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**House Veterans Affairs Committee**

**HONORING THE COMMITMENT: OVERCOMING BARRIERS TO QUALITY MENTAL HEALTH CARE FOR VETERANS**

**February 13, 2013**

Chairman Miller, Ranking Member Michaud and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding *Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans.* IAVA applauds the committee’s continued dedication in addressing the critical issues surrounding mental health care and IAVA looks forward to working closely with the committee in addressing these and other issues throughout the 113th congressional session.

IAVA is the country’s first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and has more than 200,000 member veterans and supporters nationwide. Founded in 2004, our mission is to improve the lives of Iraq and Afghanistan veterans and their families. Through assistance, awareness and advocacy, we strive to create a country which honors and supports veterans of all generations.

The veteran suicide rate is a national crisis. According to a recent VA report approximately 22 veterans a day are taking their own lives. Unfortunately, IAVA fears that these numbers may actually still be lower than the true number of veterans we lose to suicide, as some states don’t report veteran suicide and are not included in VA’s 2013 report. Regardless of the exact number, IAVA strongly believes that even one veteran or servicemember life lost to suicide is one too many.

Since 2008, nearly 1.5 million servicemembers of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) have transitioned back into the civilian population. According to multiple studies performed by the National Institute of Health, Department of Veterans Affairs (VA) and Department of Defense (DoD), upwards of 43 percent of veterans who served in OIF/OEF/OND will have experienced traumatic events causing Post Traumatic Stress Disorder (PTSD) or other psychological disorders such as depression. Left untreated, these invisible wounds can have a devastating impact on the lives of those veterans and servicemembers who suffer in silence.

As the suicide numbers show and as the prevalence of these invisible injuries demonstrate, our country must start better addressing the psychological wounds of war. Up to this point, VA and DoD have taken a very reactionary approach to addressing the psychological wounds of war. IAVA believes that it is time to start addressing these wounds in a proactive way. While our country has made significant strides in improving the care for veterans, there is still a long way to go.

There are two main approaches to providing treatment for the psychological wounds of war and the prevention of suicide. The first approach is treating psychological wounds and suicide as a public health issue and approaching it as any other public health issues, such as an influenza outbreak or HIV. This approach requires public outreach educating all sectors of the public, involving the public in solutions to the problem and ensuring that services are widely available throughout the community. The second approach is the clinical, or medical, approach. This approach focuses on intensive clinical care, prescribing medications and regular appointments with psychiatrists and psychologists. Unfortunately though, we often focus on one rather than the other. Together, both approaches provide the best quality of care and successful outcomes. The public health approach helps veterans and servicemembers understand the resources that are available to them and how to easily access the care they may need. The clinical approach ensures they receive proper treatment once there. If we are to successfully address the mental health care shortfalls and prevent suicide in our nation, it will require both approaches.

The partnering of the two approaches is also particularly important, because suicide is a tragic conclusion of the failure to address the spectrum of challenges returning veterans face. These challenges are not just mental health injuries; they include finding employment, reintegrating to family and community life, dealing with health care and benefits bureaucracy and many others. Fighting suicide is not just about preventing the act of suicide, it is about providing a “soft and productive landing” for our veterans when they return home. The bottom line is we must treat and offer resources to the entire veteran, including their community and families, and move away from treating individual symptoms, as if they are somehow mutually exclusive of one another.

Stigma is a significant barrier to veterans and servicemembers seeking mental health care. Unfortunately, even though there has been an effort to remove the stigma associated with psychological wounds in recent years by VA and DoD leadership, their message has failed to reach all ranks of servicemembers and the entire veteran population. Despite these efforts, the stigma still seems to be ever so present, and seeking mental health care is often viewed as a sign of weakness or lack of resiliency among those who have been trained to be strong and fearless.

Multiple studies confirm that veterans and servicemembers are concerned about how seeking care could impact their careers, both in and out of the military. Concerns include the effect on their ability to get security clearances and how co-workers and supervisors would perceive them. It is critical that we continue to work to reduce this stigma. We must step up our efforts in removing stigmas and immediately develop and implement newer, more confidential ways of offering assistance to those who need it most if we wish to end the cycle of preventable suicides plaguing today’s veteran and military communities.

To combat the stigma, IAVA recommends that VA and DoD partner with experts in the private and nonprofit sector to develop a robust and aggressive outreach campaign. This campaign should focus on directing veterans to services such as Vet Centers, as well as local community and state based services. It should be integrated into local campaigns such as San Francisco’s veterans 311 campaign. This campaign should be well-funded and reflect the best practices and expertise of experts in both the mental health and advertising fields. For our part, IAVA has partnered with the Ad Council to launch a public service awareness campaign that is focused on the mental health and invisible injuries facing veterans of Iraq and Afghanistan. Part of this campaign focuses on reducing the stigma of seeking mental health care. This is only one example of the multiple programs and resources IAVA has established to help combat the stigma associated with seeking care for invisible wounds.

Community partnerships will play a key role in providing quality mental health care to veterans throughout the country. Nationwide, we have private sector and non-profit organizations that are already providing mental health care and resources to the members of their individual communities. These organizations are easily accessible and have staff who are trained to address most of the unique and common mental health needs within their communities. Establishing partnerships with those organizations will ensure that veterans, servicemembers and their families receive quality care in their communities, regardless if they start seeking care at their local VA or with one of these providers.

Another critical aspect to preventing suicide, and where VA is still falling short, is ensuring timely access to care and having properly trained staff at every VA facility. This is often the difference between life and death for many veterans. According to VHA’s Strategic Plan, VHA requires suicide prevention training for all VHA staff who interact with veterans, plus additional training for health care providers. However, while this may be a policy, IAVA has doubts as to whether or not it is actually be enforced at every VA facility. The importance and need in ensuring timely care and proper training of all staff is clearly illustrated by the experience of Army veteran Jacob Manning in early 2012. Here is Jacob’s story, as told in part by Leo Shane of *Stars and Stripes*:

*Jacob Manning waited until his wife and teenage son had left the house, then walked into his garage to kill himself. The former soldier had been distraught for weeks, frustrated by family problems, unemployment and his lingering service injuries. He was long ago diagnosed with traumatic brain injury, caused by a military training accident, and post-traumatic stress disorder stemming from the aftermath. He had battled depression before, but never an episode this bad.*

*He tossed one end of an extension cord over the rafters above and then fashioned a noose. The cord snapped. It couldn’t handle his weight.*

*He called Christina Roof, a friend and national veterans policy adviser who helped him years before, and rambled about trying again with a bigger cord or a gun. She urged him to calm down sand tried to get him to call the veterans crisis line. Ms. Roof sent a message to Manning’s wife, Charity, telling her to rush home. The two of them tried for more than a day to persuade him to get professional help. Ms. Roof eventually got Manning to agree to call the veterans hospital in Columbia, Mo., near his home, after telling him that he had two choices: “Either call VA or I have no choice but to call the police,” Roof said.*

*When a VA staffer at the mental health clinic answered the phone, Manning explained what he had done, and asked if he could be taken into care. The VA staffer asked if Manning was still suicidal. He wavered, saying he wasn’t trying to kill himself right then. The hospital employee told him the office was closing in an hour, and asked if Manning could wait until the next day to deal with the problem. Ms. Roof told Manning she didn’t care what this VA staffer told him and that she was sending a car within the hour to pick him up and bring him to the VA Medical Center. She told him to pack a bag.*

Mr. Manning made it safely to the emergency room and was checked in upon his arrival. Nevertheless, this one experience raises so many other questions as to what other problems veterans in crisis are experiencing when they reach out for help.

Sadly, Manning’s story is all too familiar. In April 2012, VA’s Office of the Inspector General (OIG) found VA officials had been inflating the success rates for providing timely mental health services to veterans. VA had repeatedly reported to Congress that 95 percent of new patients seeking mental health treatment received full evaluations for care within the department’s required window of 14 days. However, VA OIG found that just 49 percent were seen within that period, and the average wait time for most veterans seeking any type of mental health care was over 50 days. IAVA strongly believes that VA must be ready and equipped with the proper care models, policies and personnel to address the huge influx of veterans they will care for in the coming years.

According to the American Psychological Association, there are “significant barriers to receiving mental health care in the Department of Defense (DOD) and Veterans Affairs (VA) system.” Mental health professionals are often unavailable to servicemembers, especially those in theatre, and to veterans, particularly those in rural areas. Even veterans in urban areas encounter lengthy wait times when seeking mental health care.

VA must ensure that every employee is trained to respond to a veteran in crisis. VA employees across the administration interact with veterans, and each employee must be aware of the signs of a veteran in crisis and be aware of all of the resources available to support a veteran in crisis. All VA employees must also be trained to provide quality customer service to every veteran they encounter. For a veteran, like Mr. Manning, to have the strength and resilience to actually seek help, only to be met by a dismissive attitude at the one place he should always be able to count on, is in itself a tragedy.

IAVA has to wonder, and so too should our nation, how many other veterans in crisis are being turned away and how many other veterans have not received the care they needed due to an encounter with an untrained VA staff member?

Additionally, IAVA has real concerns as to how many veterans have we may have lost due to inadequate training and procedures within the VA mental health care system? For a veteran, like Mr. Manning, to have the strength and resilience to actually seek help, only to be met with a dismissive attitude by a staff member at the one place he should always be able to turn to is a tragedy. IAVA believes it is critical for VA to ensure that all of their staff be properly trained to respond to a veteran in crisis and that every veteran in crisis has immediate access to emergency mental health services.

Specifically within VA, there needs to be numerous changes and corrections in the policies and procedures within the Veterans Health Administration (VHA) and the Veterans benefit Administration (VBA). In an effort to address VA’s and DoD’s issues, on August 31, 2012, President Obama signed an Executive Order (EO) entitled “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families.” While IAVA applauds the President’s actions and believes that it was a good first step to implementing solid solutions that stand to make a significant difference in the mental health care available to veterans across the country, we believe the real test will be its impact within the veteran and military communities. However, IAVA also notes that the Executive Order’s success will also be determined by how effectively and timely it is implemented. As of this hearing, there are lingering questions on the status of the implementation of several key parts of the Executive Order.

For example, the August 2012 Executive Order includes some previous VA initiatives, notably the expansion of mental health care providers and their plan to hire 1,600 new mental health clinicians and 300 mental health support staff. While this is definitely a step in the right direction, IAVA has serious concerns about VA’s ability to meet this mandate given the problems they have encountered in the past, both in finding and keeping qualified mental health care providers. Moreover, IAVA respectfully asks for clarification on VA’s recent press release stating they have hired an additional 1,000 mental health care providers. IAVA respectfully asks if these new employees were put through an expedited hiring process given the quickness of their hiring? Further, we respectfully ask if these 1,000 new mental health providers were hired to fill the current mental health care provider vacancies VA has had many years filling or if these 1,000 new providers are intended to be a part of the 1,600 new providers mandated by the Executive Order?

The Executive Order also requires the VA and DoD to establish a national suicide prevention campaign. The order reads, that *“No later than September 1, 2012, the Departments of Defense and Veterans Affairs shall jointly develop and implement a 12 month national suicide prevention campaign, focused on connecting veterans and service members to mental health services.”* However, IAVA has been left to wonder as to whether or not this deadline was met. By all accounts, we have yet to see any solid evidence that this campaign was rolled out.

Another part of the Executive Order that has had a deadline pass, states: *“By December 31, 2012, the Department of Veterans Affairs, in continued collaboration with the Department of Health and Human Services, shall expand the capacity of the Veterans Crisis Line by 50 percent to ensure that veterans have timely access, including by telephone, text, or online chat, to qualified, caring responders who can help address immediate crises and direct veterans to appropriate care. Further, the Department of Veterans Affairs shall ensure that any veteran identifying him or herself as being in crisis connects with a mental health professional or trained mental health worker within 24 hours. The Department of Veterans Affairs also shall expand the number of mental health professionals who are available to see veterans beyond traditional business hours.”* IAVA has yet to receive a response from VA as to whether or not this goal was met. We look to this committee to ensure that this part of the Executive Order was met, and if it was not, we are also interested to learn about what plans are in place to ensure its completion.

These lingering questions underscore the critical importance of strong Congressional oversight of the implementation of this Executive Order. This committee has the authority to ensure VA, DoD and the other agencies tasked with improving mental health care for our veterans and military communities are held accountable to doing so. IAVA cannot stress enough the importance of strict Congressional oversight in ensuring all programs and policies mandated by the 2012 mental health executive order are fully developed, implemented, and that all of the agencies involved are held accountable to meeting the mandated time lines.

For our part, IAVA will continue to be a critical partner in holding VA and DoD accountable for the goals outlined in the Executive Order, but we look to the members of the 113th Congress to stand up for our veterans, servicemembers and their families through real actions in bringing about change to the health care services, resources and benefits they depend on.

Finally, given the wide array of issues the Committee requested we address in this testimony IAVA makes the following recommendations on ways we can improve the mental health care system:

1. VA and DoD must immediately establish a new employee education and mentoring program to overcome the practical problems new staff and longtime staff have in establishing and implementing new programs and policies related to mental health care, especially when they are unfamiliar with VA or federal procedures. We believe the current policies and procedures being used have proved ineffective in the establishment of uniformed mental health care.
2. Involve the families in a veterans or servicemembers mental health care plan. Despite progress, the current level of effort and provision of services remains inadequate in making treatment planning a true partnership between the veteran, family members, and provider.
3. Establish national partnerships to roll out a nationwide education and public service announcement campaign focusing on reducing the stigmas attached to seeking mental health care and addressing the psychological wounds of war. All wounds sustained in war are equally important and need treatment, be they visible or invisible. We need to ensure this is done through clear and concise messaging. For example, if you had a physical injury, you would certainly seek medical care to address it. So why would you hesitate to do the same with a physiological injury?
4. Integrate mental health care screenings and resources into all aspects of a veterans and servicemember’s primary health care.
5. Implement uniformed evidence-based care in all VHA facilities and CBOCs. Veterans should have equal access to high quality mental health care regardless of where they live.
6. Conduct a thorough review of VHA Handbook 1160.01, to ensure every VA facility is in compliance. This includes ensuring that every VA facility has a trained mental health care provider on staff at all times or is readily available to care for a veteran in crisis via a page or phone call.
7. Provide easily accessible mental health care or support programs for family members who have a loved one undergoing mental health care or treatment.
8. Increase awareness efforts at the local level to educate all members of the community on the signs associated with suicidal behaviors or tendencies.
9. Conduct robust public outreach campaigns to educate the general public or the realities of the invisible wounds of war by removing all of the misinformation and myths the general public has been exposed to through inaccurate media portrayals’ of veterans.
10. Expand the peer-to-peer counseling program and immediately train more veterans to be peer support counselors.
11. Expand upon VA’s Community Toolkit Provider program by further developing and actively promoting a nationally recognized certification program which would train mental health professionals in military culture and the unique challenges faced by service members, veterans and their families. This should include best practices in providing care to this community and the nuances of military culture.
12. Integrate robust mental health awareness and suicide prevention training into DoD’s enlisted education system, as well as VA’s current employee continuing education system.

In closing, caring for the men and women who defend our freedom is a solemn responsibility that belongs to lawmakers, business leaders, and every citizen alike. Despite numerous successes, veterans’ and servicemembers’ mental health programs and care options are still not where they should be. We must remain ever vigilant and continue to show the men and women who volunteer to serve their country that we have their backs, through swift actions in correcting the gaps and shortfalls in mental health care. IAVA looks forward to working closely with this committee, VA, DoD and communities across our nation in a combined effort to finally close the gaps in our mental health care system. IAVA will also continue to work tirelessly to ensure that no veteran, servicemember or their family ever have to suffer in silence while carrying the burdens of our nation’s 11 years of war.