Ralph Ibson, Vice President for Government Affairs MENTAL HEALTH AMERICA

STATEMENT

of

Ralph Ibson, Vice President for Government Affairs
MENTAL HEALTH AMERICA

before the

Committee on Veterans Affairs

U.S. Senate

on

Mental Health Issues Facing Returning Service-members

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Mr. Chairman and Members of the Committee:
Mental Health America (MHA) is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 320 state and local Mental Health Association affiliates nationwide, we work to improve policies, understanding, and services for individuals with or at risk of mental illness and substance-use disorders. Established in 1909, the organization changed its name last November from the National Mental Health Association to Mental Health America in order to communicate how fundamental mental health is to overall health and well-being. MHA is a founding member of the Campaign for Mental Health Reform, a partnership of 17 organizations which seek to improve mental health care in America, for veterans and non-veterans alike.
Mr. Chairman, we commend you for scheduling this important, timely hearing, and in doing so, providing visibility and focus for critical questions that must be answered if we are to avoid mistakes of the past. While we know that service-members have experienced mental health problems in every war, our operations in Iraq and Afghanistan differ markedly from prior combat engagements, with critically important implications for veterans' readjustment and recovery.

Unique Aspects of Operations Iraqi Freedom and Enduring Freedom (OIF/OEF)

Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) are unique in their heavy reliance on the National Guard and Reserves who make up a large percentage of our fighting forces. Reserve forces alone have made up as much as 40 percent of U.S. forces in Iraq and Afghanistan, and at one point, more than half of all US casualties in Iraq were sustained by

members of the Guard or reserves. These operations are also unique in their reliance on repetitive deployments. Deploying to a combat zone is necessarily enormously stressful to a soldier AND his or her family; that stress increases markedly with each subsequent deployment.

The impact of those deployments on service-members has already been profound. The prevalence of mental health problems among OIF/OEF veterans appears significantly higher than had earlier been anticipated. To illustrate, recent data from the Defense Medical Surveillance System (reflecting post-deployment health self-assessments since June 2005 of servicemembers who had served in Iraq) show that 50% of Army National Guardsmen and some 45% of Army and Marine reservists have reported mental health concerns. Unexpectedly high percentages of OIF/OEF veterans are receiving VA mental health services, many with very serious problems like PTSD and depression. According to VA data, more than 35 percent of OIF/OEF veterans who accessed VA care from 2002 through November 2006 were diagnosed or being evaluated for a mental health disorder.

The high percentages of Guard and Reservists among the OIF/OEF cohort creates unique challenges that VA has not previously faced. First, these "citizen-soldiers" often live in communities remote from VA medical centers. Yet they are as likely to have readjustment issues or to experience anxiety, depression or PTSD as veterans who have good access to VA health care. Long-distance travel is a very formidable barrier to a veteran's seeking (and continuing) needed treatment. That barrier is likely to be even higher for veterans with mental health needs, given the lingering stigma surrounding mental health treatment. Second, with activation to and from active duty associated with multiple deployments, health care responsibility for these servicemembers shifts from DoD to VA to DoD, with each shift in responsibility inviting confusion.

Veterans' Mental Health Needs

OIF/OEF veterans are experiencing a broad range of post-deployment mental health issues - some of which require treatment, while others call for some combination of education, support and counseling. VA data identify PTSD (seen in 15 % of those evaluated at VA facilities), drug abuse (13%) and depression (10%) as the most prevalent disorders being treated in its facilities. Importantly, another 5% were diagnosed with a psychosis, reflecting severe mental illness. A recent study on the mental health status of Iraq veterans in the Maine National Guard provides another illuminating snapshot. That survey found that 25% of these veterans reported significant problems with PTSD, alcohol or depression. But the study data also indicate the extent to which these veterans are experiencing readjustment problems. For example, more than 43% had problems with anger (compared with 16% in Guard members who had not been deployed), more than 35% had relationship problems (vs. 15% among the nondeployed), and 22% reported sexual problems (vs. 10% among the nondeployed). Significantly, only 15% of those Maine veterans had sought help from a mental health professional.

VA's Special Committee on Post-Traumatic Stress Disorder (a statutorily-created panel of clinicians which reports annually to VA and to Congress) has provided a helpful assessment of the wide range of post-deployment mental health issues confronting veterans and their families. Its February 2006 report advised that "VA needs to proceed with a broad understanding of post deployment mental health issues. These include Major Depression, Alcohol Abuse (often

beginning as an effort to sleep), Narcotic Addiction (often beginning with pain medication for combat injuries), Generalized Anxiety Disorder, job loss, family dissolution, homelessness, violence towards self and others, and incarceration." The Committee advised that "rather than set up an endless maze of specialty programs, each geared to a separate diagnosis and facility, VA needs to create a progressive system of engagement and care that meets veterans and their families where they live...The emphasis should be on wellness rather than pathology; on training rather than treatment. The bottom line is prevention and, when necessary, recovery." Importantly, the Special Committee also advised that "Because virtually all returning veterans and their families face readjustment problems, it makes sense to provide universal interventions that include education and support for veterans and their families coupled with screening and triage for the minority of veterans and families who will need further intervention." [Emphasis added.]

Certainly our perspective is too general when we speak globally and without distinctions of "veterans' needs." Of particular significance surely are the contributions that women are making in these ongoing operations. Women represent some 15% of those in the OIF/OEF theaters. And while not serving in infantry units, they are more exposed to trauma - driving in convoys, serving in security assignments, and even flying aircraft -- than in any other military engagement in our history. It should also be acknowledged that the range of trauma to which women in service are being exposed ranges from the threat of IED's to marital and family stresses.

Family Issues

While there is widespread recognition of the prevalence of post-traumatic stress disorder (PTSD) and other war-related mental health problems among veterans of service in Iraq and Afghanistan, less attention has been given to the toll these military operations have had on the mental health of our veterans' families, and the implications of those problems on the veteran's readjustment and health. Research on PTSD, for example, has shown that it has had severe, pervasive negative effects on marital adjustment, general family functioning, and the mental health of partners, with high rates of separation and divorce and interpersonal violence. PTSD can also have a substantial impact on veterans' children. Not surprisingly, in a military engagement that has required multiple tours of duty of many service-members and in which the burden has fallen heavily on citizen-soldiers of the National Guard and military reserves, the impact on families has been particularly hard, and may be implicated directly in mental health problems in family members of the veteran.

Despite recognition in the VA regarding the mental health needs of returning veterans' families and the importance of engaging family members in the veteran's readjustment, current law and practice limit VA's assistance to, and work with, family-members. The Special Committee on PTSD reports that "the strength of a war fighter's perceived social support system is one of the strongest predictors of whether he/she will or will not develop PTSD." VA is an integrated health care system which offers a relatively full continuum of care and services for eligible veterans. Family therapy is often a component of the readjustment counseling provided at VA "Vet Centers" that are usually located in population centers and operated independently of VA medical centers and clinics. But veterans and family members who live far from a Vet Center and who rely instead on a VA medical center or clinic routinely encounter a system that

discourages family therapy. Most VA health facilities focus exclusively on the veteran-patient (rather than on the veteran as part of a family unit) and provide incentives through measures of "workload" that fail to provide any workload credit for helping the veteran's family. This patient-centered workload system effectively discourages medical-center clinicians from providing family therapy and support services that are routine in a parallel system of VA facilities. There is no sound programmatic rationale for encouraging family support at one set of VA facilities (the Vet Centers) and discouraging it at others. VA health care, and particularly mental health care, would often be more effective if barriers to family involvement were eliminated.

Current law compounds the difficulty. While the law (38 USC 1710(e)(3)(C)) authorizes VA to provide medical care and services (subject to a two-year time limit) to a veteran who served in a combat theater, section 1782(b) of title 38 of the US Code would limit counseling for a family member of a combat veteran receiving treatment to circumstances where the counseling had been initiated during a period of hospitalization and continuation is essential to hospital discharge (while family members of veterans receiving treatment for a service-connected condition can receive counseling as needed in connection with the veteran's treatment). Insofar as the law effectively treats the veteran who served in a combat theater on a presumptive service-connected basis for a time-limited period, we recommend that VA be authorized to provide immediate family members with both support services AND (when needed) mental health services to help foster the veteran's readjustment or recovery. And, to ensure that the benefits of such family support and mental health services are realized, we recommend that legislation require the Department to revise its workload measurement system to eliminate the disincentive to, and provide credit for, working with family members of veterans where such education, counseling, or therapy would help foster the veteran's readjustment or recovery. Yet additional consideration should be given to the mental health needs of survivors of those who have lost their life in Iraq and Afghanistan, including parents who generally are not even eligible for VA grief-counseling.

Stigma Surrounding Mental Health Treatment

There is wide recognition of the importance both of preventing readjustment problems from worsening and of treating behavioral disorders as early as possible. Left untreated, mental disorders like PTSD and depression are likely to become chronic and severely disabling.

The stigma surrounding mental health disorders - and the degree to which that stigma deters help-seeking - has profound implications for the long-term health and recovery of OIF/OEF veterans. Data do show some decline in the stigma associated with seeking behavioral health care (as reported in DoD's May 2006 report of its Mental Health Advisory Team on Operation Iraqi Freedom (MHAT III)), but the level of stigma among these service-members remains troublingly high. The MHAT III report indicates, for example, that among those who met criteria for mental health problems and were asked to identify factors that might affect their decision to receive mental health counseling or services, 53% thought they would be seen as weak. High percentages of OIF/OEF veterans responded affirmatively to concerns that seeking mental health assistance might (a) lead unit leadership "to treat me differently" (29%); (b) result in "members of my unit [having] less confidence in me" (26%); and (c) "would harm my career" (17%).

While substantial numbers of OIF/OEF veterans are being seen at VA facilities with behavioral health problems, there are compelling reasons to question how many are not seeking needed needed treatment. Congress and VA could learn much from an independent study on the numbers of OIF/OEF veterans who have mental health needs but elect not to seek treatment because of stigma.

VA's Capacity to Provide for Veterans' Needs

This hearing provides an important opportunity to question whether the VA health care system - with all its strengths - is adequately staffed, adequately configured, and operating with appropriate incentives - to meet the mental health needs of returning service-members. VA's health system has great strengths, and many centers of excellence within it. But we should be mindful of the gaps in that system, especially with respect to mental health needs, and find ways to fill those gaps.

VA is a facility-based system that does not necessarily provide good access to care for veterans in rural America or in other areas remote from its healthcare facilities. As noted above, these gaps are particularly pronounced in light of the pressing mental health needs of OIF/OEF veterans, many of whom are citizen soldiers of the National Guard and Reserves who have returned from overseas deployments to communities far from VA facilities. Those distances are all the more formidable in the face of the stigma still surrounding mental health care.

VA facilities themselves do not necessarily provide a full range of needed mental health services. To illustrate, experts believe that most service-members returning from a combat deployment face readjustment issues during what is essentially a transition from the trauma and horrors of war to reintegration to their communities and families. That need for readjustment should not be seen as a pathology that requires treatment; rather, readjustment counseling, education and support are a preventive, health-promoting measure. Most returning veterans could benefit from readjustment counseling, and the failure to make that these services available can lead to behavioral health problems. But VA's current capacity to provide this important service is generally limited to its array of approximately 200 readjustment counseling centers (Vet Centers). The department's extensive network of medical centers and clinics, which are provide a range of intensive treatment services, generally do not provide the largely preventive services furnished by the Vet Centers. While the unique circumstances of the Vietnam era help explain the development of these parallel systems (with their own separate administrative structures), there is no statutory barrier to VA medical centers providing readjustment counseling services, and - given the need - no obvious reasons not to make such services more widely available through other health-care facilities. We urge the Committee to explore having VA medical centers provide readjustment counseling services to OIF/OEF veterans and immediate family members. In that regard, it is important to remember that the Vet Center program was established with a "help without hassles" philosophy. For veterans struggling to readjust, and needing help with anger, feelings of grief, or problems with relationships, for example, there is great value in a "help without hassles" approach. And we find no requirement in law that OIF/OEF veterans must enroll for VA care in order to be eligible to receive readjustment counseling in a VA medical center, and urge that such a precondition not be instituted.

Another gap in the VA health care system is the still uneven distribution of treatment resources for veterans who have substance-use problems. VA's arsenal of resources for treating substance-use disorders was profoundly diminished a decade ago with the closure of inpatient programs. It is our understanding that the department's substance-use treatment capacity has grown in subsequent years, but does not appear to have been fully rebuilt. There is also need to question the breadth of the gap between women veterans' mental health needs of women veterans and VA's capacity to meet those needs, consistent both with expectations of privacy and of a welcoming climate. It would be most helpful in this connection to survey women OIF/OEF veterans, in order to understand their experiences and perceptions regarding care in a system long seen as an enclave for treating an almost exclusively male population

To its credit, Congress has appropriated additional funds in recent years to upgrade VA mental health and substance-use services. It is difficult, however, to gauge the adequacy of mental health staffing and capacity in this large health system. VA is unquestionably seeing more patients with PTSD, for example. But is that due to increased staffing or some contraction in the intensity of service-delivery? The complexities associated with distributing and allocating funding in the VA health care system invites question as to whether new funding finds its way, dollar for dollar, into increases in mental health staffing. Are there medical centers that receive new money for a specific mental health initiative, but offset such increases in part by cutting staffing of other mental health programs? It should be possible to monitor and measure the net gain in staff associated with efforts to expand mental health funding, and we urge the Committee to direct such action. But unless such monitoring is done with rigor and with consequences, one cannot be certain that the system's capacity will reflect congressional expectations.

In that connection, we also recommend that the Committee examine the incentives and disincentives in VA's resource allocation methodology (VERA) as it relates to mental health service-delivery. To its credit, VA leadership embraced the recommendations of the President's New Freedom Commission on Mental Health with its emphasis on the importance of fostering recovery from mental illness rather than simply managing symptoms. Many fine VA mental health programs are essential to fostering veterans' recovery from mental illness, and should be encouraged. But among those programs, valuable initiatives, like supported employment and peer supports, do not add to "workload" and therefore are not rewarded by VA's resource allocation methodology. We urge the Committee to explore avenues to ensure that VA fiscal incentives reward efforts to foster recovery from mental illness, not simply efforts to increase numbers of patients served.

Finally, anecdotal data suggest that some veterans are encountering barriers in getting needed VA mental health services. How many more veterans would get VA services if travel distances were not so great, or if stigma were not so pervasive, or if VA staff were perceived as more welcoming, or if VA conducted active outreach efforts using peer outreach workers? It would not be difficult to conduct an independent survey of OIF/OEF veterans to gauge the relative ease of access to VA mental health care, to determine the percentages who are not able to get services, and to identify the factors, if any, that discouraged veterans from getting needed help. We urge the Committee to consider directing the conduct of such a survey.

Closing Gaps in VA Service-Delivery

The principle that a veteran with a service-incurred health problem should have equitable access to treatment (that is, that a veteran should not be barred from getting needed care) regardless of where he or she lives is well-established. In our view, there is a growing need to establish a time-limited mechanism that could be implemented relatively quickly to provide high quality mental health and readjustment services to OIF/OEF veterans who do not have reasonable access to VA care. Specifically, we see great benefit for veterans in the development of a targeted mechanism (in areas distant from VA medical centers) that would combine (a) outreach and ongoing support from trained OIF/OEF peers with (b) provision of mental health services by clinicians knowledgeable about PTSD, the combat experience and the unique circumstances of military service and veteran status. Such a mechanism could be established through VA contracts with community mental health centers for provision of needed services for OIF/OEF veterans who live far from VA mental health centers under which such centers would be required to (1) participate in a VA-conducted national training program; (2) employ an OIF or OEF veteran who has completed a peer outreach/support training and certification program; (3) secure prior approval from VA (in accordance with a VA-provided protocol) before the Department would incur any liability for provision of services for an OIF/OEF veteran; and (4) provide VA with annual summary data on numbers of veterans served, diagnosis, course of treatment, and demographics. We recommend further that VA contract with a not-for-profit national mental health organization to train OIF/OEF veterans for employment as "stigma-busting" peer outreach workers and peer counselors. (The use of peer-counselors and support specialists is a well-established, cost-effective modality in mental health care that has been employed with success at a number of VA centers.) Instituting such a training/employment program is a step that would not only help participating OIF/OEF veterans further their own recovery, but pave the way to overcoming the stigma that remains a formidable barrier to needed counseling and treatment.

Next Steps

VA and DoD have unquestionably taken important steps to understand and address the mental health needs of OIF/OEF veterans, and Congress has played a vital role in mounting much-needed oversight and providing needed funding. Yet there remains much to be done, and, in our view, compelling reason to pursue new directions: (a) to work to fill the wide mental health service-delivery gaps in the VA health care system, (b) to address (in at least a time-limited way) the war-related mental health needs of veterans' family members, (c) to make peer-outreach and support in VA service-delivery the norm rather than the exception, (d) to develop better data to support Committee oversight and VA mental health management, and (e) to align fiscal incentives with clinical imperatives.

Such steps, in our view, will go a long way toward fostering the readjustment and reintegration of returning veterans, and the recovery of those who have experienced mental health problems as a result of their service to their country.

We look forward to working with the Committee to help achieve those goals.