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VETERAN ADVOCACY PROJECT

THE COUNCIL OF THE CITY OF NEW YORK

COMMITTEE ON MENTAL HEALTH, MENTAL RETARDATION, ALCOHOLISM, DRUG ABUSE AND DISABILITY SERVICES
Hon. Oliver Koppell, Chairperson

&

COMMITTEE ON VETERANS
Hon. Mathieu Eugene, Chairperson

Oversight Hearing:
Improving Access to Mental Health Services for Veterans

Testimony by Coco Culhane

December 5, 2011

Good morning members of the Committee on Veterans and the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services. My name is Coco Culhane and I run the Veteran Advocacy Project at the Urban Justice Center. We provide free legal services to low-income veterans with a focus on those living with mental illness. I also sit on the steering committee and chair the communications committee of the Veterans' Mental Health Coalition. Thank you for the invitation to testify about access to mental health treatment for veterans.

First, I would like to express my support for Resolution 958 urging Congress to pass H.R. 930, a bill that will improve disability compensation procedures for veterans who have suffered from military sexual trauma, or "MST." The legislative change would allow veterans with post-traumatic stress disorder ("PTSD") stemming from sexual assault to be evaluated for benefits even when there is no official record of the traumatic event. The Department of Defense's own estimate is that only 13.5 percent of sexual assault survivors report an incident.[1] While more than expanding access to PTSD treatment is needed, this bill is a first step in changing the way rape and sexual trauma are addressed.

The Department of Veterans Affairs ("VA") is making improvements to its benefits system by training claims processors about MST and by hiring more women at the request of veteran claimants. Yet a fundamental problem remains: Our military is an environment where sexual violence is not only ignored but, too often, accepted. It seems absurd, then, to expect a soldier under these conditions to create a record of an attack so that proof will be available for a claims agent someday. The men and women who have volunteered their lives for us should not be punished because they did not want to report an incident in a hostile environment; nor should they be re-traumatized by a benefits system that epitomizes systemic failure.

Veterans with post-traumatic stress, who were approved for services, can wait months for even their first appointment with a psychologist. Veterans in the New York area are lucky because of the large network of local VA facilities and the excellent social workers and doctors. But it is

[1] Department of Defense Sexual Assault Prevention and Response Office (SAPRO): "Department of Defense Annual Report on Sexual Assault in the Military" (2010), *available at*: http://www.sapr.mil/media/pdf/reports/DoD_Fiscal_Year_2010_Annual_Report_on_Sexual_Assault_in_the_Military.pdf.

difficult to feel lucky if you cannot use those resources. For a servicemember who has been denied disability compensation, the average wait for an appeal of the decision is four and a half years.[2] This past spring the 9th Circuit Court held in *Veterans for Common Sense v. Shinseki* that "the VA's unchecked incompetence has gone on long enough," and ordered an overhaul of the VA. The court declared that "the other political branches have so completely and chronically failed to respect [veterans'] constitutional rights" that the judiciary had to step in.[3] The case is being reheard en banc and will not likely result in the massive changes so desperately needed. Today, a combat veteran, even *with* documentation of trauma, will still wait years for a chance to be heard on appeal. For that veteran, the legal victory remains symbolic—his personal battle goes on.

I first read about this legal fight in 2008. And it t was in the pages of the district court's opinion that I learned the suicide rate of veterans was 18 per day.[4] It woke me up to my civic duty to give back to servicemembers. As an attorney I cannot provide them with the mental health treatment they need. I do not have the expertise that many in this room possess. I can only offer my assistance in fighting for their legal rights to housing and income, and hope that it provides a stable base for them to rebuild their lives. We can all be a part of that recovery, whatever our profession.

As a community, we must serve the veterans who cannot walk into the front door of the Manhattan VA or drop by the clinic on Chapel Street in Brooklyn. That includes veterans with "bad papers"—a dreaded Other than Honorable discharge. It includes veterans who are angry and no longer trust the government that sent them to war. And it includes the many women who do not feel safe or welcome in a system designed for men. These veterans are my clients.

Some are not eligible for VA services, but they must not be ignored. For those who think these veterans are somehow less deserving: Come and tell my client who watched his friend's jaw blow off in Iraq that his substance abuse is "other than honorable." Try to explain to my client,

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[2] *Veterans for Common Sense v. Shinseki*, 644 F.3d 845, 859 (9th Cir. 2011) *reh'g en banc granted*, 08-16728, 2011 WL 5574937 (9th Cir. Nov. 16, 2011) (citing 4.4 years average wait from filing to a BVA decision).

[3] *Ibid, at* 852.

[4] *Veterans for Common Sense v. Peake*, 563 F. Supp. 2d 1049, 1063 (N.D. Cal. 2008) *aff'd in part, rev'd in part and remanded sub nom. Veterans for Common Sense v. Shinseki*, 644 F.3d 845 (9th Cir. 2011).

who went AWOL after being raped by someone in her unit, why she doesn't deserve a HUD-VASH voucher.[5] Listen to her apologize for the tears rolling down her cheeks after you have told her she may be in a shelter with men. Answer the call from a veteran who can't seem to hold down a job and needs a lawyer for housing court. Tell him he must wait four and a half years for compensation when he whispers into the phone that he is a victim of MST.

If those are conversations you do not want to have then support H.R. 930, a bill that will make a change to the disability compensation claims process. And, please, do not stop there. New York City must reach out to *all* veterans. Every day I see the result when servicemembers have been overlooked or shunned by their community. I usually work with them when they have hit a crisis point and, by then, their uphill battle is not always winnable. We must improve the local support services that the VA cannot provide, and ensure access to the services it will not provide to all veterans. We must take care of veterans no matter their discharge type or era of service or mental health status. That is the kind of society we told these individuals they were fighting for. We can make it a reality—by funding community providers and local treatment initiatives for all who served our country. Thank you for the opportunity to speak today.

[5] According to the Housing and Urban Development-Department of Veterans Affairs Supported Housing Program VHA Handbook 1162.05, a veteran is: "For the purpose of HUD-VASH, a person who served in the active military, naval, or air service, and who was discharged or released under conditions other than dishonorable and is eligible for VA health care." *Available at:* http://www.nchv.org/docs/VASH%20Manual.pdf.

Testimony of Commissioner Terrance Holliday, Mayor's Office of Veterans' Affairs before City Council Re: Oversight- Improving Access to Mental Health Services for Veterans.

December 5, 2011

Good Morning Chairman Eugene, Chairman Koppell and members of the Veterans' Committee and the Committee on Mental Health, Mental Retardation, Alcoholism, Drug Abuse and Disability Services. My name is Terrance Holliday, Commissioner, Mayor's Office of Veterans' Affairs (MOVA). With me today is Ms. Ines Adan, Human Services Director at MOVA and previously at the Department of Homeless Services, Trish Marsik, Assistant Commissioner for Mental Health at the Department of Health and Mental Hygiene, and Beth Begier, Assistant Commissioner for the Bureau of Vital Statistics at the Department of Health and Mental Hygiene. I am here today to testify on the issue of Improving Access to Mental Health Services for Veterans.

MOVA was established by Local Law 53 in 1987 and advises the Mayor on issues and initiatives impacting the veterans and military community. MOVA works closely with the U.S. Department of Veterans Affairs (VA), the New York State Division of Veterans' Affairs (NYSDVA), City agencies, veterans' organizations, area military commanders and other stakeholders to assist active service members, veterans, their dependents and survivors. MOVA is one of only a handful of city-level veterans' offices in the United States.

New York City is home to approximately 215,000 veterans involved in conflicts from World War II to present operations in Afghanistan and Iraq. Military members suffering from Post-traumatic Stress Disorder, Traumatic Brain Injury and Military Sexual Assault will require mental health services as they regain their normal lives. Prior to addressing this hearing's

scheduled topic, I want to take the opportunity to provide additional information related to the October 11, 2011 hearing that focused on veteran suicide. The positive news is that, unlike reports from around the country, New York City does not appear to be experiencing an epidemic of suicide among its returning veterans. Perhaps that is attributable to the fact that New York City offers a robust array of readily available mental health services to all of its citizens, including veterans who may access city government services as well as VA services here. In trying to understand the issue of veteran suicide in the City, we consulted with the Chief Medical Examiner and the Bureau of Vital Statistics at the Department of Health and Mental Hygiene. As a means to update what we already have provided the Council, what we found out was that, between 2007 and 2009, citywide, 1% percent of the deaths of the general population were classified as suicide. During that same time period, 0.5% (that is one half of one percent) of deaths among veterans was suicide. The proportion of deaths from suicide for veterans is half that than seen amongst the general population.

In all, citywide, the Bureau of Vital Statistics reports that there were 22,071 veterans who died between 2007 and 2009, with 106 of them dying by suicide. In 2007, 30 veterans died by suicide, while in each of 2008 and 2009, 38 veterans died by suicide. Of these suicides during this time period, there were 3 veteran suicides among those 24 years of age and under; 5 suicides among those between 25 and 34 years of age; 11 suicides among those between 35 and 44 years of age; 19 suicides among those veterans between 45 and 54 years of age; and the remaining 68 suicides were among those veterans who were 54 years of age or older. The largest concentration of all veteran suicides (27%) was among those who were age 75 or older.

MOVA asserts that Federal, State and City government must share the responsibility of ensuring that all veterans are aware of, and have access to, available mental health services. As a constituent services agency, MOVA provides advocacy, referral and short-term case management services in an effort to ensure that veterans – including those who choose not to access VA services, are not aware of their VA entitlements, or are ineligible to receive VA benefits – have access to NYC health, mental health and social services. MOVA continuously strives to improve systems that enhance veterans' knowledge and access to all available City services. MOVA welcomes a partnership with the City Council that will produce a targeted

campaign to veterans that will increase their awareness of the various services and benefits of which they can avail themselves.

The veterans' community is especially unique in that there is a federal agency dedicated to providing benefits and medical services to returning service men and women. VA Vet Centers, hospitals, and clinics are located throughout the five boroughs and are staffed with doctors, and other professionals, specifically trained to treat ailments, such as Post-Traumatic Stress Syndrome ("PTSD") and other health problems associated with military service. Given the specialty of those employed by the VA, these centers are well-equipped with the information and resources necessary to address the specific mental health needs of veterans, while MOVA plays an active role in connecting the New York City veteran community with the VA Medical and Vet centers. Of course, one challenge veteran organizations face is that many veterans do not always utilize the VA services or seek the benefits to which they are entitled. Understanding the conflict between the potential under-utilization of the VA system and the realization that the VA is best suited to treat veteran mental health issues, the Mayor's Office of Veterans' Affairs has established a referral system that assesses benefit eligibility and matches the veteran constituent with the VA and NYC service that best suits the veteran's individual needs. We do this by establishing a veteran's immediate service needs, military discharge status, and willingness to access VA services to determine whether VA, NYC, or a combination of referral sources would best resolve a veteran's issue. As previously stated, many veterans have misconceptions of their own veteran status and the services the VA provides to eligible veterans. MOVA proactively aims to educate veterans by providing VA information at every MOVA-sponsored event and hosting various Mental Health events throughout the year; sharing VA and mental health related info through our website, facebook page, twitter. MOVA further seeks to connect veterans to VA benefits by providing linkages to partners who can assist veterans to craft military discharge upgrade dispute.

MOVA has also implemented the following preventive and educational initiatives as they relate to the mental health care needs of New York City veterans:

- MOVA partnered with CUNY and launched, in June 2011, its first Mental and Medical Healthcare Professionals Development Forum. The first forum took place on June 24th at Borough of Manhattan Community College and covered the topics of Post Traumatic Syndrome and Military Sexual Trauma. The forum enabled medical and mental healthcare professionals to hear professionals from the US Department of Veterans' Affairs discuss these important topics. The forum was attended by 62 participants from several organizations, including the Kings & Queens County Veterans courts and was followed by an in depth Q&A. The next forum will be held by MOVA at Veterans' Memorial Hall on December 16th and continue the discussion of Post Traumatic Stress.

- To address the specific issues of female service members and veterans, MOVA has initiated a Women's Action Group (WAG). WAG participants have been selected by MOVA based upon a pre-established relationship with MOVA, interaction and access to veterans and military community. WAG is charged with identifying the needs of women veterans on Federal, State and Local levels, and influence policy; service gaps, and innovative outreach methods that engage women to access available resources. WAG is entrusted with identifying crucial issues and solutions that impact civilian readjustment. Meetings will convene quarterly. The kick-off meeting is tentatively scheduled for mid January 2012. Meeting frequency and topics will be determined by group members.

- In the summer of 2012, MOVA will host its first "Healthy Veteran Heroes Fair." The fair will provide educational material, resources and basic health screening services, such as blood pressure, and glaucoma testing.

- MOVA regularly attends Pre-Deployment/Reintegration Family Readiness Conferences where the Commissioner or staff, speaks to the service members about MOVA and City services available to veterans.

These initiatives will afford MOVA the opportunity to disseminate City agency information to veteran service providers and individual veterans.

MOVA continues to assist veterans who need access to mental and medical healthcare services by providing information and referral services to providers such as the US Department of Veterans Affairs, New York City Department of Health and Mental Hygiene, The Rosen Family Wellness Center for Law Enforcement, Military Personnel and Their Families, and LIFENET to ensure that needed services are provided.

Additionally, if a veteran is ineligible for VA services, MOVA will make the necessary referrals to other City agencies, such as the Health and Hospitals Corporation (HHC) that provide assistance to all New York City inhabitants regardless of veteran status. MOVA is also a participant in the Veterans Mental Health Coalition of NYC which promotes mental health and well-being to New York City veterans, service members and their families through education, information, and collaboration of an array of mental health services.

Similarly, while the VA has the resources and the expertise to best serve veterans with mental health issues, the City's public hospital system will also treat individuals who walk through their doors regardless of veteran and health insurance status. If a veteran walks into an HHC facility and asks for mental health care, they will not be turned away even if they are a veteran and the VA can provide them with medical assistance. Likewise, the mental health care provider treating the veteran may make a referral or ask for assistance from the VA if the need arises. While the City understands the federal government's role in providing our nation's veterans with the appropriate mental health care, the City takes a proactive approach through the services HHC provides to ensure that any veteran or member of the military who seeks mental health care receives the treatment to which they are entitled.

As experience has shown, the connection between a veteran's service and his or her mental health, Post Traumatic Stress Disorder (PTSD) and/or Military Sexual Trauma (MST) may surface immediately upon discharge or many years after service. Therefore, the City monitors on a regular basis federal legislation and VA rulemaking proceedings for legislative or administrative changes in how the VA administers mental health programs and, when appropriate, submits comments and testimony accordingly.

LIFENET is the 24 hours per day/7 days per week, free, confidential help line for New York City residents experiencing a crisis. The hotline, staffed with trained mental health professionals, helps callers find mental health and substance abuse services and has authorized linkages with City Hospitals and partners' 23 mobile crisis teams and Emergency Medical Services (EMS).

MOVA will continue making efforts to ensure that self identifying veterans and those whose military service is ascertained through the intake process receive needed City services and other government referrals.

Finally, any caller that contacts NYC's 311 is referred to the appropriate agency that is responsible for responding to the specific service requested. This includes veterans who contact 311 and convey that they pose immediate danger to themselves. They are directed or transferred immediately to 911. Veterans who request non-life threatening benefits, health and mental health services assistance are referred to LIFENET, NYC Health and Hospital Corps, and MOVA. Any other needs of veterans identified to 311 are referred to MOVA.

Thank you for the opportunity to testify. At this time I will be happy to take any of your questions.

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To the members of the NYC Council on Veterans and the members of the Council on Mental Health: good morning and thank-you for the opportunity to testify in support of Resolution 958, urging the US Congress to pass & the president to sign H.R. 930. My name is Dr. Melissa J. Earle. I am a Licensed Clinical Social Worker in both New York and California. I currently serve as the Director of Professional Social Work Development and Online Learning at Touro College's Graduate School of Social Work. In addition to my current role in academia, I have 25 years of experience as a provider of treatment services for survivors of traumatic events both as a clinician and as an administrator. In 2003, in addition my work as a clinician, I wrote and facilitated a series of trainings about trauma for the Administration for Children's Services through a joint Project Liberty & Annie E. Casey grant. In 2005, I won a SAMHSA award as a program director for excellence in mental health and substance abuse treatment programming. I hold a Ph.D. from CUNY's graduate center and wrote my dissertation on the impact of trauma. As a seasoned treatment provider of post-traumatic response, I urge all of you to pass Resolution 958: it not only paves the way for a greater number of veterans to receive treatment and services for Military Sexual Trauma, but passage of this resolution will serve as an important first step in the treatment and healing of service-connected rape, sexual assault and sexual harassment.

The emotional aftermath of traumatic events is well established. In addition to the trauma-specific diagnoses of Post-Traumatic Stress Disorder and Acute Stress Disorder, trauma survivors can also experience diagnostic depression, anxiety, and panic disorders. There is an established co-morbidity of alcohol and substance abuse with post-traumatic response. For women, the prevalence of these co-existing conditions is extremely high. In community and clinical samples, 90% of women with a substance use disorder also report exposure to trauma. In a recent study of over 125,000 veterans receiving treatment at a VA primary care or mental health facility, researchers found that 15% of the women in the study group reported Military Sexual Trauma (MST) when screened. In addition to acknowledging MST, within this group of female veterans, 56.2% were diagnosed with a Depressive disorder; 51.1% were diagnosed with Post-Traumatic Stress Disorder (PTSD), 29.1% were found to have an Anxiety disorder; 13.9% had a co-occurring Alcohol and Substance use disorder and 20.6% of these veterans were

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diagnosed some form of Adjustment disorder. While the nature and the impact of traumatic events can be severe and painful, the "good news" about trauma is people can and do heal from their experiences. Unlike chronic mental illnesses such as Schizophrenia and Bi-polar disorder, with attention, time, and treatment, a victim of trauma, including sexual assault, can move to surviving and ultimately thriving following a traumatic event. Our response to traumatic events lies at the end of a continuum of responses to stress- post-traumatic symptoms signal that our ability to manage the stress of traumatic events has been overwhelmed. Drawing from this model, and putting it very simply, since we all have the capacity to recover and re-establish our equilibrium when stressed, we all have the capacity to ultimately recover from traumatic events. Severe post-traumatic responses that go unrecognized and untreated can become permanent as the survivor's emotional adaptive strategies for coping with trauma generalize to a way of coping with life and become an integral part of one's personality, repertoire of psychological defense, or overall character. I want to emphasize the obvious clinical and ethical considerations in providing veterans who were raped or sexually assaulted while overseas with trauma-informed care, however, I also want to point out it is also fiscally prudent to consider Resolution 958 in the light of these current economic times: it simply makes sense to provide veterans who survived MST with the opportunity to heal at centers that are trauma and military informed so that they can move on with their lives as a opposed to running an elevated risk of staying stuck in a loop of post-traumatic response and treatment providers at the expense of local, state and federal governments.

From the induction of Post-Traumatic Stress Disorder into the Diagnostic and Statistical Manual of Mental Disorders in 1980 through to the present, there are a number of models and treatment strategies focused on facilitating a trauma survivor's recovery from traumatic events. From Cognitive-Behavioral Therapy, to "Seeking Safety's "model for treating women who have co-existing post-traumatic response and an alcohol or substance use disorder to the practice of Yoga, all treatment interventions start from the same place (and this is where the passage of Resolution 958 becomes a clinical intervention): for a trauma victim to heal, someone must "bear witness" to their pain. Yael Danieli first coined the concept of bearing witness as an essential starting place in a survivor's recovery from a traumatic event in the mid-1980's as a result of her

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work with Holocaust survivors and their children. Bearing witness as an intervention is exactly as it sounds: the treatment practitioner, family, and hopefully the social systems that surround the survivor, should be present, listen to (bear witness), and respond as appropriate to the survivor's recount of the traumatic events endured. By providing the space for and recognition of these events, it allows the survivor to externalize and begin to cope with the idea that the unimaginable happened, that he or she is supported in their survival and is believed not to have caused or "deserved" the abuse. By supporting the proposal to "amend title 3 to improve the disability compensation evaluation procedure of the Secretary of Veterans Affairs for veterans with post-traumatic stress disorder or mental health conditions related to military sexual trauma, and for other purposes" you are bearing witness to and for these veterans by initiating an important first step in their healing.

I would like to close with some thoughts about the nature of courage and being a true warrior. Ambrose Redmoon, in an impassioned rebuke of popular culture's adaptation of the re-definition of a warrior, wrote "The warrior is not an agent of war or aggression but of peace. A warrior knows the carnage and destruction of war and has accepted that it is his role to protect the rest of us from these horrors by walking the roads that he does. The warrior goes to war so that the rest of us may know peace. The warrior protects the innocent, weak and vulnerable; the home; the sovereignty of the individual; the Mother. These are the four sacred ways of the warrior: to protect in spite of danger, fear, difficulty, and pain". Redmoon defined a warrior's courage as "courage is not the absence of fear, but the judgment that something else is more important than one's fear. The timid presume that it is a lack of fear that allows the brave to act when the timid do not… To take action regardless of fear is brave. Courage, of course, is not restricted to the warrior; anyone can be brave". So, this morning I ask the City Council Committees on Veteran's Affairs and Mental Health along with everyone in this room, as part of our appreciation of our veterans' (our warriors) service to our country, to be brave, bear witness and pass Resolution 958 so that all of our veterans can receive the help and support that they need to feel truly welcomed home. Thank-you.

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NY City Council Hearing on Veterans' Access to Mental Health Care
Eva J. Usadi, MA, BCD, Founder and Director of Trauma and Resiliency Resources, Inc.
Dec. 5, 2011

Hello. My name is Eva Usadi and I am a psychotherapist in private practice in Manhattan. I specialize in trauma and have been working with warriors for a long time – active duty military and veterans, and first responders, fire and police, and family members, since 9/11. I am also the Founder and Director of a 501c3 public charity called Trauma and Resiliency Resources, Inc. TRR has two active programs: Horses' Hooves and Warriors' Hearts, which is an outpatient equine assisted psychotherapy program, and, Warrior Camp, which is a 7-day intensive residential treatment program – our pilot Camp is scheduled for Feb. 2012.

Like many programs working with veterans we are underfunded. Even with Tricare fees we will still be operating at a deficit. The question is – why is this? Our nations' warriors are among the MOST deserving of services, and yet they tend to be underserved, both while in uniform and after discharge or retirement.

National figures are that only 37% of veterans register with the Veterans Administration upon discharge. And of those who do enroll for mental health treatment there are not enough counselors or programs to meet this growing need. In a report prepared by the San Francisco VA and the University of California, San Francisco, it was noted that, "it takes more than a year for symptoms to appear and diagnosis to be made" and the study further showed that "most mental health diagnoses were not made in the first year that a veteran entered the VA health-care system, but several years after..." It is understood by many veteran groups that this is one of the reasons veterans tend to drop out of treatment.

This is the heart of the problem – it is not correct that it takes more than a year for symptoms to appear or to properly diagnose a patient. When I was at Ft. Drum in 2007-8 I saw between 30-40 clients a week for 7 months – all of the soldiers, and many of their family members, especially the children, met criteria for PTSD.

There is one basic reason that this diagnosis is so often missed – which is that the criteria as it currently stands in the DSM IV is inadequate and efforts to include what some of us refer to as Complex PTSD symptoms are so far, unsuccessful. Complex PTSD encompasses trauma of extended duration, repeated traumatic incidents, and those inflicted interpersonally – in this regard combat veterans have more in common with survivors of sexual and physical abuse and torture, than they do with survivors of single event traumas, like car accidents. However, the most significant difference with combat trauma involves the act of killing another human being – a guilt that must be addressed for a veteran to be able to be part of family and community again.

The second is that the DoD and the VA, like many agencies, are still separating PTSD, depression and anxiety symptoms when in fact we know that depression and anxiety are often part of PTSD symptomatology[1]. If we include figures on depression and anxiety the number of troops with PTSD will be much higher. And if we factor in the veterans who are so numb that they do not experience intrusive thoughts, and therefore do not meet PTSD criteria, the numbers will be higher still.

Some thoughts on what is necessary to enable more veterans to access services and to get what they need once they do, are:

1. Training of clinicians in trauma symptomatology so as to increase uniformity of service and timely diagnosis and treatment;
2. Discussion of the most effective evidence-based treatment modalities with this population;
3. Outreach to the veteran community that expands types of services available, including community-based programs, such as ours;
4. Funding for innovative program

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[1] SFVA/ UCSF/ study collected data on 289,328 Iraq and Afghanistan veterans who sought health care at VA medical centers from 2002 to 2008. Of these 106,726 were given mental health care which included 62,929 diagnosed with PTSD and 50,432 diagnosed with depression.

VETERANS MENTAL HEALTH ACTION COMMITTEE OF NEW YORK CITY

Oversight Hearing: Improving Access to Mental Health Services for Veterans

The Committee on Mental Health, Mental Retardation,
Alcoholism, Drug Abuse and Disability Services
Hon. Oliver Koppell, Chair
&
The Committee on Veterans
Hon. Mathieu Eugene, Chair

Testimony by Kimberly Williams

December 5, 2011

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Dedicated To Improving Mental Health Policy

Chairman Koppell, Chairman Eugene, and members of the Committees, thank you for organizing this important hearing on improving access to mental health services for veterans and for the opportunity to testify. My name is Kimberly Williams, and I am the Director of the Center for Policy, Advocacy, and Education at the Mental Health Association of New York City (MHA-NYC). In 2009, MHA-NYC and NAMI-NYC Metro cofounded the Veterans Mental Health Coalition of New York City to promote the mental health and well-being of service members, veterans, and their families through education, information sharing, collaboration, and promotion of a comprehensive array of services. The Coalition has over 450 members representing a diverse cross section of veterans' service and advocacy organizations; behavioral health, health, and social services providers; and local, state, and federal government officials including representatives from the Mayor's Office of Veterans Affairs and the NYC Department of Health and Mental Hygiene. DOHMH is also providing financial support to the Coalition, for which we are grateful. The Coalition's policy and advocacy subcommittee, the Veterans' Action Committee of NYC, is on whose behalf I am speaking today.

At the City Council's hearing two months ago, we spoke of the great need to address the mental health and chemical dependence problems of returning service members, veterans, and their families, a need that will only increase over the next few months as more veterans return from Iraq and Afghanistan. We also noted that while the VA continues to face significant challenges in meeting these needs, they have made noteworthy strides in improving mental health treatment options. This includes the recent modification in guidelines for assessing PTSD benefits, which states that veterans suffering from PTSD no longer need to prove that the disorder was caused by a traumatic event they experienced in combat. This policy change has resulted in countless more veterans getting the much needed benefits that they deserve.

However, veterans who suffer from service-related PTSD due to military sexual trauma (MST) continue to be denied their disability benefits because the trauma they experienced does not easily lend itself to documentation. Many victims have a difficult time presenting records confirming the traumatic event for reasons such as insufficient record keeping by DOD and underreporting due to fear of retaliation. The VA's current regulations discriminate by mandating a higher standard of evidence for veterans whose PTSD claims arise from MST than for veterans whose PTSD claims arise from combat. All veterans who suffer the devastating impact of MST deserve to receive the benefits to which they are entitled.

Thus, we strongly support the City Council's Res. No 958 urging the United States Congress to pass and the President to sign HR 930, a bill to amend Title 38 of the US Code to improve disability compensation of the Secretary of Veterans Affairs for veterans with PTSD or mental health conditions related to military sexual trauma.

Even with this vital proposed policy change within the VA system, we must not forget that only a small portion of the behavioral health needs of veterans will, or can be, met by the Federal VA. Nationally, less than 30% of veterans use the Federal VA for health or mental health care. More would if the VA had more resources and thereby provided greater access, but many veterans prefer to return fully to civilian life and turn to local providers when they need services. States and localities have a responsibility to improve access to, and quality of, local community based services.

That is why we are calling on the New York City Council to fund a Veterans Mental Health Initiative to provide greater access to critically needed support services and to enhance the capabilities of non-VA providers. Because we understand the current fiscal constraints, we are proposing a modest initiative and asking for just $500,000 to implement it. With nearly

207,000 veterans in New York City, that's less than $2.50 per veteran. Surely a city that will find millions of dollars that are needed for education, health, and social services can find $2.50 for each of the veterans who have served their country so selflessly and often at great personal cost.

The proposed Initiative could include outreach strategies for veterans and their families to identify and engage veterans at high risk of suicide and/or in need of behavioral health services through non-traditional referral sources and military culture competency training for providers so they can have an understanding about the soldier's way of life as well as their experiences, challenges, and terminology. An outline of our proposal is attached to the testimony.

We hope you will champion New York City's brave veterans and their families by funding a Veterans Mental Health Initiative.

Thank you for the opportunity to speak today.

THE VETERANS' MENTAL HEALTH ACTION COMMITTEE OF NEW YORK CITY

New York City Council Veterans Mental Health Initiative

Service members returning from the wars in Iraq and Afghanistan suffer from tragically high rates of behavioral health disorders and suicide. According to a recent RAND Corporation report, more than half of NYS returning veterans have either a current probable mental health diagnosis (22%) or a self-indicated need for treatment (34%). Moreover, they are twice as likely to take their own lives. Despite the fact that over half of NYS veterans have a mental health need, only 1/3 in need seek help. While some veterans turn to the Veterans Administration (VA), nationally, fewer than 30% of veterans utilize the VA care system. Veterans are more likely to turn non-VA providers, if they seek care at all. To overcome this vastly unmet need, The Veterans Mental Health Action Committee of New York City requests the NYC Council to fund a Veterans Mental Health Initiative.

Intent: The purpose of the Veterans Mental Health Initiative is to confront the high rates of suicide and behavioral health problems among returning veterans by expanding supports, outreach efforts, and enhancing the capabilities of providers and other key stakeholders to effectively meet the needs of veterans.

Project Examples: The initiative should include, but not necessarily be limited to, the following project examples:

- **Military cultural competency training**: Provide education that facilitates an understanding of the military as its own sub-culture and the unique behavioral health needs of veterans. The training will provide the tools needed to help veterans and their families successfully cope with reintegration. With this knowledge all those who come in contact with veterans in distress will understand the risk factors associated with military service and reintegration which can lead to suicidal ideation and behavior as well as mental health problems and increase their capacity to respond appropriately and effectively. Targets for training include New York City Police Department, emergency room personnel, mobile crisis teams, Administration for Children Services, and housing providers.

- **Outreach to veterans and their families**: Expand outreach strategies to identify and engage veterans at high risk of suicide and/or in need of behavioral health services through non-traditional referral sources including Department of Motor Vehicles, bars, and barber shops.

Training and outreach efforts should be targeted to communities in NYC with the highest numbers of veterans.

Eligibility: Funding through this initiative should be open to community-based programs with expertise regarding veterans' behavioral health.

Request: $500,000

The Veterans' Mental Health Action Committee of New York City
50 Broadway, 19th Floor, New York, New York 10004
(212) 614-5753 • center@mhaofnyc.org
http://www.mha-nyc.org/vmhcactioncommittee.aspx

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Name: Trish Marsik
Address: Assistant Commissioner, Mental Health, DOHMH
I represent: ________
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I represent: Trauma and Resiliency Resources, Inc

Address: Same

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Name: Coco Culhane

Address: 123 William St.

I represent: Urban Justice Center

Address: 123 William NY NY

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Name: Kim Williams

Address:

I represent: Veterans Mental Health Action Committee

Address: 50 Broadway, 10004

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I represent: ______
Address: Gotham Center, Long Island City, NY

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Name: Melissa Earle
Address: 200 east 64th st, Apt A1502, NYC 10065
I represent: Touro College School of Social Work
Address: 43 West 23rd st, 8th floor, NYC 10010

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