

**STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES SENATE  
March 20, 2013**

Chairman Sanders, Ranking Member Burr, and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to provide this statement for the record of today's important hearing assessing the mental health needs of veterans. We appreciate the opportunity to provide this information.

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

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

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

### **Funding is Key**

Historically, VA has been plagued with wide variations among VA medical centers and their community-based outpatient clinics (CBOCs) in adequacy and availability of specialized mental health services. To address these concerns, over the past several budget cycles VA has provided facilities with targeted mental health funds to augment specialized mental health

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<sup>1</sup> Department of Veterans Affairs Press Release, "New VA Mental Health Outpatient Clinic to Open in Reno," August 10, 2012

services. This funding was intended to address VA's recognized gaps in access to and availability of mental health and substance-use disorder services, to address the unique and growing needs of veterans who served in Operations Enduring and Iraqi Freedom and New Dawn (OEF/OIF/OND), and to create a comprehensive mental health and substance-use disorder system of care within VHA that is focused on recovery. Experts note that timely, early intervention services can improve veterans' quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of untreated mental health problems. Despite a 39 percent increase in resources since 2009, VA continues to struggle to meet demands and provide timely mental health services to many veterans.<sup>2</sup>

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

## **Current Challenges**

As a consequence of a July 2011 hearing by this Committee, and pressed to reconcile the disparity between VA policy and practice on waiting times, VA surveyed mental health providers across the system. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages and one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.<sup>3</sup> Based on the results of this internal VA survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA efforts in mental health care. The impact of these gaps may fall greatest on our newest war veterans, many of whom are in urgent need of services.

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<sup>2</sup> Department of Veterans Affairs Press Release, "New VA Mental Health Outpatient Clinic to Open in Reno," August 10, 2012

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

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

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

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

VA indicates it is developing methods to improve access and address barriers; but veterans who seek VA assistance while struggling with mental health challenges too often face difficulty gaining timely appointments, despite VA official policies governing 24/7 access for emergency mental health care and scheduling of mental health specialty visits within 14 days of

initial contact. In April 2012, the VA Secretary announced VA would add approximately 1,600 mental health clinicians and 300 support staff to its existing mental health staff of 20,590, in an effort to help VA facilities sustain these access goals.<sup>4</sup>

## **Mental Health Services for a New Generation of War Veterans**

Mr. Chairman, eleven-plus years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD, and other combat- or stress-related mental health conditions are prevalent among veterans who have deployed to the wars in Iraq and Afghanistan and some of these veterans have been severely disabled. DAV believes that all enrolled veterans, and particularly service members, National Guardsmen, and reservists returning from contingency operations overseas, should have maximal opportunities to recover and successfully readjust to civilian life. They must be able to gain “user-friendly” and timely access to VA mental health services that have been validated by research evidence to offer them the best opportunity for full recovery.

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

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

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

<sup>5</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).

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

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

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

### **Substance-Use Disorders**

Misuse of alcohol and other substances including overuse of prescription drugs is a recognized problem for many veterans enrolled in VA care, including many OEF/OIF/OND veterans. VA reports that for FY 2011, 97 percent of VA patients were screened annually for at-risk drinking. The annual prevalence of substance-use disorder among all VA users was 8.5 percent (almost 500,000 veterans). VA offers these patients a wide variety of treatment options from motivational counseling in the primary care setting to more intensive inpatient and outpatient services. Unfortunately, there are a number of barriers to seeking or accessing treatment for substance-use disorder, including patients perceiving there is no need for treatment; believing treatment won't work; stigma of acknowledging substance use is a problem; and other family related concerns.<sup>6</sup> Experts note that an untreated substance-use disorder can result in emotional decompensation, an increase in health care and legal costs, additional stress on families, loss of employment, homelessness, and even suicide. Therefore, ready access to pharmacotherapy and psychosocial interventions are important treatment options for veterans with substance-use disorder.

The VA has acknowledged that it should focus on ways to enhance access to its substance-use disorder programs with a particular emphasis on the needs of OEF/OIF/OND populations as well as women, justice-involved, and homeless veterans. VA notes that the best resolution for substance-use disorder problems comes from early intervention. There is also a

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<sup>6</sup> Daniel Kivlahan, PhD., Associate National Mental Health Program Director Addictive Disorders, Office of Mental Health Services, "VHA Evidenced Based Practices for Identification and Management of Substance Use Conditions in VHA," PowerPoint Presentation, November 2011.

need to reduce stigma associated with seeking care for a substance-use disorder—and treatments for co-occurring conditions should be coordinated and done simultaneously. VA recommends that a community of substance-use disorder–PTSD specialists should be created and that family involvement can be very helpful in the treatment of both conditions. Additionally, VA indicates that the attractiveness of substance-use disorder services should be enhanced and that more computerized aids and the Internet should be used to provide or supplement substance-use disorder services. Most important, DAV believes that integration of services should be employed to address complex problems presented in patients with combinations of substance-use disorder and TBI, chronic pain, homelessness, nicotine dependence, and community/family readjustment deficits. VA reported that about two-thirds of patients with a substance-use disorder diagnosis are treated in a VA primary care or mental health clinic rather than in substance-use disorder specialty services.<sup>7</sup> The OMHS reports that a SUD-PTSD specialist has been funded for each VA medical center to promote integrated care but that currently there is no “Gold Standard” treatment developed for co-occurring SUD-PTSD.<sup>8</sup>

### **Suicide Prevention Program**

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

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

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<sup>7</sup> John P. Allen, PhD, MPA, National Mental Health Program Director, Addictive Disorders, Department of Veterans Affairs, “Substance Use Disorder (SUD) Services for Veterans Having PTSD” (PowerPoint presentation to veterans service organizations, 2011).

<sup>8</sup> Dr. D. Kivlahan, Substance Use Disorder PowerPoint, November 2011

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

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

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

<sup>12</sup> Steve Vogel, The Washington Post, “National suicide prevention strategy released Monday,” September 10, 2012

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

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

### **Veterans Justice Program**

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

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

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

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[http://www.washingtonpost.com/blogs/federal-eye/post/national-suicide-prevention-strategy-being-released-monday/2012/09/07/66102792-f92f-11e1-8b93-c4f4ab1c8d13\\_blog.html](http://www.washingtonpost.com/blogs/federal-eye/post/national-suicide-prevention-strategy-being-released-monday/2012/09/07/66102792-f92f-11e1-8b93-c4f4ab1c8d13_blog.html)

<sup>13</sup> Patricia Kime, Army Times, "DoD, VA roll out new suicide awareness effort," September 10, 2012

<http://www.armytimes.com/news/2012/09/military-national-suicide-prevention-strategy-091012w/>

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

## **Women Veterans: Unique Needs in VA's Post-Deployment Mental Health Services**

The number of women serving in our military forces is unprecedented in U.S. history, and today women are playing extraordinary roles in the conflicts in Afghanistan and Iraq. They serve as combat pilots and crew, heavy equipment operators, convoy truck drivers, military police officers, civil affairs specialists, and in many other military occupational specialties that expose them to the risk of serious injury and death. To date, more than 150 women have been killed in action in the two current wars, and women service members have suffered grievous injuries, with almost 950 wounded in action, including those with multiple amputations.<sup>15</sup> The current rate of enrollment of women veterans in VA health care constitutes the second most dramatic growth of any subset of veterans. In fact, VA projects the number of women veterans coming to VA for health care services is expected to double in the next two to four years. According to VA, as of June 2012, 56.2 percent of female OEF/OIF/OND veterans have received VA health care. Of this group, 89.4 percent have used VA health care services more than once; 53.5 percent have used VA health care 11 or more times.<sup>16</sup>

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

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

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

<sup>16</sup> Department of Veterans Affairs, Women Veterans Fact Sheet, August 2012 [http://www.womenshealth.va.gov/WOMENSHEALTH/docs/WH\\_facts\\_FINAL.pdf](http://www.womenshealth.va.gov/WOMENSHEALTH/docs/WH_facts_FINAL.pdf)

<sup>17</sup> Gregg Zoroya, USA Today, "Female Soldiers' Suicide Rate Triples When at War" (March 18, 2011).

<sup>18</sup> Joan Mooney, "Update on Legislation Related to Women Veterans," PowerPoint Presentation

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

### **Expanding Access through Community Mental Health Providers**

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

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

Moreover, it is imperative that if a veteran is referred by VA to a community mental health resource, we would insist the care be coordinated with VA. Because of a high degree to which this particular patient population also has difficulties with physical functioning and general health, these patients will very likely need other health services VA is able to provide. A critical component of care coordination is health information sharing between VA and non-VA providers. Information flow increases the availability of patient utilization and quality of care data and improves communication among providers inside and outside of VA. Not obtaining this kind of health information poses a barrier to implementing patient care strategies such as care coordination, disease management, prevention, and use of care protocols. These are some of the principal flaws of VA's current approach in fee-basis and contract care.

### **The Way Forward: Gaps Must Be Closed**

DAV agrees that VA must do a great deal more to meet veterans where they are, and must also improve access and timeliness of mental health care within VA facilities, reducing and hopefully eliminating gaps between national policies and variations in practice. To illustrate, in

2007, VA developed an important policy directive that identifies the wide range of mental health services that VA facilities should make available to all enrolled veterans who need them, no matter where they receive care.<sup>19</sup> But more than five years later VA has acknowledged in testimony based on external reviews that the directive is still not fully implemented.<sup>20</sup> However, we understand that VA is still conducting self-assessment surveys followed up with site visits from VA Central Office officials to verify progress and to help resolve any gaps in services, and in fiscal year 2012, all VAMCs were visited and that overall progress was observed. DAV recommends the Office of Mental Health Services brief Congress on these findings to continue fully funding VA mental health programs.

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

## Summary

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

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<sup>19</sup> Department of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA Medical Centers and Clinics.

<sup>20</sup> Senate Committee on Veterans Affairs, Hearing, "Seamless Transition—Meeting the Needs of Service Members and Veterans," May 25, 2011.

[http://veterans.senate.gov/hearings.cfm?action=release&release\\_id=fa634e3e-df82-4e87-b305-f5356fec9779](http://veterans.senate.gov/hearings.cfm?action=release&release_id=fa634e3e-df82-4e87-b305-f5356fec9779)

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

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

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

OEF/OIF/OND population, DAV urges VA to aggressively initiate early intervention programs to prevent chronic long-term substance-use disorder in this population. We are convinced that efforts expended early in this population can prevent and offset much larger costs to VA and American society in the future.

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

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

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