

**STATEMENT OF  
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OF THE  
DISABLED AMERICAN VETERANS  
BEFORE THE  
SUBCOMMITTEE ON HEALTH  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
DECEMBER 2, 2011**

Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee:

On behalf of the 1.2 million members of the Disabled American Veterans (DAV), all of whom are wartime disabled veterans, I am pleased to present our views to the Subcommittee on suicide prevention efforts in the Department of Veterans Affairs (VA) and the Department of Defense (DOD).

The increase in suicide among members of the military and veterans, and the innumerable tragic accounts by family members struggling to deal with the aftermath of suicide of a loved one, have raised deep concerns among military leaders, VA health care officials and policy makers, certainly including this Subcommittee. Every suicide by a service member or veteran is tragic, and accentuates the need for every effort to be made at multiple levels to prevent it. Unfortunately, suicide is a complex phenomenon and one that mental health experts have struggled to find solutions and strategies to prevent.

According to researchers, suicide seems to most often occur due to a combination of mental health stresses and societal triggers such as a marital or relationship breakup, a job loss or loss of social status, and is often coupled with overuse of alcohol or other intoxicating substances. The same mindset that can cause a person to take his or her own life is often the mindset that also prevents help-seeking behavior. Sadly, there are no easy fixes or answers to this problem, but according to one expert, "in order to prevent suicides, the complexity of behaviors and drivers of those behaviors need to be understood and addressed...and this requires collecting and analyzing standardized data."<sup>1</sup>

Mental health experts note that emphasis on several critical building blocks for any effective suicide prevention effort would be early intervention and routine mental health screening for all post-deployed military personnel and veterans, along with ready access to robust primary mental health care and specialty treatment programs for post-traumatic stress disorder (PTSD) and substance-use disorder. However, experts also note that having sufficient mental health programs and providers is not enough—identifying those at risk for suicide would be vital to prevention. Ongoing research is a critical component to assist in the development of evidenced-based screening and risk assessment measures to accurately identify high risk

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<sup>1</sup> The Hon. Jonathan Woodson, M.D., Asst. Secretary of Defense for Health Affairs, U.S. Department of Defense, Testimony before the United States House of Representatives Committee on Armed Services, Hearing on "Current Status of Suicide Prevention Programs in the Military." (September 9, 2011).

individuals, and in developing prevention strategies. Likewise, an effective communication strategy to increase awareness about what constitutes mental health, aimed at changing attitudes and behaviors about seeking services for mental health challenges, is another key component to addressing this problem.

According to VA, its basic strategy for suicide prevention requires ready access be made available to veterans for high quality mental health services supplemented by programs designed to help individuals and families engage and participate in care, and to address suicide prevention in the high-risk patients that treatment efforts identify.<sup>2</sup> VA has put in place policies requiring clinicians to conduct routine screenings for depression, PTSD, problem drinking and history of military sexual trauma for all veterans enrolled in VA health care. VA has reported that veterans who screen positive for PTSD are more than four times as likely to indicate suicidal thoughts as veterans without PTSD. For these reasons, if a screening is positive for depression or PTSD, an additional suicide risk assessment is conducted. According to VA, for each veteran identified as at high risk for suicide, a suicide prevention safety plan is developed, components of an enhanced care mental health package are implemented, and the veteran's medical record is flagged so that all providers are alerted to the suicide risk for the veteran.<sup>3</sup>

Every VA medical center is staffed with a suicide prevention coordinator. VA has recently re-branded its suicide hotline into a campaign promoting a broader "Veterans Crisis Hotline," which includes a chat service and a suicide prevention resource center maintained jointly with the DOD on the internet. VA has also been moving forward with programs aimed at reducing stigma and getting veterans to reach out for help. The VA Office of Mental Health Services (OMHS) recently rolled out its new mental health public awareness campaign called *Making the Connection*. This unique campaign is targeted at veterans of all eras of military service, their family members and friends and features personal testimonials from veterans who have struggled with physical injuries and post-deployment mental health challenges following service—and the positive outcomes they have experienced regarding their treatment and personal recovery. The website offers mental health information, resources and support as a way of encouraging veterans to seek help when needed. The goal of the campaign is to reduce stigma in seeking help and to build greater awareness of the numerous resources available to improve the lives of our nation's veterans. DAV appreciates this progress, and we are hopeful the new campaign is successful and improves access and support for needed services for veterans and family members. Despite the implementation of these programs and policies the continuing and troubling suicide rate of veterans still begs the question of what more can be done.

VA estimates that there are approximately 1,600 to 1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans. This estimate would mean approximately 18 veterans nationally die from suicide per day and five

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<sup>2</sup> Department of Veterans Affairs, Fact Sheet: VA Suicide Prevention Program, Facts about Veteran Suicide. (April 2011)

<sup>3</sup> Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans' Affairs, Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." (June 14, 2011).

deaths by suicide per day among veterans receiving care in VHA.<sup>4</sup> Additionally, there are 950 suicide attempts per month among veterans receiving care as reported by VHA suicide prevention coordinators (based on data collected from October 1, 2008 through December 31, 2010). In promoting its Veterans Crisis Hotline, VA notes that, as of July 2011, it has received over 400,000 calls, of which over 5,000 were from active duty service members; VA responded to over 16,000 chats and referred over 55,000 veterans to local VA suicide prevention coordinators for same-day or next-day services; over 225,000 calls received were from family members or those concerned about a loved one. Additionally, VA asserts that the Hotline initiated over 15,000 “rescues,” and that there have been over 7,000 rescues of actively suicidal veterans as of April 2011.<sup>5,6</sup>

VA reports that in FY 2010, more than 1.25 million individual veterans were treated in a VA specialty mental health program, medical center, clinic, inpatient setting or residential rehabilitation program. According to VHA guidelines, all new patients requesting or referred for mental health services must receive an evaluation within 24 hours, and undergo a more comprehensive diagnostic and treatment planning evaluation within 14 days. To meet increasing mental health demand, VA has hired over 7,500 full time professional staff since 2005, and during the last three years has trained over 4,000 staff to provide psychotherapies with the strongest evidence for successful outcome for PTSD, depression and other conditions.<sup>7</sup> Unfortunately, despite the significant increase in resources provided by Congress in recent years for veterans’ mental health care and VA’s efforts to increase staff and implement and improve its primary and specialized mental health programs, we often hear from veterans that are experiencing difficulty gaining access to the mental health treatment they need at a crisis point. We agree with the Congressional Research Service that VA’s internal policy requiring providers to make initial assessments with 24 hours, and to begin treatments within 14 days for requested mental health care, is probably not being carried out uniformly and universally.<sup>8</sup> For these reasons, DAV has recently initiated an informal mental health survey of up to 15,000 veterans focused on access to VA mental health services and the quality of care they are receiving. Although informal, it is our hope that the results of this survey, publicized through our DAV social media sites to all veterans, will provide a snapshot of veterans’ experiences, their perceptions of access to VA mental health services, and their satisfaction levels with the treatments and programs that VA offers.

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<sup>4</sup> John D. Daigh, Jr., M.D., Assistant Inspector General for Health Care Inspections, Office of Inspector General, U.S. Department of Veterans Affairs, Testimony before the United States Senate Committee on Veterans’ Affairs, Hearing on “VA Mental Health Care: Closing the Gaps.” (July 14, 2011).

<sup>5</sup> Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans’ Affairs, Hearing on “Mental Health: Bridging the Gap Between Care and Compensation for Veterans.” (June 14, 2011).

<sup>6</sup> Department of Veterans Affairs, Fact Sheet: VA Suicide Prevention Program, Facts about Veteran Suicide. (April 2011)

<sup>7</sup> Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans’ Affairs, Hearing on “Mental Health: Bridging the Gap Between Care and Compensation for Veterans.” (June 14, 2011).

<sup>8</sup> Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures, Congressional Research Service, July 18, 2011

A comparable but much smaller query of VA mental health professionals was conducted at the request of Senate Committee on Veterans' Affairs following a July 2011 hearing that examined the gaps in VA mental health care. The resulting August 2011 report, a very small sample due to the quick turnaround time requested, queried 319 general outpatient mental health providers for each facility within five Veterans Integrated Service Networks (VISNs); and 272 responded. Alarming, although not surprising based on the feedback DAV has been receiving, over 70 percent of the respondents reported that their facilities had insufficient mental health staff resources to meet veterans' demands for care, and almost 70 percent indicated that their sites had shortages in physical space to accommodate mental health services. Nearly 40 percent reported they cannot schedule an appointment in their own clinics for a new patient within 14 days, and 46 percent reported that lack of off-hour appointment times was a barrier to care. Over 50 percent reported that growth in patient workloads contributed to mental health staffing shortages, and more than 26 percent noted that the demand for Compensation and Pension examinations diverted clinicians from providing direct care.

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

In the active duty ranks, the Department of Defense (DOD) has also been coordinating data collection systems, mental health programs and research studies in an effort to reduce stigma in seeking mental health care and to prevent suicides in the active duty force. Some measureable progress can be seen in the suicide rate among the services, but overall the numbers still remain troubling. DOD acknowledges that providing mental health support to active duty troops is critical in suicide prevention. Likewise, its experts also confirm that effective, accessible, and supportive clinical care for mental, physical, and substance-use disorders are protective factors in preventing suicides. For these reasons, DOD reports it has updated its policies regarding early detection and intervention for combat and operational stress reactions in the deployment theaters. In 2007, the Department initiated a surveillance system to capture suicide data from the Services in a more central and standardized way. In addition to this effort, DOD reports that the Department and VA have developed a partnership to improve mental health access and care to service members, veterans and their families. For the past 10 months, DOD and VA have been collaborating and implementing a DOD/VA joint strategy consisting of 28 strategic actions with specific milestones and outputs. DOD has also partnered with VA in hosting an annual suicide prevention conference that provides an opportunity for the departments to share information and strengthen the provider network across the two health care systems.<sup>9</sup>

On this very note, DAV is disappointed to report that Section 401 of Public Law 111-163 has not been implemented 18 months after enactment. This measure requires VA to amend its regulations to enable current members of the armed forces who served on active duty in

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<sup>9</sup> The Hon. Jonathan Woodson, M.D., Asst. Secretary of Defense for Health Affairs, U.S. Department of Defense, Testimony before the United States House of Representatives Committee on Armed Services, Hearing on "Current Status of Suicide Prevention Programs in the Military." (September 9, 2011).

Operations Enduring or Iraqi Freedom eligible for the readjustment counseling that VA currently provides to veterans under title 38, United States Code, section 1721A. We understand this authority is still in the proposed rulemaking stage; however, we have heard this document was recently forwarded to DOD for required joint concurrence. Thus, even though Congress acted, these military personnel cannot avail themselves of a service that their peers in the veteran population have reported to be very effective in dealing with their readjustment needs. Because stigma and confidentiality still remain a significant barrier for many active duty personnel needing mental health care post- deployment, we ask VA and DOD to expedite this mandate so the Readjustment Counseling Service can open its doors to those on active duty who qualify for the counseling benefit. Again, early intervention has been found to be a key to avoiding long-term mental health conditions and other negative outcomes related to untreated post-deployment readjustment issues. VA's Vet Center Readjustment Counseling Service Program (a non-medical model) and the more recently established Justice Program/Veterans Courts have been very popular among veterans with a focus on peer to peer outreach and treatment versus incarceration respectively. VA estimates it will have approximately 300 Vet Centers operational by the end of 2011, along with 70 mobile Vet Centers for veterans living in rural communities.<sup>10</sup> We believe these resources would be of great benefit to active duty service members who need readjustment counseling but may not receive it due to bureaucratic delay.

DOD tasked the RAND Corporation to evaluate information about military suicides, identify the agreed upon elements that should be part of a state-of-the-art suicide prevention strategy, and recommend ways to make sure the programs and policies provided by each military service reflect the best practices. This request culminated in a February 2011 report from RAND, *"The War Within: Preventing Suicide in the U.S. Military,"* which concluded that people with substance-use disorders and heavy alcohol users face an increased risk for suicide, along with persons with traumatic brain injury or head trauma, those suffering from hopelessness or experiencing certain life events such as relationship problems. Additionally, it was found that availability of firearms correlates positively with suicide. RAND researchers reviewed a wide range of prevention programs but found that while promising practices exist, much still remains unknown about what constitutes a best practice. Based on available literature and discussions with experts, RAND indicated that a comprehensive suicide prevention program should include the following six practices:

- Raise awareness and promote self-care;
- Identify those at high risk;
- Facilitate access to quality care;
- Provide quality care;
- Restrict access to lethal means; and
- Respond appropriately.

RAND made a series of 14 recommendations in its report and noted research suggests that suicide can be prevented. Recommendations include: the establishment of proper tracking

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<sup>10</sup> Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans' Affairs, Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." (June 14, 2011).

and data systems; research; the delivery of high-quality care for those with behavioral health problems and those who are at imminent risk for suicide; proper communication to ensure potential at-risk population is informed and aware of the advantages of using behavioral health care; determining the adequate number of behavioral health specialists needed; and mandate training on evidence-based or state-of-the-art treatment for mental health care providers.

In October 2011, the Government Accountability Office (GAO) issued a report titled, *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, covering veterans who used VA from FY 2006 through FY 2010. According to the report, approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010 alone, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, but 88 percent (1,064,363) were veterans of earlier military service eras. GAO noted that services for the OEF/OIF/OND group had caused growth of two percent per year in VA's total mental health caseload since 2006.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care included: stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. GAO found that stigma is also a factor that may discourage veterans from accessing mental health care—especially those who have concerns that their careers could be negatively affected if employers found out that they were receiving mental health treatment. VA indicates it is aware of these barriers and continues to implement efforts to increase veterans' access to mental health care, including its integration of mental health services into primary care.

Clearly, ten years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD and other combat- or stress-related mental health conditions are prevalent among veterans who have deployed to war environments in Iraq and Afghanistan. Regrettably, as was learned from our experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are common. Experts note that if not readily addressed, such problems can easily compound and become chronic. Over the long term, the costs mount due to impact on personal, family, emotional, medical, and financial damage to those who have honorably served our nation. Delays in addressing these problems can culminate in self-destructive circumstances, including substance-use disorders, incarceration, and suicide attempts. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of behavioral health problems experienced by returning

veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of this war is likely to grow over time for those who have deployed more than once, do not seek or receive needed services, or face increased stressors in their personal lives following deployment.<sup>11</sup>

Testimony by RAND, other researchers, and VA has addressed the physical and mental health impact of these wars based on the unique nature of the wars, particular wartime risks and multiple military deployments for many service members. The current plethora of data to date on our newest generation of war veterans related to increased rates of PTSD, depression, substance-use disorders, high risk-taking behaviors, and traumatic brain injury are well known—but despite all the information available, Dr. Charles W. Hoge, a leading researcher on the mental health toll of the conflicts in Afghanistan and Iraq, observes that VA is not reaching large numbers of returning veterans, and high percentages of veterans who do seek care drop out of treatment. In a recent analysis, Hoge wrote, “...veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out...with only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment.”<sup>12</sup>

DAV agrees with Dr. Hoge’s view that VA must develop a strategy of expanding the reach of treatment, to include greater engagement of veterans, understanding the reasons for veterans’ negative perceptions of mental health care, and “meeting veterans where they are.”<sup>13</sup>

VA attempts to meet the needs of wartime veterans with post-deployment mental health challenges through two parallel treatment models: a nationwide network of medical centers and outpatient clinics that offer a more traditional medical and psychiatric approach with recent integration of mental health into primary care; and, community-based storefront Vet Centers that use a non-medical psychological model to provide readjustment counseling and related services to combat veterans and to their immediate families. In some locations, the two programs work together closely; in others, there is only limited coordination. Veterans are free to choose one model over the other or a combination of both services. However, the differences in approach may help explain why some veterans do not pursue VA treatment, and why those who do often discontinue it. While DAV strongly supports the Vet Center program, we also believe VA must maintain a robust mental health system as a part of VA medical care. Both programs are critical to veterans struggling with chronic mental illnesses and especially to new veterans who are in need of readjustment services.

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<sup>11</sup> Brett T. Litz, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs, “The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq,” A National Center for PTSD Fact Sheet (January 2007).

[http://www.nami.org/Content/Microsites191/NAMI\\_Oklahoma/Home178/Veterans3/Veterans\\_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf](http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf)

<sup>12</sup> Charles W. Hoge, MD, “*Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are*,” JAMA, 306(5): (August 3, 2011) 548.

<sup>13</sup> Ibid.

New veterans generally report having had positive experiences with Vet Centers and their staffs, a high percentage of whom are themselves combat veterans and who convey an understanding and acceptance of combat veterans' problems. While these centers do not provide mental health services in the traditional sense, their strengths tend to fill the gaps reported by younger veterans regarding mental health care in VA medical centers and primary care clinics.

Dr. Hoge echoes several of these points in urging what amounts to a call for a more veteran-centric approach to treating PTSD and other war-related conditions:

Improving evidence-based treatments...must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors...Matching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the veteran's healing process and also need their own support.<sup>14</sup>

Since the beginning of the conflicts in Iraq and Afghanistan, VA has faced a number of daunting challenges in providing care to a new generation of war veterans—particularly in post-deployment readjustment and in mental health. Initially, the needs and expectations of OEF/OIF/OND veterans and their families proved to be different from those of veterans who had typically been under VA care. We believe new veterans and their families want the DOD and VA to transform their approaches to post-deployment mental health services, and to stress family-centered treatment rather than focus solely on individual veterans—a paradigm shift for VA. Over its history, VA has concentrated primarily on the single veteran patient to the exclusion of family in almost all cases. But this new generation of veterans is younger, technologically savvy, and demands improved access to information via the Internet, access to state-of-the-art prosthetic items, expertise in trauma care, and advanced rehabilitation methods. They also expect support for their family caregivers and better transition and collaboration between DOD and VA in policies for family caregivers. Likewise, Congress, advocacy groups, and community stakeholders, including groups in the private sector offering specialized services, have been very active in pressing for change in how VA relates to community providers and how it furnishes care in its mental health and rehabilitative services.

Last year, the VA OMHS introduced a public health model for VA to meet the mental health needs of OEF/OIF/OND veterans with the precept that most war veterans will not develop chronic mental illness if VA concentrates on early intervention, de-stigmatization, use of effective mental health models, and makes greater outreach efforts. The goal of VA's strategy is to promote healthy outcomes and strengthen families, with a focus on resilience and recovery. This initiative requires VA to evolve from its more traditional medical model to an approach that would be less reliant on establishing a diagnosis and developing a treatment plan, and more on helping veterans and their families regain or retain an overall balance in their physical, social and mental well-being despite the stresses of military deployments. Most important, the strategy

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<sup>14</sup> Hoge, "Meeting Veterans Where They Are," 551.



calls for VA to reach out to veterans in their communities, adjust its message, make access easier and on these veterans' terms, and reformat programs and services to meet the needs of veterans and their families, rather than expecting veterans to fit into VA's traditional array of available services.<sup>15</sup>

In preparing for this hearing, DAV observed that DOD and VA clearly have made concerted efforts to address the challenges each Department faces in meeting the mental health needs of post-deployment active duty personnel and wartime veterans. Also, both agencies are populated with dedicated mental health experts, researchers and policymakers who continue to develop solutions to prevent suicide and the less devastating but still serious emotional and behavioral consequences of exposures to war. However, despite both Departments' obvious efforts and progress, much more needs to be accomplished to fulfill the nation's commitments to veterans who are challenged by serious and chronic mental illnesses, and those needing post-deployment mental health readjustment services. Based on studies noted earlier in this statement, it appears DOD may have less difficulty collecting data to analyze the need for policy changes simply because DOD maintains access to data on the active duty population including pertinent demographic information, recorded facts on wartime and other hardship deployments, marital status, health information and personal stressors. However, DOD is burdened by a number of barriers unique to the military services that prevent military personnel from coming forward for help. The fear of being perceived as "weak;" worry over losing rank; being identified as unreliable in stressful or hazardous situations; and anxiety about being discharged in disgrace – all these fears contribute to a reticence in military service personnel who are struggling, from revealing their feelings to others or to seek help inside their command structure. DOD leaders have publicly acknowledged these types of cultural obstacles do in fact exist and that DOD is still working to address them systemically.

On the other hand, VA is challenged with access to veterans' data for those who have not come to VHA for care. Because veterans are private citizens, and privacy of medical and personal information is the governing law, VA is at a distinct disadvantage in gaining extensive data on mental health status, suicide rates and other relevant information about the general veteran population. However, based on clinical and research experience with enrolled veterans, what VA does know can be very beneficial for all veterans. Experts note that timely, early intervention services can improve veterans' overall quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. We encourage VA to build on that knowledge and to be more transparent in dealing with the daunting challenges it faces in overcoming the existing gaps in its mental health programs and in the crucial need to address suicide, which has become so pressing. DAV believes VA is moving in an appropriate direction but needs to know more by learning directly from veterans trying to access the VA system (as well as those who don't) to better understand their unique needs and desires for treatment and services. Listening to veterans' feedback is essential to creating a system that meets them where they are, works for them, and is effective in achieving the recovery they seek.

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<sup>15</sup> Harold Kudler, VA/DOD/State and Community Partnerships: Practical Lessons on Implementing a Public Health Model to Meet the Needs of OEF/OIF Veterans and Their Families, VA Course on Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans, PowerPoint presentation (Baltimore, MD, July 28, 2010).

As a final thought, we recommend the Subcommittee review VA's implementation of sections 102-105 of the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110-387, a measure DAV strongly supported as a part of our Stand Up For Veterans initiative. These requirements, if implemented faithfully by VA, would go a long way toward addressing many of the lingering issues discussed in this testimony today. Also, we recommend a close review by your professional staff of our discussion in the FY 2012 *Independent Budget* (IB) on the topics of mental health and transition needs of OEF/OIF/OND veterans, as well as the new discussion of those subjects in the upcoming IB for FY 2013.

Madam Chairwoman and Members of the Subcommittee, this concludes my testimony on behalf of DAV. I would be pleased to respond to your questions.