HONORING THE COMMITMENT: OVERCOMING BARRIERS TO QUALITY MENTAL HEALTH CARE FOR VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
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HONORING THE COMMITMENT: OVERCOMING BARRIERS TO QUALITY MENTAL HEALTH CARE FOR VETERANS

Wednesday, February 13, 2013

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

The Committee met, pursuant to notice, at 10:04 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [Chairman of the Committee] presiding.

Present: Representatives Miller, Bilirakis, Flores, Denham, Runyan, Benishek, Huelskamp, Amodei, Coffman, Michaud, Takano, Brownley, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, and Walz.

OPENING STATEMENT OF CHAIRMAN MILLER

The CHAIRMAN. The Committee will come to order. We are awaiting some of our witnesses that were caught up in traffic this morning, and also in security outside of the building. They will be here momentarily. Before we begin our hearing this morning, I would like to recognize Mr. Takano to talk about the impact of recent events in California last night. Mr. Takano?

Mr. TAKANO. Thank you, Mr. Chairman. My district, the 41st District, is based in Riverside County, and the largest city within my district is the City of Riverside. And I would like to offer a moment of silence for Officer Michael Crain of the Riverside Police Department, who was shot and killed last Thursday by former LAPD Officer Christopher Dorner; and for the other, three other victims of Dorner's violence.

Prior to his service with the Riverside Police Department, Officer Crain served in the United States Marine Corps, and was deployed for two tours in Kuwait as a rifleman. He was awarded multiple honors for his bravery. So I would ask the Committee to take a moment of silence to honor the memory of Officer Crain, and the three other victims, three others whose lives were needlessly taken, and their families.

The CHAIRMAN. Without objection, the Committee will pause for a moment of silence.

[Moment of silence]

The CHAIRMAN. Thank you, Mr. Takano. Our thoughts and prayers are with you and your constituents, and their families.

Mr. TAKANO. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you very much. Thank you, everybody, for joining us this morning for the first Full Committee hearing of the 113th Congress, Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans.

It is only fitting that we would start with this hearing today, as we begin our oversight by addressing what I think is one of the most pressing and fundamental issues facing our servicemembers, veterans, and their families. That is, the ability to provide timely and effective mental health care to veterans who need it, when they need it. This issue is not a new one, but I think everybody will agree that it is a growing.

In the last six years there has been a 39 percent increase in VA's mental health care budget, and a 41 percent increase in VA's mental health care staff. Unfortunately these significant increases have not resulted in equally significant performance and outcomes. Less than a year ago the VA Inspector General released a review of veterans mental health care access that painted a disturbing picture, showing that the majority of veterans who seek mental health care through VA wait 50 days on average for an evaluation. That figure amounts to thousands of veterans in need. Veterans who have recognized that they need help, and who have taken the hard step of asking for that help, being told by the Federal bureaucracy tasked with caring for them that they must wait in line because VA cannot provide them with the timely access to the care that they need to begin their healing process. And it only gets worse.

Earlier this month, VA released its 2012 Suicide Data Report. The report shows, among many alarming findings that the suicide rate among our veterans has remained steady for the past 12 years, with 18 to 22 veteran deaths per day since 1999. As that report so clearly illustrates, when a veteran is in need of care, the difference of a day or a week or a month can be the difference between life and death.

This morning the department is going to testify that progress is being made to increase access to mental health care services and reduce veteran suicide. I think they are going to proclaim that they have hired just over 3,200 additional mental health care personnel. However, despite our request, VA has yet to provide evidence to verify its efforts.

While I am and will remain supportive of the improvements that the department is attempting to make, it has become painfully clear to me that VA is focused more on its process and not on its outcomes. The true measure of success with respect to mental health care is not how many people have been hired, but how many people have been helped.

Since 1999 their mental health care programs, their budget, and staff have increased exponentially and the number of veterans seeking care has grown. Yet the number of veterans tragically taking their own lives is still the same. What is more, the Suicide Data Report that I mentioned earlier shows that the demographic characteristics of veterans who die by suicide is similar among those veterans who access VA care and those veterans who do not access VA care. Something somewhere is clearly missing.

Now on our first panel this morning we will hear from representatives from our veterans service organizations, an established veterans mental health researcher, and a state commissioner of veterans affairs. Three of them are veterans themselves, and all of them will testify that the provisions of mental health care services

through VA is seriously challenged and that what is needed to fix is decidedly not more of the very same thing.

Last night the President announced that a year from now 34,000 of our servicemembers currently serving in Afghanistan are going to be back home. The one-size-fits-all path that the department is on, leaves our returning veterans with no assurance that current issues will abate and fails to recognize that adequately addressing the mental health needs of our veterans is a task that VA cannot handle by themselves.

In order to be effective, VA must embrace an integrated care delivery model that does not wait for veterans to come to them, but instead meets them where they are. VA must stand ready to treat our veterans where and how our veterans want to be treated, not just where and how VA wants to treat them. I can tell you this morning that our veterans are in towns and cities and communities all across this great land, and the care that they want is care that recognizes and respects their own unique circumstances, their preferences, and their hopes. I earnestly appreciate all of you being here today and I yield to our Ranking Member Mr. Michaud for his opening statement.

[THE PREPARED STATEMENT OF CHAIRMAN MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF HON. MICHAUD

Mr. MICHAUD. Thank you very much, Mr. Chairman, for continuing to keep the issue of access, quality, and timely mental health services provided to our veterans at the forefront of this Committee. And thank you to all of our witnesses today for coming and talking with us about the critical issues of veterans mental health access. I would also like to thank all of you in the audience who are here today for your continued support for our veterans population.

We as a Nation have a responsibility, a sacred trust to care for those whom we send into harm's way. When we send our citizens into battle around the world, we must be leading the charge here at home, within our government, to make them whole again upon their return by ensuring that adequate resources and proper programs are in place to address their needs.

Oversight of the VA's mental health programs have been a focus of this Committee for some time now. Over the years we have held numerous hearings, increased funding, and passed legislation in an effort to address the challenges of our veterans from all eras. VA spent $6.2 billion on mental health programs in fiscal year 2012. I hope to see some positive progress that this funding has been applied to the goals and outcomes for which it was intended and the programs are really working. We all know that mental health is a significant problem that the Nation is facing now, not only in the VA, but throughout our population. And the broader challenge is an opportunity for the VA to look outside of their walls to solve some of the challenges that they face rather than operate in a vacuum as they sometimes have done in the past.

One of the most pressing mental health problems we face is the issue of suicide and how to best prevent it. Fiscal year 2012 trag-

ically saw an increase in military suicides for the third time in four years. The number of suicides surpassed the number of combat deaths. Couple that with the number of suicides in the veteran population of 18 to 22 per day and the picture becomes even more alarming.

I believe VA is heading in the right direction. I believe that they have made a true effort to get a true picture of the suicide issue that surrounds veterans. But I believe a lot more can and must be done. I will be interested to hear from our panelists about the national mental health picture and helping this Committee put the veterans suicide rate in context, as well as what is happening nationally in treating mental illness.

Today's hearing will examine the progress VA has made in a variety of areas concerning mental health and providing timely access and quality care. I'm hopeful that this will be a good discussion on ways to provide the care, such as more partnering with the public and private sector, increasing the pool of providers, and other creative ways to address mental health issues.

And finally, I would be remiss if I did not acknowledge the dedication of the VA employees for providing quality mental health care to our veterans everyday. The directors, nurses, doctors, hospital workers are a team. And I want to thank them for all what they are doing. But we have to do a lot more. As you heard the Chairman talk about the President's speech last night, about our soldiers who are going to be coming back from Afghanistan. I do not know how many of those soldiers are going to be Guard and Reservists that will be going back to rural areas. Access and quality and the timeliness of care that our veterans will need to address these mental health issues should be readily available. And we definitely do have to think outside the box to make sure that they do get the help that they need when they need it.

So with that, Mr. Chairman, once again I want to thank you for your dedication, your commitment, and your willingness to keep this issue before the Full Committee so we can make sure that our veterans get the help when they need it. Thank you, and I yield back.

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

The CHAIRMAN. Thank you very much to the Ranking Member. If I could invite the first panel to the witness table. And as you are making your way forward, I would like to introduce the witnesses to the Members of the Committee. First, Dr. David Rudd, Dean of the College of Social and Behavioral Sciences, and Co-Founder and Scientific Director of the National Center for Veterans Studies at the University of Utah. We also have Dr. Linda Schwartz, Commissioner of the Connecticut Department of Veterans' Affairs. Dr. Schwartz is a Vietnam Veteran having served on active duty as a Reservist for the United States Air Force. Dr. Schwartz, thank you for your service. They are joined by Joy Ilem, the Deputy Director of Legislative Affairs for the Department of Disabled Veterans of America. Ralph Ibson, the National Policy Director for the Wounded Warrior Project. Ms. Ilem and Mr. Ibson are both veterans of the United States Army. Thank you both for your service.

I want to again say thank you to all of our witnesses for agreeing to appear this morning. This Committee is uniquely interested in what is going on. I would say that there are numerous members that are doubled up right now in an Armed Services Committee hearing as well that deals with the continuing resolution and sequestration. So their absence here does not affect the fact that they are very interested in this issue and they will be coming in and out as the hearing progresses. So with that, Dr. Rudd, please proceed with your testimony, sir.

STATEMENTS OF M. DAVID RUDD, PH.D. ABPP, DEAN, COLLEGE OF SOCIAL AND BEHAVIORAL SCIENCES, CO–FOUNDER AND SCIENTIFIC DIRECTOR, NATIONAL CENTER FOR VETERAN STUDIES, UNIVERSITY OF UTAH; LINDA SPOONSTER SCHWARTZ, RN, DR.PH, FAAN, COMMISSIONER OF VETERANS' AFFAIRS, STATE OF CONNECTICUT; JOY J. ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND RALPH IBSON, NATIONAL POLICY DIRECTOR, WOUNDED WARRIOR PROJECT

STATEMENT OF M. DAVID RUDD

Mr. RUDD. Mr. Chairman, Mr. Ranking Member, Members of the Committee, I want to thank you for the opportunity to speak with you here today. You have my written testimony. I'm not going to read that testimony other than just comment and emphasize a number of points that are embedded within the testimony.

If we look at this problem over the course of the past decade, I think it is critical that we put it in context, that we understand it in context. And I think a starting point for understanding the trajectory of this problem over the course of the last ten to 11 years is to recognize that prior to Iraq and Afghanistan, service in the military was a protective variable to suicide. That the suicide rates for young men and women of comparable ages were about half that of the general population. So prior to these wars things were different. Things have changed. There are many of us that would speculate about what that is. I would tell you it probably is related to pre-enlistment screening, how we handle screening. It's probably related to issues of unit cohesion. That ten to 11 years of war impact and affect unit cohesion in very profound ways. I have talked with many soldiers and service people about that very issue. The influence of purpose that ten to 11 years of war affects your sense of purpose, and ultimately the sense of warrior identity that we find in soldiers today which is profound and I will talk with you a little bit more about later.

As a starting point, also let me applaud the transparency and the thoroughness of the VA Suicide Data Report. Dr. Kemp is with us and I would tell you that the effort is genuinely historic. This is something that we should have done decades ago to fully understand, be able to track, and monitor the problem. We have to have a system in place to genuinely understand the problem. This is a first effort to genuinely understand the nature of the problem, have accurate data that can actually inform policy and inform decisions. I think it is simply an exceptional move on the part of the VA and I am very glad to see that.

Now when I say that, I think it is critical that we put these rates in context. When you look over the course of the last 12 years specifically, that if we look at the death rates by suicide for veterans, if you look at those death rates of VHA service users, those rates are triple the rates for the general population. They are double for the male population. And although that comparison is a little bit clouded given the nature of the two populations, if you look at the age specific data for the VA, I think it is important to understand that the 18 to 34 year age group, that the rates are double that of comparable young males in the general population. That that risk endures. And I would suggest that in very specific ways that it is probably linked to active duty risk over the course of the last ten to 11 years. And it is a significant problem that we need to think about. Starting to conceptualize this as a continuum from active duty risk, to transition to veteran status and the endurance of that risk for the first decade to decade and a half of veteran status is an important thing for us to look at.

As a result of the persistence of risk over the course of the last ten to 12 years, and the better the data we have, it seems more clear that the risk endures, I would very much agree with you, Mr. Chairman. It is time for us not to do the same thing. That more of the same simply is not working. That when these rates endure at the high levels that they are, that funding more of the same is not the route to go.

A couple of other points I would like to make about the report. I think it is a significant move in terms of establishing, maintaining, and monitoring the crisis line. I find that a wonderful addition. I would encourage you, though, that we may not be reaching the right population. That the drop from 40 percent to 30 percent of the callers in terms of individuals that identify themselves as suicidal may mean we are not reaching the right group. We have got to think about different ways of reaching those individuals.

And finally, I want to share briefly with you a story that I think is probably symptomatic of the problem. I have included it in my testimony. I am not sure that this is a clinical problem. I think it is a management, I think it is a systemic problem in terms of how we handle individuals that are at risk. And I have included in my testimony the tragic suicide of Russell Shirley. I spoke with Russell's mother over the course of the last month. I have spoken with one of his dear friends. And I think Russell is probably typical of the problem, the tragic problem which will occur over the coming years.

Russell was a son, a husband, a father. He was a soldier. He served his country proudly and bravely in Afghanistan. He survived combat. He came home struggling with PTSD and Traumatic Brain Injury. With a marriage in crisis and escalating symptoms he turned to alcohol. He received a DUI. And after ten years of dedicated service he was discharged. And part of the rationale for the discharge was the increasing pressure to reduce the size of the force. I think we are going to see more and more of that over the coming years. After the loss of his family, the loss of his career, and the loss of his identify, Russell shot himself in front of his mother.

Having spoken with Russell I would tell you, or having spoken with Russell's mother, I would tell you that a part of the tragedy

is, we knew that Russell was at risk prior to his death. We recognized, identified him as an at risk soldier prior to his discharge. But yet there are not adequate transitional services in place that allow a clean connection from an individual to an individual. And I think those are the sorts of things that we need to start talking about, we need to start thinking about. How do we connect at risk soldiers, once we identify them and they are being discharged, particularly if they are being discharged against their wishes, into the VA system? And how do we connect them with an individual and not just a system? How do we help them connect in a relationship that can potentially save a life?

I have included a picture of Russell with his two children at the end of my testimony and the reason I've done that is, I think it is important for all of us, when I read the Suicide Data Report, the one thing that is missing in this Suicide Data Report are the names of the individuals, the names of the families, the names of the loved ones that are affected and impacted by these tragic deaths. And I think it is important for all of us to remember that.

Thank you very much.

[THE PREPARED STATEMENT OF M. DAVID RUDD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you. Dr. Schwartz?

STATEMENT OF LINDA SPOONSTER SCHWARTZ

Ms. SCHWARTZ. Good morning, Mr. Chairman, and good morning, Congressman Michaud. I'm Linda Schwartz. I'm the Commissioner of Veterans' Affairs for the State of Connecticut. As the Commissioner, I've been the Commissioner for ten years, I am serving my third governor, I am responsible for 277,000 veterans in our state. I have a 75-bed substance abuse treatment recovery program. I have a chronic disease hospital. I have the second largest domicile in America which has today 380 veterans in resident. I have three cemeteries and five district offices.

I am here to kind of echo what was said by Dr. Rudd. Because let me just say this, when you talk about the suicide let us be clear. Let us be clear that no death index is going to have accurate information. In my experience, we were looking at suicides because it was a very important thing. Because I started, because I have three cemeteries, I look and see what are the causes of death? And many of these deaths are not declared suicide out of respect for the religions beliefs of the individual, for the family, or because no one wants to make that call.

The reason it is so shocking is because it is secret. And many of the things that are going on with our Reserves and our Guard are not talked about openly. So I applaud the VA for at least making an attempt to quantify.

But I also would like to move to the State of Connecticut, where for the past 25 years our Department of Mental Health and Addiction Services has been asking, "Have you ever served in the military?" They have been asking, "Are you a veteran?"

Interestingly, we did not quantify this until the late nineties. I was a public health nurse at the time so I was checking off those boxes. We had 5,000 veterans on the rolls of our State Department

of Mental Health and Addiction Services. And even though we have had the opening of community-based outpatient clinics, and Vet Centers in the State of Connecticut, those numbers have not changed significantly. We still have about 5,000 veterans receiving their care from the state. I have referred to the reasons why, most of it, in my testimony. But the proximity, access to care is a lot more than being eligible for your VA benefits. It means that if your closest VA hospital is 65 miles away, and you are having a crisis, you want somebody in your community. You want somebody who is going to listen. Additionally, VA provides wonderful services, but you do not have access to your care provider 24/7 like somebody in private practice.

My masters is in psychiatric nursing, so I have had the experience of working with mental health patients. But I would just like to say that I am just going to skip, the President's message night, that we are going to have all of these people coming down, he mentioned a very important part. Some of these people joined, you have an all volunteer force who has joined. They intended to make this their career and now you have a draw down. And that is a loss of identity. As a disabled veteran, I had to leave military service and I had a long time finding a new identity.

But I want to go quickly to what Connecticut is doing today because I believe it addresses some of the issues that others will raise. In 2005 we set aside money in our budget and the Legislature enacted legislation that we would set up a program for veterans, mostly at that time Guard and Reservist, who would not be covered by VA services. We trained medical professionals who were living in the community. We used a model that came out of 9/11 that Connecticut was tasked with a lot of mental health needs, so doing some training with people that are already in practice, already have their credentials, already have their professional requirements. We gave them 16 hours of what we called Military 101. We have a 24/7 hotline. Anybody in the State of Connecticut, whether they are the military member, the spouse, the children, the parents, the significant other, are eligible for this program. If you call that number right now, and you say, "I live in Pawtucket, Connecticut and my husband is going sailing every morning with Captain Morgan. What should I do?" They will tell me who in my geographic area has gone through this training and is part of that network. And to part of that network the professional has to agree that they will contact that individual who makes that call, the client from the Military Support Program, they must contact them within 48 hours.

This is open because many of the providers do not charge. However, the State of Connecticut has authorized 15 sessions within a calendar year for all of these family members. I did cite in my testimony that in Maine they did a study where they found out that many military members are more likely to go to treatment with their family because it does reduce the stigma. The military member can say, "I'm doing this for my family." And everybody will say, "That's a really great thing you are doing." And we hope, and we know, that they are also receiving their care and some help, too.

I realize my time is almost out, but I want to say something very important to all of you. The states, each one of your states has

someone like me, a director, responsible to the governor and the people of your state to take care of your people. States collectively put $6 billion on the table every year to take care of veterans. The VA is a vast system which cannot really meet the demands of our, the way we are doing more with our Reservists and our Guards today. So the most important thing that we are looking for is a little help from the Federal benefits and grants. Too much emphasis is put on having people go for health care where you have eligibility requirements. We have to look to the veterans benefits side of this, for outreach, for training for those individuals who will be the service officers that develop these claims. And although the VHA has a very robust and very good grant system, you need to look at having the Veterans Benefits Administration also be able to provide grants to support this. Can you imagine, I give high marks to Secretary Shinseki and Hickey, because they have done a lot to electronically do the records. But when it gets down to the real, where the rubber meets the road, it's the person who is taking the claims, it is the person that's pressing the button. I have ten service officers. Some of them are Vietnam veterans and they still feel that if they have to touch the computer they will become electrocuted. So this is a knowledge gap that is very, very essential.

I thank you so much, really, for giving me a little extra time. But if you don't remember anything else I said today, VA cannot do this by themselves. You have many good people in each one of your states that wants to do a good job for your veterans, all veterans. It's time to really look about formalizing the partnership between your states and the Federal VA. Thank you so much.

[THE PREPARED STATEMENT OF LINDA SPOONSTER SCHWARTZ APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, doctor. We appreciate all of our states and our territories for doing what they do in partnership for our veterans. We appreciate your testimony. Next, Joy Ilem from the DAV. You are recognized. Thank you.

STATEMENT OF JOY J. ILEM

Ms. ILEM. Thank you, Chairman Miller, and Members of the Committee. I am pleased to present the DAV's views on access to VA mental health services. Like the Committee, DAV is committed to fulfilling our promises to the men and women who served. And one of those promises is to ensure that veterans receive an opportunity to fully recover from physical and psychological wounds that occur as a consequence of their military service.

Given the diligent oversight by this Committee and the significant level of new resources that have been authorized to address the existing deficits and to improve VA mental health services, the current question posed by the Committee chair is a valid one. Is VA's complex system of mental health care and suicide prevention services improving the health and wellness of our heroes in need? Over the past five years, VA's Office of Mental Health Services has made significant progress and placed special emphasis on suicide prevention efforts, launched an aggressive anti-stigma outreach and advertising campaign, increased peer to peer services, mental health consumer councils, and family and couples counseling and

therapy services. Yet despite the noted progress, in our opinion there are several core issues that are likely responsible for the continued mental health access issues that are plaguing VA.

These issues have been the topic of numerous congressional and government oversight reports and include problems with VA's outdated patient scheduling system, reliability of waiting time data, proper staffing levels, and a mental health staffing model that accounts for shifting trends and demand for specific types of services. Many of these issues were addressed at the May, 2012 hearing you held and VA noted work was underway on several fronts and specifically that a prototype staffing model was being tested in three VA networks. Like the Committee, we are anxious to learn whether VA can deploy this prototype throughout its system, and whether it works well for mental health in particular. Likewise, we are eager to learn about the progress on the variety of other issues addressed in the various reports.

Mr. Chairman, another topic you asked that we address was effectively partnering with non-VA resources to address gaps that create more patient-centered network of care focused on wellness based outcomes. In this regard you addressed a VA TRICARE outsourcing alliance to serve the mental health needs of some newer veterans that VA is admittedly struggling to meet today. We urge VA to work with the Committee to ensure that if mental health care is expanded using the existing TRICARE network or some other outside network, veterans receive direct assistance by VA in coordinating such services and that the care veterans receive will reflect the integrated and holistic nature of VA care.

When a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important for VA to determine the kind of mental health services that are needed and whether the most appropriate care should come from a VA provider or a community-based source. This type of triage is absolutely critical because high quality, effective mental health treatment is dependent on a consistent continuous care relationship developed between the veteran and the provider. Once a trusting therapeutic relationship is established, that connection should not be disrupted if possible.

Mr. Chairman, DAV previously testified that in our opinion our newer veterans can particularly benefit from VA's expertise in treating coexisting PTSD, substance use disorders, traumatic brain injury, and other post-deployment transition issues. To that end, it is essential that VHA address and resolve the barriers that obstruct consistent timely access to care at VA facilities nationwide. However, if a veteran is referred by VA to a community resource, we urge that care be coordinated by VA. A critical component of care coordination is health information sharing. The absence of obtaining health information poses a barrier to implement good patient care strategies, such a chronic disease management, prevention, and use of safe care protocols within VA.

These are some of the principal flaws we see in VA's current approach in fee-basis and contract care. We believe the policy changes made by VA's Office of Mental Health Services over the past decade are positive and ultimately equate to better patient care and improved mental health outcomes. But significant challenges are

clearly evident and need continued attention. Unfortunately the root causes for these existing barriers in VA's mental health delivery system are complex, system based, and long standing, and cannot be resolved by any single reform. Therefore, we urge the Committee's continued oversight of VA's progress in correcting not only the internal processes and resolving the existing barriers that prevent some veterans from receiving the timely services they need to fully readjust and integrate following military service.

I just wanted to say I really think what Dr. Rudd said really is a poignant point. That we really need for veterans that are at risk, they need to be put together with an individual, a person, someone they connect to and not just a system. So with that, I am willing to answer any questions the Committee may have. Thank you.

[THE PREPARED STATEMENT OF JOY J. ILEM APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. I'd ask the panelists' indulgence for just a moment while we recess the hearing and enter into a quick business meeting. And with that, I recognize Mr. Michaud for a motion.

Mr. MICHAUD. Thank you very much, Mr. Chairman. I would like to offer a resolution adding Timothy J. Walz of Minnesota as a Democratic Member of the Subcommittee on Oversight and Investigations.

The CHAIRMAN. Thank you for that motion. Since we do now have a quorum, all in favor will say aye.

Opposed, no.

The motion carries. Welcome, Mr. Walz, to the O&I Subcommittee. And thank you, Mr. Michaud, for your motion. Our business meeting is now adjourned. And we will take up the hearing again. Mr. Ibson, you are recognized.

STATEMENT OF RALPH IBSON

Mr. IBSON. Thank you, Mr. Chairman. Chairman Miller, Ranking Member Michaud, Members of the Committee, let me also congratulate Mr. Walz, for Wounded Warrior Project and those we serve, the issues raised this morning, and the challenges it poses, are profound. We greatly appreciate your scheduling this hearing and greatly appreciate your powerful opening statements.

My organization's mission is to honor and empower those wounded since 9/11. And let me give you some context for the concerns we have. In a large survey of our wounded warriors last year, 69 percent of respondents screened positive for PTSD, 69 percent. Sixty-two percent indicated they were currently experiencing symptoms of major depression. More than two-thirds of those surveyed indicated that emotional problems had interfered with work or regular activities during the previous four weeks. Some acknowledged getting help from VA therapists, but more than one in three reported difficulties in accessing effective mental health care. The feedback in essence was that VA is overwhelmed.

I do want to acknowledge the hard work done by VA's central office mental health leadership, as well as the step VA took last year to increase mental health staffing. That step, though, is not a comprehensive solution. There is no single silver bullet out there in our

view, because the system faces a range of different problems. One of the leading researchers in the field, Dr. Charles Hogue, has, I think captured the scope of VA's challenge as follows. "Veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out. With only 50 percent of veterans seeking care, and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment."

So the issue is not simply improving access. One has to ask, for example, access to what? Mental health care also has to be effective. At a minimum, that requires building a trusting relationship between provider and patient. And that trust can be quickly broken when a veteran, for example, who needs one on one therapy is simply offered medication. Or when that same veteran is put into group therapy prematurely, or is only offered therapy that requires reliving the painful trauma of war when he or she is not ready for that level of intensity.

Many of our warriors become frustrated and drop out of VA treatment. But many VA clinicians as well are also frustrated. Why? Because the VA system too often bars them from exercising their best clinical judgment. Instead, VA performance requirements dictate clinical practice. As one psychiatrist told me recently, "The number of required clinical reminders I get keeps growing. I have a patient who is homeless and whose wife has recently died. But I have to take time away from treatment to administer a depression screening test, even though I know the individual is depressed." Similarly, "I need to be able to spend enough time addressing the veteran's wife's recent death rather than being required to urge him to stop smoking."

Sadly, a clinician who bucks the performance requirements in the name of exercising good clinical judgment can incur financial repercussions as a result. As one described it, "The reality is that the VA is a top down organization that wants strict obedience."

At best, these performance requirements measure processes, as you indicated Mr. Chairman, rather than determining whether the patient is getting better. And as prior hearings have documented, these requirements are often circumvented or gamed.

VA has acknowledged a need to improve mental health care deliver. But what seems to be missing in some instances is transparency. We wonder, for example, why after conducting mental health site visits at 150 VA medical centers last year, VA has not provided this Committee a detailed report of those findings. Last year to its credit, VA conducted a survey of its mental health staff. Why have we not heard about the findings?

Let us be clear. There are things that are working well in this system. The Vet Center program is one. Providing peer outreach and peer support, as VA has begun to do, and is called for in the President's Executive Order, would be another one if it were launched in full and accomplished as intended. And again, let me emphasize that there are many well intentioned, highly dedicated mental health staff at VA centers and clinics who are committed to providing good treatment.

But more must be done, in our view, to close gaps in the VA system. Close gaps between its promise and its on the ground reality. Between policy and practice. Congressional oversight has been a critical catalyst in identifying the need for system improvement.

I think there are also opportunities to break down what can be an adversarial relationship between a Committee and a department, for greater partnership, for greater dialogue. I think as you suggested in your opening statements, there are different directions to be taken. There are opportunities, as Linda indicated, for greater partnerships between VA and states, and between VA and communities. These are all steps that ought to be pursued. Vigilant oversight, again, must continue. And we stand ready to support in that effort. I would be pleased to answer any questions you might have. Thank you.

[THE PREPARED STATEMENT OF RALPH IBSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Mr. Ibson. And thank you for what the Wounded Warrior Project does as well. We appreciate, again, the testimony of our panelists, and all of your complete written statements will be entered into the record without objection. I recognize myself for five minutes for questions.

Dr. Rudd, I was struck by your comment that we need to connect veterans in need not just with the system, but with people within the system. I think everybody here has said something very similar to that. I think it is important for us from a clinical standpoint to understand the need to connect personally and the personal efficacy and the importance of choice within the mental health care field. So can you talk a little bit about why it is so critical to connect on the personal level?

Mr. RUDD. Oh, absolutely. If you look at, let us take for example the recent active duty numbers for this past year. So if we look at this, if we look at the recent active duty numbers from this past year, half of those individuals who died by suicide either were in treatment or had received care of some sort, either inpatient or outpatient care. If you look at the VA numbers from the report, you will see that 80 percent of those individuals had had a nonfatal event. In other words, made a suicide attempt. Were in treatment four weeks prior to the event.

What I would tell you that both of those numbers reveal is the nature of how they are connected to care. That the problem, if we took the active duty numbers and took those, half of those individuals that tragically died, they remained in care and were effectively treated, the problem would no longer exist. We would be back to numbers that we had seen prior to Iraq. Those rates would have dropped dramatically. And so it is the nature of those connections that really is the critical thing.

If you look at the work that we do in terms of studying effective treatment for suicidality, so we have got two clinical trials currently underway at Fort Carson in Colorado, it is the nature of the relationships that are established and maintained. Do we have mechanisms in place to maintain those relationships in an effective fashion? The question that I ask when I look at that Suicide Data Report data on, they had a contact a month prior, the question that

I ask is how long was it until the next appointment? So when they had that contact, was the next appointment scheduled six weeks out? Was that the problem? Or was the next appointment scheduled a week out, and they did not keep the appointment?

My concern is that from the individuals that we talk with that we treat, from the individuals that I know, the families, surviving family members of those that have died, oftentimes it is an issue of the system getting in the way of being able to keep an appointment, get an appointment, or get to an appointment. That those individuals that are connected need to be connected to people. They need to be connected to the same people. They need to be continued frequently in treatment. They do not need to receive care every six weeks. They are going to need more frequent care. It is those kinds of questions that I think we need to be asking, is how do we connect? How do we keep them there? Not necessarily are we getting them there. I think we are doing a good job of getting people there. I think the Army data, the military data reveals that. I think that the VA data reveals that. But ultimately the question is, how do we keep them engaged? How do we keep them involved? Have we made the system accessible so that they can, they can continue to be a part of the treatment cycle? That really is my core concern.

The CHAIRMAN. Anybody got anything they would like to add to that? Doctor?

Ms. SCHWARTZ. I would. I would say it would be very interesting, and I did not read the report, it would be very interesting to see how many of these people were, had done multiple deployments and multiple tours. In my testimony, I wrote of a situation which I hope everyone will take a look at. The fact that people, veterans of the Guard and Reserve who have come to our state, who are already rated service-connected at 70 percent or 80 percent for mental health issues have been told, and they do, sign a waiver to stop their disability checks, and then sign up for another deployment. I have had some very difficult times for these people who already are rated, which is not an easy thing to do, and yet they sign away their checks. Someone, and it is well known because there is already a form for it. So they are deployed back to the combat zones, thinking that when they return they are going to get their disability checks are just going to smooth, and they will have their disability rating. They do not realize what they jeopardize. Nor do the people at the National Guard and Reserve levels understand what this is all about.

But when you take someone who has been deployed multiple times, and in our state it varies from services. I myself am an Air Force veteran, so many deployments by the Air Force are not a whole year long. But the issue is, they come home. They just get reacquainted with their family or the community, and then they are gone again. And there is really no time for a decompression kind of experience where they can learn to be back in the community again before they have to gear up. And I do feel that some of this is they never gear down. They are always, as if the adrenaline is as if they are in the combat zones. And many families are at a loss. They think they are going to welcome them home and they find that the individual is not, that is now where it is at for them.

So these multiple deployments, using people that already have disabilities to redeploy to the combat zones, that has to stop. It's just incomprehensible to me. I mean, as a military member when I had to leave my squadron it was probably the saddest day of my life. That was me. I wanted to go back. And somebody did offer me a chance to go back, and I could have signed my life away and gone back. Gone back. But I knew that I couldn't do the work. So you have a group of people right now who will do, some of them will do anything to get back. Because of the jobs, because of the feelings that this is a very important job that they are doing. So this is, this is not a VA thing. But we are left, all of us in the veteran community are left to deal with these situations.

The CHAIRMAN. Thank you very much. Mr. Michaud?

Mr. MICHAUD. Thank you, Mr. Chairman. Dr. Schwartz, first of all thank you for your continued service to our veterans and their families. I really appreciate it. You stated in your testimony that serving veterans is a shared responsibility with state and the Federal government. And I agree with you, and I also believe that the community needs to be involved as well.

Can you elaborate a little bit more on the barriers that you have encountered while seeking to partner with the Department of Veterans Affairs? As well as, have you sought out other Federal agencies? And if you had, how has that relationship been?

Ms. SCHWARTZ. I think the VA has been operating on the notion that they have to do it all. And with the new hostilities and the heavy use of our Guard and Reserves, the real true citizen soldiers. So they have developed programs which, their counterparts in the states, or did not even know about. There is very little dialogue about, for example, I will just give you, you know, they create a program where they are working with the homeless. Well I have 380 homeless people. I have the most homeless people in the State of Connecticut. Second only in the Nation to California. But the issue is, the kind of dialogue we have, especially over some of the programs, the kind of dialogue, if they are going to start a new program to assist veterans, I do believe that VA has to at least talk to the state. If they are building a facility for assisted living in the State of Connecticut, and they really have not, the Commissioner and Mental Health and Addiction Services and I had no idea. It is being built on the premises of Newington VA. We had no idea that this was going on. However, it does affect that state. And I think that is one way.

But the other thing, and let me be very clear, there are some really good models of how it works. For example, my substance abuse treatment program has 75 beds. The VA at Newington has a 21-day program. So all of my initial people in the program go to the 21-day program at Newington. They stay in a residential mode with us. And after they, because we think maybe you need a little more than 21 days, especially with some of our veterans, then they work with my clinical staff. And they can stay up to six months because what we do is as we work with them on their sobriety, we also work with them in getting back into the community. I am very proud to say that yes, we have a lot of people. But last year over 150 veterans left my facility with a job and a place to live. So some of them, and I would also say we have over 500 veterans of Iraq

and Afghanistan have gone to this program in my time. That is ten years.

But the issue here is there is so much more that needs to be done besides calling or giving, you need to have that interaction. Perfect hand-off. I talked about the military support program. It, we have expanded that program in the State of Connecticut to all veterans and all veteran families because of our concern about suicide. So that if somebody can call even in the middle of the night and get a friendly voice, we also have veteran workers standing by as crisis intervention. And I am not, we are not the only state. Massachusetts and other states are doing wonderful work along these lines. But it is a beginning. It is not, just as was mentioned, you want somebody there that they can trust and talk to. The therapeutic alliance does not necessarily happen with the VA because in the middle of the night you cannot call your VA clinician. You cannot talk to them. Families sometimes cannot even talk to them because of the HIPAA laws. So if any of our clinicians in the community find that this is a little over their head, they will make the referral to the appropriate place. And many of them are. Many of the veterans are referred to the VA. But at least, it is almost like a triage at the local level. And the hand-off that they get is a little personalized because it is not like you are calling an 800 number.

And I would also add that some of the suicides that we have seen, do not think it is just men. I think some of the saddest things for me is that women are killing themselves, too. Women with children. And that really brought it to the forefront in our state. So the VA has to, in my testimony I do say that Secretary Shinseki has acknowledged this. The problem is, the problem is, as was noted in other testimony, that has not, that mind set has not filtered down to the people at the administrative local levels. I have a wonderful relation with my homeless outreach people at the VA level because we touch people. We are not shuffling papers. I know, I had to learn how to do that, too. But the point is, the people that touch people are deeply, deeply ingrained in making it happen. So as a, we have a new challenge here. And we have to challenge the status quo and begin to create new models. Because we are not going backwards. This is the way America is going to do war in the future. And these are, the Guard and the Reserve are going to be your clients, my clients.

Mr. BILIRAKIS. [Presiding] Thank you very much. And I will recognize myself for five minutes. The first question is for Mr. Rudd. You mention in your testimony that in order to reduce wait times and increase access to mental health care, the VA may need to explore partnerships with private community providers. What do you believe is the biggest obstacle preventing the VA from doing this?

Mr. RUDD. You know, I am really not sure what the biggest obstacle is outside of the simple fact that it has not been done, that it is a non-traditional approach. That the way that we have done this, I think, over the years, particular since the start of these wars, is that we have made the VA larger. I think the evidence would suggest that the VA does not need to continue to get larger. That I was not overly encouraged when I read the response that they have hired 1,000 individuals and some of these numbers. I do

not see that as a solution. I think the solution is that we look at partnerships like TRICARE partnering, which is a wonderful partner approach. Primarily because those providers are already in those small communities. Those providers are available, accessible in those small communities. But what that means is shifting funding, shifting money to a non-traditional model. And I think that is personally the way to go. I think that is how you connect people to people at a local level so that individuals do not have to travel great distances.

Mr. BILIRAKIS. Very good. Anyone else wish to comment on this subject matter?

Ms. ILEM. I would just comment, I think from DAV's perspective we have a little bit of a different thought on that. We are definitely invested in wanting to make sure that the VA receives the proper funding and what they need to do their job. I mean, they are the primary source of government response to this issue, you know, to when veterans are coming home and need assistance. They are going to be there for the long term. And I think VA's long term relationships with its patients are extremely important in providing really high quality care. And not to say that VA does not have to partner with the community, and in these cases we have certainly found, you know, there has just been continued issues with access. And but at the same time, I think we really want to see VA resolve some of the issues that we know have been identified by the GAO, by the Office of the Inspector General, and VA itself. So what is the problem? Where is the logjam that they cannot overcome those obstacles within the system to be more efficient and spend the money which has been provided and authorized by this Committee, and by Congress, in significant amounts to really care for these people with the specialized treatment and services that they have, you know, really, they are second to none. And especially with these coexisting disorders. But they do, I think, need to look outside the box given the issues that we're, you know, they continue to experience with access. So but I would like to see VA really step up to the plate. I know that there are a lot of people that are trying hard. But you know, the time has come where it is just absolutely critical given all of these reports with, you know, the suicide and various issues we continue to hear about.

Mr. BILIRAKIS. Thank you very much. Dr. Schwartz, in your testimony you make a valuable point that the Federal, State, and local initiatives should be coordinated. I agree with you, and I am a proponent of the one stop shop models. How do you believe that this integration can be best facilitated?

Ms. SCHWARTZ. I think there are models in the Federal government. And I know I did not respond to the question adequately. You know, with the public health, HHS gives grants. They have local level coordination across states of certain programs that are funded. I see that VA will always be, in reference to Joy Ilem's statement, VA will always be the crown jewel. But the needs of the veterans today are much different.

For example, when I was in the military, and I am going to age myself, I was not allowed to be married. Then they allowed us to be married, and when you had a child, you had to leave the military. Now, almost 83 percent of the people on active duty have fam-

ilies, and 58 percent of the Guard and Reserve all of them, the family, especially with this generation, and was referred to the camaraderie, the sense of camaraderie, the need to be with each other. But the family, the family unit is more important now than it is ever. And VA is not authorized, across the board, to help these families. So that is why other programs have evolved.

So the most important thing with these models is I would say, I am not telling you to just be dropping money everywhere, but that we would have grants to do the outreach to connect people. VA has a large grant per diem program for state homes. I have one. There is quality assurance that is built into that program, that could be built into the mental health program.

But you are not going—as long as we rely on the Guard and Reserve, it is too long for someone to drive. And we did a survey of our veterans that they had to drive more than 30 minutes to a source for anything, it was too far. I would have to drive. It is 65 miles from my home to the VA hospital. And if you had to take public transportation in the State of Connecticut, it would take you two days on public transportation.

So accessibility is much more than eligibility. Accessibility is having someone, someone, a private clinician that, that is not the model of the VA, but that is a model that can be built using clinicians. This worked very well for the State of Connecticut after 9/11. I did not mention this, but we have had over 3,500—since this program had, we have had over 3,500 clients, I would say a third of them have been referred to VA for care. But most of them are in treatment in the homes and the towns where they live, and the reimbursement if it's not coming from the—any other third party reimbursement, the State of Connecticut pays these therapists.

Many of them do, actually I have to say do this pro bono because they want to help. But this is an excellent example of how it can go to where it needs to be. Thank you.

Mr. BROWNLEY. Thank you very much. I yield back, Mr. Chairman.

Mr. CHAIRMAN. Thank you very much, Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chair, I appreciate this. I had a question actually for Dr. Rudd. And in your testimony you mentioned, you mentioned about access to service, but also transition services for people transitioning out of the military. And I recently, when I was assigned to the Committee, I decided to visit all of the veteran facilities in my district. And I visited the transition center at Naval Base Ventura County. And I was actually very, very impressed by what they are doing there, and their focused attention, and program that is very comprehensive that goes on for a pretty long period of time to prepare them for this kind of transition.

And so I am really wondering, you know, how we can capture these best practices when we see a good facility like this doing good work, how we can create new models and best practices to replicate better than we are doing throughout the country.

Mr. RUDD. Well, I agree with you. I think there's some very nice models out there. I think a part of the problem is that you can—you see one side or the other doing a nice effort, but not both simultaneously. So if you look at the death of Russell Shirley as an example. He was, because of the DUI, he was referred for treat-

ment, substance abuse treatment on the active Army side, which when his discharge was processing, was discontinued, is a part of the—as a part of the discharge process.

It is those little things that make the big difference. It is whether or not somebody actually gets into the service, gets connected with a provider in these critical moments. And so often times, those are non-clinical kinds of issues. Those are issues with commanders, those are issues with administrators, not with the clinical staff. And when I referenced, and I do not believe this is a clinical problem, I really do not believe this a clinical problem, I believe it is how we shepherd people through the system, they are at high risk with non-clinical procedures.

Ms. BROWNLEY. Uh-huh.

Mr. RUDD. I think it is how we end up connecting them and then maintaining them there that is the problem. So I think part of the difficulty in Russell Shirley's death was the fact that the company commander disconnected him from treatment, did not connect him to transition services. Those are the kind of things that we need to find policies and implement, that can be maintained and monitored so we can effectively manage these people, as we move them through the system. I think more attention has to be focused there, not at the transition center. But how do you get somebody in the door? And then how do you monitor and make sure that they stay there, and they stay all the way through? And if they disengage, what are the procedures for re-engaging them if they disengage? Those are the kind of things that I think ultimately will save lives.

Ms. BROWNLEY. And are we doing anything vis-a-vis accountability to look at these transition centers and others to see—identifying people who are in trouble after transition, and looking specifically at the transition, the transitioning that they have or have not received.

Mr. RUDD. Well, I think that we started the process. I mean, I think one of the tragedies of this, is that it has taken 10, 11 years of war, many deaths, and many tragic suicides for this to happen, that we are now putting systems in place to be able to look at this effectively. And I think the work that Dr. Kemp does genuinely is historic, but it should have happened decades ago. We should have had a system in place so we can monitor, manage and understand how many people are dying by suicide, and we can accurately the number of events. And we're still only at 21 states that have accurate data with the two largest states without accurate data at this point.

And so I think we are just building the system. That's a wonderful contribution, but it really is just a foundation. So I think that when we get the foundation set, a part of what we have to layer in is some general patients with the idea that we do not have the infrastructure in place to do the very things you are asking. And I think that we need to ask that question repeatedly to get the infrastructure in place. We have got some of that on the suicide front, but it has to happen in so many different layers. And that is very much a non-clinical problem. I mean that very much is a management problem.

And that is where I think making the VA bigger creates bigger challenges, because the management of big systems is tough. And

so I think that is where we need to think a little bit creatively about how to do this.

Ms. BROWNLEY. Thank you, sir.

The CHAIRMAN. Thank you. Dr. Benishek?

Mr. BENISHEK. Thank you, Mr. Chairman. Dr. Schwartz, you said a couple of things earlier that sort of intrigued me. I want to ask you about them a little bit more.

You said that, you know, there was a need for the private sector mental health care, because calling the VA, there is no access to people at the VA at night.

Ms. SCHWARTZ. Right.

Mr. BENISHEK. So the Veteran Affairs Mental Health does not have any on-call person to take a call?

Ms. SCHWARTZ. Well, they do have an on-call person, but in the sense of mental health care, it is very essential that they find somebody that is responsive, not just somebody in the emergency room.

Mr. BENISHEK. Right, right, right.

Ms. SCHWARTZ. And in large states, they may not even know this person. So the accessibility of trying to contact your mental health provider in the evening is not standard. We have had via the populations of veterans that I have also use VA, trying to get ahold of the person that is their primary treater for mental health, we do not have access to the primary care provider.

Mr. BENISHEK. But you are saying in the private sector——

Ms. SCHWARTZ. We do.

Mr. BENISHEK. —you do.

Ms. SCHWARTZ. I mean, I—just for example, I—my masters is in psychiatric nursing, and so a lot of clinical nurse specialists are in private practice, and they, when they are not available, any psychiatrist, they always have someone or psychologist, always have coverage. They—you have— you can call into your provider, get ahold of them if it is a crisis, and if they are on vacation, you will get somebody that they have told you will be covering for them.

Mr. BENISHEK. Right, right, right. Well, yeah.

Ms. SCHWARTZ. So it is there. It is there. It is somebody that you can really talk to.

Mr. BENISHEK. Well, I am just sort of amazed by the fact that the VA does not have that same sort of a system. And I'm disappointed to hear that frankly.

Ms. SCHWARTZ. It is a large, large system, and was very well described, the larger the system gets, there is another thing, and I bring this in my testimony, the soldiers of today expect their treaters to be competent, to understand them, to respect them, and they expect the same kind of care they would if they were going to a private provider.

Which means, if I am having trouble right now, if I want to call my psychiatrist, I want to call the office.

Mr. BENISHEK. Right.

Ms. SCHWARTZ. And I want to talk to them, or maybe I need to go somewhere. This is not available——

Mr. BENISHEK. Right.

Ms. SCHWARTZ. —on an individual basis. The large system may respond, but if I have somebody in crisis, and I get somebody at the VA that does not know this patient——

Mr. BENISHEK. Right.

Ms. SCHWARTZ. —they're not going to be as helpful as——

Mr. BENISHEK. Right, right. No, I completely understand. Mr. Ibson?

Mr. IBSON. I think it—you know, I think the concept of partnership was discussed earlier, and I think we have to recognize that there is a national shortage of mental health providers. What I think—you know, what I think Linda had indicated earlier, and I hope VA is moving away from, is the sense that we own this issue alone. I think the opportunity is there for community and VA to work closely together. And I hope that is a direction we will see.

Mr. BENISHEK. Right, right. Dr. Schwartz, you said one other thing, and that is, people waive their mental health disability to return to deployment.

Ms. SCHWARTZ. Yes.

Mr. BENISHEK. How often does that happen?

Ms. SCHWARTZ. In a very small state, but I know at least five cases of this happening, because what happens is when they come back, they expect those checks to just keep rolling, and then they come to me because I have service officers, and we have to tell them the sad truth that you just signed away—when you signed—when you said you are good to go, you signed—stopped your check, it says I am fit for duty.

Mr. BENISHEK. Right, right, right.

Ms. SCHWARTZ. So if they are deployed, and they come back and they think they are going to get that, they have not been really—they were not well informed that they are signing away something that is very important. But at the same time, it is incomprehensible to me, I served 16 years in the United States Air Force, it is incomprehensible to me that they would ask someone who is already compromised——

Mr. BENISHEK. Right, right.

Ms. SCHWARTZ. —to—at any rate, unless it was like somebody really, really unique, but these people are choosing to go back into the military because it is a job, and they feel as if they belong there. So you put that knowledge into the fact that we are going to have a drawn down of tens of thousands of people who feel that is where they belong.

Mr. BENISHEK. Well, no, it just worries me that we are taking people that have, you know——

Ms. SCHWARTZ. Yes, it worries me too. They can——

Mr. BENISHEK. —relating to mental illness to deployment are there——

Ms. SCHWARTZ. —get themselves into a lot of trouble.

Mr. BENISHEK. I do not even know that we should be allowing that to occur.

Ms. SCHWARTZ. I would hope that this Committee would really look at that, and work with people to stop that.

Mr. BENISHEK. Thank you for your comments, a lot of time.

The CHAIRMAN. Thank you, Doctor. Ms. Negrete McLeod? Mr. Runyan? Mr. Coffman?

Mr. COFFMAN. No questions.

The CHAIRMAN. Mr. Michaud, have you got anymore questions?

Okay. Thank you very much for being here. We do have some additional questions we would like to present to you for the record. Thank you so much for what you do. I look forward to a continued relationship with each of you on this very important issue and you are now excused.

I'd like to invite our second panel to the witness table. Joining us from the Department is the Honorable Dr. Robert Petzel. Dr. Petzel, thank you for making your way through traffic and all kinds of security issues to be here. Dr. Petzel is the Under Secretary for Health for the Department of Veterans Affairs. He's accompanied today by Mary Schohn, Director of the Office of Mental Health Operations, Dr. Sonja Batten, Deputy Chief Consultant for Specialty Mental Health, and Dr. Janet Kemp, Director of Suicide Prevention and Community Engagement for the National Mental Health Program. We thank you all for joining us today, and Dr. Petzel, you are recognized to proceed with your testimony.

STATEMENT OF HONORABLE DR. ROBERT A. PETZEL, M.D., UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY: DR. MARY SCHOHN, DIRECTOR, OFFICE OF MENTAL HEALTH OPERATIONS, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; DR. SONJA BATTEN, DEPUTY CHIEF CONSULTANT FOR SPECIALTY MENTAL HEALTH, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND DR. JANET KEMP, DIRECTOR, SUICIDE PREVENTION AND COMMUNITY ENGAGEMENT, NATIONAL MENTAL HEALTH PROGRAM, OFFICE OF PATIENT CARE SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF ROBERT A. PETZEL, M.D.

Mr. PETZEL. Good morning, Chairman Miller, Ranking Member Michaud, and the Committee Members. I appreciate the opportunity to come here to discuss VA's comprehensive mental health care and services for our Nation's veterans. I am accompanied today as the Chairman indicated by Dr. Mary Schohn, Dr. Sonja Batten, and Dr. Janet Kemp.

Since early 2009, VA has been transforming and expanding its mental health care delivery system. We have improved our services for veterans, but we know that there is much more work to be done. My written testimony has more detailed information, and I would submit that for the record.

Mr. CHAIRMAN. Without objection.

Mr. PETZEL. This morning, I will summarize these remarks, and update you on our major accomplishments. As the President stated last night, we will keep faith with our veterans investing in world class care, including mental health care for our wounded warriors, supporting our military families, and giving our veterans the benefits, education, and job opportunities that they have earned.

We are progressively increasing veterans' access to mental health care by working closely with our Federal partners to implement the President's Executive Order, to improve access to mental health services for veterans, servicemembers and military families, as well as implementing the 2013 National Defense Authorization Act.

We know these changes require investment. Last year VA announced an ambitious goal to hire 1,600 new mental health care clinical providers, and 300 administrative support staff. As of January 29, 2013, VA has hired 1,058 clinical providers, and 223 of the administrative staff. We are on track to meet the requirements of the Executive Order, and have these positions filled by June 30th of 2013.

VA has many entry points for care, including 152 medical centers, 821 community-based out-patient clinics, 300 vet centers, 70 vet center vans, and the VA's crisis line, to name but a few.

We have also expanded access to care by leveraging technology, Telehealth, phone calls, secure messaging, online tools, mobile applications, and outreach efforts, mental health integration into primary care, community partnerships and academic affiliations.

Out-patient visits have increased by over—to over 17 million in 2012. The number of veterans receiving specialized mental health treatment rose to 1.3 million in 2012 from 927,000 to 2006.

In part, this is because our primary care physicians proactively screen veterans for depression, PTSD, problem drinking, and military sexual trauma to help these veterans actually receive the treatment that they need.

We are also refining how we measure access to ensure we accurately reflect the timeliness of the care we provide. VA is updating scheduling practices, strengthening its performance measures, and changing timeliness measures to best track new and existing patient access times.

We will continue to measure performance, and hold employees and leadership accountable to ensure that the resources are devoted where they are needed for the benefit of America's veterans.

VA has been working with partners to address access and care delivery gaps. In response to the Executive Order, VA is collaborating with health and human services to establish 15 pilots using community-based health clinics and mental health clinics.

VA is also partnering with DoD to advance a coordinated public health model to improve access, quality, and effectiveness of our mental health services through an integrated mental health strategy.

VA is committed to ensuring the safety of our veterans, even one, even one veteran suicide is one too many. July 25th, 2012 marked five years since the establishment of the veteran crisis hotline. This offers 24/7 emergency assistance. Last year this crisis hotline received more than 193,000 calls resulting in over 6,400 rescues, people rescued from harming themselves or someone else.

Earlier this month, VA released a suicide report, developed collaboratively with the states. This report includes data on prevalence and characteristics of suicide amongst veterans, including those veterans that are not treated within the VA.

The report provides us with valuable information as we eluded to earlier, to identify populations that need targeted inventions,

such as women and Vietnam veterans. Moreover, it identifies opportunities to train providers who care for veterans in non-mental health settings.

The report makes clear that although there is more work to be done, we are making a difference. There is a decrease in suicide attempts by veterans getting care within the VA, calls to the crisis hotline are becoming less acute, also demonstrating that the VA's early intervention appears to be working.

Mr. Chairman, we know our work to improve the delivery of mental health services to veterans will never be done, and there is much more, much more to do. We appreciate your support, and encouragement in identifying and resolving challenges as we find new ways to care for this Nation's veterans.

My colleagues and I are prepared to respond to any questions you may have.

[THE PREPARED STATEMENT OF ROBERT A. PETZEL APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much. At the end, and I did not have a chance to run back to your statement, but—one of your last comments was that the number of calls coming in to the crisis line were decreasing.

Mr. PETZEL. No, actually, sir, not the number of calls were decreasing, the intensity of the calls. The patients that are calling now are less acute than they were when we first entered, first developed the crisis line indicating——

The CHAIRMAN. Well, and again, so you say that's a success?

Mr. PETZEL. I'm saying that that's an indication of the fact that we are having some impact.

The CHAIRMAN. Could they be going somewhere else other than your crisis line?

Mr. PETZEL. We do not think so. The calls are, if anything, increasing. We are seeing the volume, we are not seeing the acuity.

The CHAIRMAN. Because we had testimony from the Connecticut State Director about having 5,000 veterans on their rolls, could they be going to their mental health providers or somewhere else?

Mr. PETZEL. Let me ask Jan Kemp who runs that hotline to comment, Dr. Kemp.

Ms. KEMP. Yeah, we looked extensively at the number of people who are calling the crisis line, and what they look like, and where they are coming from. Our volumes continue to increase. We think our messaging is out there, we are reaching people. We are making an increased number of referrals, so when those people call the crisis line, we are able to refer them primarily to VA mental health providers through their suicide prevention coordinators, but we do also have partnerships with other organizations for those veterans who do not want to go to the VA, such as Wounded Warriors, and given our—and Vets for Vets, so we have lots of options to give veterans referrals to, and we are proud of those.

What is going down, however, is the number of rescues that we are having to call. So people hopefully, and we believe are calling earlier in their sort of crisis trajectory process, that we are able to get them help sooner before it comes to the point where they have already taken pills, or they are holding a gun to their head.

That was our intent. That was one of the reasons why we sort of changed our messaging campaign halfway through the stream. We changed the name of it. We want to get people sooner. We think we are doing that.

Mr. CHAIRMAN. Dr. Petzel, you said in your opening statement and I agree with this, that "our ultimate desired outcome is a healthy veteran." The problem is after you said that, the focus, I think of the majority of your testimony was processes, number of people hired, numbers, numbers, numbers, and I think the most important number is how many veterans are getting healthy or healthier or helped.

And so I think this Committee would like to know how you quantify whether or not a veteran is getting better—it is easy to quantify the number of people hired, but how do you quantify whether a veteran is being helped or is getting healthy.

Mr. PETZEL. Well, Mr. Chairman, we would agree with you, that the important data is how have we helped veterans. And we mentioned in the opening statement, and we will elaborate on that several instances. Number one is the crisis line data. No question about the fact that that indicates that there is some impact on veterans with mental health problems of the programs that we are involved in.

Number two is the suicide data. The suicide data is going to become an important part of us evaluating how well we are doing. And there is an indication in that suicide data that indeed we are having an impact that people are being treated in the VA.

The third thing is——

Mr. CHAIRMAN. And—there is a difference, though, and I apologize, but being treated is one thing. How many of them are becoming healthy again?

Mr. PETZEL. Well, if the suicide rate is declining, if there are fewer suicide attempts, if there is a decreased need to rescue, that tells me that those people are getting better.

Mr. CHAIRMAN. But not every person who has a mental health issue is—subject to a suicide attempt, or an actual suicide. They may continue with mental health and depression issues for a long time, so basing everything off of the crisis line, and the suicide numbers supposedly remaining stable—again, how do you quantify that a veteran suffering from depression or PTSD is getting better?

Mr. PETZEL. Let us take an example, Mr. Chairman, of PTSD. We can evaluate the symptoms in a patient when they initially present with PTSD, and they may go through cognitive behavior and therapy or another evidence based therapy. And subsequently they are evaluated for the presence of the symptoms related to PTSD. And we have good evidence in the literature that people that go through that program do indeed have less symptomatology associated with their PTSD, and are better adjusted to living in society.

There are many instances of the treatment protocols that we have, where we can demonstrate the direct impact on those individuals that have been through that therapy.

Mr. CHAIRMAN. Is there a disincentive for a veteran who has been rated for PTSD to show improvement?

Mr. PETZEL. I do not believe that there is. I believe that people that are suffering from PTSD do want to have that PTSD treated, and do want to go through therapy, and do want to make a better adjustment to their living circumstances, no.

Mr. CHAIRMAN. Okay. Thank you. Mr. Michaud.

Mr. MICHAUD. Thank you, Mr. Chairman. Thank you, Under Secretary for being here today.

Mr. Ibson mentioned in his testimony about central office doing a survey of clinicians as far as the best clinical judgment. Is that survey completed, and could you share with the Committee? And my other question is, you mentioned the President's Executive Order, and that it is going to establish 15 pilot sites. We heard earlier testimony today that when you look at the huge influx of soldiers that are going to be coming back, and 40 percent are in rural areas, how were the locations of those pilot sites determined, and did you take into consideration the problems we are facing in rural areas?

Mr. PETZEL. Thank you, Congressman Michaud. I am going to have to talk with Ralph Ibson about the survey that he referred to. I am not quite sure which one he meant. I know that more than a year ago, what really touched off the eventual feeling that we had to hire additional mental health workers, was a survey of our mental health providers, as to whether or not there was adequate staffing. And they may be what he is referring to, but I will talk with him after we finish——

Mr. MICHAUD. Okay.

Mr. PETZEL. —with the hearing, and then we will then get back to you.

In terms of the pilots, the—15 sites were selected, they were selected based upon the desire of the local network, our hospital to participate, and a need is identified often by how rural the areas were. There is one urban center where we are doing this in Atlanta, to get a feeling for what that might be like, because there are many, many community mental health clinics in the Atlanta area.

I want to mention just tangentially to the pilots, that we have been participating with community and mental health centers in certain parts of the country prior to the pilots. In Montana, there is a network of community mental health centers that are providing care to veterans in that phenomenally remote state where we are not able to provide mental health providers in each one of the communities.

We think that this is a—this is going to be a viable alternative in the future to us cooperating in the community with providing care in these again remote rural areas.

Mr. MICHAUD. Okay. On the suicides, I understand the VA now has a memorandum of understanding with all 50 states to report the suicide data. We heard earlier this morning that the two largest states, I think it is Texas and California have not submitted that information. Are there any other states that have not submitted that information?

Because my concern is when you look at the increase in suicide rates, it went from 18 to 22, and that is—to me that is the low number, because there is a lot more suicides, I believe out there

that are not being reported. So are there any other states out there that have not reported?

Mr. PETZEL. I would ask Dr. Kemp who runs the suicide program to comment on that. I do not know the answer.

Ms. KEMP. We now have agreements with all states that they will. We have gotten data from both Texas and California since the report came out. There is a couple of states that we are still working with over privacy issues and how we are going to share the data, and I am confident that we will get those soon.

Mr. MICHAUD. Thank you. Earlier today we also heard, I think it was actually Mr. Ibson I believe, talked about the clinicians within the VA, that they have to meet certain performance requirements set out by central office.

Last year, I think it was last year, we also heard from the former VA employee who worked in the facility, I believe it was New Hampshire, pretty much said the same thing, that they have a certain performance criteria they have to deal with, that they do not feel that they can provide the services to our veterans the way they should be providing it, because it is trying to just get them through the system, and that is a concern that I have. Can you talk about other performance requirements for the clinicians?

Mr. MICHAUD. Thank you, Congressman Michaud. Yes, there are, and there is attention and a balance between having the time available and the need to provide direct clinical care, and on the other hand, the need to document what has been done. And the need to provide information in terms of performance measures, sometimes for us to be able to answer the Chairman's question about are we having an impact on patients. And often times, the performance measures, particularly outside of mental health in the medical health system are a very important part of our being able to say yes, we have had an impact. We have helped this patient to avoid cardiac disease or whatever.

So it is important to have performance measures, and I think it is incumbent on us as the leaders to make sure that there is the proper balance between time available to do clinical care, and the necessity of meeting performance measures.

And just an example, one of them would be, a reminder will pop up, you need to immunize this patient for influenza, and that is a reminder that has got to be satisfied, and there are a number of other kinds of reminders that need to be satisfied to do those things.

Mr. MICHAUD. Would you provide the Committee with those performance standards that they have to meet?

Mr. PETZEL. Yes, we can. It is a—okay, we can. Yes, sir.

Mr. MICHAUD. I take it by your delay, that it is probably a lengthy——

Mr. PETZEL. Congressman, it is not so much it is lengthy, it varies from the kind of clinical setting that one is in, but we can do this, yes.

The CHAIRMAN. How does reminding a provider that somebody needs an immunization help them get better mentally? I mean that is what we are focused on at this point, providing mental health to the veteran. Clinically, I guess I understand if he or she needs a flu shot, but that is not what they are there for.

Mr. PETZEL. I'm sorry, Mr. Chairman. I was trying to give an example to the Congressman of the things that we hear clinicians complaining about in terms of performance measures and clinical reminders. There are clinical reminders that are related to mental health, such as——

Mr. CHAIRMAN. No, I understand that. Just a question. I apologize. Mr. Runyan.

Mr. RUNYAN. Thank you, Chairman. Some of my questions I am not even sure you can answer, because as Chairman Miller said, there is not a lot of data on what is happening day-to-day. My one question, Dr. Petzel, I do have, there seems a lot of things we do specifically in the mental health field, especially in the VA, and I think nationally, too, because I do not know if we are there yet as a medical field.

The balance of being reactive to being proactive a lot of times is way out of balance. And have you had any movement on trying to figure out how we can get in? Obviously, a lot of the PTSD that a lot of our veterans have is triggered at some point. It is there, maybe we could have proactively got in front of that. Is there anything you've been discussing or have on the horizon that we can say that we are going to move in that direction, so we do not have to wait till the last minute, till there is a crisis?

Mr. PETZEL. That is an excellent question, Congressman Runyan, and I want to harken back to what Dr. Rudd said in terms of transition.

Identifying—all the patients that we see come out of the Department of Defense, they are soldiers, sailors, Air Force members, airmen, Marines, and we need the opportunity to interact with these people before they leave the service. The new mandated transition assistance program I think is going to give us that opportunity to both present and interview the individuals before they leave the service to identify those people who are at risk, who might have a previous problem, who might have a problem in transition, so that we can do, what was referred to earlier as a hot transfer. A warm transfer between the Department of Defense, the Army, whatever it might be, and our VA health care system, so that these people do not fall through the cracks, so that we do get them into our system.

We can do, we can do a very good job, once we can get people into the system, and I think a major issue is providing for the right kind of transition. And that involves our being able to get at these individuals in this mandated transition assistance program.

The second thing that I would like to talk about in relationship to your question is another issue that came up, and that is establishing the kind of relationship with a patient, so that they will tell you their story.

I mean, there are certain—in our age population, 50 and over, particularly, there are certain things that are associated with suicide, antecedent so to speak. Substance misuse, pain, depression, maybe PTSD, life stressors, we need to have a relationship with that patient such that they will tell us about those. They will tell us their story if you will, as opposed to the usual, is anything bothering you; no, nothing is bothering me. I think you have heard the

interactions many, many times where it tends to be superficial and you don't really get the story.

So getting at patients early through transition, and developing the relationships where they will tell us where there are things that may be antecedents to suicide that are bothering them, that we can act on again before there is a crisis.

Mr. RUNYAN. Well, I think, and this is more of a statement than anything else. I think the bigger question is, it is human nature to be secluded and not do that. But how statistically can we deal with DoD data, kind of figure out people that are in the same unit, or that have been exposed to things like that, how can we proactively prod them, if you will, do you know, give us that information?

Mr. PETZEL. Well, certainly if we have access to the medical record with this integrated health record that is being developed, we will be able to see those people that have had difficulty meeting their mortgages, that have a difficulty with substance misuse, that have had behavioral problems, et cetera. Those things are all triggers that would indicate to us this person needs to be evaluated, this person needs to be looked at closely.

It is getting the information, and the contact with the individual before they have the difficulty as you have pointed out is the problem.

Mr. RUNYAN. Thank you, Chairman. I yield back.

Mr. CHAIRMAN. Dr. Petzel, you may not be able to answer this today, but going back to testimony that was received two years ago, about a study published in the Journal of Traumatic Stress on the treatment utilization rates of veterans of Iraq and Afghanistan which found that less than ten percent of those newly diagnosed with PTSD received the recommended number and intensity of VA evidence based treatment sessions within the first year of their diagnosis.

Can you comment on that? Has that gotten better?

Mr. PETZEL. I think you are right, Mr. Chairman. We are going to have to get back to the Committee. I am not familiar with the study, and I am not able to cite any specific evidence if that situation is different than what is in the study. So if we could, we would appreciate the opportunity to come back to you.

Mr. CHAIRMAN. It was Dr. Karen Seal who testified, in mid-June of 2011, but we will get you the information. I would like to measure this year against last year.

Mr. PETZEL. I would also. Thank you.

Mr. CHAIRMAN. Okay. Yes, sir. Ms. Brownley.

Ms. BROWNLEY. Thank you, Mr. Chair. Before I ask a question, I would like to ask you, I mentioned earlier that I recently visited some VA facilities or most of the VA facilities in my district, the Oxnard, CBOC, the Ventura Vet Center, and West Los Angeles Medical Center, which serves both Ventura vets as well as Los Angeles County vets. And as you know, it is the VA, the West LA Medical Center is the largest medical center in the country.

And I would just like to ask consent to include some written questions into the record for—as a result, I have questions from those visits that I had in Ventura County, as well as the West LA Medical Center, if I could submit those to the record on behalf of

myself and Congressman Waxman, who also represents specifically the West LA Medical Center?

Mr. CHAIRMAN. Without objection, and let the record show it is at the request of all Members of this Committee.

Ms. BROWNLEY. Thank you, Mr. Chair. And I just wanted to go back to, I think, you know, listening to the testimony of the first panel, I think my sort of biggest take away from that testimony is looking at our models of delivery, noting that personalization, trust, are essential components. Some of the testimony talked about looking, comparing our delivery of vet services to private practice, meaning having contact with one individual, with one therapist who you can call, you know, 24/7 if needed.

And so—and I know that they are—and your testimony that you talked about a lot of different programs which I believe are beneficial and are improving services, but it still is a concern to me if the personalization and trust is still built in to all of those programs. If you have to move from one program to the next program to the next program, I mean, that is one thing when you are having heart trouble, and you are going to get an X-ray and moving from one situation to the next. But for mental health care services, vets I believe, are different.

So in the spirit, I guess, of—in any operation, in the spirit of sort of continuous improvement, are we looking down the road to sort of other models of delivery that would improve and enhance and bring our delivery of services perhaps closer to a private practice model?

Mr. PETZEL. The answer short is yes, Congresswoman Brownley. But I mean, in a moment, I am going to ask the other witnesses to comment on the remarks that Dr. Schwartz made, which are not the case. I cannot speak specifically what is going on in Connecticut, but our providers give their cell phone numbers, develop safety plans, et cetera to individual patients, and they are available 24/7, in addition to the emergency room services that we have available in all of our medical centers, and some of our larger clinics. That is just the way the system works.

But as I said earlier, this developing of a relationship and such that people will talk to you about what is going on, I think is a very important fundamental part. And we have a newly organized task force that Dr. Kemp is chairing, that is going to look at how we can develop a different paradigm, if you will, for the way we deliver care to people that have chronic pain, sleep disorders, depression, et cetera. The thing that have the greatest impact on suicide.

The other care model that is growing rapidly in our system is the embedding of mental health providers into the primary care clinic, or the PACT team. We now have, I believe 593 places where that is actually happening, both in our medical centers, in our primary care clinics.

And there you would have a nurse practitioner in mental health, perhaps a psychologist, or a psychiatric social worker who works with that primary care team, and has a relationship back to the primary mental health group, a psychiatrist, et cetera. And that individual is able to manage the mental health issues in that panel of primary care patients. Therefore, that individual with mental

health difficulties does not have to leave that clinic. All those services are available in that same arena.

I think that is going to become a rapidly developing phenomena. The VA is a pioneer in that, but I think this is something you are going to see in other integrated delivery systems in the private sector.

And then the last thing is telemental health, which is growing very rapidly, and is the way that we are reaching, one of the ways that we are reaching into the rural parts of this country to provide the specialized mental health services.

Ms. BROWNLEY. And following up, there was also a comment about—part of the testimony saying that the larger the VA becomes, there is the possibility, I guess I should say of the quality and effectiveness of programs going down. And the notion of combining—partnering VA services with state services and I think community services to, again, I think to attract the right models of personalization and consistency and effectiveness, so.

And what you were just suggesting and looking ahead to, are you also looking at greater community partnerships for our veterans?

Mr. PETZEL. Yes, we are, Congressman. That is what the 15 pilots are all about. That is what the network that we already have established in Montana is all about. And I think that there is going to be fruitful work to be done, particularly with the community mental health systems, which is another federally funded system around the country.

You know, the difficulty in the private sector is, they have got the same problems with shortages as everybody else does. When you look at a map of this country, there are 33 states where more than 25 percent of the population is under served in terms of mental health, going all the way down the inter-mountain country, there are 18 states in that area that have a shortage of mental health providers. There is not a lot out there for us to contact within these community mental health clinics, are one of the resources that we know, you know, is there. And we intend to exploit that.

Ms. BROWNLEY. And what about pipeline issues? I read, I think, in your testimony or in another report that for example, psychiatrists, there is a shortage of psychiatrists, and I hear your concern about the limited amount of talent that is out there, that we need to secure. And so are we looking towards that sort of pipeline issue to make sure that we do, that we do indeed—am I over my time, Mr. Chair?

The CHAIRMAN. Yes. There is a clock right in front of you.

Ms. BROWNLEY. Oh, I was looking at my clock here, and it says three minutes. I apologize.

The CHAIRMAN. Yes, the little red light, the little red light, three minutes means you are three minutes over time.

Ms. BROWNLEY. Oh, I apologize.

Mr. PETZEL. May I take a moment, Mr. Chairman, to respond?

Mr. CHAIRMAN. Please.

Mr. PETZEL. In terms of the pipeline, very important question. VA is the largest health—trainer of health care professionals in the country. We devote 6,400 trainee physicians a year to mental health programs. 1,900 psychology training positions, mostly internships, the finishing year for a psychologist, 3,400 psychiatry

residency physicians, again the largest trainer of psychiatrists in the country; and then 1,100 psychiatric social worker positions.

We added last year 220 positions to that, all of them in these new concept team care organizations, training physicians in the PACT mental health embedded program, et cetera.

So we are a big trainer. Seventy percent of the people we recruited in psychiatry and psychology trained within the VA. It is a very important recruitment tool for us. But I think the Committee must recognize the fact there is a shortage of psychiatrists in this country. There are not enough training positions for psychiatric residencies.

The CHAIRMAN. Thank you very much. Mr. Coffman?

Mr. COFFMAN. Thank you, Mr. Chairman. Dr. Petzel, in your testimony you state that as of March 2012, the VA was said to have 18,587 mental health providers, and by using an approved accounting methodology, the VA currently has 19,743, but on April 19th, 2012, the VA indicated it was adding 1,900 staff, "to an existing workforce of 20,590." Now, I'm not a mathematician, but the numbers show that VA is losing mental health professionals. So in what kind of fuzzy math is your current level of 19,743 a "net increase" over the past level of 20,590?

Mr. PETZEL. Well, Congressman Coffman, it is not fuzzy math. We had a process for assessing how many people we had on board in March that I would describe as incomplete. We took one database, and applied it across the country, and came up with a number that approximated 20,500 if I remember correctly.

Over the summer, we have refined the way we count our on board strength, and what we have discovered is that there were people not doing clinical work, that were included in that 20,500. They were hired to do clinical work and research, and we were counting them a hundred percent clinical. They were hired to do clinical work and education, and we were counting them as a hundred percent clinical work.

When we went back and used two separate databases and refined these educational and research components and administrative components out of that, we came back with an on board strength in March of 18,587. Using that same methodology in November, we came on—we came to an on board strength of 19,743. Thus, an increase of 1,156. Very clear, it is not fuzzy, it is not playing with the numbers, that is the fact.

Mr. COFFMAN. I think that—it is odd that you—that VA would not know exactly how many people when asked are providing work to help our veterans. And so the—Dr. Petzel, has VA done anything to find out what your own mental health providers are saying about the work being done?

Mr. PETZEL. Yes. That is an excellent question. When we, this spring have got implemented our performance criteria for timeliness, the intention is to go out and do three things. One, look at the measures. Two, survey veterans as to whether or not they were—had timely access as well as other satisfaction related questions. And three, to survey the staff. Are they able to provide timely access for their patients, are they adequately staffed, do they have enough people to do the work that they are being required.

So, yes, we are going to do it. And we will be doing that on a regular basis. That is part of evaluating whether or not we are accomplishing what we said we would accomplish in terms of access.

Mr. COFFMAN. Great. Could you please provide a copy of the unadulterated results to the Committee by the end of the day?

Mr. PETZEL. Well, this is something we are going to be doing this spring, Congressman.

Mr. COFFMAN. But there was a recent survey done, was there not? Could you provide to the Committee any recent surveys done in the last 12 month period on your providers, in terms of what we just talked about?

Mr. PETZEL. Yes, we will.

Mr. COFFMAN. Thank you very much. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much. Mr. Michaud, anymore questions?

Dr. Petzel, thank you and the folks that have joined you for what you do. We all want to work together to resolve this issue. My last question I guess to you is, what recommendations do you have for this Committee that we can do to aid you in your quest to provide quality and timely mental health services to our veterans?

Mr. PETZEL. That is an excellent question, thank you. One is facilitating our interactions with the community health centers. I cannot be specific, but I think that is an important part of the future.

Two, is helping us work with the private sector, provide a community where it is available to provide services in areas where we are not able to do that.

And then three, I would add as I mentioned earlier, I do not know how this Committee can influence it, but there is a real shortage of psychiatrists in this country, and mental health training positions. And whatever can be done to help improve that, I think would benefit the veteran community.

The CHAIRMAN. I do find it quite interesting that you have mentioned the shortage of providers several times in your testimony, yet you are almost exceeding your goals for hiring. What do you do that the private sector cannot do that helps you fill those slots so quickly?

Mr. PETZEL. Thank you, that is also a very good question. Number one, our salaries are very competitive for nurses, for psychologists, and for social workers. Number two, is a good place to have a career. It is a large organization, and can work in many different parts of the country, and you do many different kinds of jobs.

We do have, however, difficulty in the psychiatry. I mean, I do not want to brush over that. Of all of the professionals in mental health, the most difficult problem we are having is recruiting psychiatrists, and we have barely been able to recruit half of the new ones that we said we wanted to do, and that it is in spite of raising the salary quite substantially, providing incentives for recruitment bonuses, et cetera.

The CHAIRMAN. Okay. Thank you very much. I would ask unanimous consent that all Members would have five legislative days to revise and extend their remarks, or add any extraneous material for the record. Without objection, so ordered.

Thank you everybody for being here today. Thank you to both panels. This hearing is adjourned.

[Whereupon, at 12:02 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Jeff Miller, Chairman

The Committee will come to order.

Good morning, and welcome to today's Full Committee hearing, "Honoring The Commitment: Overcoming Barriers To Quality Mental Health Care for veterans."

Today's hearing is our first Full Committee hearing of the 113th Congress and it is only fitting that we begin our oversight by addressing one of the most pressing and fundamental issues facing our servicemembers, veterans, and their families—our ability to provide timely and effective mental health care to veterans in need.

This issue is not a new one, but it is a growing one.

In the last six years, there has been a thirty–nine percent increase in VA's mental health care budget and a forty–one percent increase in VA's mental health care staff.

Unfortunately, those significant increases have not resulted in equally significant performance and outcomes.

Less than a year ago, the VA Inspector General released a review of veterans mental health care access that painted a disturbing picture, showing that the majority of veterans who seek mental health care through VA wait fifty days, on average, for an evaluation.

That figure amounts to thousands of veterans in need—veterans who have recognized they need help and who have taken the hard step of asking for it—being told by the Federal bureaucracy tasked with caring for them that they have to wait in line because VA cannot provide them with the timely access to care they need to begin healing.

And it gets worse.

Earlier this month, VA released its 2012 Suicide Data Report.

That report shows, among many alarming findings, that the suicide rate among our veterans has remained steady for the past twelve years, with eighteen to twenty–two veteran suicide deaths per day since 1999.

As that report so clearly illustrates, when a veteran is in need of care, the difference of a day or a week or a month can be the difference between life and death.

This morning, the department is going to testify that progress is being made to increase access to mental health care services and reduce veteran suicide.

They will proclaim that they have hired just over thirty–two hundred additional mental health care personnel.

However, despite our requests, VA has not provided evidence to verify its efforts.

And while I am and will remain supportive of the improvements the department is attempting to undertake internally, it has become painfully clear to me that VA is focused more on its process and not its outcomes.

The true measure of success with respect to mental health care is not how many people are hired, it is how many people are helped.

Since 1999, VA's mental health care programs, budget, and staff have increased exponentially and the number of veterans seeking care has grown, yet the number of veterans tragically taking their own lives has remained the same.

What's more, the Suicide Data Report I mentioned earlier, shows that the demographic characteristics of veterans who die by suicide is similar among those veterans who access VA and those veterans who don't.

Something is clearly missing.

On our first panel this morning we will hear from representatives from our veterans service organizations, an established veterans mental health researcher, and a state commissioner of veterans affairs.

Three of them are veterans themselves, and all of them will testify that the provision of mental health care services through VA is seriously challenged and that what is needed to fix it is decidedly not more of the same.

Last night, the President announced that a year from now thirty four thousand of our servicemembers currently serving in Afghanistan will be home.

The one size fits all path the department is on leaves our returning veterans with no assurance that current issues will abate and fails to recognize that adequately addressing the mental health needs of our veterans is a task that VA cannot handle alone.

In order to be effective, VA must embrace an integrated care delivery model that does not wait for veterans to come to them, but instead meets them where they are.

VA must stand ready to treat our veterans where and how our veterans want, not just where and how VA wants.

I can tell you this morning that our veterans are in towns and cities and communities all across this country, and the care they want is care that recognizes and respects their own unique circumstances, preferences, and hopes.

Thank you all for being here today.

Prepared Statement of Hon. Michael Michaud

Thank you, Mr. Chairman, for continuing to keep the issue of access, quality, and timely mental health services provided to our veterans at the forefront of this Committee.

Thank you to all of our witnesses today for coming and talking with us about the critical issue of veteran mental health access. I would also like to thank all of you in the audience who are here today in support of veterans.

We, as a Nation, have a responsibility – a sacred trust - to care for those whom we send into harm's way. When we send our citizens into battle around the world, we must be leading the charge here at home, within our government, to make them whole again upon their return by ensuring that adequate resources and proper programs are in place to address their needs.

Oversight of VA's mental health programs has been a focus of this Committee for some time now. Over the years we have held numerous hearings, increased funding and passed legislation in an effort to address the challenges veterans from all eras face.

VA spent $6.2 billion dollars on mental health programs in Fiscal Year 2012. I hope to see some positive progress that this funding has been applied to the goals and outcomes for which it was intended, and the programs are working.

We all know that mental health is a significant problem that the Nation is facing, not just veterans or the VA. In this broader challenge is an opportunity for the VA to look outside their own walls to solve some of the challenges they face, rather than operate in a vacuum as they sometimes have done in the past.

One of the most pressing mental health problems we face is the issue of suicide and how best to prevent it.

Fiscal Year 2012 tragically saw an increase in military suicides and for the third time in four years, the number of suicides surpassed the number of combat deaths. Couple that with the number of suicides in the veteran population of 18 to 22 per day and the picture becomes even more alarming.

I believe VA is headed in the right direction. I believe that they have made a true effort to get a good picture of the suicide issues that surround veterans. I believe more can and must be done.

I will be interested to hear from our panelists about the national mental health picture and helping this Committee put the veteran suicide rates in context, as well as what is happening nationally in treating mental illness.

Today's hearing will examine the progress VA has made in a variety of areas concerning mental health and providing timely access and quality care.

I am hopeful that this will be a good discussion on ways to provide that care such as more partnering with the public and private sector, increasing the pool of providers, and other creative ways to address mental health.

Finally, I would be remiss if I did not acknowledge the dedication of the VA employees who provide quality mental health care to our veterans every day. The directors, doctors, nurses and hospital workers are a team that when it comes together in a collaborative and synergistic way delivers on the Nation's responsibility and sacred trust to care for those who have sacrificed.

With that Mr. Chairman, I yield back.

Prepared Statement of Hon. Jackie Walorski

Mr. Chairman, it's an honor to serve on this Committee.

I thank you for holding this hearing on such an important issue facing our Nation's veterans.

I must first express my sincere gratitude to the 50,000 veterans and their families back in Indiana's Second Congressional District.[1] I am indebted to these men and women for their sacrifice in protecting this great Nation.

While I am proud of these veterans, I am appalled and saddened by the progress that has been made in providing them with timely and appropriate mental health care. It is obvious that we must work to significantly improve the procedures and systems used in providing mental health care to current veterans as well as those servicemembers soon transitioning to civilian life.

I look forward to working with my colleagues and our panelists to ensure our veterans are provided with the best access to mental health care.

Thank you.

Prepared Statement of Hon. Raul Ruiz

Thank you Mr. Chairman for holding today's hearing on mental health care services for our veterans. Oversight of VA's mental health programs has long been a focus of this Committee. And while much has been accomplished, we still have a long way to go in providing our veterans with quality, efficient mental health care.

I am always discouraged when I hear stories of struggling veterans facing delay and denial of much needed care here at home when they sacrificed so much abroad. Our health care system is not only dated, but also strained to capacity. We need to begin modernizing and streamlining the process so veterans who need care can get care quickly.

In this spirit, I am encouraged by a recent announcement last April of the addition of 1,600 mental health clinicians and 300 support staff to the VA's existing workforce. While this is a start, the VA needs to continue to focus on the many other cracks in the system including its inaccurate reporting of timely patient care.

These issues are extremely important to veterans in my district considering the location of VA's Palm Desert clinic which provides primary care services for veterans in the Coachella Valley, including mental health care services.

Thank you, Mr. Chairman, and I yield back my time.

Prepared Statement of M. David Rudd

Mr. Chairman and members of the committee, I appreciate the opportunity to speak on the issue of barriers to quality mental health care for Veterans. As revealed in the Department of Veterans Affairs 2012 Suicide Data Report, Veterans continue to die by suicide at tragically high rates, with an estimate of 22 deaths per day. However, the true scope of the problem is only realized by coupling VA and active-duty data. As has been widely reported, there were 349 suicides among active-duty service members in 2012, with that total exceeding combat deaths (and the rate doubling since 2004). Prior to Iraq and Afghanistan, military service was actually protective, with military suicide rates noticeably lower than general population rates likely secondary to pre-enlistment screening, unit cohesion, the influence of a remarkable sense of purpose, and a warrior identity. A decade of war has changed many things. It is important to recognize that Veteran suicides may actually be underreported, with reliable data only available in 21 states and data from two of our largest states (Texas and California) not included in the report. I have serious concerns that these numbers will continue to grow in the coming months and years, primarily a function of converging forces that can both be anticipated and managed more effectively.

Although I applaud the transparency and thoroughness of the VA Suicide Data Report and progress made to date, I believe it critical for the committee to put the data into context. It is correct that suicide rates among Veterans (VHA users) have

[1] There are an estimated 53,318 veterans in IN–02. This data was compiled on 09/30/2012, based on the district lines from the 112th Congress. *http://www.va.gov/vetdata/Veteran—Population.asp*

been relatively stable over the course of the past 12 years, with an overall rate of 35.9/100,000 in 2009 (and a male suicide rate of 38.3). It is critical to recognize, though, that the rate is *three times* the national rate of 12.0 in 2009 and *double* the male suicide rate (19.2) for the general population. It is also reported that although the suicide rate among Veterans rose 22 percent over the past decade the general population rate rose 31 percent. Please understand, though, that the Veteran suicide rate is already so high that the rate of growth should naturally slow. Similarly, the drop in the percentage of our nation's suicides accounted for by Veterans is important (from 25 percent to 21 percent), but that means that one in five suicide deaths in the general population is by a Veteran despite the lowest military service rates in U.S. history. Perhaps most worrisome among findings is that younger Veterans appear to be dying by suicide at disproportionate rates (when compared to the percent of Veterans in the contributing states), with rates more comparable in older age groups. This data might reflect a persistence of problems from activity-duty to Veteran status for Iraq and Afghanistan Veterans in particular. My concern is that the data need to be accepted for what they represent, a very serious and significant health problem among Veterans. Contrast and comparisons to the general population, although limited, help us recognize the magnitude and persistence of the problem. These data should challenge us to do better not reassure us the problem is under control. These data should challenge us to think about doing things differently, not simply funding "more of the same". These data can be added to almost a decade worth of findings that indicate what we have been doing has not been particularly effective.

As indicated in the report, since 2009 approximately 30 percent of callers to the national crisis line have endorsed thoughts of suicide, down from 40 percent. Although the drop could suggest progress, it is more likely that the crisis line is not actually attracting the highest risk callers. Are we reaching those at greatest risk for suicide? The persistence of high suicide rates would suggest the VA might need to explore other options for identifying and reaching those at greatest risk. The fact that 80 percent of those with non-fatal events were seen 4 weeks prior to the event suggests the need to target the continuity and intensity of care, along with raising the question of whether or not heightened risk is readily recognized by clinicians. If it is, we need to improve access, the frequency, and continuity of care. We know the VA provides high quality care. Access to predictable, frequent follow-up care is an issue to target. Similarly, the fact that 90 percent were seen in an outpatient setting suggests the need to target primary care and outpatient mental health as the focal points. The fact that the greatest risk is among Veterans over age 50 speaks to the chronicity of many of these mental health problems and the importance of not just crisis care, but ongoing long-term treatment. In order to reduce wait times and provide accessible, predictable, long-term care the VA will need to explore partnerships with private community providers. Continued centralization within VA healthcare needs to be challenged.

I am convinced that the bulk of the problem is not a clinical one. We have to do a better job of managing those at risk, providing easy and frequent access to care, and convincing Veterans to stay in care. The more difficult we make it to get or stay in care, the more Veterans will die by suicide. I believe that among the most significant barriers to care for Veterans is the lack of meaningful transitional services for those evidencing heightened risk while on active duty, only to be discharged and left alone to navigate the maze of government services. The tragic suicide of Russell Shirley demonstrates the problem. I recently spoke with Russell's mother and one of his close friends. His mother consented to me sharing his story. Russell was a son, a husband, a father and a soldier. He served his country proudly and bravely in Afghanistan. Although he survived combat, he came home struggling with post-trauma symptoms and traumatic brain injury. With a marriage in crisis and escalating symptoms, Russell turned to alcohol, with the net outcome a DUI and eventual discharge. Russell lost his family, his career, his identity, and eventually put a gun to his temple and pulled the trigger in the presence of his mother. His mother now struggles with her own brand of PTSD. Russell's high risk status was easily recognized. In order to help struggling soldiers like Russell, we need to connect them not just the VA system, but people in the system. The DoD and the VA need to work hand in hand to improve transitional services for high-risk service members being discharged or voluntarily separating. With significant budget cuts likely, these numbers will only grow. The VA needs to experiment with partnerships in local communities that allow Veterans to receive accessible and long-term care near home rather than having to travel great distances. Instead of building an even bigger and less flexible and responsive healthcare bureaucracy, now is the time to experiment with new and creative alternatives.

For the first time in history, we have conducted clinical trials with active-duty service members struggling with PTSD, depression and suicidality. Early results are promising. Can we find a way to provide treatment prior to designating a Veteran as "disabled", as we know that once someone is identified as disabled it is unlikely that status will ever change? This also speaks to the chronic nature of the problems revealed in the VA report, i.e. the highest suicide rates among those over age fifty. As the drawdown in Afghanistan continues and the DoD grapples with smaller budgets and force reductions there will be more tragedies like that experienced by the family of Russell Shirley unless we find ways to ease the transition from activity duty to VA services, improve access, retain Veterans in treatment, and experiment with alternatives to permanent disability status.

It is important to recognize that behind every statistic quoted above there is a large collection of friends and loved ones. I have included a photo of Russell with his children at the end of this document so you and I can remember the Americans touched by this problem.

M. David Rudd, Dean, College of Social & Behavioral Science, University of Utah
Co-Founder and Scientific Director, National Center for Veterans Studies

Prepared Statement of Linda Spoonster Schwartz

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

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

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

As Connecticut's Commissioner of Veteran Affairs since 2003, I have a unique position and responsibility to be sure that we do not repeat the mistakes of the past. As a veteran of the Vietnam War and a nurse who has dedicated over 20 years to advocacy for veterans, I am acutely aware of the fact that the veterans returning home now are very different than the veterans of my generation or my fathers World War II generation. While they are not encumbered with validating the legitimacy of Post Traumatic Stress, they have brought the issues of blast concussions, Traumatic Brain Injuries, suicides and the importance of families to mission readiness to the forefront. Perhaps it is because they may have trained with a unit for years and experienced the intensity of living in the danger of a war zone with their unit, that they feel isolated in their own homes. During deployments, they longed for family and friends with visions of a celebrated homecoming only to find upon their return home that crowds and daily responsibilities are both overwhelming and frightening. After living on the edge of danger for the prolonged deployment periods, life in America seem boring and mundane. Although they care deeply about their

families, they are "different" and ill at ease in their everyday existence and can't seem to find their way "HOME Along with the "Send Off" ceremonies and the "Welcome Homes", observers began to realize that families left behind experienced difficulties and stress every day of the deployment. Along with readjusting to the absence of the military member and the great unknown of what they would be encountering during their tour of duty, those of us tasked with working with these families came to the realization that there were serious gaps in the system. In addition to the day to day concerns of home repairs, young spouses managing additional duties in the home, environment and financial constraints, families were having difficulties that indicated a need for professional counseling and treatment to cope with the demands and strains they encountered.

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

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

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

Survey of Recently Returned Veterans

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

symptoms which exceeded the diagnostic threshold for Post-Traumatic Stress Disorder.

Common Barriers we have observed are:

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

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

Domestic Violence

When addressing the issue of mental health treatment for families, I would be remiss if I did not reference the increase body of evidence which links combat veterans, Post Traumatic Stress with violent and abusive traumatic events in the home. Domestic Violence has always been a factor in military life. It is not new. What is new is the fact that victims are no longer silent and someone is listening.

The American public is not as tolerant as it was decades ago to the litany of brutal deaths suffered in military communities or at the hands of a military member of veteran. While the Pentagon has made efforts to address these issues and offer support and education to military families, the present hostilities heavy reliance on citizen soldiers of the Reserve and National Guard Components accentuate the stressors on everyone involved and bring these volatile scenarios to every town and city in our Country.

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

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

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

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

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

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

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

the military and veterans culture. We realized the importance of this from the surveys we did and "Focus Groups" we convened.

Most interesting we learned:

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

b) Importance of camaraderie with fellow military or veterans

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

d) Communication difficulties with everyone except fellow military

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

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

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

A Shared Responsibility

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

State Governments, there are local programs, services and resources that have been developed to meet the needs of veterans where they live and work. State Legislators are as vitally engaged in the needs of veterans and also creating new programs and services as are Members of Congress.

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

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

Connecticut's Military Support Program

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

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

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

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

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

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

Suicides

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

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

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

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

Prepared Statement of Joy J. Ilem

Chairman Miller, Ranking Member Michaud and Members of the Committee:

On behalf of Disabled American Veterans (DAV) and our 1.2 million members, all of whom are wartime wounded, injured or ill veterans, along with 200,000 Auxiliary members, I am pleased to present our views on addressing the barriers veterans face when trying to gain access to mental health services from the Department of Veterans Affairs Veterans (VA). DAV is committed to fulfilling our promises to the men and women who served, and one of those promises is to ensure that veterans receive a full and lasting opportunity to recover from physical, emotional and psychological wounds that occur as a consequence of their military service experience.

We appreciate your determination, Mr. Chairman and Members of this Committee, for continued concentration on this important and pressing issue, as well as the opportunity to offer DAV's views on the challenges confronting the Veterans Health Administration (VHA) in meeting the critical mental health needs of our nation's veterans. DAV's statement focuses on the Committee's concerns about the status of VA's progress on growing mental health professional staffing levels; mandates outlined in the President's recent Executive Order to improve access to mental health services for veterans, service members and their families; addressing the recommendations in the 2012 Office of Inspector General (OIG) report on waiting times

for mental health services; improving data collection related to access measures; scheduling processes and procedures; and partnering with non-VA mental health providers to address gaps in VA care.

Since the wars in Iraq and Afghanistan began over a decade ago, more than 2.4 million individuals were deployed to overseas combat theaters; many have deployed several times. Of this group of brave men and women, 1.5 million have been honorably discharged and are now eligible for VA health care. VA's most recent cumulative data shows that 834,467 of them have obtained VA health care and that 53 percent, or 444,551 veterans, have been diagnosed with a mental disorder.

Additionally, there were a record 349 military suicides in 2012, exceeding the 310 combat deaths reported during that period.

More than eleven years of war have clearly taken a toll on the mental and physical health of American military forces and the veterans among them who have returned to civilian life. Research shows that post deployment mental health readjustment challenges and post-traumatic stress disorder (PTSD) are prevalent in many returning service members and veterans. We believe that everyone returning from contingency operations overseas should be empowered to achieve maximal opportunity to recover and successfully readjust to civilian life. But to do so, as warranted by their circumstances, they must be able to gain "user-friendly" and easy access to Department of Defense (DoD) and VA mental health services—services that have been validated by research evidence to ensure their best opportunities for full recovery and reintegration with their families, jobs and private life.

Over the past five years, the post-deployment health status of our servicemen and women and veterans, suicide prevention, and timely access to appropriate mental health services, have been topics of numerous Congressional hearings, government reports and regular media scrutiny. Collectively, the hearing findings, reports and coverage cast a negative impression related to appropriate and timely access to services, often highlighting barriers to care and systemic flaws in an overly "medicalized," bureaucratic health care system. Given the diligent oversight by the Veterans' Committees in both Chambers, and the significant level of new resources that were authorized to address the existing deficits and to improve VA mental health services and other care for veterans, the current question posed by the Committee Chair is a valid one: "Is the VA's complex system of mental health [care] and suicide prevention services improving the health and wellness of our heroes in need?"

Mr. Chairman, although flaws unquestionably can be found in the system, and must be addressed, DAV would be remiss in failing to recognize and applaud VA's efforts to date to improve these programs. Tens of thousands of dedicated mental health practitioners and Readjustment Counseling Service Vet Center counselors work day-in and day-out, to help veterans who are struggling in their post-deployment readjustments.

Over the past five years, VA's Office of Mental Health Services (OMHS) has developed and disseminated a comprehensive array of mental health services throughout the VA health care system, while accommodating a 35 percent increase in the number of veterans receiving mental health services and managing a 41 percent increase in mental health staff. At DAV, despite all the problems reported, we believe this is remarkable progress. In 2011 (most recent data), VA provided specialty, recovery focused mental health services to 1.3 million veterans, at very high levels of satisfaction. These services were both patient-centered and integrated into the basic care of the patients using VA services. Today, mental health is a prominent component of VA primary care – a long sought goal of DAV, other veterans' advocates and the mental health research community.

VA offers veterans a wide range of mental health services, from treatment of the milder forms of depression and anxiety in primary care settings themselves, to intensive case management of veterans with serious, chronic mental challenges such as schizophrenia, schizo-affective disorder, and bi-polar disorder. VA also offers specialized programs and treatments for veterans struggling with substance-use disorders and post-deployment readjustment difficulties, including providing evidence-based treatments for PTSD for combat veterans and for those who endured and survived military sexual trauma.

For at least the past five years, while under intense external pressure, VA has placed special emphasis on suicide prevention efforts, launched an aggressive anti-stigma, outreach and advertising campaign, and provided services for veterans involved in the criminal justice system, including direct VA participation in the veterans treatment courts initiative, to support both pre-release and jail-diversion programs in a rising number of states and cities. Peer-to-peer services, mental health consumer councils, and family and couples counseling and therapy services have also been evolving and spreading throughout the VA health care system. We at DAV

are encouraged by these developments, we believe they are humane approaches, and are saving lives.

Yet despite noted progress, the Institute of Medicine (IOM) released a report, entitled *Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations,* in July 2012, that addresses some of the Chairman's concerns—specifically, whether the readjustment services available to veterans improving the health and wellness of our nation's transitioning service members. In the report, after a comprehensive review of government programs for the treatment of PTSD, the IOM found a lack of coordination, assessment and monitoring by both DoD and VA. The IOM concluded treatment is not reaching everyone who may need it, and that the Departments are not tracking which treatments are being used, or evaluating whether and how well they work over the long term.

DAV concurs with recommendations made by the IOM that VA and DoD should invest in targeted research to fully evaluate the effectiveness and health outcomes of existing PTSD treatment and rehabilitation programs and services. Likewise, VA and DoD should support research that investigates new and emerging technologies and web-based approaches to overcome barriers to accessing mental health care, and adhering as well to more comprehensive and long-term evidence-based treatments. The report noted that the IOM committee's analysis of innovative or complementary and alternative medicine treatments such as yoga, acupuncture and animal-assisted therapy was limited since these types of treatments lacked empirical evidence of their effectiveness. Given that these alternative treatments have become more popular and requested by many veterans, DAV urges that both DoD and VA carefully study and evaluate these treatments to judge their efficacy versus other approaches.

OFFICE OF INSPECTOR GENERAL 2012 RECOMMENDATIONS, AND PRIOR EXTERNAL REVIEWS

Based on a request from both Committees on Veterans Affairs, in April 2012, the VA OIG reported on the level of accuracy the Veterans Health Administration (VHA) documents in waiting times for mental health services for new and established patients, and whether the data VA collects is a true depiction of veterans' ability to gain and keep access to needed services. The OIG found that VHA's mental health performance data is inaccurate and unreliable and that VHA's data reporting of first-time access to full mental health evaluation was not a meaningful measure of waiting.

Since the OIG had found a similar practice in previous audits nearly seven years earlier, and given that VHA had not addressed the longstanding problem, OIG urged VHA to reassess its training, competency and oversight methods, and to develop appropriate controls to collect more reliable and accurate appointment data for mental health patients. The OIG concluded that the VHA " . . . patient scheduling system is broken, the appointment data is inaccurate and schedulers implement inconsistent practices capturing appointment information." These deficiencies in VHA's patient-appointment scheduling system have been documented in numerous reports.

STAFFING ISSUES

The OIG also recommended in the 2012 report that VHA conduct a comprehensive analysis of staffing to determine if mental health provider vacancies were systemic and impeding VA's ability to meet its published mental health timeliness standards.

The DAV shares the Committee's concerns about how VA plans to resolve its mental health staffing deficits to meet rising demand for critical mental health services. In April 2012, the Secretary announced VA would add approximately 1,600 mental health clinicians and 300 support staff to VA's existing mental health staff of 20,590, in an effort to help VA facilities meet burgeoning demand. In his testimony before this Committee on May 8, 2012, Secretary Shinseki testified that he estimated six months would be required for VA to hire most of these new mental health personnel. DAV awaits VA's report on the number of new providers who have been hired, and are now providing care to veterans. As we have noted in prior testimony, the bureaucratic and cumbersome human resources process in VA, especially in credentialing new VA professional providers, continues to hamper VA's ability to quickly put newly-hired individuals on the front lines caring for patients. For more insight on these challenges, please review our discussion of VA human resources concerns in the Fiscal Year 2014 Independent Budget, at *www.independentbudget.org*.

VHA's timely access goal is simply to treat a veteran patient in clinic within 14 days from the desired date of care. One method VA uses to monitor access to health care including mental health services is to calculate a patient's waiting time by measuring the number of days between the desired date of care to the date of the

treatment appointment. Appointment schedulers at VA facilities must enter the correct desired date(s) of care in the automated scheduling system to ensure the accuracy of this measurement.

Data generated to measure a veteran patient's timely access to care continues to remain unreliable. There continues to be weaknesses in VA's policy and implementation of scheduling medical appointments based on several reports spanning more than a decade from VA's OIG and the U.S. Government Accountability Office. [1] The weaknesses reported include VA's definition of the "desired date" of the medical appointment contained in policy, [2] and VHA's training and oversight program to address the problems in measuring waiting times. We urge VA OIG to report on the status of those recommendations from its 2007 review, which indicated that five out of eight recommendations were either not implemented or were only partially implemented.

Without reliable data, VA will remain challenged in conducting meaningful analysis and decision-making that directly impact the quality, patient-centeredness and timely delivery of needed care, including mental health care.

After more than a decade of effort, VA's Office of Information and Technology has remarkably still not completed development of a replacement for VHA's antiquated, 25-plus year-old scheduling system, and one that can effectively manage the scheduling process, provide accurate workload data capture and reporting technology, and be responsive to the needs of VA's mental health patients and providers.

As noted in OIG's most recent report on veterans' access to mental health care, VA's "scheduling software is 25 years old and the software interface is not "user-friendly." This automated scheduling application has been an essential component of the Veterans Health Information Systems and Technology Architecture (VistA) electronic health record, and performs multiple, interrelated functions. VistA captures and assembles utilization data, which is intended to enable VA to measure, manage and improve access, quality and efficiency of care, and evaluate the operating and capital resources used.

GAO reported in 2010 on VA management deficiencies, principally VA's second effort at developing a replacement scheduling system for the aging VistA. [3] Since that time, VA has abandoned this project, and on December 21, 2012, VA issued a request for information in *Federal Business Opportunities* to update and rebuild the application, with responses due from industry by January 31, 2013. VA plans the new scheduling system to be standards-based, extensible and scalable and interoperable with the version of VistA held by the Open Source Electronic Health Record Agent (OSEHRA). According to VA, the new health scheduling system will rely on web- and mobile-device capabilities for quick and secure communications with veterans, and support for resource allocation decisions based on truer data, with more opportunity to adjust capacity dynamically to meet changing needs.

Because of current weaknesses in measuring veteran patients' access to care, it is unclear to DAV at this time if VA's new direction will correct lengthy VA waiting times, yield accurate access measures, or result in less cumbersome scheduling processes and procedures. DAV recommends the Committee conduct further oversight on VA's plans and intentions with respect to the replacement of VistA. This challenge has become much more acute based on VA's and DoD's joint announcement last week of their decision to abandon their long sought joint electronic health record project that would have served both the veteran and military populations, to proceed in separate directions, but to rely on a Janis GUI interface technique to translate data from one system to the other. In this case, VA scheduling software and its ongoing problems are a major weakness that must be addressed. Most importantly, the OIG report noted that meaningful analysis and decision making required reliable data, not only related to veterans' access to care, but also on shifting trends in demand for services, the range of treatment availability and mix of staffing, provider productivity and treatment capacity of the facilities. From this study, the OIG

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[1] HEHS–00–90, VA Needs Better Data on Extent and Causes of Waiting Times, May 31, 2000; GAO–01–953, More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress, Aug 31, 2001; GAO–12–12, Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, Oct 14, 2011; VA OIG Report No. 02–02129–95, Audit of Veterans Health Administration's Reported Medical Care Waiting Lists, May 14, 2003; VA OIG Report No. 04–02887–169, Audit of the Veterans Health Administration's Outpatient Scheduling Procedures, July 8, 2005; VA OIG Report No. 07–00616–199, Audit of the Veterans Health Administration's Outpatient Waiting Times, September 10, 2007, and; VA OIG Report No. 12–00900–168, Veterans Health Administration Review of Veterans' Access to Mental Health Care, April 23, 2012.

[2] VHA Directive 2010–027

[3] GAO–10–579, Management Improvements Are Essential to VA's Second Effort to Replace Its Outpatient Scheduling System, May 27 2010.

made four major recommendations to VHA. Similar to previous external reviews, the VA Under Secretary for Health concurred with all recommendations and replied that a number of responsive actions were underway. Again, in this instance we are anxious to determine from VHA the progress made thus far on the above-referenced recommendations.

In August of 2012, the President issued an Executive Order (EO) to improve access to mental health services for veterans, service members, and military families. It was noted that based on the wars in Iraq and Afghanistan, the need for mental health services will only increase in the coming years as the nation deals with the effects of more than a decade of conflict. We concur and agree that coordination between the DoD and VA during service members' transitions to civilian life is essential to achieving the goal of timely access to the provision of high quality mental health treatment for those who need it.

The EO focused on six areas including: suicide prevention; enhanced partnerships between VA and community mental health providers; expanded VA mental health services staffing; improved mental health research, and appointment of a military and veterans mental health interagency task force. Specific mandates in the EO included: expanding the 1–800–273–TALK "Veterans Crisis Line" capacity by 50 percent; developing and implementing a joint VA–DoD national suicide prevention campaign; establishing no fewer than 15 pilot programs and formal agreements with community-based mental health providers; hiring and training at least 800 new VA peer counselors by December 31, 2013; hiring 1,600 VA new mental health professionals by June 30, 2013; establishing a "National Research Action Plan" within eight months of the EO; developing in the DoD and Department of Health and Human Services (HHS) a comprehensive longitudinal mental health study with an emphasis on PTSD and TBI, including enrollment of at least 100,000 service members by December 31, 2012; and, development of an Interagency Task Force of VA, DoD and HHS to identify reforms and take actions that facilitate implementation of the strategies outlined in the EO.

This is clearly an ambitious plan, and we look forward to VA's report of progress on the outlined initiatives to improve access to mental health services for veterans, service members, and military families.

PARTNERING WITH NON–VA RESOURCES TO EXTEND ACCESS FOR VETERANS WITH MENTAL HEALTH CHALLENGES

Mr. Chairman, you recently endorsed a VA–TRICARE outsourcing alliance to serve the mental health needs of newer veterans that VA is, admittedly, struggling to meet today. Having offered little to bolster the confidence of DAV's members and millions of other veterans and their families that mental health services are, in fact, being effectively provided by VA where and when a newer veteran might need such care, we urge VA to work with the Committee to ensure that, if mental health care is expanded using the existing TRICARE network or some other outside network, veterans must receive direct assistance by VA in coordinating such services, and the care veterans receive must reflect the integrated and holistic nature of VA mental health care.

In working with Congress on this issue, the primary question is whether VA *should* partner with community mental health resources to provide this care when local waiting times exceed VA's own policies. When a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important for VA to determine the kind of mental health services needed and whether the most appropriate care would come from a VA provider or a community-based source. This type of triage is critical, because effective mental health treatment is dependent upon a consistent, continuous-care relationship with a provider. Once a trusting therapeutic relationship is established between a veteran and a provider, that connection should not be disrupted because of a lack of VA resources, a local parochial decision, or for the convenience of the government.

Moreover, it is imperative that if a veteran is referred by VA to a community resource we would insist the care be coordinated with VA. According to the IOM study cited earlier, care coordination is at the center of integration, and has been identified as a key component of high-quality health care. We agree. A critical component of care coordination is health information sharing between VA and non-VA providers. Information flow increases the availability of patient utilization and quality of care data, and improves communication among providers inside and outside of VA. The absence of obtaining this kind of health information poses a barrier to implement patient care strategies such as care coordination, disease management, prevention, and use of care protocols. These are some of the principal flaws of VA's current approach in fee-basis and contract care.

Today, as an evidence-based, data-driven and integrated health care system, VA has little meaningful information about how the care the Department currently purchases from outside communities affects clinical outcomes and health status of the veteran patient population receiving those services.

DAV's desire is to avoid this situation for veterans who may be referred by VA to receive mental health care from community sources, whether in TRICARE networks or community mental health centers. VA commissioned the RAND Corporation and the Altarum Institute to conduct an independent evaluation of the quality of the VA's mental health care system; they released a technical report in October 2011 titled, *Veterans Health Administration Mental Health Program Evaluation.* This report found a high degree to which veterans diagnosed with at least one of five mental health conditions also have difficulties with physical functioning and general health. That is, these veterans, while representing only 15 percent of the VHA patient population in 2007, accounted for one-third of all VHA health care costs because of their high levels of medical care consumption.

Because of the likelihood these veterans will need more than only mental health services, VA must be able to coordinate outside care with the services it is able to directly provide, and do so in an integrated manner. Integrated health care means the delivery of comprehensive services that are well-coordinated, with effective communication and health information sharing among providers, whether they are inside or outside of VA. Patients become informed and involved in their treatment, and when properly integrated, the care is high-quality and cost effective.

DAV believes VA's current authority to purchase by contract health care in the community ensures a continuum of medical care; however, this authority to date has been specifically intended by Congress to be a supportive (and restrictive) tool, to strengthen the VA health care system and improve the quality of health care provided to veterans, while ensuring no diminution of services that VA provides directly to veterans.

Mr. Chairman, in accordance with DAV Resolution No. 212, adopted by our members at our most recent National Convention in 2012, we urge VA to establish a purchased-care coordination program that complements the capabilities and capacities of each VA medical facility. Furthermore, we urge Congress and the Administration to conduct strong oversight of VA's purchased-care program to ensure service-connected disabled veterans are not encumbered in receiving non-VA care at VA's expense.

DAV RECOMMENDATIONS

DAV has recommended that VA develop a proper triage, and a better mental health staffing model, to help VA clinicians manage their patient workloads to address the unique treatment needs of each veteran, and to tailor treatment approaches to those needs. At your May 2012 hearing, VA also noted work was underway on a prototype staffing model that was being tested in three Veterans Integrated Service Networks (VISN). We are anxious to learn of the progress of the determination on whether VA can deploy this prototype throughout its nationwide system, and whether it works well for mental health in particular.

We have urged VA to be flexible and creative in its approach to solving this pressing issue of mental health and readjustment needs of younger veterans, including the use of treatment options ranging from non-traditional alternative and complementary care, peer- and non-medical counseling, to traditional evidence-based therapies, depending on the needs of individuals. We look forward to hearing about VA's progress in making these adjustments.

CLOSING

Despite obvious improvements, it is clear to us that much progress still needs to be accomplished by VHA to fulfill the nation's obligations to veterans who are challenged by serious and, in some cases, chronic mental illness, and particularly for younger veterans who are impacted by post-deployment mental health, repatriation, and transition challenges. Currently, we see the pressing need for more timely mental health services for many of our returning wartime wounded, injured and ill veterans, particularly in early intervention services for veterans with substance-use disorders, and for evidence-based treatments for those with PTSD, suicidal ideation, depression and other consequences of combat exposure. If these symptoms are not readily addressed at onset, they can easily compound and become chronic and lifelong. The costs mount in personal, family, emotional, medical, financial and social damage to those who have honorably served their nation, and to society in general. Delays or failures in addressing these problems can result in self-destructive acts, job and family disintegration, incarceration, homelessness, and even suicide.

Mr. Chairman, DAV has previously testified, that in our considered opinion, sending these veterans out of the system en masse is not the answer—this group particularly can benefit from VA's expertise in treating post-traumatic stress, PTSD, substance-use disorders, TBI and other post-deployment transition challenges. To that end, it is essential that VHA address and resolve the barriers that obstruct mental health and substance abuse care and prevent consistent, timely access to care at VA facilities nationwide.

Unfortunately, the problems in VA's mental health programs are complex, and cannot be resolved by any single reform. The root causes for existing barriers to care are multiple, systems-based, longstanding, and complex. DAV urges VA to address these deficits by addressing the root causes, not solely managing symptoms of the problem.

We believe the policy changes made by VA's Office of Mental Health Services over the past decade are positive and will ultimately equate to better patient care and improved mental health outcomes—but significant challenges are evident and need continued attention, intensity, resources and oversight—and the development of sound and workable solutions to ease the pressure while meeting veterans' needs. In our opinion, VHA must develop a number of short- and long-range goals to resolve existing problems identified by the OIG, GAO, Congress and the veterans' service organization (VSO) community. VHA must develop reliable data systems; fix the flaws in its appointment and scheduling system with effective policies and IT systems that fill the current gaps and are responsive to mental health needs; develop an accurate mental health staffing model that accounts for both primary and a multitude of complex specialty mental health capacity demands; revolutionize its hiring practices and eliminate the barriers that obstruct timely hiring of mental health providers and support staff; adjust its practices to address the complexities of co-occurring general health, mental health and psychosocial problems of veterans, in a truly patient-centered manner, and re-establish trust with the veterans that VA is charged to serve.

The DAV appreciates the efforts made by VA to improve the safety, consistency, and effectiveness of mental health care programs for all veterans. We also appreciate that Congress is continuing to provide increased funding in pursuit of a comprehensive set of services to meet the mental health needs of veterans, in particular veterans with wartime service who present post-deployment readjustment needs. We urge the Committee's continued oversight of VA's progress in fully implementing its Mental Health Strategic Plan and resolving the existing barriers that prevent some veterans from receiving the services they need to fully readjust and reintegrate following military service.

Chairman Miller and Members of the Committee, this concludes my prepared statement. DAV appreciates the opportunity to provide this testimony for the record of this important hearing.

Prepared Statement of Ralph Ibson

Chairman Miller, Ranking Member Michaud and members of the Committee:

We are grateful to you for conducting this hearing and for your continued oversight on the important issue of Veterans' Mental Health Care. Thank you for inviting Wounded Warrior Project (WWP) to offer our perspective.

With WWP's mission to honor and empower wounded warriors, our vision is to foster the most successful, well-adjusted generation of veterans in our nation's history. The mental health of our returning warriors is clearly a critical element. As has been well documented, PTSD and other invisible wounds can affect a warrior's readjustment in many ways – impairing health and well-being, compounding the challenges of obtaining employment, and limiting earning capacity. VA does provide benefits and services that are helping some of our warriors overcome such problems, but there is much more to do.

With the drawdown of forces in Afghanistan, more and more servicemembers will be transitioning to veteran status and the issues of engaging veterans and providing effective mental health care will continue to grow. We applaud the oversight and focus your Committee has provided, particularly regarding access to timely treatment, and we welcome such initial steps as VA hiring additional mental health providers. But increased staffing alone will not close all the gaps we see in VA's mental health system.

Engagement in Treatment as a First Step

The scope of the problem is not limited to timely access. We see evidence suggesting that veterans at many VA facilities may not be getting the kind of mental health care they need or the appropriate intensity of care. In a recent survey of over 13,000 WWP alumni, over a third of respondents reported difficulties in accessing effective mental health care. The identified reasons for not getting needed care were inconsistent treatment (eg. canceled appointments, having to switch providers, lapses in between sessions, etc.) and not being comfortable with existing resources at the VA.[1] Some report that the VA is quick to provide medications,[2] and others identify the limited types of treatment available as potential barriers. VA is pressing clinicians to employ exposure-based therapies that – without adequate support—are too intense for some veterans, with the result that many drop out of treatment altogether. VA is also not reaching large numbers of returning veterans. As described by one of the leading mental health researchers on the mental health toll of the conflict in Afghanistan and Iraq, Dr. Charles W. Hoge,

" . . . veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out...With only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment.[3]

Without access or adequate care, one apparent consequence of only 1 out of 5 warriors getting sufficient treatment is a disturbing rise in the number of suicides. Recent data have only begun to describe the issue. Past research has shown that veterans were at an increased risk of suicide during the 5 years after leaving active duty.[4] There is an urgent need for intervention and an ongoing issue of identifying and tracking the scope of the problem. While access to care is the first step in preventing suicide, identifying the factors that lead warriors to drop out of therapy is a critical factor in reversing this troubling trend.

Another area of needed engagement is on mental health treatment for victims of military sexual trauma (MST). Victims' reluctance to report these traumatic incidents is well documented, but many also delay seeking treatment for conditions relating to that experience.[5] The VA reports that some 1 in 5 women and 1 in 100 men seen in its medical system responded "yes" when screened for MST.[6] While researchers cite the importance of screening for MST and associated referral for mental health care, many victims do not currently seek VA care. Indeed, researchers have noted frequent lack of knowledge on the part of women veterans regarding eligibility for and access to VA care, with many mistakenly believing eligibility is linked to establishing service-connection for a condition.[7] In-service sexual assaults have long-term health implications, including PTSD, increased suicide risk, major depression and alcohol or drug abuse and without outreach to engage victims of MST on needed care, the long-term impact may be intensified.[8]

With projections of only 1 in 5 veterans receiving adequate treatment, the importance of early intervention and consequences of delaying mental health care, and the rising rates of suicide and MST, we must heed growing evidence that a majority of soldiers deployed to Afghanistan or Iraq are not seeking needed mental health

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[1] Franklin, et al, 2012 Wounded Warrior Project Survey Report, ii (June 2012). WWP surveyed more than 13,300 warriors, and received responses from more than 5,600. (Hereinafter "WWP Survey").

[2] Id. at 105. Studies document widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, and the finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. D. Leslie, S. Mohamed, and R. Rosenheck, "Off-Label Use of Antipsychotic Medications in the Department of Veterans' Affairs Health Care System" 60(9) Psychiatric Services, 1175–1181 (2009); John Krystal, et al., "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service–Related PTSD: A Randomized Trial," 306(5) JAMA 493–502 (2011).

[3] Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," JAMA, 306(5): (August 3, 2011) 548.

[4] *http://articles.washingtonpost.com/2013*–02–01/national/36669331—1—afghanistan-war-veterans-suicide-rate-suicide-risk

[5] Rachel Kimerling, et al., "Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning From Afghanistan and Iraq," 100(8) Am. J. Public Health, 1409–1412 (2010).

[6] U.S. Dept. of Veterans' Affairs and the National Center for PTSD Fact Sheet, "Military Sexual Trauma," available at *http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp.*

[7] See Donna Washington, et al., "Women Veterans' Perceptions and Decision-Making about Veterans Affairs Health Care," 172(8) Military Medicine 812–817 (2007).

[8] M. Murdoch, et al., "Women and War: What Physicians Should Know," 21(S3) J. of Gen. Internal Medicine S5–S10 (2006).

care.[9] While stigma and organizational barriers to care are cited as explanations for why only a small proportion of soldiers with psychological problems seek professional help, soldiers' negative perceptions about the utility of mental health care may be even stronger deterrents.[10] To reach these warriors, we see merit in a strategy of expanding the reach of treatment, to include greater engagement, understanding the reasons for negative perceptions of mental health care, and "meeting veterans where they are."[11]

Importantly, current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral health care.[12] Underscoring the benefit of warriors reaching out to other warriors, our recent survey found that nearly 30 percent identified talking with another Operation Enduring Freedom (OEF)/Operation Iraqi Freedom (OIF) veteran as the most effective resource in coping with stress.[13] Many of our warriors benefit greatly from the counseling and peer-support provided at Vet Centers, but VA leaders are failing other warriors when they resist implementing a nearly two-year-old law that requires VA to provide peer-support to OEF/OIF veterans at VA medical facilities as well.[14]

While high percentages of OEF/OIF veterans are not engaging or dropping out of mental health programs, peer support has been identified as a critical element in reversing that trend. Last August's Executive Order on Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families was clear on improving care for the mental health needs of those who served in Iraq and Afghanistan. We applaud its directive that VA hire and train 800 peer counselors by the end of this calendar year. We are concerned, however, that VA's approach to the peer-support initiative in the Order is not focused or targeted to OEF/OIF veterans.

In addition to peer outreach, enlisting family members in mental health care helps foster recovery and facilitates warrior engagement. VA has lagged in addressing family issues and involving caregivers in mental health treatment.[15] Given the impact of family support and strain on warriors' resilience and recovery, more must be done to implement provisions of law to provide needed mental health care to veterans' family members.

The VA has certainly taken significant steps over the years to improve veterans' access to mental health care. But for all the positive action taken, too many warriors still have not received timely, effective treatment. In short, and as WWP has testified,[16] wide gaps remain between well-intentioned policies and on-the-ground practices.

Need for Outcome Measurements

Against the backdrop of a series of congressional hearings highlighting long delays in scheduling veterans for mental health treatment, the VA last April released plans to hire an additional 1900 mental health staff.[17] While appreciative of VA's course-reversal, WWP has urged that other related critical problems also be remedied. It is not clear that VA medical facilities are sufficiently flexible in accommodating warriors. Access remains a problem, particularly for those living at a distance from VA facilities and for those whose work or school requirements make it difficult to meet current clinic schedules. Mental health care must also be *effective*, of course. As one provider explained,

"Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment."[18]

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[9] Paul Kim, et al. "Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care Among Soldiers," 23 Military Psychology 66 (2011).

[10] Id. at 78.

[11] Hoge, supra note 14.

[12] National Defense Authorization Act for Fiscal Year 2013, Public Law 112–239, §730, (Jan. 2, 2013). Additionally, the President issued an Executive Order in August 2012 which included among new steps to improve warriors' access to mental health services, a commitment that VA would employ 800 peer-specialists to support the provision of mental health care. Exec. Order No. 13625 "Improving Access to Mental Health for Veterans, Service Members, and Military Families" (Aug. 31, 2012)

[13] WWP Survey, at 54.

[14] Sec. 304, Public Law 111–163.

[15] Khaylis, A., et al. "Posttraumatic Stress, Family Adjustment, and Treatment Preferences Among National Guard Soldiers Deployed to OEF/OIF,"176 Military Medicine 126–131(2011).

[16] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs, 112th Cong. (May 8, 2012) (Testimony of Ralph Ibson, National Policy Director, Wounded Warrior Project).

[17] Dept. of Veterans' Affairs Press Release, "VA to Increase Mental Health Staff by 1,900," (Apr. 19, 2012), available at: *http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302.*

[18] Id.

Providing effective care requires building a relationship of trust between provider and patient – a bond that is not necessarily instantly established.[19] Accordingly, congressional testimony highlighting that many VA medical centers routinely place patients in group-therapy settings rather than provide needed individual therapy merits further scrutiny.[20] We have also urged more focus on the soundness and effectiveness of the VA's mental health performance measures; these track adherence to process requirements, but fail to assess whether veterans are actually improving.[21]

Unfortunately, the imperative of meeting performance requirements can create perverse incentives, at odds with good clinical care. As one provider explained, "Veterans face many obstacles to care that are designed to meet 'measures' rather than good clinical care, i.e. having to wait hours to be seen in walk-in clinic as the only point of access, being forced to attend groups, etc."[22] Prior hearings also documented instances of such measures being "gamed."[23]

WWP has been encouraged by the VA's willingness to dedicate research resources and additional mental health providers to addressing gaps in veterans' mental health care. But it's not necessarily just about reaching particular funding or staffing levels. It's about outcomes—ultimately honoring and empowering warriors, and, in our view, about making this the most successful generation of veterans. It's not enough for VA administrators to set performance metrics for timeliness or other process-measures (especially when those metrics may not adequately reflect the true situation), they must establish performance measures that recognize and reward successful treatment outcomes.

Recent reports from VA Inspector General and Government Accountability Offices have highlighted the need for more effective measures to aid oversight.[24] [25] WWP shares concerns about scheduling and wait times and urges VA to implement a reliable, accurate way to measure how long veterans are waiting for appointments in order to resolve problems effectively. Waiting too long during a time of intense need undermines a veteran's trust in the system.

The reports underscore concerns that VA is unable to measure a range of pertinent mental health matters, including timely access, patient outcomes, staffing needs, numbers needing or provided treatment, provider productivity, and treatment capacity. Greater VA transparency and continued oversight into VA's mental health care operations are starting points for closing those gaps.

Need for Continued Congressional Oversight

WWP welcomes the Department's acknowledgment of a "need [for] improvement" in its mental health system.[26] While there has been movement in response to recent critical congressional oversight, the VA's actions have often lacked needed transparency. To illustrate, the VA testified to having conducted a "comprehensive first-

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[19] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm, on Health of the H. Comm. on Veterans' Affairs, 112th Cong. (May 8, 2012) (Testimony of Nicole Sawyer, PsyD, Licensed Clinical Psychologist).

[20] VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans' Affairs, 112th Cong. (Apr. 25, 2012) (Testimony of Nicholas Tolentino, OIF Veteran and former VA medical center administrative officer).

[21] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs, 112th Cong. (2012) (Testimony of Ralph Ibson), supra note 21.

[22] WWP Survey of VA Mental Health Staff (2011).

[23] As one WWP-survey respondent explained in describing practices at a VA facility, "Unreasonable barriers have been created to limit access into Mental Health treatment, especially therapy. Vets must go to walk-in clinic so they are never given a scheduled initial appointment. Walk-in only provided medication management, but Vets who just want therapy must still go to walk-in. After initial intake, Vets are required to attend a group session, typically a month out. After completing the group session, Vets can be scheduled for individual therapy, typically another month out. Performance measures are gamed. When a consult is received, the Veteran is called and told to go to walk-in. The telephone call is not documented directly (that would activate a performance measure) . . . Then the consult is completed without any services being provided to the Veteran. Vets often slip through the cracks since there is no follow-up to see if they actually went to walk-in. Focus of the Mental Health [sic] is to make it appear as if access is meeting measures. There is no measure for follow-up, so even if Vets get into the system in a reasonable time, the actual treatment is significantly delayed. Trauma work is almost impossible to do since appointments tend to be 6–8 weeks apart."

[24] U.S. General Accountability Office, "Reliability and Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement," GAO–13–130 (Dec 2012).

[25] VA Office of Inspector General, "Review of Veterans' Access to Mental Health Care"' (Apr 2012).

[26] VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs, 112th Cong. (May 8, 2012) (Testimony of Eric Shinseki, Secretary of the Dept. of Veterans' Affairs).

hand assessment of the mental health program at every VA medical center,"[27] but it would not afford advocates the opportunity to participate in such visits (despite a request to do so) and has not disclosed its site-visit findings, the expectations for each such facility, or facility remediation plans. The VA also cited its adoption, on a pilot basis, of a prototype mental health staffing model, without meaningful explanation of the foundation or reliability of its model. VA Central Office recently also surveyed mental health field staff; but while its survey effort could represent a healthy step, officials have neither disclosed the survey findings nor indicated how the data might be used, if at all.

It bears emphasizing that PTSD and other war-related mental health conditions can be successfully treated – and in many cases, VA clinicians and Vet Center counselors are helping veterans recover and thrive. But these problems have their origin in service, and more can and must be done both to prevent and to treat behavioral health problems at the earliest point – during, rather than after, service. That will require not only overcoming negative perceptions among servicemembers about mental health care, but affording them assurance of confidentiality.[28] Vet Centers – long a source of confidential, trusted care—can and should be a greater resource. Provisions of the National Defense Authorization Act for 2013 (NDAA) direct both DoD and the VA, respectively, to close critical gaps in their mental health systems, targeting particularly the importance of suicide prevention in the armed forces and the VA's need to provide wounded warriors timely, effective mental health care.[29] Among its provisions, the NDAA requires the VA – in consultation with an expert study committee under the auspices of the National Academy of Sciences (NAS)– to establish and implement both mental health staffing guidelines and comprehensive measures to assess the timeliness and effectiveness of its mental health care.[30] WWP urges VA to give high priority to entering into a contract with NAS as soon as possible – and bring some "sunshine" and outside expertise into what should be an important step toward improving VA behavioral health care.

Finally, as we suggested in testimony before the Health Subcommittee last May, it is important to consider the "culture" within which VA mental health care is provided. As one clinician described it succinctly in responding to a WWP survey,

"The reality is that the VA is a top-down organization that wants strict obedience and does not want to hear about problems."

Mental health staff at some VA facilities have described a leadership climate that employs a command and control model that imposes administrative requirements which too often compromise providers' exercise of their own clinical judgment, and thus frustrate effective treatment.

Without answers to what Central Office has learned through its site visits or surveys about the extent to which clinicians have needed latitude to exercise their best clinical judgment, we are left to question whether morale or other problems compromise effective mental health care and whether remedial steps are being taken. We cannot answer such questions without greater VA transparency.

In the recent past, congressional oversight has been a critical catalyst in identifying the need for major system improvements in the provision of mental health care for wounded warriors and in effecting necessary reforms. Such vigilant oversight must continue in order to close remaining gaps in VA's mental health system. Among these, we urge that congressional oversight include focusing on the following:

- Given new statutory requirements to work with the NAS to establish new staffing guidelines and measures to assess timeliness and effectiveness of mental health care, the VA must give high priority to expeditiously contract with NAS to conduct the necessary assessments and establish the framework for reforms required by law;
- DoD and the VA must work collaboratively, not simply to improve access to mental health care, but to identify and further research the reasons for—and solutions to – warriors' resistance to seeking such care;
- As provided for in law and Executive Order, the VA in 2013 must carry out large-scale training and employment of at least 800 returning warriors (who

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[27] Id.

[28] See Lt. Col. Paul Dean and Lt. Col. Jeffrey McNeil, "Breaking the Stigma of Behavioral Healthcare," U.S. Army John F. Kennedy Special Warfare Center and School, 25(2) Special Warfare (2012), available at: *http://www.soc.mil/swcS/SWmag/archive/SW2502/SW2502BreakingTheStigmaOfBehavioralHealthcare.html.*

[29] National Defense Authorization Act for Fiscal Year 2013, supra note 18, at §§ 580–583 and 723–730.

[30] Id. at § 726.

have themselves experienced combat stress) to provide peer-outreach and peer-support services as part of VA's provision of mental health care to wounded warriors, and DoD must support that initiative by referring servicemembers to be considered for such employment;
- The VA should partner with and assist community entities or collaborative community programs in providing needed mental health services to wounded warriors, to include providing training to clinicians on military culture and the combat experience;
- The VA must implement provisions of law that require it to provide needed mental health services to immediate family members of veterans whose own war-related mental health issues may diminish their capacity to support those warriors;
- The VA should improve coordination between its medical facilities and Vet Centers, and increase both Vet Center staffing and the number of Vet Center sites, with emphasis on locating new ones near military facilities; and
- The VA should provide for Vet Center staff to participate in VSO-operated recreational programs that are designed to encourage veterans' readjustment, as provided for by law.

Thank you for consideration of WWP's views on this most important subject.

Prepared Statement of Robert A. Petzel

Good morning, Chairman Miller, Ranking Member Michaud and Members of the Committee. Thank you for the opportunity to discuss VA's delivery of comprehensive mental health care and services to the Nation's Veterans and their families. I am accompanied today by Dr. Mary Schohn, Director, Office of Mental Health Operations; Dr. Sonja Batten, Deputy Chief Consultant for Specialty Mental Health; and Dr. Janet Kemp, National Mental Health Program Director, Suicide Prevention and Community Engagement, all from the Veterans Health Administration (VHA)'s Office of Patient Care Services, Mental Health Services.

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan with unprecedented duration and frequency. Long deployments and intense combat conditions require optimal support for the emotional and mental health needs of our Veterans and their families. VA continues to develop and expand its mental health delivery system. Since 2009, VA has learned a great deal about both the strengths of our mental health care system, as well as areas that need improvement. VA constantly strives to enhance the services provided to our Veterans and will use any data and assessments to achieve that goal.

VA is working closely with our Federal partners to implement President Barack Obama's Executive Order 13625, "Improve Access to Mental Health Services for Veterans, Service Members, and Military Families," signed on August 31, 2012. The executive order reaffirmed the President's commitment to preventing suicide, increasing access to mental health services, and supporting innovative research on relevant mental health conditions. The executive order strengthens suicide prevention efforts by increasing capacity at the Veterans/Military Crisis Line and through supporting the implementation of a national suicide prevention campaign. The executive order supports recovery-oriented mental health services for Veterans by directing the hiring of 800 peer specialists, to bring this expertise to our mental health teams. It also supports VA in using a variety of recruitment strategies to hire 1,600 new mental health clinicians and 300 administrative personnel in support of the mental health programs. Furthermore, it strengthens building partnerships between VA and community providers by directing VA to work with the Department of Health and Human Services (HHS), to establish 15 pilot agreements with HHS-funded community clinics to improve access to mental health services in pilot communities, and to develop partnerships in hiring providers in rural areas. Finally, it promotes mental health research and development of more effective treatment methodologies in collaboration between VA, Department of Defense (DOD), HHS, and Department of Education.

VHA has begun work on implementation of Fiscal Year 2013 National Defense Authorization Act (P.L. 112–239) (NDAA), signed on January 2, 2013, including developing measures to assess mental health care timeliness, patient satisfaction, capacity and availability of evidence-based therapies, as well as developing staffing guidelines for specialty and general mental health. In addition, VA is formulating a contract with the National Academy of Sciences to consult on the development and implementation of measures and guidelines, and to assess the quality of mental

health care. VA is also expanding efforts to recruit mental health providers without compensation to support delivery of mental health services.

My written statement will describe how VA delivers quality mental health care and engages in ongoing research in such specialty areas as post-traumatic stress disorder (PTSD), military sexual trauma, and suicide prevention. It will then cover how we are refining mental health access, and finally examine VA's recent enhancement of mental health staffing.

I. Mental Health Care

VA operates one of the highest-quality care systems. VA is a pioneer in mental health research, discovering and utilizing effective, high-quality, evidence-based treatments. It has made deployment of evidence-based therapies a critical element of its approach to mental health care. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, such as PTSD, consequences of military sexual trauma, substance use disorders, and suicidality. While VA is primarily focused on evidence-based treatments, we are also monitoring and assessing those complementary and alternative treatment methodologies that need further research, such as meditation in the care of PTSD. Our ultimate desired outcome is a healthy Veteran.

VHA provides a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. VA has trained over 4,700 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD: Cognitive Processing Therapy and Prolonged Exposure Therapy. The Institute of Medicine (IOM) report and the VA/DOD Clinical Practice Guideline have consistently affirmed the efficacy of these treatment approaches. Furthermore, VA operates the National Center for PTSD, which guides a national PTSD Mentoring program, working with every specialty PTSD program across the country to improve care. The Center has also begun to operate a PTSD Consultation Program open to any VA practitioner (including primary care practitioners and Homeless Program coordinators) who requests expert consultation regarding a Veteran in treatment with PTSD. So far, 500 VA practitioners have utilized this service. The Center further supports clinicians by sending subscribers updates on the latest clinically relevant trauma and PTSD research, including the Clinician's Trauma Update Online, PTSD Research Quarterly, and the PTSD Monthly Update. As IOM observed in its recent report, "Spurred by the return of large numbers of veterans from [Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND)], the VA has substantially increased the number of services for veterans who have PTSD and worked to improve the consistency of access to such services. Every medical center and at least the largest community-based outpatient clinics are expected to have specialized PTSD services available onsite. Mental health staff members devoted to the treatment of OIF and OEF veterans have also been deployed throughout the system." [1]

Specialized care is available for Veterans who experienced military sexual trauma (MST) while serving on active duty or active duty for training. All sexual trauma-related care and counseling is provided free of charge to all Veterans, even if they are not eligible for other VA care. In FY 2012, every VHA facility provided MST related outpatient care to both women and men and over 725,000 outpatient MST-related mental health clinical visits were provided to 64,161 Veterans with a positive MST screen. This is a 13.3 percent increase from the previous year (FY 2011). Additionally, in FY 2012, of those who received care in a VA medical center or clinic, over 500,000 Veterans with a Substance Use Disorder (SUD) diagnosis received treatment for this problem. VA developed and disseminated clinical guidance to newly hired SUD–PTSD specialists who are promoting integrated care for these co-occurring conditions, and provided direct services to over 18,000 of these Veterans in FY 2012.

Use of complementary and alternative medicine (CAM) for treating mental health problems is widespread in VA. A 2011 survey of all VA facilities by VA's Healthcare Information and Analysis Group found that 89 percent of VA facilities offered CAM. VA's Office of Research and Development (ORD) recently undertook a dedicated effort to evaluate CAM in the treatment of PTSD with the solicitation of research applications examining the efficacy of meditative approaches to PTSD treatment. The result was three new clinical trials; all are currently underway, recruiting participants with PTSD. VA has also begun pilot testing a mechanism for conducting multi-site clinical CAM demonstration projects within mental health that will provide a roadmap for identifying innovative treatment methods, measuring their effi-

[1] Institute of Medicine of the National Academies. Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations Initial Assessment. July 13, 2012.

cacy and effectiveness, and generating recommendations for system-wide implementation as warranted by the data. Nine medical facilities with meditation programs were selected for participation in the clinical demonstration projects. A team of subject matter experts in mind-body medicine from the University of Rochester has been asked to provide an objective, external evaluation. The majority of the clinical demonstration projects are expected to be completed by March 2013, and the aggregate final report by the outside evaluation team is due later in 2013.

Veteran Suicide

Even one Veteran suicide is too many. VA is absolutely committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on the principle that in order to decrease rates of suicide, we must provide enhanced access to high quality mental health care and develop programs specifically designed to help prevent suicide. In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line (VCL) connects Veterans in crisis and their families and friends with qualified, caring Department of Veterans Affairs responders through a confidential toll-free hotline that offers 24/7 emergency assistance. VCL has recently expanded to include a chat option and texting option for contacting the Crisis Line. Since its establishment five years ago, the VCL has made approximately 26,000 rescues of actively suicidal Veterans. The program continues to save lives and link Veterans with effective ongoing mental health services on a daily basis. In FY 2012, VCL received 193,507 calls, resulting in 6,462 rescues, any one of which may have been life-saving. In accordance with the President's August 31, 2012, Executive Order, VA has completed hiring and training of additional staff to increase the capacity of the Veterans Crisis Line by 50 percent. However, VCL is only one component of the VA overarching suicide prevention program that is based on the premise that ready access to high quality care can prevent suicide.

VA has placed Suicide Prevention Teams at each facility. The leaders of these teams, the Suicide Prevention Coordinators, are specifically devoted to preventing suicide among Veterans, and the implementation of the program at their facilities. The coordinators play a key role in VA's work to prevent suicide both in individual patients and in the entire Veteran population. Among many other functions, coordinators ensure that referrals from all sources, including the Crisis Line, e-mail, and word of mouth referrals are appropriately responded to in a timely manner. Coordinators educate their colleagues, Veterans and families about risks for suicide, coordinate staff education programs about suicide prevention, and verify that clinical providers are trained. They provide enhanced treatment monitoring for veterans at risk. They assure continued care and treatment by verifying that each "high risk" Veteran has a medical record notification entered; that they receive a suicide-specific enhanced care package, and any missed appointments are followed up on. The coordinators track and monitor all suicide-related events in an internal data collection system. This allows VA to determine trends and common risk factors, and provides information on where and how best to address concerns.

VA has developed two hubs of expertise, one at the Canandaigua Center of Excellence for Suicide Prevention (Canandaigua, NY), and another at the VISN 19 Mental Illness Research Education and Clinical Center (Denver, CO), to conduct research regarding intervention, treatments and messaging approaches and has developed a Suicide Consultation Program for practitioners that opened in 2013 and is already in use.

On February 1, 2013, VA released a report on Veteran suicides, a result of the most comprehensive review of Veteran suicide rates ever undertaken by the VA. The report shows current interventions and programs have been able to maintain relatively stable rates despite increasing rates of suicide in like populations in America. With assistance from state partners providing real-time data, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA to identify where at risk Veterans may be located and improve the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. The data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary care in order to replicate effective programs in other areas.

II. Mental Health Care Access

At VA, we have the opportunity, and the responsibility, to anticipate the needs of returning Veterans. Mental health care at VA is an unparalleled system of comprehensive treatments and services to meet the individual mental health needs of

Veterans. We have many entry points for VHA mental health care: through our 152 medical centers, 821 community-based outpatient clinics, 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, VA staff on college and university campuses and other outreach efforts.

Since FY 2006, the number of Veterans receiving specialized mental health treatment has risen each year, from 927,052 to more than 1.3 million in FY 2012, partly due to proactive screening to identify Veterans who may have symptoms of depression, PTSD, problematic use of alcohol, or who have experienced MST. Outpatient visits have increased from 14 million in FY 2009 to over 17 million in FY 2012. Vet Centers are another avenue for access, providing services to 193,665 Veterans and their families in FY 2012. The Vet Center Combat Call Center, an around-the-clock confidential call center where combat Veterans and their families can talk with staff, comprised of fellow combat Veterans from several eras, has handled over 37,300 calls in FY 2012. The Vet Center Combat Call Center is a peer support line, providing a complementary resource to the Veterans Crisis Line, which provides 24/7 crisis intervention services. This represents a nearly 470 percent increase from FY 2011.

In response to increased demand over the last four years, VA has enhanced its capacity to deliver needed mental health services and to improve the system of care so that services can be more readily accessed by Veterans. VA believes that mental health care must constantly evolve and improve as new research knowledge becomes available. As more Veterans access our services, we recognize their unique needs and needs of their families—many of whom have been affected by multiple, lengthy deployments. In addition, proactive screening and an enhanced sensitivity to issues being raised by Veterans have identified areas for improvement.

For example, in August 2011, VA conducted an informal survey of line-level staff at several facilities, and learned of concerns that Veterans' ability to schedule timely appointments may not match data gathered by VA's performance management system. These providers articulated constraints on their ability to best serve Veterans, including inadequate staffing, space shortages, limited hours of operation, and competing demands for other types of appointments, particularly for compensation and pension or disability evaluations. In response to this finding, VA took three major actions. First, VA developed a comprehensive action plan aimed at overcoming barriers to access, and addressing the concerns raised by its staff in the survey as well as concerns raised by Veterans and Veterans groups. Second, VA conducted focus groups with Veterans and VA staff, conducted through a contract with Altarum, to better understand the issues raised by front-line providers. Third, VA conducted a comprehensive first-hand assessment of the mental health program at every VA medical center and is working within its facilities and Veterans Integrated Service Networks (VISNs) to improve mental health programs and share best practices.

Ensuring access to appropriate care is essential to helping Veterans recover from the injuries or illnesses they incurred during their military service. Access can be realized in many ways and through many modalities, including:

- through face-to-face visits;
- telehealth;
- phone calls;
- online systems;
- mobile apps and technology;
- readjustment counseling;
- outreach;
- community partnerships; and
- academic affiliations.

Face-to-Face Visits

In an effort to increase access to mental health care and reduce the stigma of seeking such care, VA has integrated mental health into primary care settings. The ongoing transfer of VA primary care to Patient Aligned Care Teams will facilitate the delivery of an unprecedented level of mental health services. As the recent IOM report on Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations noted, it is VA policy to screen every patient seen in primary care in VA medical settings for PTSD, MST, depression, and problem drinking.[2] The screening takes place during a patient's first appointment, and screenings for depression and problem drinking are repeated annually for as long as the Veteran uses VA services. Furthermore, PTSD screening is repeated annually for the first 5 years after the

[2] Institute of Medicine of the National Academies. Treatment for Posttraumatic Stress Disorder in Military and Veteran Populations Initial Assessment. July 13, 2012.

most recent separation from service and every 5 years thereafter. Systematic screening of Veterans for conditions such as depression, PTSD, problem drinking, and MST has helped VA identify more Veterans at risk for these conditions and provided opportunities to refer them to specially trained experts. The PTSD screening tool used by VA has been shown to have high levels of sensitivity and specificity.

Since the start of FY 2008, VA has provided more than 2.5 million Primary Care-Mental Health Integration (PC–MHI) clinical visits to more than 700,000 unique Veterans. This improves both access by bringing care closer to where the Veteran can most easily receive these services, and quality of care by increasing the coordination of all aspects of care, both physical and mental. Among primary care patients with positive screens for depression, those who receive same-day PC–MHI services are more than twice as likely to receive depression treatment than those who did not. Treatment works and there is hope for recovery for Veterans who need mental health care. These are important advances, particularly given the rising numbers of Veterans seeking mental health care.

Telehealth

VA offers expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate rapid access to mental health services. Telemental health allows VA to leverage technology to provide Veterans quicker and more efficient access to mental health care by reducing the distance they have to travel, increasing the flexibility of the system they use, and improving their overall quality of life. This technology improves access to general and specialty services in geographically remote areas where it can be difficult to recruit mental health professionals. Currently, the clinic-based telehealth program involves the more than 580 VA community-based outpatient clinics (CBOCs) where many Veterans receive primary care. In areas where the CBOCs do not have a mental health care provider available, VA is implementing a new program to use secure video teleconferencing technology to connect the Veteran to a provider within VA's nationwide system of care. Further, the program is expanding directly into the home of the Veteran with VA's goal to connect approximately 2,000 patients by the end of FY2013 using Internet Protocol (IP) video on Veterans' personal computers.

Mobile Apps and Technology

VA has made massive strides towards providing all of those in need with evidence-based treatments, and we are now working to optimize the delivery of these tools by using novel technologies. From delivery of the treatments to rural Veterans in their homes, to supporting treatment protocols with mobile apps, VA's objective is to consistently deliver the highest quality mental health care to Veterans wherever they are. The multi-award winning PTSD Coach, co-developed with the DOD, has been downloaded nearly 100,000 times in 74 countries since mid-2011. It is being adapted by government agencies and non-profit organizations in 7 other countries including Canada and Australia. This app is notable as it aims to assist Veterans with recognizing and managing PTSD symptoms, whether or not they are comfortable engaging with VA mental health care.

For those who are kept from needed care because of logistics or fear of stigma, PTSD Coach provides an opportunity to better understand and manage the symptoms associated with PTSD as a first step toward recovery. For those who are working with VA providers, whether in specialty clinics or primary care, this app provides evidence-informed tools for self-management and symptom tracking between sessions. VA is planning to shortly roll out a version of this app that is connected to the electronic health record for active VA patients.

A wide array of mobile applications to support the evidence-based mental and behavioral health care of Veterans will be rolled out over the course of 2013. These apps are intended to be used in the context of clinical care with trained professionals and are based on gold-standard protocols for addressing smoking cessation, PTSD and suicidality.

Apps for self-management of the consequences of traumatic brain injury and crisis management, some of the more challenging issues facing Veterans and our healthcare system, will follow later in the year. Mobile apps can help Veterans build resilience and manage day-to-day challenges even in the absence of mental health disorders. Working with DOD, VA will release mobile apps for problem-solving and parenting in 2013 to help Veterans navigate common post-deployment challenges. Because we understand that healthy families are at the center of a healthy life, we are creating tools for families and caregivers of Veterans as well, including the PTSD Family Coach, a mobile app geared towards friends and families that is expected to be rolled out in mid-2013.

Technology allows us to extend our reach, not just beyond the clinic walls but to those who need help but have not yet sought our services, and to those who care for them and support their personal and professional missions. In November 2012, VA and DoD launched www.startmovingforward.org, interactive Web-based educational life-coaching program based on the principles of Problem Solving Therapy. It allows for anonymous, self-paced, 24-hour-a-day access that can be used independently or in conjunction with mental health treatment.

Readjustment Counseling – Vet Centers

In addition to integrating mental health care with primary care, VA provides a full range of face-to-face readjustment counseling services through the network of 300 community-based Vet Centers located in all 50 states, the District of Columbia, American Samoa, Guam, Puerto Rico, and the U.S. Virgin Islands. In FY 2012, the Vet Centers experienced over 1.5 million visits from Veterans and their families, a 9 percent increase in visits from FY 2011. The Vet Center program has cumulatively provided services to 458,795 OEF/OIF/OND Veterans and their families. This represents over 30 percent of the OEF/OIF/OND Veterans that have left active duty.

The Vet Centers provide targeted outreach to returning combat Veterans through a fleet of 70 Mobile Vet Centers that can provide confidential counseling and outreach to Veterans who live geographically distant from VA facilities, ensuring availability of access to mental health care for Veterans, no matter where they may live. In 2010, Public Law 111–163 expanded eligibility of Vet Center services to members of the Armed Forces (and their family members), including members of the National Guard or Reserve, who served on active duty in the Armed Forces in OEF/OIF/OND. VA and DOD are working together to implement this expansion of services.

The recently passed FY 2013 NDAA also includes provisions that expand the peer support counseling program to members of the Armed Forces and expand the Vet Center program to include counseling to certain members of the Armed Forces and their family members. One cornerstone of the Vet Center program's success is the added level of confidentiality for Veterans and their families. Vet Centers maintain a separate system of record which affords the confidentiality vital to serving a combat-exposed warrior population. Without the Veteran's voluntary signed authorization, the Vet Centers will not disclose Veteran client information unless required by law. Early access to readjustment counseling in a safe and confidential setting goes a long way to reducing the risk of suicide and promotes the recovery of Servicemembers returning from combat. Furthermore, more than 72 percent of all Vet Center staff are Veterans themselves. This allows the Vet Center staff to make an early empathic connection with Veterans who might not otherwise seek services even if they are much needed.

Outreach

In November 2011, VA launched an award-winning, national public awareness campaign, Make the Connection, aimed at reducing the stigma associated with seeking mental health care and informing Veterans, their families, friends, and members of their communities about VA resources (www.maketheconnection.net). The candid Veteran videos on the Web site have been viewed over 4 million times, and over 1.5 million individuals have "liked" the Facebook page for the campaign (www.facebook.com/VeteransMTC). AboutFace, launched in May 2012, is a complementary public awareness campaign created by the National Center for PTSD (www.ptsd.va.gov/public/about—face.html). This initiative aims to help Veterans recognize whether the problems they are dealing with may be PTSD related and to make them aware that effective treatment can help them "turn their lives around." The National Center for PTSD has been using social media to reach out to Veterans utilizing both Facebook and Twitter. In FY 2012, there were 18,000 Facebook "fans" (up from 1,800 in 2011), making 16 posts per month and almost 7,000 Twitter followers (up from 1,700 in 2011) with 20 "tweets" per month. The PTSD Web site, www.ptsd.va.gov, received 2.3 million visits during FY2012.

VA, in collaboration with DOD, continues to focus on suicide prevention though its year-long public awareness campaign, "Stand By Them," which encourages family members and friends of Veterans to know the signs of crisis and encourage Veterans to seek help, or to reach out themselves on behalf of the Veteran using online services on www.veteranscrisisline.net. VA's current suicide awareness and education Public Service Announcement titled "Common Journey" has been running in the top one percent of the PSA Nielsen ratings since before the holidays. It is now being replaced with a PSA designed specifically to augment the Stand By Them Campaign titled "Side By Side," which was launched nationally in January 2013.

In order to further serve family members who are concerned about a Veteran, VA has expanded the "Coaching Into Care" call line nationally after a successful pilot

in two VISNs. Since the inception of the service January 2010 through November 2012, "Coaching Into Care" has logged 5,154 total calls and contacts. Seventy percent of the callers are female, and most callers are spouses or family members. On 49 percent of the calls, the target is a Veteran of OEF/OIF/OND conflicts; Vietnam or immediately post-Vietnam era Veterans comprises the next highest portion (27 percent).

Community Partnerships

VA recently developed and released a "Community Provider Toolkit" which is an on-line resource for community mental health providers to learn more about mental health needs and treatments for Veterans. The Veterans Crisis Line has approximately 50 Memoranda of Agreement with community and internal VA organizations to refer callers, accept calls, and provide and receive services for callers. Furthermore, suicide Prevention Coordinators at each VA facility are required to provide a minimum of 5 outreach activities a month to their communities to increase awareness of suicide and promote community involvement in the area of Veteran suicide prevention.

VA has been working closely with outside resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes. In response to the Executive Order, VA is working closely with HHS to establish 15 pilot projects with community-based providers, such as community mental health clinics, community health centers, substance abuse treatment facilities, and rural health clinics, to test the effectiveness of community partnerships in helping to meet the mental health needs of Veterans in a timely way. These are being established in areas where there are access issues or staffing concerns.

VHA will continue to work closely with DOD to educate Servicemembers, VA staff, Veterans and their families, public officials, Veterans Service Organizations, and other stakeholders about all mental health resources that are available in VA and with other community partners. VA has partnered with DOD to develop the VA/DOD Integrated Mental Health Strategy (IMHS) to advance a coordinated public health model to improve access, quality, effectiveness and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

Academic Affiliations and Training

VA is strategically working with universities, colleges and health professional training institutions across the country to expand their curricula to address the new science related to meeting the mental and behavioral needs of our Nation's Veterans, Servicemembers, Wounded Warriors, and their family members. In addition to ongoing job placement and outreach efforts through VetSuccess, VA has implemented a new outreach program, "Veterans Integration to Academic Leadership," that places VA mental health staff at 21 colleges and universities to work with Veterans attending school on the GI Bill.

VA's Office of Academic Affiliations trains roughly 6,400 trainees in mental health occupations per year (including 3,400 in psychiatry, 1,900 in psychology, and 1,100 in social work, plus clinical pastoral education positions). Currently, VA has one of only two accredited psychology internship programs in the entire state of Alaska. VA is committed to expanding training opportunities in mental health professions in order to build a pipeline of future VA health care providers. VA continues to expand mental health training opportunities in Nursing, Pharmacy, Psychiatry, Psychology, and Social Work. For example, over 202 positions were approved to begin in academic year 2013–2014 at 43 VHA facilities focused on the expansion of existing accredited programs in integrated care settings such as General Outpatient Mental Health Clinics or Patient Aligned Care Teams (PACT). These include over 86 training positions for Outpatient Mental Health Interprofessional Teams and 116 training positions for PACTs with Mental Health Integration, specifically 12 positions in Nursing, 43 in Pharmacy, over 34 in Psychiatry, 62 in Psychology, and 51 in Social Work. The Office of Academic Affiliations is scheduled to release the Phase II Mental Health Training Expansion Request for Proposals in Spring 2013 which will further assist with VA future workforce needs.

III. Mental Health Care Staffing and Hiring

VA is committed to hiring and utilizing more mental health professionals to improve access to mental health care for Veterans. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and is increasing the number of staff in support of mental health services. VA has taken aggressive action to recruit, hire, and retain mental health professionals to improve Veterans' access to mental health care. The department has also used many tools to hire the mental health workforce, including pay-setting authorities, loan repay-

ment, scholarship programs and partnerships with health care workforce training programs to recruit and retain one of the largest mental health care workforces in the Nation. As a result, VA is able to serve Veterans better by providing enhanced services, expanded access, longer clinic hours, and increased telemental health capability to deliver services.

Mental Health Staffing

VHA began collecting monthly vacancy data in January 2012 to assess the impact of vacancies on operations and to develop recommendations for further improvement. In addition, VA is ensuring that accurate projections for future needs for mental health services are generated. Finally, VA is planning proactively for the expected needs of Veterans who will soon separate from active duty status as they return from Afghanistan.

Since there are no industry standards defining accurate mental health staffing ratios, VHA is setting the standard, as we have for other dimensions of mental health care. VHA has developed a prototype staffing model for general mental health delivery and is expanding the model to include specialty mental health care. VHA developed and implemented an aggressive recruitment and marketing effort to fill existing vacancies in mental health care occupations. To support implementation of the guidance, VHA announced the hiring of 1,600 new mental health professionals and 300 support staff in April 2012. Key initiatives include targeted advertising and outreach, aggressive recruitment from a pipeline of qualified trainees/residents to leverage against mission critical mental health vacancies, and providing consultative services to VISN and VA stakeholders. Despite the national challenges with recruitment of mental health care professionals, VHA continues to make significant improvements in its recruitment and retention efforts. Focused efforts are underway to expand the pool of applicants for those professions and sites where hiring is most difficult, such as creating expanded mental health training programs in rural areas and through recruitment and retention incentives.

As part of our ongoing comprehensive review of mental health operations, VHA has considered a number of factors to determine additional staffing levels distributed across the system, including:

- Veteran population in the service area;
- The mental health needs of Veterans in that population; and
- Range and complexity of mental health services provided in the service area.

Specialty mental health care occupations, such as psychologists, psychiatrists, and others, are difficult to fill and will require a very aggressive recruitment and marketing effort. VHA has developed a strategy for this effort focusing on the following key factors:

- Implementing a highly visible, multi-faceted, and sustained marketing and outreach campaign targeted to mental health care providers;
- Engaging VHA's National Health Care Recruiters for the most difficult to recruit positions;
- Recruiting from an active pipeline of qualified candidates to leverage against vacancies; and
- Ensuring complete involvement and support from VA leadership.

Mental Health Hiring

In April 2012, VA announced a goal to hire an additional 1,600 clinical providers and 300 administrative support staff. As of January 29, 2013, VA has hired 1,058 clinical providers and 223 administrative staff in support of this specific goal. President Obama's August 31, 2012, executive order requires the positions to be filled by June 30, 2013.

In order to provide greater access to mental health services, VHA knew that it would have to set aggressive goals to fill these new positions as well as existing mental health staff vacancies. Like any large health care system, VHA is constantly managing changes within its existing mental health workforce levels (e.g., retirements, transfers, promotions and resignations) to ensure providers are available to deliver care. Therefore, VHA set a hiring target of 5,000 mental health providers and administrative support staff to: 1) hire for new positions; 2) fill existing vacancies; and 3) replenish naturally occurring turnover. This ensures a robust flow into the workforce as we anticipate and respond to the needs of both workforce staffing and our Veterans. VHA has made significant progress to this end, by hiring a total of 3,262 clinical and administrative support staff to directly serve Veterans since May 2012. This progress has improved the Department's ability to provide timely, quality mental health care for Veterans.

In March 2012, VHA reported a core mental health workforce of 20,590. This calculation was based upon data from VHA's Allocation Resource Center (ARC), which reports monthly updates of Full Time Equivalent Employees (FTEE) based on departmental accounting of accumulated mental health clinical and administrative workload costs. Using this methodology demonstrates a core mental health workforce of 21,502, an increase of 912, as of November 30, 2012.

In our continued efforts to ensure we are providing effective direct care to our Veterans, VHA re-evaluated this methodology and concluded that the inpatient mental health care data in ARC was adequate – it measured what it was designed to measure. However, FTEE is not a head count of the workforce, and the data for outpatient mental health care included some non-clinical activities such as workload associated with mental health education, research, and administration. Additionally, a small amount of mental health clinical workload which is provided outside of core mental health was not included in the original workforce calculation. The ARC data also uses year-to-date methodology, which essentially prorates gains made over the year and does not adequately reflect hiring in real time. For these reasons, VHA developed an improved methodology for capturing mental health on-board strength. This methodology permits provider-level detail – including comparisons of staffing over time - to ensure accurate reporting of the direct care clinical workforce providing mental health services.

This improved methodology required VA to develop a new system of accountability by combining information from three existing databases, which enhances our accuracy and allows VHA to:

1) Ensure better visibility of mental health clinical outpatient data to the provider-level;

2) Ensure that non-clinical workload is properly accounted for and not included in direct care calculations; and

3) Obtain consistency in the application of the current comprehensive definition of mental health providers across VA.

Using this improved accounting methodology, VA determined the mental health workforce providing direct patient care to be 18,587 as of March 2012. Applying this accounting methodology to the November 2012 data provides a more accurate picture of the on board strength, which has increased from 18,587 to 19,743 mental health FTEE, for a total, net increase of 1,156 providing direct care to our Veterans. Regardless of accounting methodology used, the data reflects a net increase in the number of mental health professionals providing clinical health services thus increasing the access to quality mental health care for our Nation's Veterans. We always strive to improve our data collection to better serve Veterans, and to ensure that our methods are transparent.

Peer Support

There are many Veterans who are willing to seek treatment and to share their experiences with mental health issues when they share a common bond of duty, honor, and service with the provider. While providing evidence-based psychotherapies is critical, VA understands Veterans benefit from supportive services other Veterans can provide. To meet this need in accordance with the Executive Order and as part of VA's efforts to implement section 304 of Public Law 111–163 (Caregivers and Veterans Omnibus Health Services Act of 2010), VA has hired over 100 Peer Specialists in recent months, and is hiring and training nearly 700 more. Additionally, VA has awarded a contract to the Depression and Bipolar Support Alliance to provide certification training for Peer Specialists. This peer staff is expected to be hired by December 31, 2013, and will work as members of mental health teams. Simultaneously, VA is providing additional resources to expand peer support services across the Nation to support full-time, paid peer support technicians.

Performance Measures

VA is reengineering its performance measurement methodologies to evaluate and revamp its programs. Performance measurement and accountability will remain the cornerstones of our program to ensure that resources are being devoted where they need to go and are being used to the benefit of Veterans. Our priority is leading the Nation in patient satisfaction regarding the quality, effectiveness of care and timeliness of their appointments.

Recognizing the benefit that would come from improving Veteran access, VA is modifying the current appointment performance measurement system to include a combination of measures that better captures each Veteran's needs. VA will ensure

this approach is structured around a thoughtful, individualized treatment plan developed for each Veteran to inform the timing of appointments.

In April 2012, VA's Office of Inspector General (OIG) report on VA's mental health programs gave four recommendations: 1) a need for improvement in our wait time measurements, 2) improvement in patient experience metrics, 3) development of a staffing model, and 4) provision of data to improve clinic management. Further, in January 2013, the U.S. Government Accountability Office reviewed VA's healthcare outpatient medical appointment scheduling and appointment notification processes, specifically focusing on Veterans wait times, local VA Medical Center implementation of national scheduling policies and processes as well as VHA initiatives to improve Veterans' access to medical appointments.

In direct response, VA is using OIG and GAO results along with our internal reviews to implement important enhancements to VA mental health care. Based on OIG and GAO findings, VA is updating scheduling practices, and strengthening performance measures to ensure accountability. VA has examined how best to measure Veterans' wait time experiences and how to improve scheduling processes to define how our facilities should respond to Veterans' needs and commissioned a study to measure timely appointment access and resulting patient satisfaction. Based on the results of this study, VA is changing its timeliness measures to best track different populations (new vs. established patients) using the approach which best predicts patient satisfaction and clinical care outcomes. In addition, VA is developing measures based on timeliness after referral to mental health services, patient perceptions of barriers to care, and measures of clinic capacity. By taking these steps, we are confident that we will be able to deliver accessible, high quality mental health care to Veterans.

The development of improved performance metrics, more reliable reporting tools, and an initial mental health staffing model, will enable VHA to better track wait times, assess productivity, and determine capacity for mental health services. All of these tools will continue to be evaluated and improved with experience in their use.

Conclusion

Mr. Chairman, we know our work to improve the delivery of mental health care to Veterans will never be truly finished. However, we are confident that we are building a more accessible system that will be responsive to the needs of our Veterans while being responsible with the resources appropriated by Congress. We appreciate your support and encouragement in identifying and resolving challenges as we find new ways to care for Veterans. VA is committed to providing the high quality of care that our Veterans have earned and deserve, and we continue to take every available action to improve access to mental health care services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

Statements For The Record

OFFICE OF INSPECTOR GENERAL

Mr. Chairman, Ranking Member Michaud, and members of the Committee, thank you for the opportunity to provide information to the Committee on the work of the Office of Inspector General (OIG) regarding the delivery and efficacy of mental health care by the Department of Veterans Affairs (VA).

VA provides medical care to eligible veterans throughout the United States through VA medical centers, VA community based outpatient clinics, and private providers in the community under the Non-VA Fee Care Program ("Fee Basis"). The activation of National Guard and Reserve units from across the country and the duration of the conflicts in Iraq and Afghanistan, combined with the increased utilization of VA mental health services by prior service-era veterans have stressed the ability of VA to provide ready and reliable access to necessary mental health care for returning veterans. The OIG has continued to report on the challenges that VA faces in delivering health care to address complex mental health issues including preventing suicides among returning veterans, addressing post traumatic stress and related clinical issues that result from prolonged combat, assisting female veterans to overcome the issues related to military sexual trauma, and providing appropriate treatment for substance use disorders while treating chronic pain conditions. Attached is a list of selected OIG reports dealing with these issues, which can be found on our website, *www.va.gov/oig*.

The Committee requested the OIG comment on five areas:

- **Fulfilling the promise to hire additional mental health personnel and fill the large number of existing vacancies** - In April 2012, VA announced a hiring initiative for mental health providers. As of December 26, 2012, which is the most recent information that VA provided to the OIG, less than half of the desired psychiatrists (260 of 558) have been hired and less than 70 percent of the desired psychologists (507 of 854), social workers (686 of 981) and mental health nurses (688 of 1032) have been hired. The goals identified in VA's plan are very ambitious given the limited number of mental health professionals trained each year and the increased competition for qualified mental health providers as economic and related conditions increase the non-governmental need for mental health professionals.

VA has exceeded the hiring goal for non-clinical support staff (341 against a goal of 300). However, hiring more non-clinical staff than required does not compensate for the lack of clinical staff and may not improve efficiency.

- **Implementing the Executive Order on "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families"** – The OIG has not reviewed VA's actions related to the requirements in the Executive Order.
- **Addressing the recommendations of the recent VA Inspector General and Government Accountability Office reports** – As of today, all four recommendations from the OIG report, Veterans Health Administration - Review of Veterans' Access to Mental Health Care (April 23, 2012) remain open. The recommendations relate to improving the metrics used by VA to measure appointment wait times and the utilization of related metrics designed to effectively reflect the patient experience of access to mental health care and to improve management oversight of these clinical activities. In addition, VA committed to performing a staffing analysis to determine the personnel needs to provide the required mental health services. VA indicates that progress has been made toward accomplishing these goals but VA has not provided evidence of those efforts to the OIG to verify.
- **Correcting lengthy wait times, misleading access measures, and cumbersome scheduling processes and procedures** – As the OIG reports have indicated, VA mental health access times are not accurately reported and may not be the most useful measures to monitor clinical performance. While workgroups have been established and move ahead, changes to these metrics have not been finalized and/or implemented.

The OIG has reported on the inefficiencies of the current patient appointment system for many years. The business rules of the current system also limit the usefulness of management data derived from the system. The installation of a new patient appointment system will take many months if not years to occur.

- **Effectively partnering with non-VA resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes** – VA has an inconsistent record of contracting effectively with non-VA providers to obtain health care for veterans. At present, the procurement of specialty medical services through Fee Basis does not provide a seamless compliment to in-house VA medical care. The use of the current Fee Basis business rules is cumbersome for VA facilities, and in practice, the business rules do not create certainty in the minds of veterans or Fee Basis providers that the goal of timely, appropriate health care will be delivered and paid for.

The OIG has consistently reported on contracting issues with both in-patient and out-patient fee care. Weaknesses include reviewing bills to ensure the proper payment is made and ensuring clinical data is easily incorporated within the VA medical record. OIG has reported on instances of improper payment and/or inadequate integration of the treatment through purchased care into the veteran's medical records.

With the return of servicemen and servicewomen from our ongoing conflicts and the aging veteran population, VA faces a number of critical challenges in order to improve current performance and increasingly and consistently meet the complex mental health needs of veterans. The OIG will continue to review and report on VA actions at this critical time. Our veterans deserve no less.

SELECTED OIG REPORTS

Healthcare Inspection – Appointment Scheduling and Access Patient Call Center, VA San Diego Healthcare System, San Diego, California - 1/28/2013

Healthcare Inspection – Inpatient and Residential Programs for Female Veterans with Mental Health Conditions Related to Military Sexual Trauma- 12/5/2012

Healthcare Inspection – Alleged Clinical and Administrative Issues, VA Loma Linda Healthcare System, Loma Linda, California - 11/19/2012

Healthcare Inspection – Delays for Outpatient Specialty Procedures, VA North Texas Health Care System, Dallas, Texas - 10/23/2012

Healthcare Inspection - Delay in Treatment, Louis Stokes VA Medical Center, Cleveland, Ohio - 10/12/2012

Healthcare Inspection – Consultation Mismanagement and Care Delays, Spokane VA Medical Center, Spokane, Washington - 9/25/2012

Healthcare Inspection – Alleged Staffing and Quality of Care Issues, VA Black Hills Health Care System, Hot Springs, South Dakota - 9/11/2012

Healthcare Inspection – Access and Coordination of Care at Harlingen Community Based Outpatient Clinic, VA Texas Valley Coastal Bend Health Care System, Harlingen, Texas - 8/22/2012

Healthcare Inspection – Management of Chronic Opioid Therapy at a VA Maine Healthcare System Community Based Outpatient Clinic, Calais, Maine - 8/21/2012

Healthcare Inspection – Service Delivery and Follow-up After a Patient's Suicide Attempt, Minneapolis VA Health Care System, Minneapolis, Minnesota -7/19/2012

Homeless Incidence and Risk Factors for Becoming Homeless in Veterans - 5/4/2012

Healthcare Inspection – Suicide of a Veteran Enrolled in VA Supported Housing, Bay Pines VA Healthcare System, Bay Pines, FL - 4/18/2012

Healthcare Inspection – Alleged Mental Health Access and Treatment Issues at a VA Medical Center - 3/21/2012

Healthcare Inspection – Select Patient Care Delays and Reusable Medical Equipment Review Central Texas Veterans Health Care System Temple, Texas - 1/6/2012

Healthcare Inspection – Clinical and Administrative Issues in the Suicide Prevention Program Alexandria VA Medical Center Pineville, Louisiana - 8/30/2011

Healthcare Inspection – Attempted Suicide During Treatment West Palm Beach VA Medical Center, West Palm Beach, Florida - 7/25/2011

Healthcare Inspection – Electronic Waiting List Management for Mental Health Clinics Atlanta VA Medical Center Atlanta, Georgia - 7/12/2011

Healthcare Inspection – A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs (MH RRTP) - 6/22/2011

Healthcare Inspection – Prescribing Practices in the Pain Management Clinic, John D. Dingell VA Medical Center, Detroit, Michigan - 6/15/2011

Healthcare Inspection – Post Traumatic Stress Disorder Counseling Services at Vet Centers - 5/17/2011

Review of Combat Stress in Women Veterans Receiving VA Health Care and Disability Benefits - 12/16/2010

GOVERNMENT ACCOUNTABILITY OFFICE

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am pleased to have the opportunity to comment on overcoming barriers for quality mental health care for veterans—particularly those who are returning from deployment. In 2011, we reported that the number of veterans receiving mental health care had increased each year from fiscal year 2006 to 2010, and veterans who served in Afghanistan and Iraq accounted for an increasing proportion of veterans receiving mental health care during this period.[1] We also reported on the key barriers that may hinder veterans from accessing mental health care from the Department of Veterans Affairs (VA), which included difficulty scheduling appointments.[2] More recently, in December 2012, we reported on problems with VA's oversight of outpatient medical appointment scheduling processes and measurement of outpatient medical appointment wait times.[3]

In fiscal year 2011, there were more than 8 million veterans enrolled in VA's health system, which is operated by the Veterans Health Administration (VHA). VHA provided nearly 80 million outpatient medical appointments to veterans

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[1] GAO, VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access, GAO-12-12 (Washington, D.C.: Oct. 14, 2011).

[2] We identified key barriers from the literature, and corroborated the barriers through interviews with VA officials.

[3] GAO, VA Health Care: Reliability of Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement, GAO-13-130 (Washington, D.C.: Dec. 21, 2012).

through its primary and specialty care clinics.[4] Although access to timely medical appointments is critical to ensuring that veterans obtain needed medical care, long wait times and inadequate scheduling processes at VA medical centers (VAMC) have been long-standing problems that persist today. For example, in 2001, we reported on the timeliness of medical appointments and found that two-thirds of the specialty care clinics visited had wait times longer than 30 days, although some clinics had made progress in reducing wait times, primarily by improving their scheduling processes and making better use of their staff.[5] Later, in 2007, the VA Office of Inspector General (OIG) reported that VHA facilities did not always follow VHA's scheduling policies and processes and that the accuracy of VHA's reported wait times for medical appointments was unreliable.[6] Most recently, in 2012, the VA OIG reported that VHA was not providing all new veterans with timely access to full mental health evaluations, and had overstated its success in providing veterans with timely new and follow-up appointments for mental health treatment.[7] Although VHA has reported continued improvements in measuring and achieving timely access to medical appointments, patient complaints and media reports about long wait times have persisted, prompting renewed concerns about excessive medical appointment wait times.

VHA has a scheduling policy intended to help its VAMCs meet its commitment to scheduling medical appointments with no undue waits or delays.[8] The policy establishes processes and procedures for scheduling medical appointments and ensuring the competency of staff directly or indirectly involved in the scheduling process. It includes several requirements that affect timely appointment scheduling, as well as accurate wait time measurement.[9] For example, the policy requires schedulers to record appointments in VHA's Veterans Health Information Systems and Technology Architecture (VistA) medical appointment scheduling system, including the date on which the patient or provider wants the patient to be seen—known as the desired date.[10]

At the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the patient's or provider's desired date, as recorded in the VistA scheduling system by VAMCs' schedulers. According to VHA central office officials, VHA measures wait times based on desired date in order to capture the patient's experience waiting and to reflect the patient's or provider's wishes. In fiscal year 2012, VHA had a goal of completing primary care appointments within 7 days of the desired date, and scheduling specialty care appointments within 14 days of the desired date.[11] VHA established these goals based on its performance reported in previous years.[12] To help facilitate accountability for achieving its wait time goals, VHA includes wait time measures—referred to as performance meas-

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[4] Outpatient clinics offer services to patients that do not require a hospital stay. Primary care addresses patients' routine health needs and specialty care is focused on a specific specialty service such as orthopedics, dermatology, or psychiatry. Throughout this statement we will use the term "medical appointments" to refer to outpatient medical appointments.

[5] GAO, VA Health Care: More National Action Needed to Reduce Waiting Times, but Some Clinics Have Made Progress, GAO-01-953 (Washington, D.C.: Aug. 31, 2001).

[6] Department of Veterans Affairs, Office of Inspector General, Audit of the Veterans Health Administration's Outpatient Waiting Times, Report No. 07–00616–199, (Washington, D.C.: Sept. 10, 2007).

[7] Department of Veterans Affairs, Office of Inspector General, Veterans Health Administration: Review of Veterans' Access to Mental Health Care, Report No. 12–00900–168, (Washington, D.C.: Apr. 23, 2012).

[8] VHA medical appointment scheduling policy is documented in VHA Directive 2010–027, VHA Outpatient Scheduling Processes and Procedures (June 9, 2010). We refer to the directive as "VHA's scheduling policy" from this point forward.

[9] VHA has a separate directive that establishes policy on the provision of telephone service related to clinical care, including facilitating telephone access for medical appointment management. VHA Directive 2007–033, Telephone Service for Clinical Care (Oct. 11, 2007).

[10] VistA is the single integrated health information system used throughout VHA in all of its health care settings. There are many different VistA applications for clinical, administrative, and financial functions, including the scheduling system.

[11] In 2012, VA also had several additional goals related to measuring access to mental health appointments specifically, such as screening eligible patients for depression, post-traumatic stress disorder, and alcohol misuse at required intervals; and documenting that all first-time patients referred for or requesting mental health services receive a full mental health evaluation within 14 days of their initial encounter. As noted earlier, in its Report No. 12–00900–168, the VA OIG found that some of the mental health performance data were not reliable. VA is dropping several of these mental health measures in 2013.

[12] In 1995, VHA established a goal of scheduling primary and specialty care medical appointments within 30 days to ensure veterans' timely access to care. In fiscal year 2011, VHA shortened the wait time goal to 14 days for both primary and specialty care medical appointments. In fiscal year 2012, VHA added a goal of completing primary care medical appointments within 7 days of the desired date.

ures—in its Veterans Integrated Service Network (VISN) directors' and VAMC directors' performance contracts, [13] and VA includes measures in its budget submissions and performance reports to Congress and stakeholders. [14]

This statement highlights key findings from our December 2012 report that describes needed improvements in the reliability of VHA's reported medical appointment wait times, scheduling oversight, and VHA initiatives to improve access to timely medical appointments. [15] For that report, we reviewed VHA's scheduling policy and methods for measuring medical appointment wait times and interviewed VHA central office officials responsible for developing them. We did not include mental health appointments in the scope of our work, because this issue was already being reviewed by VA's Office of Inspector General. We also visited 23 high-volume outpatient clinics at four VAMCs selected for variation in size, complexity, and location; these four VAMCs were located in Dayton, Ohio; Fort Harrison, Montana; Los Angeles, California; and Washington, D.C. At each VAMC we interviewed leadership and other officials about how they manage and improve medical appointment timeliness, their oversight to ensure accuracy of scheduling data and compliance with scheduling policy, and problems staff experience in scheduling timely medical appointments. We examined each VAMC's and clinic's implementation of elements of VHA's scheduling policy and obtained documentation of scheduler training completion. In addition, we interviewed schedulers from 19 of the 23 clinics visited, and also reviewed patient complaints about telephone responsiveness, which is integral to timely medical appointment scheduling. We interviewed the directors and relevant staff of the four VISNs for the sites we visited. We also interviewed VHA central office officials and officials at the VAMCs we visited about selected initiatives to improve veterans' access to timely medical appointments. We performed this work from February 2012 through December 2012 in accordance with generally accepted government auditing standards.

In brief, we found that (1) VHA's reported outpatient medical appointment wait times are unreliable, (2) there was inconsistent implementation of certain elements of VHA's scheduling policy that could result in increased wait times or delays in scheduling timely medical appointments, and

(3) VHA is implementing or piloting a number of initiatives to improve veterans' access to medical appointments. Specifically, VHA's reported outpatient medical appointment wait times are unreliable because of problems with correctly recording the appointment desired date—the date on which the patient or provider would like the appointment to be scheduled—in the VistA scheduling system. Since, at the time of our review, VHA measured medical appointment wait times as the number of days elapsed from the desired date, the reliability of reported wait time performance is dependent on the consistency with which VAMC schedulers record the desired date in the VistA scheduling system. However, aspects of VHA's scheduling policy and related training documents on how to determine and record the desired date are unclear and do not ensure replicable and reliable recording of the desired date by the large number of staff across VHA who can schedule medical appointments, which at the time of our review was estimated to be more than 50,000. During our site visits, we found that at least one scheduler at each VAMC did not record the desired date correctly, which, in certain cases, would have resulted in a reported wait time that was shorter than the patient actually experienced for that appointment. Moreover, staff at some clinics told us they change medical appointment desired dates to show clinic wait times within VHA's performance goals. Although VHA officials acknowledged limitations of measuring wait times based on desired date, and told us that they use additional information, such as patient satisfaction survey results, to monitor veterans' access to medical appointments, reliable measurement of how long veterans wait for appointments is essential for identifying and mitigating problems that contribute to wait times.

At the VAMCs we visited, we also found inconsistent implementation of VHA's scheduling policy, which can result in increased wait times or delays in scheduling timely medical appointments. For example, four clinics across three VAMCs did not

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[13] Each of VA's 21 VISNs is responsible for managing and overseeing medical facilities within a defined geographic area. VISN and VAMC directors' performance contracts include measures against which directors are rated at the end of the fiscal year, which determine their performance pay.

[14] VA prepares a congressional budget justification that provides details supporting the policy and funding decisions in the President's budget request submitted to Congress prior to the beginning of each fiscal year. The budget justification articulates what VA plans to achieve with the resources requested; it includes performance measures by program area. VA also publishes an annual performance report—the performance and accountability report— which contains performance targets and results achieved compared with those targets in the previous year.

[15] GAO-13-130.

use the electronic wait list to track new patients that needed medical appointments as required by VHA's scheduling policy, putting these clinics at risk for losing track of these patients. Furthermore, VAMCs' oversight of compliance with VHA's scheduling policy was inconsistent across the facilities we visited. Specifically, certain VAMCs did not ensure the completion of scheduler training by all staff required to complete it even though officials stressed the importance of the training for ensuring correct implementation of VHA's scheduling policy. VAMCs also described other problems that impede the timely scheduling of medical appointments, including VA's outdated and inefficient VistA scheduling system, gaps in scheduler staffing, and issues with telephone access. The current VistA scheduling system is more than 25 years old, and VAMC officials reported that using the system is cumbersome and can lead to errors.[16] In addition, shortages or turnover of scheduling staff, identified as a problem by all of the VAMCs we visited, can result in appointment scheduling delays and incorrect scheduling practices. Officials at all VAMCs we visited also reported that high call volumes and a lack of staff dedicated to answering the telephones impede the scheduling of timely medical appointments. Although we did not specifically review mental health clinic wait times, some of the problems we identified were pervasive, and may also affect clinics other than those we visited.

VHA is implementing or piloting a number of initiatives to improve veterans' access to medical appointments that focus on more patient-centered care; using technology to provide care, through means such as telehealth and secure messaging between patients and their health care providers; and using care outside of VHA to reduce travel and wait times for veterans who are unable to receive certain types of outpatient care in a timely way through local VHA facilities. For example, VHA is piloting a new initiative to provide health care services through contracts with community providers that aims to reduce travel and wait times for veterans who are unable to receive certain types of care from VHA in a timely way. Although VHA collects information on wait times for medical appointments provided through this initiative, these wait times may not accurately reflect how long patients are waiting for appointments because they are counted from the time the contracted provider receives an authorization from VA, rather than from the time the patient or provider first requests an appointment from VHA.

In conclusion, VHA officials have expressed an ongoing commitment to providing veterans with timely access to medical appointments and have reported continued improvements in achieving this goal. However, unreliable wait time measurement has resulted in a discrepancy between the positive wait time performance VA has reported and veterans' actual experiences. More consistent adherence to VHA's scheduling policy and oversight of the scheduling process, allocation of staff resources to match clinics' scheduling demands, and resolution of problems with telephone access would potentially reduce medical appointment wait times. VHA's ability to ensure and accurately monitor access to timely medical appointments is critical to ensuring quality health care to veterans, who may have medical conditions that worsen if access is delayed.

To ensure reliable measurement of how long veterans are waiting for appointments and improve timely medical appointment scheduling, we recommended that the Secretary of VA direct the Under Secretary for Health to take actions to (1) improve the reliability of its medical appointment wait time measures, (2) ensure VAMCs consistently implement VHA's scheduling policy, (3) require VAMCs to routinely assess scheduling needs for purposes of allocation of staffing resources, and (4) ensure that VAMCs provide oversight of telephone access and implement best practices to improve telephone access for clinical care. VA concurred with our recommendations and identified actions planned or underway to address them.

This concludes my statement for the record.

GAO Contacts and Staff Acknowledgments

For questions about this statement, please contact Debra A. Draper at (202) 512–7114 or draperd@gao.gov. Contact points for our Offices of Congressional Relations and Public Affairs may be found on the last page of this statement. Individuals making key contributions to this statement include Bonnie Anderson, Assistant Director; Rebecca Abela; Jennie Apter; Lisa Motley; Sara Rudow; and Ann Tynan.

[16] In October 2012, VA announced a contest seeking proposals for a new medical appointment scheduling system from commercial software developers.

THE AMERICAN COUNSELING ASSOCIATION

Chairman Miller, Ranking Member Michaud and Members of the Committee, I want to thank you for inviting me to submit testimony to the Committee today. It is an honor and a privilege to speak on behalf of the American Counseling Association and we appreciate the opportunity to contribute to this very important discussion. We share the concerns of this committee regarding the well-being of our service members, and we consider it a national tragedy that on average, one of our veterans commits suicide every 80 minutes. I can think of no more pressing concern for this committee than stopping this terrible toll.

The American Counseling Association is the country's largest and oldest professional association representing the counseling profession, with over 52,000 members across the United States and overseas. Our members have diverse backgrounds and many of them specialize in treating substance abuse disorders, mental health issues, trauma, family issues and depression among others.

There are more than 120,000 licensed professional counselors (LPC's) nationwide, authorized under licensure laws enacted in all 50 states and other U.S. jurisdictions

to practice independently. As with the profession of social work, states use slightly differing titles for those licensed as professional mental health counselors, the most commonly used title being "licensed professional counselor." LPCs meet education, training, and examination requirements similar to—and in many states, more stringent than—those of marriage and family therapists and clinical social workers. Licensed professional counselors have to have a master's degree in counseling or a related field, pass a national exam (in some cases two exams), and accumulate thousands of hours of post-degree supervised experience. As with other health care professionals, counselors must adhere to a code of ethics, are required to practice within the scope of their expertise, and practice subject to the oversight and approval of their state's licensure board. Counselors provide outpatient psychotherapy independently under private sector health plans nationwide, as authorized by state licensure laws, and form a significant part of the nation's mental health workforce.

Licensed professional counselors can make a valuable contribution to treating the mental health concerns of service members, and as the committee knows, psychological and cognitive injuries and their consequences are the signature wounds of the Iraq and Afghanistan conflicts. Policymakers both inside and outside the Department of Veterans Affairs have repeatedly said that there aren't enough mental health providers available to meet veterans' treatment needs. From our perspective this problem is to a large extent a self-inflicted wound, because despite a past press release to the contrary, the VA has effectively decided not to utilize LPCs as part of its mental health workforce. The VA's rules and policies have kept far too many counselors from operating under either of those two areas at a time when we need them most. And these rules could be changed by the Administration in a fairly simple and quick manner so that we can begin to deliver the care and treatment that our troops need right now.

As I mentioned, there are more than 120,000 licensed professional counselors across the country, all meeting stringent education, training, experience, examination, and ethical standards. In all of 2012, a grand total of 58 LPMHC ("licensed professional mental health counselor") VA positions were posted on USAJobs.com. In comparison, 1,527 clinical social worker positions were posted. In terms of the number of licensees at the highest level of licensure, the ratio for the two professions nationwide isn't 26 to 1; it's roughly 1.7 to 1.

While we understand that the local needs of VA Medical Centers and Community-Based Outpatient Clinics are varied and that the local staff or those facilities are positioned to identify and meet those needs, it is clear to us that LPCs are an overlooked solution to the staffing problem. Also, in many cases, both VAMCs and CBOCs are unable to integrate LPCs into their staff due to the fact that there are barriers that have been created by the VA itself. To cite one important example, the VA's Office of Academic Affiliations each year establishes paid traineeship positions for both psychologists and clinical social workers counselors, which serve as a pathway to service in the VA health care system. The Office of Academic Affiliations has denied our request that they establish paid traineeship positions for professional counselors. The most recent justification given for this denial is the unsubstantiated, false claim that there is a different "community standard" regarding paid internships within the mental health counseling profession than exists for the clinical social work and psychology professions. Less than a year ago, the justification given was that there was "not a need" for professional mental health counselors at VA facilities.

Despite the current crisis in veterans' mental health care, the VA is using overly restrictive eligibility criteria for LPMHC positions, which includes graduation from counseling programs that are specifically named. ACA supports the highest standards of accreditation. In fact, organizations such as the Council on Accreditation of Counseling and Related Educational Programs (CACREP) is one that our organization helped to create. However, while we understand the VA's interest in relying on national accreditation to ensure provider quality, large numbers of highly qualified, experienced LPCs will be denied the ability to provide critical mental health services of our returning wounded warriors. We believe this is unconscionable.

By mandating such a strict accreditation requirement, the VA is shutting out many highly-trained mental health counselors—many of them veterans themselves—at a time when veterans are literally dying for want of help. We have asked the VA to increase job listings for LPCs and adopt grand parenting standards to allow an alternative route to eligibility for LPMHC positions for the tens of thousands of fully-licensed counselors who right now can't apply, but the VA has said they are not interested. The result is that our members are being told that they should go back to school and obtain another degree if they wish to work in a VA facility, if and when the VA decides to begin hiring LPMHCs in large numbers.

ACA recommends that the VA expand the eligibility criteria for LPMHC positions to include mental health counselors who:

1) Holds at least a master's degree in counseling from a regionally accredited program;

2) Is licensed as a professional counselor in a U.S. jurisdiction at the highest level of licensure offered; and

3) Passes the National Clinical Mental Health Counseling (NCMHCE) Exam.

ACA believes that by adopting grandfathering provisions such as these, at least during this time of severe need for more clinicians, the VA can recruit more LPCs without sacrificing the quality of care to our veterans. It could also allow many veterans who are counselors to serve their country and their compatriots.

In addition to adopting these grandfathering provisions, ACA has several other specific policy recommendations that we have recommended to the VA and would like to share with the committee. And while these recommendations may seem like small steps that the VA could take, they would be huge strides for the LPC community and would go a long way toward opening the door to members of our profession who want to care for our veterans:

- The VA's Office of Academic Affiliations should include counselors in its paid trainee program. These positions are a well-trod pathway to careers within the VA, and counselors are being unfairly and arbitrarily discriminated against by being excluded from the program.
- That the VA collaborate with ACA and other groups to help fill vacancies in the VA. ACA has a national network and an office of professional affairs that can help find applicants for these positions.
- That the VA appoint a liaison to work with the counseling community toward hiring more LPCs in the VA.
- VA Secretary Eric Shinseki should issue a public notice to the entire VA healthcare system (Specifically to VISN Directors, VMAC Directors and HR Directors) reminding them that they are empowered to hire counselors, and asking them not to shut-out an entire profession that can provide desperately needed help to our vets.

All of these recommendations could be undertaken by the VA immediately, and without the need for congressional authorization. They could be acted upon today and thus hasten the ability for the VA to expand the opportunities for our service members to receive quality mental healthcare.

I hope that by sharing these recommendations with you, we can work together toward implementing these recommendations and get more LPCs into the VA. More LPCs in the system would mean that we are increasing the availability of mental health clinicians to our veterans and their family members. In the end, improving the quality and accessibility of mental health services for our veterans and their families should be what we are all focused on.

THE AMERICAN LEGION

Chairman Miller, Ranking Member Michaud and distinguished Members of the Committee:

The United States of America lost 22 veterans to suicide every day in 2010 according to the Department of Veterans Affairs (VA) study released earlier this month. According to the report's estimations, a veteran took his or her own life every 66 minutes [1]. With veteran suicide at an all time high, naturally we must question whether VA's mental health care system is equipped to meet the demands of the veteran population it was created to serve. The VA may offer veterans the best mental health care option available, but if we face difficult barriers to access that care, then veterans are not really being served.

On behalf of Commander James Koutz and the 2.4 million veterans of The American Legion, we would like to thank you for this opportunity to provide testimony for the record in order to highlight issues with overcoming barriers to quality mental health care provided by VA.

Specifically, we will address the following five issues:

[1] "Suicide Data Report, 2012" Department of Veterans Affairs Mental Health Services Suicide Prevention Program, p 15

1) Fulfilling the promise to hire additional mental health personnel and fill the large number of vacancies

2) Implementation of the E.O to improve access to mental health care for veterans and their families

3) Addressing the recommendations in the IG and GAO report

4) Correcting lengthy wait times and misleading access measures, and cumbersome scheduling processes, and

5) Effective partnering with non-VA resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes

The Large Number of Existing Vacancies

During the past half decade, VA has nearly doubled their mental health care staff, jumping from just over 13,500 providers in 2005 to over 20,000 providers in 2011. However, during that time there has been a massive influx of veterans into the system, with a growing need for psychiatric services. With over 1.5 million veterans separating from service in the past decade, 690,844 have not utilized VA for treatment or evaluation. The American Legion is deeply concerned about nearly 700,000 veterans who are slipping through the cracks unable to access the health care system they have earned through their service.

On June 11th, 2012, a VA Press Release outlined an aggressive recruitment effort to hire 1,600 mental health professionals and 300 support staff. The release stated that all of the positions would be filled by the 2nd Quarter of FY2013. Unfortunately, despite repeated requests for updates on the progress of the hiring, The American Legion had not received any numbers or date until a belated, eleventh hour press release from VA that was released just hours before this hearing.

In order to instill confidence in the veterans' mental health care stakeholders, VA must improve the transparency of their process and work to foster meaningful two-way communication. The veteran community wants to work with VA to ensure the needs of our veterans are being met, yet effective communication is impossible without open access to the information we need to discuss. The American Legion urges VA to provide more information on the status of hiring for these positions, throughout the entire process. If the concerned veterans' community only learns of unfilled positions after a deadline is missed, it will be too late for stakeholders and partners to work together to achieve meaningful solutions.

Implementing the Executive Order on Improving Access to Mental Health Services for Veterans, Servicemembers and Military Families

The Executive Order on Improving Access to Mental Health Services for Veterans, Servicemembers and Military Families dealt with suicide prevention, enhancing partnerships between the VA and community providers, expanding VA mental health services staffing, improved research & development, and the creation of a Military and Veterans Mental Health Interagency Task Force.

After reviewing the Executive Order and examining the implementation, The American Legion has identified certain gaps that may need to be considered in the future development and implementation of this Executive Order.

The Executive Order Section 1: Policy order states that "as part of our ongoing efforts to improve all facets of military mental health, this order directs the Secretary of Defense, Health and Human Services, Education, Veterans Affairs, and Homeland Security to expand suicide prevention strategies and take steps to meet the current and future demand for mental health and substance abuse treatment services for veterans, service members and their families."

However, The American Legion is gravely concerned about the February 5, 2012 decision by VA and DOD to abandon efforts to create a single medical records system. Rather than supporting the vision of the Executive Order to work with multiple agencies, this decision can only lead to greater distance and fragmentation. With veterans waiting on average 374 days for Medical Evaluation Board (MEB)/ Physical Evaluation Board (PEB) claims and 257 days for a traditional VA claim, veterans need faster processing which will only come from a smooth transition of records. These records are needed for decisions and the lack of a shareable record is hurting veterans.

Suicide Prevention

According the Executive Order, the Veterans Crisis Line was to be increased by 50%, which The American Legion applauds because it increases the capacity to serve veterans in a timely manner. It also called for the creation of a 12 month national suicide prevention campaign, and on bringing down the negative stigma associated with mental health needs for the veteran, but the American Legion is con-

cerned this campaign does not adequately target families and community members. Because PTSD is comparable to other societal issues such as substance abuse, where the victim may not recognize their own problem, reaching out to the existing support structures around those victims is all the more critical. Veterans may have a lack of understanding or awareness of mental health care, and may not understand their conditions or may feel that their mental health conditions are not severe enough to warrant asking for help. Family and community members can help increase awareness and encourage the veteran to seek help[2].

One of the impediments VA has faced has been with the collecting and tracking of accurate suicide data. In the Suicide report, it found that "as of November 2012, data had only been received from 34 states and data use agreements have been approved by an additional eight states." However, agreements are still under approval or development by other states which impacts VA's ability to accurately calculate the total number of veteran suicides. In order to improve the collection and reporting of suicide data, Congress should urge the states to share this information with VA. Without accurate suicide prevention and mortality data, the estimates that 18 to 21 veterans commit suicide are not truly accurate and these estimates in reality in all actuality could be much higher or lower.

Enhanced Partnerships Between the VA and Community Providers

VA and Health & Human Services (HHS) were asked to establish at least 15 pilot programs with community providers in order to ensure that the needs of veterans are being met, by providing access to mental health services within 14 days of the patient's requested date.

While DOD has led the effort in utilizing pro-bono community provider programs to treat service members for mental health conditions, including PTSD; Senate testimony from a November 30th, 2011 Veterans Affairs Committee hearing[3] made it clear that VA was not working with non-profit organizations to minimize patient wait times for appointments, thus exacerbating the problem of the veterans ability to receive care in a timely manner.

In a congressional hearing, VA Fee Basis Care: Examining Solutions to a Flawed System, on September 14, 2012 The American Legion found many problems with VA's non-VA purchased care programs such as:

- need for VA to develop and implement fee-basis policies and procedures with a patient-centered strategy that takes veterans' interest and travel distance into account;
- lack of training and education programs for non-VA providers; lack of integration of VA's computer patient record system with non-VA providers which creates delay in contractors submitting appointment documentation;
- VA does not have a process to ensure all VA and non-VA purchased care contracts are inputted into a tracking system to ensure they do not lapse.

Without these VA reforms and improvements, VA cannot adequately leverage non-VA and community partnerships.

The American Legion demands that veterans have access to quality and timely mental health care, which should be based in an adequately funded budget for mental health. However, the VA should be leveraging community resources to help alleviate the issue associated with wait times whenever possible. In addition, it is crucial that the VA ensure that the community providers performing this important work are trained to provide the quality of care equal to what is delivered by VA providers. Ultimately, given the experience in dealing with military matters such as the unique complexities of PTSD, VA and DOD providers are, and should be, the gold standard of care, and VA planning should have the ultimate goal of fulfilling the needs of veterans within the VA system. While working to achieve that goal VA should ensure that no veterans slip through the cracks by leveraging all available community resources until the care can be completely met by VA resources.

It should be noted that the VA is working with community providers through the five-site, 3-year pilot program, Project Access Received Closer to Home (ARCH), which is administered through the Office of Rural Health. This program utilizes contracting and a fee-basis payment system to help meet the needs of rural veterans. The American Legion notes that processing the authorizations for certain services were concerns that were brought up in April 2012 during the evaluation of the Montana Project ARCH program. The 2012 System Worth Saving Task Force Report on Rural Health recognized that the ARCH project was a three year pilot, yet concerns existed regarding effective utilization of budget for patient care, a lack

[2] GAO Report 13–130, December 2012
[3] Testimony of Dr. Van Dahlen – 11/30/11 Senate Veterans Affairs Committee

of outreach guidelines and communication and the difference in structures between VA care and non-VA care.

While Community providers are an option, The American Legion is concerned that a main issue associated with using community providers lies in the continuity of care. To address this concern, the VA is implementing a program that will address the lack of providers, while increasing the continuity of care, called; VA Specialty Care Access Networks – Extension for Community Healthcare Outcomes (SCAN–ECHO). This unique program utilizes primary care physicians to provide specialty care to veterans who choose to enroll in the program. The primary care physician presents the veteran's case to a panel of medical professionals, including specialists, who discuss diagnoses and treatments. By incorporating the primary care physician in the treatment, there is an increased level of continuity of care. Primary care physicians bring in a more holistic approach of the veteran that The American Legion believes will benefit the veteran patient.

Expanding VA Mental Health Services Staffing

The Executive Order also calls for the addition of 800 peer-to-peer counselors by December 2013, while providing hiring incentives and evaluating reporting requirements to reduce paperwork requirements to bring on new staff.

Peer-to-peer counseling has been used as an effective treatment to help veterans in the rehabilitation process, which is clearly exemplified by the Vet Center program implemented across the nation. The American Legion advocates expanding the program of peer-to-peer support networks, and believe this would be very instrumental in moving from a treatment based model to a recovery model.

The American Legion continues to encourage the Secretary of Veterans Affairs to utilize returning service members for positions as peer support specialists in the effort to provide treatment, support services and readjustment counseling for those veterans requiring these services. If appropriately skilled unemployed veterans can receive training to fulfill staffing needs in the mental health care system, VA will be solving multiple problems with a single, forward thinking solution. Robust recruitment and vocational training in this area should be a priority and The American feels so strongly about this issue that we passed a resolution during our National Convention last year specifically to call upon VA to institute a peer to peer outreach program [4].

Hiring incentives may entice providers to apply to work for the VA over the private sector, and reducing the cumbersome process of credentialing and privileging to bring providers on board more quickly could help meet VA's needs, provided it is done in a manner that does not sacrifice quality and competency of care. VHA needs to conduct a staffing analysis to determine if psychiatrists or other mental health provider vacancies are systemic issues impending VHA's ability to meet mental health timeliness goals [5]. Many facilities visited through The American Legion's System Worth Saving program have demonstrated difficulties competing with the private sector, and complained that the Credentialing & Privileging process for physicians is too lengthy.

Improved Research & Development

The Executive Order called for the creation of a National Research Action Plan to be developed within 8 months by DOD, VA, HHS, and the Office of Science & Technology Policy (OSTP). This plan was supposed to develop better prevention, diagnosis, and treatment for PTSD, other mental health conditions, and Traumatic Brain Injury (TBI). Additionally it calls for DOD and HHS to engage in a comprehensive longitudinal health study on PTSD, TBI, and related injuries with minimum enrollment of 100,000 service members.

The American Legion applauds this effort, because it is inclusive of TBI which has a high level of co-morbidity with PTSD. It also looks at long term effects of TBI, PTSD, and other mental health conditions, while focusing on the whole process of prevention, diagnosis, and treatment. The American Legion has long supported research efforts that address the signature wounds of the Iraq and Afghanistan conflicts and supports these efforts through a series of membership based resolutions that were passed during our National Convention last summer [6].

In addition to traditional treatment measures currently in use through the VA and DOD health care systems, The American Legion urges Congress to provide

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[4] American Legion Resolution No. 136: The Department of Veterans Affairs to Develop Outreach and Peer to Peer Programs for Rehabilitation

[5] OIG Report 12–00900–168, April 23, 2012

[6] Resolution No. 108: Request Congress Provide the Department of Veterans Affairs Adequate Funding for Medical and Prosthetic Research, Resolution No. 285: Traumatic Brain Injury and Post Traumatic Stress Disorder Programs

oversight and funding to the DOD and VA for innovative TBI and PTSD research currently used in the private sector, such as Hyperbaric Oxygen Therapy and Virtual Reality Exposure Therapy, as well as other non-pharmacological treatments. The American Legion also recommends the creation of a joint office for DOD & VA research in order to increase agency collaboration and communication. Finally, The American Legion finds it troubling that DOD and VA are not designated as the lead agencies for this effort, with HHS and OSTP providing advisory roles.

Military and Veterans Mental Health Interagency Task Force

The creation of a taskforce, which is designed to implement the Executive Order, met with all the stakeholders in January. The American Legion encourages the Task Force to continue to involve VSOs at all stages of their work.

Addressing the recommendations in recent VA Inspector General (OIG) and Government Accountability Office (GAO) reports

Since 2005, multiple reports from the OIG have stated that the schedulers were entering incorrect desired appointment dates for veterans who were requesting mental health appointments. Recommendations have repeatedly directed VA to reassess their training, competency, and oversight methods to ensure reliable and accurate appointment data is captured.

The American Legion is extremely concerned that an overall lack of accountability will make this goal difficult to achieve. Much like the school system, the VA medical centers are trying to meet a standard they are mandated to achieve, and as in the case of the school systems, tests can be modified by the states to show success that is not occurring. The American Legion is further concerned that VHA statistics and data are being manipulated in order to show the desired results, and that this data is not accurately depicting the situation. Policies and measurements are created in order to monitor the information, but if individuals feel that their performance is based upon this measure, then the predilection to alter the data becomes problematic.

The American Legion also notes that the measurements are not always the issue. Staffing, technology, and veteran perceptions & circumstances also can play a big role in delaying treatment provided to veterans.

The VHA system has multiple issues with scheduling that could be alleviated with more funding[7]. Chief among these concerns are an outdated VistA Scheduling System, problems with scheduler turnover, and the ongoing provider staffing gaps. As the primary scheduling system, the outdated VistA can cause difficulties in scheduling due to a lack of multitasking ability inherent to the software. A more modern system could alleviate this, and will require funding to develop and implement. Consistency with staffing, not only of providers but also with schedulers, will ensure more consistency delivering appointments.

Although not mentioned in the report, the centralization of Informational Technology (IT) has created a shared pot where the different VA entities are now competing for the same technology storage space and resources. This creates and issue with updating programs such as the VistA Scheduling System or other IT solutions for scheduling. Facilities need to have flexibility in meeting their IT needs.

The more recent GAO report focuses on barriers faced and efforts to increase access[8]. The report mainly addresses the negative stigma, lack of understanding of mental health, logistical challenges, and concerns about the VA that may hinder veterans from accessing care.

Most notable in this report was the information regarding the values and priorities that veterans may have. For example, due to family, work, or schooling commitments, many veterans have concerns about scheduling VA appointments during traditional hours of operation.

VA attempted to address this issue with a Directive issued on September 5th, 2012 developed by the VHA[9], however, the directive was rescinded less than a week later on September 11th, 2012 through VHA Notice 2012–13, and the changes never took place. On January 9, 2013, VHA Directive 2013–001 was sent to the field to extend hours access for veterans requiring primary care, including women's health and mental health services. Unfortunately, the implementation of this regular is expected by July 31, 2013 and they are only required to have one weekend shift that is limited to only two hours. In addition, extended hours are only required in VA

[7] GAO Report13–130, December 2012

[8] Ibid

[9] Directive 2012–023, "Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs Medical Centers and Selected Community Based Outpatient Clinics"

Medical Centers and Community Based Outpatient Clinics with 10,000 unique patients or greater. The American Legion is concerned about the impact of this on veterans, particularly in rural areas.

Correcting lengthy wait times, misleading access measures, and cumbersome scheduling processes and procedures.

Thus far, VA is taking a multi pronged approach to address the scheduling issue, by looking at the issues associated with technology, access measures, training, and funding.

Technology

The VA announced in the Federal Register in October of 2012 the opportunity for companies to provide adjustments to the open-source VistA electronic health system, and all submissions are due by June 2013. By creating the Medical Appointment Scheduling System (MASS) contest, the VA appears to be moving ahead on this issue.

Additionally, the GAO has determined that the VA telephone system is outdated [10]. The VHA directed all VISN directors to provide plans to assess their current phone system needs, and develop strategic improvements plans with a target completion of March 30th, 2013, 6 weeks from now.

Because the correction of the substandard VistA system and phone systems is vital to helping alleviate some of the associated difficulties with access to mental health care, The American Legion urges Congress to ensure VA's budget receives adequate funding to address these issues.

Access Measures and Training

The VA is scheduled to have both the new measurements and the training package for schedulers by November 1st, 2013. The American Legion would like the VA to be more transparent regarding the updates associated with any progress associated with scheduling procedures. Furthermore, as VA develops these methods, The American Legion encourages strong cooperation with veterans' groups and other stakeholders throughout the entire process.

Funding

In FY 2012 H.R. 2646 authorized the VA sufficient appropriations to continue to fund and operate leased facility projects that support our veterans all across the country. In November of 2012 the FY 2013 appropriations for the same facilities was eliminated from appropriations due to a "scoring change" initiated by the Congressional Budget Office (CBO). While the locations, projects, leases, and funding requirements did not change – the way in which CBO scored the projects did, which resulted in the appearance that the project would cost more than 10 times the actual needed revenue. According to VA, CBO refuses to share their evaluation process and will only issue the final score. As a result of CBO's adjustment in scoring review, Congress refused to introduce the FY 2013 appropriations bill needed to keep these community based centers open. As these leases now become due, there are 15 major medical facilities that will be forced to close unless Congress acts quickly to provide the appropriate funding to these centers.

If these centers are allowed to close due to insufficient funding, the impact on our veterans, and the VA would be devastating. Not only would the center employees have to either relocate within the VA or be terminated, the VA could be subject to legal action for prematurely defaulting on their leases. The veterans currently being served by these facilities would then have to either travel long distances to the nearest VA facility, or would have to find care at local hospital that the VA would be required to pay for, at a fee-for-services basis. This would ultimately cost the VA an estimated 4 times what the original appropriations would have cost for these shuttered facilities. The facilities currently in jeopardy are located in; Albuquerque, New Mexico, Brick, New Jersey, Charleston, South Carolina, Cobb County, Georgia, Honolulu, Hawaii, Lafayette, Louisiana, Lake Charles, Louisiana, New Port Richey, Florida, Ponce, Puerto Rico, San Antonio, Texas, West Haven, Connecticut, Worchester, Massachusetts, Johnson County, Kansas, San Diego, California, and Tyler, Texas.

The American Legion implores Congress to fund these centers as originally planned. The funds that these centers need has already been obligated, and refusal to fund these centers will cause a false perception of excess monies to exist within the federal budget, which The American Legion is afraid will be falsely reported as a money saving initiative.

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[10] GAO Report13–130, December 2012

Effectively partnering with non-VA resources to address gaps and create a more patient-centric network of care focused on wellness-based outcomes

The Department of veteran Affairs has not engaged The American Legion in the development of any of the 15 pilot programs that VA is engaging in, pursuant to the Presidential Executive Order. As such, we have concerns regarding the quality and viability of the non-VA resources. The American Legion has made clear that they would prefer to be one of the VA's primary resources for dealing with mental health care for veterans, for a variety of reasons which should be obvious.

The VA health care program is a holistic program as it takes into account all of the patient's doctors, to develop an approach that recognizes the interconnectivity of multiple or complicated disorders. Doctors in the VA system have access to all of a patient's records, which is helpful and relevant when dealing with disorders having co-morbid symptoms such as PTSD and TBI. Furthermore, VA mental health care providers are perhaps the most uniquely qualified practitioners available to address military related PTSD and other related emotional conditions. Civilian providers may lack the requisite experience and finite training to deal with these issues.

Because outside providers lack the sharing of information and military experience inherent to the VA system, the ideal solution is to ensure that veterans receive their care in the VA system. They have earned access to this system through their service, and deserve to be able to benefit from the VA's healthcare system, sans scheduling difficulties or unreasonable and potentially deadly delays. However, when that system proves unable to cope with the demand, outside help may be needed until the VA system can be adjusted to once again handle the scope and scale of the influx of veterans who need mental health care assistance.

The American public has expressed a tremendous outpouring of support for those who serve and there is a vast and growing assortment of community based groups who are eager to provide help to veterans who are suffering. Given this level of community support veterans should be able to find the help they need within their communities. Understanding that the VA health care system is uniquely qualified to meet the needs of the veterans, and the ultimate goal should be to ensure that the system has the capacity to serve all veterans; local resources can and should be used to fill in the gaps until a suitable system is in place.

Conclusion

In conclusion, The American Legion is deeply concerned about the issues associated with the barriers to access, the timeliness, and quality of care available to our veterans, many of whom are suffering. The Legion urges VA to work with stakeholders, the Veterans Service Organizations, and Congress to develop a plan to increase transparency and address existing barriers to quality healthcare so we can all work together to ensure that veterans receive the timely and quality mental health services they deserve – especially for those veterans located in remote rural areas.

The American Legion recognizes that the VA is working hard to fulfill its mission; however they will only be successful if they are able to enjoy the full support of Congress, the VSOs, and the community.

IRAQ AND AFGHANISTAN VETERANS OF AMERICA

Chairman Miller, Ranking Member Michaud and distinguished members of the committee, on behalf of Iraq and Afghanistan Veterans of America (IAVA) I would like to extend our gratitude for being given the opportunity to share with you our views and recommendations regarding Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans. IAVA applauds the committee's continued dedication in addressing the critical issues surrounding mental health care and IAVA looks forward to working closely with the committee in addressing these and other issues throughout the 113th congressional session.

IAVA is the country's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan and has more than 200,000 member veterans and supporters nationwide. Founded in 2004, our mission is to improve the lives of Iraq and Afghanistan veterans and their families. Through assistance, awareness and advocacy, we strive to create a country which honors and supports veterans of all generations.

The veteran suicide rate is a national crisis. According to a recent VA report approximately 22 veterans a day are taking their own lives. Unfortunately, IAVA fears that these numbers may actually still be lower than the true number of veterans

we lose to suicide, as some states don't report veteran suicide and are not included in VA's 2013 report. Regardless of the exact number, IAVA strongly believes that even one veteran or servicemember life lost to suicide is one too many.

Since 2008, nearly 1.5 million servicemembers of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND) have transitioned back into the civilian population. According to multiple studies performed by the National Institute of Health, Department of Veterans Affairs (VA) and Department of Defense (DoD), upwards of 43 percent of veterans who served in OIF/OEF/OND will have experienced traumatic events causing Post Traumatic Stress Disorder (PTSD) or other psychological disorders such as depression. Left untreated, these invisible wounds can have a devastating impact on the lives of those veterans and servicemembers who suffer in silence.

As the suicide numbers show and as the prevalence of these invisible injuries demonstrate, our country must start better addressing the psychological wounds of war. Up to this point, VA and DoD have taken a very reactionary approach to addressing the psychological wounds of war. IAVA believes that it is time to start addressing these wounds in a proactive way. While our country has made significant strides in improving the care for veterans, there is still a long way to go.

There are two main approaches to providing treatment for the psychological wounds of war and the prevention of suicide. The first approach is treating psychological wounds and suicide as a public health issue and approaching it as any other public health issues, such as an influenza outbreak or HIV. This approach requires public outreach educating all sectors of the public, involving the public in solutions to the problem and ensuring that services are widely available throughout the community. The second approach is the clinical, or medical, approach. This approach focuses on intensive clinical care, prescribing medications and regular appointments with psychiatrists and psychologists. Unfortunately though, we often focus on one rather than the other. Together, both approaches provide the best quality of care and successful outcomes. The public health approach helps veterans and servicemembers understand the resources that are available to them and how to easily access the care they may need. The clinical approach ensures they receive proper treatment once there. If we are to successfully address the mental health care shortfalls and prevent suicide in our nation, it will require both approaches.

The partnering of the two approaches is also particularly important, because suicide is a tragic conclusion of the failure to address the spectrum of challenges returning veterans face. These challenges are not just mental health injuries; they include finding employment, reintegrating to family and community life, dealing with health care and benefits bureaucracy and many others. Fighting suicide is not just about preventing the act of suicide, it is about providing a "soft and productive landing" for our veterans when they return home. The bottom line is we must treat and offer resources to the entire veteran, including their community and families, and move away from treating individual symptoms, as if they are somehow mutually exclusive of one another.

Stigma is a significant barrier to veterans and servicemembers seeking mental health care. Unfortunately, even though there has been an effort to remove the stigma associated with psychological wounds in recent years by VA and DoD leadership, their message has failed to reach all ranks of servicemembers and the entire veteran population. Despite these efforts, the stigma still seems to be ever so present, and seeking mental health care is often viewed as a sign of weakness or lack of resiliency among those who have been trained to be strong and fearless.

Multiple studies confirm that veterans and servicemembers are concerned about how seeking care could impact their careers, both in and out of the military. Concerns include the effect on their ability to get security clearances and how co-workers and supervisors would perceive them. It is critical that we continue to work to reduce this stigma. We must step up our efforts in removing stigmas and immediately develop and implement newer, more confidential ways of offering assistance to those who need it most if we wish to end the cycle of preventable suicides plaguing today's veteran and military communities.

To combat the stigma, IAVA recommends that VA and DoD partner with experts in the private and nonprofit sector to develop a robust and aggressive outreach campaign. This campaign should focus on directing veterans to services such as Vet Centers, as well as local community and state based services. It should be integrated into local campaigns such as San Francisco's veterans 311 campaign. This campaign should be well-funded and reflect the best practices and expertise of experts in both the mental health and advertising fields. For our part, IAVA has partnered with the Ad Council to launch a public service awareness campaign that is focused on the mental health and invisible injuries facing veterans of Iraq and Afghanistan. Part of this campaign focuses on reducing the stigma of seeking men-

tal health care. This is only one example of the multiple programs and resources IAVA has established to help combat the stigma associated with seeking care for invisible wounds.

Community partnerships will play a key role in providing quality mental health care to veterans throughout the country. Nationwide, we have private sector and non-profit organizations that are already providing mental health care and resources to the members of their individual communities. These organizations are easily accessible and have staff who are trained to address most of the unique and common mental health needs within their communities. Establishing partnerships with those organizations will ensure that veterans, servicemembers and their families receive quality care in their communities, regardless if they start seeking care at their local VA or with one of these providers.

Another critical aspect to preventing suicide, and where VA is still falling short, is ensuring timely access to care and having properly trained staff at every VA facility. This is often the difference between life and death for many veterans. According to VHA's Strategic Plan, VHA requires suicide prevention training for all VHA staff who interact with veterans, plus additional training for health care providers. However, while this may be a policy, IAVA has doubts as to whether or not it is actually be enforced at every VA facility. The importance and need in ensuring timely care and proper training of all staff is clearly illustrated by the experience of Army veteran Jacob Manning in early 2012. Here is Jacob's story, as told in part by Leo Shane of Stars and Stripes:

Jacob Manning waited until his wife and teenage son had left the house, then walked into his garage to kill himself. The former soldier had been distraught for weeks, frustrated by family problems, unemployment and his lingering service injuries. He was long ago diagnosed with traumatic brain injury, caused by a military training accident, and post-traumatic stress disorder stemming from the aftermath. He had battled depression before, but never an episode this bad.

He tossed one end of an extension cord over the rafters above and then fashioned a noose. The cord snapped. It couldn't handle his weight.

He called Christina Roof, a friend and national veterans policy adviser who helped him years before, and rambled about trying again with a bigger cord or a gun. She urged him to calm down sand tried to get him to call the veterans crisis line. Ms. Roof sent a message to Manning's wife, Charity, telling her to rush home. The two of them tried for more than a day to persuade him to get professional help. Ms. Roof eventually got Manning to agree to call the veterans hospital in Columbia, Mo., near his home, after telling him that he had two choices: "Either call VA or I have no choice but to call the police," Roof said.

When a VA staffer at the mental health clinic answered the phone, Manning explained what he had done, and asked if he could be taken into care. The VA staffer asked if Manning was still suicidal. He wavered, saying he wasn't trying to kill himself right then. The hospital employee told him the office was closing in an hour, and asked if Manning could wait until the next day to deal with the problem. Ms. Roof told Manning she didn't care what this VA staffer told him and that she was sending a car within the hour to pick him up and bring him to the VA Medical Center. She told him to pack a bag.

Mr. Manning made it safely to the emergency room and was checked in upon his arrival. Nevertheless, this one experience raises so many other questions as to what other problems veterans in crisis are experiencing when they reach out for help.

Sadly, Manning's story is all too familiar. In April 2012, VA's Office of the Inspector General (OIG) found VA officials had been inflating the success rates for providing timely mental health services to veterans. VA had repeatedly reported to Congress that 95 percent of new patients seeking mental health treatment received full evaluations for care within the department's required window of 14 days. However, VA OIG found that just 49 percent were seen within that period, and the average wait time for most veterans seeking any type of mental health care was over 50 days. IAVA strongly believes that VA must be ready and equipped with the proper care models, policies and personnel to address the huge influx of veterans they will care for in the coming years.

According to the American Psychological Association, there are "significant barriers to receiving mental health care in the Department of Defense (DOD) and Veterans Affairs (VA) system." Mental health professionals are often unavailable to servicemembers, especially those in theatre, and to veterans, particularly those in rural areas. Even veterans in urban areas encounter lengthy wait times when seeking mental health care.

VA must ensure that every employee is trained to respond to a veteran in crisis. VA employees across the administration interact with veterans, and each employee

must be aware of the signs of a veteran in crisis and be aware of all of the resources available to support a veteran in crisis. All VA employees must also be trained to provide quality customer service to every veteran they encounter. For a veteran, like Mr. Manning, to have the strength and resilience to actually seek help, only to be met by a dismissive attitude at the one place he should always be able to count on, is in itself a tragedy.

IAVA has to wonder, and so too should our nation, how many other veterans in crisis are being turned away and how many other veterans have not received the care they needed due to an encounter with an untrained VA staff member?

Additionally, IAVA has real concerns as to how many veterans have we may have lost due to inadequate training and procedures within the VA mental health care system? For a veteran, like Mr. Manning, to have the strength and resilience to actually seek help, only to be met with a dismissive attitude by a staff member at the one place he should always be able to turn to is a tragedy. IAVA believes it is critical for VA to ensure that all of their staff be properly trained to respond to a veteran in crisis and that every veteran in crisis has immediate access to emergency mental health services.

Specifically within VA, there needs to be numerous changes and corrections in the policies and procedures within the Veterans Health Administration (VHA) and the Veterans benefit Administration (VBA). In an effort to address VA's and DoD's issues, on August 31, 2012, President Obama signed an Executive Order (EO) entitled "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families." While IAVA applauds the President's actions and believes that it was a good first step to implementing solid solutions that stand to make a significant difference in the mental health care available to veterans across the country, we believe the real test will be its impact within the veteran and military communities. However, IAVA also notes that the Executive Order's success will also be determined by how effectively and timely it is implemented. As of this hearing, there are lingering questions on the status of the implementation of several key parts of the Executive Order.

For example, the August 2012 Executive Order includes some previous VA initiatives, notably the expansion of mental health care providers and their plan to hire 1,600 new mental health clinicians and 300 mental health support staff. While this is definitely a step in the right direction, IAVA has serious concerns about VA's ability to meet this mandate given the problems they have encountered in the past, both in finding and keeping qualified mental health care providers. Moreover, IAVA respectfully asks for clarification on VA's recent press release stating they have hired an additional 1,000 mental health care providers. IAVA respectfully asks if these new employees were put through an expedited hiring process given the quickness of their hiring? Further, we respectfully ask if these 1,000 new mental health providers were hired to fill the current mental health care provider vacancies VA has had many years filling or if these 1,000 new providers are intended to be a part of the 1,600 new providers mandated by the Executive Order?

The Executive Order also requires the VA and DoD to establish a national suicide prevention campaign. The order reads, that "No later than September 1, 2012, the Departments of Defense and Veterans Affairs shall jointly develop and implement a 12 month national suicide prevention campaign, focused on connecting veterans and service members to mental health services." However, IAVA has been left to wonder as to whether or not this deadline was met. By all accounts, we have yet to see any solid evidence that this campaign was rolled out.

Another part of the Executive Order that has had a deadline pass, states: "By December 31, 2012, the Department of Veterans Affairs, in continued collaboration with the Department of Health and Human Services, shall expand the capacity of the Veterans Crisis Line by 50 percent to ensure that veterans have timely access, including by telephone, text, or online chat, to qualified, caring responders who can help address immediate crises and direct veterans to appropriate care. Further, the Department of Veterans Affairs shall ensure that any veteran identifying him or herself as being in crisis connects with a mental health professional or trained mental health worker within 24 hours. The Department of Veterans Affairs also shall expand the number of mental health professionals who are available to see veterans beyond traditional business hours." IAVA has yet to receive a response from VA as to whether or not this goal was met. We look to this committee to ensure that this part of the Executive Order was met, and if it was not, we are also interested to learn about what plans are in place to ensure its completion.

These lingering questions underscore the critical importance of strong Congressional oversight of the implementation of this Executive Order. This committee has the authority to ensure VA, DoD and the other agencies tasked with improving mental health care for our veterans and military communities are held accountable

to doing so. IAVA cannot stress enough the importance of strict Congressional oversight in ensuring all programs and policies mandated by the 2012 mental health executive order are fully developed, implemented, and that all of the agencies involved are held accountable to meeting the mandated time lines.

For our part, IAVA will continue to be a critical partner in holding VA and DoD accountable for the goals outlined in the Executive Order, but we look to the members of the 113th Congress to stand up for our veterans, servicemembers and their families through real actions in bringing about change to the health care services, resources and benefits they depend on.

Finally, given the wide array of issues the Committee requested we address in this testimony IAVA makes the following recommendations on ways we can improve the mental health care system:

1. VA and DoD must immediately establish a new employee education and mentoring program to overcome the practical problems new staff and longtime staff have in establishing and implementing new programs and policies related to mental health care, especially when they are unfamiliar with VA or federal procedures. We believe the current policies and procedures being used have proved ineffective in the establishment of uniformed mental health care.

2. Involve the families in a veterans or servicemembers mental health care plan. Despite progress, the current level of effort and provision of services remains inadequate in making treatment planning a true partnership between the veteran, family members, and provider.

3. Establish national partnerships to roll out a nationwide education and public service announcement campaign focusing on reducing the stigmas attached to seeking mental health care and addressing the psychological wounds of war. All wounds sustained in war are equally important and need treatment, be they visible or invisible. We need to ensure this is done through clear and concise messaging. For example, if you had a physical injury, you would certainly seek medical care to address it. So why would you hesitate to do the same with a physiological injury?

4. Integrate mental health care screenings and resources into all aspects of a veterans and servicemember's primary health care.

5. Implement uniformed evidence-based care in all VHA facilities and CBOCs. Veterans should have equal access to high quality mental health care regardless of where they live.

6. Conduct a thorough review of VHA Handbook 1160.01, to ensure every VA facility is in compliance. This includes ensuring that every VA facility has a trained mental health care provider on staff at all times or is readily available to care for a veteran in crisis via a page or phone call.

7. Provide easily accessible mental health care or support programs for family members who have a loved one undergoing mental health care or treatment.

8. Increase awareness efforts at the local level to educate all members of the community on the signs associated with suicidal behaviors or tendencies.

9. Conduct robust public outreach campaigns to educate the general public or the realities of the invisible wounds of war by removing all of the misinformation and myths the general public has been exposed to through inaccurate media portrayals' of veterans.

10. Expand the peer-to-peer counseling program and immediately train more veterans to be peer support counselors.

11. Expand upon VA's Community Toolkit Provider program by further developing and actively promoting a nationally recognized certification program which would train mental health professionals in military culture and the unique challenges faced by service members, veterans and their families. This should include best practices in providing care to this community and the nuances of military culture.

12. Integrate robust mental health awareness and suicide prevention training into DoD's enlisted education system, as well as VA's current employee continuing education system.

In closing, caring for the men and women who defend our freedom is a solemn responsibility that belongs to lawmakers, business leaders, and every citizen alike. Despite numerous successes, veterans' and servicemembers' mental health programs and care options are still not where they should be. We must remain ever vigilant and continue to show the men and women who volunteer to serve their country that

we have their backs, through swift actions in correcting the gaps and shortfalls in mental health care. IAVA looks forward to working closely with this committee, VA, DoD and communities across our nation in a combined effort to finally close the gaps in our mental health care system. IAVA will also continue to work tirelessly to ensure that no veteran, servicemember or their family ever have to suffer in silence while carrying the burdens of our nation's 11 years of war.

NATIONAL GUARD ASSOCIATION OF THE UNITED STATES (NGAUS)

Thank you for all you have done for our veterans since 9/11 and for this opportunity to present this statement for the record.

Background - Unique Citizen Service Member/Veteran

The National Guard is unique among components of the Department of Defense (DoD) in that it has the dual state and federal missions. While serving operationally on Title 10 active duty status in Operation Iraqi Freedom (OIF) or Operation Enduring Freedom (OEF), National Guard units are under the command and control of the President. However, upon release from active duty, members of the National Guard return as veterans to the far reaches of their states, where most continuing to serve in over 3,000 armories across the country under the command and control of their governors. As a special branch of the Selected Reserves they train not just for their federal missions, but for their potential state active duty missions such as fire fighting, flood control, and providing assistance to civil authorities in a variety of possible disaster scenarios.

Since 9/11, nearly a half a million National Guard members have deployed in contingency operations to gain veteran status. When they return from deployment, they are not located within the closed structure of a 24/7 supported active military installation, but rather reside in their home town communities where they rely heavily on the medical support of the Veterans Administration (VA) when they can overcome time and distance barriers to obtain it.

Using the National Guard as an operational force will require a more accessible mental health program for members and their families post-deployment in order both to provide the care they deserve as veterans and to maintain the necessary medical readiness required by deployment cycles. It cannot be a simple post-deployment send off by the active military of "Good job. See you in five years." To create a seamless medical transition from active duty to the VA, an improved medical screening of our members before they are released from active duty is essential to identify the medical issues that will be passed to the VA. The Department of Defense must also recognize its responsibility of sharing the burden with the VA in funding mental health care for our National Guard members between deployments, which remains an unmet readiness need.

The Department of Defense must also be called to task for the mishandling and disappearance of National Guard medical records in the OIF/OEF theaters and the shoddy administration of Guard and Reserve demobilization. Statistics published last year by the VA show that the VA denies National Guard and Reserve disability benefit compensation claims at four times the rate of those filed by active duty veterans. Lacking clear records to establish the service connection for their injuries, our Guard members face failure when they later file their VA disability claims for undocumented physical and behavioral injuries. This is a blot on the integrity of our federal government in its treatment of our veterans. This Committee must seriously and separately in another hearing consider legislation to establish a presumption of service connection for certain war common injuries of National Guard and Reserve veterans who later file disability benefit compensation claims based upon those injuries.

Military service in the National Guard is uniquely community based. The culture of the National Guard remains little understood outside of its own circles. When the Department of Defense testifies before Congress stating its programmatic needs, it will likely recognize the indispensable role of the more cost efficient National Guard as a vital operational force, but it will say little about, and seek less to, redress the benefit disparities, training challenges, and unmet medical readiness issues for National Guard members and their families at the state level before, during, and after deployment. We continue to ask Congress to give the Guard a fresh look with the best interests of the National Guard members, their families, and the defense of the homeland in mind.

FULLY LEVERAGE THE VET CENTER MODEL

For behavioral support, Guard veterans often look to the stellar Vet Centers located throughout the country where they and their families can obtain confidential peer to peer counseling as well as behavioral treatment from on site clinicians; telehealth programs; or from referrals to fee based clinicians paid for and pre approved by the Vet Centers.

Confidentiality is vital in bringing our veterans still serving in the Guard to treatment in order to assuage real concerns about the sharing of medical records with the Department of Defense which VA Medical Centers are authorized to do. The fee basing of referred care by the Vet Center to community providers establishes a model for this Committee to consider expanding to close the treatment gaps in our rural communities. A voucher program administered by the Vet Centers authorizing paid for treatment to qualified community providers would maximize scheduling flexibility and plug direct access gaps to care for our Guard veterans.

IMPLEMENT A VOUCHER PROGRAM FOR VETERAN COMMUNITY BASED MENTAL HEALTH CARE

The issues of veterans' unemployment and mental health maintenance cannot be separated. Before veterans can maintain gainful employment in a challenging job environment, they must be able to maintain a healthy mental status and establish supportive social networks.

In 2007, the Rand Corporation published a study titled, "The Invisible wounds of War." It found that at the time 300,000 veterans of Operation Iraqi Freedom and Operation enduring Freedom suffered from either PTSD or major depression. This number can only have grown after five more years of war. The harmful effects of these untreated invisible wounds on our veterans hinder their ability to reintegrate with their families and communities, work productively, and to live independently and peacefully.

Rand recommended that a network of local, state, and federal resources centered at the community level be available to deliver evidence-based care to veterans whenever and wherever they are located. Veterans must have the ability to utilize trained and certified services in their communities. In addition to training providers, the VA must educate veterans and their families on how to recognize the signs of behavioral illness and how and where to obtain treatment.

VA and Vet Center facilities are often located hundreds of miles from our National Guard veterans living in rural areas. Requiring a veteran, once employed, to drive hundreds of miles to obtain care at a VA facility necessitates the veteran taking time off from work for reasons likely difficult to explain to an employer. Most employees can ill afford to miss work, particularly after an extended absence from deployment in the case of our Guard veterans. The VA needs to leverage community resources to proactively engage veterans in caring for their mental health needs in a confidential and convenient manner that does not require long distance travel or delayed appointments.

To facilitate the leveraging of mental health care providers in our communities, the VA through its Office of Mental Health Services or through its highly effective Vet Centers can actively exercise its authority to contract with private entities in local communities, or creatively implement a voucher program that would allow our veterans to seek fee-based treatment locally with certified providers outside the brick and mortar of the Veterans Administration facilities and even the Vet Centers.

The Vet Center in Spokane for example serves an area as big as the state of Pennsylvania. It is not practical for veterans in this catchment area to drive hundreds of miles to seek counseling or behavioral clinical care. That Vet Center pre screens fee based providers to whom it will refer veterans for confidential treatment in its management area. It also monitors the process to make sure the veteran is actually receiving care paid for by the Vet Center. This system already works. However, a voucher process would improve efficiencies by relieving the Vet Center of its scheduling burden by allowing the veteran to directly make his or her own appointment with providers as needed.

The VA and Vet Centers also need to fully leverage existing state administrative mental health and veteran networks. Working with the state mental health care provider licensing authorities, community providers certified by the VA or Vet Center to treat veterans could be identified at the state agency level with vouchers to pay for treatment by those providers administered by the state department of veterans affairs who likely may have an even greater list of veterans in the state than the VA or Vet Center.

Several of our veterans have fallen through the cracks of the VA health care system, and will continue to do so. According to the Vietnam Veterans of America, last year only 30% of our veteran population had enrolled in VA medical programs.

Many veterans end up in the care of state social service programs in cooperation with state and national veteran organizations. The VA has the authority to assist in maintaining this safety net of care for veterans in a stressful economic climate for our states with a voucher program or expanded contracting with private entities. It needs to act.

HIPPA CONFIDENTIALITY MUST BE OBSERVED WITH MENTAL HEALTH CARE

Most of our National Guard veterans of OIF/OEF eligible for VA care post-deployment are still serving with their units and subject to redeployment. Given the evolving electronic medical records interoperability between the VA and the Department of Defense (DoD), a confidentiality issue exists relative to mental health treatment records for these veterans who remain in the military who do not want their records shared by the VA with their military commanders for fear of career reprisals.

It is essential that HIPPA confidentiality be maintained by the VA for the mental health treatment records of these veterans to encourage their treatment with VA providers. Our Vet Centers already operate with full confidentiality which makes them the service center of choice for Guard members who want to maintain confidentiality of their mental health counseling records relative to protect against perceived negative repercussions in their units. HIPPA rules observe confidentiality but draw the line with patients who are dangers to themselves or their communities whose cases must be reported. Prevent.

It is critical that confidentiality this be established as soon as possible legislatively with the VA much the same as it is currently observed in Vet Centers. We believe that the VA is operating under advice from its legal staff that all VA medical records can be transferred to DoD. Lack of confidentiality will chill the treatment process and is likely contributed to the under utilization of VA medical care by our veterans.

REQUIRE THE VA TO FULLY IMPLEMENT SECTION 304 OF THE CAREGIVERS AND VETERANS OMNIBUS HEALTH SERVICES ACT 0F 2009, PUBLIC LAW 111–163, TO PROVIDE MENTAL HEALTH SERVICES TO VETERAN AND THEIIMMEDIATE FAMILY MEMBERS OF OIF/OEF VETERANS USING PRIVATE ENTITIES

Post-deployment, our National Guard members and their families heavily rely on the VA for mental health care. Congress recognized as much in passing The Caregivers and Veterans Omnibus Health Services Act of 2009, **Public Law 111–163, enacted May 6, 2010,** now requires the VA to reach out not just to veterans but to their immediate families as well to assist in the reintegration process.

The law also authorized the VA Secretary the Secretary to contract with community mental health centers and other qualified entities to provide the subject services only in areas the Secretary determines are not adequately served by other health care facilities or vet centers of the Department of Veterans Affairs. It is not clear how thoroughly the VA has fully taken advantage of this authority to contract with private entities to deliver community based mental health services.

Section 304 of the Family Caregiver Act (reproduced in the Appendix) required the VA to make full mental health services available also to the immediate family members of OIF/OEF veteran for three years post-deployment. However, the VA delayed for at least two years in making the full range of its Office of Mental Health Services (OMHS) programs available to immediate to families as required by Section 304. It is not clear today that the program has been fully implemented.

Section 304 was enacted on May 6, 2010. For many, the three year post-deployment period will begin to lapse in 2013. The VA OMHS needed to fully comply with Section 304 in a timely manner. Because the VA's unreasonably delayed implementation of this important program, this Committee needs to consider extending the subject three year post deployment limitation period another three years to allow family members to access their care.

It also needs to lean harder on the VA to fully utilize its contracting to better leverage private entities and to use a voucher system described above to make community based treatment more accessible and convenient. Our veterans and their immediate families may be a small subset, but they are worth it.

THE DEPARTMENT OF DEFENSE MUST COOPERATIVELY WORK WITH THE VA IN SCREENING BEHAVIORAL HEALTH CARE NEEDS OF OUR MEMBERS BEFORE THEY ARE RELEASED FROM ACTIVE DUTY

At all stages of PTSD and depression, treatment is time sensitive. However, this is particularly important after onset, as the illness could persist for a lifetime if not promptly and adequately treated, and could render the member permanently disabled. The effects of this permanent disability on the member's entire family can

be devastating. It is absolutely imperative that members returning from deployment be screened with full confidentiality at the home station while still on active duty by trained and qualified mental health care providers from VA staff and/or qualified health care providers from the civilian community. These providers could include primary care physicians, physician assistants, and nurse practitioners who have training in assessing psychological health presentations. Prompt diagnosis and treatment will help to mitigate the lasting effects of mental illness. This examination process must be managed by the VA in coordination with the National Guard Director of Psychological Health for the respective state, and the state's Department of Mental Health to allow transition for follow up treatment by the full VA and civilian network of providers within the state.

As an American Legion staffer at Walter Reed once stated, the main problem for Reserve Component injured service members is that they are "rushed out of the system" before their service connected injuries and disability claims have been resolved. Our injured members should not be given the "bum's rush" and released from active duty until a copy of their complete military medical file, including any field treatment notes, has been transferred to the VA, their discoverable service connected military medical issues have been identified, any service connected VA disability physicals have been performed similar to what is provided to the active forces before they are released from active duty, and the initial determination of any service connected VA disability claim has been rendered. Unless medically not feasible, our members should be retained on active duty in their home state for treatment to discourage them from reporting injures out of fear of being retained at a distant demobilization site.

It is absolutely necessary to allow home station screening for all returning members by trained health care professionals who can screen, observe, and ask relevant questions with the skill necessary to elicit medical issues either unknown to the self-reporting member, or unreported for fear of being retained at a far removed demobilization site. In performing their due diligence before the issuance of an insurance policy, insurance companies do not allow individuals to self assess their health. Neither should the military. If geographical separation from families is causing some to underreport, or not report, physical or psychological combat injuries on the PDHA, then continuing this process at the home station for those in need would likely produce a better yield at a critical time when this information needs to be captured in order for prompt and effective treatment to be administered.

Please see the copy of a November 5, 2008 electronic message to NGAUS from Dr. Dana Headapohl set forth in the Appendix that still pertains. Dr. Headapohl strongly recommended a surveillance program for our members before they are released from active duty. Dr. Headapohl opines the obvious in stating that **inadequate medical screening of our members before they are released from active duty is "unacceptable to a group that has been asked to sacrifice for our country." (emphasis added)**

Conclusion

Thank you for that you have done for our veterans since 9/11. Please view our efforts as part of a customer feedback process to refine and improve the ongoing vital and enormous undertaking of the VA. Our National Guard veterans, both still serving and separated, will remain one of your largest base of customers who will continue to require your attention. Thank you for this opportunity to testify.

E-mail from Dana Headapohl, MD, to NGAUS

Colonel Duffy - I am sending links to articles about the importance of providing medical surveillance examinations for workers in jobs with specific hazardous exposures. I believe this approach could be modified to evaluate National Guard members returning from Iraq and Afghanistan for PTSD, TBIs and depression.

The OSHA medical surveillance model includes the following basic elements:

1. Identification of potential hazardous exposures (chemical, physical, biologic).

2. Screening workers for appropriateness of placement into a specific work environment with such exposures. For example, individuals with compromised liver functions should not be placed in environments with unprotected exposures to hepatotoxins.

3. Monitoring workers after unprotected exposure incidents. Examples- monitoring pulmonary function in a worker exposed to a chlorine gas spill, or following hepatitis and HIV markers in a nurse after a needle stick injury.

4. Conducting exit examinations at the end of an assignment with hazardous exposures, to ensure that workers have not suffered adverse health effects from those exposures.

(including concussive explosions or other traumatic events).

Surveillance exams of all types (OSHA mandated surveillance programs, population health screening for chronic disease risk factors) have been a part of my practice of Occupational and Preventive Medicine in Montana for the past 22 years. Early diagnosis and treatment is especially essential for potential medical problems facing military members serving in Iraq and Afghanistan - post traumatic stress disorder (PTSD), traumatic brain injury (TBI) and depression. Timely diagnosis and aggressive treatment is essential especially for these problems, to maximize treatment success and functioning and to mitigate suffering.

There are a number of organizations that design and implement medical surveillance programs. There is no reason the same approach could not be applied to the specific exposures and potential medical problems facing National Guard troops in Iraq and Afghanistan. With proper program design and local provider training, this program would not need to be costly. In my clinical experience, male patients especially are more likely to report symptoms of PTSD, TBI, or depression in the context of an examination rather than questionnaire. Findings can present subtly, but if untreated can have devastating effects on the individual, family and work place.

In my practice, I have seen a number of Vietnam veterans, and more recently National Guard members who have returned from deployment in Iraq or Afghanistan, who have been inadequately screened and/or are suffering unnecessarily because of geographical barriers to adequate treatment. This is unacceptable treatment of group that has been asked to sacrifice for our country. They deserve better.

I applaud your organization's efforts to lobby for better post deployment screening and treatment of the National Guard members returning from Iraq and Afghanistan.

Dana Headapohl MD

http://www.aafp.org/afp/20000501/2785.html

https://www.desc.dla.mil/DCM/Files/QSRHealth%20Medical%20Exam—1.pdf

This is about military surveillance exams.

http://www.lohp.org/graphics/pdf/hw24en06.pdf

http://www.cdc.gov/niosh/sbw/management/wald.html

http://www.ushealthworks.com/Page.aspx?Name=Services—MedSur

NATIONAL MILITARY FAMILY ASSOCIATION

The National Military Family Association is the leading nonprofit organization committed to strengthening and protecting military families. Our over 40 years of accomplishments have made us a trusted resource for families and the Nation's leaders. We have been at the vanguard of promoting an appropriate quality of life for active duty, National Guard, Reserve, retired service members, their families and survivors from the seven uniformed services: Army, Navy, Air Force, Marine Corps, Coast Guard, and the Commissioned Corps of the Public Health Service and the National Oceanic and Atmospheric Administration.

Association Volunteers in military communities worldwide provide a direct link between military families and the Association staff in the Nation's capital. These volunteers are our "eyes and ears," bringing shared local concerns to national attention.

The Association does not have or receive federal grants or contracts.

Our website is: *www.MilitaryFamily.org.*

Chairman Jeff Miller, Ranking Member Michael Michaud, and Distinguished Members of the Veterans' Affairs Committee, the National Military Family Association thanks you for the opportunity to submit testimony for the record on "Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans." After 11 years of war, we continue to see the impact of repeated deployments and separations on our service members, veterans, and their families. We appreciate your recognition of the service and sacrifice of these families, as well as the unique mental health challenges facing them. Our Association will take the opportunity to discuss the mental health challenges and needs of our veterans and their families.

Behavioral Health Care

Our Nation must help veterans, transitioning service members, National Guard and Reserve members, and their families cope with the aftermath of over a decade

of war. Frequent and lengthy deployments have created a sharp need in behavioral health services. The Department of Veterans Affairs (VA), Department of Defense (DoD), and State agencies must partner in order to address behavioral health issues early in the process and provide transitional mental health programs, especially when leaving active duty and entering veteran status (voluntary or involuntary). Partnering will also capture the National Guard and Reserve member population and their families, who often straddle these agencies' health care systems.

There are barriers to access for some in our population. Many already live in rural areas, such as our National Guard and Reserve members, or they will choose to relocate to rural areas lacking available mental health providers. We need to address the distance issues families face in finding mental health resources and obtaining appropriate care. Isolated service members, National Guard and Reserve members, veterans, and their families do not have the benefit of the safety net of services and programs provided by the VA facilities, Community-Based Outpatient Centers, and Vet Centers, or DoD's network of care.

The VA should examine DoD's alternative methods of mental health services as possible solutions to their access issues. DoD discovered embedding mental health providers in medical home modeled clinics allows for easier access for mental health services. DoD has created a flexible pool of mental health providers that can increase or decrease rapidly in numbers depending on demand on the Military Health System side. Currently, Military Family Life Consultants and Military OneSource non-medical counseling are providing this type of preventative and entry-level service. DoD has been offering another vehicle for service members, National Guard and Reserve members, and their families through a web-based (Skype) medical and non-medical mental health counseling. This works extremely well especially for those who live far from counselors. Veterans and their families need this flexibility of support.

The VA, along with the DoD, should examine the possibility of adopting the United Kingdom's model of community involvement in providing mental health services and programs to their military, veterans, and their families. This model of care identifies local resources and creates buy-in by the community to help their own. The model creates a direct reporting line from the community to Parliament and back to the community.

Families Impacted from Stresses of War

In the research they conducted for us, RAND found military children reported higher anxiety signs and symptoms than their civilian counterparts. A study by Gorman, et. al (2010), Wartime Military Deployment and Increased Pediatric Mental and Behavioral Health Complaints, found an 11 percent increase in outpatient mental health and behavioral health visits for children from the ages of 3–8 during 2006–2007. Researchers found an 18 percent increase in pediatric behavioral health visits and a 19 percent increase in stress disorders when a parent was deployed. Additional research has found an increase in mental health services by non-deployed spouses during deployment. A study of TRICARE claims data from 2003–2006 published last year by the New England Journal of Medicine showed an increase in mental health diagnoses among Army spouses, especially for those whose service members had deployed for more than one year. The VA needs to be aware of the mental health needs of veterans' children when allowing access to service and implementing support programs.

Our Association's research also found the mental health of the caregiver directly affects the overall well-being of the children. Therefore, we need to treat the family as a unit as well as individuals. Communication is key in maintaining family unit balance. Our study also found a direct correlation between decreased communication and an increase in child and/or caregiver issues during deployment. Research is beginning to validate the high level of stress and mental strain our military families are experiencing. This stress is carried over with them when they enter veteran status. The answer is making sure our families have access to behavioral health providers with the VA's system of care, as well.

Successful reintegration programs will require strong partnership at all levels between the various mental health arms of the VA, DoD, and State agencies. Opportunities for the entire family and for the couple to reconnect and bond again must also be provided. Our Association has recognized this need and established family retreats under our Operation Purple ® program in the National Parks, promoting families the opportunity to reintegrate and readjust following the stresses of war and deployment. The VA should provide similar types of venues for veterans and families to reintegrate.

Wounded Veterans have Wounded Families

Our Association asserts that behind every wounded service member and veteran is a wounded family. It is our belief the government, especially DoD and VA, must take a more inclusive view of military and veterans' families. Those who have the responsibility to care for the wounded, ill, or injured service member or veteran must also consider the needs of the spouse, children, parents of single service members/veterans, and their siblings, and their caregivers. The VA and DoD need to think proactively as a team and one system, rather than separately, and address problems and implementing initiatives upstream while the service member and their family is still on active duty status.

Reintegration programs become a key ingredient in the wounded service members, veterans, and their family's success. For the past three years, we have held our Operation Purple ® Healing Adventures camp to help wounded, ill, or injured service members and their families learn to play again as a family. We hear from the families who participate in this camp that many issues still create difficulties for them well into the recovery period. Families find themselves having to redefine their roles following the injury of the service member. They must learn how to parent and become a spouse/lover with an injury/illness. Each member needs to understand the unique aspects the injury/illness brings to the family unit. Parenting from a wheelchair brings a whole new challenge, especially when dealing with teenagers. Parents need opportunities to get together with other parents who are in similar situations and share their experiences and successful coping methods. Our Association believes everyone must focus on treating the whole family, with VA and DoD offering mental health counseling and skill based training programs for coping, intervention, resiliency, and overcoming adversities. Injury interrupts the normal cycle of the reintegration process causing readjustment issues. The VA, DoD, and non-governmental organizations must provide opportunities for the entire family and for the couple to reconnect and bond, especially during the rehabilitation and recovery phases.

The VA and DoD must do more to work together both during the treatment phase and the wounded service member's transition to ease the family's burden. They must continue to break down regulatory barriers to care and expand support when appropriate through the Vet Centers, the VA medical centers, and the community-based outpatient clinics (CBOCs), along with DoD's system of care. We recommend the VA allow veteran families access to mental health services throughout the VA's entire network of care. Before expanding support services to families, however, VA facilities must establish a holistic, family-centered approach to care when providing mental health counseling and programs to the wounded, ill, or injured service member or veteran. Family members are a key component to a veteran's psychological well-being. They must be included in mental health counseling and treatment programs for veterans.

Caregivers of the Wounded

Caregivers need to be recognized for the important role they play in the care of their loved one. Without them, the quality of life of the wounded service members and veterans, such as physical, psycho-social, and mental health, would be significantly compromised. They are viewed as an invaluable resource to VA and DoD health care providers because they tend to the needs of the service members and the veterans on a regular basis. Their daily involvement saves VA, DoD, and State agency health care dollars in the long run. However, their long-term psychological care needs must be addressed. Caregivers of the severely wounded, ill, or injured service members, who are now veterans, have a long road ahead of them. In order to perform their job well, they will require access to robust network of mental health services.

We have observed from our own Healing Adventure Camps the lack of support and assistance to the spouse/caregiver of our wounded, ill, or injured. Many feel frustrated with not being considered part of the care team and not included in long-term care decisions. The level of frustration displayed by the spouses/caregivers at our recent Healing Adventure Camp at Ft. Campbell about lack of information and support was disturbing. Even the Congressionally mandated Recovering Warrior Task Force (RWTF) discovered the same level of frustration during their site visit to Ft. Carson and raised their concerns to the Military Treatment Facility (MTF) and Warrior Transition Unit (WTU) Commanders. The VA and DoD need to make sure the spouse/caregiver and the family are also cared for and provided them the support they need to perform their role as a caregiver and provide them with the tools to care for themselves as well. The VA and DoD need to establish spouse/caregiver support groups and mentoring opportunities. Spouses/caregivers need a platform where they can voice their concerns without the fear of retribution.

The VA has made a strong effort in supporting veterans' caregivers. Our Association still has several concerns with the VA's interpretation of P.L.111–163. The VA's eligibility definition does not include illness, which means it does not align with DoD's Special Compensation for Service. This means the benefit ends once the ill service member transfers to veteran status. We believe the VA is waiting too long to provide valuable resources to caregivers of our wounded, ill, or injured service members and veterans who served in Operation Iraqi Freedom/Operation Enduring Freedom/Operation New Dawn (OIF/OEF/OND). The intent of the law was to allow caregivers to receive value-added benefits, such as mental health counseling, in a timely manner in order to improve the caregiver's overall quality of life.

Educating Those Who Care for Veterans and their Families

The families of veterans must be educated about the effects of Post-Traumatic Stress Disorder (PTSD), and suicide in order to help accurately diagnose and treat the veteran's condition. These families are at the "pointy end of the spear" and are more likely to pick up on changes attributed to either condition and relay this information to their health care providers. Programs are being developed by the VA and each Branch of Service. However, DoD's are narrow in focus, targeting line leaders and health care providers, but not broad enough to capture our military family members and the communities they live in. The VA's message is broader, but still lacks the direct outreach needed to educate veterans' families.

There are many resources for veterans and their families provided by DoD, VA, State agencies, and non-government agencies. However, there is often difficulty navigating this sea of good will and knowing which resource to access when. We recommend an extended outreach program to veterans and their families of these available mental health resources.

Health care and behavioral health providers must also be educated about our military culture. We recommend a course on military culture be required in all health care and behavioral health care college curriculums and to offer a standardized VA and DoD approved military culture Continuing Education Unit (CEU) for providers who have already graduated. Providers should be incentivized to take these courses. VA providers must be educated about stigma among veteran families, who are experiencing secondary PTSD. These families, often caregivers, are afraid to tell someone they too have PTSD. Veterans' families must be told it is okay to seek help for themselves.

Families want to be able to access care with a mental health provider who understands or is sympathetic to the issues they face. We appreciate the VA allowing family member access to Vet Centers. However, families need to have access without gaining permission from the veteran first. Once the service members become veterans, families have fewer access points for mental health services. Barriers, such as the requirement for families to first obtain the veteran's permission, only further prevent access to timely mental health care. Treatment through the VA should include access to medication along with therapy. Currently, the VA is only allowing therapy for families and caregivers. We also encourage the VA to develop more family-oriented programs and offer web-based Skype group meetings.

The VA must also look beyond its own resources to increase mental health access by working with other government agencies. We appreciate President Obama's recent Executive Order allowing the VA to partner with the Substance Abuse and Mental Health Services Administration (SAMHSA). However, we encourage the VA to include SAMHSA's Military Families Strategic Initiative and Service member, veteran, and family Policy Academy States and Territories in their partnership. SAMHSA's initiative encourages State agencies to provide already established services and programs to service members, veterans, and family members. Our Association has been actively working with SAMHSA providing valuable input on military families and military culture. We encourage committee members to ask fellow Members of Congress and the Administration to fund SAMHSA's initiative so they may educate the remaining States and Territories about the unique needs of the military, veterans, and their families.

Survivors

The VA must work together to ensure surviving spouses and their children can receive the mental health services they need through all of VA's venues

Recommend the VA examine DoD's alternative methods of mental health services and possibly adopt the United Kingdom's model of community involvement as possible solutions to their access issues.

Recommend the VA be aware of the mental health needs of veterans' children and families when allowing access to service and implementing support programs.

Recommend the VA and DoD think proactively as one team and one system, in order to successfully address problems and implement initiatives upstream while the service member and their family is still on active duty status.

Recommend the VA establish a holistic, family-centered approach to care.

Recommend the VA and DoD establish spouse/caregiver support groups and mentoring opportunities.

Recommend the VA educate family members of veterans about the effects of Post-Traumatic Stress Disorder (PTSD) and suicide.

Recommend the VA create outreach programs to veterans and their families about all of the available VA, DoD, State agencies, and non-government agencies behavioral health resources.

Recommend the VA and DoD educate health care and behavioral health providers about our military culture and stigma among veterans' families.

Recommend committee members ask fellow Members of Congress and the Administration to fund SAMHSA's initiative so they may educate the remaining States and Territories about the unique needs of the military, veterans, and their families.

Recommend the VA ensure surviving spouses and their children receive the behavioral health services they need through all of VA's venues.

Military Families – Our Nation's Families

The National Military Family Association would like to thank you again for the opportunity to submit testimony on overcoming barriers to quality mental health care for veterans and their families. Veteran families have supported the Nation's military mission. The least their country can do is make sure they have consistent access to high quality behavioral health care. Wounded service members and veterans have wounded families. The VA and DoD systems of care should work together in providing quality behavioral health services. We ask this Committee to assist in meeting that responsibility. We look forward to working with you to improve the quality of life for service members, veterans, their families and caregivers, and survivors.

PARALYZED VETERANS OF AMERICA

Chairman Miller, Ranking Member Michaud, and members of the Committee, thank you for allowing Paralyzed Veterans of America (PVA) to submit a statement for the record concerning the Department of Veterans Affairs' (VA) mental health services. Overcoming barriers to quality mental health care for veterans is extremely important as the number of veterans enrolled in the VA health care system continues to grow, and the newest generation of veterans and their families acclimate to civilian life after war. PVA thanks the Committee for their continued oversight and hard work on this important health care issue.

The increased demand for VA mental health services has put greater emphasis on the areas in which VA can improve upon its delivery and approach to providing quality mental health care. In the past year, both the VA Office of Inspector General and the Government Accountability Office have released reports identifying issues that preclude veterans from receiving timely, quality VA mental health care. Such issues include inadequate staffing of VA mental health professionals, unreasonable wait times for appointments, and inaccurate reporting of mental health metrics and program outcomes.

In August 2012, the President issued an Executive Order #13625, "Improving Access to Mental Health Services for Veterans, Service Members, and Military Families." The Executive Order focuses on suicide prevention, mental health research and development, VA mental health staffing, and partnerships between the VA and mental health community providers. PVA believes that the aforementioned report findings, and the Executive Order substantiate the need for Congress, the Administration, VA leadership, and the veteran community to work together to develop innovative approaches for providing VA mental health care that meets the evolving needs of all veterans.

As we work to improve VA mental health care, PVA believes that it is important to recognize that VA is the best health care provider for veterans. Providing primary care and specialized health services is an integral component of VA's core mission and responsibility to veterans. In the area of mental health it is vital that veterans receive care that is tailored to their unique experiences and needs as veterans. The VA has made tremendous strides in the quality of care and variety of "veteran spe-

cific" mental health services. These improvements include incorporating mental health into VA's primary care delivery model, increasing the number of Vet Centers, launching mental health public awareness campaigns, and creating call centers that are available to veterans 24 hours a day, 7 days a week. While these improvements were much needed and have helped many veterans, we agree with this Committee that more must be done.

The VA must focus on recruiting and retaining qualified mental health professionals to meet the growing mental health care demand. Last year, the VA announced its plan to increase the mental health workforce by an additional 1,900 mental health professionals. In response to this hiring goal, PVA recommends that the VA conduct a comprehensive analysis of the mental health care needs of veterans, and create a mental health strategic plan for staffing to accurately assess current staffing needs and appropriately place newly hired employees.

In addition to increased staffing, PVA recommends that the VA work to improve and expand current mental health services that have proven beneficial to veterans such as peer to peer support programs. As recommended in the FY 2014 Independent Budget, VA medical centers should work to hire veterans as peer counselors to provide individual counseling, as well as reach out to veterans to promote the importance of mental health, and help veterans currently receiving VA mental health services sustain treatment. Additionally, as the VA works to improve and increase access to mental health care, it must identify and adapt to the varying needs of the different generations of veterans. The VA must work to address the mental health needs of veterans returning from the most recent conflicts, as well as the larger population of disabled veterans who are dealing with severe illnesses and catastrophic injuries.

To meet the varying mental health needs of veterans, the VA must work with veterans, veteran service organizations, and stakeholders in the community to create innovative ways to provide quality mental health services. In fact, the President's Executive Order mandates enhanced partnerships between the VA and community mental health providers to ensure that veterans are able to receive care in a timely manner. Specifically, it states that the VA and the Department of Health and Human Services shall establish pilot projects to contract with community based providers to help meet veterans' mental health care needs in a timely manner. While PVA understands the urgent nature of providing veterans with timely mental health care, we believe that the quality of that care is equally important.

As it relates to contracted care, mental health services are unique in that it is difficult to move from one provider to another after trust and a rapport have been established. It is important to consider that when veterans are referred to providers outside of the VA for mental health care, they may not return to the VA for those services, and ensuring that veterans seek additional mental health services through the VA may become more difficult. When developing community partnerships with non-VA providers there must be a balance that allows VA to provide contracted services for mental health care without discouraging veterans from utilizing other VA mental health services, or VA's primary care and specialized services that are readily available to them. Therefore, PVA strongly recommends that the first phase of implementation of the Executive Order should require VA to work closely with veteran service organizations to determine the guidelines and policies under which the VA may provide a veteran with mental health care in the community setting. Specifically, PVA believes that before the VA provides veterans with care through contracted services, mechanisms must be in place to ensure care coordination, and allow VA to monitor the quality of care provided. The VA must also make certain that the professionals providing the care meet VA standards and are familiar with cultural norms of military service and experiences of veterans.

While PVA believes that the greatest need is still for qualified VA mental health professionals to provide veterans with the care they need, veterans should not have to wait for such essential care. The VA must work to hire and officially assign mental health staff, improve administrative processes that lead to lengthy wait times, and develop ways to increase access to VA mental health services while maintaining VA's high quality of care and providing care that is centered on the unique needs of veterans. When veterans have timely access to quality mental health care services they in turn have the opportunity to establish productive personal and professional lives.

PVA would like to once again thank this Committee for the opportunity to provide a statement for the record, and we look forward to working with you to improve VA mental health services for our veterans.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2013

No federal grants or contracts received.

Fiscal Year 2012

No federal grants or contracts received.

Fiscal Year 2011

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation—National Veterans Legal Services Program— $262,787.

VIETNAM VETERANS OF AMERICA

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the House Veterans Affairs Committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record on "Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans".

First, VVA recognizes that the Veterans Health Administration (VHA) has made some significant progress in its efforts to improve the quality of mental health care for America's veterans. For example, although not all mental health clinical staff has yet been trained, VA should be commended for its system-wide adoption (finally) of evidence-based cognitive behavioral treatment modalities for PTSD. In addition, the development of various web-based program applications and social media mental health outreach campaigns reflect a much better effort to reach America's veterans. While these efforts are laudable, VVA continues to believe they have not gone far enough.

VVA remains very concerned about three related mental health areas: suicides, especially among the older veterans' cohort; recruitment, hiring, and retention of VA mental health staff; and timely access to VA mental health clinical facilities and programs, especially for our rural veterans.

To be fair, since media reports of suicide deaths and suicide attempts began to surface back in 2003, the VA has developed a number of strategies to reduce suicides and suicide behaviors which include: the development of the Veterans Crisis Hotline and Chatline (in partnership with the Substance Abuse and Mental Health Administration) and a social media campaign emphasizing VA crisis support services; the creation of suicide prevention coordinator (SPCs) positions at all VA medical facilities whose duties include education, training, and clinical quality improvement for VHA staff members; and the hiring and training of additional staff to increase the capacity of the Veterans Crisis Line by 50 percent.

However, the VA's report of February 1, 2013 on veterans who die by suicide paints a shocking portrait of what's happening among our older vets (see chart below).

Percentage of suicides by age and veteran status among males

Age group	Non-veteran	Veteran
29 and younger	24.4%	5.8%
30-39	20.0	8.9
40-49	23.5	15.0
50-59	16.9	20.0
60-69	7.4	16.8
70-79	4.2	19.0
80 and older	3.6	14.5

Over two-thirds of veterans who commit suicide are age 50 or older. Among the report's other findings:

- The average age of veterans who die of suicide is just short of 60; for non-veterans, it's 43.
- Female veterans who commit suicide generally do so at younger ages than males. Two-thirds of women who killed themselves were under 50 years of age; one-third were under 40 and 13 percent were under 30. For men, the comparable figures were 30 percent, 15 percent and 6 percent.
- About 15 percent of veterans who attempt suicide, but don't succeed, try again within 12 months.

VVA asks **why?**

VVA understands that it is very challenging to determine an exact number of suicides. Some troops who return from deployment become stronger from having survived their experiences. Too many others are wracked by memories of what they have experienced. This translates into extreme issues and risk-taking behaviors when they return home, which is one of the reasons why veteran suicides have attracted so much attention in the media. Many times, suicides are not reported, and it can be very difficult to determine whether or not a particular individual's death was intentional. For a suicide to be recognized, examiners must be able to say that the deceased meant to die. Other factors that contribute to the difficulty are differences among states as to who is mandated to report a death, as well as changes over time in the coding of mortality data. In fact, previously published data on veterans who died by suicide were only available for those who had sought VA health care services. But for the first time, the February 1st report also includes some limited state data for veterans who had not received health care services from VA.

Nevertheless, according to the American Foundation for Suicide Prevention, in more than 120 studies of a series of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their death. The most important interventions are recognizing and treating these underlying illnesses, such as depression, alcohol and substance abuse, post-traumatic stress and traumatic brain injury. Many veterans (and active duty military) resist seeking help because of the stigma associated with mental illness, or they are unaware of the warning signs and treatment options. **These barriers must be identified and overcome.**

VVA has long believed in a link between PTSD and suicide, and in fact, studies suggest that suicide risk is higher in persons with PTSD. For example, research has found that trauma survivors with PTSD have a significantly higher risk of suicide than trauma survivors diagnosed with other psychiatric illness or with no mental pathology (1). There is also strong evidence that among veterans who experienced combat trauma, the highest relative suicide risk is observed in those who were wounded multiple times and/or hospitalized for a wound (2). This suggests that the intensity of the combat trauma, and the number of times it occurred, may indeed influence suicide risk in veterans, although this study assessed only combat trauma, not a diagnosis of PTSD, as a factor in the suicidal behavior.

Considerable debate exists about the reason for the heightened risk of suicide in trauma survivors. Whereas some studies suggest that suicide risk is higher due to the symptoms of PTSD (3,4,5), others claim that suicide risk is higher in these individuals because of related psychiatric conditions (6,7). However, a study analyzing data from the National Co-morbidity Survey, a nationally representative sample, showed that PTSD alone out of six anxiety diagnoses was significantly associated with suicidal ideation or attempts (8). While the study also found an association between suicidal behaviors and both mood disorders and antisocial personality disorder, the findings pointed to a robust relationship between PTSD and suicide after controlling for co-morbid disorders. A later study using the Canadian Community Health Survey data also found that respondents with PTSD were at higher risk for suicide attempts after controlling for physical illness and other mental disorders (9).

Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide (3). Anger and impulsivity have also been shown to predict suicide risk in those with PTSD (10). Further, some cognitive styles of coping such as using suppression to deal with stress may be additionally predictive of suicide risk in individuals with PTSD (3).

Other research looking specifically at combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt, especially amongst Vietnam veterans (11). Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war, and these thoughts can often overpower the emotional coping capacities of veterans.

Researchers have also examined exposure to suicide as a traumatic event. Studies show that trauma from exposure to suicide can contribute to PTSD. In particular, adults and adolescents are more likely to develop PTSD as a result of exposure to suicide if one or more of the following conditions are true: if they witness the suicide, if they are very connected with the person who dies, or if they have a history of psychiatric illness (12,13,14). Studies also show that traumatic grief is more likely to arise after exposure to traumatic death such as suicide (15,16). Traumatic grief refers to a syndrome in which individuals experience functional impairment, a decline in physical health, and suicidal ideation. These symptoms occur independent of other conditions such as depression and anxiety.

VVA strongly suggests that until VA mental health services develops a nationwide strategy to address the problem of suicides among our older veterans—**particularly Vietnam-era veterans**—it immediately adopt and utilize the appropriate suicide risk and prevention factors for veterans found in the "National Strategy for Suicide Prevention 2012: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention" that's available on-line at the web sites for both the Surgeon General's Office and SAMHSA.

The second item with which VVA has grave concerns is the recruitment, hiring, and retention of VA mental health staff. In its February 1st report, the VA claims to be "currently engaged in an aggressive hiring campaign to expand access to mental health services with 1,600 new clinical staff, 300 new administrative staff, and is in the process of hiring and training 800 peer-to-peer specialists, who will work as members of mental health teams". Nice words, but VVA asks: Of these 1,600 clinical positions, do they represent new additional staff, or replacements for those who've retired or left VA employ? What mental health clinical job categories do these hires represent? And what is the VA's staffing plan for these hires? In other words how many staff is VA hiring, in what positions, and how many do they currently have? It appears that we need a scorecard to determine what is going on . . .

And last, but certainly not least, VVA remains concerned about timely access to VA mental health services and programs, especially since the 2012 Inspector General's report illustrated in incredible clarity how top VA facility and VISN administrators "game the system" to make wait times appear shorter for the veterans they serve. The I.G.'s report said that, rather than starting the clock from the moment a vet asks for mental health care, the VA has been counting from whenever the first appointment became available, adding weeks or months to the wait time. So while the VA was saying 95 percent of vets were seen as quickly as they were supposed to be, nearly 100,000 patients had to wait much longer. At the VA Medical Center in Salisbury, N.C., for example, the average wait was three months.

Once again, on behalf of VVA's National Officers, Board, and general membership, thank you for your leadership in holding this important hearing on a topic that is literally of vital interest to so many veterans, and should be of keen interest to all Americans who care about our nation's veterans.

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VIETNAM VETERANS OF AMERICA

FUNDING STATEMENT

FEBRUARY 8, 2013

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact: Executive Director for Policy and Government Affairs, Vietnam Veterans of America, (301) 585–4000, extension 127

Questions For The Record

Letter From: Hon. Jeff Miller, Chairman, To: Hon. Robert A. Petzel, M.D., Under Secretary for Health, Department of Veterans Affairs

March 1, 2013

The Honorable Robert A. Petzel, M.D.
Under Secretary for Health
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Dr. Petzel:

On Wednesday, February 13, 2013, you testified before the Committee during an oversight hearing entitled, "Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans." As a follow-up to the hearing, I request that you respond to the attached questions and provide the requested materials in-full by no later than close of business on Friday, April 1, 2013.

If you have any questions, please contact Dolores Dunn, Staff Director for the Subcommittee on Health, at *Dolores.Dunn@mail.house.gov* or by calling (202) 225–9154.

Your timely response to this matter and your commitment to our nation's veterans and their families are both very much appreciated.

With warm personal regards,

Sincerely,

JEFF MILLER
Chairman

CJM/dd/sg

Questions From: Hon. Jeff Miller, Chairman, Congressman Jeff Denhan, and Congresswoman Jackie Walorski To: Department of Veterans Affairs

1. In a Full Committee hearing on June 14, 2011, entitled, "Mental Health: Bridging the Gap Between Care and Compensation for Veterans," Dr. Karen Seal of the San Francisco Department of Veterans Affairs (VA) Medical Center testified regarding a study she had recently published in the Journal of Traumatic Stress regarding mental health services utilization rate for veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) using VA healthcare from 2002–2008. Dr. Seal testified that less than 10% of those newly diagnosed with post-traumatic stress disorder (PTSD) received the recommended number and intensity of VA evidence-based treatment sessions within the first year of their diagnosis. She also testified that only about a quarter of veterans received VA's recommended PTSD treatment protocol of nine or more sessions, and only about 10% attended such sessions within VA's recommended timeframe of fifteen weeks following their initial diagnosis.

- Please provide, for each fiscal year (FY) 2008 through 2012, the number of OEF/OIF veterans using VA healthcare who have: (1) been diagnosed with PTSD, (2) received the recommended PTSD treatment protocol of nine of more sessions following their initial diagnosis; and, (3) attended such sessions within fifteen weeks of their initial diagnosis.

2. Of the approximately 3,262 mental health professionals VA alleges to have hired as of January 29, 2013, please provide the following:

- the number of such providers broken down by occupation and status (i.e., on-board, firm or tentative job offer, awaiting credentialing and privileging, pending interview, etc.);
- the number of such providers broken down by Veterans Integrated Service Network and VA medical center or clinic;
- the number of such providers who perform disability evaluations, either full-time or part-time;
-the average length of time it takes the Department to credential and privilege each such provider;
- the number of such providers who were transferred from other VA facilities.

3. During the hearing, in response to my question about how VA evaluates patient outcomes with regard to mental health care, you stated that, " . . . we have good evidence in literature that people that go through [VA treatment programs] do indeed have less symptomatology associated with their PTSD and are better adjusted to living in society. There are many instances of the treatment protocols that we have, where we can demonstrate the direct impact on those individuals that have been through that therapy."

- Please provide a copy of any and all of the "literature" that you referred to in the above statement.
- Please describe each incident referenced in your above statement where VA is able to demonstrate "the direct impact" of the mental health care VA provides on the subsequent mental health of the veterans who access that care.

4. In response to my question regarding how the Committee can assist VA in providing quality and timely mental health care services to veteran patients, you stated that the Committee may help in: (1) facilitating interactions between VA and community health centers; (2) helping VA interact better with private sector providers; and, (3) addressing the shortage of psychiatrists.

- Please expand on how you believe the Committee could be of assistance to the Department in each of the three areas listed above.

5. In response to my question regarding how VA has been able to hire increased numbers of mental health providers, you stated that, "[o]f all of the professionals in mental health, the most difficult problem we are having is recruiting psychiatrists, and we have barely been able to recruit half of the new ones that we said we wanted to do, and that it is in spite of raising the salary quite substantially, providing incentives for recruitment, bonuses, etc."

- Please provide further details on the salary raises, recruitment incentives, bonuses, and any and all other actions VA has taken in an effort to recruit and retain psychiatrists.

- Please describe any and all actions beyond the ones referenced above that VA has taken or is considering taking to alleviate the the difficulties VA has experienced recruiting psychiatrists (i.e. undertaking additional recruitment and retention incentives, increasing partnerships with non-VA resources, recruiting increased numbers of other mental health professionals, etc.).

6. In response to a question from Ranking Member Michaud regarding Section 3 of the Executive Order on Improving Access to Mental Health Servicemembers, Veterans, and Their Families, you stated that, " ... 15 pilots sites were selected ... based upon the desire of the local network to participate, our hospital to participate, and a need ... identified often by how rural the areas were. There is one urban center where we are doing this in Atlanta to get a feel for what they might be like, because there are many, many community mental health clinics in the Atlanta area." You further stated that, "[w]e think that this is ... going to be a viable alternative in the future to us cooperating in the community with providing care in these again remote rural areas."

- Please name the location of each of the 15 selected pilot sites.

- Please describe, in detail, the criteria the Department used to choose each of the sites named above.

- Please expand on your statement above that enhanced partnerships between VA and community partners is going to be a "viable alternative" to "cooperating in the community," to include what you see these partnerships as an alternative to and whether or not you see them as an asset in rural areas only or, potentially, in urban communities as well and why.

7. In response to a question from Ranking Member Michaud regarding veteran suicide data, Dr. Janet Kemp, the Director of VA's Suicide Prevention and Community Engagement Program, stated that, "[t]here [are] a couple of states that we are still working with over privacy issues and how we are going to share data and I am confident that we will get those soon."

- Please name the states referenced above.

- Please describe any and all barriers, including privacy issues, to the states referenced above providing VA with the requested data on veteran suicide rates.

- When does the Department expect that complete veteran suicide rate data will be received from all 50 states?

8. In response to a question from Ranking Member Michaud regarding performance requirements for VA mental health providers, you stated that, " ... .it is important to have performance measures, and I think it is incumbent upon us as the leaders to make sure that there is the proper balance between time available to do clinical care, and the necessity of meeting performance measures."

- Please name each of the current performance measures (including any and all clinical reminders) currently in place for VA mental health care providers, to include the justification for using each measure and how long it has been in place.

- Please describe how you, as the Under Secretary for Health, ensure a "proper balance" between measuring provider performance and ensuring sufficient clinical care.

9. In response to a question from Representative Runyan regarding the need to be proactive in addressing veterans' mental health needs, you discussed the need to develop close, trusting relationships between veteran patients and VA mental health providers. You stated that VA needed to focus on, " ... developing the relationships where [veteran patients] will tell us where there are things that may be antecedents to suicide that are bothering them," and, "[i]t is getting the information, and the contact with the individual before they have the difficulty as you have pointed is the problem." In response to a similar question from Representative Brownley, you stated that," ... we have a newly organized task force that Dr. Kemp is chairing that is going to look at how we can develop a different paradigm if you will for the way we deliver care to people that have chronic pain, sleep disorders, depression, etc., the things that have the greatest impact on suicide."

- How does VA foster such relationships between VA providers and veteran patients?
- What different paradigms is the taskforce referenced above looking at regarding the delivery of mental health care and when is that work expected to be complete?

10. In response to a question from Representative Coffman regarding VA mental health care providers, you stated that, " . . . this spring [we have] implemented our performance criteria for timeliness, the intention is to go out and do three things. One, look at the measures. Two, survey veterans as to whether or not they were – had timely access as well as other satisfaction related questions. And three, to survey the staff. Are they able to provide timely access for their patients, are they adequately staffed, do they have enough people to do the work that they are being required. So, yes, we are going to do it. And we will be doing that on a regular basis"
- Please provide the timeliness performance criteria referenced above.
- Please provide information regarding the survey of veteran patients referenced above, to include the number of veteran patients expected to be surveyed, the questions expected to be included on the survey, the method expected to be used to conduct the survey (i.e., in person, electronic, via telephone, etc.), the expected survey results, the expected total cost of the survey, and any and all follow-up actions expected to result from the survey.
- Please provide information regarding the survey of VA mental health care providers referenced above, to include the number of VA mental health providers expected to be surveyed, the questions expected to be included on the survey, the method expected to be used to conduct the survey (i.e., in person, electronic, via telephone, etc.), the expected survey results, the expected total cost of the survey, and any and all follow-up actions expected to result from the survey.
- When does the Department expect all three of the above actions to be completed?
- How often does the Department expect to conduct follow-up surveys of veteran patients accessing VA mental health care?
- How often does VA expect to conduct follow-up surveys of VA mental health providers?

Questions for the Record from Congressman Jeff Denham

1. As we have heard the hearing, the conflicts in Afghanistan and Iraq have created extraordinary demands for care as veterans return from theater. For those with PTSD or other mental health issues, long waits for treatment can put them at risk for suicide or other behavioral problems.
- Has VA considered short-term solutions to address the immediate mental health need while it recruits and hires the staff it needs long term?

2. I understand that VA has been conducting pilot programs designed to provide veterans with access to community-based mental health services in several rural communities like mine. For veterans that are able to get into one of these programs, they provide needed care closer to the veteran's home. However, I understand that use of these pilots by VA facilities has been very low.
- What are you doing to encourage use of these programs in rural communities?
- Are there any plans to expand these rural pilot programs, to other rural communities across the country?

Questions for the Record from Congresswoman Jackie Walorski

1. During the hearing, we heard how veterans are discouraged with long wait times in-between appointments and consequently drop out of treatment.
- What is VA doing to improve mental health wait times for veteran patients accessing VA mental health care?
- How is VA working to better accommodate veterans who have transitioned into the civilian world and all the new responsibilities they must deal with while trying to seek the health care they need?

RESPONSES FROM THE U.S. DEPARTMENT OF VETERANS AFFAIRS

1. In a Full Committee hearing on June 14, 2011, entitled, "Mental Health: Bridging the Gap Between Care and Compensation for Veterans," ???Dr. Karen Seal of the San Francisco Department of Veterans Affairs (VA) Medical Center testified regarding a study she had recently published in the Journal of Traumatic Stress regarding mental health services utilization rate for veterans of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF) using VA healthcare from 2002–2008. Dr. Seal testified that less than 10% of those newly diagnosed with post-traumatic stress disorder

(PTSD) received the recommended number and intensity of VA evidence-based treatment sessions within the first year of their diagnosis. She also testified that only about a quarter of veterans received VA 's recommended PTSD treatment protocol of nine or more sessions, and only about 10% attended such sessions within VA's recommended timeframe of fifteen weeks following their initial diagnosis.

Please provide, for each fiscal year (FY) 2008 through 2012, the number of OEF/OIF veterans using VA healthcare who have: (1) been diagnosed with PTSD, (2) received the recommended PTSD treatment protocol of nine of more sessions following their initial diagnosis; and, (3) attended such sessions within fifteen weeks of their initial diagnosis.

VA Response:

We identified all Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans who have enrolled in VA care and received any outpatient VA services between the date of their separation from military service (for regular Armed Forces), or the end date of their last deployment (for Reserve and National Guard), and the end of fiscal year (FY) 2011.[1] The Veterans Health Administration (VHA) has treated 728,705 of these Veterans.

Table 1 indicates the numbers that were diagnosed with Post-traumatic Stress Disorder (PTSD) in the same time frame. Those diagnosed with PTSD are those who had at least two outpatient visits, or one inpatient or residential bed day, where a diagnosis of PTSD was present. This methodology for counting those with a diagnosis of PTSD differs from Dr. Seal's methodology, but is consistent with how Mental Health Service and Office of Mental Health Operations report numbers on PTSD. Over all of the years, a cumulative total of 166,604 (22.9 percent) OEF/OIF Veterans treated by VHA were diagnosed with PTSD.

Table 1. Number of OEF/OIF Veterans diagnosed with PTSD, by year of diagnosis

Year	Number with PTSD	% of all OEF/OIF Veterans with PTSD
2002	10	0.01
2003	94	0.06
2004	2216	1.33
2005	8054	4.83
2006	12369	7.42
2007	19154	11.5
2008	26674	16.01
2009	30537	18.33
2010	32582	19.56
2011	34914	20.96

Next, we calculated the proportion of those who received a diagnosis of PTSD who also had at least nine outpatient mental health visits in the year after their initial diagnosis. That data is presented in Table 2. Note that while Dr. Seal's analysis included only mental health visits to sub-specialty PTSD, mood disorder, or substance use clinics, and visits to mental health clinicians embedded in primary care, she did not include a number of settings where evidence-based PTSD treatment can be delivered, such as psychology and psychiatry individual visits and general mental health clinics. We included these locations in our analysis of mental health care utilization.

[1] The FY12 data are not included because the outcomes measures (any care in one year, any psychotherapy in one year, and 9 visits in 15 weeks at any time within one year of diagnosis) required at least one year in which to examine. Therefore, we included all Veterans through the end of FY11 and examined their utilization through the end of FY12.

Table 2. Number and proportion of OEF/OIF Veterans diagnosed with PTSD who received at least nine visits in the year after initial diagnosis

Year	Number of OEF/OIF Veterans with PTSD who had 9 visits in a year	% of all OEF/OIF Veterans with PTSD in the year
2002	4	40.00
2003	46	48.94
2004	817	36.87
2005	2374	29.48
2006	3530	28.54
2007	5551	28.98
2008	7654	28.69
2009	9196	30.11
2010	9711	29.80
2011	9905	28.37

Finally, we calculated the proportion of those diagnosed with PTSD who received nine visits within a 15 week period during the year after their initial diagnosis. We used the same list of possible locations of care as in Table 2. This data is in Table 3.

Table 3. Number and proportion of OEF/OIF Veterans diagnosed with PTSD who received at least nine visits within a 15 week period in the year after initial diagnosis

Year	Number with PTSD who had 9 visits in 15 weeks	% of all Veterans with initial PTSD diagnosis in the year
2002	2	20.00
2003	28	29.79
2004	501	22.61
2005	1403	17.42
2006	2082	16.83
2007	3222	16.82
2008	4396	16.48
2009	5512	18.05
2010	5957	18.28
2011	6156	17.63

2. Of the approximately 3,262 mental health professionals VA alleges to have hired as of January 29, 2013, please provide the following:

The number of such providers broken down by occupation and status (i.e., on-board, firm or tentative job offer, awaiting credentialing and privileging, pending interview, etc.);

VA Response:

All of the 4,308 mental health professionals hired as of June 30, 2013, reported by VA were brought are on-board to provide services to our Veterans.

a) The break out of the occupations is as follows:

Occupations	LMFT [1]	LPMHC [2]	Nurse	Physician	Psychologist	Social Worker	Other clinical [3]	Non-clinical	Grand Total
Number	31	40	986	403	757	990	626	475	**4,308**

TABLE 1: Mental Health Professionals Hired as of January 29, 2013

[1] Licensed Marriage and Family Therapist.

[2] Licensed Professional Mental Health Counselors.

[3] Other Mental Health Professions include: Addiction Therapists, Health Technicians, Health Science Specialists, Nurse Assistants, Pharmacists, Occupational

Therapists, Physician Assistants, Recreational Therapists, and Vocational Rehabilitation Therapists.

b) Tentative job offer as of January 29, 2013: **Already on board**

c) Firm job offer as of January 29, 2013: **Already on board**

d) Pending interview as of January 29, 2013: **Already on board**

e) Awaiting credentialing and privileging: **Already on board**

The number of such providers broken down by Veterans Integrated Service Network and VA medical center or clinic;

VA Response:

VISN	Hired
1	128
2	55
3	144
4	326
5	59
6	166
7	345
8	394
9	280
10	121
11	167
12	188
15	132
16	375
17	243
18	167
19	127
20	199
21	176
22	232
23	176
VCL [1]	108
Total	**4,308**

[1] Veterans Crisis Line

TABLE 2: Number of Mental Health Providers Hired by the VA

the number of such providers who perform disability evaluations, either full-time or part-time;

VA Response:

That number is unknown, as the number of providers who perform disability evaluations is only tracked locally.

the average length of time it takes the Department to credential and privilege each such provider;

VA Response:

Category	Average Days from enrollment in VetPro* to Submission	Average Days from Submission in VetPro* to Complete Verification
All provider	10	35
Licensed independent provider (Physician)	20	48
Psychologist (licensed)	13	31
Psychologist (unlicensed)	10	32
Licensed Professional Mental Health Counselor	3	20
Marriage and Family Therapist	5	26
Social Worker (licensed)	5	27
Social Worker (other)	4	27

*VetPro is used in VA to credential and privilege VA providers

TABLE 3: Length of Time to Credential and Privilege VA Providers

the number of such providers who were transferred from other VA facilities.

VA Response:

Of note, VA is tracking the backfills of these positions. If a current VA provider transfers from one facility to a different VA facility, VA does not count the transfer itself as a new hire. As stated above in condition 3, a new hire is counted only when the original position is backfilled with an external hire. In no instance has VHA counted current VHA employees who vacated a mental health position to fill a different mental health position as this would not meet the intent of VHA's drive towards the initiative.

3. During the hearing, in response to my question about how VA evaluates patient outcomes with regard to mental health care, you stated that, "...we have good evidence in literature that people that go through [VA treatment programs] do indeed have less symptomatology associated with their PTSD and are better adjusted to living in society. There are many instances of the treatment protocols that we have, where we can demonstrate the direct impact on those individuals that have been through that therapy."

Please provide a copy of any and all of the "literature" that you referred to in the above statement.

VA Response:

The following is an annotated bibliography of research literature supporting the efficacy of PTSD treatments provided at VA. Published International Literature on Traumatic Stress (PILOTS) ID numbers noted at the end of each reference are unique identifiers that can be used to locate the reference within the National Center for PTSD's PILOTS database.

Cognitive Processing Therapy (CPT)

1.Alvarez, J., McLean, C., Harris, A. H. S., Rosen, C. S., Ruzek, J. I., and Kimerling, R. E. (2011). The comparative effectiveness of cognitive processing therapy for male Veterans treated in a VHA posttraumatic stress disorder residential

rehabilitation program. Journal of Consulting and Clinical Psychology, 79, 590–599. doi:10.1037/a0024466 PILOTS ID: 37362

This was one of the first studies to demonstrate that CPT is more effective than a usual care treatment within a VA clinical setting. The 104 Veterans treated with group CPT in a VA PTSD Residential Rehabilitation Program had greater improvement in PTSD, depression, and psychological quality of life, and were more likely to lose their PTSD diagnosis than 93 Veterans treated with trauma-focused group therapy, the usual treatment being delivered prior to CPT's implementation.

2.Chard, K. M., Schumm, J. A., Owens, G. P. and Cottingham, S. M. (2010). A comparison of OEF and OIF Veterans and Vietnam Veterans receiving cognitive processing therapy. Journal of Traumatic Stress, 23, 25–32. doi:10.1002/jts.20500 PILOTS ID: 83687

This study addressed the important question of whether OEF/OIF Veterans respond differently to outpatient PTSD treatment than Vietnam Veterans. The investigators found that compared with 50 Vietnam Veterans, 51 OEF/OIF Veterans had lower PTSD severity after CPT, yet attended fewer treatment sessions. The study suggests that the chronic nature of PTSD among the Vietnam cohort may be more difficult to treat and requires a longer course of therapy.

3.Chard, K. M., Schumm, J. A., McIlvain, S. M., Bailey, G. W., and Parkinson, R. B. (2011). Exploring the efficacy of a residential treatment program incorporating cognitive processing therapy-cognitive for Veterans with PTSD and traumatic brain injury. Journal of Traumatic Stress, 24, 347–351. doi:10.1002/jts.20644 PILOTS ID: 85169

To better understand how TBI affects response to PTSD-focused treatment, this study of 42 Veterans examined outcomes from a residential VA PTSD–TBI treatment program that incorporates CPT. Results showed that the treatment led to better outcomes for Veterans with mild TBI and Veterans with moderate/severe TBI, with no differences between the TBI groups. This is the first study to show that Veterans with PTSD and TBI experience decreased PTSD and depression following participation in a residential trauma-focused treatment program.

4.Chard, K. M., Ricksecker, E. G., Healy, E. T., Karlin, B. E., and Resick, P. A. (2012). Dissemination and experience with cognitive processing therapy. Journal of Rehabilitation Research & Development, 49, 667–678. doi:10.1682/JRRD.2011.10.0198 PILOTS ID: 86801

The study is a program evaluation of VA's national training rollout of CPT. Outcome data from 374 Veterans who received CPT from therapists trained via the program indicated statistically significant and clinically meaningful improvements in PTSD. Veterans from Vietnam, OEF/OIF, and the Persian Gulf War benefited equally from CPT.

5.Monson, C. M., Schnurr, P. P., Resick, P. A., Friedman, M. J., Young-Xu, Y.,and Stevens, S. P. (2006). Cognitive processing therapy for Veterans with military-related posttraumatic stress disorder. Journal of Consulting and Clinical Psychology,74, 898–907. doi:10.1037/0022–006X.74.5.898 PILOTS ID: 28862

The study is the first randomized controlled trial of CPT for Veterans with PTSD. In the sample of 60 Veterans, CPT led to significantly greater improvements in PTSD, depression, and social adjustment, among other outcomes, compared to a wait-list control group. Importantly, Veterans with PTSD-related disability improved just as much as Veterans without PTSD-related disability.

6.Surís, A., Link-Malcolm, J., Chard, K., Ahn, C., and North, C. (2013). A randomized clinical trial of cognitive processing therapy for Veterans with PTSD related to military sexual trauma. Journal of Traumatic Stress, 26, 28–37. doi:10.1002/jts.21765 PILOTS ID: TBD

This is the first randomized controlled trial of CPT for PTSD-related to military sexual trauma (MST). This study found CPT to be more effective than Present-Centered Therapy, a non-trauma-focused PTSD treatment, in reducing self-reported PTSD symptoms in a sample of 86 Veterans (73 female, 13 male).

Prolonged Exposure (PE) and other Exposure Therapies

1. Rauch, S. A., Defever, E., Favorite, T., Duroe, A., Garrity, C., Martis, B., and Liberzon, I. (2009). Prolonged exposure for PTSD in a Veterans Health Administration PTSD clinic. Journal of Traumatic Stress, 22, 60–64. doi:10.1002/jts.20380 PILOTS ID: 82589

This pilot study showed that PE was effective in reducing PTSD and depression in a small sample of 10 men and women Veterans from various war eras seen in a VA PTSD clinic. Half the patients were seen by therapists participating in the

national VA training program in PE. Outcomes for these patients were just as positive as those for patients seen by clinicians experienced with PE.

2. Schnurr, P. P., Friedman, M. J., Engel, C. C., Foa, E. B., Shea, M. T., Chow, B. K., . . . Bernardy, N. C. (2007). Cognitive behavioral therapy for posttraumatic stress disorder in women: A randomized controlled trial. Journal of the American Medical Association, 297, 820–830. doi:10.1001/jama.297.8.820 PILOTS ID: 29137

This study is one of the largest clinical treatment trials conducted, with a sample of 284 female Veterans and active duty personnel, and the first of PTSD in female Servicemembers. Women who received PE had greater improvements in PTSD, depression, anxiety, and quality of life than women who received Present-Centered Therapy, a non-trauma-focused PTSD treatment.

3.Strachan, M., Gros, D. F., Ruggiero, K. J., Lejuez, C.W., and Acierno, R. E. (2011). An integrated approach to delivering exposure-based treatment for symptoms of PTSD and depression in OIF/OEF Veterans: Preliminary findings. Behavior Therapy, 43, 560–569. doi:10.1016/j.beth.2011.03.003 PILOTS ID: 37822

This study presents preliminary data from an ongoing clinical trial and indicates that a brief behavioral treatment incorporating exposure was effective in significantly improving PTSD, depression, and anxiety among 31 OEF/OIF Veterans, whether delivered using home-based telehealth or in-person. The findings suggest that exposure treatment can be effectively administered using telehealth technology, which may expand the reach of this evidence-based approach.

4.Thorp, S. R., Stein, M. B., Jeste, D. V., Patterson, T. L., and Wetherell, J. L. (2012). PE therapy for older Veterans with posttraumatic stress disorder: A pilot study. American Journal of Geriatric Psychiatry, 20, 276–280. doi:10.1097/JGP.0b013e3182435ee9 PILOTS ID: 38445

This preliminary study begins to fill the gap in research on PTSD treatment in older Veterans. Findings indicated that PE was well received by a small sample of 10 Veterans age 56 to 78 and effective in improving PTSD symptoms to a significant and large degree. Dropout was similar to that seen in other PTSD treatment studies. Improvement in PTSD was larger in the PE group than in a nonrandomized comparison sample of older Veterans receiving usual treatment (medication appointments or case management) in the same clinic.

5.Tuerk, P. W.; Yoder, M.; Grubaugh, A. L.; Myrick, H.; Hamner, M. B.; and Acierno, R. E. (2011). Prolonged exposure therapy for combat-related posttraumatic stress disorder: An examination of treatment effectiveness for Veterans of the wars in Afghanistan and Iraq. Journal of Anxiety Disorders, 25, 397–403. doi:10.1016/j.janxdis.2010.11.002 PILOTS ID: 35452

This is one of the few studies of real-world treatment effectiveness exclusively focused on OEF/OIF Veterans. The trial found that a sample of 65 OEF/OIF Veterans treated with PE by VA PTSD Clinical Teams (PCT) had significant improvements in PTSD that were similar in size to those found in randomized controlled trials of PE in civilians. Importantly, PTSD improved irrespective of service connection disability status.

6.Tuerk, P. W., Yoder, M., Ruggiero, K. J., Gros, D. F., and Acierno, R. E. (2010). A pilot study of prolonged exposure therapy for posttraumatic stress disorder delivered via telehealth technology. Journal of Traumatic Stress, 23, 116–123. doi:10.1002/jts.20494 PILOTS ID: 83699

This is the first trial of PE delivered via telehealth technology. Results indicated that 12 Veterans who received PE via telehealth at their local VA Community-Based Outreach Clinic experienced large reductions in PTSD and depression. These improvements were generally similar to those experienced by a group of 35 Veterans who received the treatment in-person at the main VA Medical Center (VAMC). PE via telehealth was safe and feasible, with acceptable, albeit slightly higher than in-person, rates of treatment completion.

7.Wolf, G. K., Strom, T. Q., Kehle, S. M., and Eftekhari, A. (2012). A preliminary examination of prolonged exposure therapy with Iraq and Afghanistan Veterans with a diagnosis of posttraumatic stress disorder and mild to moderate traumatic brain injury. Journal of Head Trauma Rehabilitation, 27, 26–32. doi:10.1097/HTR.0b013e31823cd01f PILOTS ID: 37922

This small study demonstrated that prolonged exposure with minimal procedural enhancements was feasible and effective for treating PTSD and depression in OEF/OIF Veterans with traumatic brain injury. Improvements were large and 9 out of the 10 Veterans no longer meeting criteria for PTSD based on a self-report measure.

8.Yoder, M., Tuerk, P. W., Price, M., Grubaugh, A. L., Strachan, M., Myrick, H., and Acierno, R. E. (2012). Prolonged exposure therapy for combat-related posttraumatic stress disorder: Comparing outcomes for Veterans of different wars. Psychological Services, 9, 16–25. doi:10.1037/a0026279 PILOTS ID: 37575

This study added to the literature examining whether there is variability in PTSD treatment response across different cohorts of Veterans. The investigators examined archival data from 112 Veterans treated with PE by a PCT. The treatment was very effective at reducing PTSD and depression for the overall sample, although Gulf War Veterans experienced less improvement compared with Vietnam or OEF/OIF Veterans and also had a slower rate of improvement. The factors that may account for this differential effectiveness have yet to be explored.

Other Cognitive-Behavioral Treatments

1.Beidel, D. C., Frueh, B. C., Uhde, T. W., Wong, N., and Mentrikoski, J. M. (2011). Multicomponent behavioral treatment for chronic combat-related posttraumatic stress disorder: A randomized controlled trial. Journal of Anxiety Disorders, 25, 224–231. doi:10.1016/j.janxdis.2010.09.006 PILOTS ID: 35248

The randomized clinical trial compared a multicomponent cognitive-behavioral therapy, Trauma Management Therapy. This therapy combines exposure therapy and social emotional rehabilitation, to exposure therapy only in a group of 35 male combat Veterans with chronic PTSD. Veterans in both conditions had moderate improvements in PTSD, with no difference between groups. The Trauma Management Therapy group had greater decreases in social impairment after receiving the treatment component that focuses on social functioning.

2.Frueh, B. C., Monnier, J., Yim, E., Grubaugh, A. L., Hamner, M. B., and Knapp, R. G. (2007). A randomized trial of telepsychiatry for post-traumatic stress disorder. Journal of Telemedicine and Telecare, 13, 142–147. doi:10.1258/135763307780677604 PILOTS ID: 29644

This randomized clinical noninferiority trial of group therapy compared video teleconferencing with in-person format in a sample of 38 male Veterans with PTSD. Change in self-reported PTSD from before to after treatment was small in both groups and did not differ between groups, who also did not differ in session attendance and treatment satisfaction. However, the same-room group was more likely to complete assigned homework and reported greater comfort when talking with their therapist.

3.Jakupcak, M., Roberts, L. J., Martell, C., Mulick, P. S., Michael, S. T., Reed, R., McFall, M. E. (2006). A pilot study of behavioral activation for Veterans with posttraumatic stress disorder. Journal of Traumatic Stress, 19, 387–391. doi:10.1002/jts.20125 PILOTS ID: 80064

This pilot study evaluated the feasibility and effectiveness of behavioral activation for treating PTSD in 11 Veterans who received 16-weekly individual sessions of treatment, 9 of whom completed the protocol. There were moderate pre-post improvements in PTSD, but no improvement in depression and quality of life.

4.Morland, L. A., Greene, C. J., Rosen, C. S., Foy, D. W., Reilly, P. M., Shore, J. H., . . . Frueh, B. C. (2010). Telemedicine for anger management therapy in a rural population of combat Veterans with posttraumatic stress disorder: A randomized noninferiority trial. Journal of Clinical Psychiatry, 71, 855–863. doi:10.4088/JCP.09m05604blu PILOTS ID: 33947

This randomized clinical noninferiority trial of anger management therapy for 125 Veterans with PTSD found that those who received treatment by video teleconferencing had comparable symptom improvements to those who received in-person therapy. There were no differences in attrition, adherence, satisfaction, or treatment expectancy, although Veterans in the in-person condition reported higher therapeutic alliance.

5.Monson, C. M., Fredman, S. J., Macdonald, A., Pukay-Martin, N. D., Resick, P. A., and Schnurr, P. P. (2012). Effect of cognitive-behavioral couple therapy for PTSD: A randomized controlled trial. Journal of the American Medical Association, 308, 700–709. doi: 10.1001/jama.2012.9307 PILOTS ID: 39124

Forty couples in which one partner had PTSD (including 9 couples in which the PTSD partner was a Veteran) were randomized to receive couple therapy or to a waitlist. Couple therapy resulted in greater decreases in PTSD and other symptoms and increased relationship satisfaction in the PTSD partners, but no differential improvement in relationship satisfaction in the non-PTSD partners.

6.Rotunda, R.J., O'Farrell, T.J., Murphy, M., and Babey, S.H. (2008). Behavioral couples therapy for comorbid substance use disorders and combat-related

posttraumatic stress disorder among male Veterans: An initial evaluation. Addictive Behaviors, 33, 180–187. doi:10.1016/j.addbeh.2007.06.001 PILOTS ID 30123

This randomized controlled trial compared outcomes of behavioral couples therapy in 38 Veterans who had comorbid PTSD and alcohol use disorder or alcohol use disorder only. There were similar improvements in both groups in relationship satisfaction, alcohol consumption, negative consequences of drinking male-to-female violence, and psychological distress.

Supported Employment

1.Davis, L. L., Leon, A. C., Toscano, R., Drebing, C. E., Ward, L. C., Parker, P. E., . . . Drake, R. E. (2012). A randomized controlled trial of supported employment among Veterans with posttraumatic stress disorder. Psychiatric Services,63,464–470. doi:10.1176/appi.ps.201100340 PILOTS ID: 38033

A randomized clinical trial of 85 Veterans who were randomized to receive either individual placement and support (IPS) or standard VHA vocational rehabilitation found that found that Veterans who received IPS were much more likely to gain competitive employment (approximately 76 percent in IPS vs. 28 percent in vocational rehabilitation). Veterans who received IPS also spent more time in competitive employment and had greater income.

Eye Movement Desensitization and Reprocessing (EMDR)

1.Carlson, J. G., Chemtob, C. M., Rusnak, K., Hedlund, N. L., and Muraoka, M. Y. (1998). Eye movement desensitization and reprocessing (EMDR) treatment for combat-related posttraumatic stress disorder. Journal of Traumatic Stress, 11, 3–24. doi:10.1023/A:1024448814268 PILOTS ID: 13921

In this randomized clinical trial (RCT), 47 male combat Veterans with PTSD were assigned to receive either EMDR, relaxation, or a wait list. The authors reported greater improvements in PTSD and other outcomes for the 35 Veterans who completed the trial; Intention-to-Treat analysis was not reported.

2.Rogers, S., Silver, S. M., Goss, J., Obenchain, J. V., Willis, A., and Whitney, R. L. (1999). A single session, group study of exposure and eye movement desensitization and reprocessing in treating posttraumatic stress disorder among Vietnam War Veterans: Preliminary data. Journal of Anxiety Disorders, 13, 119–130. doi:10.1016/S0887–6185(98)00043–7 PILOTS ID: 14686

In this small RCT, 12 Vietnam War Veterans with PTSD were either a single session of exposure therapy or EMDR. Both groups showed improvement in self-reported overall PTSD symptom severity but groups did not differ. EMDR treatment resulted in greater positive changes in within-session subjective units of discomfort levels and on self-reported intrusive symptoms.

3.Silver, S. M., Brooks, A., and Obenchain, J. V. (1995). Treatment of Vietnam War Veterans with PTSD: A comparison of eye movement desensitization and reprocessing, biofeedback, and relaxation training. Journal of Traumatic Stress, 8, 337–342. doi:10.1007/BF02109568 PILOTS ID: 12519

Program evaluation of 100 Veterans treated in a VA specialized inpatient program showed that those who received EMDR had greater improvements than those who received relaxation or biofeedback in PTSD and other symptoms.

Complementary and Alternative Medicine

1.Bormann, J. E., Thorp, S. R., Wetherell, J. L., Golshan, S., and Lang, A. J. (2012, March 12). Meditation-based mantram intervention for Veterans with posttraumatic stress disorder: A randomized trial. Psychological Trauma: Theory, Research, Practice, and Policy. Advance online publication. doi:10.1037/a0027522 PILOTS ID: 38465

In this RCT, 146 outpatient Veterans with PTSD were assigned to receive usual care (medication and case management alone) or usual care plus a mantram repetition program. Participants who received mantram repetition had greater improvements in self-reported and clinician-rated PTSD symptoms and in depression, mental health status, and existential spiritual well-being.

2.Niles, B. L., Klunk-Gillis, J., Ryngala, D. J., Silberbogen, A. K., Paysnick, A., and Wolf, E. J. (2012) November 14). Comparing mindfulness and psychoeducation treatments for combat-related PTSD using a telehealth approach. Psychological Trauma: Theory, Research, Practice, and Policy, 4, 538–547. doi:10.1037/a0026161 PILOTS ID: 37920

In this RCT, 33 male combat Veterans with PTSD were assigned to one of two telehealth treatment conditions: mindfulness or psychoeducation. In the 24 participants who completed all assessments, participation in the mindfulness intervention was associated with a temporary reduction in PTSD symptoms. The authors con-

cluded that a brief mindfulness treatment may not be of adequate intensity to sustain effects on PTSD symptoms.

Integrated Care

1.Cigrang, J. A., Rauch, S. A. M., Avila, L. L., Bryan, C. J., Goodie, J. L., Hryshko-Mullen, A., . . . STRONG, S. C. (2011). Treatment of active-duty military with PTSD in primary care: Early findings. Psychological Services, 8, 104–113. doi:10.1037/a0022740 PILOTS ID: 36597

This pilot study evaluated a brief cognitive behavioral therapy protocol that included elements of PE and Cognitive Processing Therapy for treating PTSD in 15 Veterans in a primary care setting. There were large decreases in self-reported and clinician-rated PTSD but symptoms still remained high after treatment.

2.Jakupcak, M., Wagner, A. W., Paulson, A., Varra, A. A., and McFall, M. E. (2010). Behavioral activation as a primary care-based treatment for PTSD and depression among returning Veterans. Journal of Traumatic Stress, 23, 491–495. doi:10.1002/jts.20543 PILOTS ID: 80064

This pilot study of 8 OEF/OIF Veterans who received Behavioral Activation as a primary care-based treatment for PTSD found that there improvements in PTSD following treatment that were maintained at 3-month follow up. The majority of Veterans demonstrated meaningful improvements on depression and quality of life and reported high treatment satisfaction.

3.McFall, M., Saxon, A. J., Malte, C. A., Chow, B., Bailey, S., Baker, D. G., Beckham, J. C., Boardman, K. D., et al., for the CSP 519 Study Team. (2010). Integrating tobacco cessation into mental health care for posttraumatic stress disorder: A randomized controlled trial. Journal of the American Medical Association, 304, 2485–2493. doi:10.1001/jama.2010.1769 PILOTS ID: 35450

This randomized clinical of integrated smoking cessation for 943 smokers with military-related PTSD, recruited from outpatient PTSD clinics at 10 VAMCs found that Veterans who were referred to integrated smoking cessation treatment had better smoking outcomes relative to Veterans who were referred to usual care VA smoking cessation clinics. There was no worsening of PTSD symptoms in either group. Both groups had small (10 percent) reductions in clinician-rated PTSD.

- Please describe each incident referenced in your above statement where VA is able to demonstrate "the direct impact" of the mental health care VA provides on the subsequent mental health of the veterans who access that care.

VA Response:

As part of its strong commitment toward providing high quality mental health care, VHA has been working to nationally disseminate and implement specific evidence-based psychotherapies (EBP) for PTSD and other mental and behavioral health conditions. As part of this effort to make these treatments widely available to Veterans, VHA has implemented competency-based staff training programs in PE therapy and CPT for PTSD, as well as training programs in EBPs for other conditions. Both PE and CPT are recommended in the VA/Department of Defense Clinical Practice Guideline for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." As of March 1, 2013, VHA had provided training in PE and/or CPT to more than 4,700 staff. Program evaluation results indicate that the implementation of PE and CPT by newly-trained staff has resulted in significant positive patient outcomes, with average reductions of approximately 20 points on the PTSD checklist (Chard, Ricksecker, Healy, Karlin, & Resick, 2012; Eftekhari, Ruzek, Crowley, Rosen, Greenbaum, and Karlin, 2012). Program evaluation results associated with the implementation of EBPs for other conditions, including Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression and Cognitive Behavioral Therapy for insomnia, indicate large overall reductions in symptoms and improvements in quality of life among Veterans (Karlin et al., 2012, in press; Karlin, Trockel, Taylor, Gimeno, and Manber, in press).

REFERENCES

Chard, K. M., Ricksecker, E. G., Healy, E., Karlin, B. E., and Resick, P. A. (2012). Dissemination and experience with Cognitive Processing Therapy. Journal of Rehabilitation Research and Development, 49, 667–678.

Eftekhari, A., Ruzek, J. I., Crowley, J., Rosen, C., Greenbaum, M. A., and Karlin, B. E. (2012). Effectiveness of national implementation of Prolonged Exposure Therapy in VA care. Manuscript submitted for publication.

Karlin, B. E., Brown, G. B., Trockel, M., Cunning, D., Zeiss, A. M., and Taylor, C. B. (2012). National dissemination of Cognitive Behavioral Therapy for depression in the Department of Veterans Affairs health care system: Therapist and patient-level outcomes. Journal of Consulting and Clinical Psychology, 80, 707–718.

Karlin, B. E., Trockel, M. Taylor, C. B., Gimeno, J., and Manber, R. (in press). National dissemination of Cognitive Behavioral Therapy for insomnia in Veterans: Clinician and patient-level outcomes. Journal of Consulting and Clinical Psychology.

Karlin, B. E., Walser, R. D., Yesavage, J., Zhang, A., Trockel, M., and Taylor, C. B. (in press). Effectiveness of Acceptance and Commitment Therapy for depression: Comparison among older and younger veterans. Aging and Mental Health.

4. In response to my question regarding how the Committee can assist VA in providing quality and timely mental health care services to veteran patients, you stated that the Committee may help in: (1) facilitating interactions between VA and community health centers; (2) helping VA interact better with private sector providers; and, (3) addressing the shortage of psychiatrists.

Please expand on how you believe the Committee could be of assistance to the Department in each of the three areas listed above.

VA Response:

VA appreciates the on-going support of the Committee for its mission of providing quality and timely mental health care to Veterans. Regarding interactions between VA and community health centers and interactions between VA and private sector providers, expanding opportunities in both areas would benefit from improved information technology (IT) capabilities. On-going support for graduate medical education and training in psychiatry is important to continue.

5. In response to my question regarding how VA has been able to hire increased numbers of mental health providers, you stated that, "[o]f all of the professionals in mental health, the most difficult problem we are having is recruiting psychiatrists, and we have barely been able to recruit half of the new ones that we said we wanted to do, and that it is in spite of raising the salary quite substantially, providing incentives for recruitment, bonuses, etc."

Please provide further details on the salary raises, recruitment incentives, bonuses, and any and all other actions VA has taken in an effort to recruit and retain psychiatrists.

Please describe any and all actions beyond the ones referenced above that VA has taken or is considering taking to alleviate the difficulties VA has experienced recruiting psychiatrists (i.e. undertaking additional recruitment and retention incentives, increasing partnerships with non-VA resources, recruiting increased numbers of other mental health professionals, etc.).

VA Response:

VHA diligently uses the 3Rs (Recruitment, Relocation, Retention) to recruit and retain psychiatrists, as well as providing competitive salaries.

These are salary data for the psychiatrist (occupational series = 602 and assignment code = 31) at 5 points in time, presented as the mean, minimum, and maximum at the end of each calendar year plus March 2012:

PSYCHIATRIST SALARY	12/31/2009	12/31/2010	12/31/2011	3/31/2012	12/31/2012
MEAN	175000	180487	182436	182991	186884
MIN	119000	124123	128117	129000	117589
MAX	277721	292987	250107	286848	286848

From 2009 to 2012 the psychiatrist average salary increased by $11,884 or 6.3 percent, the minimum salary dropped by $1,411 or 1.2 percent, and the maximum salary increased by $9,127 or 3.2 percent.

From March 31, 2012 to December 31, 2012, the psychiatrists' average salary increased by $3,893 or 2 percent, the minimum salary dropped by $11,411 or 9.7 percent, and the maximum salary stayed steady.

These are the incentives the psychiatrist (occupational series = 602 and assignment code = 31) from the nature of action file (codes = 815, 816 and 827) for the 3Rs:

Time Period of Incentives Paid to Psychiatrists	Recruitment	Relocation	Retention	Grand Total 3Rs
March 2012 - December 2012	$1,677,722	$503,674	$1,219,001	$3,400,397
CY 2011	$1,240,674	$332,752	$1,581,375	$3,154,801
CY 2012	$1,963,484	$543,174	$1,667,961	$4,174,619

From March 2012 to December 2012, VHA paid $3,400,397 in 3R incentives to psychiatrists. In Calendar Year (CY) 2011, VHA paid $3,154,801 in 3R incentives. In CY 2012, VHA paid $4,174,619 in 3R incentives. This is an increase of $1,019,818 in 3R incentives, over a single calendar year for this occupation.

VHA has implemented a robust and aggressive recruitment and marketing strategy creating national awareness for the mental health hiring initiative. Our practice opportunities were highlighted at 11 national and regional clinical conferences specifically targeting psychiatrists and other mental health professionals. VHA requested that its national recruiters recruit 170 psychiatrists for critical mental health positions. They successfully recruited 166 psychiatrists against that initial tasking. As a result of this success, VHA National Recruiters have expanded their efforts with medical centers to aggressively recruit the remaining psychiatrist vacancies. From March 2012 through June 2013, VHA has hired 403 psychiatrists.

Significant marketing milestones include national TV recruitment commercials and public service announcements, 16 online campaigns, 15 direct mail campaigns (to include e-newsletters), 11 print advertising campaigns, and an integrated social media plan on Facebook and Twitter. We have established committed non-VA partnerships with 85 mental health associations including American Psychological Association, 25 universities, and the National Rural Recruitment and Retention Network; while continuing ongoing collaborative engagement with Veterans Service Integrated Networks (VISN), program offices, and field public affairs offices. Finally, we continue to adapt our strategy as needed, most recently by implementing a Web form application feature on www.vacareers.va.gov/mental-health/. Since finalizing the form on February 26, 2013, we have processed over 1,000 online inquiries—highlighting the tremendous interest from mental health practitioners.

Detailed Milestones in Effort to Hire Mental Health Professions:

- VHA National Recruiters staffed booths at multiple mental health professional association meetings nationwide from May to November 2012 to collect contact information for candidates interested in VHA mental health careers. Events included: American Psychiatric Association, American Psychiatric Nurses Association, US Public Health Service Scientific Symposium, VA for Veterans, Greil Mental Health Hospital job fair, Career MD (multiple regions), NC Psychiatric Association, International Association for Traumatic Stress Study, and US Psychiatric and Mental Health Congress.
- Print marketing templates targeted to Mental Health available to facilities on May 30, 2012.
- VISN, Program Office, and field Public Affairs Officers were all briefed on the Mental Health Initiative.
- VA Careers website updated to spotlight Mental Health positions launched on May 18, 2012. Refresh of Mental Health banner on VAcareers.va.gov.
- Revised VHA Mental Health Hiring Initiative Poster approved in collaboration with Office of Mental Health and uploaded on AdCreator in VHA Recruiter Toolkit online for use in various sizes that can be easily customized for local recruitment events to support the initiative.
- Mental Health Public Service Announcement featuring VA Employee/ Olympic medalist Natalie Dell on VA YouTube. Distribution of video nationally with hard copies to 200 media stations and digital copies to 800 media outlets on October 1, 2012. Airings began on October 10, 2012. Promotion on www.VAcareers.va.gov also went live October 10, 2012. Reported as showing over 3800 times for a value exceeding $1 million in free television advertising. This is currently 11 times the return on investment.

- Mental Health Marketing Campaign has launched with updates to www.VAcareers.va.gov making contact more readily accessible. These efforts have already yielded more than 200 new leads in February and March 2013. We are now targeting our efforts to the hard-to-fill psychiatrists and PhD psychologists with leads assigned to VISN Recruiters for follow-up. Enhanced Mental Health social media plan has begun on Facebook and Twitter with record reach to over 68,000 prospects. Twitter #WorkatVA Launch: A twitter chat occurred on March 21, 2013, targeting Mental Health providers. VHA has promoted the event as well.
- VHA remains an ongoing partner with National Rural Recruitment and Retention Network.
- TV Recruitment Commercial has been awarded. Kickoff meeting was conducted February 11, 2013. Existing content was aired beginning the second week of March. Additional recruitment commercials and public services announcements targeting health care providers will be aired beginning in July to increase hiring and to increase hiring awareness for VA hard-to-fill occupations nationwide.
- Website Updates: We are developing a mockup of a material download center that we will include on the VA Careers mental health site. We feel that a designated download center on the mental health hiring page will be the best way to ensure that our materials are readily available to our target audience.
- VHA's Workforce Management & Consulting Office (WMC) has been actively working with the Office of Human Resource Management (OHRM) to develop clear objectives for a Healthcare Recruitment contract with a private sector search firm. OHRM has contacts with the Office of Personnel Management (OPM) and the capability to establish task orders against OPM contracts. Discussion with OPM regarding VA's use of OPM contracts is ongoing. Since March 2012, the VHA National Recruiters have successfully recruited 205 psychiatrists including the initial 170 positions described above. Recruiters continue to actively pursue candidates nationwide. When combined with the efforts of HR staff nationwide, VHA has hired 403 psychiatrists since March 2012.
- WMC continues to collaborate with the VHA Office of Mental Health to market to relevant mental health provider associations and recruitment events in FY 2013 as part of the Mental Health marketing contract with partners Reingold and TMP Government.

Targeted Paid Media:

- Psych News - quarter page, full-color print ad in the June 15, 2012 issue (40,000+ circulation)
- Psychiatric Times - quarter page, full-color print ad in the June 2012 issue (40,000+ circulation)
- Targeted email blast to 23,241 Psychiatry members of the American Medical Association launched June 13, 2012
- Psychiatric Times Career Opportunities eNewsletter sponsorship reaching 65,000 Psychiatry opt-in subscribers - June 2012 issue
- American Journal of Psychiatry eToc sponsorship reaching 30,000+ APA members - June 2012 issue
- American Psychological Association (APA) also published the following at no cost for VA:

-A lead news story in APA Access, APA's all member e-newsletter
-Placed the provided VA banner ad in APA Access
-Published a lead news story in PracticeUpdate, the e-newsletter of the APA Practice Organization

Targeted Online Banner Advertising:

- USAJobs Spotlight (received over 65,000 click-throughs to VACareers)
- AMHCA (American Mental Health Counselors Association)
- NASW (National Association of Social Workers) through June 2012
- SocialWorkToday.com
- American Psychiatric Association
- American Counseling Association
- Negotiated free 4-week banner run with HealtheCareers on their Mental Health Specialty site
- VA was November's featured Employer on National Rural Recruitment and Retention Network (tie-in to Veterans Day)
- Eleven website banner advertisements through Joining Forces partnership across their networks

6. In response to a question from Ranking Member Michaud regarding Section 3 of the Executive Order on Improving Access to Mental Health

Servicemembers, Veterans, and Their Families, you stated that, "...15 pilots sites were selected ...based upon the desire of the local network to participate, our hospital to participate, and a need ...identified often by how rural the areas were. There is one urban center where we are doing this in Atlanta to get a feel for what they might be like, because there are many, many community mental health clinics in the Atlanta area." You further stated that, "[w]e think that this is...going to be a viable alternative in the future to us cooperating in the community with providing care in these again remote rural areas."

Please name the location of each of the 15 selected pilot sites.

VA Response:

As of May 31, 2013, the Department of Veterans Affairs (VA) has established pilot projects with 24 community-based mental health and substance abuse providers across nine states and seven Veterans Integrated Service Networks (VISNs). The twenty-four pilots have been established across Georgia, Tennessee, Wisconsin, Mississippi, Alaska, South Dakota, Nebraska, Indiana and Iowa. Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Sites may include capabilities for tele-mental health, staff sharing, and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community provider available capacity and wait times, community treatment methodologies available, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

MAY 31 PILOTS FOR VA COLLABORATION WITH COMMUNITY PROVIDERS

	Geographic Location	VISN	VAMC	Community Provider
1	Griffin, Georgia	7	Atlanta VAMC	McIntosh Trail Community Service Board (CSB)
2	Flowery Branch, Georgia.	7	Atlanta VAMC	Avita Community Partners
3	Atlanta, Georgia	7	Atlanta VAMC	Peachford Behavioral Health System
4	Atlanta, Georgia	7	Atlanta VAMC	DeKalb Community Service Board (CSB)
5	Canton, Georgia	7	Atlanta VAMC	Highland Rivers Community Service Board (CSB)
6	Lawrenceville, Georgia.	7	Atlanta VAMC	View Point Health
7	Newport, Tennessee.	9	James H. Quillen VAMC, Mountain Home, TN	Cherokee Health Systems
8	Mountain City, Tennessee.	9	James H. Quillen VAMC, Mountain Home, TN	Frontier Health
9	Bedford, Indiana	11	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)

MAY 31 PILOTS FOR VA COLLABORATION WITH COMMUNITY PROVIDERS—Continued

	Geographic Location	VISN	VAMC	Community Provider
10	Columbus, Indiana	11	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)
11	Kokomo, Indiana ...	11	Richard L. Roudebush VAMC, Indianapolis, IN	Affiliated Service Providers of Indiana, Inc. (ASPIN)
12	Cashton, Wisconsin	12	Tomah VAMC	Scenic Bluffs Health Center
13	Bolivar County, Mississippi.	16	G. V. (Sonny) Montgomery VAMC, Jackson, MS	Delta Community Mental Health Services (DCMHS)
14	Gulfport/ Coastal Mississippi.	16	VA Gulf Coast Veterans Health Care System, Biloxi, MS	Gulf Coast Community Mental Health Clinic
15	Wrangall, Alaska ...	20	Alaska VA Healthcare System	Alaska Island Community Services (AICS)
16	Southeastern Alaska.	20	Alaska VA Healthcare System	South East Alaska Regional Health Consortium (SEARHC) Behavioral Health Department
17	Huron, South Dakota.	23	Sioux Falls VA Health Care System	Community Counseling Services
18	Sioux Falls, South Dakota.	23	Sioux Falls VA Health Care System	Southeastern Behavioral Health Care
19	Mitchell, South Dakota.	23	Sioux Falls VA Health Care System	Dakota Counseling Institute
20	Cedar Rapids, Iowa	23	Iowa City VA Health Care System	Abbe Center for Community Mental Health
21	Des Moines, Iowa ..	23	Central Iowa VA Health Care System	Eyerly Ball Community Mental Health Center
22	Iowa City, Iowa	23	Iowa City VA Health Care System	Community Mental Health Center for Mid-Eastern Iowa
23	Omaha, Nebraska ..	23	VA Nebraska-Western Iowa Health Care System	One World Community Health Center

MAY 31 PILOTS FOR VA COLLABORATION WITH COMMUNITY PROVIDERS—Continued

	Geographic Location	VISN	VAMC	Community Provider
24	Omaha, Nebraska ..	23	VA Nebraska-Western Iowa Health Care System	Charles Drew Health Center

Please describe, in detail, the criteria the Department used to choose each of the sites named above.

VA Response:

To determine our top priorities for collaboration, VA assessed recruitment success and difficulties as well as access to care issues (performance measure information), such as wait times for appointments and geographic distances to medical centers and/or Community-Based Outpatient Clinics (CBOC). These factors were used as VA developed its first round of pilot programs for community partnerships. Challenges in recruitment vary across VHA due to the differences among VHA facilities, patient need, and the local availability of mental health professionals. Additionally, when developing the pilot programs VHA considered not only community provider available capacity and wait times, but treatment methodologies, Veteran acceptance of external care, location of care with respect to the Veteran population, and mental health needs in specific areas.

-Please expand on your statement above that enhanced partnerships between VA and community partners is going to be a "viable alternative" to "cooperating in the community," to include what you see these partnerships as an alternative to and whether or not you see them as an asset in rural areas only or, potentially, in urban communities as well and why.

VA Response:

These partnerships are being explored as an alternative to traditional care defined as administered solely in a VA medical facility setting. By utilizing the community partners, not only will care be delivered closer to Veterans but potentially in a more familiar and comfortable setting within the Veteran's own community. Bringing care to a closer, familiar setting has been a successful model rolled out in other areas of VA including: campus outreach Vet Centers, and previous mental health programs partnership in particular the North Shore-Long Island Jewish Health System. Additional care modalities are also being explored through these pilot programs to determine their feasibility as alternative methods of delivering care. Telemental health will be evaluated at a number of sites and in various representations through the pilots. Some pilots will include video equipment being placed in community centers, with primary mental health care provided by a clinician at the supporting VAMC. The community provider will assist with administrative and crisis support. This will be a closely monitored collaborative approach to the Veterans' recovery.

Pilot programs are being explored in both rural and urban communities. A shortage of providers is not limited to rural areas, and returning Veterans will go back to all geographic areas. It is important to determine the validity of community partnerships in both settings to give all Veterans the opportunity for the quality care in the setting they desire. Urban pilots may face their own set of challenges. For example, urban pilots may be located in larger, busier, louder areas that may require a different model of collaboration and oversight. In one urban pilot, VA is placing liaisons in the community centers to assist in Veteran-centric issues and follow up.

7. In response to a question from Ranking Member Michaud regarding veteran suicide data, Dr. Janet Kemp, the Director of VA's Suicide Prevention and Community Engagement Program, stated that, "[t}here [are] a couple of states that we are still working with over privacy issues and how we are going to share data and I run confident that we will get those soon."

Please name the states referenced above.

Please describe any and all barriers, including privacy issues, to the states referenced above providing VA with the requested data on veteran suicide rates.

When does the Department expect that complete veteran suicide rate data will be received from all 50 states?

VA Response:

We are continuing to receive information from the states. We have attached the latest worksheet we are using to collect this information. There are concerns expressed from the states concerning how we will use the information, how we will protect the privacy of the people listed in their data bases, and if the information can legally be sent to us. Over time, VA has been able to resolve these issues with each State. See the attached sheet with the information as of March 7th, which is the latest available. The States with "R" – requested but not received are the States we are currently still working with. South Carolina has refused the initial request but is currently processing a second request which we anticipate will also be denied.

Updated State Data Availability (March 7)

State/Area	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Alabama	I	I	I	I	I	I	I	I	I	I	I	I	P
Alaska	I	I	I	I	I	I	I	I	I	I	I	I	P
American Samoa	R	R	R	R	R	R	R	R	R	R	R	R	R
Arizona	R	R	R	R	R	R	R	R	R	R	R	R	R
Arkansas	A	A	A	A	A	A	A	A	A	A	A	A	A
California	P	P	P	P	P	P	P	P	P	P	P	P	P
Commonwealth N. Mariana Islands	R	R	R	R	R	R	R	R	R	R	R	R	R
Colorado	A	A	A	A	A	A	A	A	A	A	A	A	P
Connecticut	R	R	A	A	A	A	A	A	A	A	A	R	R
Delaware	P	P	P	P	P	P	P	P	P	P	P	P	P
Florida	I	I	I	I	I	I	I	I	I	I	I	I	I
Georgia	P	P	P	P	P	I	I	I	I	I	I	P	P
Guam	R	R	R	R	R	R	R	R	R	R	R	R	R
Hawaii	A	A	A	A	A	A	A	A	A	A	A	A	P
Idaho	I	I	I	I	I	I	I	I	I	I	I	I	A
Illinois	R	R	R	R	R	R	R	R	R	R	R	R	R
Indiana	R	R	R	R	R	R	R	R	R	R	R	R	R
Iowa	A	A	A	A	A	A	A	A	A	A	A	A	A

Updated State Data Availability (March 7)—Continued

State/Area	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
Kansas	I	I	I	I	I	I	I	I	I	I	I	I	P
Kentucky	R	R	R	R	R	R	R	R	R	R	R	R	R
Louisiana	A	A	A	A	A	A	A	A	A	A	A	A	P
Maine	I	I	I	I	I	I	I	I	I	I	I	P	P
Maryland	R	R	R	R	R	R	R	R	R	R	R	R	R
Massachusetts	I	I	I	I	I	I	I	I	I	I	I	P	P
Michigan	I	I	I	I	I	I	I	I	I	I	I	I	P
Minnesota	I	I	I	I	I	I	I	I	I	I	I	I	P
Mississippi	P	P	P	P	P	P	P	P	P	P	P	P	P
Missouri	I	I	I	I	I	I	I	I	I	I	I	P	P
Montana	A	A	A	A	A	A	A	A	A	A	A	A	P
Nebraska	I	I	I	I	I	I	I	I	I	I	I	I	P
Nevada	I	I	I	I	I	I	I	I	I	I	I	I	P
New Hampshire	A	A	A	A	A	A	A	A	A	A	A	A	A
New Jersey	I	I	I	I	I	I	I	I	I	I	I	I	P
New Mexico	P	P	P	P	P	P	P	P	P	P	P	P	P
New York	I	I	I	I	I	I	I	I	I	I	I	I	P
New York City	I	I	I	I	I	I	I	I	I	I	I	I	P

North Carolina	I	I	I	I	I	I	I	I	I	I	I	I	I
North Dakota	A	A	A	A	A	A	A	A	A	A	A	A	A
Ohio	A	A	A	A	A	A	A	A	A	A	A	A	A
Oklahoma	I	I	I	I	I	I	I	I	I	I	I	A	P
Oregon	A	A	A	A	A	A	A	A	A	A	A	A	P
Pennsylvania	A	A	A	A	A	A	A	A	A	A	A	A	P
Philippines	R	R	R	R	R	R	R	R	R	R	R	R	R
Puerto Rico	R	R	R	R	R	R	R	R	R	R	R	R	R
Rhode Island	A	A	A	A	A	A	A	A	A	A	A	A	A
South Carolina	C	C	C	C	C	C	C	C	C	C	C	C	C
South Dakota	P	P	P	P	P	P	P	P	P	P	P	P	P
State Department	R	R	R	R	R	R	R	R	R	R	R	R	R
Tennessee	A	A	A	A	A	A	A	A	A	A	A	A	A
Texas	A	A	A	A	A	A	A	A	A	A	A	A	A
Utah	A	A	A	A	A	A	A	A	A	A	A	A	A
Vermont	I	I	I	I	I	I	I	I	I	I	I	P	P
Virgin Islands	R	R	R	R	R	R	R	R	R	R	R	R	R
Virginia	I	I	I	I	I	I	I	I	I	I	I	I	I
Washington	I	I	I	I	I	I	I	I	I	I	I	I	I
Washington D.C.	P	P	P	P	P	P	P	P	P	P	P	P	P

Updated State Data Availability (March 7)—Continued

State/Area	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010	2011
West Virginia	I	I	I	I	I	I	I	I	I	I	I	I	P
Wisconsin	A	A	A	A	A	A	A	A	A	A	A	A	P
Wyoming	A	A	A	A	A	A	A	A	A	A	A	A	A

I = data included in initial report,
A = available for future analysis,
P = pending state approval/processing,
R = requested but not received,
C = being processed

8. In response to a question from Ranking Member Michaud regarding performance requirements for VA mental health providers, you stated that, "....it is important to have performance measures, and I think it is incumbent upon us as the leaders to make sure that there is the proper balance between time available to do clinical care, and the necessity of meeting performance measures."

Please name each of the current performance measures (including any and all clinical reminders) currently in place for VA mental health care providers, to include the justification for using each measure and how long it has been in place.

VA Response:

There are 4 mental health performance measures in VHA's FY 2013 Performance Plan:

- Percent of new mental health appointments completed within 14 days of the create date for the appointment – New as a performance measure in FY 2013.
- Percent of established mental health patients with a scheduled appointment within 14 days of the desired date for the appointment – New as a performance measure in FY 2013.
- Percent of patients discharged from an inpatient mental health unit who receive outpatient mental health follow-up within seven days of discharge – Started in FY 2009.
- Percent of targeted population of OEF/OIF/OND Veterans with a primary diagnosis of PTSD who receive a minimum of eight psychotherapy sessions within a 14-week period – Started in FY 2012.

Clinical reminders are not considered performance measures. The clinical reminder system helps providers deliver higher quality care to patients for both preventive health care and management of chronic conditions, and helps ensure that timely clinical interventions are initiated. Reminders assist clinical decision-making and also improve documentation and follow up, by allowing providers to easily view when certain tests or evaluations were performed and to track and document when care has been delivered. They can direct providers to perform certain tests or other evaluations that will enhance the quality of care for specific conditions. The clinicians can then respond to the reminders by placing relevant orders or recording clinical activities on patients' progress notes.

Clinical reminders may be used for both clinical and administrative purposes. However, the primary goal is to provide relevant information to providers at the point of care, for improving care for Veterans. Clinical reminders support clinicians by providing pertinent data for clinical decision-making, reducing duplicate documenting activities, assisting in targeting patients with particular diagnoses and procedures or site-defined criteria, and assisting in compliance with VHA performance measures and with health promotion and disease prevention guidelines.

While some clinical reminders are national, facilities/VISNs also develop clinical specific reminders to support quality improvement efforts. Responsibility for completing clinical reminders is also left to the discretion of facilities/ VISNs.

The national mental health clinical reminders, deployed throughout the system, include:

Primary care screens: Primary care providers complete most of these reminders but are supported by mental health. These reminders are conducted annually to ensure all primary care patients are assessed for common mental health diagnoses. If the screen is positive for the first three measures below, additional follow up is required. The Military Sexual Trauma (MST) screen is completed one time to assess for a history of MST during military service. All Veterans who respond positively to the screen are offered a referral for mental health services. VA medical centers are expected to refer the Veteran to appropriate services in the event the Veteran tests positive from the homeless screener. If homelessness screen is positive for actual homelessness, the Veteran is immediately referred to the local VA facility homeless services team and if the homelessness screen is positive for being at risk for homelessness, the Veteran is referred to social work services.

- Alcohol Use Screen
  - Alcohol Use Positive follow-up evaluation
- Depression Screen
  - Depression Positive follow-up evaluation
- PTSD Screen
  - PTSD Positive follow-up evaluation
- Military Sexual Trauma (MST) Screening

- Homelessness Screening

Specialty mental health reminders:

- PTSD Reassessment - to support administration of the PTSD checklist for patients receiving treatment for PTSD
- Mental health high risk no show follow up – to support tracking high risk patients that have missed an appointment

Please describe how you, as the Under Secretary for Health, ensure a "proper balance" between measuring provider performance and ensuring sufficient clinical care.

VA Response:

VHA's performance measurement system was developed to improve quality of care and to support strategic planning. The key aspects of the Performance Measurement Program are to:

- Demonstrate an integrated health system consistently using the best scientific evidence in clinical practice to reliably and efficiently achieve the highest quality health outcomes
- Set national benchmarks for the quality of preventive and therapeutic healthcare services that exceed private sector performance
- Facilitate provision of care to a larger Veteran population without increasing health care expenditures
- Align resources to support strategic initiatives

While strategic directions are codified by VHA leadership, performance measures typically require review and input from front line providers, subject matter experts, external stakeholders, health care policy experts, regulators, and others as they are developed and implemented. In the past, these measures frequently were also used as part of employee performance plans to support implementation. In the last few years, VHA has been reducing its use of the performance measurement system in reviewing individual performance and has sought to achieve system compliance with the measures without inclusion in performance plans.

9. In response to a question from Representative Runyan regarding the need to be proactive in addressing veterans' mental health needs, you discussed the need to develop close, trusting relationships between veteran patients and VA mental health providers. You stated that VA needed to focus on, "...developing the relationships where [veteran patients] will tell us where there are things that may be antecedents to suicide that are bothering them," and, "[i]t is getting the information, and the contact with the individual before they have the difficulty as you have pointed is the problem." In response to a similar question from Representative Brownley, you stated that," ...we have a newly organized task force that Dr. Kemp is chairing that is going to look at how we can develop a different paradigm if you will for the way we deliver care to people that have chronic pain, sleep disorders, depression, etc., the things that have the greatest impact on suicide."

How does VA foster such relationships between VA providers and veteran patients?

VA Response:

Establishment of healing relationships between providers and Veterans is fundamental to care. This includes not only the individual provider but the healthcare team as a whole. Mental health providers are trained to reach out to Veterans and develop relationships based upon trust, including the ethical principles of respect for autonomy, beneficence, non-malfeasance, justice, and integrity. VA providers and Veterans jointly develop goals for treatment (VHA Strategic Plan, FY 2013) based on Veteran preferences. The VA mental health provider is charged with providing a full breadth of information about mental health services available to assist the Veteran in collaboratively establishing the plan of care and ensuring that the Veteran receives any needed care. In VA, mental health providers are embedded in multiple settings including the Patient Aligned Care Team (PACT), Geriatric and Extended Care settings, as well as in specialty mental health to support both individualized outreach and coordination of care. The VHA Strategic Plan emphasizes personalized, proactive, patient-driven healthcare with the sub-goals of effective communication and convenient access to information, advice and support.

What different paradigms is the taskforce referenced above looking at regarding the delivery of mental health care and when is that work expected to be complete?

VA Response:

The VA's Mental Health Innovations Task Force is embarking on a groundbreaking proactive, population-based approach that is designed to address antecedents to suicidal behavior, by creating strategies to reach Veterans before they are in crisis and establishing a sustained relationship that connects all aspects of their life with an emphasis on mental health and wellbeing. This holistic approach to addressing suicide prevention will build on our understanding of diagnoses known to increase risk and effective evidence-based treatments and will expand our approaches to proactive strategies which are often not a part of our current treatment plans, moving beyond simple identification and treatment of specific diseases. Our goal is to focus on the Veteran (whole person), the community where he or she lives, and the inclusion of proactive health strategies and approaches to optimize mental health and wellbeing. This will require a culture change, which takes time in any organization along with a communications strategy and the development of tools providers can use to assist them in creating this climate of personalized care. The initial strategic plan for the taskforce includes a series of action steps with delivery dates that began in February 2013 and extend into 2014, and beyond that there will be an on-going process of implementing the lessons learned through this initiative.

10) In response to a question from Representative Coffman regarding VA mental health care providers, you stated that, "...this spring [we have] implemented our performance criteria for timeliness, the intention is to go out and do three things. One, look at the measures. Two, survey veterans as to whether or not they were- had timely access as well as other satisfaction related questions. And three, to survey the staff. Are they able to provide timely access for their patients, are they adequately staffed, do they have enough people to do the work that they are being required. So, yes, we are going to do it. And we will be doing that on a regular basis"

Please provide the timeliness performance criteria referenced above.

VA Response:

VHA has two measure of timeliness for mental health:

- Percent of new mental health appointments completed within 14 days of the create date for the appointment – new as a performance measure in FY 2013.
- Percent of established mental health patients with a scheduled appointment within 14 days of the desired date for the appointment – new as a performance measure in FY 2013.

Please provide information regarding the survey of veteran patients referenced above, to include the number of veteran patients expected to be surveyed, the questions expected to be included on the survey, the method expected to be used to conduct the survey (i.e., in person, electronic, via telephone, etc.), the expected survey results, the expected total cost of the survey, and any and all follow-up actions expected to result from the survey.

VA Response:

The Veteran survey is attached below, and VHA plans to distribute the survey to 10,000 Veterans. VHA is still developing the method of distribution; cost of distribution will be related to the actual method used. VHA will use the information in two ways: 1) as an overall measure of Veteran perceptions of care that can be trended over time; 2) as feedback to assist individual facilities in developing action plans to address barriers to access perceived by Veterans at their sites.

OFFICE OF MENTAL HEALTH VETERAN SATISFACTION SURVEY

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of this Act. Accordingly, we may not conduct or sponsor and you are not required to respond to a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who complete this survey will average 15 minutes. This includes the time it will take to read information provided and gather the necessary facts to fill out the form. Submission of this form is voluntary and failure to respond will have no impact on benefits to which you may be

entitled. Responses to the survey will be reported in aggregate form and will be anonymous.

For each item identified below, circle the number to the right that best fits your judgment of its occurence at your facility. Use the scale above to select the frequency number

Survey Item	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree	NA or Unknown
1. I get appointments with my mental health provider on the day that I want or within two weeks of the day that I want	1	2	3	4	5	NA
2. I can see my mental health provider who prescribes my medications as frequently as needed	1	2	3	4	5	NA
3. If I have a question about my psychiatric medications, I can get in touch with a mental health provider or pharmacist by phone to get my question answered	1	2	3	4	5	NA
4. I talk to the person who prescribes my mental health medication by Telemental health (V-Tel)	1	2	3	4	5	NA
5. I talk to my counselor/therapist by Telemental health (V-Tel)	1	2	3	4	5	NA
6. There are problems getting the Telemental health (V-Tel) equipment to work	1	2	3	4	5	NA
7. Mental health treatment has been helpful in my life	1	2	3	4	5	NA
8. I was able to choose which of the psychotherapies I wanted to try after good discussion with my mental health provider about the options	1	2	3	4	5	NA
9. I believe it is necessary for me to stay in mental health treatment to keep my service connected disability	1	2	3	4	5	NA
10. I would like to schedule mental health appointments during extended hours (early mornings, evenings, or on weekends)	1	2	3	4	5	NA

For each item identified below, circle the number to the right that best fits your judgment of its occurence at your facility. Use the scale above to select the frequency number

Survey Item	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree	NA or Unknown
11. It is hard to get to my mental health appointments because of transportation problems	1	2	3	4	5	NA
12. Parking is a problem at my facility	1	2	3	4	5	NA
13. My mental health appointments are scheduled by VA without any input from me	1	2	3	4	5	NA
14. I get a reminder call or letter about my mental health appointments	1	2	3	4	5	NA
15. I attend group mental health treatment, and the room comfortably fits all the group participants	1	2	3	4	5	NA
16. When I have an individual mental health session with my provider, we meet in a room that is private	1	2	3	4	5	NA
17. I know that I will get a call back if I leave a message for my mental health provider	1	2	3	4	5	NA
18. My mental health provider and I agree on how often I should have appointments	1	2	3	4	5	NA
19. I can't see my mental health provider as much as I should because the provider does not have time to see me	1	2	3	4	5	NA
20. I am comfortable in the waiting area for mental healthcare	1	2	3	4	5	NA
21. The staff is open to my suggestions regarding improvements to mental health services	1	2	3	4	5	NA
22. I am treated with respect and kindness at the mental health programs	1	2	3	4	5	NA

For each item identified below, circle the number to the right that best fits your judgment of its occurence at your facility. Use the scale above to select the frequency number

Survey Item	Strongly Disagree	Disagree	Neither Disagree or Agree	Agree	Strongly Agree	NA or Unknown
23. During our appointments, my mental health provider focuses on the computer rather than engaging with me in face-to-face eye contact	1	2	3	4	5	NA
24. I know that there are mental health providers available right in Primary Care	1	2	3	4	5	NA
25. My primary care provider prescribes my psychiatric medications, such as medicine to help with depression or nervousness	1	2	3	4	5	NA
26. My family has been involved in mental health treatment with me as much as I would like them to be involved	1	2	3	4	5	NA

WRITE IN SECTION:

27. My Mental Health Treatment Coordinator is:

28. The biggest problem or concern I have about Mental Health Treatment is:

29. The biggest compliment or positive I have about Mental Health Treatment is:

If you wish to discuss your experience, please feel free to contact your Mental Health Treatment Coordinator, facility Mental Health Chief, Local Recovery Coordinator, or other Mental Health staff.

Please provide information regarding the survey of VA mental health care providers referenced above, to include the number of VA mental health providers expected to be surveyed, the questions expected to be included on the survey, the method expected to be used to conduct the survey (i.e., in person, electronic, via telephone, etc.), the expected survey results, the expected total cost of the survey, and any and all follow-up actions expected to result from the survey.

When does the Department expect all three of the above actions to be completed?

VA Response:

VA has completed the implementation of the new performance measures although we will be rolling out new processes to support the implementation of these measures throughout FY 2013, notably the use of the "Agreed upon Date" for documenting the desired date. VA has administered the Mental Health Provider Survey in September 2012 to collect baseline data, although additional data was collected from non-responding facilities in January 2013. VHA will re-administer this survey in September 2013. VHA will implement the Veteran Survey in the summer 2013.

How often does the Department expect to conduct follow-up surveys of veteran patients accessing VA mental health care?

VA Response:

Annually.

How often does VA expect to conduct follow-up surveys of VA mental health providers?

VA Response:

Annually.

Department of Veterans Affairs Responses to Questions from Congressman Jeff Denham

1. As we have heard the hearing, the conflicts in Afghanistan and Iraq have created extraordinary demands for care as veterans return from theater. For those with PTSD or other mental health issues, long waits for treatment can put them at risk for suicide or other behavioral problems.

Has VA considered short-term solutions to address the immediate mental health need while it recruits and hires the staff it needs long term?

VA Response:

VA has been expanding the use of technology to improve access to care especially in rural areas or areas where it is difficult to hire staff. VA has increased the use of telemental health to allow VA to use provider resources from areas with capacity to deliver services to areas that have limited provider resources. VA has expanded this service to begin implementation of telemental health home based care ensuring further improvements in accessibility. In addition, VA continues to develop Mobile Applications such as the PTSD Coach to support clinical service delivery.

VA recognizes that not all access issues can be resolved through staffing. In some instances, access issues may be the result of inefficient care delivery processes or difficulties in implementation of specialty programs. VA has been conducting site visits at all of its health care systems to review mental health program implementation and to provide consultation on areas needing improvement.

Also, VA is utilizing community providers to provide mental health services through the Non-VA Medical Care Program. Also, as part of the President's Executive Order, VA has established 15 pilot programs to support improving access to care. In addition, VA will continue to monitor access and wait times to ensure continual improvement in access going forward.

2. I understand that VA has been conducting pilot programs designed to provide veterans with access to community-based mental health services in several rural communities like mine. For veterans that are able to get into one of these programs, they provide needed care closer to the veteran's home. However, I understand that use of these pilots by VA facilities has been very low.

What are you doing to encourage use of these programs in rural communities?

VA Response:

The first pilots, initiated under the direction of the Executive Order, were brought on line during the last week of February 2013. These pilots include a number of rural community sites. There has been a positive response not only from the medical center staff and the community partners but among the Veterans. VA management, from the Under Secretary of Health to network directors to center directors, has made this a priority to implement and oversee these pilots. By early inclusion of both sides of the partnership and allowing the sites the leeway to define their programs based on local needs, we have achieved early buy in from facilities and staff. To preserve the initial enthusiasm about these pilots regular calls are conducted not only with each local site but with the nationwide group to encourage information sharing and lessons learned. Veterans are encouraged to participate in a number of ways. The sites are using email and local announcements to ensure staff are aware of the pilot program and the potential for inclusion of Veterans the pilot. Veteran case files must be reviewed for Veterans that match the treatment types and locations being offered through the pilot. VA staff contact the Veteran and explain the program and offer the opportunity to participate. One key to working towards a successful outcome and continued participation by all parties will be continued communication and coordination between the VA, the community partner, and the Veteran. Community partners are also reviewing their case files for Veterans that may not be enrolled with the VA, and working with their pilot contacts at the medical centers to contact and enroll these Veterans.

Are there any plans to expand these rural pilot programs, to other rural communities across the country?

VA Response:

Although only 15 pilots were required in the Executive Order, as of May 31, 2013, the Department of Veterans Affairs (VA) has established pilot projects with 24 community-based mental health and substance abuse providers across nine states and

seven Veterans Integrated Service Networks (VISNs). The twenty-four pilots have been established across Georgia, Tennessee, Wisconsin, Mississippi, Alaska, South Dakota, Nebraska, Indiana and Iowa. VA plans to allow these pilots to move forward for one year and then evaluate whether further expansion is recommended.

Department of Veterans Affairs Responses to Questions from Congresswoman Jackie Walorski

1. During the hearing, we heard how veterans are discouraged with long wait times in-between appointments and consequently drop out of treatment.

What is VA doing to improve mental health wait times for veteran patients accessing VA mental health care?

VA Response:

VA has the responsibility to meet and anticipate the needs of returning Veterans. VA has a multipronged strategy for improving mental health wait times for Veterans accessing VA mental health including:

- Hiring and staffing initiatives;
- Expansion of the use of technology;
- Quality improvement initiatives; and
- Development of community contracts.

In FY 2012, VA began the development and implementation of a general outpatient mental health staffing model to provide guidance to VA facilities and VISNs to ensure a consistent level of mental staffing. To support the implementation of the model, VA initiated an aggressive hiring plan to hire 1,600 mental health clinicians and 300 clerical support staff, as well as to ensure that vacancies are filled in a timely fashion. VA is also enhancing the training programs for mental health professionals over the next few years to increase the number of psychiatrists, psychologists, nurses, social workers, and pharmacists. In addition, as part of the President's Executive Order, VA is hiring 800 peer specialists to provide additional coverage for mental health treatment teams.

VA has been expanding the use of technology to improve access to care especially in rural areas or areas where it is difficult to hire staff. VA has increased the use of telemental health to allow VA to use provider resources from areas with capacity to deliver services to areas that have limited provider resources. VA has expanded this service to begin implementation of telemental health home-based care ensuring further improvements in accessibility. In addition, VA continues to develop mobile applications such as the PTSD Coach to support clinical service delivery.

VA recognizes that not all access issues can be resolved through staffing. In some instances, access issues may be the result of inefficient care delivery processes or difficulties in implementation of specialty programs. VA has been conducting site visits at all of its health care systems to review mental health program implementation and to provide consultation on areas needing improvement.

Also, VA is utilizing community providers to provide mental health services through the non-VA Medical Care Program. As part of the President's Executive Order, VA is in the process of establishing 15 pilot programs to support improving access to care. In addition, VA will continue to monitor access and wait times to ensure continual improvement in access going forward.

2. How is VA working to better accommodate veterans who have transitioned into the civilian world and all the new responsibilities they must deal with while trying to seek the health care?

VA Response:

In order to expand the number of providers available beyond traditional business hours, VHA released a directive on January 9, 2013, on "Extended Hours Access for Veterans Requiring Primary Care Including Women's Health and Mental Health Services at Department of Veterans Affairs (VA) Medical Centers and Selected Community-Based Outpatient Clinics." This increases VA's commitment to offering appointments during evenings or weekends. Benchmarks are currently being set to ensure implementation of this directive across the VA system.

Integrating mental health care into primary care settings is a critical element of increasing the availability of mental health care for Veterans. VA's Primary Care-Mental Health Integration programs combine co-located collaborative care and care management (often by telephone) to support primary care providers in treating common mental health conditions within the primary care setting. Through the first quarter of FY 2013, 88 percent of VA medical centers and COBCs classified as large

and very large have integrated behavioral health programs, and 6.3 percent of all primary care patients at these sites were directly served by these programs.

As part of the Department of Defense (DoD)/VA Integrated Mental Health Strategy, VA and DoD are collaborating on the development of Web-based self-help resources for common issues experienced by Veterans after they have transitioned into the civilian world. These programs allow for 24-hour, anonymous, self-paced access and can be used by Veterans on their own or in conjunction with mental health treatment. In November 2012, the Moving Forward program was launched online (www.startmovingforward.org). Moving Forward is an educational, life-coaching program for individuals who are having problems, but are not yet in need of or willing to engage in mental health treatment. The program is based on the principles of Problem Solving Therapy, an evidenced-based cognitive behavioral treatment for depression and other distress. The Moving Forward Web course uses highly interactive, multi-media presentations to teach problem-solving skills through text, videos, exercises and games. The second course, Parenting for Servicemembers and Veterans, is in the final stages of development and will be launched in FY 2013. It is a free online course that will provide Military and Veteran parents with tools to help them reconnect with their families and build closer relationships with their children. Using stories from real Veteran and Military families, videos, interactive activities, and original curriculum developed by leading experts, this Web-based course is intended to help parents learn how to address both everyday parenting problems and family issues unique to their military experience.

In addition to innovative Web-based approaches, VA and DoD are collaborating on mobile applications for smartphones and tablet computers to enhance access to mental health information and care for Veterans and Servicemembers. For example, VA and DoD jointly launched the PTSD Coach smartphone application in April 2011. As of March 1, 2013, the PTSD Coach application has been downloaded more than 100,000 times in 74 countries. PTSD Coach helps users track their PTSD symptoms, links them with public and personalized sources of support, provides accurate information about PTSD, and teaches helpful strategies for managing PTSD symptoms. PE Coach, another joint VA/DoD mobile application, guides and facilitates evidence-based PE treatment for PTSD. The application is designed to be installed onto a patient's personal phone, brought into therapy sessions, and used during and between treatment sessions. The application includes the ability to audio record the therapy session (as required by the treatment protocol) directly onto the patient's phone, removing the typical logistical challenges associated with audio recording in the past. The application also delivers text-based psychoeducational handouts as multi-media experiences; provides all patient homework in a digital format; utilizes an interactive breathing retraining tool to improve learning and rehearsal of the PE relaxation skill; provides clinicians with the ability to review compliance with PE protocol homework based on patient's actual use of the various components of the PE Coach application; integrates phone calendar functionality with the PE Coach application to increase the likelihood of patient recall and attendance of PE therapy sessions; tracks a patient's self-reported symptoms and subjective distress over time; and, display outcomes for convenient review of progress. These technological approaches are designed to ensure availability of mental health information and facilitate meaningful participation in mental health interventions in ways that are more convenient and accessible to the Veteran.

Questions From: Hon. Michael Michaud, Ranking Minority Member, To: Department of Veterans Affairs

1. As you heard in my opening statement, mental health is a significant problem that faces the nation, not just veterans or the VA. We have been told that shortages in mental health clinicians are affecting health care systems across the nation. I imagine that difficulty in finding qualified providers is most acute in the rural and highly rural areas.

a. What have you done to work on a more collaborative basis with other Federal agencies to implement programs that will grow the numbers of qualified mental health providers?

2. The President's Executive Order required VA and HHS to work together to establish 15 pilot projects with community based providers, such as community mental health clinics, health centers, substance abuse treatment facilities and rural health clinics.

a. Have these pilot sites been established?

b. Where are they located?

c. How were the locations of the pilot sites determined?

3. The President's Executive Order required VA to hire and train 800 peer to peer counselors by December 31, 2013.

a. Please provide us with an update on how many you have hired, where they have been placed, and a brief description of the training that VA will be providing to these new counselors.

4. Considerable concern has been voiced about the lack of transitional services between the Department of Defense and VA, especially as it relates to mental health and those on active duty who are evidencing heightened risk of mental health issues. In testimony, Dr. Rudd from the first panel stated that he is convinced that the bulk of the problem is not a clinical one. He said we have to do a better job of managing those at risk, providing easy and frequent access to care, and convincing veterans to stay in care.

a. What are VA and DoD doing to work together to ensure that those transitioning with mental health issues are not falling through the cracks? Are we getting communities involved early in the process?

b. Is there something similar to a "warm handoff" that servicemembers who are severely disabled experience?

c. If not, are we working toward that goal?

5. It is my understanding that VA now has Memorandums of Understanding with all 50 States to share suicide data and that the Suicide Data Report recently released by VA now includes State veteran data which is a big step forward. However in this report many States are not included, which limits the report somewhat. Could you please tell the Committee:

a. What States are not included in the data?

b. What are the barriers or reasons why some States did not participate?

c. Has VA reached out and made a good faith effort to get these States to participate?

d. Moving forward how is VA planning to improve data collection?

6. I understand that since March VA has an additional 1150 mental health clinical providers on board. I also understand that in addition to the new hires of 1600 clinical and 300 administrative, VA continues to fill existing and projected mental health vacancies within the VA system.

a. What is VA's combined goal of new and existing vacancy hires?

b. Do you have a projected number of mental health clinicians that will be on board and providng services to veterans?

c. Please provide an update on the total number of additional mental health staff hired to-date, broken down by occupation, status (whether full-time, part-time, clinical, administrative, other, or a combination), Veterans Integrated Service Network (VISN) and veteran status.

7. VA has reported that they need to substantially increase the number of mental health trainees exposed to VA in their training years by increasing the number of clinical training positions in mental health to include nursing, pharmacy, psychology, psychiatry, and social work for the 2013–14 academic year.

a. How is VA progressing with this increase in training positions?

b. What are the difficulties VA encounters when trying to recruit residents who have not been exposed to VA?

c. Please provide a breakdown by discipline and number of positions of the increase.

d. Have these positions been allocated throughout the VA health care system?

8. There is concern in the community that veterans may not be getting the kind of mental health care they need or the appropriate intensity of care. Wounded Warrior Project conducted a survey of over 13,000 alumni, over a third of respondents reported difficulties in accessing effective mental health care. Reasons given were inconsistent treatments (e.g. canceled appointments, switch of providers, lapses in between sessions, etc..) and not being comfortable with existing resources.

a. Please provide a copy of the survey.

9. VHA policy requires all first-time patients referred to or requesting mental health services receive an initial evaluation within 24 hours and a more comprehensive diagnostic and treatment planning evaluation within 14 days. The primary goal of the initial 24 hour evaluation is to identify patients with urgent care needs and to trigger hospitalization or the immediate initiation of outpatient care when needed.

a. Can you tell us what percentage of first-time patients are actually identified as needing urgent care or hospitalization?

10. Please provide a copy of the mental health performance requirements for all mental health settings.

Questions From: Congresswoman Julia Brownley, Ranking Minority Member, Subcommittee on Health, Veterans Affairs, and Congressman Waxman, To: the Department of Veterans Affairs

1. Mental Health Staffing

a. How many full-time mental health professionals have been hired at each of the following facilities since January 1, 2012: the Oxnard CBOC, Ventura Vet Center, and West LA VA?

b. How many part-time mental health professionals have been hired at the Oxnard CBOC, Ventura Vet Center, and West LA VA over that time period?

c. Please identify the program to which each full time and part time mental health professional has been assigned.

2. Mental Health Funding

a. Please identify the funding levels for mental health services at the Oxnard CBOC, Ventura Vet Center, and West LA VA for FY12 and FY 13.

b. Please include a detailed description of how those funds are allocated across the Oxnard CBOC, Ventura Vet Center, and West LA VA programs.

3. Social Worker Staffing

a. How many social workers have been hired at the Oxnard CBOC, Ventura Vet Center, and West LA VA HUD–VASH programs since January 1, 2012?

b. Has the VA met its set goal for the ratio between social workers and veterans?

c. How many additional social workers need to be hired to meet the ratio the VA set as a goal?

4. Waiting Times

a. What is the current average waiting time for veterans to receive mental health screenings and services at the Oxnard CBOC, Ventura Vet Center, and West LA VA?

b. What is the average waiting time over the past 6 months?

c. What the median waiting time over that period?

d. What is the range of waiting times over that period?

e. If the Oxnard CBOC, Ventura Vet Center, and West LA VA do not track this data on waiting times please provide an explanation of why they do not.

5. What changes in the treatment of mental health does the VA plan to implement at the Oxnard CBOC, Ventura Vet Center, and West LA VA during FY13?

6. What transportation options are available for veterans traveling from Ventura County, and outlying areas of LA County, to the West LA VA for medical treatment?

a. Does the VA provide door-to-door bus or vanpool service for veterans?

b. Are veterans expected to find their own means of transportation?

c. If so, does the VA reimburse veterans for the cost of private or public transportation?

7. Does the Department of Veterans Affairs have in place a pipeline system for identifying and recruiting qualified mental health professionals from colleges and universities across the country?

a. How does the VA conduct outreach to mental health professionals for recruiting purposes?

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