mental health, with community providers through sharing arrangements, contracting, or non-VA fee basis care to the extent the Veteran is eligible. Providing education on emergency mental health issues, including how to identify them and what to do about them, are addressed in our graduated continuum of services that meet the varying needs of Veterans and their families.

The continuum of family services includes:

- Family Consultation. Family consultation involves the family meeting with a trained mental health professional as needed to resolve specific issues related to the Veteran's treatment or recovery, which may include emergency mental health issues. The intervention is brief, typically one to five sessions are scheduled for each consultation. Consultations may be provided on an as needed or intermittent basis; if more intensive ongoing effort is required, the family can be referred for Family Psychoeducation.
- Family Education. Family education is a set of techniques to provide families with the factual information necessary to partner with the treatment team to support a Veteran's recovery. Typical topics include symptoms, likely treatments, recognizing relapse, identifying and managing sources of stress, minimizing crises, and increasing problem-solving skills. Family education may be offered through written and video materials, one day workshops and/or regularly scheduled meetings conducted over time by professionals (e.g. the Support and Family Education (SAFE) program) or by trained family members (e.g. the National Alliance on Mental Illness Family to Family Education Program (NAMI FFEP)). The Veteran may or may not be present at family education meetings.

In June 2008, VHA signed an MOU with NAMI to offer the NAMI FFEP in at least one VHA facility in each state during a two year period starting in June 2008. The selected VHA facility and local NAMI affiliate serve as models to continue this partnership throughout all VISNs.

• Family Psychoeducation (FPE). Family psychoeducation is a type of evidence-based family therapy that focuses on developing coping skills for handling problems posed by mental illness in one member of the family. The models of family psychoeducation share a number of components, including careful assessment, provision of education, problem-solving training, and an emphasis on improving current functioning. Interventions can be offered in a single family format (e.g. behavioral family therapy) or multi-family group format (e.g. multiple family group therapy). Veterans are typically present during the FPE sessions.

With regard specifically to emergency mental health issues, massive outreach programs have been established by the Suicide Prevention Coordinators at each facility. These include face-to-face presentations about how to recognize when someone is in trouble and how to get help. In addition, posters, mailings and mass media public service announcements have been made available across the country. VA has developed its own Veteran-specific "gatekeeper" training program for communities and families called Operation S.A.V.E. (Signs Ask Validate Encourage) which is provided in all communities. VA has developed family and age-specific suicide and suicide attempt education materials for distribution. VA will continue to seek out ways on local levels to communicate with families and communities.

In addition, in FY 2009 VA produced Public Service Announcements (PSAs) starring actor Gary Sinise and news personality Deborah Norville. The PSAs aired from October 2008 to September 2009. The company contracted for PSA distribution reported that the PSA aired over 17,000 times across the country in 118 markets on 222 stations, one national cable outlet, and one local cable outlet. Although no longer airing, the PSAs are available on a number of Web sites: VA's Mental Health Service; House Committee on Veterans' Affairs; the official Web site for the US Air Force; and, the Web sites for the Military Officers Association of America, Military Lawyer Blog, American Legion, National Association of State Directors of Veterans Affairs, YouTube, CBS News, etc. A Google search of "Suicide Prevention PSA Gary Sinise," displays 20 pages of citations. Mr. Sinise has agreed to do another PSA for which funding is available in FY 2010. Production of this new PSA is planned for the summer of 2010 with release over the 2010 holiday season.

Question 9. Is the VA utilizing peer-based support to help them with their behavioral health issues? What are you doing to try to build peer-based support for Veterans?

Response. Currently, peer services are provided at 33 percent of VA facilities and the number of such services is growing; these are a vital component of optimal Veteran-centered mental health care. VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics, requires medical centers and very large CBOCs to provide individual and group counseling for Veterans with serious mental illness through the use of Peer Support Technicians. In addition, Residential Rehabilitation Treatment Programs and Psychosocial Rehabilitation and Recovery Centers require the inclusion of Peer Support Technicians as part of their staffing.

OMHS has developed job-specific competencies for Peer Support Technicians to ensure the high quality of the services provided by peers. These competencies are based on the certification examinations for peers as administered by some states and outside-VA mental health organizations. Finally, OMHS is providing funding for currently-employed Peer Support Technicians to become certified by an outside agency.

Question 10. How does one diagnose, treat, and prevent depression and mental health disturbances in remote areas, for Veterans or civilians, this is a difficult task. The use of telepsychiatry and methods of selecting high risk populations after discharge are important, what methods are being used? Any evidence they are successful?

Response. The diagnosis, treatment and prevention of depression in both Veteran and non-Veteran populations in remote areas is based upon the same clinical, legal, evidence and health care organizational principles as for patients in non-remote areas. The challenges in remote areas are the logistic ones of access for both patients and practitioners. There are circumstances where there is an obvious need for face-to-face service delivery in which case physical health care access and associated travel provide the solution. Increasingly tele-mental health provides a mechanism for specialist care within VA to diagnose, treat and prevent depression with expanded accessibility to patients locally using health information and telecommunication technologies. There is good evidence to show that these Telehealth interventions are effective and comparable to face-to-face delivery of services. Over 30 peer-reviewed scientific articles have substantiated the role for tele-mental health in expanding access to care.

Question 11. If a family member of a suicide victim requests an Inspector General investigation, and their benefits have already been approved, can they be denied due to a request for a further investigation or the filing of an IG complaint?

Response. Following the death of a Veteran due to suicide, a determination may be made that service connection for cause of death is established, and Dependency and Indemnity Compensation benefits may be awarded to surviving family members. The request by family members for an Inspector General (IG) investigation or the filing of an IG compliant would not affect the continued eligibility for those benefits.

All decisions rendered by the Veterans Benefits Administration regarding entitlement to or eligibility for benefits, are made based on all the evidence of record. The results of an IG investigation would only affect previously approved decisions if they provided new evidence altering a prior VBA entitlement or eligibility decision.

Question 12. There are cases in which family members have been encouraged to seek help for their spouse or child when they fear they may be suicidal as a result of combat related PTSD. Is there a plan to provide families with a safe place to call where they can access care for their loved one?

Response. Family members are encouraged to call the VA Suicide Hotline (and many do) to get help for their loved ones. The Hotline works with all third party callers (families, friends, co-workers, etc.) to get Veterans the help they need.

Question 13. What are the staffing levels in VA facilities and how do you see that growing and sustaining?

Response. VA currently has over 20,000 "Core Mental Health Staff" (psychiatrists, psychologists, social workers, and nurses) who provide care to Veterans with mental health conditions. This represents a 44 percent increase over the staffing levels in VA at the end of FY 2005, when there were 13, 950 mental health providers. We anticipate sustaining this staffing level, with some slight additional growth over time, as facilities hire additional approved staff in hard-to-recruit parts of the country.

Question 14. Do you have outside groups/evaluators to determine if the VA programs are successful?

Response. VA has numerous outside groups that provide evaluation of VA programs. Some key examples include:

- The Joint Commission includes review of mental health programs in all medical facility reviews.
- VA's Suicide Hotline was recently reviewed by the American Association of Suicidology Crisis Center Accreditation Team and received the highest scores possible and a full accreditation. The Hotline also has a full CARF accreditation.
- VA requires that many rehabilitation programs receive CARF accreditation, including Residential Rehabilitation Treatment Programs (RRTPs) and Psychosocial Rehabilitation and Recovery Centers.
- In addition, VHA contracts with Mathematica to conduct evaluations of all RRTPs, including on-site visits.
- VHA is currently in the process of a Government Performance and Results Act (GPRA) evaluation project to evaluate mental health programs; the study is contracted to the RAND Corporation.

Question 15. Should the Mental Health professionals who are working with DOD carryover to VA? For example, the professionals (case manager, etc.) follow the person, rather than go from DOD to VA, continuity of service provider?

Response. We do not believe that mental health professionals should "carry over" from DOD to VA, as this would involve significant logistical concerns and would work geographically for a minority of servicemembers. However, we do agree that efforts should be made to provide continuity of transition from DOD to VA for mental health patients transferred from one Department to the other, for either inpatient or outpatient care. For this reason, the in-Transition Program was developed in response to a DOD Mental Health Task Force recommendation to "maintain continuity of care across transitions" (5.2.2). This new program went active within DOD on February 1, 2010. The in Transition voluntary coaching and assistance program can provide a bridge of support for servicemembers while they transition between health care systems or providers. VA is enthusiastically partnering with DOD to implement this program for those transitioning to VA mental health care.

Question 16. What type of classes is the VA offering for education and prevention of suicide and MH issues?

Response. All VA staff are required to take suicide prevention training. There is a web-based clinical program that includes risk assessment and treatment strategies for all providers and a general awareness program for non-clinicians. In addi-

tion, a variety of training regarding specific Veteran populations and providers has been developed and is offered on a regular basis via national and regional suicide prevention conferences and web-based training efforts. Monthly calls are held with the Suicide Prevention Coordinators and programs have been developed for them to share with their facility staff on specific suicide prevention strategies such as safety planning.

Question 17. What are the non-traditional programs the VA is providing?

Response:

- Veterans Chat is an innovative way for Veterans to seek help through VA. VA is exploring ways to provide patient information and education through MyHealtheVet. Pilot sites now allow Veterans to interact directly with their providers.
- VA also offers care online through MyHealtheVet, as covered in other questions.
- VA's use of tele-mental health for direct care provision is also innovative and unmatched in any other part of the health care system in the United States.
- VA's intensive training to ensure that Veterans can receive evidence-based psychotherapy for a variety of mental health problems is innovative.
- VA has a work group to review Complementary and Alternative Medicine (CAM) approaches to mental health care, as well as for other medical problems. Currently no approaches reach a sufficient level of evidence for VHA to endorse their use, but we remain open to expansion as evidence supports such action.

Question 18. What are the faith-based programs the VA have or work with?

Response. VA Center for Faith-based and Neighborhood Partnerships (CFBNP) is a staff office in the Office of the Secretary of Veterans Affairs.

The CFBNP develops partnerships, works collaboratively, and provides relevant information to faith-based, non-profit, community and non governmental organizations. Our goal is to assist these organizations in working effectively with our Veterans and their families.

Our purpose is to expand the participations of our external partners in VA programs equipping them to better serve the needs of our Veterans and their families. CFBNP is the only faith-based program at the Department of Veterans Affairs.

In FY 2009 and 2010, VA CFBNP has worked with the organizations listed below in the following ways: attendance at VA CFBNP roundtables, forums, trainings and or conferences. We have also presented at various events hosted by some of these organizations.

- South Avenue United Methodist, Pittsburgh, PA
- YWCA of Greater Pittsburgh, PA
- Salvation Army of Pittsburgh, PA
- Church under the Bridge, Waco, TX
- Greater Vision Church, Houston, TX
- Mission WACO, Waco, TX
- Salvation Army of WACO, Waco, TX
- Korean Churches For Community Development, Los Angeles, CA
- Cassa Madad Community Development Corp., Woodworth, LA
- Goodwill Industries International, Inc., Rockville, MD
- Quad Area CAA, Inc., Hammond, LA
- Catholic Charities, New Orleans, LA
- First Baptist Church of New Orleans, New Orleans, LA
- Mount Olive Baptist Church, Pensacola, FL
- American Red Cross, Washington, DC
- First Non-Denominational Church of Jesus Christ, Arcola, TX
- Abundant Life Church, Edgewater Park, New Jersey
- Emmanuel House Recovery Community, Detroit, MI
- Coming Home Project, San Francisco, CA
- Volunteers of America Greater New Orleans, New Orleans, LA
- Dare Mighty Things, Arlington, VA
- Ministry on the Go!—Baton Rouge, LA
- Eighth Episcopal District African Methodist Episcopal Church, Jackson, MS
- Non-profit for Utah, Provo, UT

Question 19. What is the outreach to Veterans from the VA to get information to Vets?

Response. Numerous mechanisms exist to get information to Veterans. There are formal mailings, calls and VA participation in DOD events as well as informal mass public health messaging on buses and public transportation vehicles. We have developed public service announcements on suicide prevention and safe driving. We have developed a large internet presence through web pages and social media sites.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO CAITLIN THOMPSON, PH.D., CLINICAL CARE COORDINATOR

Question 1. Are any resources needed to make the Suicide Hotline program more successful?

Response. No additional monetary resources are needed at this time. We need everyone to continue to urge Veterans and their families to call the Hotline or use the Chat Service. Additionally, we need public support to destigmatize the concept of getting help for emotional issues.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO ANTONETTE ZEISS, PH.D., ASSOCIATE DEPUTY CHIEF CONSULTANT AND CHIEF PSYCHOLOGIST, OFFICE OF MENTAL HEALTH SERVICES

Question 1. Do you believe VHA is conducting adequate ongoing analysis of its suicide reduction programs to determine the most effective strategies to reduce suicide?

Response. We believe that VHA is conducting extremely thorough analyses of its suicide reduction programs. All of the following are done:

- We continually analyze available data to look at rates and effectiveness.
- We require a monthly report from each facility which is reviewed to identify trends, not only in numbers but also risk factors and care elements.
- We do annual aggregate reviews on both suicides and suicide attempts.
- Our Evaluation Center in Ann Arbor, MI is continually looking at VA information in regards to national data.
- We have weekly meetings with the Suicide Prevention Staff and the Evaluation Center to continue to look at the information we have to provide the most current information to the field. Recently, we have released two memorandums to field staff to ensure they are aware of recent suicide risk findings. A direct result of these weekly reviews has been a memo concerning the relationship between pain and suicide and another memo concerning suicide risk in patients with Traumatic Brain Injury (TBI).

Question 2. How effectively do you believe VHA monitors patient adherence to treatment?

Response. Monitoring adherence to treatment is an essential clinical function done by staff directly delivering care to Veterans. VHA does not have a national program to monitor adherence to mental health care, nor is this best handled at the national level. VHA does have a policy that any patient receiving mental health care who misses an appointment unexpectedly (i.e. not calling in or otherwise notifying the provider of a need to change an appointment) must be contacted to determine the reason for the missed appointment and to establish a new return appointment (unless the Veteran refuses to do so). A minimum of three follow-up attempts to contact the Veteran are required to ensure the patient is linked back into care. If the patient is known to be at high risk for suicide, follow-up attempts should include a visit to the patient's home with the assistance of community based local crisis response teams or law enforcement if the patient cannot otherwise be contacted. This requirement for active follow-up also triggers an opportunity for providers to discuss adherence and any concerns the Veteran may have about their treatment regimen.

Question 3. How fully has VHA integrated the TIDES Project into each of its outpatient facilities system-wide?

Response. Translating Initiatives for Depression into Effective Solutions (TIDES) is an evidence-based care management model that VHA has implemented in routine practice as part of the primary care-mental health integration (PC-MHI) program. Consistent with the PC-MHI program, it has expanded to include activities addressing anxiety disorders, problem use of alcohol, other substance use disorders, and Post Traumatic Stress Disorder (PTSD). TIDES is one of several care management models that may serve as a component to a facility's PC-MHI program. Presently, 24 VHA facilities across 12 VISNs have care management programs based on the TIDES model. The Steering Committee for Mental Health/Primary Care integration continues to conduct training to assist additional sites in developing a TIDES component for their care. Training on another model, the Behavioral Health Lab, also is provided, and sites can select which of these care management programs to institute.

Question 4. We know that the stigma associated with mental health problems is a serious barrier to Veterans seeking treatment. What else, in addition to VA's current efforts to overcome stigma, would be beneficial?

Response. VA has been diligent in dealing with the stigma issues associated with mental health problems and will continue to work on them. In the area of suicide prevention specifically, VA has developed a mass media campaign including posters, bus and train displays, public service announcements and community education programs. VA has recently increased the required number of outreach activities from three to five per month for all of our local Suicide Prevention Coordinators and they have been asked to focus on both local Veterans Service Organizations (such as the American Legion, which has partnered with VA to promote suicide prevention awareness) and college campuses. VA has increased access to care mechanisms by developing the Suicide Hotline and VA Chat Service which allows Veterans to access care anonymously initially. VA has asked the suicide prevention coordinators, OEF/OIF coordinators, and homeless coordinators to initially meet with Veterans outside of VA to establish relationships. The Vet Centers offer services that are not associated with the "stigma" of mental health in the form of readjustment counseling.

It will take all of these approaches, and more, to break down these barriers. VA needs community support and assistance to do this. VA knows that leadership at all levels can be influential in breaking down barriers and setting examples. Senior DOD leaders are providing this support, which is very beneficial. Dr. Rudd spoke to this in his testimony. VA is working with national and community leaders to provide support and examples of effective actions. VA continues to work with families to make them aware of the signs and symptoms of people in trouble and provide them with ways to seek help. VA plans to work with employers to recognize signs of difficulty and encourage them to assist Veterans to get assistance. This is a national undertaking and VA will continue to do its part.

Question 5. Do patient outcomes indicate that inpatient or outpatient mental health programs are more cost effective when considering the cost of the patient recidivism?

Response. A global statement cannot be made because some conditions are better treated in an inpatient setting, and many others can be treated very effectively in an outpatient setting. VA provides care in a number of inpatient, residential rehabilitation, and outpatient settings, and strives to provide care in the least restrictive setting possible. The general trend in recent decades has been a substantial transition to care predominantly in outpatient settings, with increased utilization of residential rehabilitation care and decreased utilization of inpatient care and length of stay in inpatient. Fewer patients with mental health conditions are being treated in inpatient settings, and their average length of stay on an inpatient unit has also declined substantially, compared to 10 and 20 years ago. These changes are driven primarily by the mandate to provide care in the least restrictive setting, to sustain a Veteran's contact with and identity with the community (i.e. avoid institutionalization), and to promote a model of care that emphasizes psychosocial rehabilitation with a recovery orientation. This model of care is well supported by evidence and provides the greatest hope for quality of life to Veterans being treated for mental health problems.

Question 6. How can VA better address the unique challenges of providing mental health services in the rural setting in light of the unique challenges that face rural communities?

Response. Availability of VA's CBOCs and use of tele-mental health services have improved access to mental health care for rural Veterans. Contracting with community providers is another vehicle for improving access to mental health care. Each of these continues to be expanded to make the full array of mental health services available and accessible to Veterans living in rural areas. In addition, several innovative strategies are underway:

- Section 107, Pub. L. 110–387 authorized VA to conduct a three year pilot program to assess the feasibility and advisability of providing mental health services to OEF/OIF Veterans who reside in rural areas and do not have ready access to VA mental health services. VISNs 1, 19 and 20 (VA New England Healthcare System, Rocky Mountain Network and Northwest Network) are participating in the pilot program and are in the process of negotiating contracts with community providers. It is anticipated that all the pilot programs will be operating by October 2010 and be completed by the end of September 2012.
- An expansion of the Mental Health Care Intensive Care Management—Rural Access Network for Growth Enhancement (MHICM-RANGE) initiative has been supported by VA's Office of Rural Health. This initiative adds mental health staff to CBOCs, enhances tele-mental health services and uses referrals to community mental health services and other providers to increase access to mental health care in rural areas. The expansion of MHICM-RANGE has also led to four research studies initiated in VISN 16 (South Central VA Health Care Network) to investigate

clinical policies or programs that improve access, quality and outcomes of mental health and substance abuse treatment services for rural and underserved Veterans.

• The Vet Centers provide a continuum of social and psychological services including community outreach to special populations, professional readjustment counseling to Veterans and families, and brokering of services with community agencies that provide a key access link between the Veteran and other needed VA and non-VA services. A core value of the Vet Centers is to promote access to care by helping Veterans and families overcome barriers that impede the receipt of needed services. To extend the geographical reach of Vet Center services, the Readjustment Counseling Service (RCS) has implemented initiatives to ensure that new OEF/OIF combat Veterans living at a distance from existing services have access to care. Following the on-set of hostilities in Afghanistan and Iraq, the Vet Center program hired 100 OEF/OIF Veteran Outreach Specialists to proactively contact their fellow returning Veterans at military demobilization sites, including National Guard and Reserve locations. The RCS' Mobile Vet Center (MVC) program is another major initiative for extending the geographical outreach and counseling services to OEF/OIF combat Veterans and their families. To facilitate access to services for Veterans in hard-to-reach outlying areas, RCS has deployed 50 Mobile Vet Centers to strategically selected Vet Centers across the country. The placement of the vehicles is designed to cover a national network of designated Veterans Service Areas (VSAs) that collectively cover every county in the continental United States. The 50 MVCs are used to provide early access to returning combat Veterans via outreach to active military demobilization sites, including National Guard and Reserve sites, and extending services to Veterans at PDHRAs. The vehicles are also extending Vet Center outreach to more rural communities distant from existing VA services.

• OMHS has partnered with the My HealtheVet Program office and Office of Information and Technology (OI&T) to develop online resources designed to complement traditional mental health services, and to expand access to these services to Veterans in rural areas. OMHS is working closely with the Office of Health Information and OI&T to develop My Recovery Plan—an online, interactive application designed to support Veteran-centered, evidence-based mental health practices. Sections of My Recovery Plan will be available for self-paced independent work, while other areas will be made available to Veterans in conjunction with work with a provider. Both approaches can facilitate treatment for Veterans in rural areas.

Question 7. Access to care is a critical concern. Dr. Rudd's testimony suggested putting providers on college campuses to reach OEF/OIF Veterans. What else should VA be doing to make mental health care more available?

Response. VHA is implementing the Uniform Mental Health Services Handbook, designed to ensure consistent access to services for Veterans in VAMCs and CBOCs. A recent survey of the field indicated that as of December 31, 2009, the VAMC Handbook implementation rate for VAMCs and CBOCs was 98 percent.

Among the initiatives that are in place to assist community and rural health care providers is an Internet Web site with basic information on assessment and treatment of PTSD designed for college mental health counselors who, like many community providers, may not have knowledge about military service or experience treating combat related PTSD and other disorders associated with war. It can be accessed on the Internet at www.mentalhealth.va.gov/College/index.asp. Access to services is supported increasingly by Internet-based resources such as the VA OEF/OIF web site at www.oefoif.va.gov and the National Center for PTSD's web site at www.ptsd.va.gov, as well as a VA presence on social media sites such as Facebook and Twitter.

Other initiatives from OMHS include implementation of Public Law 110–387 (Veterans' Mental Health and Other Care Improvements Act of 2008) Title I, Section 107. Three pilots will be implemented in VISNs 1, 19, 20 to assess the feasibility and advisability of providing mental health services to OEF/OIF Veterans who reside in rural areas and do not have ready access to mental health services through VA facilities. The effort will focus on Veterans who served as members of the National Guard or Reserves as well as those separated from active duty. Services will be provided through collaboration with community-based entities including community mental health centers, the Indian Health Service (IHS), and other providers. The three VISNs are negotiating contracts with community providers. It is anticipated that all the pilot programs will be operating by October 2010 and be completed by the end of September 2012.

Telehealth capability is being expanded in rural CBOCs and also for home Telehealth approaches. tele-mental health brings expert clinical care and consultation services as close as possible to the Veteran.

In addition, VA's RCS has deployed 50 Mobile Vet Centers across the Nation specifically to meet the needs of rural Veterans and families. The placement of the 50

Mobile Vet Centers was designed to cover a national network of designated Veterans Service Areas, inclusive of every county in the continental US and not to augment the services at any particular Vet Center.

RESPONSE TO ADDITIONAL POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO ANTONETTE ZEISS, PH.D., ASSOCIATE DEPUTY CHIEF CONSULTANT AND CHIEF PSYCHOLOGIST, OFFICE OF MENTAL HEALTH SERVICES

Question 1. Please elaborate on the differences between inpatient care for women veterans and residential care for women veterans.

Response. Inpatient care and residential care are significantly different models of care The inpatient care model is a very short length-of-stay (a few days to at most a couple of weeks) for those who are most acutely ill, are a danger to themselves or others, and cannot safely receive treatment in a less restrictive environment. The goal is symptom stabilization. Inpatient care is typically in locked units, with patients not able to come and go at will.

Residential care is rehabilitation-focused care, with lengths of stay of many weeks or even months, with time for prolonged treatment. Residential programs provide a strong emphasis on rehabilitation and recovery services and offer this longer-term treatment to Veterans who may have a wide range of problems, illnesses, or rehabilitative care needs requiring more intensive treatment than can be provided in an outpatient setting. Residential care programs are typically open units that instill personal responsibility and support and strengthen the patient's links to family and community.

Thus, the goals, structure, and personal experience of someone in the inpatient level of care vs. the residential level of care would be extremely different.

Question 2. How many "women only" residential care units are there in the VA system? Where are they located? How many Veterans does each of them accommodate? What condition are they treated for in these facilities?

Response. Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) provide residential treatment in a 24-hour, 7 days per week, supervised and therapeutic milieu for Veterans in need of more intensive treatment of mental health conditions and addictive disorders than can be provided in an out-patient setting. Women Veterans comprised 5.2 percent (1,789) of the total episodes of care in MH RRTP in FY 2009 (North East Program Evaluation Center—NEPEC). Most MH RRTPs have the capacity to serve women Veterans. In FY 2009, there were a total of 237 operational MH RRTP providing more than 8,440 treatment beds, which includes 252 beds dedicated to women Veterans in 35 of the programs (NEPEC). Of those, there are six MH RRTP that are dedicated to serving women Veterans in a setting where no male patients would be receiving care on the same unit at the same time:

- Boston, MA: 8 beds
- Brockton, MA: 8 beds
- Batavia, IL: 6 beds
- Lyons, NJ: 10 beds
- Temple, TX: 8 beds
- Palo Alto, CA: 10 beds

The most prevalent diagnoses of women Veterans receiving services in MH RRTP are substance use disorder (SUD), PTSD, and depression.

Question 3. Of the women requiring inpatient care services at VA facilities, how many of them are receiving care for Military Sexual Trauma (MST)? What other conditions require inpatient care for women Veterans? Do you receive many complaints from women veterans with regard to the location of the inpatient care services for them within the VA facilities?

Response. OMHS produces reports annually on the amount of outpatient Military Sexual Trauma (MST) related care at each facility and the proportion of all patients with a history of a positive MST screen who have received MST-related care. MST-related care is monitored using the MST encounter form checkbox in the Computerized Patient Record System (CPRS) electronic medical record system. The encounter form checkbox allows clinicians to specially designate VHA encounters when they have provided MST-related care as part of the check-out procedure for an outpatient visit. This designation is available for any outpatient VHA encounter of a patient with a positive MST screen. However, inpatient care does not have a parallel check-out process that would allow providers to designate that an inpatient stay was related to MST. Therefore at this time, OMHS is not able to track the number of women receiving inpatient MST-related care.

Inpatient care is appropriate for women Veterans who are acutely ill and are a danger to themselves or others and cannot safely receive treatment in a less restrictive environment than the locked, controlled inpatient unit.

OMHS does not receive many complaints from women Veterans regarding the location of the inpatient care services for them within VA facilities. However, OMHS understands that continued efforts to enhance safety and security on inpatient units, and especially the psychological experience of safety and security on inpatient units, is a priority effort for mental health care settings as well as other health care settings in VHA. Clear standards for such enhanced safety and experience of psychological safety are laid out in the Uniform Mental Health Services Handbook and OMHS continues to monitor toward full implementation of those standards.

It is important to understand, however, that the majority of care in a setting with bed capacity for women (and men) Veterans is provided in the RRTPs. VHA also offers mental health care to women Veterans on Residential Rehabilitation Treatment Program (RRTP) units.

Question 4. What is the percentage of women mental health providers within VA?

Response. Among VHA employees at the start of FY 2010, 55.1 percent of psychologists are female; 72.2 percent of social workers are female; and 41.2 percent of psychiatrists are female.

Question 5. What is the percentage of women veterans receiving health care services for MST? What other mental health conditions require women veterans to receive care?

Response. Among women outpatients in FY 2009, 21.9 percent (53,295) had a positive screen for MST. Among women with a positive MST screen 69.7 percent (37,132) had at least one MST-related outpatient encounter during FY 2009.

MST is an experience, not a diagnosis. Women Veterans receive mental health care, including MST-related mental health care, for a variety of mental health conditions diagnosed by VA providers. In FY 2008, the top five primary diagnoses for women associated with MST-related mental health encounters were PTSD (46.6 percent), major depression (20.1 percent), mania or bipolar disorder (7.7 percent), schizophrenia and psychoses (5.6 percent), and SUDs (4.0 percent).

Women Veterans receive care for all mental health conditions, including depression, PTSD, SUDs, and various psychotic disorders.

RESPONSE TO POST-HEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO THERESA GLEASON, PH.D., DEPUTY CHIEF MENTAL HEALTH SERVICES, OFFICE OF RESEARCH AND DEVELOPMENT

Question 1. Can you describe how the Quality Enhancement Research Initiatives (QUERI) have translated evidence-based practice into real-world clinical care and how VA might use such findings to improve the delivery and patient outcomes of its mental health and substance abuse services?

Response. The QUERI program uses a systematic approach to translate evidence-based practices in high-priority areas such as mental health. QUERI identifies proven practices, examines where there are gaps in delivering those practices and why, creates and tests interventions to close those gaps, and finally demonstrates how these strategies can be implemented on a larger scale within VHA. One of the most important lessons from QUERI is the need to align multiple parts of the health care system to make sure important practices are measured, prioritized, rewarded and facilitated at multiple levels of the organization. The QUERI program has participated in developing VA guidelines, performance measures, training programs, education for Veterans and tools to help facilities implement new practices.

The Mental Health QUERI, under a series of projects beginning ten years ago with "TIDES" (Translating Initiatives for Depression into Effective Solutions), developed interventions to address problems in care for the large number of Veterans with depression. They used a proven model of collaborative care where mental health nurse care managers assist primary care providers in managing depressed patients and facilitate collaboration between primary care and mental health specialists. To facilitate the uptake of this, they developed educational and training materials for providers and managers, specialized software for care managers to monitor their patients, and programs to help new sites implement this new model of care. QUERI studies demonstrated that the intervention led to more patients receiving effective treatments and to improvements in quality of life and demonstrated that the program was cost-effective. This model has been implemented in over 50 practices in VA as part of efforts to meet Uniform Mental Health Services handbook requirements and improve care of depressed patients in primary care. The model

has also been extended to patients being treated in Human Immunodeficiency Virus (HIV) care settings and substance abuse clinics.

Investigators are also testing methods to disseminate telemedicine-based collaborative care for depression to rural, community-based outpatient clinics (CBOCs). Participating CBOCs have improved performance on the national measure for antidepressant medication continuity and 32 percent of Veterans completing the intervention responded to treatment. This web-based clinical information system for depression care management also is being used at some primary care mental health integration (PCMHI) sites to support clinical activities.

As a result of QUERI Substance Use Disorder (SUD) projects, VA has implemented national clinical reminders for alcohol screening and for brief intervention which can prevent more serious alcohol-related problems. As a result, over 95 percent of all Veterans are routinely screened for problem drinking, and rates of documented brief alcohol intervention have been increasing steadily since January 2008, when the clinical reminder developed by the QUERI was disseminated. In the first year, rates of brief intervention increased from 42 to 58 percent.

QUERI investigators have also developed a care model for patients who do not respond to brief interventions, decline referral to addictions specialty care, and are at high risk of having alcohol use disorders. This care model provides brief interventions that reduce problem drinking in over 50 percent of Veterans getting the intervention and provides outpatient medical withdrawal and pharmacotherapy for preventing relapse in those Veterans with alcohol dependence. Prescribing these medications like naltrexone has substantially increased over the past three years, although it remains well below optimal utilization.

QUERI investigators have also developed a reminder for assessing depressive symptomatology among persons in treatment for substance use disorders. The reminder incorporates the PHQ–9 (the nine item depression scale of the Patient Health Questionnaire) depression screen with additional questions needed to discern if current symptoms are likely non-substance-induced. The reminder provides the assessment tool, scores it, and provides evidence-based treatment recommendations based on the score.

QUERI SUD investigators have improved continuity of care and treatment retention through Veteran engagement in self-help groups and specific improvements and expansions in opiate maintenance treatment. They have developed a Web site that provides clinicians with an empirically-based "3-Step Referral Method" for engaging SUD patients in 12-step and other self-help groups. Opiate maintenance treatment has been substantially improved through three evidence-based QUERI interventions: 1) extensive training and Drug Enforcement Agency (DEA) certification of providers to prescribe buprenorphine for cost-effective maintenance treatment in the over 120 VA facilities where methadone maintenance is not available, 2) Doubled medication doses in methadone and buprenorphine maintenance from sub-therapeutic levels to national guideline levels, and 3) Implemented contingency management therapies throughout SUD programs.

Question 2. What are the determinants of best practices that optimize the cost-effectiveness of mental health and substance abuse care?

Response. Standards for mental health care are driven primarily by evidence regarding the evidence-base for interventions, with the philosophy that the most effective care is also the most cost-effective given VHA's life time commitment to the Veterans we serve. Short term cost-benefit is not as important as knowing that care is provided that will decrease current symptoms, increase psychosocial rehabilitation and recovery, and that have been shown to have the greatest likelihood of decreasing future relapses. VA and DOD develop Clinical Practice Guidelines for major mental health conditions. These are developed and regularly updated to incorporate all of the current evidence on effective care and also contain information relevant to cost effectiveness. VHA endorses utilization of these Clinical Practice Guidelines and they have been incorporated into the Uniform Mental Health Services Handbook to provide consistent guidance to mental health providers in the field.

Question 3. With regard to the integration of mental health services into primary care settings, have any studies measured the success of these initiatives at various phases of the treatment and recovery process? For instance, while the integration of mental health services into the primary care setting may increase access to mental health services by reducing the stigma for seeking help, has the primary care setting been effective at retaining patients in need of more extensive, ongoing mental health care?

Response. Implementation of PC-MHI into routine practice within VHA is an evidence-based practice supported by prior VA and non-VA research. PC-MHI imple-

mentation began during FY 2007 and expanded with the requirements of the Uniform Mental Health Services Handbook in FY 2009. Studies presenting data on these implementation efforts have not presently been published; however, there are several sources of pertinent data to report:

a. First, significant improvements in screening for depression, alcohol misuse and PTSD have occurred during the period of PC-MHI implementation. Specifically, depression screening performance was 83 percent in FY 2008, 93 percent in FY 2009, and 96 percent in FY 2010 (first quarter); alcohol misuse screening was 87 percent in FY 2008, 95 percent in FY 2009, and 97 percent in FY 2010 (first quarter); and PTSD screening was 79 percent in FY 2008, 94 percent in FY 2009, and 98 percent in FY 2010 (first quarter).

b. Second, a study presently undergoing peer review found that the prevalence of diagnoses for depression, anxiety, PTSD, and alcohol abuse increased more from FY 2007 to FY 2008 in facilities with PC-MHI program encounters than those without such program activity. This demonstrates PC-MHI program activity is building on screening to achieve greater case identification.

c. Third, the average number of PC-MHI encounters per unique Veteran was 2.38 in FY 2008 and 2.42 in FY 2009. This demonstrates engagement beyond initial case identification within the primary care setting.

d. Finally, another study presently under peer review found no decrease in rates of mental health clinic encounters for new patients by facility PC-MHI status during 2008–2009.

Together, the data above show improvements in screening, case identification, overall uptake, and retention of Veterans in mental health care across all care settings within the VHA system.

Question 4. Access to care is a critical concern. Dr. Rudd's testimony suggested putting providers on college campuses to reach OEF/OIF veterans. What else should VA be doing to make mental health care more available?

Response. VHA is implementing the Uniform Mental Health Services Handbook, designed to ensure consistent access to services for Veterans in VAMCs and CBOCs. A recent survey of the field indicated that as of December 31, 2009, the VAMC Handbook implementation rate for VAMCs and CBOCs was 98 percent.

Among the initiatives that are in place to assist community and rural health care providers is an Internet Web site with basic information on assessment and treatment of PTSD designed for college mental health counselors who, like many community providers, may not have knowledge about military service or experience treating combat related PTSD and other disorders associated with war. It can be accessed on the Internet at www.mentalhealth.va.gov/College/index.asp. Access to services is supported increasingly by Internet-based resources such as the VA OEF/OIF web site at www.oefoif.va.gov and the National Center for PTSD's web site at www.ptsd.va.gov, as well as a VA presence on social media sites such as Facebook and Twitter.

Other initiatives from OMHS include implementation of Public Law 110–387 (Veterans' Mental Health and Other Care Improvements Act of 2008) Title I, Section 107. Three pilots will be implemented in VISNs 1, 19, 20 to assess the feasibility and advisability of providing mental health services to OEF/OIF Veterans who reside in rural areas and do not have ready access to mental health services through VA facilities. The effort will focus on Veterans who served as members of the National Guard or Reserves as well as those separated from active duty. Services will be provided through collaboration with community-based entities including community mental health centers, the Indian Health Service (IHS), and other providers. The three VISNs are negotiating contracts with community providers. It is anticipated that all the pilot programs will be operating by October 2010 and be completed by the end of September 2012.

Telehealth capability is being expanded in rural CBOCs and also for home Telehealth approaches. tele-mental health brings expert clinical care and consultation services as close as possible to the Veteran.

In addition, VA's RCS has deployed 50 Mobile Vet Centers across the Nation specifically to meet the needs of rural Veterans and families. The placement of the 50 Mobile Vet Centers was designed to cover a national network of designated Veterans Service Areas, inclusive of every county in the continental US and not to augment the services at any particular Vet Center.

Question 5. How effectively is VHA utilizing an evidence-based screening methodology for determining which treatment setting might be more effective for certain patients with specific risk factors?

Response. VHA is effectively using evidence-based screening for identifying cases of depression, alcohol misuse and PTSD; performance for these respective screenings

was 96 percent, 97 percent, and 98 percent in the first quarter of FY 2010. Furthermore, primary care-mental health integration is an evidence-based program that enhances subsequent evaluation and treatment planning, including identification of the treatment setting most appropriate to a Veteran's clinical needs and preferences.

Question 6. In addition to Veterans severely injured and those returning from combat zones, do any of you have any recommendations for identifying less obvious groups of veterans who might be at an increased risk for suicide?

Response. We know the common risk factors for suicide and do screen for depression and PTSD on a regular, recurring basis. If Veterans screen positive for these they are then assessed for suicide risk.

Question 7. We know that the stigma associated with mental health problems is a serious barrier to veterans seeking treatment. What else, in addition to VA's current efforts to overcome stigma, would be beneficial?

Response. VHA is implementing the Uniform Mental Health Services Handbook, designed to ensure consistent access to services for Veterans in VAMCs and CBOCs. A recent survey of the field indicated that as of December 31, 2009, the VAMC Handbook implementation rate for VAMCs and CBOCs was 98 percent.

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Question 8. Have male and female veterans differed much in their treatment outcomes for various models of mental health services? If so, how well do you believe VA has factored such differences into its treatment programs?

Response. VA utilizes evidence-based treatments that have been shown to be effective for both men and women in numerous research trials, and VA uses adaptations for women as needed and supported by evidence. Analyzing the impact of gender on outcomes specifically among Veterans is complicated, and somewhat time-consuming. Women make up about 10% of our treated patient population, so there is a constant imbalance in sample sizes that needs to be addressed. This is further complicated by the fact that female Veterans are disproportionately younger—a greater percentage of them are from the current OEF/OIF era, while a greater percentage of male Veterans are from the older, Vietnam era. The table below documents these trends, showing the numbers of unique Veterans treated in recent years in Mental Health settings, and in any VA treatment setting.

	Mental Health			Female
Year	All	Male	Female	% of all
2009	1,115,710	1,014,347	101363	9.1%
2008	1,046,380	953,824	92,556	8.8%
2007	985,593	901,693	83,900	8.5%
2006	930,845	855,949	74,896	8.0%
2005	905,714	837,065	68,649	7.6%
2004	833,983	773,830	60,153	7.2%

All Health			Female
All	Male	Female	% of all
5,447,894	4,957,636	490,258	9.0%
5,299,865	4,834,268	465,597	8.8%
5,230,342	4,791,416	438,926	8.4%
5,188,836	4,761,842	426,994	8.2%
5,094,494	4,682,413	412,081	8.1%
4,976,773	4,573,287	403,486	8.1%

Data Sources:
Mental Health - NorthEast Program Evaluation Center Annual Reports
All Health - VHA Support Service Center (VSSC) Patient Counts Table

These factors skew direct comparisons between all males and females, or the average male versus the average female. Nonetheless, we do gather and analyze data on relative utilization, lengths of stay, and similar variables for male versus female Veterans being served in specific settings such as Residential Rehabilitation Treatment Programs (RRTPs).

Within RRTPs, we have observed that:

- Women have shorter lengths of stay (approx 2 days);
- They are less likely to have an irregular discharge;
- They are more likely to be discharged to a VA hospital;
- They are less likely to be readmitted; and
- They have more outpatient care after discharge than men.

See attached table on outcomes for RRTP programs.

Females vs. Males Client Characteristics; FY 2008 MHRRTP

Variables	Female Vets n=1,738		Male Vets n=31,513	
	N	mean or %	N	mean or %
Age (years)	1,738	44.7	31,513	49.7
Length of Stay (days)	1,738	60.0	31,513	63.5
Mental Health Readmission†				
Within 14 days	24	2.9%	357	2.3%
Within 30 days	35	4.2%	626	4.1%
Within 180 days	126	15.1%	2,193	14.2%
Mental Health Outpatient Visits†				
Within 14 days	557	66.9%	9,347	60.7%
Within 30 days	647	77.7%	11,101	72.1%
Within 180 days	767	92.1%	13,547	88.0%

† Data based on only those discharges that occurred during the first 6 months of FY 2008.

Among patients with Alcohol Use Disorders or Substance Use Disorders (AUD/SUD), we have observed that women tend to:

- engage in specialty treatment at higher rates than men;
- stay in treatment longer; and
- have better long-term outcomes.

In short, women tend to be more comfortable seeking help for AUD/SUD treatment as it is generally provided.

However, other studies, including some in VA, have found that women with SUD may have more psychiatric comorbidities and additional psychosocial challenges which may complicate treatment engagement and recovery.

VA has been putting efforts into making specialty SUD treatment more appealing and accessible for Veterans of both genders. Recognizing that women Veterans may be more likely to reach specialty care, but have special needs once engaged, VA has

been developing a special mix of services for female Veterans at its specialty SUD treatment programs. In FY 2008, approximately one-third of VA specialty SUD treatment clinics offered specific treatment services for women, and we (who is WE?) VHA expects these services will continue to expand.

Among Veterans with Serious Mental Illness (SMI), a group of VA researchers reported in 2008 a number of gender differences they observed. They found that the females in their sample, as compared to males, were:

- younger;
- more likely to be diagnosed as having bipolar disorder;
- more likely to have completed a high school education;
- more likely to be employed;
- less likely to be married; and
- more likely to live alone.

In addition, female respondents in the study reported greater use of health services outside of the VA. In this study, the female Veterans were found to have more severe symptoms on average, but rated their own self-perceived health and mental health more positively.

Among Veterans with Post Traumatic Stress Disorder (PTSD), we have observed that women treated in intensive PTSD programs had:

- Significantly lower PTSD symptoms;
- Significantly lower alcohol use scores (ASI);
- No difference in drug use scores;
- No difference in reports of violence;
- No difference in days worked; and
- No difference in satisfaction with care.

In short, there is a complex pattern of gender differences observed among the Veterans treated in the VA. VA continues to recognize and respond to gender-based differences and needs. Clinicians or officials continue to monitor the impacts our programs have on men and women, and continue to make adjustments in the delivery of services in response to any patterns observed.

Question 9. Do you believe VHA is conducting adequate ongoing analysis of its suicide reduction programs to determine the most effective strategies to reduce suicide?

Response. We believe that VHA is conducting extremely thorough analyses of its suicide reduction programs. All of the following are done:

- We continually analyze available data to look at rates and effectiveness.
- We require a monthly report from each facility which is reviewed to identify trends, not only in numbers but also risk factors and care elements.
- We do annual aggregate reviews on both suicides and suicide attempts.
- Our Evaluation Center in Ann Arbor, MI is continually looking at VA information in regards to national data.
- We have weekly meetings with the Suicide Prevention Staff and the Evaluation Center to continue to look at the information we have to provide the most current information to the field. Recently, we have released two memorandums to field staff to ensure they are aware of recent suicide risk findings. A direct result of these weekly reviews has been a memo concerning the relationship between pain and suicide and another memo concerning suicide risk in patients with Traumatic Brain Injury (TBI).

Chairman AKAKA. Thank you very much, Dr. Cross.

Dr. Thompson, do you have any further comments for me?

Ms. THOMPSON. It is just such an honor to be here today and especially to be representing the staff of 160 hotline responders and their staff who are up in Little Canandaigua, New York.

I do have a story that I would like to tell about one of the rescues that we had. I am just going to tell it. This happened in October. At about 1 p.m., one of my colleagues took a call from a Vietnam veteran in his 60s who said that he was on his way into a Wal-Mart to purchase razor blades for the sole purpose of killing himself. As Bruce, my colleague, tried to gather more information from the veteran, he hung up. He tried to call back, but there was no answer, and the veteran appeared to use a cell phone, which is sometimes really hard to trace.

About a half-hour later, another colleague—her name is Gloria—answered the call of a veteran who told her that he had purchased razor blades and was going to kill himself. Again, Gloria tried to keep him on the phone, trying to engage him, asking about his location, but the veteran again hung up. Our staff tried to pinpoint his location through his phone number, but we couldn't. There wasn't enough information.

Finally, 20 minutes passed again and this time it was my hotline phone that rang. An older man started to yell that he was bleeding. He had slit open his wrists with broken razor blades, he had told me. I tried to calm him down, asking him to tell me where he was, but he initially refused. He didn't want me to send help. He wanted to die, he told me. He was homeless, lost contact with his family. He said that he really had nothing to live for.

I tried to work through why he was actually calling. Just that very act of picking up a telephone and dialing a number for a suicide hotline usually signifies an ambivalence that people really—whether or not they do or they don't want to die. I was able to keep him on the line, and as we talked, he would vacillate between saying that he wanted to die and he wanted to live. And then the conversation was just punctuated by these moments when he would panic and scream about his bleeding and begging me to help him.

Of course, my first priority was to keep him engaged and awake and also to gather as much information about his location as possible so that rescue could be sent immediately. After a while, he started to give clues. He said he was near a dumpster in an Applebee's parking lot. He was wearing a green T-shirt and jeans. He was in a small town in North Carolina. And finally, he told me the intersection near the parking lot. With that, he hung up the phone.

And with the help of other hotline staff and local North Carolina authorities, we found him within 15 minutes. He was still alive. He was taken to a local hospital and then had continued care with his suicide prevention coordinator at his local VA.

And I tell this story because it is so indicative of the stories that happen every day. It illustrates so powerfully how this immediate access to mental health professionals over the phone can save lives. Even though this veteran wasn't able to engage immediately and accept the help that he needed within the first couple calls, he just continued to call back until he was ready to engage and we were always ready for him. So I just happened to be the responder who answered the phone when he was ready.

Thank you for letting me tell this story.

Chairman AKAKA. Thank you very much, Dr. Thompson.

Dr. Cross, thank you for sharing the chart on the reduction in suicides for VA patients. It is good to see rates going down for VA patients. Dr. Cross, does this chart represent suicides for all patients or does this chart just represent suicides that have occurred related to an inpatient stay?

Dr. CROSS. Sir, these were folks who have engaged with any part of our VA Health Care programs, inpatient, outpatient, and we worked with the CDC to get the national death index data and we bump up our enrollees, or the folks who are using our services, against that data set. It is probably the best data we have. That

is the most current data, by the way, from the CDC that is available. It takes—there is a little bit of lag time.

Chairman AKAKA. Dr. Thompson, at the outset, thank you for what you do on behalf of veterans. I believe the suicide prevention lifeline is one of the great successes in the fight against suicide. Can you illustrate for us what one of the calls you take might sound like?

Ms. THOMPSON. What it would sound like? Well, the person—you mean what the veteran would sound like when he calls?

Chairman AKAKA. Yes.

Ms. THOMPSON. It really—it varies so greatly. We have calls from veterans who are just coming home, so from ages 18 to over 80. We have had World War II veterans who also call. Many times, their calls are, I am not quite sure why I am calling. I am not sure if this is the right place for me. Or if there is an immediate crisis, then there is a serious panic. We are also getting so many calls from family and friends who are calling for their veterans who don't know what to do and this is their first way to reach out. So it certainly varies quite a bit.

Chairman AKAKA. Thank you.

We will have a second round. Let me pass it on to Senator Burr for his questions.

Senator BURR. Dr. Cross, welcome, and to your talented team, I thank all of you for your commitment to our country's veterans.

Dr. Thompson, let me ask you, I found it shocking, because we have been focused on OEF and OIF—that seems to be the immediacy that we are dealing with, and all of a sudden you tell us a story about a Vietnam veteran. How do the counseling techniques differ from a Vietnam veteran to a veteran that you might get a call from today that is out of Iraq or Afghanistan; or do they?

Ms. THOMPSON. They differ in the way that we have to manage how raw the emotions are, particularly for the OEF/OIF veteran. The memories are so fresh, so at times, we will have to talk veterans down from flashbacks, for instance, in the middle of the night if they are calling, and those tend to occur more frequently with our newer veterans coming home.

I wouldn't say that the counseling techniques vary dramatically. Our immediate assessment is of safety and of their risk of suicide and whether or not they have means at home. And then what goes on from there is just support and attempting to get them as quickly as possible connected with their local services and their local VA. So I wouldn't say that it varies too dramatically.

Senator BURR. OK. And again, I want to reiterate what the Chairman said. A great deal of congratulations on the direction of the trend right now, that we are doing much better, and I think we are learning. But let me go to Mr. Hanson's story specifically. I would like to get an idea from you as to once you take that phone call, and this was Daniel Hanson calling in this case, and you have walked him back from the ledge, you have referred him to a VA service, what follow-up happens, if any, on the handoff of him to that local VA entity. Is there any boot in the butt, to use the terminology he and I used, that happens? Is there an offensive effort on the part of the local VA with that individual, not waiting for Mr. Hanson to call, that they call him?

And then I will go back to Dr. Cross just to address, is there more we can do when you have got a clinician that is working with somebody that has finally opened up to them and said, you know, I do think about this. I do think about this. Well, we have got this service, this service, and this service. Do we need to do more to actively get them involved, enrolled, treated?

Ms. THOMPSON. So the hotline has this wonderful collaboration with each of the local VAs across the country and the suicide prevention coordinators at each of those VAs. If anybody calls and they are—if any of our veterans calls—if Mr. Hanson had called and said, yes, I would like to be connected with the suicide prevention coordinator, that suicide prevention coordinator would have called him within 24 hours, hands down. So that always happens. There is always a reaching out. And then the hotline follows up to ensure that that handoff happened.

From there, the Suicide Prevention Coordinators, and Dr. Kemp may be able to speak more about this in terms of how much they attempt to find the person. But there is always a real effort to follow up with the veteran.

Senator BURR. So let me go to you, Dr. Cross. Is the red flag that she gets different than the red flag that a clinician might get when they have got the veteran in seeing them on a regular treatment basis and the veteran says, you know, yes, last night, I thought about suicide. Does the same red flag go off?

Dr. CROSS. You know, Senator Burr, your opening question was, is there more that should be done, and my response is, I think, in my view, there is always more to be done with any situation, however complex it may be, and that situation sounded pretty darn complex to me. We can always find more somewhere within the system, some other route that we can pursue, and we should do that.

One of those routes, by the way, is our Vet Centers. A great program that we have, and I think we are going to have about 299 of them by the end of the year. Dr. Al Batres is in the audience and runs that program. Sometimes that provides an alternative venue, a different kind of feel, maybe a little bit less—a lot less bureaucratic, very focused on combat veterans being treated by combat veterans themselves. Sometimes those different venues work for the different situations and we have those available. So that would have been a good resource in that situation.

Senator BURR. Just one statement, and with the Chair's indulgence, I will ask one last question. I know I have got colleagues that are here. I can't stay for a second round, and so I will be very quick.

I sense that if the call went to Dr. Thompson's area, that it would initiate a very proactive effort on the part of the VA entity to connect with this person and to pull them in. I am not sure from Mr. Hanson's experience being inpatient when he talked about suicide it initiated the same proactive effort. It was more of a buffet presentation of services that he might look at taking advantage of, and that may be an area we want to look at. You may tell me the data shows everybody that walks in at some point mentions this, so everybody would be in a proactive state. I personally believe the earlier we can get them into treatment, the longer we can keep

them there, the less likely we are to get a phone call to Dr. Thompson's area, and I think the goal should be to make sure that we don't need the functions that her area actually does. That is the best data.

I want to go very quickly, though, to the treatment that Mr. Hanson did find that worked for him. It is community-based, and I think it is faith-based. How open are we at VA to look at contract partnerships for efforts, not just exclusively rural because we don't have a facility close enough or a treatment plan, but say we have identified a program that has a proven track record of working—and as we weed through and find we need to look at other maybe non-traditional ways to do it, that we are willing to insert people into those programs?

Dr. CROSS. Senator, I am going to ask Dr. Zeiss to comment just a bit more, but I was pleased to see the representative from NAMI here today discuss the relationship that we have with them out in the civilian community. You know, from a budgetary point of view, we are spending about $4 billion a year on various types of fee-based services out in the community. A portion of that is related to mental health. But I would like to ask Dr. Zeiss to comment.

Ms. ZEISS. Well, I am happy to do that. I think that Mr. Hanson's case is very complex and it is important for us to think through together what could VA do, what more should we be thinking about doing, and what kind of partnerships would make sense.

I think that there have been some changes since his time with VA. We are constantly trying to improve. Some things we have already done that might have made it different for him: we now require that everyone receiving mental health care have a principal mental health provider. A person who is receiving multiple services, as he was, would be assigned someone who is that core central person who he could feel cares about him, would know him best, would be the person to turn to to get a more clear sense of how to integrate different treatment components. We think that can make a difference.

We also have instituted throughout the system far more intensive outpatient programs. So instead of 1 hour a week, which we agree for the complexity he is describing would not be sufficient, these are at least 3 hours a day, at least 3 days a week, with an interdisciplinary team working to deliver very complex and intensive services.

There are other things. I could go on. We have been trying to bolster many of the kinds of gaps that he describes and that we also saw and have been very committed to filling.

In addition, we completely agree with statements that we need to have partnerships, that we can't do it alone, which we need to continue to explore. If there is a level of care that VA is not able to provide in rural or in urban or suburban settings, we should look for what are well-tested programs. We do have the mechanisms for doing either fee-basis or contract care, and the Uniformed Mental Health Services Handbook does mandate that people should look at those if there is something beyond what VA is able to provide.

Again, we need to keep looking at how well our advancements might help cases like Mr. Hanson's that we weren't ready for a few years ago. But we also need to continue to look at partnerships.

Senator BURR. Thank you for that answer. More importantly, thank you for the ever-changing treatment process that we go through. It does prove that the VA is listening and learning and making every effort to try to pass that on to the veterans.

Thank you, Mr. Chairman. Thank you.

Chairman AKAKA. Thank you, Senator Burr.

Senator Murray, your questions.

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

Senator MURRAY. Thank you very much, Mr. Chairman. I really appreciate your having this hearing. It is an extremely important issue that affects so many people and their families and their communities and everyone around them. How we deal with this issue, I think, is really visible to our men and women who serve, that we are going to be there for them when they come home. So I really appreciate the focus on this.

I want to thank all the witnesses who are here today, especially those who are sharing their personal stories. I know how difficult it is and challenging to you, yet it helps us understand what you go through so that we can make sure we have got the right resources and are doing the right thing at the VA. So, I really appreciate that, in particular.

Mr. Chairman, everything is exacerbated for a man or woman coming home from service, particularly in this tough economic time when they are struggling to get a job, when they are dealing with PTSD issues, mental health issues, and coming home in this current economic climate. Not being able to find a job exacerbates it for a lot of our men and women who have served us.

I have been looking at this issue of employment and veterans and have been working on legislation that I hope to introduce shortly to help our veterans when they come home to get a job and to feel more secure as part of this piece of the puzzle, to help them feel more stable and secure versus going to the downward cycle that we have seen so many of our veterans go. So I will be looking forward to sharing that with all of you and getting your input on it.

One of the things that concerns me on this issue in particular is that veterans who come home and have PTSD, suicidal behavior, or mental health issues, require intensive care for a very long time. It isn't just a matter of a few days or a few weeks or a few months or even a few years. We know that triggers for relapse—whether it is marital issues or inability to find and hold a job, as I just talked about—exist in everyday life for everyone, and we know that a lot of our veterans self-medicate to deal with those issues which contributes to this, as well.

I understand that the VA is working really hard now to deal with PTSD and provide care for those who are affected, but how are you working to transition them from their intensive care regime that you are providing back into civilian life for the long-term?

Dr. CROSS. Senator, let me ask Dr. Zeiss and Dr. Kemp both if they could comment on that.

Ms. ZEISS. Well, we agree with you very much about veterans returning to work and to full roles in the community, at school for many returning veterans, which we expect will ultimately lead to work, but also being part of their families, their places of worship, all those community roles that are important. We are working with the Department of Labor. They have a wonderful program called Heroes at Work that you are probably aware of.

We also have within mental health a strong compensated work therapy and supported employment program. So, if it is mental health problems that are preventing people from being able to find or keep a job, part of their mental health plan can be utilizing these vocational rehabilitation programs. Those are designed to get them back to work in the community.

The success of those programs is pretty great, and we are happy to gather some information for you about that, given your interest in employment.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO ANTONETTE ZEISS, PH.D., ASSOCIATE DEPUTY CHIEF CONSULTANT AND CHIEF PSYCHOLOGIST, OFFICE OF MENTAL HEALTH SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Senator Murray requested information on VA Office of Mental Health Services (OMHS) efforts to assist Veterans with employment issues.

Response. OMHS provides work restoration and employment services for Veterans with mental health problems through its Compensated Work Therapy (CWT) and vocational rehabilitation programs. These programs are incorporated into the Veteran's treatment as part of VHA's comprehensive efforts to improve community integration for Veterans. CWT is authorized by 38 U.S.C. Section 1718 to provide work skills training and career enhancement, job development and placement, and post-employment support services. As a part of Patient Care Services, Therapeutic and Supported Employment Services within OMHS, administers the CWT programs. VA service connection is not required to receive treatment in CWT, nor can VA benefits be reduced, denied, or discontinued based on participation. Only individuals with Veteran status who are eligible for VHA services can participate, and a VHA clinical referral is required.

Per VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics, each medical center must offer Therapeutic and Supported Employment Services to Veterans who are receiving care through VA and who have a mental health diagnosis with associated functional impairment and whose treatment plan includes a goal for the Veteran to receive employment assistance. Therapeutic and Supported Employment Services guide the CWT programs, which consist of both the Transitional Work program and the Supported Employment program. CWT partnerships for both Transitional Work and Supported Employment are developed through Memoranda of Agreement with Federal Government agencies, county and state entities, and local businesses.

Transitional Work for involved Veterans occurs in a variety of work settings at all VA medical centers as well as in partnership with community employers. Veterans work a specified number of hours per week under the direct supervision of VHA staff or private company employees in their Transitional Work assignment. Transitional Work placements are generally time limited, and participants receive compensation at or above the Federal or state minimum wage (whichever is greater). Participants are paid at wages commensurate with comparable wages for workers employed in the community. There is no employer-employee relationship between VA, participating companies or organizations, and Veterans for those in Transitional Work experiences.

Supported Employment is an evidence-based practice integrating vocational services into treatment at the earliest possible time for individuals with severe mental illness. The primary focus of Supported Employment is to provide the on-going support services—including workplace accommodations and on-the-job support—these Veterans need to obtain and maintain employment. Supported Employment positions are developed in both public and private sector businesses, and individuals are

not prevented from receiving Supported Employment services because of the lack of prior work history or vocational goal.

In FY 2009, Transitional Work and Supported Employment served over 30,000 Veterans at 169 VHA locations, and Veterans earned in excess of $50 million. The personnel expenditure for the CWT programs in combination for FY 2009 was $26,000,000. Approximately 40% of Veterans participating in any component of CWT secure competitive employment at the time of discharge from the program (including approximately 70% of Transitional Work Veterans and approximately 25% of Supported Employment Veterans).

Ms. ZEISS. In addition, there is this kind of interesting relationship between Mr. Hanson's situation and his need for more long-term possibly inpatient care and evidence that, in many ways, having care provided in an outpatient environment that is intensive enough to meet the complexity and severity of the problems and which keeps people connected with their families and their communities and where the family can be a part of the treatment is one of the things we also really want to emphasize and make sure that we are thinking about—not just treating the individual mental health problem of the veteran, but treating that in the context of his home situation, his family, and making sure that we are supporting re-entry and the ability to recover and thrive in the community.

Senator MURRAY. I think that is really important, because we can't just treat this like coming to the VA with a cold and we are sending you home.

Ms. ZEISS. Absolutely.

Senator MURRAY. And the transition and long-term support of this is extremely important and I will be exploring that more as I put my legislation together, so I appreciate that.

Dr. Cross, I wanted to ask you, because I was deeply disturbed, as I think everyone was, by the news in January that the VA's preliminary data shows a dramatic increase in veteran suicide between 2005 and 2007. The fact that our veterans are serving and sacrificing only to return to spiral into this depression and suicide is appalling, I think, to all of us.

The preliminary data did suggest that access to VA service does make a difference in suicide prevention. That is good news. But if we are truly going to make a difference, the VA needs a more comprehensive effort. These numbers show that the duty of providing mental health services and outreach to returning veterans is still a challenge at the VA. The 2008 RAND study revealed that nearly 20 percent of military servicemembers who have returned from Iraq and Afghanistan reported symptoms of post traumatic stress or major depression, but only half sought treatment.

So I wanted to ask—it has been 9 years for the post-9/11 war effort. What the VA is doing, is it a matter of resources? Is it a matter of hiring people? Is it a matter of greater attention? What is it we could be doing to dramatically turn this around?

Dr. CROSS. Senator Murray, I would like to ask Dr. Kemp, sitting right next to me, who is the Director of the Suicide Hotline, to talk in just a moment about the specific part on the rates and so forth.

You know, I think the biggest challenge that we have is getting folks to come in and getting them engaged in treatment. We were concerned when looking at the numbers coming back from OIF and OEF, the numbers of soldiers who had not yet come in for any

health care-related service. So we have a program called Seven Touches, where through a variety of mechanisms that we reach out to them.

One of those, by the way, was we called them all. We hired a contractor to make 700,000 phone calls and called every one of them. We made 500,000 contacts of them. We found that we got wrong phone numbers, and sometimes they had left off—they had changed their phone number when they went over for deployment, shut down their phone line, shut down their address, and so the information we had was incorrect. We then hired a detective agency to go find the new phone numbers and feed them to the contractor to make those calls. As a result of that, or partially as a result of that, at least a couple hundred thousand people are now in our health care system that might not have been otherwise.

A key point for me is there is no one mechanism of outreach that is going to work for everybody. Sending a letter out is very nice. It probably doesn't work that well.

You know, the thing that really matters, ultimately, is looking somebody in the eye, being there personally, being onsite, and talking to them by saying, hey, I am from the VA. I am available. So, we are doing that at the post-deployment sessions. Our Vet Center staff and others, our medical services staff, go out there and do that face-to-face.

Senator MURRAY. With the veteran.

Dr. CROSS. With the veteran——

Senator MURRAY. Are you working with the families——

Dr. CROSS [continuing]. With the servicemembers returning.

Senator MURRAY [continuing]. And the employers and the schools and everywhere else the VA might touch so they know that——

Dr. CROSS. Part of the Yellow Ribbon effort is related to families. But I am going to ask Dr. Kemp to talk about that. And if I have a chance, I would really like to have Dr. Batres talk about some of his work in outreach, as well.

Senator MURRAY. OK.

Ms. KEMP. Thank you, Senator, for your question. I think it is incredibly important. In my written testimony, I do explain a little bit more about how we got some of the rate information that we are presenting.

One of the issues within the VA is when we look at what we call the case mix of people that we care for. It is higher than in the general population, which means that when we look at veterans who come back and have taken the Post-Deployment Health Screening, out of those who screen positive for PTSD and depression, they are more likely to come to the VA for care, which is, in essence, a good thing. They are the people who really do need us immediately.

But it does give us a population that is somewhat different than the rest of the country when we are working with people with mental illness and who do show some evidence of suicide risk. So we are dealing with a little different population to begin with, and the fact that we have been able to decrease the rates of suicide among veterans who get care at the VA, then it is a really very positive——

Senator MURRAY. Yes, I know the chart, but that doesn't show—that is only inpatient data, right? That is not clinics?

Ms. KEMP. It is all patients who receive care in any—who touch the VA in any way.

Senator MURRAY. OK, but it doesn't include veterans who have not——

Ms. KEMP. It does—right. Right. So I think we have—and people have brought it up a couple of times today—there is that group of people that we don't see and that we don't touch, and while their rates are remaining constant or in general probably they are at higher risk for suicide, we are obligated morally and ethically to try to find them.

So we have done several new outreach programs with the Suicide Prevention Coordinators. They are required at their sites to do five programs a month now out in their communities, and not just the communities where the medical centers are, but the communities within their network of care; so communities where all the community-based clinics are and surrounding areas.

We have developed a program called Operation Save, which is the VA version of a gatekeeper program which is veteran-specific, and we have provided this thousands of times in various communities over the past year across the country and will continue to do so.

The Suicide Prevention Coordinators themselves go to the Yellow Ribbon events and the post-deployment events to make sure that people have the number, the information, know how to get in touch with us. We have worked with the Department of Defense to develop materials and programs that are similar to theirs so that especially families are comfortable with the materials that they get and they know what it means. It provides our access information, like the ACE program for suicide prevention which is now a program that goes through the DOD and VA.

We have done a great deal of public media campaigning. We have had posters on buses and mass transport situations across the country. We have had Public Service Announcements—I don't know if you have seen them—by Gary Sinise and Deborah Norville, which have been immensely successful.

We just completed work with SAMHSA to do a series of focus groups for younger veterans in rural areas to see if the message that we are trying to get across is resonating with them. And to be honest, we found out that it is not always, that they are sometimes not relating to some of these posters and the Public Service Announcements that we have done. So we are reworking those quickly to provide a different message. They like the flags. They like the patriotic message. We didn't always get the symbols right. We didn't get the right uniforms on the right people asking the right questions. So we are quickly trying to work that out.

I think it is, as we talked about earlier, not just a VA problem. This is a national issue and we all have to work together to get that number out. We chose to use the National Suicide Prevention number for a reason, so that people would not have a different number than their spouses or their families or their coworkers. And if people see other people asking for help, it makes it a little easier for them to ask. So the things that Dr. Rudd said about mes-

saging are extremely important, and we know we have to work hard to do that.

Senator MURRAY. And do you have the resources? Have we given you enough——

Ms. KEMP. We do have the resources to do that, but we need your continued help to do it outside the VA, too. You know, one of the stigma issues is that this is not just a veteran problem, either. This is a national problem and we are all in this together. It is OK for everybody to get help, and veterans deserve the help in very special ways. And we are here for them.

Senator MURRAY. Mr. Chairman, I have gone way over my time.

Dr. Cross, did you have someone else you wanted to speak? With the Chairman's permission, if we could——

Mr. RUDD. Dr. Batres runs the Vet Centers, one of our highly successful programs, and I want him to talk about outreach for a moment, as well.

Senator MURRAY. Mr. Chairman, if you wouldn't mind, if he could respond to that.

Mr. BATRES. Good morning, Senator Murray. A couple of things. One is the increase in Vet Centers that I want to flag out. We have gone from 232 to almost 300 by the end of this fiscal year. So there has been an increase in our services in that fashion.

Inherent in that is who we hire, and over 33 percent, more than a third of all my employees have served in Iraq and Afghanistan, and they are the ones who are staffing and they tend to reflect the community. And that, to me, is an important transformational change, that we need to hire the young folks to balance the old folks, like myself, in terms of connecting and doing the outreach, because that is a very important component.

I believe I am free to talk about this, but we are going to be hiring a trained family therapist at every Vet Center. And so at every Vet Center, we will have the capacity to see families, because that is an increasing need for the veterans who are coming out, and be more integrated——

Senator MURRAY. What is your timeline for having that?

Mr. BATRES. We are hoping to hire 70 by the end of this fiscal year, but 180 by the end of next year, and we do have the funding, because I am sure that will be the second question. The Secretary has approved that and we are moving forward in doing that.

We are also exploring and have committed part of our outreach to OEF/OIF women veterans because of the increasing number of them. So when we talk family therapy, sometimes the recipient is not a male but a female who is married to a combat veteran who is female, and we are embracing all of those challenges and trying to do the best we can to address that.

The other element that Dr. Cross referred to was our 50 Mobile Vet Centers that are now canvassing areas, in particular VMOBE sites, outreach, PDHRAs, which gives us a lot of capacity to address those issues more directly; and our partnerships with some other organizations like the Wounded Warrior Project and other groups where we are recruiting returning troops early on with their family members and providing activities for them together so that we can engage the family more in educating them about the returning needs of veterans.

I hope my response is helpful.

Senator MURRAY. OK, that is, and Mr. Chairman, if you wouldn't mind, he brought up women veterans. I just wanted to ask about inpatient facility care for women veterans. They have very few options, and of the $218 million in the President's budget geared toward women veterans, are there funds to expand that capability?

Dr. CROSS. Yes, Senator, and I would like Dr. Zeiss to give you some more details on what we are going to do.

Ms. ZEISS. Well, first of all, we make a distinction within VA that I think is an important one between inpatient and residential rehabilitation and we need to make efforts in both those arenas. They offer different levels and types of care.

Currently, in terms of classic acute inpatient—that would be a very short length of stay for someone at risk of harm to themselves or others—we have not tried to establish separate women's inpatient units but to create in our current units areas that are separated, where the woman has the opportunity to lock her door, although staff can access it certainly since there might be suicide risk; to create greater safety and security, emotionally, and psychologically for women veterans; and to increase our staff with providers who are sensitive to women's issues and who can then provide care in those settings.

We do track the percent of women mental health staff that we have since one of the requirements is that women can request a mental health provider of the same gender, or opposite gender if they prefer, and we do have sufficient staff to do that.

Senator MURRAY. Can I interrupt you? So you are saying that you are establishing a room for women in the facilities——

Ms. ZEISS. A section.

Senator MURRAY. Anecdotally, most women tell me that military sexual trauma is a part of their experience. So putting them into a facility with men is really intimidating.

Ms. ZEISS. Right. Well, and that is why I wanted to make the distinction to the residential rehabilitation facilities, which are a longer stay, deal with not that immediate urgent need but with the needs of women who may have mental health disorders after military sexual trauma or for other reasons, you know, after a combat experience.

We do have an increasing number of women-only units for the residential rehabilitation for treatment of PTSD and other mental health problems. They have staff that are very sensitive to the needs of women veterans. We have been gradually growing those and follow closely how fully they are utilized and how we need to keep expanding such units as the number of women veterans continues to grow and they continue to enter VA at a very high rate. So we will be expanding those programs.

Senator MURRAY. All right. Well, my time is way over, so if I could explore with you outside the Committee hearing where those are and where the numbers are——

Ms. ZEISS. Sure.

Senator MURRAY [continuing]. Because I am hearing a lot there is not enough mental health——

Ms. ZEISS. We would be happy to.

[The information requested during the hearing follows:]

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO ANTONETTE ZEISS, PH.D., ASSOCIATE DEPUTY CHIEF CONSULTANT AND CHIEF PSYCHOLOGIST, OFFICE OF MENTAL HEALTH SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question. Are there Mental Health Residential Rehabilitation and Treatment Programs (MH RRTP) that provide separate physical areas for women Veterans?

Response. MH RRTPs provide residential treatment in a 24-hour, seven days per week, supervised and therapeutic milieu for Veterans in need of more intensive treatment of mental health conditions and/or addictive disorders. All MH RRTPs have the capacity to serve women Veterans. In Fiscal Year (FY) 2009, there were a total of 237 operational MH RRTPs providing more than 8440 treatment beds which includes 252 beds dedicated to women Veterans in 35 of the programs (North East Program Evaluation Center, NEPEC). Women Veterans comprised 5.2% (1,789) of the total episodes of care in MH RRTP in FY 2009 (NEPEC).

VA has initiated numerous enhancements to ensure the privacy, safety and security of women Veterans. In January 2008, all MH RRTP were mandated and funded to provide 24/7 on-site supervision, keyless entry and locks for all female bedrooms and bathrooms as well as closed circuit monitoring of all public areas. By January 2009, all programs reported 100% compliance to VA Central Office. Further, the MH RRTP Handbook released in May 2009, addresses the unique needs of women Veterans by requiring that all MH RRTP must maintain environments that support women Veterans' dignity, respect and safety; separate and secure sleeping and bathroom arrangements must be provided for women Veterans; that gender-specific treatment and rehabilitation services be available and that services provided to women Veterans must be on par with services for male Veterans.

Senator MURRAY. Thank you. Thank you, Mr. Chairman. I apologize.

Chairman AKAKA. Thank you very much, Senator Murray.

Dr. Thompson, at the outset, again, I want to thank you on behalf of our veterans. I believe that your work has made a difference and we want to continue to move in the areas where we can kind of get the help.

Dr. Zeiss, the veterans outreach is one of my primary concerns. VA certainly has a number of excellent VA initiatives in this regard. A compelling op-ed in today's *Washington Post* on suicides makes the point that when someone at risk of suicide makes a decision to take their own life, it becomes difficult to change their mind. Everything they see and do reinforces their decision.

Dr. Zeiss, with that in mind, what else can VA do to reach out to more veterans and bring them into the VA health care system?

Ms. ZEISS. Well, I am happy to answer that, but I think there are others here on the panel who also can address that.

In the Office of Mental Health Services, our suicide prevention plan begins with the notion that the best suicide prevention is good mental health care that will address needs before people get to the point of being in suicidal crisis. So we have developed very effective mechanisms to help people who are in suicidal crisis that Dr. Kemp and Dr. Thompson can talk about, and they do guide many outreach efforts.

In addition, we have bolstered our basic mental health services and we have tried very much to get the word out about that so that veterans who may have thought that if they came to VA, we really did not have the staffing or the programs or the commitment to serve their needs, can hear that, in fact, we have hired over 5,000 new mental health staff in the last few years, we have new programs, we have the capacity and, very strongly, the commitment to help them.

Our office does outreach primarily through the Suicide Prevention Coordinator program, so I would want Dr. Kemp to speak to that. We also try to collaborate and support the excellent efforts of the Vet Centers, who are very committed to outreach efforts.

I think what our office has tried to do and will continue to try to do in terms of outreach is to support the Post-Deployment Health Reassessments by joining the Vet Center staff who are always there. They have staff who can meet with the veteran face-to-face, help him get enrolled in VA right at the Post-Deployment Health Reassessment if they are Reserve, Guard, or other separated veterans, and make sure that they get linked to primary care and to any mental health appointments that they should need.

We also work with SAMHSA to try to get out destigmatizing messages and to try to let the country know what is available for veterans and the importance of coming in to receive mental health care.

We certainly agree there is always more we can do, so we are open to other ideas.

Chairman AKAKA. Are there any further comments on this from the panel? Dr. Kemp?

Ms. KEMP. You know, again, thank you for the question. Monday, I had the opportunity to speak here in Washington to a convention of American Legion commanders who were here wanting to know—what they wanted to know from me is what they could do to make a difference. One of the things that we talked about was setting an example for both our newer veterans and their friends, a lot of older veterans across America, and just letting them know that it is OK to get help. We discussed ways that we could provide all of the Legionnaires across the country with Operation Safe Training so that they would know the signs and symptoms of someone having difficulty and how to get them services.

At this point, one of our biggest outreach needs, I believe, is for the community to be aware of what we do and what we offer, and help each other get our services. That is our goal.

The American Legion, by the way, has really pledged their support to this effort, so it is an exciting opportunity for us.

I think, also, leadership at all levels needs to set examples and people need to know, again, that it is OK to ask for services and to tell us that they are in trouble. When community leaders, political leaders, their military leaders set those examples, it is our obligation to be there to provide those services that people are seeking. We can help them with those messages, but we need everybody's help in this effort.

Chairman AKAKA. Are there any further comments on that question?

Otherwise, Dr. Cross and Dr. Kemp, we have two different answers with regard to what this important chart shows. For the record, is this all points of care, clinics included, or only inpatient settings?

Ms. KEMP. My understanding is that this chart represents all points of care, and the numbers that I have worked with and that are in my written testimony deal with veterans who utilize any point of care within the VA system.

Chairman AKAKA. Dr. Cross, do you have any further comments on that?

Dr. CROSS. No, sir. That is my understanding, as well.

Chairman AKAKA. Yes. Well, in closing, again, I want to thank all of you for appearing today. Your contribution is important as this Committee moves forward on improving VA's mental health care and suicide prevention efforts. With rising suicide rates, these issues are all too pressing for all of us. For me and for this Committee, our focus is ensuring that VA fully implements all the mental health programs that have been authorized in recent years. VA now has resources and the tools with which to help veterans in need. We still are searching for at what point we can determine who needs the help and to try to get them into the services that are available, and we need to also work with the active service side before they become veterans.

So, this is something we will continue to work on. We look forward to partnering with you in doing this and also with the community and, of course, the families. So all of us working together, we think we can help the cause of preventing suicides.

So with this, thank you very much again. This hearing is now adjourned.

[Whereupon, at 11:25 a.m., the Committee was adjourned.]

A P P E N D I X

PREPARED STATEMENT OF HON. ROLAND W. BURRIS,
U.S. SENATOR FROM ILLINOIS

Thank you Mr. Chairman, and thank you to our witnesses for being here today. Every time a veteran commits suicide in our country, the VA has failed in its responsibilities. It is the charge of VA, and this Committee, to continue working until no veteran falls through the cracks and every veteran gets the mental health services that he or she needs.

The 2004 VA Mental Health Strategic Plan was a good start, and Senator Akaka's 2008 mental health improvement bill took further strides in addressing substance abuse and co-morbid disorders. These efforts have led to some great successes, and likely saved thousands of lives. However, clearly, we are not doing enough, in either the VA OR Department of Defense. Suicide rates continue to climb, and suicide now claims more lives from our Armed Forces than war efforts in the Middle East.

I am anxious to hear the expertise and experience of our esteemed panel. Their testimony will no doubt bring needed attention to this issue and help us as we move forward in our efforts to fully meet the mental health needs of our veterans.

PREPARED STATEMENT OF HON. FRANK R. LAUTENBERG,
U.S. SENATOR FROM NEW JERSEY

As a young man, I answered the call to service and wore our Nation's uniform with pride. I was not a hero, but I did my duty for the country I love. And one principle I have always insisted on is this: we can't just stand by our military on the battlefield—we have to stand by them when they return home, too.

Right now, military personnel are committing suicide at disturbing rates, and the trend is getting worse. Last year, more U.S. military personnel took their own lives than were killed in combat in Iraq. And for our veterans, the picture is just as bleak: the Veterans Administration estimates that 18 veterans take their own lives every day.

The need to improve mental health care for our servicemembers and veterans is clear and demands a new sense of urgency.

We must do better, and we can do better.

In my home state of New Jersey, there's a model of success for confronting this problem.

Along with our state's Department of Military and Veterans Affairs, the University of Medicine and Dentistry of New Jersey has created an innovative program called Vet2Vet. This program, which works with members of the New Jersey National Guard, has kept thousands of military personnel, veterans and their loved ones from suffering in silence.

While suicide rates are rising at a startling pace nationally, there has not been a single suicide among the New Jersey National Guard during Vet2Vet's first four years of operation.

Instead of waiting until they return from combat, Vet2Vet starts its work with servicemembers pre-deployment and then helps them readjust when they return from service.

Central to the program is the veteran-operated helpline that provides servicemembers, veterans and their families access to all types of support services, not just mental health support. Vet2Vet closes gaps in the system by working in coordination with state and community-based programs to take advantage of existing resources.

One of the reasons Vet2Vet has worked is that it relies on the skills and know-how of veterans. These trained vets counsel fellow veterans and their families—getting them the resources they need and doing regular, comprehensive follow-ups.

Putting veterans on the frontlines of the phone lines helps eliminate the stigma that discourages servicemembers and veterans from reaching out for help. It also gives veterans good-paying jobs doing what they do best: serving and protecting.

We are fortunate that our state has taken the lead on this critical issue, but there's no reason the rest of the country's military shouldn't have access to the same quality care that's being offered in New Jersey.

New Jersey's success should not be an anomaly—it should be the norm.

That is why I have urged Secretary Erick Shinseki to take UMDNJ's model and make it available to every military member and every veteran in every state.

We have a responsibility to serve our military and their families as well as they've served us. Until military suicides are a thing of the past, we cannot rest.

Thank you.

PREPARED STATEMENT OF THREE WIRE SYSTEMS, LLC AND HEALTH NET, INC.

Mr. Chairman and distinguished Members of the Committee, we appreciate the offer from Ranking Minority Member Burr to submit testimony for the record. Our statement will provide an overview and results to date of the VetAdvisor® Support Program (VetAdvisor), an innovative evidence-based program designed to provide mental health outreach and health coaching services to Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) Veterans and their families, regardless of their geographical location. VetAdvisor uses non-traditional telehealth/virtual health delivery platforms to improve Veteran awareness of, and access to, the mental health support to which they are entitled.

VetAdvisor is an ongoing Veterans Integrated Service Network (VISN) 12 program, augmenting and supporting existing VA behavioral health care services, and assisting Veterans with challenges they face during reintegration into civilian life. Working in partnership with VA, VetAdvisor assists Veterans and their families on a continuous basis, providing complementary, non-clinical support to Veterans identified and referred to the program by VA. VetAdvisor provides telephonic screening and referral to a VA medical facility, when necessary, and also offers an internet-based or telephonic health coaching component to assist these Veterans with the challenges they face as they work to reintegrate into their communities and families. The program focuses on identifying and working with Veterans who have, or are at risk for, PTSD, substance abuse, suicide and homelessness. This telephonic and virtual approach to screening and coaching helps eliminate the stigma Veterans often associate with seeking mental health services.

We thank the Committee for its leadership and appreciate its interest in this important issue. We believe VetAdvisor has the potential to assist veterans not only in VISN 12, but in VISNs across the country, especially in rural areas. It provides a cost-effective, appropriate and popular expansion of VA's reach to allow for convenient follow-up with Veterans VA identifies as at risk. Without this program, many of these Veterans might not return to VA to get the help they need to successfully return to their jobs, school and families.

VetAdvisor was initiated in 2007 by VISN 12, in partnership with Three Wire Systems, LLC (Three Wire), a Service Disabled Veteran Owned Small Business, and MHN, a Health Net company. VetAdvisor targets veterans who are already enrolled at VA medical facilities using primary health care services, but are not participating in mental health care.

Veterans who sign up with VA after returning home do not always seek help until their mental health needs are critical. This may be due to a lack of understanding of symptoms, denial that a problem exists, lack of awareness of available mental health support, or stigma. VetAdvisor addresses these barriers through its telephonic/virtual approach to behavioral health care. VetAdvisor contacts those Veterans who may not take the initiative to get involved in mental health care before a tragedy or problems occur. VetAdvisor does this by using a proactive outreach approach:

- Using Computerized Patient Records provided by VA, Client Service Representatives call Veterans to thank them for their service. When appropriate, the representative offers immediate access to a licensed, trained and experienced behavioral health clinician (e.g., Licensed Clinical Social Worker) called a Health Coach.
- The Health Coach telephonically assesses the Veteran through a series of VA-approved screenings. The screenings cover both medical and behavioral health conditions associated with serving in combat to include: Post Traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), suicidal ideation, substance abuse, depression and common medical screenings.

• The VA medical facility is provided with the results of these screenings. The results are used for follow-up and further evaluation. Once Veterans with behavioral issues are identified, they are encouraged to enroll in the Health Coaching Program.

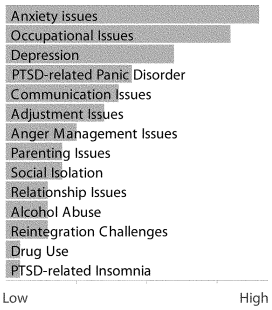
• The Health Coaching Program facilitates and supports Veteran involvement in existing VA services. A Health Coach is assigned to the Veteran for regular contact, advocacy and support.

• Coordination continues with the Veteran, Health Coach, and Primary Care Physician for as long as necessary.

In addition to telephonic communication, VetAdvisor provides Health Coaching through virtual collaboration technology—the VetAdvisor Virtual Room (VVR). In the VVR, the Veteran and the Coach interact as avatars. This highly immersive virtual environment provides strong feedback that enhances collaboration and communication. Virtual technology assists Veterans in their reintegration efforts in a number of ways. One of the major advantages is that it allows for the Veteran to discuss personal issues from the privacy of his or her own home. Second, it saves the Veteran time and travel costs associated with office visits. For today's Internet savvy generation of Veterans and their families, this form of communication feels more natural than traditional communication methods.

The initial VetAdvisor pilot in VISN 12 covered an 18-month period and a population of over 10,000 Veterans. Through this pilot, over 1,100 Veterans were directed to VA medical facilities for follow-up on positive screening results. The statistics support the program's success: when a Veteran was successfully contacted, there was a 95 percent acceptance for Health Coach screening appointments.

The types of issues discussed in Health Coaching sessions cover a wide range. The top issues are anxiety, occupational, PTSD and depression. The figure below illustrates the range of issues addressed in the sessions.



Relative Frequency of Issues Discussed During Health Coaching Sessions

VetAdvisor's proactive outreach and screening for behavioral issues has proven to be an effective tool in helping Veterans access services to treat or prevent potential issues such PTSD, depression, substance abuse, suicide and homelessness. It is designed to provide support when and where the Veteran chooses, and to help motivate those who realize they may benefit from help to seek help. It augments existing VA services by being pro-active rather than just waiting for the Veteran to seek care. The VetAdvisor program would be a way to immediately improve the VA's involvement and assistance to OEF/OIF Veterans in all VISNs, and would ensure that these Veterans do not fall through the cracks following their initial visit to and enrollment in VA.

On behalf of Three Wire Systems and Health Net, we would like to thank you again for your interest in the VetAdvisor program and for your commitment to ensuring that our veterans and their families receive the care and services they may need.

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