

**MAKING A DIFFERENCE: SHATTERING BARRIERS
TO EFFECTIVE MENTAL HEALTH CARE FOR
VETERANS**

FIELD HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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MAKING A DIFFERENCE: SHATTERING BARRIERS TO EFFECTIVE MENTAL HEALTH CARE FOR VETERANS

Tuesday, September 17, 2013

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON HEALTH,
Washington, D.C.

The Subcommittee met, pursuant to notice, at 10:00 a.m., at 7850 Five Mile Road, Anderson Township, Ohio, Hon. Dan Benishek [Chairman of the Subcommittee] presiding.

Present: Representatives Benishek and Wenstrup.

Also Present: Representative Massie.

OPENING STATEMENT OF CHAIRMAN DAN BENISHEK

Mr. BENISHEK. Please remain standing for the Pledge of Allegiance, led by Commander Rick Simpson.

[Pledge of Allegiance.]

Mr. BENISHEK. Good morning. Thank you all for joining us this morning. It is a pleasure for us to be here in beautiful Cincinnati with all of you.

To start, I would like to ask unanimous consent for our friend and colleague from Kentucky, Congressman Thomas Massie, to sit at the dais and participate in today's proceedings.

Without objection, so ordered.

I am honored to serve as the Chairman of the House Veterans' Affairs Committee, Subcommittee on Health, and to be joined on the Subcommittee by your Congressman and my friend, Dr. Brad Wenstrup. As –

[Audio Disturbance.]

Mr. BENISHEK.—lieutenant colonel. In the spring of 2005, he was deployed to Iraq for a year, and while there he served his fellow soldiers, sailors, airmen and Marines, as well as prisoners and civilians, in the Abu Ghraib prison as Chief of Surgery and Deputy Commander of Clinical Services. For his brave and loyal service there, he earned numerous awards and accolades, including the Bronze Star. Brad is a doctor of podiatric medicine and former small-town business owner.

Needless to say, the immense wealth of knowledge, experience and insight that Brad brings to the Subcommittee is very invaluable. I am extremely grateful to work side by side with him and with his leadership on behalf of our Nation's veterans and their families.

So when Brad asked me to come to Cincinnati, his hometown, to address an issue of such importance to us all, the provision for

high-quality and effective mental health care to veterans in need, I was happy to take the opportunity.

Yesterday, Brad and I paid a visit to the Cincinnati Department of Veteran Affairs Medical Center. While there, we had an in-depth discussion with medical center leaders and toured the facility. Having worked myself as a surgeon in the Iron Mountain VA Medical Center, I most enjoyed the meeting with some of our hard-working Ohioans who strive day in and day out to provide the best possible care and services to the veterans in this community.

I would like to take a moment to thank each of those health care providers, administrative personnel and support staff for their dedication to our servicemembers, veterans and their families. It is clear that there are some very special things going on here in Cincinnati for our heroes, and you have much to be proud of here in Ohio.

However, where the health care and services provided for our veterans is concerned, exercising our responsibility for oversight and policy in Congress is paramount. This past February, the VA issued a sobering report which showed that for the last 12 years there have been 18 to 22 suicide deaths among our veterans every single day.

Ladies and gentlemen, we have lost far too many of our veterans on the battlefield of mental illness. We have to do better, and we have to do it now. Key to that effort is breaking down barriers to care that veterans in the midst of struggle often face when attempting to access the care they need to successfully transition home and maintain happy, healthy and productive lives. No veteran should be reluctant to ask for help because they are ashamed or embarrassed; and no veteran who takes the brave step of seeking care should be told they have to wait for an appointment that is weeks or months away, or travel long distances from their home and family to receive the services that they need.

Today, we will discuss the actions we must take to reduce the stigma and improve the accessibility and availability of mental health care for veterans here in Ohio and across the VA health care system. We will also discuss the increasingly vital role that faith-based and community groups play in helping our veterans and what we need to do to increase and improve meaningful partnerships between the VA and these community resources, who are often the first and most trusted point of contact for veterans and families in need.

Finally, we will also discuss the critical part that family members and other loved ones play in the healing of our heroes and the need to increase family awareness, involvement, and the integration of mental health services, particularly for those veterans most in need of support.

I look forward to hearing from the local Ohioans, many of them veterans, who will testify today. I thank you for being here and for your devotion to improving the lives of Ohio's veterans. With the help of communities like Cincinnati and discussions like the one we were having here this morning, I am hopeful that we will shatter the mistaken perceptions that mental health care is not available, not appropriate, or not effective, and there will come a day when

no veteran is discouraged from reaching out and seeking care, and no family suffers alone.

With that, I now recognize your Congressman and my colleague and friend, Dr. Brad Wenstrup, for his opening statement.

[THE PREPARED STATEMENT OF HON. BENISHEK APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. BRAD R. WENSTRUP

Mr. WENSTRUP. Thank you, Mr. Chairman.

If you would, everyone, I would like for us to bow our heads and let us take a moment to remember those who lost their lives in yesterday's tragic Washington Navy Yard attack. Their service and sacrifice will forever be remembered by their families and loved ones.

[Moment of silence.]

Mr. WENSTRUP. Good morning, everyone, and welcome to the House Committee on Veterans' Affairs, Health Subcommittee field hearing entitled, "Making a Difference: Shattering Barriers to Effective Mental Health Care for Veterans." I want to formally and officially welcome you to Cincinnati.

As you have seen in the past few days, this district is a district that I am privileged and proud to represent. I want to thank you for the leadership you have shown on the issue of veterans' mental health care and for hosting this field hearing today. I am also grateful that Representative Thomas Massie, a strong supporter of our military and our Nation's veterans, has taken time out of his busy schedule to be here with us as well. Congressman Massie, thank you.

To the witnesses on our panels, to each person in the audience, and especially to every veteran present today, thank you for joining us. It is important for us all to be engaged in this issue if we are going to truly improve the care that our veterans receive.

A field hearing is an opportunity to bring Congress to Cincinnati, and I am pleased that the Subcommittee on Health will hear directly from the veterans, the family members of veterans, the service officers, and the community providers of this region, who will provide a valuable perspective on the common barriers to mental health care that our veterans face.

Veterans of Southern and Southwest Ohio are a diverse group. They were raised on farms, urban high-rises, and in suburban neighborhoods. But they share a common bond. They made the voluntary commitment to serve our Nation. Only 1 percent of Americans have served in uniform. Their accomplishments have been amazing and truly unmatched by the rest of the world.

As a veteran of the war in Iraq and a member of the Army Reserve, I have witnessed the heroism of my fellow veterans and have deep respect for them. We can never repay them for their sacrifice, but we can honor it by ensuring that they and their families receive the care that they deserve.

In Ohio, we have a robust system of veteran service commissions that serve our veterans with zeal and dedication. I am grateful to have representatives from commissions in three different counties present to testify here today.

There is a growing recognition that we must develop better treatment for the invisible wounds that veterans bring home, including depression, post-traumatic stress disorder, substance abuse, and traumatic brain injury. These wounds affect veterans of all our past wars, but the veterans of Operations Enduring Freedom and Iraqi Freedom face unique mental health challenges. Because of technology and advances in that, more soldiers are surviving physical combat injuries, but they present disproportionate neurological and psychological wounds.

Studies suggest that 1-in-5 veterans of the wars of Iraq and Afghanistan have PTSD. A decade of war with frequent and extended deployments have made it more critical than ever before to create a quality mental health care system for our veterans.

There are many challenges in our current system that do not allow veterans to get the care they need. Sometimes veterans are simply unable to access care. They have difficulties in scheduling timely appointments, or the office is simply too far away. Other times, veterans are unwilling to ask for or accept help. They feel ashamed of their mental injuries. Each veteran has unique struggles and needs, and we need a mental health care system that is able to provide effective individualized care.

But today, we will discuss how the Department of Veterans Affairs can better improve its approach to and delivery of mental health care. Truly effective care, however, will extend beyond the VA. It will require the involvement of veterans' families and their communities, including veteran service organizations, community health care providers, and faith organizations. Each of us has a role to play in improving veterans' access to mental health care.

Again, I want to thank each and every one of you for being here today for this important discussion.

Mr. Chairman?

[THE PREPARED STATEMENT OF HON. BRAD R. WENSTRUP APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, sir.

We will start with our first panel who are already seated today at the tables.

Doctor, would you please introduce the panelists?

Mr. WENSTRUP. Yes. On our first panel joining us today is Mr. Howard Berry, the father of Army Staff Sergeant Joshua Berry. Josh served in Afghanistan and was stationed at Fort Hood during the shooting on November 5, 2009. Josh suffered from PTSD and ultimately took his own life on February 13, 2013. Howard is here to tell his son's story, as well as his own.

Barriers to effective mental health care exist not only for our servicemembers, but for their loved ones as well. I sincerely appreciate Mr. Berry's willingness to share his experiences as a way to improve outcomes for veterans and their families.

Also with us today is Mr. Nate Pelletier, Executive Director of the Joseph House here in Cincinnati. Mr. Pelletier is an Army veteran of Operation Iraqi Freedom.

Mr. Rodger Young, veteran service officer at Claremont County Veterans Service Commission. He is an Air Force Master Sergeant with 20 years of service.

Paul Worley, Army veteran who has agreed to represent the Adams County Veterans Service Commission here today. He has served three tours in the global war on terror.

Ms. Kristi Powell, veteran service officer at the Scioto County Veterans Service Commission, Air Force veteran.

Thanks to each of you for your service to our Nation and for the work you do every day to help your fellow veterans. I look forward to your input on this important issue.

On the second panel, I will be pleased to welcome Ms. Linda Smith, the Director of Cincinnati VA Medical Center, here to testify on behalf of the VA. She is accompanied by Dr. Kathleen Chard, Director of Trauma Recovery Center at the Cincinnati VA Medical Center, Professor of Clinical Psychiatry at the University of Cincinnati; and also accompanied by Ms. Emma Bunag-Boehm, primary care provider for the OIF/OEF/OND Clinic and the Persian Gulf Registry clinician at the Cincinnati VA Medical Center; and also by Mr. Chadwick Watiker, an Air Force veteran, Cincinnati Vet Center Team Leader. I want to thank you all for being here today.

Mr. BENISHEK. Thank you, Doctor.

Once again, thank you all for being here.

Mr. Berry, I think we will begin with you. Please proceed with your testimony.

We are trying to keep it around 5 minutes each, so I appreciate your consideration there.

Please begin.

STATEMENT OF HOWARD BERRY, FATHER OF JOSHUA BERRY (DECEASED); NATE PELLETIER, EXECUTIVE DIRECTOR, JOSEPH HOUSE, INC.; RODGER YOUNG, CLERMONT COUNTY VETERANS SERVICE COMMISSION; PAUL WORLEY, ADAMS COUNTY VETERANS SERVICE COMMISSION; KRISTI D. POWELL, SCIOTO COUNTY VETERANS SERVICE COMMISSION

STATEMENT OF HOWARD BERRY

Mr. BERRY. Good morning. My name is Howard Berry. I am the father of the late Staff Sergeant Joshua Berry. My son was injured both physically and mentally during the shooting at Fort Hood in 2009. I am not an expert on the diagnosis and treatment of PTSD, but I am an expert on the pain and suffering of the surviving family members of soldiers who turn to suicide as a final solution to their problems.

Please read what I submitted for the record. Some of the observations and possible solutions to consider are not just my thoughts. I solicited input from family, friends, soldiers who served with my son, veterans and caregivers. All have contributed to what I hope you will read.

The reason I am humbly asking you to read what I wrote is simple. I am skeptical due to the fact that I have already written the President twice, all 100 senators, and all Members of the House of Representatives. To date, I have received eight responses. That is less than 2 percent.

I had the opportunity to attend some of the trial at Fort Hood several weeks ago. I was fortunate to stay with my son's former

commanding officer and his family. I learned that Josh's captain sustained a traumatic brain injury during a subsequent deployment to Afghanistan. He also suffers from PTSD. He described what it is like to live with PTSD to members of Senator Cornyn's staff during a meeting I scheduled while in Texas.

He said, "I have a wonderful wife and three children. I retired from the Army after 21 years of service. I have a good job and a house and two cars. I am living the American Dream. I have PTSD. I don't know where, when, or how long an episode will last when it starts. When it does, I cannot see the wife, kids, career, job, home. All I feel is pain, guilt, and shame. I should have died in Afghanistan. I have no worth. I should take my life. The PTSD I have is mild compared to what Staff Sergeant Berry had. His was severe."

Stigmas encountered by soldiers with PTSD start in the military, continue through treatment at the WTUs, the VA, and into society. Current perceptions are that PTSD-affected soldiers are different or messed up. We need to keep them at arm's length. We need to watch them.

I recently spoke with a director from a local company. I asked him if he had one job to fill and two equally qualified applicants, one a veteran with a Purple Heart, which one would he hire? He replied, "The veteran." I then asked him to consider the same scenario, only the veteran has PTSD. He did not respond.

I understand that he has a responsibility to look out for the company's interest, that he must look out for the welfare and the safety of all the people employed there. That is his job. The society we live in has to change. PTSD-affected soldiers deserve better treatment, like all of us.

The suicide rate is still rising among our veterans. I hope my coming here today to speak to you is not a waste of our time. I hope this is the beginning of better days for veterans with PTSD. After all, we are all responsible.

Please read what I submitted.

Thank you; God bless.

[THE PREPARED STATEMENT OF HOWARD BERRY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Berry. I truly appreciate your testimony. I am so sorry for the loss of your son. Thank you for telling some of us his story.

Mr. Pelletier, please go ahead.

STATEMENT OF NATE PELLETIER

Mr. PELLETIER. Thank you, Mr. Chairman, and thank you, Mr. Berry, for being here. I would first like to say that on behalf of all veterans, this is why we continue to serve our population, so that your son is remembered and so others do not follow in his footsteps.

I would first like to say that in my testimony, I am very, very proud of our VA Medical Center that we have here in Cincinnati and the work that has been done. I personally received best-in-class care here as a disabled veteran. As a veteran leader here in the community, I have a vested interest in ensuring that our Fed-

eral and community resources enable our warriors that are in transition to soon be veterans and that our current veterans successfully reintegrate into our communities.

I have recently conducted research that studied the impact of transitioning veterans and drafted a proposal to assist not only the VHA, which is the main effort post-transition, but the Departments of Defense, Labor, HUD, Human Resources, and all supporting agencies within our community to make sure that we improve and implement a sustainable transition system for our veterans or before they become veterans.

As the executive director of a local agency supporting veterans' needs, I am in the fight every day. I have witnessed what can happen if those who have served our country fall into what I call the "distrust gaps" of an inefficient transition and support network within the veteran community. I lived that on the very first day of the Joseph House on April 1st. One of my War on Terror clients overdosed on heroin and nearly died in his room. Thankfully, his roommate, who was also there for addiction reasons, was EMT-certified and saved his life that day. That day, I knew it was real.

Over the next three years, roughly 300,000 new veterans are going to return to our communities, and we want to make sure that we utilize their talents in every way that we can. To this end, I want to show the interconnected ways that draw attention to this Committee on the VHA side. We need to address the scope of expansion of our local VHAs, and also address the administrative leadership's ability to support community partnerships.

During the transition of new veterans into the community, the VHA currently feels the burden to fill gaps in the process due to the absence of a seamless transitioning system. I define this as "scope creep." The DoD, VA, all parts of the VA, including benefits and health, the Department of Labor, as well as other agencies and community organizations have acknowledged that the transition process is inefficient and that the responsibilities of each organization are unclear.

With this in mind, some examples of VHA scope creep include, but are not limited to employment assistance, which can be handled in our community, as well as education assistance, benefits assessment, family supportive services, and some maybe unrelated medical tasks that can be handled through the partnerships in our communities.

As we attempt to define these responsibilities, I feel it is necessary to look at the process in the three different categories: the processes that the VHA can fund and own responsibility to execute; processes that the VHA funds and outsources to the community partners to execute; and finally, processes that the VHA outsources to the community partners who are either VA or privately funded and can own the responsibility to execute on their own.

In addition to addressing the systems and process responsibility to reduce scope creep, I think it is important for the VA administrative leadership to empower and leverage VHA and community partnerships.

In an attempt to fully assess the effectiveness of the VHA in our community and scope creep, we really need to say what are the primary responsibilities of our local VAMCs. In my mind, the purpose

of the VHA is very focused and clear: support the medical needs of veterans who qualify for medical services post military service. Any services in addition to these primary responsibilities should be assessed according to those three categories that I previously mentioned.

The first step to effectively optimize the veteran support administration is to take an active role in partnering and oftentimes leading the convening of mobilized community efforts in our community. We are doing this right now in Cincinnati. We need more involvement from the VHA.

We can assess two areas of concern nationally and locally, particularly locally here as it concerns us, one being employment and chemical dependency, that we are seeing real difficulty among our returning veterans. In my mind, employment is a critical node in the process. If you look at all the different nodes to ensure the ecosystem is best for our veterans, sustaining income and having a job that not only provides that income but a sense of purpose is vital to their successful reintegration.

Often, what I have talked from the sources at the Joint Chiefs of Staff Office for Warrior and Family Support, that it is not just PTSD. Not having that stability to be able to provide for yourself and your family can also trigger symptoms of depression, self-esteem, a sense of purpose, other things that may not be directly related to combat-related issues.

Too frequently, these breakdowns lead to the use of unhealthy coping mechanisms, which then leads to things such as substance abuse. This is what I call the downward spiral of the veteran's reintegration or lack of reintegration back into our communities.

To really assess the importance of employment again, the Joint Chiefs of Staff Office for Warrior and Family Support said they are accountable for \$960 million in unemployment compensation to veterans without the ability to fix the problem because in the transition to the community, those veterans are no longer a part of the Department of Defense.

I feel that we see that the first access the VHA has, that veterans have, is to our local VHA, and they feel the burden to meet some of these gaps. I think this is an example of scope creep within the VHA due to the inefficiencies related to who owns what in the transitional process.

Besides veteran employment efforts, I think the VA administration can optimize the partnerships with the community agencies to provide clinical treatment for our veterans. This is a very specific topic here. As the director here of the Joseph House, my clients are prime examples of the system breakdown within the ecosystem of support. I have currently identified that 12 out of 27 of my clients are not only suffering from chemical addiction, but also from a co-occurring disorder related to mental health, most of them from PTSD.

Recently, we just reassessed those numbers, and it is 78 percent of my current clients from yesterday suffering from co-occurring disorders related to chemical addiction and mental health. Subsequently, those are broken down to family support, employment, and all those other things that they need to be able to successfully reintegrate.

I would also like to mention that although the VA administration has provided exceptional support through their VHA Community Outreach Division to fund and evaluate current programs like the Joseph House, VA has been reluctant to partner in the community-based veteran mobilization efforts or the community action team effort here in Cincinnati. We can really do better by having participation in there, not just to figure out what they can do to support us, but what we can do to relieve the burden of their scope creep.

Local agencies such as the Joseph House, Talbert House, Volunteers of America in the region provide services and treatment for veterans that are suffering from chemical dependency. The majority of these programs are actually funded by VA Grant Per Diem programs. Although the VA provides a series of measures to validate funding each year, they also operate their own internal substance clinic within the hospital. Again, a very action item where we can look at what can the VA do internally, and what can we do externally to serve our veterans. We are already funded to do it in our communities.

Also we have seen, although it is not true everywhere, but that the private agencies or funded agencies in the VA and the community require certifications of their clinical counselors. We are not often seeing the same at the VA hospital, where it is not part of the hierarchy to actually have an LICDC or a CDCA certification to be a clinical counselor. Just a couple of examples of things we can look at.

And then also related back to chemical dependency locally here, we are seeing an increasing rise in the use of opiates in our community versus alcohol. This is an alarming effect, and we have power within our community agencies to really partner to do that very well, to relieve the burden on our local VAs.

Just in summary, I would like to reiterate the opportunities to optimize VHA scope creep and the VA administrative leadership for the community are not a reflection of the dedicated staff and those that are leading them, but an opportunity to optimize our processes.

If I could, in closing, just give you an example of how I experienced the stress of a veteran who recently was discharged from our local VA. In 2011, I received a call from a soldier on a Wednesday, a weekday night. I believe it was a Wednesday at 10:30 p.m. Actually, the call came from the local VA hospital, to see if I could house a War on Terror veteran for the night. He was no longer able to stay in the hospital because his time was up.

At around 11:30 he arrived at the house, at my house, and for the next two hours he tearfully told me his story. Like many soldiers, he signed up to serve his country and suffered severe trauma related to combat that came home with him post deployment. If I recall correctly, his father had also recently passed away, and his mother was suffering from chemical dependency as well.

Despite the breakdown of his support, he soldiered on and secured a meaningful job, but was later laid off like so many other Americans. Without stable housing or employment, he found solace on the streets and had built a relationship with local law enforcement to allow him to just spend a few nights on the street while he reached out for help during the day. And unfortunately, like

many homeless citizens in distress, he turned to alcohol and other drugs as his coping mechanism.

While he fortunately found his way to the VA where he completed their chemical dependency program, he did not have the support network to sustain his sobriety post treatment, and my home became his last resort that night.

This story, like so many others, is simply unacceptable. We must think strategically, we must act operationally, and continue to identify opportunities to improve the system while always keeping the end-state in mind, ensuring our veterans thrive and are productive members of our society. One veteran left behind is one too many.

[THE PREPARED STATEMENT OF NATE PELLETIER APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Pelletier.
Mr. Young, you are up.

STATEMENT OF RODGER YOUNG

Mr. YOUNG. Good morning. My name is Rodger Young. I am a Veteran Service Officer for the Clermont County Veterans Service Commission. Veteran Service Officers assist veterans in obtaining their VA benefits. This can include enrolling into health care, applying for compensation or pension, education benefits, burial benefits—can you hear me now?

Mr. BENISHEK. Pull the microphone closer.

Mr. YOUNG. Can you hear me now? How is that?

Good morning. My name is Rodger Young. I am a Veteran Service Officer for the Clermont County Veterans Service Commission. Veteran Service Officers assist veterans in obtaining their VA benefits. This can include enrolling into health care, applying for compensation or pension, education benefits, burial benefits, VA home loans, and financial assistance programs. We are also charged with aiding veterans with their appeals and dealing with the overpayments and billing issues at the VA. We are pretty much the proverbial one-stop-shopping for VA benefits.

Our office was invited here today for this Committee to provide feedback on the services the Veterans Healthcare Administration provides and also comment on the programs and stigmata associated with the PTSD programs.

To start off, I would like to give some positive feedback first. I have noticed—I have been with the Veterans Service Commission for five years, and within the last couple of years, the VA has transitioned into nursing teams. The nursing teams have been very well organized, and it opened up the communications between the veterans and their doctors.

Along with that, they also opened up the MyHealthyVet Web site, which is a great way again to open up communication channels between the veterans and their doctors, and also for them to download some of their medical information.

Coupled with that, VBA, the Veteran Benefit Administration, also has their own Web site, and the E-Benefits Web site also is a major hub for VA benefits and downloading of VA correspondence.

I want to personally commend the staff, especially at the CBOC Clermont County. They always have great service, great nursing teams, very cooperative and friendly with the VSOs, and they treat every veteran with the utmost care and respect.

The quick reference flipbooks are also a great way of passing on information concerning health care, and I have seen the Ohio Department of Veterans Services is also tagged on to that.

The areas I feel that we need to improve on over at the VA as far as health care goes, non-VA health care—fee basis is what it used to be called—it is not as easy as it sounds. Many veterans are confused about the program and when VA will actually pay for the emergency or care and transportation. VHA needs to be clear on what VA will pay and the requirements before the health care is covered. Again, the handout makes it sound easy. There should also be a claim form to send in to VHA along with the hospital bills.

The processing time is another big concern. It takes so long for the veteran to even receive an answer if the VA is going to cover their bills or not. And by this time, the bills are handed over to collections, and the veteran, of course, their credit is going to go bad and everything else.

VHA also needs, I feel, a call center for billing specific non-VA care alone. Normally, you are going to get an answering machine when you call, and very rarely will we get a call back on that.

Another problem that they are having down there, especially at the medical center, is average wait time for surgeries, anywhere from six months to a year. I feel personally if the VA does not have the facilities available for surgeries, they should fee base it out somewhere, to one of the local hospitals.

Still getting complaints about the professionalism down there at the VA Medical Center. I know there are a lot of great folks down there, but there are a lot of angry folks down there also, which concerns me. A lot of the angry folks we have identified. As one veteran put it to me, some of those folks down there at the medical center need to go to Happy College.

[Laughter.]

Mr. YOUNG. I get little to no complaints over at the Georgetown facilities or the Clermont CBOC.

Another problem that we have, disability questionnaires. I know we are looking for a way to expedite some of these claims. That is the key. That is probably the best idea I have heard since I have been a service officer, is to bring in these DBQs, which the doctors can fill out there at the CBOCs and at the VA medical centers. Matter of fact, the central office there in Washington, Tom Moe—I'm sorry, Tom Murphy; I misspoke there. Tom Murphy actually told us that they are supposed to be doing that. The CBOCs, we have no problem with this, with the medical centers.

We are having an issue with filling out the DBQs, and these disability questionnaires, once filled out—take a diabetes claim, for instance. You have a Vietnam vet in-country. These disability questionnaires will clearly identify that he has a diagnosis of diabetes, what he is doing for the diabetes, medication. That is a 20 percent rating. That is easy. Versus a claim that is going to take eight months to a year-and-a-half just to identify the same things.

Also, another thing that we run into, if doctors refer veterans to file a claim, especially to our office, please ensure the diagnosis and notes are annotated in CAPRI or in their systems. It makes everybody's life much easier. I get a lot of veterans coming into the office, and I will file a claim for PTSD, no problem there, especially if a psychiatrist sends a veteran over there. But please, if you send a veteran over there under the impression he has PTSD, please annotate that he has PTSD. There are times when we get claims back. The claim was denied because there was no diagnosis.

Veterans endure many adjustments when returning home from deployment to include indoctrination back into family life, adjusting back into their home station and their rules, and trying to process what has happened while deployed. In general, many veterans are reluctant to seek help for mental issues due to the stigmata associated with PTSD. Employment is a big issue to include separation from the military if they self-identify. Also, they may run into problems with their family, and also with current gun laws. Many veterans will not self-identify as having PTSD or won't seek help because of these things.

Feedback from the CBOC staff indicate cognitive therapy is working on many veterans, and I will vouch for that. It does work. Success stories, to be honest, though, I don't have any. PTSD, folks, you can get treated for that, but it does not go away.

Many veterans who seek help for PTSD receive some relief through medications to tone down the symptoms, but I have never seen a veteran completely cured of it. Realize in past wars, veterans would endure one to two deployments in the warzone. Contemporaneously, it is not uncommon to see five to eight deployments nowadays.

PTSD programs have prevented many suicides, but I think we still have a long road ahead of us in treating PTSD. In my opinion, we need to fix the stigmatas associated with PTSD so more veterans will seek help, and then we need to rehabilitate them to function in today's society outside the military.

Veterans, they feel disconnected when they come home. They are totally disconnected from the civilian society. They are programmed for military.

Our office appreciates the invitation today to outline some of the hurdles VA faces and the vast improvements it has made to ensure the veterans are taken care of. Partnerships within VHA, VBA, and the VSO offices will solidify a smooth transition for the returning veterans and their families. Standardization, consistency and communication within these agencies is the key element to minimize the confusion within the veteran communities.

[THE PREPARED STATEMENT OF RODGER YOUNG APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much, Mr. Young.
Mr. Worley, could you begin, please?

STATEMENT OF PAUL WORLEY

Mr. WORLEY. Good morning, Mr. Chairman, Members of the Committee. It is an honor to testify before you today. Thank you

for allowing me the opportunity to speak this morning about mental health care for veterans.

My name is Paul Worley, and I am an Army veteran. I served as an infantry rifle platoon leader and scout platoon leader in the 2nd Battalion, 502nd Infantry Regiment, 101st Airborne Division in Iraq in 2005 to 2006. In 2008, I went to Afghanistan and served as an operations officer for Regional Command South in Kandahar. In 2010, I went back to Iraq as a company commander and saw the drawdown and was there for Operation New Dawn.

At times and places few will ever know, we fought for each other against an unseen enemy. I was honored to serve my country and privileged to lead the best soldiers in the world. Today, I am equally proud to represent my fellow veterans and to talk about the issues we face in regards to mental health.

When it comes to mental health care for veterans, the major issues are access and availability. The VA is the largest integrated health care system in the country. There are going to be issues, as there are in every health care system, but that does not mean that the system is broken.

In Adams County, Ohio, our veterans are faced with the issue of getting reliable transportation to their mental health appointments. The nearest clinics are located in Portsmouth and Chillicothe, which are at least a 45-minute drive for the majority of our veterans. For those who receive services in Cincinnati and Columbus, the task of getting to their appointments is even more daunting.

Our local veteran service commission and our local veteran service organizations, including our VFW Post 8327 and our Disabled Veteran Chapter 71, currently provide transportation, but it is not enough to meet the demands of our veterans and their families. I believe it is essential that we provide more mobile veteran centers to provide access to our rural residents.

Another access issue we face in southern Ohio is Internet availability. Our Internet infrastructure in Adams County is extremely limited due to the terrain and the financial challenges of our local population. Many veterans do not have ready access to fill out forms online or to obtain the information they need about mental health services. As more and more information is shared online, it is critical that we provide our veteran population with this essential basic modern need.

I believe that the military as a whole has made positive progress to reduce the stigma of post-traumatic stress disorder within its ranks over the past 10 years. However, I believe that there is still a great amount of work to do to reduce the stigma of PTSD among the American people. Young veterans seeking civilian jobs are extremely reluctant to seek help because of the risk of an employer not hiring them. All veterans deal with the stigma that seeking help for mental health is a sign of weakness. More education is needed to make sure that the American public comprehends the issues associated with PTSD.

It is very encouraging that the VA has recently hired an additional 1,300 mental health care workers that will potentially alleviate some of the availability issues. I believe that the VA employees and leadership want nothing but the very best care and benefits for

our veterans. However, we need to continue to improve the mental health care system. We need to be prepared to pay for veteran health care services as readily as we were to fund the wars that caused these issues. The price tag may be great, but that truth does not take away the Nation's duty to care for its veterans.

The country sent us to war. Now is the time to make sure that this country is delivering on the solemn promise made to our veterans for their voluntary service. No one gets left behind. Thank you.

[Applause.]

[THE PREPARED STATEMENT OF PAUL WORLEY APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you, Mr. Worley.

Ms. Powell, please begin.

STATEMENT OF KRISTI D. POWELL

Ms. POWELL. Good morning. Thank you for this opportunity.

My name is Kristi Powell. I work with Scioto County Veterans Service Office. It is through my job there that I get the opportunity to work with my fellow veterans, and it is through this job that I will be their voice today for victim survivors of military sexual trauma, as I will refer to as MST throughout.

The Department of Veterans Affairs Web site states that about 1-in-5 women and 1-in-100 men seen in VHA respond "yes" when they are screened for MST. This is a very high rate, and it is very alarming and concerning.

The veterans in my county are struggling with the services that the VA can provide. Although a disabled vet myself, I do go to the VA, and I strongly advocate for veterans to utilize the VA, but we need to recognize that we are struggling with programs for specialized things like PTSD, TBI, and MST.

The veterans in my community, when they do raise their hand and address themselves as being a survivor of MST, they are not getting the care that they received in the cases that I provided in my testimony. What I would like to see is that we recognize this as an ongoing problem, a current problem, and one that is not going away. It would be great if we could see every VA develop a plan to help these veterans.

Currently, veterans have to travel very far distances. There is not a lot of facilities to treat women survivors of MST. Currently, one of my veterans had to go all the way to New York State just for the care that she deserves. So there is not care locally being provided.

In the cases that I did give you, the women were subjected to being in all-men counseling groups and around individuals that they should not have been around when trying to struggle with a rape and the scars that it has left on them.

A survivor and a victim of MST should be able to go to their local VA with confidence that they are going to receive the care that they deserve, and that care should be available, like I said, at every VA that is around. For my veterans, a drive one way to get care is over an hour.

The VA is responsible for serving the needs of veterans by providing health care, rehabilitation, and this just is not being done. I would like to just raise awareness on this subject today, and I won't go into detail. I hope that everybody received a copy and can read the cases that I provided on the veterans in my community. Thank you.

[THE PREPARED STATEMENT OF KRISTI D. POWELL APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony, Ms. Powell.

I really appreciate you all being here today.

I think I am going to start by yielding myself 5 minutes for questions. I think I want to start with a question for Mr. Berry.

I think you have some very compelling testimony there concerning the loss of your son, of course. Were you able to talk to a veteran service coordinator at the VA? Were you involved at all with your son getting care from the VA? Were you a part of it?

Mr. BERRY. PTSD?

Mr. BENISHEK. Yes.

Mr. BERRY. For his care?

Mr. BENISHEK. Well, apparently they have a family services coordinator that helps families of veterans with veterans that have to deal with the VA. So were you involved with a family service coordinator?

Mr. BERRY. No, I wasn't. None of my family members nor I were ever approached in any way to learn about PTSD or participate in what needed to be done as far as the care for my son, what we could do, what to look out for, anything. And when I did try to ask questions, they always kept tossing the HIPAA laws up, "We can't communicate with you because of the HIPAA laws."

These soldiers are brittle. We need to surround them with a circle of care, and the door was closed. Even after his death, I found out that a lot of the things that—the HIPAA law doesn't go away. I am, like, well, I don't understand. But, see, I don't understand a lot of things that took place regarding my son's care, and all I have had have been questions since the day he died. I still haven't had any answers.

Mr. BENISHEK. Well, I hope today that the second panel will review your testimony and maybe come up with some answers for us regarding that question. I brought up the veterans service coordinator and making sure we try to have the family and friends of the veterans more involved with the care. So, I appreciate that.

Mr. Pelletier, I have a question for you, too. You told me about a veteran that showed up at your house at 11 o'clock at night after being discharged from the VA hospital. Is that correct?

Mr. PELLETIER. That is correct.

Mr. BENISHEK. Didn't they have a discharge plan for the patient? I mean, how is it that the guy ended up on your doorstep?

Mr. PELLETIER. What I know, Mr. Chairman, is only what he told me, that he had finished the program and was not allowed to be there for another night based on, I guess, the regulations of the program. Now, he was able to go back the next day, so it was more or less a one-night event where he needed a place to sleep.

Mr. BENISHEK. All right. It just seems to me that, as a physician, I know when the patient has a discharge plan to be going the same day. We know where the patient is going that day, and it seems odd that there would be no plan for his discharge or a place for him to be, and then he would call you. So I was just wondering if there was a plan, it wasn't carried out or the patient wasn't satisfied with that plan, or he just didn't have anything else to do and he finally showed up at your door.

And how often has that occurred? Where do you get your people from? Are they from discharges, or are they just from people finding homeless people on the street?

Mr. PELLETIER. That relates to Joseph House, your first question. I was contacted by a staff member at the VA hospital in reference to him and his need, and I talked to him on the phone. So it was from VA. Now, I don't know—and I won't speak on what I don't know. So if he had a program aligned for him, he may have. I was not aware of it. All I know is that I felt the need for it to happen.

Mr. BENISHEK. Right. Does it turn out that many of your patients come from discharges from the hospital?

Mr. PELLETIER. Are you referring to the Joseph House?

Mr. BENISHEK. Yes.

Mr. PELLETIER. That house was actually my personal house where he came to stay with me, not at the Joseph House.

Mr. BENISHEK. Right.

Mr. PELLETIER. He stayed in my own home. It was not until about a year-and-a-half I took over the Joseph House.

So at the Joseph House, we do receive clients from the VA. We receive clients from multiple sources. Given our location, we are right in the middle of the area, we have a lot of walk-ins because they are literally sleeping a block away from where we exist.

But we do have a lot of referrals from the VA to the program, and keep in mind that a lot of clients that I serve have chemical dependency. It requires them to go through multiple programs. That doesn't mean that one is better than the other, but it will take maybe a few different attempts to find the right fit, which also establishes, I think, why we need to have a great partnership, to understand the needs of each client to make sure we try to get them in the right place the first time.

Mr. BENISHEK. All right. Thank you.

Ms. Powell, let me just take another moment here and ask you a question. This military sexual trauma issue, I am very interested in this issue. It is my understanding that many people don't report the fact that they have been a victim of military sexual trauma because of the fact that they are just afraid as to what is going to happen to them or if they are going to be discharged, are they going to be segregated. I am working on legislation to take the reporting and the prosecution of offenders out of the military chain of command.

Do you feel that that would be helpful, removing the prosecution from the military chain of command? Are you familiar with that?

Ms. POWELL. Yes, sir, I am. In the cases with the female veterans I am currently dealing with, that is an issue. None have reported. They did not report while they were active duty due to

being afraid of reprimand, and also being afraid to testify against their perpetrator.

Mr. BENISHEK. You mentioned a circumstance where a victim, a female victim of military sexual trauma was in a treatment program that was all men involved. Is that a frequent circumstance?

Ms. POWELL. When it happened the second time with the second case, a female, then I realized that it was a problem, and it is due to there not being separate wings or individualized treatment plans available for care. If there were separate female units, then they definitely would not have been put in the group counseling with the men.

But, yes, this is occurring frequently, and that was the issue that I addressed. As soon as they identify themselves as MST, the red flag should go up and they should not be subjected to that type of group counseling.

Mr. BENISHEK. Well, yes. All right. Well, I am hoping that the next panel will address some of these questions that you all have brought up here this afternoon.

I will now yield the floor to my colleague, Mr. Wenstrup, for his questions.

Mr. WENSTRUP. Thank you, Mr. Chairman.

Mr. Berry, I want to again thank you for being here today. I think that your testimony clearly depicts the challenges that so many face when they return from war, and I think that it clearly depicts our need for a greater transition for our soldiers as they exit the military and go to the VA side. There seems to be a wall there and a disconnect, and I think that attention will be focused more on transitioning as we move forward, and I think it is very important, and your story clearly depicts that, and I thank you for bringing that out for us today.

On that front with transition and support, I have a question for you, Mr. Pelletier. You identified the need for a stronger referral system between the VA and the community providers. Would you clarify some of the weaknesses in the current referral system and ways that maybe we can make it better?

Mr. PELLETIER. Right. I think to sum up, if you have seen one VA, then you have only seen one VA. Speaking locally here, given that we have a very robust community effort to mobilize our sources externally from the VA, what we found in these convening sessions that we have is that there are vital people in the VA who could be part of those groups, whether it is around—particularly around health, but housing and chemical dependency are very interconnected when it comes to health issues, that they are not allowed to participate, period, due to restrictions on the administrative side, to participate in those convening sessions.

We have five active teams right now in our community. They are focusing on the—well, every community is different, but five major efforts to support our veterans who don't have that support. We are here to help because, like I said, the VHA has taken on so much responsibility that it is hard to do the primary tasks. But it is hard to help if we can't interact in an effective way, and they have the most access to our clients.

I am a big fan of the OIF/OAF clinic and Operation New Dawn and Karen Cartwright's leadership there. She says that she has ac-

cess to the majority of the new veterans coming in. We need to be able to understand the landscape and for them to be involved.

Mr. WENSTRUP. Thank you.

Mr. Young, I believe you mentioned about the disability questionnaire. Were you speaking to that? And are those claims done electronically or hand-written?

Mr. YOUNG. Hand-written.

Mr. WENSTRUP. They are hand-written, the questionnaires?

Mr. YOUNG. Right.

Mr. WENSTRUP. Just one thought that I had on that. Sometimes with an electronic type of form, if they are obligated to fill it out, it won't let them complete it if there are missing portions of it, and I think that that might be a solution for us. Does that sound like it may work? Because you commented on parts not being there, like the diagnosis, which is key. So if you can't complete the form without having all the boxes checked, might that be of help?

Mr. YOUNG. That could be one solution. Actually, the diagnosis would show up in CAPRI, which they could see up there at the VA regional office. The disability questionnaires we will actually expedite, and those are normally hand-written. I am not sure how we would get that integrated to their system so they could do that.

Mr. WENSTRUP. Thank you.

Ms. Powell, this has been a very major issue for us. I am on the Armed Services Committee as well as Veterans' Affairs Committee, and the sexual trauma, military sexual trauma has been highlighted.

One question I have is when you are seeing some of these victims, are they mostly clearly recent incidents, or are some people from 20 years ago that are now coming forward? What are you seeing?

Ms. POWELL. Okay, sir. Yes. When I had the roundtable discussion in case number 3, I was really taken aback that the different eras of women that served were all survivors of MST. There is a woman who served in the '80s, one from the '90s, and then others from currently today. So it has been going on for some time now.

The women from the past are misled and don't have current information as well because they think that to receive care, that they have to provide information about their specific incident, so they stay silent.

And I would like somehow to make that—they have to become aware of the services that can be provided and they don't have to stay silent anymore, because that is a long time that she has been the way she is, where she cannot even leave the house, she cannot work, she self-medicates, just to deal.

Mr. WENSTRUP. For those in uniform today that are victims, I just returned from Madigan Army Medical Center in Washington, and they started a new program that I hope is successful and that can carry on throughout the military, and it is a sexual assault response team where people can come in anonymously and start to engage, usually with a legal team and social workers, on what their options are. So when they take this step, they don't have to be afraid because it is not anything that goes on their record, and they get better guidance through that.

Through the National Defense Authorization Act, this year, we put in many whistle-blower protections and things like that. So it is being addressed very seriously, and hopefully that will have long-term benefits.

It doesn't change your challenge for today on the VA side, but hopefully it will, and maybe some of the models of what we are seeing with that program can reap some benefits. I appreciate you taking that on.

Ms. POWELL. Thank you.

Mr. WENSTRUP. Thank you.

Mr. Chairman, I yield back.

Mr. BENISHEK. Now I will yield to Mr. Massie for questions. Thank you.

Mr. MASSIE. Thank you, Chairman Benishek. I want to thank you for your work on the recent bill, the first appropriations bill that we passed, reallocating priorities so that we can try and get rid of the backlog in the VA filings, and that did pass the House of Representatives. Hopefully, we can get that through as part of the latest budget and continuing resolution.

Also, I want to thank you for traveling such a long distance to come and help us in our region on this issue.

Mr. Wenstrup, I appreciate you organizing this hearing. I think among all the congressmen, you are probably the most qualified to cover this issue given your service in the military, and also in the health care profession.

What strikes me today is that we are trying to ameliorate or work on an issue for people that starts in the military. It starts sooner than when they are discharged. So the question that I have for really anybody on the panel here is, what policies could our military adopt during active service to reduce the onset of mental illnesses or to mitigate the effects of mental illness after military discharge? For instance, you mentioned one of the nodes was employment. Are we doing enough in the military to prepare people for employment, or are there ways that we can prevent MST by preventing the acts? Would anybody like to speak to that?

Mr. PELLETIER. Congressman, I would be happy to. There are several ways to address it. The way I have been addressing it is looking at the holistic picture of someone who is about to get out of the service, who is about to sign that paperwork, and the next step will be to reintegrate into society.

So if you look at kind of a TedX model, there are all kinds of things that could break down within transitioning warriors, as we like to call them, and it relates to employment, it relates to mental health. I just want to bring attention to that PTSD is certainly a diagnosis. It can go beyond what happens in combat. It can happen within the community. Something can trigger it after you get out that may not have been picked up. Or it could just be mental health issues related to combat stress, which is not always PTSD, transitional stress that can relate to mental health.

So, yes, I do think it needs to be addressed before they get out and that we figure the accountability for it. I think what we need to do is when those soldiers or warriors have decided to make the next step and sign the paperwork, they don't get out the next day.

There is a period of time. We need to figure out how long that period of time we can invest in their transition.

My proposal is an actual recommendation of a process we could look at. It is not an answer, but it is a process where we address all those things that we need to look at with our veterans or soon-to-be veterans. We do a very good job right now, at least where I came from at Fort Stewart, in addressing the mental health. PTSD, I had gotten out in '08. Employment is not addressed, but it is also not the responsibility.

So what we need to look at is where do the responsibilities lie in the system and that overlap of where, even before the DoD hands over, when can we bring in community or national partnerships to begin that work. The Joint Chiefs of Staff Family and Warrior Support Command is absolutely where I think the discussion can happen, because they overlap from DoD and community partnerships, but they are only facilitators. They are not the leaders.

Mr. MASSIE. Thank you very much.

Mr. Berry, along the lines of that question, do you think that multiple deployments or extended deployments contributed to your son's condition?

Mr. BERRY. My son served in Afghanistan, was only deployed one time. Ultimately, the incident that led to his taking his life, making that choice, was what took place at Fort Hood, and then the subsequent—I call it pussyfooting around for the next three-and-a-half years, or whatever.

There were so many things that I couldn't understand, and his skill sets were compromised. So how could I expect him to understand what decisions were being made regarding the trial and how it was being handled? I couldn't wrap my brain around them. How could I expect him to?

And I even actually have letters that were written on numerous occasions by doctors that were involved in his care, and I asked permission to use them, and I was told that if I did, that his physicians would terminate from their positions.

I just thought that that was—I wasn't doing anything to disparage anyone. It was just a statement that was made that just said that the decision that my son made to end his life was based on what happened at Fort Hood, and I am not allowed to share that.

Mr. MASSIE. I also share your concern over how that incident was characterized in the official story, and I appreciate you coming today to testify.

Mr. Young, you mentioned something that I don't want to let it be swept under the rug. You said you are still getting complaints about the VA in Cincinnati. What are veterans telling you about the professionalism there, and are you concerned that they don't seek treatment because of the stigma or something associated with that particular center? Can you elaborate on your comment?

Mr. YOUNG. I will address the OEF/OIF clinic, very professional. I have heard nothing but good things come out of the OEF/OIF clinic. But there are other physicians down there that I hear they either tell them or kind of disregard of, "No, you don't have that." They kind of give them the brush-off, is what I normally hear, or

“I don’t believe in that.” I have heard that one more than once. “I don’t believe in PTSD.” Coming from a VA, that is ridiculous.

Mr. MASSIE. Is there a system or a method to report those incidents?

Mr. YOUNG. Yes, there is. There is patient advocacy, and that is usually who we refer them to first. If we hear many incidents coming out of there, typically we will address the director on what is going on.

Mr. MASSIE. Thank you.

I yield back.

Mr. BENISHEK. Thank you.

Brad, do you have any other questions?

Mr. WENSTRUP. I just have one question.

We talked a lot today about transitions, deployment actions, things like that, and I do hear the DoD side trying to take part in that. I hope that that comes to fruition.

My question to each of you is, for those that you serve, when they come to you, especially veterans that are new veterans, just leaving the military, do you feel that they come to you with any guidance before they get to you on how to navigate the VA system?

We can go down the line.

Ms. POWELL. My answer is no. The new veterans that are getting out today are not receiving any kind of beneficial information on what to do next. So they are getting out, and they experience a lot of separation anxiety. They don’t know what to do next. They weren’t told to copy their medical records, and now we are having problems locating those for when they got hurt in service. They know nothing about the VA at all until someone, an older person they see on the street tells them to come into our office, basically.

Mr. WORLEY. And I just recently got out two years ago, and I left from Fort Stewart, Georgia. I saw a big transition when I first came in the Army from 2004 to where we were in 2011. I think these soldiers are armed with—everyone is armed with the right information, but a lot of times they are out processing when they get back from a deployment, and all that is on their mind is, I’m getting out, I have to show up to these mandatory classes, but they are not paying attention until when they get out and it has been a year and their unemployment has ran out, and then all of a sudden, well, I probably should have paid attention, but then they don’t have leadership in place. They can’t go to their team leader or squad leader and say, “Sergeant, can you tell me what I need to do?”

So it is tricky, but at least in Adams County, we have made strides to make our veterans service office more available to our veterans. It is just hard with younger veterans because they are starting their lives when they get back. They are concentrating on their family, and it may be, like you said earlier, they may not get those issues until something triggers it later on.

But I do believe that they are armed with the information. They just don’t pay attention. They are focused on other things when they leave.

Mr. YOUNG. I concur with Mr. Worley there. I think the TAPS briefs are very good, and they have a lot of information, but I think the veterans with the—I think mine was a week-and-a-half long,

and I think they are just inundated with so much information, and they are more concentrating on family and employment upon discharge.

The VA, I know back when I had a TAPS brief, they lightly touched on VA and moved on. The first thing that went through my mind is VA health care, I am thinking a guy is missing limbs. I am not thinking that is a health care for me.

But I think they need to touch more on the VA and the VA benefits available to them. I think the employment information was good that they gave us, but they need to hit on a little more about the VSO offices so we can kind of guide them on where to go when they get out. I think that would definitely help.

Mr. WENSTRUP. Thank you.

I yield back.

Mr. BENISHEK. I want to thank you all so much for appearing here this morning. It is very, very helpful for this Committee to hear this input.

You all are now excused, and I will ask the second panel to come forward.

Dr. Wenstrup introduced the second panel a bit earlier, and we were fortunate enough to meet with most of the panel yesterday in our visit to the medical center. I want to thank you all for being here today. I know that, Ms. Smith, you are going to be the one testifying, but I would hope that maybe you would address some of the issues that the first panel brought up in your testimony. We have your written testimony already, what you are prepared to say, but I think that some of the testimony that we heard in the previous panel is pretty compelling, and I know that we will later on, if you don't address those or if I can't think of all the things, we are going to submit questions to you later to try to address the issues that that panel brought up so that I don't forget any of those details later, so we would appreciate that.

But in saying that, please proceed with your testimony.

STATEMENT OF LINDA D. SMITH, FACHE, MEDICAL CENTER DIRECTOR, CINCINNATI VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY KATHLEEN M. CHARD, PH.D. DIRECTOR, COGNITIVE PROCESSING THERAPY IMPLEMENTATION; DIRECTOR, TRAUMA RECOVERY CENTER, CINCINNATI VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND EMMA BUNAG-BOEHM, PRIMARY CARE PROVIDER, OEF/OIF/OND CLINIC; CLINICIAN, PERSIAN GULF REGISTRY, CINCINNATI VA MEDICAL CENTER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND CHADWICK WATIKER, CINCINNATI VET CENTER TEAM LEAD, READJUSTMENT COUNSELING SERVICE, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF LINDA D. SMITH

Ms. SMITH. Thank you for the privilege of being here, for all those in the audience who are attending, and in particular for the previous panel. We definitely will follow up on every issue that was raised earlier this morning.

Good morning, Chairman Benishek, Dr. Wenstrup, and Representative Massie. Thank you for the opportunity to discuss the Cincinnati VA Medical Center's efforts to provide high-quality care, specifically mental health care, to veterans in our catchment area, and our pilot Veterans Transportation Service.

I am accompanied today by Dr. Kathleen Chard, Director of the Trauma Recovery Division of our Mental Health Care Line, and Professor of Psychiatry and Behavioral Science at the University of Cincinnati's College of Medicine; Emma Bunag-Boehm, a primary care provider for the Post-Deployment Clinic, Cincinnati VAMC; and Mr. Chad Watiker, Cincinnati Vet Center Team Leader.

The Cincinnati VAMC is a two-division campus located in Cincinnati, Ohio, and Fort Thomas, Kentucky. The medical center serves 17 counties in Ohio, Kentucky and Indiana, with six community-based outpatient clinics. We are a highly affiliated teaching hospital, providing a full range of patient care services, with state-of-the-art technology, medical education and research capabilities. The Medical Center provides primary care, the full range of mental health services, and tertiary and medical surgical care.

Over 42,000 veterans are enrolled in VA health care through our facility. This number includes about 3,600 female veterans and 3,500 OIF/OEF veterans. The medical center has 15 full-time staff in our OEF/OIF/OND clinic providing primary care, mental health care, social work services, pain management care, and other services for military personnel returning from all recent combat theaters.

The Cincinnati VAMC's Trauma Recovery Center consists of an outpatient PTSD clinical team and a residential PTSD program which offers eligible individuals family education, medication management, and evidence-based PTSD treatments in a variety of formats. These unique programs have been featured in national media for their patient-centered, evidence-based treatment programs for PTSD. The VAMC also provides care and services to veterans who have experienced military sexual trauma.

Mental health services at the Cincinnati VAMC are unified under a multidisciplinary Mental Health Care Line. A comprehensive variety of mental health services is offered by the seven divisions of the Mental Health Care Line through 303 staff members. To date, the Mental Health Care Line provides care to an additional 1,482 unique veterans that were seen over the same period in Fiscal Year 2012.

VHA has developed many metrics to monitor performance in the delivery of our health care services. Cincinnati VAMC consistently scores above targets set by VHA regarding key areas of mental health treatment, including follow-up rate for veterans discharged from acute inpatient mental health treatment and percentage of qualifying veterans receiving evidence-based psychotherapy sessions.

The Cincinnati VAMC has also seen tremendous success in improving patients' access to care, receiving an outstanding 5-star quality rating under the category "Mental Health Wait Time."

Recognizing that increasing access to care improves health care outcomes, the Cincinnati VAMC began operation of the Veterans Transportation Service in May of 2012, offering mobility manage-

ment and transportation services. Mobility management guides veterans to the most medically appropriate and cost-effective means available through a private, veteran-focused agency or public transportation services. VTS fills in the remaining gaps, providing door-to-door, wheelchair-accessible transportation for those veterans living in the medical center's catchment area who have no other viable transportation options.

In August 2013, the Cincinnati VAMC hosted its first Community Mental Health Summit, where facility leadership and staff met with 66 individuals from 36 community agencies. At the summit there was an open exchange of detailed information about mental health programs and services available through VA and the community.

In conclusion, VHA and the Cincinnati VAMC are committed to providing the high-quality care that our veterans have earned and deserve, and we continue to improve access and services to meet the mental health care needs of veterans residing in Cincinnati and the local surrounding area. We appreciate the opportunity to appear before you, and we appreciate the resources Congress provides VA to care for veterans. We are happy to respond to any questions you have.

[THE PREPARED STATEMENT OF LINDA D. SMITH APPEARS IN THE APPENDIX]

Mr. BENISHEK. Thank you very much for your testimony.

Mr. Berry's testimony is pretty compelling. He lost his son while the son was being treated for PTSD as an out-patient. How many patients in the last two years under your care have committed suicide?

Ms. SMITH. In the last year, a total of three veterans in Fiscal Year 2013 actually committed suicide that were receiving our health care services. In Fiscal Year 2012 it was five, and in Fiscal Year 2011 it was nine. So we are seeing, I believe, improvements in our outreach for veterans at risk for suicide. We have a full-time suicide prevention coordinator. The month of September is designated as a special month to recognize the suicide risk, and we will be outreaching in the community and to all veterans who come to our medical center with a comprehensive package of information about suicide and ways to avoid it.

Mr. BENISHEK. Mr. Watiker, you are with the veterans center, so it is somewhat different than the VA hospital. Tell me about your program and are you seeing an increasing number of patients, and is your staffing adequate to get people in on a regular basis, what is your wait time. Give me a little bit of an example of the challenges that you have and what could be better about your system.

Mr. WATIKER. Yes, sir. Thank you for that question, Dr. Benishek. The vet center program is geared toward readjustment counseling services for war-zone veterans and their families to help them with the transition from military life to civilian life. There is no time-limit restriction, and the cost is free because they have paid for the service already with the time that they served, being in a deployment status.

We have well-trained clinicians that provide individual counseling, group intervention, couples, marital counseling, military

sexual trauma, and bereavement counseling for those who have had loved ones die while in active duty service.

Mr. BENISHEK. How long does it take to get in to see you?

Mr. WATIKER. Our access to our services, if a veteran comes into our office today, they are going to be seen by a clinician, assessed, develop a plan, and coordinate a follow-up that meets the best to their schedule.

Mr. BENISHEK. Is there like a suicide notation made on the initial visit?

Mr. WATIKER. We definitely do it as part of our —

Mr. BENISHEK. Your evaluation?

Mr. WATIKER. Yes, sir. As part of our initial assessment we do a comprehensive assessment, a bio-psychosocial assessment with the individual. But with everyone we screen, we screen any type of suicidal ideation or homicidal ideation.

Mr. BENISHEK. Dr. Chard, we were talking earlier, but I don't quite remember your answer to how long does it take for someone to call and get into an outpatient evaluation in your setting.

Ms. CHARD. Thank you, sir. If someone called today for an outpatient appointment in the PTSD division, we can get them in within the week. So if you called me today, we can get them in within this week to see both an individual therapist and a psychiatrist or a nurse-practitioner for a medication consult.

Mr. BENISHEK. And is there any sort of a suicide evaluation done on the phone when somebody calls in? Because to me, even a week seems like a long time if somebody is calling in desperate for help.

Ms. CHARD. Exactly. When we do our initial phone screen, we do a suicide assessment, and we actually complete a suicide assessment on every visit that the patient has within the PTSD and the Mental Health Care Line.

Mr. BENISHEK. All right.

Mr. Wenstrup?

Mr. WENSTRUP. Thank you, Mr. Chairman.

A couple of questions. We saw a lot of things yesterday when we visited, and that is the Cincinnati VA. Can you share with us some of the differences from state to state? Do you feel that every VA is the same? Obviously, there are some differences. And how do you think we are dealing with that on a national level compared to what we have here in Ohio?

Ms. SMITH. I really can't comment nationally. I can comment on what we do, and I know that we get a lot of direction from VA central office through our network about changes and improvements in the ways that we provide care. It seems that the changes are evolving even more and more quickly. I have been with VA almost 33 years now, and the pace of change and the pace of improvement in services is really remarkable, just from Dr. Chard's program as an example, and the ongoing improvements that have been made in the treatment provided for PTSD, including now the three separate programs, Emma Bunag-Boehm's program where we have gone from two staff and in our OIF/OEF clinic to now 15. So I would say the pace of change is just incredible and driven by, in large part, the interest that Congress has had in continuing to improve VA health care services, and I thank you for that.

Mr. WENSTRUP. Thank you. You know, I know when I returned from the war, I got notices from the VA saying you need to get in and get enrolled. The outreach was there, and I think it continues, and I do give the VA tremendous credit for that.

On the lines of suicide prevention, in the Army there is a lot being done proactively in what to look for, how to watch out for your buddy, don't be afraid to say, hey, I'm taking you in, you need help. That is great. We know that most of the suicides are occurring after they are out of uniform. How do we build that type of system once they are out, as opposed to when they are in?

Ms. SMITH. And this is part of what I see as a really increased sophistication and improvement in the mental health care at Cincinnati, and I am sure at other facilities. I will let Dr. Chard provide details.

Ms. CHARD. So with a team of three people in the suicide prevention office, we are able to do a lot more outreach than I think ever before. We do attend a lot of civic activities locally. We make sure that we attend all of the NAMI meetings that we are invited to. We always have our staff at the PDHRAs, and they are there to do the vesting visits because sometimes they don't want to come to the VAs, as you spoke about. We do need to vest them early and let them see a face that they can see when they come to the VA. So we do a lot of outreach there.

One of the things that I love that VA has created is a peer support technician program where we actually hire veterans as peer supporters so that you can attend a group that is not run by clinicians, but is run by a trained peer support person so they can have that private environment to share their experiences, talk about their needs with someone who has already been through the program and can speak about what it was like to go through it, what obstacles they encountered, what they found to be helpful, and I think that has been a really strong success throughout the VA and the Nation.

Mr. WENSTRUP. That is something that comes with the length of time that this has been going on. You have alumnus, if you will, who can participate and help.

I know it is sometimes difficult, too. I will ask you, Emma. You see patients for the first time, often. And as we talked about before, there are people who don't want to come forward to mention what they are struggling with, and sometimes they refuse to go there.

I can remember in Iraq, we had to do a physical on Saddam Hussein, who was on a hunger strike, and he wouldn't let us evaluate his mental status. He refused psychiatry or psychology. So we had to use a little psychology and work within his physical exam to ask questions to really assess where he was mentally.

So have you found that over the time of doing this, that you are able to sort of break through that, when you sense somebody doesn't want to tell you something, that you can break that down a little bit? And how do you do that? And if you do feel like you have gotten through and detect something, where do you go from there?

Ms. BUNAG-BOEHM. Thank you, Representative or Dr. Wenstrup, for this opportunity to come and speak with you. I thank you for your service to our Nation.

To answer your question, we, in our clinic, we have a team of nurses who does the initial intake, and we have those clinical reminders that we need to complete. Now, a lot of times, the servicemembers or veterans will not answer those questions. So when they come to my office and I develop this rapport with them, then along the way I go back in and ask them the same questions, and a lot of times they will be honest with me and start opening up more.

In our clinic, after they see me as the primary care provider, we have a psychologist and social workers who are trained mental health providers as well. So if I identify that something is going on with this veteran, I also want to say that our clinic is like a medical home and it is a one-stop visit store or something. So they are aware that they might be there for a while because we want to make sure that everything that they need we give to them on that same day.

Now, if they cannot do it because they are busy, then they have the option of coming back. But we try to do everything at that one visit, and a lot of times they will agree to that. So then it is handed off to the psychologist, and then we go from there.

As you are aware, our clinic is—I mean, it has been very, very effective, and our clinic has really gone far. And thank you again to Congress for giving us those resources. Thank you.

Mr. WENSTRUP. I think you have made a lot of strides. I know servicemembers that have been treated by you that have been very grateful for the care that they have received, and I know it is a difficult challenge. And this somewhat addresses Mr. Berry's concerns today on how we get the families engaged, because I think that is important, and I hope that we can continue to do that.

I just have one last question. So, we have been at war for 12 years, and we have a lot of returning veterans, especially to this area of the country. What would you say are some of the major things that you have changed since, say, 2001, 2002, 2003, 2004, compared to today?

I will ask both of you, all three of you actually.

Ms. CHARD. Certainly. I think some of the most significant changes have actually been in the increase in mental health staff. So we have had an exponentially larger number of staff hired. Thank you, obviously, to your efforts.

Speaking more specifically to the PTSD program, we have grown by three-fold. We have opened a women's program, which we did not have until 2007, and now we have the Traumatic Brain Injury PTSD Residential Program, and we are currently the only one in the Nation. So we are able to serve veterans in our area with both male issues, female issues, or TBI/PTSD issues in that program, both residential and outpatient.

Mr. BENISHEK. I would just ask that the speakers use the microphone because we have had some comments that it has been difficult to hear your testimony.

Ms. SMITH. There are so many changes, it is hard to think through what has just happened in the last few years. Certainly, construction funding has allowed us, and also money for additional lease space has allowed us to really expand. We moved our eye program off campus, which opened up additional space for clinical

care. We have, I think, four concurrent construction projects going on at every corner of the hospital to not only increase our capacity to provide care, but also to make that care more convenient and easier to get to.

Probably the biggest improvement in terms of ease of access is the parking garage that is just now in the process of opening that should make it very easy for veterans to get into our health care services.

We are building a brand-new community living center, what used to be called our nursing home care unit, and this is in recognition of the fact that moving veterans back and forth from Fort Thomas, Kentucky across the river to Cincinnati creates a lot of unnecessary trips for many of those nursing home residents, and now we will be able to have them located closer to clinical care and at the same time give them private rooms and immediate access to all health care services.

We have done a lot to renovate our domiciliary and PTSD programs in recognition of the large number of veterans returning needing mental health care, and also those veterans who either have substance abuse or homeless issues and need some residential treatment. I see us significantly expanding those services at Fort Thomas and really make that a real state-of-the-art and evidence-based program that I believe will rival any in the VA Nation in terms of the types and quality of services provided there.

And again, this has all been done with funding that Congress has given us, and we are very appreciative that we have been able to add all those services.

Ms. BUNAG-BOEHM. And with the increase of our staff in our OIF/OEF/OND clinic, we are able to do more outreach. We have partnered up with units in and around the greater Cincinnati area, Reserve and Guardsmen units. So we are often invited into their 30-day, 60-day and 90-day family gatherings.

So on the 30th day, or actually whenever they come home, our program manager, Karen Cartwright, or our outreach coordinator, Mary Plummer, who is herself a veteran, they go into the units to give briefings. So with those briefings, they talk about the VA and what the VA offers them, from medical health care to benefits to everything else that they need to do.

We have a mobile van which you saw yesterday, and we go outreach to places where we are invited. So we take the opportunity to enroll veterans and at the same time get them vested into the VA health care, and then get them started. So if they need to be referred to a specialty clinic, then we get them referred, and these are from counties, and a lot of our community-based outpatient clinics offer those specialty clinics.

Another thing that we would like to highlight is that we have the VITALS program wherein our psychologist is the liaison between our local universities in and around greater Cincinnati again, and a lot of times my veterans go back to school, and Dr. Jessica Theed is my liaison. So if they cannot come to me right away, they will seek her out, and then Dr. Theed will notify me if we need to see the patient, if I need to do more for the patient.

And again, we would like to thank you for giving us the resources to do what we are doing now. Thank you.

Mr. WATIKER. First of all, I would like to thank you on behalf of the Readjustment Counseling Service for the resources that you provided for us, because one of the biggest changes for RCS is that you have allowed us, with the resources you have provided, to purchase 70 mobile outreach vet centers across the Nation. We have two here in Ohio. This allows us to do, not only mobile outreach to the local community, but outreach to the whole community to provide clinical and veteran services if we don't have a community access point. It also allows us to work with our VA counterparts for emergency response teams to national crises, as needed, to support the veterans and families outside of the State of Ohio, or within the state as well.

When I talk about the community access points, it is one of the things that, with our outreach efforts, we were able to provide face-to-face connections with our veterans and families to easily engage them into vet center and VA resources. For example, we have outreach now to Highland County where it is a rural community. I heard earlier about the difficulty in accessing mental health care. One of my clinicians goes up there to a community access point through the veterans service office and provides mental health care to those veterans and families and helps them get linked up to VA resources.

I thank you for the question.

Mr. BENISHEK. Thanks.

Mr. Massie?

Mr. MASSIE. Thank you, Mr. Chairman.

Dr. Chard, we heard from Mr. Berry that no one from the VA reached out to him to help the family understand the effects of PTSD or to participate in care. And then he later also stated that the HIPAA laws were an impediment to learning about his son's condition.

Can you respond to Mr. Berry's testimony and also share with us how you have to work within the HIPAA laws, and if there is anything that Congress can do to change those laws, or do they strike the right balance of privacy for the patient, or do they restrict you too much from involving the family?

Ms. CHARD. Thank you. And, of course, any loss of any individual is one loss too many. It was very tough for me to hear that story because of my desire to always want to help every veteran that comes in our door.

And the sad truth is exactly what you said. HIPAA laws prevent us. If an individual veteran does not want us to talk to their family members, they can invoke that right, and we are therefore not allowed to provide education, answers, support, any information at all to that person's family.

Now, you asked about the balance, and I think the hard part is the situations where the veteran wants to be protected. I can't tell you the number of situations where I have had veterans going through custody hearings, going through difficult divorces, having difficult bosses who have asked for information from us and we have been able to protect them as they are going through those custody hearings where someone is trying to take away their child, saying they have PTSD and they cannot be trusted.

So it is a very difficult situation that we are in, in that we do have to have a balance where we both protect the rights or personal care of an individual, but also try to get as much information out to family members as we can.

Mr. MASSIE. Is that a right they have to assert? Do they invoke it, or is it an opt-in?

Ms. CHARD. HIPAA is a standard thing that all of us are given when we go to the doctor's office. There is HIPAA information that we are given, and we sign a statement saying we understand the HIPAA law. It is a standard for every one of us every time we go to a doctor's office.

Mr. MASSIE. So it is basically an opt-in.

Ms. CHARD. You can opt out of HIPAA and give someone rights. You actually have to sign that you agree to let me talk to someone.

Mr. MASSIE. So it is opt-out.

Ms. CHARD. Yes.

Mr. MASSIE. By default, you can't share that. They would have to voluntarily ask you to do that.

Ms. CHARD. Correct. But I do encourage everyone here to talk about the National Center for PTSD Web site. We have one of the best Web sites, funded by Congress, for information for family members and veterans and civilians about PTSD, and it is the National Center for PTSD Web site at VA.gov, and there is great information for family members there.

Mr. MASSIE. Can you encourage the veterans to engage their families? I mean, do you do that?

Ms. CHARD. We certainly do.

Mr. MASSIE. And let them know about their HIPAA rights, that they can be waived, that they can share that information?

Ms. CHARD. We actually try in all the cases that I can ever remember to engage the family literally from step 1, because we do, at our orientation group, ask that the veteran bring a family member to our orientation group. We then, in addition to our psychosocial history, we ask if they have any family members that they are willing to have involved in their care. And then finally, we offer couples and family-based treatments that are evidence-based where we actually encourage the veteran to not just have them informed about their care but be a part of their weekly care, if they are willing.

Mr. MASSIE. Thank you.

Ms. Smith, Mr. Berry testified that his son was upset about the hassles involving going to the Cincinnati VA Medical Center, up to and including having to answer the same questions over and over. He felt that that caused him to relive his experience at Fort Hood. And then also, I think perhaps in his written testimony he stated that having doctors in residency treating vets kind of breaks this tendency that the patient would like to have the same doctor every time they go so they don't have to answer the same questions, because you want to build a connection with the doctor and trust.

Do you agree with Mr. Berry why or why not should folks who are undergoing treatment for mental illness see doctors in residency, or should there be some continuity?

Ms. SMITH. Let me try to answer that question as broadly as I can. Every one of our mental health veterans will eventually have

a mental health treatment coordinator, and I believe we are close to achieving that, somebody that can kind of navigate their care through the various areas where they get care or treatment.

Our veterans, when they come to clinic, whether it is to one of Dr. Chard's PTSD clinics or with Emma, do have an attending physician or an attending provider responsible for their care. We are a site for training, and we have a large number of training programs which we are very proud of. But it is not the responsibility of a medical student or a psychiatric resident or a clinical social work trainee to provide care for our veterans. That responsibility resides with the individual provider, as in the case with Emma in our clinic, or the physician that also covers the OIF/OEF clinic, and also for Dr. Chard's clinic. Those are permanent providers.

Now, it may be true if a veteran is seen at a specialty clinic, especially med surge specialty clinics, where their first contact may be with a medical resident or surgical resident. But there is always an attending physician at those clinics.

I will let Dr. Chard just briefly talk about how we assign mental health providers.

Ms. CHARD. Certainly. So when someone comes into the VA, they are immediately attached to a provider, whether it is a psychiatrist, a psychologist, or a social worker, and whoever they first meet is attached as their mental health treatment coordinator. That person's name is on the front page of their chart. So if that individual calls in the middle of the night, if that person comes into our psychiatric emergency room saying "I don't remember who that person is, I have walked away from the VA for six months, but I need somebody," we have a name on the very front cover page that everyone can see, including the vet center, and call that individual and say Mr. Jones, Mr. Smith is back and he needs care, where did he leave off, what can we do for him, and that individual will reinitiate care with him and get him to the best environment, or her to the best environment.

Mr. MASSIE. Thank you. I yield back.

Mr. BENISHEK. Mr. Watiker, I just have one more question. I understand that you have authority for bereavement counseling for families. Were you made aware of Mr. Berry's son's suicide, and do you reach out to families that have suicide that you are aware of?

Mr. WATIKER. As far as in the specific case of Mr. Berry, we get referrals from a variety of different organizations.

Mr. BENISHEK. I'm sorry, I can't understand what you are saying.

Mr. WATIKER. I'm sorry, sir. As far as speaking to Mr. Berry's case, we get referrals from a variety of different organizations, whether that is through family members or through veteran service officers, or even from our national organization or our national bereavement headquarters out of Colorado. And from there, once we get a referral, for whatever family member is requesting services, we make contact with that family member and engage them for services.

Mr. BENISHEK. So you have to be notified by the family, then.

Mr. WATIKER. The family member or another representative, an organization who is acting on behalf of the family members. And once we get that referral, then we will make contact with that specific family member to offer bereavement services.

Mr. BENISHEK. All right. Thank you.

Mr. WATIKER. Thank you.

Mr. BENISHEK. Well, I appreciate you all being here this morning. I know you are very proud of the service that you provide there. As you said, Dr. Chard, even one suicide is one too many. You all know that there is definitely room for improvement despite the statistics that you have shown us that you are doing well.

It is our job really to be sure that the system works as efficiently as possible. With 18 to 22 suicides a day among our veteran population, you can understand our concern as to what the VA is really doing to make it better. Despite your statistics that look good, it is very distressing to me and, I'm sure, my fellow Members here on the panel, that our veterans deserve the absolute best, and we want to make sure that your agency is doing the best they can.

So I really want to thank all of our witnesses and members of the audience for joining us today. It has been a pleasure for me to spend time in southern Ohio and see the medical center and some of the other great medical facilities here in town.

Before we conclude, are there any veterans in the audience? Could any veterans in the audience please stand up or raise their hands so we can recognize them?

[Applause.]

Mr. BENISHEK. Thank you. Thank you. I want to thank you very much for your service. We owe you a great debt that we still remain a free country. It has been an honor for us to be here with you this morning.

And with that, I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and include extraneous material, and we may submit further questions for the panel, which we will expect answers to. So, without objection, I will order that.

The hearing is now adjourned.

[Whereupon, at 11:53 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Dan Benishek M.D.

Good morning and thank you all for joining us this morning. It is a pleasure for us to be here in beautiful Cincinnati, Ohio, with all of you.

I am honored to serve as the Chairman of the House Veterans' Affairs Committee Subcommittee on Health and to be joined on the Subcommittee by your Congressman and my friend, Dr. Brad Wenstrup.

As I am sure you know, Brad has served for the last fifteen years as a member of the U.S. Army Reserves, where he has achieved the rank of Lieutenant Colonel.

In the spring of 2005, he deployed to Iraq for a year. While there, he served his fellow soldiers, sailors, airmen, and marines - as well as prisoners and civilians - in Abu Ghraib as the Chief of Surgery and the Deputy Commander for Clinical Services.

For his brave and loyal service there, he earned numerous awards and accolades, including the Bronze Star.

Brad is also Doctor of Podiatric Medicine and a former small business owner.

Needless to say, the immense wealth of knowledge, experience, and insight that Brad brings to the Subcommittee is invaluable. I am extremely grateful to work side by side with him and for his leadership on behalf of our Nation's veterans and their families.

So, when Brad asked me to come to Cincinnati - his hometown - to address an issue of such importance to us all - the provision of high quality and effective mental health care to veterans in need - I seized the opportunity.

Yesterday, Brad and I paid a visit to the Cincinnati Department of Veterans Affairs (VA) medical center. While there, we had an in-depth discussion with medical center leaders and toured the facility.

Having worked myself as a surgeon at the Iron Mountain VA Medical Center, I most enjoyed meeting with some of the hard working Ohioans who strive day-in and day-out to provide the best possible care and services to the veterans in this community.

I would like to take a moment to personally thank each of those health care providers, administrative personnel, and support staff for their dedication to our servicemembers, veterans, and their families.

It is clear that there are some very special things going on in Cincinnati for our heroes and you have much to be proud of here in Ohio.

However, where the health care and services provided to our veterans is concerned, exercising our responsibility for oversight of policy and practice is paramount.

This past February, VA issued a sobering report which shows that - for the last 12 years - there have been 18 to 22 suicide deaths among our veterans every single day.

Ladies and gentleman, we have lost far too many of our veterans on the battlefield of mental illness. We have to do better. And we have to do it now.

Key to that effort is breaking down barriers to care that veterans in the midst of struggle often face when attempting to access the care they need to successfully transition home and maintain happy, healthy, and productive lives.

No veteran should be reluctant to ask for help because they are ashamed or embarrassed. And, no veteran who does take the brave step of seeking care should be told they have to wait for an appointment that is weeks or months away and/or travel long distances away from their homes and families to receive the services they need.

Today, we will discuss the actions we must take to reduce stigma and increase the accessibility and availability of mental health care for veterans here in Ohio and across the VA health care system.

We will also discuss the increasingly vital role that faith-based and community groups are playing in helping our veterans and what we need to do to increase and

improve meaningful partnerships between VA and these community resources, who are often the first and most trusted point of contact for veterans and families in need.

Finally, we will also discuss the critical part that family members and other loved ones play in the healing of our heroes and the need to increase family awareness, involvement, and integration in mental health care services, particularly for those veterans most in need of support.

I look forward to hearing from the local Ohioans – many of them veterans – who will testify today. I thank you for being here and for your devotion to improving the lives of Ohio’s veterans.

With the help of communities like Cincinnati and discussions like the one we are having this morning, I am hopeful that we will shatter mistaken perceptions that mental health care is not available, not appropriate, or not effective and there will come a day when no veteran is discouraged from reaching out and seeking care and no family suffers alone.

Prepared Statement of Hon. Brad Wenstrup

Good morning, and welcome to the House Committee on Veterans’ Affairs Health Subcommittee field hearing, “Making a Difference: Shattering Barriers to Effective Mental Health Care for Veterans.”

Mr. Chairman, I want to formally and officially welcome you to Cincinnati! As you have seen these past two days, this district – a district I am so privileged to represent – has an incredibly rich tradition of military service. I want to thank you for the leadership you have shown on the issue of veterans’ mental health care and for hosting this field hearing here today. I am also grateful that Representative Massie, a strong supporter of our military and our Nation’s veterans, has taken time out of his schedule to be here. Congressman Massie, thank you.

To the witnesses on our panels, to each person in the audience, and, especially, to every veteran present today: thank you for joining us. It is important for us all to be engaged in this issue if we are going to truly improve the care our veterans receive.

This field hearing is an opportunity to bring Congress to Cincinnati. I’m pleased that the Subcommittee on Health will hear directly from the veterans, the family members of veterans, the service officers, and the community providers of this region. They will provide a valuable perspective on the common barriers to mental health care that our veterans face.

The veterans of Southern and Southwest Ohio are a diverse group. They were raised on farms, in urban high-rises, and in suburban neighborhoods. But they share a common bond: they made the voluntary commitment to serve our Nation. Only one percent of Americans have served in uniform. Their accomplishments have been amazing and truly unmatched by the rest of the world. As a veteran of the war in Iraq and a member of the Army Reserve, I have witnessed the heroism of my fellow veterans and have deep respect for them.

We can never repay them for their sacrifice, but we can honor it by ensuring that they and their families receive the care that they deserve. In Ohio, we have a robust system of Veterans Service Commissions that serve our veterans with zeal and dedication. I am grateful to have the representatives from commissions in three different counties present to testify today.

There is growing recognition that we must develop better treatment for the “invisible wounds” that veterans bring home, including depression, posttraumatic stress disorder, substance abuse, and traumatic brain injury. These wounds affect veterans of all our past wars, but the veterans of Operations Enduring Freedom and Iraqi Freedom face unique mental health challenges. Because of technological advances, more soldiers are surviving physical combat injuries, but they present disproportionate neurological and psychological wounds. Studies suggest that one in five veterans of the wars in Iraq and Afghanistan has PTSD. A decade of war with frequent and extended deployments has made it more critical than ever before to create a quality mental health care system for our veterans.

There are many challenges in our current system that do not allow veterans to get the care they need. Sometimes, veterans are simply unable to access care: they have difficulties in scheduling timely appointments or the office is simply too far away. Other times, veterans are unwilling to ask for or accept help. Each veteran has unique struggles and needs, and we need a mental health care system that is able to provide effective, individualized care.

Today, we will discuss how the Department of Veterans Affairs can better improve its approach to and delivery of mental health care.

Truly effective care, however, will extend beyond the VA: it will require the involvement of veterans' families and their communities, including veterans service organizations, community health care providers, and faith organizations.

Each of us has a role to play in improving veterans' access to mental health care. Again, thanks to each of you for being here for this important discussion.

Prepared Statement of Howard Berry

My name is Howard Berry. I am the father of the late SSG Joshua Berry. He was wounded both physically and mentally as a result of the shooting at Fort Hood on 5 Nov 2009. My son suffered terribly from PTSD. He chose to end his life on 13 February 2013. I am not an expert on PTSD. I am however an expert on the pain that this disorder places on the surviving family members of soldiers who do not respond to treatment, soldiers who look to suicide as the solution to end their suffering.

I am left with a lot of questions, many that will only be answered by the passage of time. Please bear with me as I attempt to share with you some of the experiences my son had while being treated for PTSD. I will also share some of the changes I believe will give other soldiers a better chance to find success in their recovery.

Soldiers suffering from PTSD have skill sets that have been compromised. The simple things that we encounter in our day to day lives were extremely difficult, if not impossible, for my son. He had tremendous difficulty adjusting to civilian life. We do a marvelous job taking a civilian and turning him into a soldier. We do a lousy job helping that soldier make the transition back to civilian life. My son was one of those who could not successfully return to civilian life, as he was given limited training to transition, which was combined with the damage done to his skill sets.

The invitation to this symposium listed four topics for discussion, and I will attempt to share my thoughts on each.

(1) The impact of patient waiting and travel times on veterans' ability to receive mental health care and actions needed to increase the accessibility and availability of mental health care services for veterans.

Josh travelled by car to get to his appointments. During his treatment, he had valid concerns about travel time and fuel cost. He had to consider how long it would take to find a parking space at the Cincinnati VA, and if he would have enough gas left to go home after his appointment. Josh was upset about the hassles involved in going to the Cincinnati VA, up to and including having to answer the same questions again and again, resulting in reliving the horror he experienced at Fort Hood. He saw no benefit in answering the same questions repeatedly.

Josh was even involved in an accident one afternoon when leaving the VA to go home. This was another excuse that he would give to not go to the VA. It was just one more bad experience, added to a list of bad experiences, to, in his mind, deter him from seeking treatment. His skillsets were so broken that he also failed to maintain auto insurance coverage, which created yet another financial obstacle. When I asked him why he had not paid his bills, I discovered that he was not opening mail, period. He said he only got bad news whenever he did, so he didn't see the point.

I am sure Josh's story of broken skillsets is similar to the stories of other soldiers. It must be difficult to admit the need for help. Our goal is to find a way to improve their skillsets, and their ability to seek treatment for their injuries.

One way to improve the accessibility of treatment is to consider the needs of the soldiers themselves. A lot of folks are parents. How many appointments are missed, or aren't even scheduled, because vets cannot find someone to watch their children? Is there childcare available on site for veterans' children while they are receiving healthcare?

Many of these soldiers are busy people. Transitioning into life as a civilian includes taking on financial and family responsibilities. Are appointments currently consolidated, so the veteran makes one trip instead of several to get treatment? For instance, can a vet schedule appointments back to back to see a physical therapist and a psychiatrist?

Many soldiers who suffer from PTSD also miss appointments. If they stop calling and stop coming in, does anyone take notice? Do they fall through the cracks?

I believe taking a battle buddy approach to making sure their fellow soldiers are OK will greatly improve the care they ultimately receive. This will also work well

in rural areas where vets have limited access to care. Just talking with another person makes a world of difference. When my son enlisted, he told me that if something bad happened to him, someone had his back. After returning from deployment and trying to transition to civilian life, I asked him the same question. For him the answer was no. I could see and hear the pain he felt before he died. He felt that his country had wiped its feet on him. He felt that he had gone from a hero to a zero. I'm sure a battle buddy/mentor would have given him a better chance at recovering. I bet lot of soldiers returning home would jump at the chance to continue to be of service to their brothers and sisters in arms.

Essentially, there needs to be a mentoring program, a pairing of a vet with a similarly ranked veteran. Consider the Alcoholics Anonymous concept of a sponsor/sponsee relationship. They meet as equals, the sponsor listening to the sponsee and sharing their experience, strength and hope with him, simply showing what he did to recover. I know this works. I cannot explain why. I do know we are only as sick as our secrets. I wish Josh had someone to share his secrets with; knowing that he wouldn't be judged or looked down upon would have helped him.

In addition to a sponsor, there needs to be support groups where veterans can freely speak to one another anonymously, removing the fears and stigma that a person with PTSD suffers from.

Furthermore, there needs to be a review of practices in all VA locations. Are the standards of care used to treat PTSD affected soldiers the same in all 50 states? If not, why? Are successful programs copied and less effective ones phased out? Do VA facilities across our country freely communicate with one another in a timely and consistent manner? What programs will result in a reduction of the suicide rate? We must determine what works and what doesn't work. After all, the goal is to reduce the number of service men and women who take their own lives when they feel they have no other option.

Another area in need of improvement is the early identification of warning signs in soldiers who are likely to take their lives due to the severity of their PTSD. We need to identify these brittle soldiers as soon as possible. This group of combat soldiers has a disproportionate suicide rate when compared to other groups of servicemen and women. Those who need additional attention, due to the severity of their PTSD, should subsequently receive a higher level of care. Can resources be allocated to provide for their needs?

Although accessibility, timeliness, and availability are important, continuity is just as crucial. Having doctors in residency treating vets with PTSD inhibits the development of strong doctor/patient relationships. A vet may begin to build a connection with a doctor, someone he is starting to trust, only to have that person replaced on the next visit. Having to start over from square one only forces our vets to relive painful experiences. How many times would you be willing to tell your story before it felt futile? I have been telling my son's story for over six months now. I know how it feels.

(2) The effect of stigma on veterans' willingness to seek mental health care and actions needed to eliminate it in the veteran community.

The stigma placed on our veterans starts in the military. My son was trained to suck it up and roll on, as I'm sure countless others have and are currently taught to do. If there is not bone or blood showing, you don't speak up, as it is looked on as a sign of weakness. Josh was told on one particular occasion by a superior that he was nothing but an old, broken down NCO, who needed to get out of this man's army. This was after he had experienced the horror at Fort Hood and was getting treatment for his PTSD. I know he felt that he was betrayed by some of the people put in place to help him.

Why don't we begin by calling PTSD what it is? It is a wound. We need to give veterans a reason to hold their heads high and not be ashamed by the perceived weakness associated with PTSD.

My son felt that he was as expendable as a broken rifle or a worn out pair of boots. I'm sure there are other veterans who are silently suffering and feel the same way. I believe that one way to help soldiers suffering from PTSD sustained in combat is to award them with a Purple Heart. They should be given the same considerations as servicemen and women who have shed blood for our country. This would help to even out the playing field in civilian life. Giving them the same benefits, including points towards employment, education and healthcare would be proof that their country acknowledges the sacrifices they have made to protect others' freedom. Their injuries merit equal treatment.

I know there is a lot of resistance to this. I have been disappointed to hear from older veterans who are reluctant to support this change. They feel their sacrifice

will be diluted by the inclusion of those with PTSD. I thought soldiers were trained to look out for one another. Why aren't they included in this Band of Brothers?

If Purple Hearts are not awarded, then Congress needs to step up and create a separate award, one with equal benefits, one that will give these vets the recognition they deserve, one that honors the sacrifice they have made. Give these veterans a reason to hold their heads up high. It is the right thing to do.

I recently had a discussion with a director where I work. I gave him a scenario: "you have one position to fill with two equally qualified candidates. One of them is a veteran with a Purple Heart. Who would you hire?" He responded with, "The veteran." I then asked him to consider the same scenario, only this time, the veteran has PTSD. He did not immediately respond. I apologized for putting him on the spot. After all, he has an obligation to protect the company's interests, including the other employees' wellbeing and safety. If society puts these veterans at a disadvantage, it is no wonder that many don't seek treatment for PTSD. I'll bet many do not take their medication as directed or at all, fearing this may have an impact on their employability if their medication is discovered on a drug screen.

(3) The role of faith-based and community providers in assisting veterans in need and actions needed to increase and improve meaningful, collaborative partnerships between VA and these critical community resources.

One way we can support these veterans is through media coverage. Our society is driven by what we hear and see. Positive media coverage, starting from within the military, will help to remove the stigma associated with PTSD. Sharing the successes of programs that have proven to be effective as well as success stories of soldiers who have transitioned to civilian life will show the nation that vets with PTSD deserve a fair shake.

We must strive to create connections, emotional bonds, with the rest of Americans, showing them that the veterans in their community are just like them. The difference is that they stand up in the face of danger and fight for our freedom. PTSD should not be a reason for fear in our society. Soldiers being treated for PTSD should be looked up to, not down on. We need to show our nation that they are not broken by the violence they have seen. We need to show them that they have worth and are included in the pursuit of happiness, something that is currently out of reach for many of them. The media can help create a bridge to bring churches and non-profit organizations together to support our vets. By including stories of success in our media outlets, we can change how society looks at PTSD affected veterans.

I know I could not continue to speak for my son and others like him without a deep sense of faith. If a guy like me can learn how to do this, I believe anyone can.

(4) The role of family in mental health care treatment and actions needed to increase family awareness, involvement, and integration in mental health care services.

Families are directly and indirectly affected by soldiers returning home with PTSD. The anger, resentments and hopelessness carried by these returning vets are often carried over to civilian life. If nothing changes, the family suffers their own version of PTSD. We love them, but we don't understand what to do. We don't want to make things worse, yet we have no solution to work towards. We learn to suffer as silently as the veteran.

Neither I nor any of my family members were ever asked if we wanted to learn how to help someone with PTSD. I could not communicate freely with anyone regarding my son's care due the HIPAA laws. These laws were enacted to protect the individual. However, I see compliance to this law as a major contributing factor in the death of my son.

I also feel the law is currently used to protect the agency, not the individual. Letters that were written on my son's behalf could not be used by me without putting those who authored them at risk. The bottom line is this: if I choose to use them, the people responsible for authoring them would be dismissed. I don't understand the reasoning behind this. It must be fear. If more administrators spend less time covering their backsides and use a common sense approach instead, more would be accomplished.

My son felt that the PTSD he suffered from was acquired through such a unique experience, the shooting at Fort Hood, that no one could ever understand. He could not focus on any of the similarities between his experiences and those of other soldiers—all he could see were the differences. In his eyes, he could have managed the PTSD from his tour in Afghanistan, but that going eye to eye with a superior officer who was shooting to kill amplified his trauma to another level, a terminal uniqueness that grew from the fact that his injuries were sustained in the center of a military installation, and not in a war zone.

I am sure that there are other soldiers who feel just like Josh did, that their unique set of circumstances can't be understood, that their experiences are too traumatic for others to comprehend. And to a degree, we don't understand because we have not really tried to. But we have to find a way to break down these walls. We have to convince them that we want to understand, that they are not alone as we support them in their recovery. We need to make these soldiers feel like they're a part of the solution, and not a part of the problem. Their ability to succeed begins with creating a circle of care that includes the military, the VA, the family, and our society as a whole.

Families need the opportunity to work with the medical professionals, social organizations, both religious and non-profit. PTSD affected soldiers need to see support in every direction they look. If we work together to make their burdens lighter, we have a chance to have the kind of country my son fought for.

The suicide rate is still rising among our veterans. I hope my speaking to you today was not a waste of our time. I hope it is the beginning of positive changes. After all, we are all responsible.

Prepared Statement of Nate Pelletier

The Cincinnati VAMC is a best in class medical center; and, as a disabled Veteran, I've personally received outstanding care. As a Veteran leader, I have a vested interest in ensuring our federal and community resources enable all Warriors in transition and Veterans to successfully reintegrate. I've conducted research that studied the impact of transitioning Veterans and drafted a proposal¹ to assist not only the VHA, but the Departments of Defense, Labor, HUD and HHS², as well as supporting agencies and community partners on how to improve and implement a sustainable transition system. As an Executive Director of a local agency supporting Veterans in need, I've witnessed what can happen if those who have served our country fall into the "gaps" of an inefficient transition and support network. On my very first day of work at the Joseph House, Inc., one of our War on Terror clients overdosed on heroin and nearly died in his room. Thankfully, his roommate was EMT certified and saved his life that day.

Over the next 3 years, more than 300,000 new Veterans will return to civilian society. Our communities need to be ready to serve them and utilize their talents in the community and in the workforce. To this end, there are two topics that are interconnected and deserving of this Committee's attention- VHA's scope expansion and VA administrative leadership's support for community partnerships.

During the transition of new Veterans into the community, the VHA currently feels the burden to fill "gaps" in the process due to the absence of a seamless transitioning system. I define this as "scope creep". The DOD, VA (VBA/VHA), DOL, as well as other agencies and community organizations have acknowledged that the transition process is very inefficient and that the responsibilities of each organization are unclear. With this in mind, some examples of VHA scope creep include but are not limited to: employment assistance, education assistance, benefits assessment and family supportive services unrelated to medical services. As we attempt to define the responsibilities of the VHA during this process, we can categorize the decision making process into three groups - 1) processes that VHA funds and owns responsibility to execute, 2) processes that VHA funds and outsources to community partners to execute, 3) processes that VHA outsources to community partners who are VA or privately funded and can own the responsibility to execute. In addition to addressing the systems and process responsibility to reduce scope creep, it is important for the VA administrative leadership to empower and leverage VHA and community partnerships.

In an attempt to fully assess the effectiveness of our VHA and recommend areas to partner with the community to reduce scope creep, we must define "what are the primary responsibilities of the VHA?" The purpose of the VHA is very focused and clear- support the medical needs of Veterans who qualify for medical services post military service. Any services in addition to their primary responsibilities should be assessed according to the three process categories mentioned previously.

The first step to effectively optimize the system of Veteran support is for the VA administration to take an active role in partnering and often time leading the con-

¹ Clifford, P., Fischer, R. & Pelletier, N. (2013). Exploring Veteran disconnection: Using culturally responsive methods in the evaluation of Veterans Treatment Court services. Unpublished manuscript.

² Pelletier, N. (2012). Successful Warrior to Successful Veteran. Cincinnati, OH: Author.

vening of mobilized community action teams to collectively meet the needs of our Veterans. To quantify and provide some examples of how the VA administration could partner more effectively in Cincinnati in order to reduce scope creep, we can assess two areas of concern nationally and locally- employment and chemical dependency, as well as their potential relation to co-occurring mental health disorders.

Employment is a critical “node” that a Veteran must attain and sustain to successfully reintegrate (with the exception of those who are 100% disabled and unable to work). If this node collapses, it is most often the catalyst that dissolves secondary nodes within the ecosystem of support for a Veteran such as mental health stability (i.e. triggers PTSD symptoms- depression, self-esteem, sense of purpose, etc.) and can cause a Veteran to retract from social reintegration as well as lead to even further breakdowns in the ecosystem of support such as family relations, and sustainable housing. Too frequently, these breakdowns lead to the use of unhealthy coping mechanisms such as a reliance on drugs and alcohol. This is often the beginning of the “downward spiral” and collapse of a Veteran’s sustainable reintegration. So where does the responsibility lie for disconnection in Veteran employment during the transition from Warrior to Veteran?

According to sources at the Joint Chief of Staff’s Office for Warrior and Family Support, the DOD is accountable for more \$960 million dollars in unemployment compensation to Veterans (unfortunately without the ability to fully evaluate their progress due to the fact Veterans are no longer tracked in the DOD system post out-process). However, more often than not, the VHA receives the primary burden of responsibility to assist unemployed Veterans given that they usually have the most access to the Veteran population in the region. This is an example of scope creep within our local VHA due to the inefficiencies related to “who owns what” in the transitional process from Warrior to Veteran. Therefore, the VA administration should emphasize the importance of engaging with the private sector and community partners who focus entirely on job placement. More often than not, this will be supported under category 3 mentioned above and secondarily, could reduce both the DOD and VHA scope creep.

Besides Veteran employment efforts, the VA administration can also optimize their VHA partnerships with the community agencies providing clinical treatment for Veterans with addictions. As the Executive Director of the Joseph House, Inc. for homeless Veterans with addictions, my clients are prime examples of the systematic breakdown of a Veteran’s ecosystem of support. My clinical team has conservatively identified that 12 out of our 27 clients in our treatment program as of September 2013 have also been prescribed psychotropic medication for a co-occurring mental health disorder. It is important to note, that up to 78% or more of my senior clients (post-Vietnam) are suffering from co-occurring mental health and addiction disorders that are either unrelated to military service, possibly caused by socio-economic struggles, childhood adversity or other past experiences. However, a majority of our younger clients (War on Terror) are suffering from disorders related to PTSD, combat stress, and/or transitional anxiety in addition to these past experiences that have either led to chemical dependency or enhanced a pre-service addictive behavior. As it relates to our clients, mental health and chemical dependency are the primary nodes that have broken down within their ecosystem of support that likely caused their current state of homelessness.

Although the local VA administration has provided exceptional support through their VHA Community Outreach Division to fund and evaluate current programs like the Joseph House, Inc., it has been reluctant to support VHA participation in community-based Veteran mobilization efforts or “community action teams.” The VHA could optimize the impact of Veterans recovering from chemical addiction with effective engagement in both the housing and health sub-committees of the local Veteran community action team. VHA participation at an operational level will allow them to better assess funding support for community agencies according to the three process categories mentioned above. Furthermore, a more interactive relationship with community agencies will enable them to share and assess best practices so that they can not only help improve the local agencies they currently fund, but their internal treatment program as well.

Local agencies such as the Joseph House, Inc., Talbert House Parkway Center, Volunteers of America to name a few in our region, provide services and treatment for Veterans suffering from homelessness and chemical dependency. The majority of our funding is provided through the VA Grant Per Diem program. Although the VA provides a series of measures to validate our funding each year, they also operate their own internal substance use program within the VAMC hospital. After reviewing their internal hospital program compared to local agencies, it is evident that they fund a higher percentage of staff treating a smaller percentage of Veterans compared to our external agencies. It is important to note that the qualifications

and certifications per ODMHAS (Ohio Dept. of Mental Health and Addiction Services) for our cliental programs and staff are parity to the VAMC's program. Also, many of our clients have been referred to us from the VAMC hospital program due to negative discharges or time limitations of the program. Thus, a more collaborative partnership could potentially enable a more effective program match as soon as a Veteran is identified for treatment. Moreover, it is important to acknowledge the changing landscape in chemical addictions.

More Veterans, particularly the War on Terror Veterans are choosing opiates such as heroin vs. alcohol. It is important that we address the treatment options for opiate addiction vs. alcoholism and which programs are more qualified to provide treatment services - VHA or community agencies, or at minimum, create a stronger referral system between the two to ensure that the Veteran receives the proper care in a timely manner as soon as they are diagnosed. Recent studies have pointed out that, while substance use remains a key issue for Veterans, there has been a decline in specialized programs. Clients often respond better and stay engaged longer with specialized drug treatment programs. Therefore it is beneficial for the VHA and local agencies to partner to meet the treatment needs of new Veterans.³ This is why it is essential that the VA administration encourage their VHA teams to partner with the community in order to channel resources into one of the three process categories mentioned above, optimize internal and external treatment programs, and ensure that a Veteran is referred to the most relevant program to meet their treatment needs.

In summary, it is important to reiterate that the opportunities to optimize VHA scope creep and VA administrative leadership's support for community engagement are not a reflection of the dedicated VA/VHA/VAMC leadership and staff, but the opportunity to optimize internal processes in order to sustain their primary responsibility of providing medical care for Veterans who qualify for benefits and treatment. To this end, it is the responsibility of all us who have "skin in the game" to operate more collaboratively to improve the transitional system and process of new Veteran reintegration and community efforts to sustain the well being of all our Veterans and their families.

In 2011, I received a call from the local VAMC at 10:30pm on a weekday to see if I could house a War on Terror Veteran for the night that had. Although he had just completed the chemical dependency program at the VAMC, he now had nowhere to go, no friends to call, no family to help and his time was up per the VA program guidelines. At around 11:30pm he arrived at my home, and for the next 2 hours he tearfully told me his story. Like many Soldiers, he signed up to serve his country, and suffered severe trauma related to combat that came home with him post deployment. If I recall correctly, his father had also recently passed away, and his mother was suffering from her own chemical dependency. Despite the breakdown of his support system, he "Soldiered on" and secured a meaningful job, but was later laid off like so many other Americans. Without stable housing or employment, he found solace on the streets and had built a relationship with local law enforcement to allow him to just spend a few nights on the street while he reached out for help during the day. And unfortunately like many homeless citizens in distress, he turned to alcohol as his coping mechanism. While he fortunately found his way to the VA where he completed their chemical dependency program, he did not have the support network to sustain his sobriety post treatment, and my home became his last resort that night. This story like so many others is simply unacceptable. We must think strategically, act operationally and continue to identify opportunities to improve the sytem while always keeping the end-state in mind- ensuring our Veterans thrive in our as productive members of our society. One Veteran left behind is one too many.

Prepared Statement of Rodger Young

My name is Rodger Young, I'm a Veteran's Service Officer for the Clermont County Veteran Service Commission. Veteran Service Officers assist veterans in obtaining their VA benefits. This can include enrolling into healthcare, applying for compensation/pension, education benefits, burial benefits, VA Home Loans, and financial assistance. We are also charged with aiding veterans with their appeals and dealing with overpayments and billing issues. We are the preverbal "one-stop-shopping" for VA benefits.

³Eggleston, M., Straits-Tröster, K. & Kudler, H. (2009). Substance use treatment needs among recent Veterans. *North Carolina Medical Journal*, 70(1), 54-58.

Our office was invited to attend this Committee to provide feedback on the services Veteran Healthcare Administration (VHA) provides and also comment on the programs/stigmata associated with Post Traumatic Stress (PTSD).

1) Positive Feedback:

- a) The nursing teams are working well; open communications is the key to successful healthcare.
- b) MyHealtheVet is a great way to open the communication channels from veteran to doctor.
- c) Love the Ebenefits website which is the main hub for VA benefits/downloading VA correspondence ect . . .
- d) I commend the staff at CBOC Clermont County Ohio . . . great service, great teams, very cooperative/friendly with VSOs and they treat every veteran with the utmost respect.
- e) The quick reference flipbooks are great for passing on information concerning healthcare

2) Areas to improve upon (our feedback from the veterans):

- a) Non-VA care (FEE Basis) – I attached the handout VHA mailed concerning paying for outside medical care due to a medical emergency. Many veterans are confused about the program and when VA will pay for emergency care/transportation. VHA needs to be clear on what VA will pay and the requirements before the care is covered; the handout makes it sound easy. There should also be a claim form to send to VHA along with the hospital bills. The processing time is another concern. It takes so long to obtain an answer many veterans are turned over to collections/credit ruined while waiting for an answer; appeal take even longer. VHA needs a call center for billing/non VA care alone; normally will get an answering machine and no return call.
- b) Average wait time for surgeries
- c) Still getting complaints about the professionalism at VAMC Cincinnati (friendliness), little to no complaints on Georgetown/Clermont CBOCs
- d) DBQs
- e) If doctors refer veterans to file a claim, please ensure diagnosis/notes are annotated in CAPRI. Makes everyone's life much easier when filing a claim.

Veterans endure many adjustments when returning from deployment to include indoctrination back into family life, adjusting back into their home station and their rules, and trying to process what had happened while deployed. In general, many veterans are reluctant to seek help for mental issues due to the stigmata associated with PTSD (employment to include separation from the military, family and current gun laws). Feedback from the CBOC staff indicate cognitive therapy is working on many veterans. Success stories to be honest I don't have any.

Many who seek help for PTSD receive some relief through medications (to tone down the symptoms) but I've never seen a veteran completely cured. Realize in past wars veterans would endure 1–2 deployments into the

warzone; contemporaneously, it's not uncommon to see 5–8 deployments. PTSD programs have prevented many suicides but I think we still have a long road ahead in treating PTSD. In my opinion, we need to fix the stigmatas associated with PTSD so more veterans will seek help and then we need to rehabilitate them to function in today's society outside the military.

Our office appreciates the invitation today to outline some of the hurdles VA faces and the vast improvements it has made to ensure the veterans are taken care of. Partnerships within VHA/VBA/VSO will solidify a smooth transition for the returning veterans and their families. Standardization, consistency and communication within these three agencies are essential to minimizing the confusion within the veteran communities.

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Prepared Statement of Paul D. Worley

Mr. Chairman and Members of the Subcommittee, it is an honor to testify before you today. Thank you, for allowing me the opportunity to speak this morning about mental health care for veterans. My name is Paul Worley and I am an Army veteran. I served as an infantry rifle platoon leader and scout platoon leader in 2nd Battalion, 502nd Infantry Regiment, 101st Airborne Division (AASLT) in Iraq in 2005–2006. In 2008, I served as an operations officer at Regional Command South, NATO Headquarters in Kandahar, Afghanistan. My last tour of duty in Iraq was from 2009–2010, where I served as a mechanized infantry company commander for 3rd Battalion, 69th Armor Regiment, 1st Brigade Combat Team, 3rd Infantry Division. At times and places few will ever know we fought for each other against an unseen enemy. I was honored to serve my country and privileged to lead the best soldiers in the world. Today, I am equally proud to represent my fellow veterans and to talk about the issues we face in regards to mental health.

When it comes to mental health care for veterans the major issues are access and availability. The VA is the largest integrated health care system in the country. There are going to be issues, as there are in every health care system, but that does not mean that the system is broken.

In Adams County, Ohio, our veterans are faced with the issue of getting reliable transportation to their medical and mental health appointments. The nearest clinics are located in Portsmouth and Chillicothe, which are at least a forty five minute drive for most veterans. For those who receive services in Cincinnati and Columbus the task of getting to appointments is even more daunting. Our local veterans' service commission and veteran service organizations, including VFW Post 8327 and DAV Chapter 71, currently provide transportation, but it is not enough to meet the demands of our veterans and their families. I believe it is essential that we provide more mobile veteran centers to provide access to our rural residents.

Another access issue we face in southern Ohio is internet availability. Our internet infrastructure is extremely limited due to the terrain and the financial challenges of our local population. Many veterans do not have ready access to fill out forms online or to obtain the information they need about mental health services. As more information is shared online it is critical that we provide our veteran population with access to this basic modern need.

I believe that the military as a whole has made positive progress to reduce the stigma of post-traumatic stress disorder within its ranks over the past ten years. However, I believe there is still a great amount of work to do reduce the stigma of PTSD among the American people. Young veterans seeking civilian jobs are reluctant to seek help because of the risk of employers not hiring them. All veterans deal with the stigma that seeking help for mental health is a sign of weakness. More education is needed to make sure the American public comprehends the issues associated with PTSD.

It is very encouraging that the VA has recently hired an additional 1300 mental health care workers that will potentially alleviate some of the availability issues. I believe that the VA employees and leadership want nothing but the very best care and benefits for our veterans. However, we need to continue to improve the mental health care system. We need to be prepared to pay for veteran health care services as readily as we were to fund the wars that caused these issues. The price tag may be great, but that truth does not take away the nation's duty to care for our veterans. The country sent us to war.

Now is the time to make sure that this country is delivering on the solemn promise made to our veterans for their voluntary service.

Prepared Statement of Kristi D. Powell - USAF Veteran

I would like to thank the panel for this opportunity to discuss the issues that veterans face when seeking mental health care services through the VA, especially for MST (Military Sexual Trauma). I will touch on the four particular topics of discussion that cause barriers for the veteran when trying to receive mental health and other care and also of specific cases/examples of these barriers that we have in my county and with the VA's in our area. I would like to begin by introducing myself and giving you the specific examples of problems that veterans are currently facing when trying to receive treatment for MST.

My name is Kristi Powell, I am a United States Air Force Veteran. I hold a Bachelor's Degree in Substance Abuse Counseling and a Masters Degree in Criminal Jus-

tice. I am currently employed at a job which allows me to assist in the needs of veterans. It is through my job and outside involvement with veterans' activities that I am able to hear veterans' stories, hold roundtable discussion groups, and help aid in their healthcare. I have also been blessed to have the opportunity to be their voice today. These examples are of different veterans of different ages, different eras served in the military and all separate times frames of when they experienced their problems within the VA as far as their health care.

Case/Example 1: A female veteran in her late 40's came into the office very distraught. She showed signs of anxiety; she was crying and it was very apparent that something was wrong. After talking for awhile, she confided in me what had happened that was making her so distraught. She began to tell me how she was raped in the military by an officer and that it has impacted her life so severely that she can hardly function. She cannot work, she doesn't leave her apartment very often and she is on numerous medications just so she can get through the day and also to be able to sleep at night. Through the VA she learned of a program referred to as PRRTP (Psychosocial Residential Rehabilitation Treatment Program) that could possibly help her with her MST. She also felt that if she went to this program that it would help her in getting her service-connected claim for MST/PTSD so atleast the VA would know that she has severe problems with the MST that she was trying to address. She entered the PRRTP program at the VA hoping to receive the care that the VA claimed that they could give her and that they advertise. (Note: when referring to the care that the VA advertises I am specifically referring to the Department of Veterans Affairs website on MST in which it gives the following information that I copied and pasted):

Outpatient

- Every VA health care facility has providers knowledgeable about treatment for problems related to MST. Because MST is associated with a range of mental health problems, VA's general services for posttraumatic stress disorder (PTSD), depression, anxiety, substance abuse, and others are important resources for MST survivors.
- Many VA facilities have specialized outpatient mental health services focusing specifically on sexual trauma.
- Many Vet Centers also have specially trained sexual trauma counselors.

Residential/Inpatient Care

- VA has programs that offer specialized MST treatment in a residential or inpatient setting. These programs are for Veterans who need more intense treatment and support.
- Because some Veterans do not feel comfortable in mixed-gender treatment settings, some facilities have separate programs for men and women. All residential and inpatient MST programs have separate sleeping areas for men and women.

How can I get more information about services?

- Knowing that MST survivors may have special needs and concerns, every VA health care facility has an MST Coordinator who serves as a contact person for MST-related issues. He or she can help Veterans find and access VA services and programs.

So the veteran enters the VA PRRTP program as inpatient treatment for MST/PTSD. The veteran's anxiety began immediately upon arriving. After being admitted to the program the VA told her she was done for the day and that she go get chow. Upon entering the chow hall, she noticed that she was the only female veteran in the dining facility with all males. The veteran returned to her floor where she immediately found a VA nurse. She told the VA nurse she was having extreme anxiety and that she was told that the VA could help her with her MST/PTSD. The veteran felt betrayed that the VA would enter her in a program and then put her around all males throughout the day. On her first day of the program, she reported to where they told her to go, again she walked in the room to discover that she was the only female. Although confused and very uneasy about the situation she told herself that she had to stay because the VA briefed her that if she left the program early then she would not be allowed to be readmitted later and she still believed at the time she had to do it for her pending claim. In these group sessions she was told to participate, participation including stating the reason that you are there. She stated, when it was her turn, that she was there for MST. The males in the group automatically started in on insults and taunting her with comments about MST. A male in the group even stated to her "why would you put yourself in that position by joining the military knowing that would happen." The same male then started

bashing homosexuals by calling them derogatory names. This veteran responded by saying that it offended her and he responded back by saying "you don't get excited by men?" The facilitator of that group allowed this to go on and did nothing to stop or correct the conversation. After the group session was over, the female veteran went over to the facilitator and asked if there was a female psychologist that she could speak to. The facilitator gave her a name and so the female veteran immediately went and told the psychologist what transpired in group. The psychologist said that she would refer the veteran to the PCT program (PCT programs I was told specialize in the treatment of combat-related PTSD). Even after this horrific event, the veteran still continued on with group. She completely isolated herself and refused to participate anymore while suffering severe anxiety attacks from being surrounded by all men. The same male from the group started following her around and making comments to her. He triggered her anxiety associated with her rape so much that the psychologist and the social worker stated that maybe this was not the program for her. The next morning the social worker came and talked to the veteran about what had transpired and what some options were. The comments continued by the male in the group in front of everyone, these comments were usually sexual in nature and as before, the facilitator did nothing to object to it. Finally the veteran had enough, she checked herself out of the VA and came back home. While at home, the veteran could not get the male or his comments to leave her mind. Something told her to Google his name, when she did numerous things came up. She noticed one was a mug shot so she clicked on it and it was that same male that taunted her in her group. He was listed as a convicted sex offender. He had raped a woman in Mansfield, Ohio and had his address listed on the website as the VA's. This VA allowed an MST survivor who suffers from severe mental health conditions associated with her rape to be in a group counseling session and freely around a convicted rapist. This veteran is now so traumatized that she refuses to go back to the VA for any type of healthcare. This event has completely set her back in any progress that the veteran had made prior to entering the VA for help.

Case Example 2: A female veteran in her 20's came into the office. After talking to her, she disclosed that she was living in the homeless shelter and that she had a substance abuse problem. She was crying and stating that she did not know what she was going to do. I told her about the programs that are being offered at the VA and asked her if she would like me to help her see if one of the programs was open for her to enter treatment. She told me that she was already in a program up there and left and that she was not allowed back into any of them because of leaving. I asked her which one and what happened. She told me that she was raped while deployed to Afghanistan by her Lt. After being raped and her being harassed continually by him she started self medicating when she returned to the states. Her performance declined at work and she was eventually discharged from the military. When she came home, her substance abuse continued as she tried to mask her pain. She started using harder drugs such as heroin just to deal with life. Her parents did not know how to handle her so they kicked her out which forced her into the homeless shelter. She entered the VA in hopes of getting help with her MST and substance abuse problem. While at the VA, she also was put into an all male group session in which the taunting began immediately with name calling. They would call her "princess" and tell her to sit down when she told the group that she was there for MST. The taunting from the males became so bad that she left treatment and immediately got high to deal with pain that resurfaced from being raped. It was with this second veteran that I realized that this is not a coincidence; this is an on-going and unchanging issue at the VA. Since this vet was going through withdraws I took her back to the VA. While waiting for her to be admitted through Urgent Care, I took her with me to talk to the patient advocate. My first stop was the OEF/OIF patient advocate since she was from that era. I told the patient advocate that this was the second case that I knew of and that it was a severe problem. I asked him because I wanted to know what I personally had to do or who I had to talk to for this issue to be addressed and so it would not happen to another veteran trying to receive care. The patient advocate looked at me and asked "at what point do you feel that these MST veterans would be able to attend group sessions?" I honestly looked at him in disbelief, I could not believe that this was his first question and only concern. My reply was "probably never. It would only be when the veteran states for themselves that they are ready." I then got up, left his office and went to the next person in line which was the Women's Health Social Worker. The social worker listened to my concerns and complaints about how MST veterans are being treated and the lack of care that they are receiving; she could not however give me any explanation to why this was happening but more or less said that the VA does not have the space or resources to have an all-female area. I stated to her

although I completely understood budget restraints, as soon as a veteran discloses that they are a MST victim/survivor that should be the red flag for the VA to do an ITP (Individualized Treatment Plan). Under no circumstances should the veteran be subjected to the same sex and/or race of the person that sexually harassed and/or assaulted them. The social worker agreed and said she would definitely let the director of the VA know. The social worker gave me her word that she would find the appropriate care for my fellow young veteran that was suffering from so many mental health and substance abuse issues. The catch to waiting for new treatment would be that it might take some time to find something so she would be stuck at the VA in the same scenario with all men until then. I talked to my veteran and I asked her what she wanted to do, she agreed stating it's either this, the homeless shelter or die. Since I admitted her through the urgent care, the standard rule from what I understand is that the veteran goes to the psych ward for 3 days. I escorted this vet up to the psych ward and it was filled again with all male vets that were in their for numerous different types and levels of mental illness with no separate section for female and/ or male vets that were survivors of MST. I informed the staff on the ward that she was suffering from MST. The one guy that was working that floor did not even know what MST was. I told the vet to call me at anytime if she felt she could not handle it and it was triggering her anxiety or want to use drugs or anything else. She did call me but she also made it through her three days. The social worker did keep her promise to me and this vet by later transferring her to New York State where she has been referred to an all-female treatment facility with other female vets where she gets to stay for a year. In her correspondence she tells me that I saved her life by being active in her health care and being her voice when no one cared. She loves the facility where she is at and she celebrates every day that she is alive and sober and getting help for all the pain that she has hide within herself. This worked out for this particular veteran but not all veterans are given this opportunity for treatment.

Case/Example 3: Due to the problems that I have seen within the VA when it comes to women's healthcare, I had participated in a Roundtable discussion with an Ohio Senator. Again I voiced my concerns about what was taking place and what I was witnessing at the VA when it came to treatment for MST. Months later, a representative from his office called and asked if I would be interested in hosting another roundtable in which she could come down and sit with me and about 10 other women veterans to discuss problems they are having in receiving care. I started calling women veterans from the area. I picked one (the veteran from case #1) to join me to discuss MST. The other four female veterans were random and I had never met them nor knew anything about their time in service or if they even utilized the VA. I called random women veterans in hopes of creating a roundtable full of different women to voice their concerns about VA healthcare. After meeting and talking for awhile, I brought up MST to the representative and started voicing my concerns. As soon as I opened this discussion up and the other women veterans knew that this was my passion and my new fight, they began to open up and all five women veterans were MST victims/survivors. As I listened to what they were willing to share, it occurred to me that this problem has been present for quit some-time and although progress is occurring, the VA is still not where it should be with the number of MST statistics that they are reporting on their website. According to the Department of Veterans Affairs website, "About 1 in 5 women and 1 in 100 men seen in VHA respond "yes" when screened for MST. Though rates of MST are higher among women, there are almost as many men seen in VA that have experienced MST as there are women. This is because there are many more men in the military than there are women."

With the statistics that the VA has provided and from what I have witnessed in my county alone, I am in hopes that positive changes occur. Men and women who served their country and are victims/survivors of MST/PTSD should not be left to fight this battle alone. The VA should do the necessary steps to develop Individualized Treatment Plans and separate wings/facilities that are specially staffed to meet the needs of MST victims/survivors. Women veterans should not have to worry about encountering all men when they go to the VA for treatment; with separate wings/facilities a female could feel more confident in choosing to get care through the VA without fear. The services provided for MST/PTSD should be available at every VAMC. At the present time, only certain locations throughout the United States have all-female treatment areas and the wait time for a veteran to get into the program is very lengthy (6 months or more). The veteran also has to apply and be accepted into the program and they are then placed on a waiting list. Even in the cases I mentioned above, the drive one way to this particular VA is one hour.

In some areas of Ohio, a female veteran is expected to drive 3 plus hours one way for a gynecology exam.

The VA is the federal agency responsible for serving the needs of veterans by providing health care, disability compensation and rehabilitation, education assistance, home loans, burial in a national cemetery, and other benefits and services. The VA bears the words, "To care for him who shall have borne the battle and for his widow, and his orphan." Not only are these words a reminder to the VA of the commitment they made to care for those injured in our great nation's defense but I am here as well to remind them and let them know that more needs to be done to fulfill their commitment to the veterans of this country.

I thank you again for allowing me this opportunity to speak before you.

Sincerely,
 ///SIGNED///
 Kristi D. Powell

Prepared Statement of Linda D. Smith, FACHE

Good morning, Chairman Benishek, Ranking Member Brownley, and Members of the Committee. Thank you for the opportunity to discuss the Cincinnati VA Medical Center's (VAMC) efforts to provide high quality care, specifically mental health care, to Veterans in our catchment area and our pilot Veterans Transportation Service. I am accompanied today by Dr. Kathleen Chard, Director of the Trauma Recovery Division of our Mental Health Care Service Line, and Professor of Psychology and Behavioral Neuroscience at the University of Cincinnati, College of Medicine; Emma Bunag-Boehm, Primary Care Provider for the Post-Deployment Clinic, Cincinnati VAMC, and Mr. Chad Watiker, Cincinnati Vet Center Team Leader.

I will begin my testimony with an overview of the Cincinnati VAMC. I will then focus on our comprehensive mental health programs and end with a brief overview of the Veterans Transportation Service, which has improved access to care for many of our Veterans.

Cincinnati VAMC Overview

The Cincinnati VAMC is a two-division campus located in Cincinnati, Ohio and Fort Thomas, Kentucky. The Medical Center serves 17 counties in Ohio, Kentucky, and Indiana with six Community-Based Outpatient Clinics, located in Bellevue, Kentucky; Florence, Kentucky; Lawrenceburg, Indiana; Hamilton, Ohio; Clermont County, Ohio; and Georgetown, Ohio. The Cincinnati VAMC is a tertiary referral facility. We are a highly-affiliated teaching hospital, providing a full range of patient care services, with state-of-the-art technology, medical education and research capabilities. The Medical Center provides comprehensive health care through primary care, dentistry, specialty outpatient services, and tertiary care in areas of medicine, surgery, mental health, physical medicine and rehabilitation, and neurology.

Our facility is the Veterans Integrated Service Network (VISN) 10 referral site for a number of surgical and medical programs and a regional referral center for posttraumatic stress disorder (PTSD). The PTSD program at the Fort Thomas division of the Cincinnati VAMC in northern Kentucky also provides training to practitioners from various active duty military branches and other VAMCs. Our Inpatient Mental Health Unit is frequently visited by other VA facility staff to learn about our Recovery Model of Care.

The Cincinnati VAMC has an active affiliation with the University of Cincinnati College of Medicine and is connected both physically and functionally to the University. Over 500 fellows, residents, and medical students are trained at the Cincinnati VAMC each year. In addition, there are also over 85 other academic affiliations involving dentistry, pharmacy, nursing, social work, physical therapy and psychology.

The Cincinnati VAMC is fully accredited by The Joint Commission, the College of American Pathologists, the Commission on Cancer of the American College of Surgeons, the Commission on Accreditation of Rehabilitation Facilities, the Accreditation Council on Education, the Accreditation Council for Graduate Medical Education, the American Association of Cardiovascular and Pulmonary Rehabilitation and accrediting bodies for residencies in Optometry, Pharmacy and Radiology. Our research programs are also fully accredited.

Over 42,000 Veterans are enrolled in VA health care through our facility. This number includes over 3,600 female Veterans and 3,500 Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Veterans. Growth in terms of enrolled Veterans has increased by over 4 percent this fiscal year (FY) and approximately 25 percent over the past 5 years. We also have seen a 13percent increase

(322 cases) in surgeries performed and a 15 percent increase in referrals from other VAMCs this fiscal year compared to FY 2012.

The Cincinnati VAMC recently volunteered for the first VA survey of our Patient Aligned Care Team (PACT)/Medical Home Program by The Joint Commission and was commended for the quality of care and services we provide. Seventeen out of 43 four-person teams (physician, nurse, licensed practical nurse, and clerk) received national PACT recognition from the Veterans Health Administration. We also recently implemented a Hospital in Home Program that has enrolled over 100 Veterans since February 2013. This program has allowed us to avoid admission of Veterans to an inpatient unit by providing daily services in the home, thus avoiding some health care expenses. Since the program began in February 2013, we estimate a cost savings of over \$700,000 and a 245-day reduction in Bed Days of Care.

Our facility continues to grow in order to meet increased demand for services. Construction projects include a recently-completed parking garage, a new imaging center, patient-centered renovations to our first floor, a new research building which will break ground in September 2013, an off-campus, state-of-the-art Eye Center, an ambulatory surgery center, and an expansion of our operating rooms. We also have a number of construction projects of interest to include: a Sleep Study Center, a new Traumatic Brain Injury (TBI) Clinic and new Community-Based Outpatient Clinics in Florence, Kentucky and Georgetown, Ohio.

The Cincinnati VAMC has 15 full-time staff in the OEF/OIF/Operation New Dawn (OND) clinic providing primary care, mental health care, social work services, and pain management care for military personnel returning from Iraq, Afghanistan, and all recent combat theatres. Efforts to reach returning military personnel involve re-deployment briefings, post-deployment briefings, family readiness meetings, local Veterans Service Organizations meetings/functions, community events and letters, and personal phone calls to recently-discharged Servicemembers. Our pilot Veterans Integration to Academic Leadership Program (VITAL) places a psychologist on local college and university campuses with the sole task of connecting with student Veterans and providing services on-site. The Post Deployment Integrated Clinic model of care and outreach efforts by the Cincinnati VAMC staff for the OEF/OIF/OND population are considered best practices within VA. As a result, we have been able to enroll approximately 65 percent of eligible OEF/OIF/OND Veterans in our catchment area.

One of the most exciting new initiatives at the Medical Center is our Tele-Intensive Care Unit (ICU), which allows the delivery of critical care services across a geographic distance through the use of electronic devices and connections. Critical care nurses and physicians perform sophisticated 24/7 remote monitoring of Veterans in VA critical care units throughout the State of Ohio and soon will be monitoring critically-ill Veterans in the VA Southeast Network (VISN 7).

Trauma Recovery Center

The Cincinnati VAMC's Trauma Recovery Center consists of an outpatient PTSD clinical team (PCT) and a Residential PTSD Program. The PCT offers eligible individuals individual family education, medication management, and evidence-based PTSD treatments in individual, group, and couples formats including Prolonged Exposure and Cognitive Processing therapy (CPT), Couples-Based PTSD treatment, Virtual Reality Therapy and Dialectical Behavior Therapy.

The Residential PTSD Program, described in Veterans Health Administration (VHA) Handbook 1162.02, Mental Health Residential Rehabilitation Treatment Program, is a 7-week, cohort-based program for men and women and an 8-week program for Veterans with PTSD and a history of TBI. The Residential programs are unique and highly-successful programs that have been featured in national media for their patient-centered, evidence-based treatment programs for PTSD. In addition to utilizing CPT, the residential groups focus on anger, communication, distress tolerance, life skills, interpersonal effectiveness, nutrition, communication, and sleep. The women's residential program was identified as a best practice, and the TBI/PTSD residential program is the only one of its kind in the Nation.

The Cincinnati VAMC also provides care and services, including counseling, to Veterans who have experienced military sexual trauma (MST) and come to VA for care. Under Title 38 United States Code, Section 1720D, VA is authorized to provide counseling and appropriate care and services, as required, to Veterans to overcome "psychological trauma, which in the judgment of a mental health professional employed by the Department, resulted from a physical assault of a sexual nature, battery of a sexual nature, or sexual harassment which occurred while the veteran was serving on active duty or active duty for training." Section 1720D defines sexual harassment as "repeated, unsolicited verbal or physical contact of a sexual nature which is threatening in character."

Mental Health Care

Mental health services at the Cincinnati VAMC are unified under a multidisciplinary Mental Health Care Line (MHCL). A comprehensive variety of mental health services is offered by the seven divisions of the MHCL. The divisions are Outpatient Mental Health, Substance Dependence, Assessment and Intensive Treatment, Trauma Recovery Center, Domiciliary Care for Homeless Veterans, Community Outreach, and Special Services. Presently, the MHCL employs 30 psychiatrists, 53 psychologists, 72 social workers, and 83 nursing personnel. The total number of staff working for the MHCL is 303. From FY 2007 to FY 2012, our MHCL staffing grew approximately 74 percent, and the number of Veterans treated grew 55 percent. In the first 10 months of FY 2013, the MHCL provided care to approximately 15.5 percent more Veterans than were seen over the similar period in FY 2012. That amounts to an additional 1,482 unique Veterans. During this period of growth, the Cincinnati VAMC has been successful in recruiting highly-qualified, mental health staff in all professions.

VHA has developed many metrics to monitor performance in the delivery of mental health services. These monitors include the following:

1) Patients who are discharged from acute inpatient mental health treatment have follow up within 7 days. VHA's goal is that 75 percent of Veterans in this category should have contact. This year, the Cincinnati MHCL has successfully contacted approximately 85 percent of Veterans discharged from acute inpatient mental health treatment for follow up.

2) Qualifying Veterans should have a Mental Health Treatment Coordinator (MHTC) assigned to them. VHA's goal is that 75 percent of qualified Veterans should be assigned an MHTC. The Cincinnati MHCL currently has approximately 85 percent of qualifying Veterans assigned to an MHTC. As new Veterans access Mental Health services, assignment of an MHTC is part of the treatment planning process.

3) In the OEF/OIF/OND clinic, Veterans diagnosed with PTSD who agree to treatment are expected to have 8 evidence-based psychotherapy sessions over a 14-week period. VHA's target is that 67 percent of Veterans who agree to treatment receive 8 sessions in a 14-week period. The Cincinnati MHCL is currently at approximately 72 percent.

4) In FY 2013, VHA began using two measures to evaluate Veteran access to mental health care. For Veterans who have established mental health treatment, the Medical Center tracks the percentage of Veterans who are able to schedule an appointment within 14 days of their desired date, which is VHA's goal. The Cincinnati MHCL has achieved that goal approximately 99 percent of the time. For Veterans who are new to seeking mental health care, the Medical Center tracks VHA's goal of having Veterans complete an initial appointment in 14 days or less of when the appointment was made. For FY 2013, the Cincinnati MHCL has provided this level of access approximately 83 percent of the time. In July 2013, the average wait time for a new mental health care patient's first appointment was 8 days, and approximately 85 percent of Veterans had their first appointment within VA's goal of 14 days. In the most recent VA Strategic Analytics for Improvement and Learning report, the Cincinnati VAMC received an outstanding 5-star quality rating which included the category "Mental Health Wait Time."

While these metrics are important, we realize they tell only part of the story of Cincinnati VAMC's mental health accomplishments. In addition to the aforementioned Trauma Recovery Center, Cincinnati has an array of strong mental health services. For example, the acute inpatient mental health ward has 20 beds and has received multiple national recognitions for its patient-centered, recovery-oriented program. The Substance Dependence Division is also strong as a leader in tobacco cessation treatment and ambulatory detoxification. Our opiate substitution program is an important resource for local Veterans. Our Primary Care Mental Health Integration Program has one of the highest rates of utilization in the Nation. For 2013 to date, the VAMC had 1,717 tele-mental health encounters, an 89 percent increase over FY 2012, and as a result, increased access to care for Veterans and reduced requirements for travel.

The Cincinnati MHCL has had a Family Services Coordinator for many years, supporting the families of Veterans with severe mental illness. We are responding to the new generation of OEF/OIF/OND Veterans with programs such as brief family consultation, Support and Family Education, Behavioral Family Therapy, and couples counseling. A VHA-funded research project, Couple-Based Treatment for Alcohol Use Disorders and PTSD, is investigating the effects of couple-based coun-

seling for alcohol dependency, PTSD, and partner relationships. The Cincinnati VAMC has also been chosen as a site for the Practical Application of Intimate Relationship Skills (PAIRS) program. This is a 9-hour, intensive weekend training program to improve a Veteran's relationship with their partner.

Homeless Programs/Initiatives

The Cincinnati VAMC is also working actively with many other Federal, state, and local entities to meet Secretary Shinseki's goal of ending homelessness among Veterans in 2015. The homeless programs at the Cincinnati VAMC are robust, consisting of strong outreach/community partnerships, Grant and Per Diem (GPD), Housing and Urban Development/Veterans Affairs Supportive Housing (HUD/VASH), Health Care for Homeless Veterans (HCHV) contract beds, and Veterans Justice Outreach (VJO) programs. We have developed a Homeless/Low Income Resource Guide and the HUD/VASH Quarterly Newsletter that VA Central Office recognized as best practices. Our VJO program was featured in a recent rehabilitation accreditation newsletter, CARF International's "Promising Practices Innovation in Human Services," April 2013.

On May 3, 2013, the Cincinnati VAMC held its 4th Annual Homeless Summit, which was attended by a broad base of community partners, including Joseph House, Greater Cincinnati Behavioral Health, Talbert House, Drop Inn Center, and Strategies to End Homelessness. Additionally, the Cincinnati VAMC works closely with numerous faith-based organizations, such as City Gospel Mission, Interfaith Hospitality Network, St. Francis/St. Joseph Catholic Worker House, Mercy Franciscan at St. John's, and the Mary Magdalen House.

The Community Outreach Division of the MHCL, under which the homeless programs fall, will be moving to Downtown Cincinnati this month to a strategic location allowing increased access and walk-in service. A portion of the division will remain in Fort Thomas, Kentucky to allow access for homeless Veterans in Northern Kentucky. Listed below are the homeless programs and initiatives available through the Cincinnati VAMC:

GPD - We have 173 beds, including seven beds for female Veterans. Our programs run at capacity and have a high success rate, short length of stay, and low cost per episode.

HUD/VASH - We have 275 vouchers in Hamilton and Clermont counties in Ohio and Northern Kentucky and were awarded an additional 40 vouchers for FY 2014. The Cincinnati VAMC was among the first medical centers in the Nation to incorporate Housing First principles within HUD/VASH by piloting a 25-voucher program in October 2010 and retooling the entire program to incorporate Housing First principles in March 2011. According to the Homeless Operations Management Evaluation Systems (HOMES) Database, our chronically homeless housed rate is approximately 89.26 percent, among the highest in the Nation. We finished FY 2012 with a 94.84 percent housed rate and the Medical Center is on target to exceed that rate in FY 2013.

HCHV Contract Beds - We have 12 beds (six, two-bedroom apartments) under this program. Each bedroom is private and locked, ensuring safety, security, and privacy.

Veterans Justice Outreach - We actively collaborate with four operational Veterans Treatment/Diversion Courts and look forward to collaborating with a fifth court in the planning stages moving towards implementation. The addition of this fifth court will give us partnerships with Veterans Treatment Courts in all three states within our catchment area, providing Veterans with help in meeting treatment goals instead of incarceration.

Veterans Transportation Service (VTS)

Recognizing that increasing access to care improves health care outcomes, the Cincinnati VAMC began operation of the VTS in May 2012, offering both mobility management and transportation services. Mobility management guides Veterans to the most medically-appropriate and cost-effective means available through a private, Veteran-focused agency or public transportation resources. VTS fills the remaining gaps, providing door-to-door, wheelchair-accessible transportation for those Veterans living in the Medical Center's catchment area who have no other viable transportation options. VTS has served 750 unique Veterans, approximately 40 percent of whom are wheelchair-bound, providing nearly 10,000 rides, since its inception.

Community Partnerships

The Cincinnati VA has been building community mental health partnerships by holding annual homelessness prevention summit meetings for the past 4 years.

Those summit meetings inspired our development of the Cincinnati Homeless/Low Income Resource Guide. In addition to having been cited by VHA as a best practice, the guide has become a highly valued document for community agencies. Based on events like the homelessness summits, VHA has been holding Community Mental Health Summits during the Summer of 2013.

In August 2013, the Cincinnati VAMC hosted its first Community Mental Health Summit. At the Summit, facility leadership and staff met with 66 individuals from 36 community agencies. The facility was joined by staff from the local delegation of Members of Congress, one state agency, one county agency, and six universities.

Presentations were made on the following topics:

University Liaison. The Cincinnati VAMC has a well-established outreach program which partners with local colleges and universities to ease the transition of Veterans seeking higher education.

PTSD Treatment. Cincinnati MHCL discussed its programs with Dr. Chard speaking on this topic.

Suicide Prevention. Each VAMC has been allocated at least one full time suicide prevention coordinator. The MHCL has 3 full time social workers devoted to this task. VHA works steadily to reduce stigma associated with receiving mental health care. VHA has declared that September 2013 is Suicide Prevention Month, and VHA is sponsoring the public service announcement "Talking About It Matters". During September 2013, the Cincinnati MHCL Suicide Prevention team will give 11 presentations in the community focusing on eliminating the stigma that complicates preventing suicides.

At the Mental Health summit, there was considerable open exchange of detailed information about mental health programs and services available through VA and in the community. This was an opportunity to share ideas and promote further collaborations. Particular suggestions that emerged included annual follow-on summit meetings and for MHCL to develop a simple telephone access to respond to Community Agency queries about MHCL services.

Conclusion

VHA and the Cincinnati VAMC are committed to providing the high-quality care that our Veterans have earned and deserve, and we have continued to improve access and services to meet the mental health needs of Veterans residing in Cincinnati and the local surrounding area. We appreciate the opportunity to appear before you today, and we appreciate the resources Congress provides VA to care for Veterans. Dr. Chard, Ms. Bunag-Boehm, Mr. Watiker, and I are happy to respond to any questions you may have.