STATEMENT OF
CONSTANCE A. WALKER, CAPT, USN (RET.)
NATIONAL ALLIANCE ON MENTAL ILLNESS
MEMBER, NAMI VETERANS COUNCIL
PRESIDENT, NAMI SOUTHERN MARYLAND

SUBMITTED TO
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

OCTOBER 24, 2007

Chairman Akaka and Members of the Committee –

As a member of the Veterans Council of the National Alliance on Mental Illness (NAMI), I appreciate your invitation to provide testimony for your consideration of several legislative proposals related to mental health programs in the Department of Veterans Affairs (VA). On behalf of NAMI's Executive Director, Mr. Michael Fitzpatrick, and our Veterans Council Chairman, Ms. Sally Miller, of Bozeman, Montana, please accept our thanks for this opportunity to speak with you today.

NAMI is the nation's largest non-profit organization representing and advocating on behalf of persons living with chronic mental health challenges. Through our 1,200 chapters and affiliates in all 50 states, NAMI supports education, outreach, advocacy and biomedical research on behalf of persons with schizophrenia, bipolar disorder, major depression, severe anxiety disorders, post-traumatic stress disorder (PTSD), and other chronic mental illnesses that affect children and adults.

NAMI and its veteran members established the Veterans Council in 2004 to assure close attention is paid to mental health issues in the VA and within each Veterans Integrated Service Network (VISN). We advocate for an improved VA continuum of care for veterans with severe mental illness. The council includes members from each of VA's 21 VISNs. These members serve as NAMI liaisons with their VISNs; provide outreach to national Veterans Service Organizations; increase Congressional awareness of the special circumstances and challenges of serious mental illness in the veteran population; and work closely with NAMI State and affiliate offices on issues affecting veterans and their families. Council membership includes veterans who live with serious mental illness, family members of this population of veterans, and NAMI supporters with an involvement and interest in the issues that affect veterans living with mental illness. The Council's monthly meetings are conducted via teleconference and often feature guest speakers who provide updates on developments in treatment, research, program initiatives, and service delivery for veterans, active duty service members, and family

members with serious mental illness. We also use these opportunities to stay current on developments in Congress and the Executive Branch that have the potential to affect mental healthcare for veterans.

Mr. Chairman, as you indicated in my introduction, my name is Constance "Connie" Walker. I am a retired Navy Captain with over 22 years of active duty service; a member of NAMI's Veterans Council; and, the President of a regional, rural NAMI affiliate in southern Maryland. My son, Michael, is a disabled veteran of Operation Iraqi Freedom (OIF). He enlisted in the Army as a Motor Transport Operator in June 2001, associate's degree in hand, but Mike was more impressed by an enlistment bonus and a chance to see the world than the idea of two more years of college.

In January 2003, Mike's unit deployed to northern Kuwait in support of the first phase of OIF and our advance into Baghdad. That deployment ended in July. In December of that year – at my insistence, after a season of observable physical and mental decline in him, and an aborted effort by the Army to administratively separate him – my son received a full mental and physical evaluation. In January 2004, Mike was diagnosed with PTSD, major depression, and schizophrenia; he was hospitalized, and medically retired later that year. Today my son lives with my husband and me in southern Maryland.

Throughout that period and since my son's medical retirement, I have been his primary advocate in working with military, VA, and civilian mental healthcare, insurance, and disability benefit systems. Navigating these waters is always challenging and sometimes debilitating – even to someone like me, with over twenty years of experience in recruitment, accession, retention, and retiree policy and program management; having strong supporters within the VA, TRICARE, and other Federal and State agencies; and professional involvement in a local resource network that spans three Maryland counties. My family's experiences; my advocacy work on behalf of OIF and Operation Enduring Freedom (OEF) veterans and families in rural areas of Maryland, North Carolina, Georgia, and California; and, connections to veteran advocates across the country, have led me to this conclusion:

> *It is impossible to overstate the stressors that rural and frontier family caregivers are bearing on a daily basis as they search for limited treatment and rehabilitative services, and work to support a loved one whose cognitive abilities have been severely and sometimes permanently impaired by the invisible injuries of PTSD or other serious mental illness.*

There is a looming reality over all discussions about recovery-based treatment and rehabilitation services for rural OIF and OEF veterans living with PTSD or other serious mental illness. The likelihood of obtaining those specialized services on a consistent basis is very small for veterans living in rural and frontier areas beyond a reasonable commute to a VA Medical Center (VAMC) or without access to an appropriately and consistently staffed VA Community Based Outpatient Clinic (CBOC).

This is a sobering fact, Mr. Chairman. Early intervention and regular access to appropriate treatment, rehabilitation, and support services are as vital to a disabled veteran's prospects for recovery from serious mental illness as they are for recovery from serious physical injury.

Mr. Chairman, with that background, I offer the following comments on the legislation before the Committee today, as requested in your invitation letter:

S. 2162 Mental Health Bill

Title I – PTSD and Substance Use Disorder

This bill would establish new VA requirements and re-emphasize existing VA programs for the treatment of PTSD and substance use disorder (SUD), with special procedures for VA to address the treatment of veterans who suffer from co-morbid association of these disorders. It would require VA to expand its offering of services for SUD, including counseling, outpatient care, prevention, aftercare, opiate substitution and other pharmaceutical treatments, detoxification and stabilization services, and other services the Secretary deems necessary, at every VAMC and CBOC. It would create a joint program of care for veterans with PTSD and a SUD, and authorize VA to spend $50 million a year in FY08, FY09, and FY10 on this program. VA would also designate six "National Centers of Excellence on Post-Traumatic Stress Disorder and Substance Use Disorder."

Following orthopedic problems, mental health is the second largest area of illness for which OIF and OEF veterans are seeking treatment at VA medical centers and clinics, and the demand for mental health services is increasing at a faster rate than orthopedic care. If this trend continues, we can expect to see mental health care at the top of the VA's treatment list in the future. Within the range of mental health issues that OIF and OEF veterans are experiencing, PTSD tops the list. PTSD is a special emphasis area for NAMI in its work to support veterans in the VA health care system.

The requirement in this legislation to emphasize concurrent treatment for veterans who have PTSD or other mental illness and a SUD is an important step forward in the treatment and recovery of veterans with PTSD or other mental illness who self-medicate with alcohol and/or drugs. Expanded VA efforts to treat co-occurring disorders would be welcome, and is long overdue. That said, for OIF and OEF veterans who need these services in rural and frontier areas, the only practical avenue to VA care for co-occurring disorders would be through VA's CBOCs. The Substance Abuse and Mental Health Services Administration (SAMHSA) reports that substance abuse is a large and growing problem in rural America. There would need to be a sense of urgency in ensuring CBOCs in rural areas have a fully staffed and consistent treatment capability for this population of veterans. Even under those circumstances, veterans who need mental health treatment and are self-medicating in America's frontier areas are likely to be beyond reach.

This legislation would also require a review of all VA residential mental health care facilities, including domiciliary facilities. The results of the review would produce a report to Senate and House Committees on Veterans' Affairs that addresses the availability of care and provides, for each one, an assessment of supervision and support; staff-to-patient ratio, assessment of rules and procedures for medication management; description of protocols for handling missed appointments, and recommendations for improvements to residents' care and the facilities themselves.

This is an issue of extreme significance but I am personally puzzled by the need for legislation to conduct this review. Unless there are legal constraints to doing so, it should be possible to avoid delays inherent to the legislative process by requesting GAO or any of the audit or inspection agencies available for tasking by Congress (to include the VA's Inspector General) to conduct this review and deliver the report.

Title II – Mental Health Accessibility Enhancements

This legislation would require the establishment of a three-year pilot program in two VA networks to provide peer outreach, peer support, readjustment counseling and other mental health services to OIF and OEF veterans, particularly National Guard and Reserve veterans, who live in rural areas and are unable to routinely access comprehensive mental health services through the VA. These services would instead be provided through community mental health centers or facilities of the Indian Health Service participating in the pilot as VA's partners. Clinicians at these facilities would receive VA training to help them address mental health concerns unique to the experiences of OIF and OEF veterans. These facilities would be required to annually report the following information to the VA: number of veterans served; courses of treatment provided; and demographic information for services, diagnoses, and courses of that treatment.

Mr. Chairman, the goal of this legislation is vitally important: increasing access to mental healthcare programs and rehabilitation services for veterans returning to rural and frontier areas where VA resources are limited or do not exist. It is similar in its proposals to S.38, but downsized. In an effort to address this need using in-house resources, the VA recently launched a program at selected test sites to provide Mental Health Intensive Case Management (MHICM) services in some rural areas, but this program is in its infancy.

If legislation can increase mental health resources for veterans and families who live in rural areas, it should be supported. However, there are concerns that cause NAMI to question whether legislation alone can achieve this goal.

The lack of availability of mental healthcare specialists, programs and services in rural areas is a national issue. Most rural areas do not have the mental health resources in place to meet the needs of the existing population. More than 60% of rural Americans live in mental health professional shortage areas. Sixty-five percent get their mental health care from their primary care physicians. St. Mary's County, Maryland received its federal designation as a psychiatric services shortage area in 2005. Individuals seeking

psychiatric care often wait three or four months for their first appointment.

Community Mental Health Center programs are funded primarily through grants from the Department of Health and Human Services. There are very few centers in rural areas. Those there are tend to operate at capacity, and many of their clients have lived with chronic mental illness for years. These centers would be attempting to assimilate a very different client population in terms of OIF and OEF veterans' average age, psychiatric treatment, and rehabilitative needs. Given these considerations, the legislation's requirement for VA training of clinical staff takes on even more significance.

These considerations raise a question as to whether legislation alone will be able to create an acceptable solution for OIF and OEF veterans in rural areas, who need timely and regular access to recovery-based mental healthcare treatment and rehabilitative services.

S. 38

This legislation would establish a three-year program of services for members of the immediate families of new veterans diagnosed with PTSD or other serious mental illness. Services would include education, support, counseling and other programs for families to increase their understanding of their veteran's illness, enabling them to more effectively support their veteran's journey to recovery. These programs would also improve the family's coping skills and ability to more effectively manage the stressors that family caregivers deal with every day. VA would have to develop a program based on these requirements – but these families are in desperate need of help. There is an equally important subject this bill does not address: compensation for family caregivers. Their role, in advocating for a seriously disabled veterans' physical and mental healthcare and supporting their recoveries, is a fulltime job. My circumstances are unusual. I draw retired O-6 pay from the United States Navy and have a supportive spouse who is willing and able to work past retirement eligibility age. We can support my son. The vast majority of family caregivers supporting a seriously disabled veteran's recovery do not enjoy these luxuries. In many cases, family caregivers have had to quit their jobs to take on fulltime caregiving responsibilities – placing the family under even more stress as it struggles to deal with the loss of income.

S. 2142

This bill would require the Secretary of Veterans Affairs to reimburse veterans with service-connected disabilities for costs incurred as a result of emergency treatment in civilian hospitals, for the period of inpatient care needed before they can be transported to VA facilities.

It is a fact that a percentage of OIF and OEF veterans with PTSD or other mental illness, TBI, and other injuries not visible to the eye, go undiagnosed until symptoms become obvious. A VA facility is not always within commuting distance when the veteran with a service connected disability needs emergency inpatient care. NAMI supports legislation that broadens the entitlement of service-disabled veterans to emergency

inpatient care covered by the VA, certainly until the veteran can be safely transported to a VA facility. Therefore, since this bill clarifies that VA responsibility, NAMI supports it.

S. 2004 and S. 2160

Mr. Chairman, these two bills do not deal with mental illness, so NAMI takes no position on them.

Conclusion

The National Alliance on Mental Illness is committed to supporting VA efforts to improve and expand mental healthcare programs and services for veterans living with serious mental illness. Our members directly see the effects of what the national Veterans Service Organizations have reported through the *Independent Budget* for years: chronic under-funding of veterans' health care has eroded the VA's ability to quickly and effectively respond to present-day and projected requirements, even with the infusion of new funds it now is receiving. Forward motion has been stalled for three years on VA's "National Mental Health Strategic Plan," to reform its mental health programs – a plan that NAMI helped develop and fully endorses. A Government Accountability Office (GAO) report released in September 2006 noted that the VA had failed to spend all of a promised $300 million in 2005 that was allocated towards improved awareness of mental illness treatment services in the VA; improved access to mental health services for Veterans returning from Iraq and Afghanistan, as well as others diagnosed with serious mental illness – all important initiatives within the VA strategic plan. NAMI hopes the Committee will agree that oversight of VA's implementation of its National Mental Health Strategic Plan would be beneficial to ensuring its progress toward full implementation, to provide help to OIF-OEF veterans and all veterans who live with mental illness.

Chairman Akaka and Members of the Committee, thank you for your invitation for NAMI to offer testimony as you consider this legislation. I would be pleased to respond to any questions you may have.