HOUSE VETERANS’ AFFAIRS COMMITTEE

HEARING

“HONORING THE COMMITMENT: OVERCOMING BARRIERS

TO QUALITY MENTAL HEALTH CARE FOR VETERANS”

 FEBRUARY 13, 2013

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Good morning Mr. Chairman and Members of the Committee, my name is Linda Schwartz and I have the honor to be Commissioner of Veterans’ Affairs for the State of Connecticut. I am medically retired from the United States Air Force Nurse Corps and hold a Doctorate in Public Health from the Yale School of Medicine. I also serve as North East Vice-President and Chairman of Health Care for the National Association of State Directors of Veteran Affairs. I want to thank you for holding this hearing and for being concerned about overcoming barriers to quality mental health care for veterans.

I served 16 years in the United States Air Force both on Active Duty and as a Reservist (1967-1986), since that time, a great deal has changed in the composition and needs of America’s military and the Nation’s expectations for the quality of life and support for the men and women of our Armed Forces. Now women comprise approximately 20 % of the military force, a stark contrast to the fact that before the advent of the all volunteer force, women were limited by law to only 2% of the Active Duty force. Another striking feature of our military force today is the heavily reliance on the “citizen soldiers” of our Reserve and National Guard and the increasing number of military men and women on Active Duty who are married with children. The Department of Defense reports that 93% of career military are married and the number of married military personnel not considered career is more than 58% today. Because military families of our Reserve and National Guard units are no longer housed on military instillations, they do not have the support systems and sense of community enjoyed by previous generations of military members.

As America has continued to task Reserve and National Guard units with greater responsibilities in combat areas the realities of multiple deployments, loosely configured support systems and traditional military chain of command mentalities are challenging mental health delivery systems. Transitioning in and out of family life is not only difficult for the military member, the family, spouse, children, mother, father, sister, brothers and/or significant others are also traumatized as well. This is not happening on a remote site or military base, this time we read about our neighbor next door, the young woman who teaches kindergarten, our friend from school or church.

As Connecticut’s Commissioner of Veteran Affairs since 2003, I have a unique position and responsibility to be sure that we do not repeat the mistakes of the past. As a veteran of the Vietnam War and a nurse who has dedicated over 20 years to advocacy for veterans, I am acutely aware of the fact that the veterans returning home now are very different than the veterans of my generation or my fathers World War II generation. While they are not encumbered with validating the legitimacy of Post Traumatic Stress, they have brought the issues of blast concussions, Traumatic Brain Injuries, suicides and the importance of families to mission readiness to the forefront. Perhaps it is because they may have trained with a unit for years and experienced the intensity of living in the danger of a war zone with their unit, that they feel isolated in their own homes. During deployments, they longed for family and friends with visions of a celebrated homecoming only to find upon their return home that crowds and daily responsibilities are both overwhelming and frightening. After living on the edge of danger for the prolonged deployment periods, life in America seem boring and mundane. Although they care deeply about their families, they are “different” and ill at ease in their everyday existence and can’t seem to find their way “HOME Along with the “Send Off” ceremonies and the “Welcome Homes”, observers began to realize that families left behind experienced difficulties and stress every day of the deployment. Along with readjusting to the absence of the military member and the great unknown of what they would be encountering during their tour of duty, those of us tasked with working with these families came to the realization that there were serious gaps in the system. In addition to the day to day concerns of home repairs, young spouses managing additional duties in the home, environment and financial constraints, families were having difficulties that indicated a need for professional counseling and treatment to cope with the demands and strains they encountered.

State of Connecticut Mental Health Services and Programs for Veterans For more than 25 years, the State of Connecticut Department of Mental Health and Addiction Services (DMHAS) has documented the veteran status of their clients. As a Public Health Nurse working with psychiatric patients in the community, I was impressed that the question was included in the application for services. However it was not until the late 1990’s that someone thought to quantify this population and found that over 5,000 Connecticut Veterans were receiving their Mental Health Service from the State. Over time that number has fluctuated but remains steady at the 5,000 mark. In that time VA has increased their outreach to veterans across our small State and established six Community Based Outpatient Clinics (CBOCS) in addition to 5 Vet Centers. I believe our experience with these services and the veterans in our State illustrate some of the “barriers” you are discussing today.

As the wars in Iraq and Afghanistan have continued, the needs of veterans of those hostilities as well as veterans from previous periods of service, who need mental health services, have challenged the VA systems of care on several fronts. The deployment of Connecticut’s largest National Guard Unit to Iraq brought to light the question of how this utilization of the true “citizen soldiers” would be assessed and addressed and what did we need to do to assure they received the help they earned when they came home. With over 1,000 members each town and city in our town had someone deployed to an active combat zone. As the State agency tasked by Statute with providing services and assuring the quality of services for those who “are and have served in the Armed Forces of the United States”. I realized that our State needed to decisively address the issues of this new generation of soldiers and begin to plan for their return and programs that would be effective, timely and appropriate.

Thus, Connecticut embarked on three major efforts: a) Survey of Recently Returned Veterans conducted in conjunction with the Center for Policy Research at Central Connecticut University; b) Summit for Recently Returned Veterans; c) Military Support Program spearheaded by the Department of Mental Health and Addiction Services. All of these efforts were implemented in 2007. I will refer to these programs and will be happy to provide details on how we accomplished and implemented the Summit and Survey. Most important and a strength of what we have learned is that these findings came from our veterans and have been preserved in their own words. I use them to illustrate my points but wish to stress that Connecticut Governors, Congressional and State Legislators, Commissioners and Directors of State Departments of Mental Health, Public Health, Labor, and Education were and have remained deeply committed and engaged in this effort.

**Survey of Recently Returned Veterans**

With the reality that troops being deployed to Iraq, Afghanistan represented a striking departure from the mobilization of American troops in previous wars, the pro forma conventional methods and remedies relied on in the past seemed inadequate for addressing the emerging needs of military and veterans in the 21st Century. Thus, we embarked on a survey of returning veterans to “take the pulse” of their thinking, needs and expectations. To assess the growing population of returning “Warriors” and “Heroes” and specific problems they were encountering, as well as their expectations for services and the goals, we embarked on a series of surveys (2005 and 2010) in collaboration with Central Connecticut State University’s O’Neil Center for Public Policy. More than 650 veterans, a mix of Active Duty, Reserve and National Guard, with the majority being veterans of Iraq and Afghanistan and married (63%) who identified their major concerns as problems with spouses (41%), trouble connecting emotionally with others (24%), connecting emotionally with family (11%) and looking for help with these problems (10%). Using the “Post Traumatic Stress Checklist – Military scale developed by VA National Center for PTSD which indicated that the responses of more than a quarter of the respondents reported symptoms which exceeded the diagnostic threshold for Post-Traumatic Stress Disorder.

Common Barriers we have observed are:

**1. Proximity to VA** - Most veterans today do not want to travel distances for care. We tend to think of access to care as being a question of eligibility for VA care. However we need to broaden the context of access to include transportation, hours of operation, qualifications of the provider, consistency in health care provider and availability to contact the primary care provider. Most mental health providers are available at the local level, have coverage after hours and are available to talk with their patients at any time of the day or night. This access to primary mental health providers is not standard operating procedures for most VA mental health providers. Additionally it is a common practice, that many providers in the VA System are not Board Certified or professionally credentialed. However these expectations are not unreasonable given the requirements for providers in the private sector. It is important to remember that veterans in today’s society are very informed and often have acquired an expectation of competency, understanding and support that a health care provider especially a mental health provider should have. It is not uncommon for veterans to drop out of treatment because they are disappointed with the wait times for appointments. Many veterans are unwilling to devote and entire day to coming to the VA for care. Additionally they expect and deserve clinicians that have an understanding and respect for them. Clinicians, who do not meet the veteran where they are both with the symptoms they are experiencing and understanding and appreciation for the military service, will fail to engender a sense of trust that is essential to a therapeutic relationship.

**2. Treatment of Family Members** - As mentioned earlier families, more than any other time, in the history of the Armed Forces are an essential consideration when considering the well being and mission readiness of our military today. While VA publications actually acknowledge that with the return of the veterans from deployments, the entire family will go through a period of transition. Along with many suggested activities, there is specific reference for a need for opportunities to reacquaint families with one another. Part of the transition is expected to be a process or restoring trust, support and integrity to the family circle. While there is an expectation that “Things have changed” there is also the daunting task of beginning the difficult work of transition from soldier to citizen and reestablishing their identity in the family, work environment and community. Although the publication does a fine job of identifying the circumstances and the perils, the directions are not for family but how family can assist the veterans. Because services are focused on the military member and/or veteran the options for family members is limited. VA advises “Families may receive treatment for war related problems from a number of qualified sources: chaplain services, mental or behavioral health assistance programs.” In other words, as a rule, most VA Mental Health Programs do not treat family members or include them in the treatment of veterans or military members. While some VA facilities and individual programs have loosened the restrictions for providing services to family members either on an individual, couples or family therapy, serious consideration must be given to include these vital members of the veterans’ support system. Vet Centers have been providing this care on a regular basis for decades, this is a model of how a system can adapt to the needs of veterans without compromising quality of care and managing existing resources. An example from our Summit for Recently Returned veterans illustrates the disparity this creates. A young Veteran recounted that he felt that treatment at the VA was preventing him from getting on with his life which he implied really meant VA was doing the exact opposite of what it should be doing for veterans and their loved ones. He said that for him, not attending the VA meetings “was not about stigma, it’s just that the VA is unhelpful.” When he did go to the VA for help, his wife went with him, and they (VA) expressed surprise that she and her husband had come in as a couple. The wife was told to stay out of it, that it was “his problem” and not hers. She felt cut off. This spurred a more generalized discussion about how families have no idea how to interact with their veterans and feel lost. The conclusion was “What little the VA does for veterans, it does even less for their families”.

**Domestic Violence**

When addressing the issue of mental health treatment for families, I would be remiss if I did not reference the increase body of evidence which links combat veterans, Post Traumatic Stress with violent and abusive traumatic events in the home. Domestic Violence has always been a factor in military life. It is not new. What is new is the fact that victims are no longer silent and someone is listening. The American public is not as tolerant as it was decades ago to the litany of brutal deaths suffered in military communities or at the hands of a military member of veteran. While the Pentagon has made efforts to address these issues and offer support and education to military families, the present hostilities heavy reliance on citizen soldiers of the Reserve and National Guard Components accentuate the stressors on everyone involved and bring these volatile scenarios to every town and city in our Country.

Additionally over 1 million children in America have had one of both of their parents deployed since 9/11. The long separations and multiple deployments which have become the standard for todays’ military can create a sense of isolation, confusion, anxiety which can create higher levels of stress and more difficulties within the family. The total impact this environment has for members of these families has far reaching effects we have yet to know. The high rates of divorce within the military community verify that these dynamics are disruptions in family life which creates erosions of trust, instability that deeply wounds and destroys families.

**3. Women Veterans** - The rising number of women serving in the military is a well known fact. They are pushing the envelope, serving as never before in the combat areas and rising to new leadership roles. As a woman veteran, I want to say that along with these achievements and advancements, women have come to expect equal respect for their contributions to the military mission and defense of this Nation. In fairness, we must acknowledge that VA has come a long way with their programs for women veterans with programs that have evolved to options we only dreamed of in the past.. However when we look at cause and effect, we see that reports of Military Sexual Trauma perpetrated on women in the military by other military members is both astonishing and unacceptable.

In our States, we see women reluctant to seek treatment because of the experiences and victimizations they have had in the military. When the Department of Defense acknowledges that 23% of the women in combat areas report being victims of sexual assaults…not to mention the harassment which is not reported, there has not been an adequate response to deter these violent acts from reoccurring. Congress and the Department of Defense must take more stringent steps to ending the decades of this injustice for the women who wear our Nations uniform. What would happen if there was a report that 23% of the women working at IBM had been assaulted by their coworkers? Where is the demand for a “Congressional Investigation”? Why do these reports go unanswered? Why would a woman veteran victimized by their own Government look of help at the VA? Until Congress, deems this an unacceptable statistic, it will continue and these veterans and military members will continue to be second class citizens.

**4. Concerns About Confidentiality** - With the perfusion of social and electronic technology and breaches of confidentiality, there is a great deal of concern on the part of military members, private providers and veterans about preserving the confidentiality of their health care, especially mental health care. Veterans, of deployments who are still in the military services as Reservists and National Guardsmen have a great deal of anxiety about seeking treatment at the VA and how that will affect their military careers and promotion potential. Additionally how those records are handled when they are transported or used to substantiate a Service Connected Disability are deeply troubling and do influence where these veterans receive their care. VA is a large system and there is a lack of clarity about what access DOD has to these records and where the information will travel.

The issue of stigma associated with individuals who receive professional treatment for mental health problems is a big deterrent for veterans in need of this care. In our two surveys of Connecticut Veterans the most frequent reason cited for not seeking treatment was stigma. Veterans indicated their reluctance because:

“I would be seen as weak”; “Commanders would not trust me”; “My Unit would have less confidence in me”; “Leaders would blame me for problems”; and “It would harm my career”. Interestingly respondents to the surveys with the most symptoms suggestive of Post-Traumatic Stress were also the participants who most often reported that “stigma” was the greatest barrier to treatment.

**5. Understanding the Military/Veteran Culture** - Failure of the treatment providers to understand key aspects of the military/veteran culture can influence both the willingness to seek treatment and continue in treatment. Effective communications is key to any encounter but more so when we are dealing with populations that have the shared experiences and values of serving in the Armed Forces. In the current veteran population, the sense of community that comes from training and being deployed in Units strengthens the sense of solidarity, friendship and acceptance. Increased emphasis to orienting VA providers that care for veterans is essential for success in treatment and trust to stay in treatment. It is important that VA acknowledge and support educational experiences with include an introduction to the military and veterans culture. We realized the importance of this from the surveys we did and “Focus Groups” we convened.

Most interesting we learned:

a) Being in combat in Iraq of Afghanistan is profoundly life-altering

b) Importance of camaraderie with fellow military or veterans

c) A sense of isolation from the community and not being understood

d) Communication difficulties with everyone except fellow military

e) The experiences of women were not the same as men

**6. Multiple Deployments** - It is no secret that a common strategy during the wars in Iraq and Afghanistan has been the multiple deployments of Active Duty, Reserve and National Guard Units. The cycles of these deployments is another consideration which needs to be addressed when discussing the quality of mental health services. America is yet to know the real consequences of this process. However there is a particularly disturbing aspect of this process which bears heavily on the individual military member, the quality of their mental health services and the defense of our Nation. We have become aware that Iraq and Afghan veterans who have received VA Service Connected Disability Ratings, some as great as 80-100% are being redeployed. Some of these veterans have been rated for mental health disabilities but have signed paperwork to stop their disability compensation so that they can qualify for mobilizations and redeployments. You cannot imagine what kind of difficulties they face after multiple tours, many of them expect that their VA checks and Disability Ratings will be reinstated upon their return home. Not only are the realities of the system a shock, when they learn this does not happen, many face the disability rating process all over again. It is incomprehensible to me that this practice is permitted and known by the military.

**7. Coordination of Services and Resources** - Although Congress, DOD and the VA may identify a problem, and derive solutions to these needs, the process of enacting legislation and implementing programs is years in the making. In the age of text messaging, the response time is considered by many to be out of touch and negligent compared to what returning “Wounded Warriors” or “Heroes”, their families and most importantly the Public have come to expect in exchange for their service to the Country. Because our National Guard, comes under the authority of Governor’s and State Legislatures, there is much more demand for accountability at the State and Local Levels that has not been experienced by DOD or VA in the past. Active Duty and Reservists, who return to their homes as individuals are also of concern because their immediate problems and needs arise where they live far from Federal Systems. This group is especially vulnerable because, for the most part they have retained or received little or no information about what is available to them or where to go for help. Many of these veterans have undiagnosed injuries or disabling conditions and cognitive difficulties which further complicates their ability to articulate their needs for help. Currently there exist within large public services agencies, including VA, many layers and silos of the administration and delivery of services but little emphasis on oversight activities and accountability directly effecting veterans at the grassroots levels.

**A Shared Responsibility**

The task of serving veterans is a shared responsibility with States and the Federal Government. There is a need to move away from the idea that all services and programs must and should be provided by the Federal Government. Collectively State Governments spend more than $6 Billion a year to support their veterans. In order to develop the best seamless transition, maximize existing resources and improve the accountability for these services t dedicated to the care and support of veterans and their families, we must challenge the status quo. Just as our military has changed, we must accept the realities that vast system changes in support of the military and their families are in order. Too often VA on the National and State level do not coordinate or even communicate with the State Departments and agencies tasked with caring and providing services for our veterans. State based programs are augmented by thousands of private-sector, community volunteers and faith based initiatives that attempt to help disabled and injured service members and their families meet housing, transportation, childcare, employment, mental health and short-term financial aid. We are not lacking in people wanting to help, we are lacing in a coordinated effort, accountability and creative approaches to solving problems in the local communities Just as all politics are local, the care and welfare of each military member, veterans and their families is not only a priority for State Governments, there are local programs, services and resources that have been developed to meet the needs of veterans where they live and work. State Legislators are as vitally engaged in the needs of veterans and also creating new programs and services as are Members of Congress.

A true partnership of Federal and State resources can only improve the opportunities for our veterans, especially the troops returning today, and their families. My Governor and the citizens of Connecticut expect the best for our veterans and know that holding VA accountable is often an exercise in futility. While I am heartened that Secretary Shinseki has acknowledged States as partners in providing for our Nations veterans and has brought this relationship to new prominence, it is disappointing that individual administrators and staffs do no share his opinion or vision. This is not the continuum of service and care that veterans have earned and deserve.

Several times, Congress has considered legislation which would authorize funding to States agencies to support service programs of outreach to veterans. Challenge grants, matching funds and program grant opportunities are vehicles which must be considered to meet the unique needs of veterans and further the work of VA. Consider how much time and money has been expended on addressing the backlog for processing disability claims and compensation. While the “Big VA” has made many efforts to streamline the process, consider the possibilities of improving the quality of the claim at the start of that process. Grants to support, educate and initiate quality assurance at the State Veteran Service Officer level from the initial intake, development of the claim and final submission has the potential to create fully developed claims from the beginning which will facilitate the entire rating process.

**Connecticut’s Military Support Program**

In 2004 the Connecticut General Assembly enacted legislation authorizing the Department of Mental Health and Addiction Services (DMHAS) to provide “behavioral health services, on a transitional basis, for the dependents and any member of any reserve component of the armed forces of the United States who has been called to active service in the armed forces of this state or the United States for Operation Enduring Freedom or Operation Iraqi Freedom. Such transitional services are to be provided when no Department of Defense coverage for such services was available or such member was not eligible for such services through the Department of Defense or until an approved application is received from the federal Department of Veterans' Affairs and coverage is available to such member and such member's dependents.” (CGS 27-103).

From the beginning, this initative was a collaborative effort between Connecticut’s Departments of Mental Health and Addiction Services (DMHAS), Veteran Affairs (CTVA), National Guard (CTNG) Department of Families and Children (DCF) and the Family Readiness Group. Building on the experience DMHAS had gained in assisting families in the aftermath of 9/11, the concept of working with mental health professionals in the community was ideally suited for the broad context of the legislation and the geographical distribution of potential clients.

Also taking from previous “lessons learned”, the scope of the program was created not only to include military members, their spouses and children but immediate family members (parents, siblings) and significant others were also eligible for care. With the assistance of the Connecticut and Federal Departments of Veteran Affairs and the Adjutant General, sixteen hours of training in Military 101, dynamics of deployments and post traumatic stress including panel discussions by OIF/OEF veterans and their families was provided to 400 volunteer mental health professionals licensed in Connecticut. Only clinicians, completing the training were eligible to participate in the program.

The Military Support Program (MSP) was designed to streamline the process of access to care with an emphasis on confidential services throughout the state. The goal of delivering quality, appropriate, timely and convenient services was further enhanced by a 24/7 manned toll free center, veteran outreach workers and State reimbursement for clinical services when there was no other funding available.

Typically, anyone eligible for the program can call the 24/7 number. In this day and age, it is important that a real person answers the call. If the nature of the call does not involve a mental health issue, the caller is directed to an individual at the appropriate agency. Should the nature of the call be a request for help with a problem best handled by a mental health professional, the caller is given the names of clinicians in their immediate geographical area, who have completed the training and are registered with DMHAS.

Another very attractive aspect of this approach is the fact that families including the military member can have the opportunity to work out their issues together. Due to the limitations of VA Health Care, families are often excluded from the therapeutic process which can be counterproductive in the long run. Family therapy is less threatening to a military member who may not seek treatment because of the stigma associated with mental health problems. A 2005 study of Iraq Veterans assigned to the Maine National Guard indicated that 30% of those in the study expressed a likelihood of participating in “confidential services in the community”. Responses to the question of who they would be most likely to participate in support groups included “with other veterans (32%), couples’ communication skills training (28%) and couples/marital counseling (26%). (Wheeler, 2005) lends credence to the concepts we have implemented.

**Suicides**

Although there is no exact method to determine the actual numbers of suicides, even matches with the Death Index would be under reported because of concern for the family, religious beliefs or unanswered questions. Even the press has no idea of the true numbers of suicides in the military or veteran communities because the “secret” is also part of the shock. However the increased awareness and concern for the number of these events and the great hope that these could be prevented with better systems, Connecticut Governor Malloy, in consultation with the Departments of Mental Health and Veteran Affairs, authorized the expansion of the Military Support Program in 2012 for all military, veterans and their families.

Since the Connecticut Military Support Program (MSP) has been in operation, they have responded to over 3,500 calls. A particularly important aspect of this program is the fact that there is an immediate response to a caller with an offer to help. Part of the responsibility of a Clinician in the network is to respond within 48hrs of being contacted by the MSP client. Many veterans and their families can be treated in the communities where they live. While some may require more intense care or services offered by the US Department of Veteran Affairs the immediate need, assessment, crisis intervention and if need be referral to VA provides appropriate, timely and professional responses that the situations require.

Connecticut has been caring for veterans since 1863. From that time to this, each generation of Americans, who have shouldered the responsibility of serving in our Armed Forces, has influenced the development of the collective service systems provided by Federal, State and Local governments. Just as the business of conducting war and defending the Nation has changed dramatically, America and this Committee need to rethink the delivery system and the care we extend to those who have borne the battle. The old adage that “if the military wanted you to have a spouse they would have issued you one” has been outstripped by the number of married military members we rely on to protect our freedoms. In this day and age, the expectation of caring for our military must include tending to the health of their families.

Mr. Chairman this concludes by testimony, I will be happy to answer any questions you may have.