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VA MENTAL HEALTH CARE: CLOSING THE GAPS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

JULY 14, 2011

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VA MENTAL HEALTH CARE: CLOSING THE GAPS

THURSDAY, JULY 14, 2011

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:02 a.m., in room 418, Russell Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Begich, Burr, and Brown of Massachusetts.

OPENING STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning and welcome to today's hearing on how we can close the gaps in mental health care for our Nation's veterans.

We all know that going to war has a profound impact on those who serve. And after more than 8 years of war, in which many of our troops have been called up for deployments again and again, it is very clear that the fighting overseas has taken a tremendous toll and one that will be with us for years to come.

More than one-third of veterans returning from Iraq and Afghanistan who have enrolled in VA care have Post Traumatic Stress Disorder. An average of 18 veterans kill themselves every day. In fact, the difficult truth is that somewhere in this country, while we hold this hearing today, it is likely that a veteran will take his or her own life.

Last week, the President reversed a longstanding policy and started writing condolence letters to the family members of servicemembers who commit suicide in combat zones. This decision is one more acknowledgment of the very serious psychological wounds that have been created by the wars in Iraq and Afghanistan and an effort to reduce the stigma around the invisible wounds of war. But clearly much more needs to be done.

In the face of thousands of veterans committing suicide every year, and many more struggling to deal with various mental health issues, it is critically important that we do everything we can to make mental health care more accessible, timely, and impactful.

In fact, according to data VA released just yesterday, more than 202,000 Iraq and Afghanistan veterans have been seen for potential PTSD at VA facilities through March 31, 2011. This is an increase of 10,000 veterans from the last quarterly report. Any vet-

eran who needs mental health services must be able to get that care rapidly and as close to home as possible.

Over the years, VA has made great strides in improving mental health services for veterans. But there are still many gaps.

As many of you know, just this past May, the 9th Circuit Court of Appeals issued an opinion that called attention to many of these gaps in mental health care for veterans. And while that ruling has gotten the lion's share of attention, it is one of far too many warning signs.

Today, we will hear from the Inspector General about ongoing problems with delays in receiving health care for those veterans suffering from the invisible wounds of war, like PTSD.

In one report, published just this week by the IG, several mental health clinics at the Atlanta VA were found to have unacceptably high patient wait times. The report shows that facility managers were aware of long wait lists for mental health care, but were slow to respond to the problem. The report also called into question the adequacy of VA's performance measurements for mental health access times across the entire system.

And as the IG noted, the VA only tracks the time it takes for new patients to get their first appointment. That means that since the VA is not tracking the timeliness of second, third, or additional appointments, facilities can artificially inflate their compliance with mental health access times. That is unacceptable, and it has to change.

In another report on veterans in residential mental health care, the IG found that an unacceptable number of veterans were not contacted by VA between the time they were accepted and the beginning of the program, and that staffing levels for mental health workers fell short of VA guidelines.

GAO has also recently published a report on sexual assault complaints in VA mental health units that found many of these assaults were not reported to senior VA officials or the Inspector General. VA clinicians also expressed concern about referring women veterans to inpatient mental health units because they did not think the facilities had adequate safety measures in place to protect these women.

And just 2 weeks ago GAO issued a report that found the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury cannot adequately account for tens of millions of dollars it spent to improve treatments for the invisible wounds of war.

Taken together, these reports show very clearly that there is significant work to do to improve mental health care outreach and treatment.

One way to fill in these gaps, to overcome the stigma associated with mental health care and to eliminate wait times is to provide primary and mental health care at the same visit.

In the hearing today, we will hear from Providence Health and Services, which was recently recognized as one of the five most integrated health systems in the country, about how they have integrated mental health services into their medical home. I believe we need to look to Providence and those VA programs that work for guidance on making real progress.

Through its suicide hotline, VA has reached many veterans who might have otherwise taken their own lives. Each life saved is a tremendous victory, and we should celebrate those with the VA. But we also have to recognize that these are veterans who reached out to VA.

We want to hear about how VA is reaching out to veterans and how easy or hard it is for veterans to access the care they earned through their service to this country. As we will hear today, despite VA's best efforts, veterans continue to experience problems when they reach out to the VA for mental health care.

I have heard from veterans who have walked into VA clinics and asked to be seen by a mental health provider, only to be told to call a 1–800 number. I have heard from VA doctors who have told me VA does not have enough staff to take care of the mental health needs of veterans. And I have heard from veterans' families, who have seen first-hand what effects untreated mental illness can have on the family. We are here today to see that that ends.

I am looking forward to hearing from all of our witnesses today.

And I hope it helps us to better understand these issues and to address them so that our veterans can receive the timely, quality care they earned through their service.

With that opening statement, I do want to take a moment to publicly express my deepest condolences to my friend, Senator Burr, on the recent loss of his father. I know that Dr. David Burr was a Navy veteran, who left Princeton to enlist back in 1942 and served in the Pacific Theater in a frogman unit. He served more than 25 years as a pastor in Winston-Salem.

Senator Burr and I are both children of World War II veterans. So, I know that his father's experience and example are what makes Senator Burr so dedicated to the veteran's issues that come before this Committee.

Senator Burr, all of our thoughts and prayers are with you and your family at this difficult time, and I appreciate you being here today.

Senator BURR. Thank you.

Chairman MURRAY. With that, I will turn it over to Senator Burr for his opening statements.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Madam Chairman, and good morning. And I can assure all that when you have the opportunity to live to the age of 90, you have not been cheated relative to the length of time on this earth, and my dad was certainly blessed and is blessed today.

I want to particularly welcome Mr. Williams; Sergeant Sawyer and his wife Andrea. And I want to thank you for your willingness to come and to share your experiences firsthand with him. I know many of which are probably a little painful to recount.

As Members of the Committee, it is important that we have an opportunity to hear firsthand from veterans and their caregivers about their personal experiences in seeking mental health services through the VA.

Back in May, as the Chairman said, the U.S. Court of Appeals for the 9th Circuit issued a scathing decision addressing delays in providing VA mental health care to our Nation's veterans. While I do not intend to comment on the merits of the ongoing litigation, I do believe that it is worth our time to look into the issues raised in the case to ensure that veterans receive the care they deserve and have earned in a timely fashion.

As I have said before, early intervention offers the best hope for improvement and recovery from PTSD, depression, and substance-abuse disorders.

Madam Chairman, it appears that early intervention continues to be challenging within VA. According to the IG statement, even veterans who sought help and were accepted into the mental health program ended up waiting for the actual services. This is unconscionable.

This Committee has worked aggressively over the years, through oversight hearings such as the one we are holding today, to improve the health care for our veterans and reduce the barriers preventing veterans and servicemembers from seeking mental health services.

For example, this is the third hearing in 4 years conducting oversight examining the gaps that exist in VA's mental health care program. And yet, gauging from testimony we will hear from the first panel, there is still a tremendous amount of work that has to be done.

It is troublesome to learn of the issues both Mr. Williams and Mr. Sawyer encountered in seeking care from VA. Both encountered problems finding someone at VA to listen to what they needed, more importantly, what they wanted from the standpoint of their treatment. Their experiences lead me to ask, where is the veteran in the Department of Veterans Affairs policies? How does VA's policy include the veteran when putting together a treatment plan?

I look forward to hearing VA's testimony. I am particularly interested in learning how VA is working to address the issues raised by this first panel and the recommendations made by the IG reports.

I thank you, Madam Chairman.

Chairman MURRAY. Thank you very much.

Senator Begich, we will turn to you for an opening statement.

STATEMENT OF HON. MARK BEGICH, U.S. SENATOR FROM ALASKA

Senator BEGICH. Madam Chair, because of limited time that I will have here, I will hold, and I really want to hear the testimony that folks have. I do have a list of questions that I will submit for the record, specifically about some work the VA is doing with regard to mental health services in Alaska and the coordination that is going on there.

So, I will hold there, especially around some of our hospital work with Providence Hospital. So I will hold, and I want to hear their testimony.

Chairman MURRAY. Very good.

Senator Brown, your opening statement.

STATEMENT OF HON. SCOTT BROWN, U.S. SENATOR FROM MASSACHUSETTS

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair. The same as Senator Begich; I would like to hear the witness testimony. I appreciate your holding this hearing, and I concur with Senator Burr, you know, concering the veteran. I hear these stories all the time, and I would like some answers. So, thank you.

Chairman MURRAY. Thank you. At this time then we will turn to welcome our first panel of witnesses. I very much appreciate all of you being here today and sharing your information. We are going to hear first from Daniel Williams. He is a veteran representing the National Alliance on Mental Illness.

Next we will hear from Andrea Sawyer. She is a caregiver and a spouse representing Wounded Warrior Project, and I would also like to welcome her husband Loyd Sawyer, who is here with us in the audience today. He is truly one of America's heroes, and we want to thank him for his service and all of your family.

We will then hear from David Underriner with Providence Health and Services in Oregon, and finally, we will hear from Dr. David Daigh from the VA's Office of Inspector General. He is accompanied today by Dr. Michael Shepherd.

Mr. Williams, with that, we will begin with you and thank you so much for joining us today.

STATEMENT OF DANIEL WILLIAMS, VETERANS COUNCIL REPRESENTATIVE FOR THE NATIONAL ALLIANCE ON MENTAL ILLNESS, ALABAMA

Mr. WILLIAMS. Thank you, Madam Chairman, Ranking Member Burr, and Members of the Committee, on behalf of the National Alliance on Mental Illness, NAMI, thank you for inviting me to speak before you all today and give my testimony.

The VA mental health program is a program that I have been in since 2007, from the time that I was put out of the service. Earlier this week, NAMI's national office submitted my official statement for the record of this hearing. The statement contains additional information and the comments about NAMI and our priorities and recommendations.

Madam Chairman, I was asked to appear at this hearing to tell you about the journey of my life since 2003 to 2004, I am sorry, to 2007. In 2003 to 2004, I was in the Army. I served as a biochemist. I was deployed to Iraq in 2003, was deployed with the 4th Infantry Division out of Fort Hood, Texas.

During that combat deployment, I suffered mental and physical injuries that will forever be part of my life. I was exposed to an improvised explosive device that injured my body, my brain, and my mind.

I received a Traumatic Brain Injury, TBI, but I believe that the most severe of my injuries is the Post Traumatic Stress Disorder, PTSD, an invisible injury that no one else can see, but it haunts my every move.

From the moment I got injured until the time that I was honorably discharged, I received very little help from the Army or even acknowledgment of my mental health state.

I went to the base clinic at Fort Hood, TX, where I was told that I was having an anxiety disorder and readjustment issues. But I would need to wait 6 months before I could get an appointment with a psychiatrist, just an initial appointment, to be looked at.

In the winter of 2004, after receiving no help or any hope of help, I attempted suicide by putting a 45 caliber pistol in my mouth while I was locked in a bathroom. My ex- wife begged me to let her in, but I would not agree.

She called the police. When they arrived, I argued with them. Then they kicked down the door, and at that time I pulled the trigger. By the grace of God, the weapon did not go off.

The officer handcuffed me and put me in the seat in the back of his police car. One of the offices attempted to clear the weapon, but at that moment the weapon went off. The same round that refused to kill me went off perfectly for him. Thankfully no one was injured.

I was admitted to the psychiatric ward of the base hospital and remained an inpatient for 2 weeks. At this time I was diagnosed with readjustment anxiety disorder, but the physicians also acknowledge that I had PTSD. I was told by the doctors that the treatment record would be kept confidential, and it was not.

It took me over a year to be able to be put out of the military service because of my mental illness. I was introduced to the DAV, Disabled American Veterans, which handled my claims, taking me from the service to the VA. I was never contacted by the VA, only by the DAV.

When I first went to the VA medical center in Birmingham, Alabama in 2007, I felt lost and had no guidance. With the drain of PTSD, I wanted to give up. I had to wait for hours just to see a doctor.

This was unacceptable, not only to me but to watch other veterans having the same issue; and honestly the small little things were there that I could not handle, the smells, the sights, the sounds, the crowds. These things made my condition worse. I had to relive this pain over and over every time I went to the VA.

I recently went to the VA, 2 days ago, and was told I could have my appointment rescheduled because I was coming here to speak and was not going to be able to make my appointment. My appointment was going to be put off for 4 months.

That is not acceptable by any standard, and I am sorry that not only I have to go through this but my fellow soldiers and servicemembers do.

There is many different issues that need to be changed in the VA system. Can these all be changed in 1 day? No, they cannot. But there are the small things that need to be looked at that are very huge issues to us.

The time of care that we have for an appointment is very slow to the point that it is almost, it is a crawl. There needs to be more community services to be able to reach out to in the community to help the veteran through the process of the VA system because the VA system makes you want to give up and try something else.

Madam Chairman, the VA system has its flaws and has its perks. There is an OEF/OIF transition team that handled my care, that helps me with my appointments that does try to help me

through these times, but it is not always successful, not because of their efforts, because of the non-efforts on behalf of the VA.

The VA has many resources open to them very freely but yet they stay in close knit with themselves and will not reach out to the local and national people that are out there and organizations that can help them make this a less difficult transition not only from a soldier but to a civilian again.

Servicemen and women are taught to be soldiers through the service. We are not taught how to be civilians again; and once we are put out, we are left out to hang dry.

I am asking that this Committee look at the possibility of having a peer movement in the VA facility, that the peers, a person like myself or others that have been through the same thing, that know the system, that know the people to talk to to help them through it because otherwise we are going to lose more than 16 people a day to suicides.

We have got to take action now and not tomorrow. And I thank you. Madam Chairman, this concludes my statement and I will be pleased to answer any questions from other Members of the Committee.

[The prepared statement of Mr. Williams follows:]

PREPARED STATEMENT OF DANIEL WILLIAMS, U.S. ARMY COMBAT VETERAN, RESIDENT OF HOMEWOOD, ALABAMA, MEMBER, NATIONAL ALLIANCE ON MENTAL ILLNESS (NAMI)

Chairman Murray, Ranking Member Burr, and Members of the Committee: On behalf of the National Alliance on Mental Illness (NAMI), please accept NAMI's collective thanks for this opportunity for me to provide testimony at today's oversight hearing to assess the Department of Veterans Affairs' (VA) mental health programs.

INTRODUCTION

NAMI is the Nation's largest grassroots consumer organization dedicated to improving the lives of individuals and families affected by mental illness. Through NAMI's 1,100 chapters and affiliates in all 50 states NAMI supports education, outreach, advocacy and research on behalf of persons with schizophrenia, bipolar disorder, major depression, severe anxiety disorders, Post Traumatic Stress Disorder (PTSD), and other chronic mental illnesses that affect both adults and children. In my opinion what NAMI does best as an organization is to advocate for, train and educate family members of persons living with mental illness. In recent years NAMI began to realize that the lives of our newest veterans and the experiences that they've had while serving our country in combat necessitate not only that they receive post-deployment services essential to get well afterward, but also that their families have needs that must be addressed to ensure that a family recovers from the experience.

NAMI is very proud that the VA has recognized that NAMI can play an important role within VA mental health in helping families of veterans cope with, and recover from, mental illness, whether acute or chronic. One NAMI signature program in particular, Family-to-Family, is designed to meet the needs of family members who have questions relative to what their loved one—the veteran home from deployment in war—is experiencing, not only from the standpoint of what the illness is, but the treatment protocol, the various medications and prognosis, and what they can expect in supporting and caring for their loved one in gaining the ultimate goal of recovery.

MY STORY

Madam Chairman, I was asked to appear at this hearing to tell you about the journey of my life since 2003 to the present day. In 2003 and 2004 as an Army infantryman I was deployed to Iraq with 4th Infantry Division based at Fort Hood, Texas. During my deployment to Iraq I suffered mental and physical injuries that will forever be a part of my life. I was exposed to a detonated improvised explosive device (IED) that injured my body and my mind. I received a Traumatic Brain In-

jury (TBI) immediately, but I believe the most severe of these injuries is my Post Traumatic Stress Disorder (PTSD)—an invisible injury that no one can see but it haunts my every move.

From the moment I got injured until the time that I was honorably discharged from the Army, I received very little help from the Army, or even an acknowledgement of my mental state. I went to the base clinic at Ft. Hood where I was told that I was having anxiety and readjustment issues but that I would need to wait six months before I could get an appointment with a psychiatrist. In the winter of 2004 after receiving no help or hope of help I attempted suicide by shoving a .45 caliber pistol in my mouth while I was locked in the bathroom. My wife Carol begged me to let her in but when I wouldn't agree, she called the police. When the police arrived I argued with them. When they kicked open the door I pulled the trigger, but by the grace of God the weapon misfired. The officers handcuffed me and seated me in the back of the police car. One of the officers attempted to clear my weapon, but at the moment he did so, the same round that refused to kill me went off perfectly for him. Thankfully, no one was injured.

I was admitted to the psychiatric ward of the base hospital and remained an inpatient for two weeks. At this time I was formally diagnosed with readjustment and anxiety disorders, but my physicians also acknowledged that I had PTSD. I was told by the doctors that my treatment records would be kept confidential. However, my platoon sergeant was notified and she then proceeded to tell my fellow soldiers which in turn caused much heartache and turmoil for these guys with whom I had gone through war and had shed blood, sweat and tears. They began to look down on me, because in their eyes, I was weak and they thought that I would not be able to do my job, nor could they trust me to go back to war with them if we were called to do so.

I think that there needs to be more punishment for non-commissioned officers or any other soldier who has access to soldier's private mental health records and does not keep that information confidential. As in the past and still today, if a soldier has a mental health issue and fellow soldiers learn about it, then confidence is broken and military careers unquestionably are harmed. It took over a year for me to receive my medical evaluation board decision, and during that entire period I felt the effects of almost daily ridicule from members of my unit, a great pressure that affected my PTSD. I felt I let my soldiers down—that I was of no use to them anymore. I had lost my brotherhood. When I was finally discharged from the Army, I was diagnosed as having an anxiety disorder. In clearing the post prior to being released, I met with the Disabled American Veterans (DAV) representative who told me about the VA system and the entitlements that were available to me. That DAV representative assisted me in filing my claim for disability. I am grateful for the help of the DAV.

When I first went to the VA in Birmingham, Alabama in 2007, I felt lost and had no guidance. With the drain of PTSD, I wanted to give up due to it being so difficult. I had to wait for hours just to see a doctor, then also wait in lines to do anything at the VA while constantly hearing and seeing on the televisions while sitting in the waiting rooms the war and bad news of soldiers being injured and killed. I wanted to run and hide so I could be safe. At one point I was put on an OIF/OEF transition team but then was removed from it because I was told I did not have a high-enough disability rating. Honestly, I couldn't handle the smell of that hospital, the crowds and VA's decision to assign me a doctor of Middle Eastern origin. I requested another doctor at the Huntsville, Alabama VA community-based outpatient clinic. There, I enjoyed my regular MD but the psychiatric doctor was a nightmare. Her recommendation was for me to go to the Tuscaloosa VA Medical Center for inpatient treatment, which would have included shock treatments to reset my brain. I did not want to do this, so I discussed this with my wife and we both agreed that we would try psychotherapy for a while to see if there could be some improvement.

After many sessions with my therapist, however, I could feel myself getting worse, not better. I began avoiding my wife and my family. I couldn't keep myself from crying, and I locked myself into my bedroom. The therapy was not working. My wife would come home from work not knowing what I had been going through, but she could see that I was despondent. I explained that I couldn't talk to my therapist, that she didn't listen to me, she just threw another pill at me, and I felt like I was getting worse, not better. I asked her to go to the therapist with me to see what I was talking about. She did, and she saw what I saw.

My wife then proceeded to call the local VA helpline and explain what was happening, but still there was not much help available through that means. Therefore, my wife and I returned to the Birmingham VA for help. We argued loudly with the receptionist in the psychiatric unit to try to get better services for me. The VA police

officers stationed on that unit heard our argument and came to investigate. At that critical moment when I felt I was in jeopardy, we met Dr. Ryan. With the help of my wife, we explained to him my struggles with the VA, my PTSD, and with my overall health, and for the first time a doctor actually listened to us. Dr. Ryan is still is my psychiatric doctor of medications and also he keeps up with my overall psychology. A wonderful doctor he is. Dr. Ryan arranged for me to see a therapist weekly, ensured that I had proper medications, was assigned to support groups and was able to take classes. Later I met with the local recovery coordinator. Since that time I was asked to serve on the medical center's veterans' mental health council, an activity VA initiated to give veterans a voice to help make the local VA system better for mental health.

MORE OUTREACH TO VETERANS IS NEEDED

It's important for people, veterans and non-veterans, to realize that there are different types, causes and levels of mental illness, and that the most important thing they can do if they think they have problems is to step forward and talk to a mental health professional to find out, even when barriers are in the way. My experience also teaches that veterans need to advocate for themselves, because going to the VA can be a difficult experience.

I believe that the VA must do a better job of reaching out and making its services known to a larger share of the veteran population (both those recently discharged-demobilized and older generations), and work more cooperatively with the military service branches, other Federal agencies, state governments, and private mental health providers. Today, we have over 23 million living veterans, yet VA sees only a quarter of them in its health care programs, and even a smaller fraction in its mental health services. Given our experience to date in the wars in Afghanistan and Iraq, plus the overlay of combat experiences of prior generations of veterans, it is obvious that more veterans need readjustment and mental health counseling and other mental health services than those who are appearing at VA facilities to seek these services.

NAMI deeply appreciates the existence of 273–TALK, the nationwide suicide hotline. NAMI's national office has commended VA's Office of Mental Health Services and SAMHSA for having established this vital link to VA counselors, who have saved the lives of thousands of veterans, but we believe a larger group of veterans still is in need and is not being reached.

NAMI NATIONAL VETERANS COUNCIL

Despite our concerns about the need for broader outreach, not only to prevent suicides but to ensure that more veterans can become aware of VA services, NAMI has enjoyed a long-term interest and involvement in mental health programs within the VA. For 30 years NAMI has served as an advocate for veterans under care in VA programs, because VA is caring for our family members. NAMI and its veteran members formally established a Veterans Council in 2004 to assure close attention is paid to mental health issues and policies in the VA, especially within each Veterans Integrated Services Network (VISN) and programs at individual VA facilities. Council membership includes veterans who live with serious mental illness, family members of these veterans, and other NAMI supporters with an involvement and interest in the issues that affect veterans living with and recovering from mental illness. The Council members serve as NAMI liaisons with their VISNs; provide outreach to veterans through local and regional veterans service organization chapters and posts; increase Congressional awareness of the special circumstances and challenges of serious mental illness in the veteran population; and work closely with NAMI's State and affiliate offices on issues affecting veterans and their families. Currently, NAMI's national board of directors is engaging in a comprehensive policy review of the role of the Veterans Council with the expectation of strengthening the council's involvement with both VA and the Department of Defense.

NAMI FAMILY TO FAMILY EDUCATION PROGRAM

Our members are directly involved in consumer councils at more than growing number of VA medical centers and we advocate for even more councils to be established throughout the VA system. Also, VA and NAMI executed an important memorandum of understanding in 2007 formally establishing our signature *Family to Family* education program within VA facilities. As I mentioned above, *Family to Family* is a formal twelve-week NAMI educational program that enables families living with mental illness to learn how to cope with and better understand it. The program provides current information about schizophrenia, major depression, bipolar disorder (manic depressive illness), Post Traumatic Stress Disorder (PTSD),

panic disorder, obsessive-compulsive disorder, borderline personality disorder, co-occurring brain disorders and addictive disorders, to family members of veterans suffering from these challenges. *Family to Family* supplies up-to-date information about medications, side effects, and strategies for medication adherence. During these sessions participants learn about current research related to the biology of brain disorders and the evidence-based, and most effective, treatments to promote recovery from them.

Family members of veterans living with mental illness gain empathy by understanding the subjective, lived experience of a person with mental illness, and *Family to Family* has recently been attested as an evidence-based practice in a journal of the American Psychiatric Association. Our *Family to Family* volunteer teachers provide learning in special workshops for problem solving, listening, and communication techniques. They provide proven methods of acquiring strategies for handling crises and relapse. Also, *Family to Family* focuses on care for the caregiver, and how caregivers can cope with worry, stress, and the emotional overload that attends mental illness in families. We at NAMI are very proud of *Family to Family*, and we were especially pleased that Under Secretary for Health Dr. Robert Petzel approved a renewal of our *Family to Family* agreement. We greatly appreciate that support and confidence and look forward to widespread adoption of *Family to Family* programs in VA treatment settings.

The *Family to Family* education program has been a great success to date, functioning and growing in more than 100 VA medical centers. We at NAMI are hoping to continue building on that success, and hope to introduce to VA more of NAMI's signature programs, such as our Peer to Peer and NAMI Connections programs. We believe veterans and their families could greatly benefit from these programs.

NAMI AND VA: PARTNERS IN RECOVERY

Mr. Chairman, as you can see from some of these examples, and from my own experience, NAMI is deeply concerned about the newest generation of repatriated war veterans, whether they remain on active duty, serve in the Guard or Reserves, or return to civilian life following service. We want to see the Department of Veterans Affairs take a more leading role in coordinating both inter-governmental and public-private arrangements that would do a better job at outreach, screening, education, counseling and care of the veterans who fought and are still fighting these wars, and to help their families recover from these experiences. NAMI is committed to recovery, whether from transitional readjustment problems coming to a family that welcomes an Army or Marine infantryman back from war, or one dealing with chronic schizophrenia in a young adult who never served in the military. In the case of our professional military services, we want to ensure that those serving in the regular force are well cared for by DOD when they return to their duty stations after combat deployments; by both DOD and VA for those in the National Guard or Reserve components when they return to garrison in their armories; and, by VA for those who become veterans on completion of their military service obligations and return to their families—whether in urban or rural areas.

INTERGOVERNMENTAL AND PUBLIC-PRIVATE SOLUTIONS ARE ESSENTIAL

NAMI believes many tailored approaches will need to be made for these new veterans, but that all of the civilian efforts should be led by VA, in coordination with other agencies (including DOD, SAMHSA, the Public Health Service and the Indian Health Service), the National Guard Bureau, State Guard leaderships, and the leaders of State public mental health agencies, as appropriate to the need. In some cases, private mental health providers should be enlisted and coordinated by VA to ensure they can provide the quality of care veterans may need, and are trained to do so in the case of Post Traumatic Stress Disorder and other disorders consequent to combat exposure and military trauma, including military sexual trauma. We realize that finding qualified private mental health providers in highly rural areas is an extreme challenge and will require VA and other public agencies to be creative. Nevertheless, we believe these unmet needs can be dealt with if VA establishes a firm will to do so. We note in VA's Office of Rural Health a number of inter-governmental pilot programs are beginning to take hold in rural areas, in VA's effort to reach out to National Guard, Reserve and Native American veterans who live far from VA facilities. NAMI applauds this progress, and we hope these pilot projects can set a pattern for additional initiatives of outreach and care.

VETERANS' COURTS—A CRUCIAL NEED

NAMI also urges this Committee and other relevant groups in Washington and in state capitals, to expand the establishment of diversionary courts for veterans.

In the few instances where veterans courts exist, they have become effective tools to get veterans who are struggling with mental illnesses the help that they need. NAMI urges the Committee to support the development of diversionary courts for veterans, and especially combat veterans, and to make sure that VA reaches out and coordinates with the existing courts systems in cities and States to ensure post-deployment combat veterans receive the most timely and effective care possible, rather than allowing sick and disabled veterans suffering with mental illnesses consequent to their war service to be convicted of crimes and sent to jail or prison. These veterans need care, not confinement.

Mr. Chairman, the National Alliance on Mental Illness is committed to supporting VA efforts to improve and expand mental health care programs and services for veterans living with serious mental illness. For a time, forward motion was stalled on VA's "National Mental Health Strategic Plan," to reform its mental health programs—a plan that NAMI helped develop and fully endorses. NAMI wants to see VA stay on track to provide improved access to mental health services to veterans returning from Iraq and Afghanistan today, as well as to other veterans diagnosed with serious mental illness—all important initiatives within the VA strategic plan. Three years ago VA established a "Uniform Mental Health Service" benefits package, one that NAMI supports as beneficial to ensuring VA progress toward full implementation, and will provide help to the newest war veteran generation and all veterans who live with mental illness. We hope the Committee will through oversight spur VA forward in implementing and perfecting this reform.

Finally, NAMI is an endorser organization of the *Independent Budget* for Fiscal Year 2012. In that budget and policy statement, AMVETS, Disabled American Veterans, Paralyzed Veterans of America and Veterans of Foreign Wars of the United States recommend a series of good ideas that, if implemented would further improve VA's mental health programs. I ask the Committee to consider these recommendations and to ensure, whether through oversight or legislation that VA (and the Department of Defense in some instances) carries out the intent and spirit of these recommendations.

This concludes my testimony on behalf of NAMI, and I thank you for the opportunity. I would be happy to answer questions from you and other Members of the Committee.

POSTHEARING QUESTION SUBMITTED BY HON. MARK BEGICH TO DANIEL WILLIAMS, VETERANS COUNCIL REPRESENTATIVE FOR NATIONAL ALLIANCE ON MENTAL ILLNESS, ALABAMA

Question 1. You focused your prepared testimony on the difficulties you had in finding the proper care and provider to meet your needs. Based on your working knowledge of the system, what existing gap do you see that must be fixed?

[Responses were not received within the Committee's timeframe for publication.]

Chairman MURRAY. Thank you very much, Mr. Williams, for your very compelling testimony and your courage to be here today and for all the work you do for others to make a difference in their lives. Thank you.

Mrs. Sawyer.

STATEMENT OF MRS. ANDREA SAWYER, CAREGIVER AND SPOUSE OF U.S. ARMY SERGEANT LOYD SAWYER

Ms. SAWYER. Chairman Murray, Ranking Member Burr, and Members of the Committee, my name is Andrea Sawyer, caregiver and spouse of U.S. Army Sergeant Loyd Sawyer retired, and the mother of our two children.

Loyd served as an Army mortuary affairs soldier working first at Dover Port Mortuary with the deceased servicemembers and later serving in the Balaad mortuary in Iraq where he processed countless civilian and military casualties. While there, he began exhibiting signs of severe mental distress.

Upon his return, I tried for 11 months to get him help. Ultimately, I sat in a room with an Army psychiatrist, watched Loyd pull a knife from his pocket and listened to him describe his plan of slitting his throat.

Multiple episodes of hospitalization and intense outpatient treatment followed before he was permanently medically retired from the Army due to severe PTSD and major depression.

Loyd immediately enrolled in care at the Richmond PolyTrauma Center. In October 2008, he received 100 percent permanent total disability rating from the VA.

Given his urgent need for extensive help, we tried to get him into the PTSD clinic at Richmond, but the first available appointment required a 2-month wait. When he was finally seen, we were told that the only thing available in the clinic would be a quarterly medication management session and a once every 6-week therapy appointment.

Knowing that his depression was spiraling and his PTSD symptoms were worsening, we elected to use his TRICARE. He began treatment with a civilian counselor. He was able to see him once or twice a week. But over the next 8 months, I became increasingly concerned about the imminent possibility of suicide.

Despite giving little help from our local VA, but thanks very much to our Federal recovery coordinator, Loyd was able to enroll in an inpatient PTSD program at the VA medical center in Martinsburg, West Virginia.

We had high hopes for this hospitalization, but it turned out to be a nightmare. The program delivered on none of its promises. His counselors and doctors there never coordinated with his local VA mental health clinician, his civilian counselor, or his Federal recovery coordinator.

He was placed on medication that made them physically and verbally aggressive despite having been taken off that same medication for the same reason while on active duty. Over the course of the 90-day program, Loyd had fewer than five individual therapy sessions; and on returning home, promptly discontinued all of his new medication, which was a step backward as he had been completely meds compliant for the 18 months leading up to hospitalization.

In calling the Richmond PTSD clinic for help, I was told that it would be 4 weeks before they could see him. I tried to have his primary care physician intervene but was told that I and his FRC were wasting the time of his primary care manager.

Eventually, again with help from our Federal recovery coordinator, I was able to get Loyd an appointment within a week with a VA psychiatrist outside of the PTSD clinic.

She suggested that he attend a weekly therapy group that met with a clinician inside the Richmond PTSD clinic. Feeling rather hopeless, he decided to try the therapy group and actually found great solace in being able to relate with others who were experiencing the same symptoms that he was.

Unfortunately, four months later and without consultation of the patients, the medical center staff announced that the VA was changing its treatment model and would be disbanding the group by year's end.

For those wishing to continue in a group setting, the VA would be turning them over to an untested, community- based program without a clinician.

Despite the veterans' petitioning to remain in a VA clinical program, their year-long effort has been unsuccessful except to temporarily keep the clinician.

The 40-member group has withered to an average of five to seven because now, as the support group located off the VA campus, veterans cannot take sick leave to attend their meeting.

My husband is a veteran with a well-documented, severe, chronic post-traumatic stress. We have all the advantages that should guarantee him good treatment: an excellent, caring Federal recovery coordinator; 100 percent service- connected disability rating; a fabulous OIF case manager; and the assistance of the super VSO.

If a veteran with all of these advantages can not access timely, consistent, appropriate veteran-centered care in this system, what confidence can just this Committee have that any OIF veteran will have any greater success?

Loyd's experience is reflective of the challenges that the VA faces. A detailed VA directive identifies what mental health services should be available to all enrolled veterans who need them; but as the VA acknowledged in testifying before this Committee, those directives are still not fully implemented some 4 years later.

VA reports its health care facilities have seen significant numbers of OEF/OIF veterans enrolling and screening positively for PTSD. A study of 50,000 of those vets with the PTSD diagnoses found that fewer than 20 percent had a single mental health follow-up visit in the first year after diagnosis. VA's own performance measures indicate that less than 11 percent of veterans are completing an evidence-based treatment program for PTSD.

There is a mental health crisis. The VA cannot have a higher goal than helping these veterans recover from the mental scars of war. A Department of Veterans' Affairs that routinely comes before this Committee with a continuous list of mental health programs and initiatives is a department that is failing many of these warriors.

Wounded Warrior Project and I would like to work with this Committee and the VA to close these gaps and to transform the VA mental health system into one that is truly accessible and veteran-centered.

My written statement includes many suggestions that would help VA move toward achieving these goals, and I am happy to answer questions of the Committee.

Thank you.

[The prepared statement of Mrs. Sawyer follows:]

PREPARED STATEMENT OF ANDREA SAWYER, WOUNDED WARRIOR PROJECT

Chairman Murray, Ranking Member Burr, and Members of the Committee: Thank you for holding this very important hearing and for inviting me to testify. My name is Andrea Sawyer, caregiver and spouse of U.S. Army Sgt. Loyd Sawyer, retired. My testimony will both review my husband's experience in seeking treatment for severe PTSD as well as provide the perspective of the Wounded Warrior Project, with which Loyd and I have been associated, on these important issues.

I believe Loyd's story not only illuminates critical issues, but highlights the need for major changes. Let me share his story.

Loyd was a civilian funeral director and embalmer before joining the Army Mortuary Affairs team. As a mortuary affairs soldier, Loyd did a tour at Dover Port Mortuary where all deceased servicemembers returning from Iraq and Afghanistan re-enter the United States. Loyd worked in the Army uniform shop (where paperwork is processed and final uniforms prepared for deceased servicemembers) and embalmed on the days he was not in the uniform shop. Loyd then served a tour in Iraq, first in Talil and then the Balaad mortuaries where he processed countless deceased civilians and servicemembers. While there, he began exhibiting signs of mental distress including anger, hypervigilance, and insomnia.

Upon his return home, I tried for eleven months to get him help. We encountered delay in getting that help because the base had only one psychiatrist; but the help he ultimately got was ineffective. Finally I found myself in a room with an Army psychiatrist and my husband, and watched Loyd pull a knife out of his pocket and describe his plan of slitting his throat. He was clearly delusional and in great psychiatric distress, and shortly before Christmas in 2007, he was admitted to Portsmouth Naval Medical Center (PNMC). He had multiple episodes of intensive treatment while in service: an initial crisis hospitalization of five weeks (three exclusively inpatient and two intensive outpatient), a separate one week crisis hospitalization for homicidal ideations, eight months in an Army Warrior Transition Unit (WTU), and then appointments three days a week at PNMC two hours away from our home Army base of Fort Lee. Loyd then underwent a medical and physical evaluation (MEB/PEB) process that resulted in a 70% permanent Department of Defense (DOD) retirement from active duty for Post Traumatic Stress Disorder and a secondary diagnosis of major depressive disorder. The accompanying medical paperwork summed up his condition: "The degree of industrial and military impairment is severe. The degree of civilian performance impairment is severe at present, though over time—likely measured in years (emphasis added)—with intensive psychotherapy augmented by pharmacotherapy to control his anxiety and depressive symptoms—his prognosis MAY improve."

In July 2008 while still on Active Duty, but with retirement paperwork in hand, Loyd enrolled for care at our local VA medical center, the Richmond polytrauma center, better known as Hunter Holmes McGuire VA Medical Center (HHM VAMC). In October, with help from Wounded Warrior Project (WWP), Loyd received a 100% permanent and total disability rating from VA, thus giving him the highest priority status for VA care.

Knowing that Loyd needed extensive help quickly, we tried getting him into the VA PTSD clinic immediately. But the first available appointment required a two-month wait. When he was finally seen, Loyd presented his history, including that he had been seen two to three times weekly at PNMC for the last eight months of active duty, that he remained suicidal, and that he needed intensive therapy. Notwithstanding the severity of his case, we were advised that the only thing available in the PTSD clinic would be a quarterly medication-management appointment and a once-a-month to once-every-six-weeks one-hour therapy appointment. Knowing that Loyd was spiraling into a depression and an unchecked increase in his PTSD symptoms, we elected to use our TRICARE coverage, and began treatment with a local civilian counselor who had trained at the VA's National Center for PTSD. The counselor was able to see Loyd once or twice a week depending on the severity of the symptoms. Throughout the winter of 2008 and the spring of 2009, I became increasingly concerned at the out-of-control depression I was witnessing, and feared that suicide was an imminent possibility. After getting little response from VA mental health, his TRICARE counselor and I discussed sending him to a VA long-term inpatient PTSD program for PTSD. I contacted Loyd's Federal Recovery Coordinator (FRC) for help in finding a program. We did eventually do phone interviews, made a site visit, and enrolled him in a PTSD program at VAMC Martinsburg, WV. I got little to no help from our local VA hospital in finding this program, but Loyd's Federal Recovery Coordinator provided invaluable assistance.

The hospitalization was a nightmare! The program delivered on none of its promises. His doctors there never coordinated with his local VA mental health clinician, his civilian counselor, or his FRC. At one point, his civilian counselor, his FRC, and I were calling the facility daily because we were concerned the medication change they had made was making him physically and verbally aggressive. Even more concerning, he had been taken off that medication while on active duty for the same reasons. Over the course of this ninety-day inpatient program, Loyd had fewer than five individual therapy sessions. Upon completing the program, which I truly believe was just about marking time, he was released and told to follow up with his local VAMC. For my husband, who had already expressed suicidal ideations, there was no care-coordination or communication between any of his treatment providers. He came home and promptly discontinued ALL of his medication because he did not

like the way it made him feel. This was a step backward, since for the year and a half prior to the Martinsburg hospitalization, he had been completely compliant with his medication plan.

When I realized that he had stopped taking his medication, I immediately called the Richmond PTSD clinic. I was told that it would be four weeks before they could see him to re-evaluate his medications. I asked the FRC to intervene with the primary care provider (PCM) to try and speed up the process, but this physician simply told me, I was "wasting his time." Eventually with the help of the FRC, I was able to get him an appointment within a week with a VA psychiatrist in general psychiatry. (Since then, this psychiatrist has managed Loyd's medication, as she very clearly listened to what symptoms needed to be controlled, and, even more importantly, listened to what he needed and wanted as a patient.) At that time, we agreed with her, that for counseling, Loyd was better off continuing with the civilian counselor because he could be seen once/twice a week. By involving Loyd, this VA clinician made it much more likely that he would continue with his pharmacotherapy regimen. She also asked that neuropsych testing be redone and suggested that Loyd try the PTSD ("Young Guns") therapy group that met weekly with a clinician in the Richmond PTSD clinic.

Loyd's repeat neuropysch testing in January 2010 showed that his PTSD symptoms were still severe. On a psychiatric scale test for symptoms of PTSD used frequently by the VA (DAPS), Loyd scored 20 out of 20 on all the indicators except for suicidality for which he scored a 16, meaning he still fell into the extremely high-risk category and was actively suicidal. His authenticity score was a five, which is as high as you can score. So after more than a year in the VA, a ninety-day hospitalization, and weekly therapy, Loyd was not really improving. Feeling rather hopeless, Loyd did decide to try the Young Guns group. He found great solace in this group in being able to relate with others who experienced the same symptoms, but also because he saw people in different stages of recovery who, led by a clinician, were able to analyze their behaviors and suggest multiple positive coping strategies that they each found successful. Unfortunately, four months into the group and without consultation with the patients, medical center staff announced that the VAMC was changing its treatment model and would be disbanding the group by year's end. For those who wished to continue in a group setting, the VA would be turning them over to a yet untested regional division of a new community-based program which had only two employees for a twenty-three county region, neither of whom was trained in counseling. As discussed in more detail below, the resulting year-long saga of trying to keep the group on campus has been unsuccessful, and the 40-member group has withered to an average of 7 to 10.

I believe Loyd's experience raises a strong oversight question for this Committee:

> My husband is a veteran with well-documented severe chronic PTSD who gets treatment at one of VA's major VA polytrauma centers. We have all the advantages that should guarantee him good treatment—an excellent, caring Federal Recovery Coordinator; the priority associated with a 100% service-connected disability rating; an OIF case manager; and the assistance of a super VSO. If a veteran with all these advantages cannot access timely, consistent, appropriate veteran-centered care in a system dedicated to the care of veterans, what confidence can this Committee have that a newly enrolled veteran who has recently returned from the war zone will have greater success?

This Committee has rightly identified access as a barrier to quality, comprehensive mental health care. Two other closely-related issues impact that care as well:

Despite the goal of intervening early, VA is failing to reach most returning veterans.

VA reports that nearly 600 thousand, or 49% of all, OEF/OIF veterans have been evaluated and seen as outpatients in its health care facilities, and reports further that approximately one in four showed signs of PTSD.[1] But more than half of all OIF/OEF veterans have not enrolled for VA care. Unique aspects of this war—including the frequency and intensity of exposure to combat experiences; guerilla warfare in urban environments; and the risks of suffering or witnessing violence—are strongly associated with a risk of chronic Post Traumatic Stress Disorder.[2] The last-

[1] VA Office of Public Health and Environmental Hazards, "Analysis of VA Health Care Utilization among Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans," October 2010.

[2] National Center for PTSD. "National Center for PTSD Fact Sheet." Brett T. Litz, "The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq," Janu-

Continued

ing mental health toll of the wars in Iraq and Afghanistan are likely to increase over time for those who deploy more than once, do not get needed services, or face increased demands and stressors following deployment.[3] Chronic post-service mental health problems like PTSD are pernicious, disabling, and represent a significant public health problem. Indeed mental health is integral to overall health. So it is vitally important to intervene early to reduce the risk of chronicity.

In 2008, VA instituted an initiative to call the approximately half million OEF/OIF veterans who had not enrolled for VA health care and encourage them to do so. This unprecedented initiative was apt recognition that we must be concerned not just about those returning veterans who come to VA's doors, but about the entire OIF/OEF population. But a single telephone contact is hardly enough of an outreach campaign.

VA has not been successful in retaining veterans in treatment.

Until recently, little had been known about OEF/OIF veterans' actual utilization of VA mental health care. The first comprehensive study of VA mental health services' use in that population found that of nearly 50,000 OEF/OIF veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received recommended mental health treatment for PTSD (clinically defined in this report as attending 9 or more mental health treatment sessions in 15 weeks) at a VA facility; 20 percent of those veterans did not have a single mental health follow up visit in the first year after diagnosis.[4]

These data raise a disturbing concern. They show that enrolling for VA care and being seen for a war-related mental health problem does not assure that a returning veteran will complete a course of treatment or that treatment will necessarily be successful.

Yet VA has set a very low bar for reversing this trend. Consider performance measures reported in VA budget submissions. One such performance measure calls for tracking the percentage of OEF/OIF veterans with a primary diagnosis of PTSD who receive a minimum of 8 psychotherapy sessions within a 14-week period. The FY 2010 performance goal for that measure was only 20%.[5] In other words, having only one in five veterans attend the recommended number of treatment sessions constituted "success." This year's budget submission shows that actual performance fell short of even that very modest goal, with only 11% of PTSD patients receiving that minimum.[6] In contrast, VA is meeting its performance target that 97% of veterans are screened for PTSD.[7] This wide gap between VA's high rate of identifying veterans who have PTSD and its low targets for successful treatment needs to be addressed.

TWO VA "MENTAL HEALTH" SYSTEMS

VA operates a vast health care system, and there are many examples of excellence—just as VA employs many excellent, dedicated clinicians. It is somewhat misleading, however, to speak of "the VA mental health system," because not only is there wide variability across VA, but in some respects VA can be said to operate two mental health systems. First, VA provides a full range of mental health services through its nationwide network of medical centers and outpatient clinics. That system has increasingly emphasized the provision of "evidence-based-," recovery-oriented care. VA's much smaller Readjustment Counseling program—operating out of community-based Vet Centers across the country—provides individual and group counseling (including family counseling) to assist veterans to readjust from service in a combat theater. In some areas, these two "systems" work closely together; in others, there is relatively little coordination between them.

The differences between these two systems may help explain why greater numbers of veterans do not pursue VA treatment, and why those who do often discontinue.

In our daily, close work with warriors and their families, WWP staff consistently hear of high levels of satisfaction with their Vet Center experience. Warriors strug-

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ary 2007 http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf (accessed 10 June 2011).

[3] Ibid.

[4] Karen Seal, Shira Maguen, Beth Cohen, Kristian Gima, Thomas Metzler, Li Ren, Daniel Bertenthal, and Charles Marmar, "VA Mental Health Service Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses," *Journal of Traumatic Stress*, 2010.

[5] Department of Veterans Affairs, FY 2011 Budget Submission, Vol. 2, p. 1J–5.

[6] Department of Veterans Affairs, FY 2012 Budget Submission, Vol. 2, p. 1G–7.

[7] Ibid.

gling with combat stress or PTSD typically laud Vet Center staff, who are often combat veterans themselves and who convey understanding and acceptance of warriors' problems.

In contrast with the relative informality of Vet Centers, young warriors experience VA treatment facilities as unwelcoming, geared to a much older population, and as rigid, difficult settings to navigate. Warriors have characterized clinical staff as too quick to rely on drugs, and as often lacking in understanding of military culture and combat. Medical center and clinic staff sometimes have more experience treating individuals who have PTSD related to an auto accident or domestic abuse than to combat. VA treatment facilities have had little or nothing to offer family members. Unlike Vet Centers that have an outreach mission, VA treatment facilities conduct little or no direct outreach—placing the burden on the veteran to seek treatment.

In essence, the strengths of the Readjustment Counseling program highlight the limitations and weaknesses that afflict the larger system. Too often, that larger system:

- Passively waits for veterans to pursue mental health care, rather than aggressively seeking out warriors one-on-one who may be at-risk;
- Gives insufficient attention to ensuring that those who begin treatment continue and thrive;
- Emphasizes training clinicians in so-called evidence-based therapies but fails to ensure that they have real understanding of, and relate effectively to, OEF/OIF veterans' military culture and combat experiences;
- Fails to provide family members needed mental health services, often resulting in warriors struggling without a healthy support system;
- Largely fails to establish effective linkages and partnerships with the communities where warriors live and work, and where reintegration ultimately must occur.

Perhaps the most disturbing perception warriors have expressed regarding their experiences with VA mental health treatment is that VA officials operate in a way that too often seems aimed at serving the VA rather than the veteran.

RICHMOND: A CASE STUDY

In describing what it termed its "FY 11–13 Transformational Plan to Improve Veterans' Mental Health," VA emphasizes its core reliance on providing evidence-based, recovery-oriented, veteran-centric care. But when those three concepts are not in alignment, experience now suggests that the veteran's voice may go unheard. The Richmond VAMC PTSD therapy group, described above, illustrates the point.

The Young Guns group in which Loyd participated petitioned the medical center director to reinstate the group. The petition, signed by 27 members of the group, explained both the importance to the members of the group therapy and expressed their strong view that VA's alternative—for the group to operate as a community-based peer group—was not an effective substitute.[8] While WWP also urged the Medical Center Director to reinstate the group at the medical center, the director's reply stated that "while these * * * PTSD groups have proven effective in providing environments of social support * * *, they are not classified as active treatment for PTSD symptoms." The upshot of the Director's ignoring the veterans' strong views and proceeding with the plans was that only 7 members of the Young Guns group attended the initial "community-based" group meeting (which was neither adequately staffed or facilitated). Most have dropped out altogether—having lost trust, feeling "discarded," or in some instances—because it is no longer a "VA group"—they could no longer get approval to take time off from jobs. The all important ability to access the care was no longer available.

Veterans too often confront a gap between well-intentioned VA policy and real-world practice. In this instance, the applicable VA policy (set forth in a handbook setting minimal clinical requirements for mental health care) is clear and on point:

> The specifications in this Handbook for enhanced access, evidence-based care, and recovery or rehabilitation must not be interpreted as deemphasizing respect for the needs of those who have been receiving supportive care. *No longstanding supportive groups are to be discontinued without consideration of patient preference*, planning for further treatment, and the need for an adequate process of termination or transfer. (Emphasis added.)

Throughout our efforts to advocate for these warriors—writing to the Medical Center Director, meeting with VA Central Office officials, meeting with the Medical

[8] WWP would be pleased to provide, at the Committee's request, a copy of the petition and subsequent WWP correspondence on the issue with VA officials.

Center Director, and finally writing to the Secretary—VA's position at every level remained inflexible. Honoring the veterans' wishes was simply not considered a VA option and while numerous "alternatives" were listed, few took into consideration the sensitivities of these particular patients.

VA did not terminate an ineffective program at Richmond VA. Medical Center officials even acknowledged that it was helping these veterans. VA's cavalier insistence on the appropriateness of this action brings into question the department's ability to adequately address the growing mental health needs of this generation of warriors.

VA MENTAL HEALTH CARE POLICY: STILL IN TRANSITION, IGNORING GAPS

VA has certainly instituted policies aimed at providing timely, effective, and accessible care to veterans struggling with mental illness. But as the above-cited situation at the Richmond VA illustrates, the gap between VA mental-health policy and practice can be wide.

In 2007, VA developed an important detailed policy directive that identified what mental health policies should be available to all enrolled veterans who need them, no matter where they receive care, and set certain timeliness standards for scheduling treatment.[9] But as VA acknowledged in testifying before this Committee on May 25th, those directives are still not fully implemented. Funding is not the problem, VA testified at the time.

The fact that a policy aimed at setting basic standards of access and timeliness in VA mental health care has yet to be fully implemented—four years after the policy is set—has profound ramifications for warriors struggling with war-related mental health problems, and who face barriers to needed VA treatment. Of VA's many "top priorities," the mental health of this generation of warriors should be of utmost importance as it will directly impact other areas of concern such as physical wellness, success in employment and education, and homelessness.

Geographic barriers are often the most prominent obstacle to health care access, and can have serious repercussions on the veteran's overall health. Research suggests that veterans with mental health needs are generally less willing to travel long distances for needed treatment than veterans with other health problems and that critical aspects of a veteran's mental health treatment (including timeliness of treatment and the intensity of the services the veteran ultimately receives) are affected by how geographically accessible the care is.[10]

VA faces a particular challenge in providing rural veterans access to mental health care. VA has stated that of all veterans who use VA health care, roughly 39% reside in rural areas and an additional 2% reside in highly rural areas;[11] over 92% of enrollees reside within one hour of a VA facility, and 98.5% are within 90 minutes.[12] But many of these VA facilities are small community-based outpatient clinics (CBOC's) that offer very limited or no mental health services.[13] Overall, CBOC's are limited in their capacity to provide specialized or even routine mental health care. Indeed, under current VHA policy, large CBOC's (those serving 5,000 or more unique veterans each year), mid-sized CBOC's (serving between 1,500 and 5,000 unique veterans annually), and smaller CBOC's (serving fewer than 1,500 veterans annually) have the option to meet their mental health provision requirements by referring patients to "geographically accessible" VA medical centers.[14] CBOC's are only required to offer mental health services to rural veterans in the absence of a "geographically accessible" medical center.[15] Notably, current policy does not define what constitutes "geographic inaccessibility." Moreover, in those instances in which small and mid-sized CBOC's do have mental health staff, VA does not require the CBOC to provide any evening or weekend hours to accommodate veterans who work and cannot easily take time off for treatment sessions.

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[9] Department of Veterans Affairs, VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics.

[10] Benjamin Druss and Robert Rosenheck, "Use of Medical Services by Veterans with Mental Disorders," *Psychosomatics* 38 (1997) 454.

[11] *Testimony of Gerald Cross, Acting Principal Deputy Undersecretary for Health Department of Veterans' Affairs, before the House Committee on Veterans' Affairs, Subcommittee on Health*, (Washington DC: April 18, 2007), http://www.va.gov/OCA/testimony/hvac/sh/070418GC.asp.

[12] Ibid.

[13] John R. Vaughn, Chad Colley, Patricia Pound, Victoria Ray Carlson, Robert R. Davila, Graham Hill, et al, "Invisible Wounds: Serving Servicemembers and Veterans with PTSD and TBI," National Council on Disability, 4 March 2009, *National Council on Disability*, [www.ncd.gov/newsroom/publications/2009/veterans.doc], Accessed 14 May 2009, 46.

[14] *VHA Handbook 1160.01*, 8.

[15] Ibid., 18.

Since long-distance travel to VA facilities represents a formidable barrier to veterans' availing themselves of mental health treatment, it is important that VA provide community-based options for veterans who would otherwise face such barriers. VA policy—as reflected in the uniform services handbook—calls for ensuring the availability of needed mental health services, to include providing such services through contracts, fee-basis non-VA care, or sharing agreements, when VA facilities cannot provide the care directly.[16] But VA officials have informally admitted that, despite the policy, VA facilities have generally made only very limited use of this new authority—often leaving veterans without good options.

Yet there is evidence that this rural access problem could be overcome if there were the will to meet it. In Montana, for example, the VA Montana Healthcare System has been contracting for mental health services since 2001. According to a report by the VA Office of Inspector General (OIG), more than 2000 Montana veterans were treated under contracts with community mental health centers in FY 2007, and more than 250 were treated under fee-basis arrangements with 27 private therapists.[17] The OIG report also indicates that the VA Montana Healthcare System has sponsored trainings for contract and fee-basis providers in evidence-based treatments.[18]

It is not enough for VA simply to promulgate policies and directives on access-to-care and timeliness. Surely we owe those suffering from war-related mental health conditions real access to timely, effective care, not the hollow promise of a policy that is still not fully implemented four years later.

Finally, a four-year-old policy must itself be open to re-assessment. VA must continue to adapt to the needs of younger veterans whose obligations to employers, school, or young children may compound the challenge of pursuing mental health care. To illustrate, a recent WWP survey found that among veterans who are currently participating in VA medical center and Vet Center support groups, 29% said they are considering no longer attending due to the location of the group being far from their place of work or home. Another 39% of respondents indicated they are considering no longer attending because groups are held at a time that interferes with their work schedule.

NEEDED: A VETERAN-CENTERED APPROACH TO THE MENTAL HEALTH OF OEF/OIF VETERANS

PTSD and other war-related mental health problems can be successfully treated—and in many cases, VA clinicians and Vet Center counselors are helping veterans recover. But, as discussed above, VA is not reaching enough of our warriors, and is not giving sufficient priority to keeping veterans in treatment long enough to gain its benefits. What can VA do, beyond fully implementing its policies and commitments? What should it do? WWP asked warriors and caregivers these questions at a summit I attended, as well as consulted with experts. Our recommendations follow:

Outreach: WWP recommends that VA adopt and implement an aggressive outreach campaign through its medical centers, employing OEF/OIF warriors—who have dealt with combat stress themselves—to conduct direct, one-on-one peer-outreach. Current approaches simply fail to reach many veterans. For example, post-deployment briefings that encourage veterans to enroll for VA care tend to be ill-timed, or too general and impersonal to address the warriors' issues. An outreach strategy must also take account of many warriors' reluctance to pursue treatment. An approach that reaches out to engage the veteran in his or her community, and provides support, encouragement, and helpful information for navigating that system can be impactful. VA leaders for too long have limited such outreach efforts to Vet Centers. Given what amounts to a public health challenge with regard to warriors at risk of PTSD, there is a profound need for a broad VA effort to conduct one-on-one peer outreach to engage warriors and family in their communities.

Cultural competence education: WWP urges that VA mount major education and training efforts to assure that its mental health clinicians understand the experience of combat and the warrior culture, and can relate effectively to these young veterans. Health care providers, to be effective, must be "culturally competent"—that is, must understand and be responsive to the diverse cultures they serve. WWP often hears from warriors of frustration with VA clinicians and staff who, in contrast to what many have experienced in Vet Centers, did not appear to understand

[16] *VHA Handbook 1160.01*, paragraphs 13.i.; 13.k.; 23.f.(1)(c); 23.h.(2)(b); 28.d.(1).

[17] VA Office of Inspector General, *Access to VA Mental Health Care for Montana Veterans*, (March 31, 2009), 4–5.

[18] Ibid., 63.

PTSD, the experience of combat, or the warrior culture. Rather than winning trust and engaging warriors in treatment, clinical staff are often perceived as ignorant of military culture or even as dismissive. Warriors reported frustration with clinicians who in some instances do not appear to understand combat-related PTSD, or who pathologize them or characterized PTSD as a psychological "disorder" rather than an expected reaction to combat.[19] Dramatically improving the cultural competence of clinical AND administrative staff who serve OEF/OIF veterans through training, standard-setting, etc.—and markedly improving patient-education—must be high priorities.

Peer-to-peer support: WWP recommends that VA employ and train peers (combat veterans who have themselves experienced post-traumatic stress) to provide support to warriors undergoing mental health care. (Peer-support must be an adjunct to, not a replacement for, quality clinical care.) In describing highly positive experiences at Vet Centers, warriors emphasized the importance of being helped by peers on the Vet Center staff—combat veterans who themselves have experienced combat stress and who (in their words) "get it." Given the inherent challenges facing a patient in a medical setting and data showing high percentages discontinuing treatment, it is important to have the support of a peer who, as a member of the treatment team, can be both an advocate and support. Public Law 111–163 requires VA within 180 days of enactment to provide peer-outreach and peer-support services to OEF/OIF veterans along with mental health services, and to contract with a national nonprofit mental health organization to train OEF/OIF veterans to provide such services. It is critical that the Department design and establish a national peer-support program, initiate recruitment of OEF/OIF veterans for a system-wide cohort of peer-support-specialists and institute the required training at the earliest possible date.

Provide family mental health services: One of the strongest factors that help warriors in their recovery is the level of support from loved ones.[20] Yet the impact of lengthy, multiple deployments on family may diminish their capacity to provide the depth of support the veteran needs. One survey of Army spouses found that nearly 20 percent had significant symptoms of depression or anxiety.[21] While Vet Centers have provided counseling and group therapy to family members, VA medical facilities have offered little more than "patient education" despite statutory authority to provide mental health services. It took VA nearly two years to implement a legislative requirement to provide marriage and family counseling.[22] Section 304 of Public Law 111–163 directs VA to go further and provide needed mental health services to immediate family of veterans to assist in readjustment, or in the veteran's recovery from injury or illness. This provision—covering the 3-year period beginning on return from deployment—must be rapidly implemented, particularly given its time-limit on this needed help.

Expand the reach and impact of VA Vet Centers: Although many OEF/OIF veterans have been reluctant to pursue mental health treatment at VA medical centers, Vet Centers have had success with outreach and working with this population. Given that one in two OEF/OIF veterans have not enrolled for VA care and many are likely to be experiencing combat-stress problems, WWP recommends that VA increase the number of Vet Center locations, and give priority to locating new centers in close proximity to military facilities. As Congress recognized in Public Law 111–163, Vet Centers—in addition to their work with veterans—can be an important asset in helping active duty, guard, and reserve servicemembers deal with post-traumatic stress. Vet Centers can serve as an important asset to VA medical centers as well, and we urge greater coordination and referral between the two.

Foster community-reintegration: VA mental health care can play an important role in early identification and treatment of mental health conditions. Yet success in addressing combat-related PTSD is not simply a matter of a veteran's getting professional help, but of learning to navigate the transition from combat to home.[23] In addition to coping with the often disabling symptoms, many OEF/OIF veterans with PTSD, and wounded warriors generally, are likely also struggling to readjust to a "new normal," and to uncertainties about finances, employment, education, career and their place in the community. While some find their way to VA programs, no single VA program necessarily addresses the range of issues these young veterans face, and few, if any, of those programs are embedded in the veteran's community.

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[19] Id, 9, 51.

[20] C.W. Hoge, *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home*, (Globe Pequot Press, 2010), 28.

[21] Ibid, 259.

[22] Veterans Health Administration, IL 10–2010–013, "Expansion of Authority to Provide Mental Health and Other Services to Families of Veterans," August 30, 2010.

[23] Hoge; *Once a Warrior Always a Warrior*.

VA and community each has a distinct role to play. The path of a veteran's transition, and successful community-reintegration, must ultimately occur in that community. For some veterans that success may require a community—the collective efforts of local community partners—businesses, a community college, the faith community, veterans' service organizations, and agencies of local government—all playing a role. Yet there are relatively few communities dedicated, and effectively organized, to help returning veterans and their families reintegrate successfully, and other instances where VA and veterans' communities are not closely aligned. The experience of still other communities, however, suggests that linking critical VA programs with committed community engagement can make a marked difference to warriors' realizing successful reintegration. With relatively few communities organized to support and assist wounded warriors, WWP urges the establishment of a grant program to provide seed money to encourage local entities to mobilize key community sectors to work as partners in support of veterans' reintegration. In short, a grant to a community leadership entity (which, in any given community, might be a non-profit agency, the mayor's office, a community college, etc.) could enable a community partnership with a VA medical center or Vet Center in supporting veterans and their families on their path to community reintegration. There is ample precedent for use of modest grants to stimulate the development of community-based coalitions working in concert with government to provide successful wraparound services.[24]

WWP has offered most of these recommendations to VA officials, and urged them to implement section 304 of Public Law 111–163. The response was little different from the responses WWP received in advocating on behalf of the veterans in Richmond. In essence, the message seems to be, "No thank you, we'll do it our way, and we'll do it when we get to it."

The stakes are high. With a generation of servicemenbers at risk of chronic health problems associated with combat stress, VA and Congress can have few higher priorities, in our view, than to address these issues. With these concerns in mind, WWP is developing draft legislation that incorporates the recommendations we have discussed, and would welcome the opportunity to work with the Committee on instituting these reforms.

SUMMARY

In closing, VA can have few higher goals than to help veterans who bear the psychic scars of combat regain mental health and thrive. While we recognize and acknowledge that VA conducts some quality programs and laudable initiatives, there are regrettably too many disconnects between those programs and initiatives and the needs Loyd and so many others have. WWP's work with warriors struggling with mental health issues—and with the caregivers who support them—reminds us daily of the gaps plaguing the system: gaps arising from VA's largely- passive approach to outreach; gaps in access to mental health care in a system still marked by wide variability; gaps in sustaining veterans in mental health care; gaps in clinicians' understanding of military culture and the combat experience; gaps in family support; and gaps in coordination with the benefits system. We look forward to working with this Committee on these important issues and to witness the development of a truly transformative veteran-centered approach to VA mental health care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO MRS. ANDREA SAWYER, CAREGIVER AND SPOUSE OF U.S. ARMY SGT. LOYD SAWYER

Question 1. Mrs. Sawyer, I appreciate your compelling testimony and I am truly sorry for the challenges you and your husband have faced is seeking care. Are there specific recommendations that you could make about the eligibility criteria of the Caregivers and Veterans Omnibus Health Services Act of 2010 and how it will affect families and veterans dealing with severe mental health and PTSD concerns?

Response. Congress gave VA very clear direction as it relates to eligibility for caregiver-assistance in cases involving veterans with severe PTSD or other mental health conditions. But VA's implementing regulation has established such restrictive eligibility criteria in the case of a veteran with any severe mental health condition that many caregiver who should be eligible under the law have been discouraged from even attempting to apply for the comprehensive benefits.

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[24] M. Libby, M. Austin. "Building a Coalition of Non-Profit Agencies to Collaborate with a County Health and Human Services Agency." Administration in Social Work. 26,4 (2002): 81–99.

The regulation states the broad criteria of the "need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury," but then proceeds to set up a very strict criterion of meeting a certain threshold using a subjective functional-assessment tool of a GAF (Global AFfect) score.

Specifically, the GAF-score criterion requires that a veteran have a continuous GAF score of 30 or less over a 90-day period. Under the criterion, an examiner—someone who may see the veteran for as little as 15 minutes—must therefore find that "behavior is considerably influenced by delusions or hallucinations OR serious impairment, in communication or judgment (e.g., sometimes incoherent, acts grossly inappropriately, suicidal preoccupation) OR inability to function in almost all areas (e.g., stays in bed all day, no job, home, or friends)."[1] In a graphic example as to unreasonable criterion of a 30 GAF score, on the day Loyd was admitted to the hospital, fully suicidal, highly egodystonic, he received a 31.

The first problem with this criterion is that a GAF score is subjective. Depending on who the clinician is and how they apply the scale, the score can vary widely. As such, GAF by itself is never used as the only criterion to hospitalize or diagnose a patient for any type of treatment. GAF is used as an instrument in a battery of tests. Nor is a GAF routinely administered at every VA pysch appointment. If the VA is going to require this, then these scores must be put in for every visit as well as with notes that accompany the score.

The second problem with using a GAF score of 30 is that a safety risk actually occurs at a much higher score than a 30. Suicidal ideation which demonstrates a risk to a veteran's safety is actually present at a GAF score as high as 50. At any given moment depending on the stressor, a fragile veteran could change from ideation to intention; that is why a caregiver is required for a veteran with a 50, and why usually veterans with scores of 50 are hospitalized.

The third problem is that if a current caregiver is good at the job of caregiving they defeat themselves. For instance, were it up to Loyd, he would stay in bed all day—a criterion for a 30 GAF score. Many days, even now four years later, Loyd is in bed until one or two in the afternoon when I put my caregiver foot down and force him out of bed. This is not behavior that would be seen by the VA. It would be up to the veteran to self-report as the VA does not ask me what his behaviors are. Because I force him to bathe every other day when he is in a severe cycle of depression means that he appears clean for purposes of VA evaluation. The fact that I am doing a good job forcing him out of bed, forcing him to interact with others, forcing him to bathe, essentially means that I disqualify myself for the benefit. A GAF score does not take into account what goes into getting Loyd clean and awake to get him to the VA, it only takes into account how he appears as he walks into the office of the clinician.

The fact that Loyd uses the VA for minimal mental health treatment—medication management only—also means that he is at a distinct disadvantage when qualifying for services. Loyd receives his mental health treatment with a civilian counselor because VA is unable to provide him with the care that he needs, therefore when it comes time to evaluate him, there are no records for the VA to evaluate, not to mention the caregiver criterion is evaluated by a a primary care physician, who is not involved in any of his mental health treatment.

Because severe PTSD can impair memory and function at GAF scores much higher than 30, supervision is necessary for medical care and medication management. Due to Loyd's cognitive processing disorder and memory impairment, I monitor his medication. I am also responsible for supervising and coordinating his medical care. This spring that meant that I had to step in when the VAMC kept repeatedly saying that a part of his large intestine was missing when it is actually his small intestine. Failure to supervise his medication and to manage his healthcare means that at any point his situation can rapidly decline. All of these are safety issues which fall into nuanced definitions of the ADLs and have nothing to do with GAF scores.

In a recent appeals court decision, VA's own statistics prove that veterans who admit suicidality are not being monitored carefully. The statistics show that if a veteran answers yes to only one of the two suicide questions no VA safety plan is triggered, yet answering yes to only one of those questions indicates that a veteran is at risk for suicide. Since the VA is not monitoring that veteran's behavior, it is up to the caregiver to assume that role. Caregivers are taking up the burden of monitoring at risk behaviors, but VA refuses to acknowledge our role in protecting veterans. They are setting impossible standards for mental health caregivers to meet in order get compensation.

Another problem in determining need for caregiver assistance based on a GAF score is that it creates a disparity between physical injuries and mental health con-

[1] Federal Register (May 5, 2011): 26150.

ditions. For example, a veteran who may need limited assistance with the adjustment of a prosthetic would be eligible for caregiver support, but a veteran who suffers from suicidal ideation because of his PTSD and needs another's supervision would not qualify. The GAF-score criterion sets an unreasonably high, arbitrary, subjective, and inequitable standard and should be deleted from the eligibility criteria.

There is no need for a GAF score criterion since the interim regulation provides an eligibility criterion that can generally apply to veterans with caregiver needs based on a mental health condition. That broad criterion is "need for supervision or protection based on symptoms or residuals of neurological or other impairment or injury." As written, the regulation includes seven circumstances that may warrant a caregiver under the criteria. But those listed factors do not include certain common manifestations of Post Traumatic Stress Disorder (PTSD) and anxiety, such as significant avoidant behaviors and fearfulness, that could create a need for protection or supervision. That list of seven factors should be expanded to include common symptoms of PTSD, anxiety and depression that could create a need for supervisory or protective assistance.

Question 2. How would you suggest that VA improve its coordination efforts and use of electronic records to prevent the gaps in care and problems in handling your husband's case?

Response. VA must not only set care-coordination as an organizational priority, but must both provide clinicians and administrative staff the time to do this important work and create system-wide incentives (or eliminate disincentives) to ensure care-coordination occurs at all levels. This must start with committed leadership and consistent vision at all levels of VA.

It is critical that VA improve clinical coordination in delivering mental health care both within and between VA facilities and between VA and non-VA mental health providers. VA and DOD must continue to aggressively pursue a joint electronic medical record (Joint Information Sharing Initiative). Not only must the systems be interoperable, there must be a mechanism to ensure that there is a coordination of medical care and records between providers, facilities, and VISNs, as well as a way to coordinate with civilian practitioners that see VA patients through the use of TRICARE and Medicare. The first impediment to care in my husband's case came about because VA (VISTA) and DOD (ALTHA) systems were not compatible. Knowing that was the case, in late 2008, we provided a copy of my husband's active duty medical (mental and physical health) records to the Hunter Holmes McGuire Veterans Affairs Medical Center (Richmond VA). At that time, someone within the VA should have scanned his active duty medical records into the system or at least had the critical, relevant information transcribed into the VISTA system. Now, three years later, despite a VA initiative to put these records into the system, it is my understanding that Loyd's ALTHA records are still not entered into the VISTA system. My fear is that critical information contained in my husband's DOD medical records will ultimately disappear rather than become a part of his permanent VA record.

Despite not having direct access to his DOD records, the Martinsburg VAMC did have access to Loyd's Federal Recovery Coordinator who was located at Walter Reed. Loyd's FRC did have access to those records and routinely tried to convey critical treatment history information to Martinsburg officials through repeated phone calls. Since the program specifically requested information on any problems with prior treatments, medications, or therapies, I also took a paper copy of his active duty medical (both physical and mental) records to Martinsburg during his third week of hospitalization. Unfortunately when I arrived on Friday afternoon, the records office was closed and no one at the hospital would take his records. With young children at home three hours away in another state, I was unable to stay until the office reopened on Monday, so I left the records in Loyd's possession. On Monday, the FRC called to tell the program personnel that he was in possession of his records, yet they refused to ask him for these records. Loyd's civilian counselor also made repeated attempts to contact the program. As Loyd's healthcare power-of—attorney, I also gave express permission to have this counselor speak with program staff. In addition to a willful refusal to review critical treatment history record, the program also refused any professional assistance from a care provider familiar with this veteran's situation.

Despite repeated assertions to the contrary, Martinsburg VAMC did had the ability to access and use the medical records from the Richmond VAMC. Clearly electronic medical records are accessible system-wide. Martinsburg simply chose not to or personnel did not know how to use them. This became blatantly obvious when Loyd broke his collarbone at Martinsburg and then required a visit to the Richmond VAMC that weekend because the bone was not set correctly and pain medication

was not accurately prescribed. Richmond had access to all his electronic records from Martinsburg. They were able to compare his Martinsburg x-rays to his Richmond x-rays and comment on the need to provide the proper dose of pain medication. They documented all of this information in his electronic medical record so that Martinsburg would be able to access the information when he returned after the weekend. This was a clear indication that the Martinsburg VA had not fully and effectively employed known capabilities to make coordinated care the priority it should be.

While Loyd was still in the PTSD in-patient program at Martinsburg, they changed his drugs to substances that were previously documented, while he was on active duty, to make him violent. In spite of my repeated attempts, as well as attempts by the FRC and Loyd's civilian counselor to discuss this concern, Martinsburg officials simply refused the dialog. Following a paranoid, aggressive episode while the children and I were in town for a visit, I had the civilian counselor call and ask that the program not allow him to come home until the end of the program. Loyd's behavior was erratic and was creating upheaval within the home and with the children. The program disregarded this request and allowed Loyd to come home anyway, arriving at 7 a.m. on a Sunday morning, letting himself into the house silently. I would not have woken, terrified and screaming, to him standing over me staring had ANYONE read any of his records or even attempted to acknowledge the wealth of mental health history that was readily available to them.

Following Loyd's completion of the Martinsburg in-patient program, no effort was made to communicate with his civilian counselor, his FRC, or with staff at the Richmond VAMC. His discharge instructions were passively typed into the computer and Loyd returned home only with a certificate of completion. No follow-up plan was coordinated with any of his practitioners. This lack of active transfer was further complicated when he promptly ceased taking all the "new" old medication and slipped further out of control while the medication worked its way out of his system. After repeated unsuccessful attempts to get Loyd into the PTSD clinic at the Richmond VAMC, it required active intervention from his FRC to have Loyd seen by a psychiatrist in general psychiatry at the Richmond VAMC. She asked about his active duty medication, saw in his prior to Martinsburg hospitalization records that he had been meds compliant on the old meds, saw that he was not appropriately medicated, and began working with him to find a medication regimen that did not make him feel bad physically while also addressing the behaviors that needed to be controlled. I believe this psychiatrist coordinated with the civilian counselor as has our FRC. Unfortunately, despite repeated attempts to get the PTSD clinic at VAMC Richmond to do so, that important contact outside of the VA has never been made. When the PTSD clinic worked to cancel the Loyd's Young Guns therapy, I again tried to get the clinic to reach out to the civilian counselor who would explain to them that it was unsafe for Loyd to be in a clinically unsupervised group. I finally had the civilian counselor write a letter detailing his concerns. In April 2011, I took the letter to the neuropsychiatrist and the OIF team manager and asked them both to see that it got put in his record. I do not know yet if it is actually in there.

Electronic medical records are only effective if used as a tool to enhance coordination of care, otherwise the electronic format is just that, a mere record in an electronic form. Repeatedly, the Martinsburg and Richmond VAMC PTSD programs have had the opportunity to interact with other members of his care team, and these clinics chose to not do so. If the VAMC is unwilling to talk to the other non-VA members of the care team or to input or look at the records, electronic medical records make no difference. When calls from a civilian counselor, GI specialist, or new civilian Primary Care Manager are ignored, when active duty records are dismissed, and even data included in the VA's own electronic record is not shared—the issue becomes more than just about record maintenance, it is about a culture of not caring. Refusing to communicate with other members of the care team can lead to life-threatening situations involving mixed medications or failure to act in the instance of an at-risk veteran. In our situation, simply giving the FRC oversight power/authority to do something if a member of the VA care team refuses to communicate would have helped tremendously.

Finally, Patient Aligned Care Teams (PACTs) should be improved to ensure that if a warrior is identified as being at-risk for PTSD he actually gets follow up care. VA has testified that placing mental health professionals in a "Medical Home" model and as a part of PACTs should materially improve mental health care-coordination at a medical center. As part of the PolyTrauma clinic at Richmond, we were part of a PACT, as are most Polytrauma teams within the VA. The problem was, Loyd was supposed to be followed by PolyTrauma, but was not. Eventually we asked to be assigned a caseworker outside of PolyTrauma since not once in the entire first year did his PolyTrauma case manager ever contact us. Even if a PACT were to

catch veterans who needed mental health help, they would likely just refer them to the PTSD clinic which, as of right now is, even as documented by the VA IG, understaffed. PACTs simply increase the number of patients identified as needing treatment without providing the clinical personnel to treat them, frustrating veterans even further. Models are great, but the system is filled with a culture of not following up, and the culture does not change just because the model does. Nor will the number of appointments available change just because a PACT refers a patient to MH treatment. When VA fails to serve those veterans identified as needing help, there must be accountability top to bottom.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO MRS. ANDREA SAWYER, CAREGIVER AND SPOUSE OF U.S. ARMY SGT. LOYD SAWYER

Question 1. Mrs. Sawyer, in your prepared testimony, you stated that "enrolling for VA care and being seen for a war-related mental health problem does not assure that a returning veteran will complete a course of treatment or that treatment will necessarily be successful." You went on to describe the VA measure of success as having 20 percent of veterans attend the recommended number of psychotherapy treatment sessions. The fact the only 11 percent of PTSD patients received that minimum treatment objective is concerning. What should VA do to ensure that the 97 percent of veterans receiving PTSD screening receive the recommended treatment?

Response. Ultimately, VA must raise the bar to ensure more veterans who screen positively for PTSD are receiving the treatment they need. In order to do so, VA must involve veterans in their treatment plans, ensure services are delivered in a way that is truly accessible to the lifestyle of this new generation, and utilize peers to continue to engage veterans in various forms of treatment while ensuring that staff are properly trained and informed concerning the experiences and needs of this generation of warriors.

Treatment must be made available in a timely manner. VAs new treatment model suggests that veterans should be seen/complete a minimum of nine visits with VA PTSD clinicians for either group or individual therapy during a period of fifteen weeks. With veterans currently waiting months between available appointments and many required to drive hours to reach these appointments, this does not seem to be a model that can be realistically achieved. A standard of treatment should be predicated on what is clinically best for the veteran, not a mere metric that begs the question of why so few are completing said treatment. If there is a shortage of providers, all means necessary should be used to ensure timely, quality care—to include using mechanisms such as fee-basis more often to accommodate the needs of this growing population.

Treatment must be practical. This new generation of veterans is a young, working population. Veterans must be able to access services at times and locations that allow them to continue with other activities of daily living—their jobs, schooling, and family responsibilities. I have spoken to many veterans who were unable to continue VA mental health treatment because it was not offered at locations or times that were convenient—often forcing them to make a choice between employment and treatment.

VA continues to focus on veteran unemployment, yet a veteran following the new VA Mental Health (MH) guidelines within the current scheduling and appointment constraints would require an extremely flexible employer in order to retain a job. Assuming a veteran attempts to attend nine treatment sessions in a fifteen week period. In an average scenario drive time to that appointment could approach an hour away. This veteran must tell his employer that he will miss nine half days of work at his job within that fifteen week period. Should this be a new job for newly discharged veteran, the likelihood of having this time available is non-existent. If the veteran required all elements of the recovery model, factor in additional time for recovery and mindfulness/anger management coping skills group meetings. This could mean a veteran, active in his recovery, could be required to miss significant hours of work and only for mental health treatment purposes, this does not take into consideration any other physical health issue for which a veteran may need treatment. Few employers would hire or retain that individual. It is not practical. Eventually a veteran would have to choose between his job and his care. That is not a choice a veteran should have to make.

To complicate matters, veterans nationwide are not allowed to choose their appointment times, leading to inconvenient and missed appointments and constant rescheduling requirements. No patient-centered medical system in this country operates in such a manner. Currently, the VA sets the appointment time, and veterans

are simply expected to show up regardless of other obligations. This obviously prevents a veteran from scheduling appointments around employment needs or scheduling multiple appointments on the same day. Again, young veterans are forced to choose between employment and treatment.

In light of the intensive requirements of the MH guidelines and out of respect for the time of individual veterans, the VA needs to allow veterans a choice when scheduling appointments as well as offer limited evening and weekend hours to accommodate working veterans and veterans with families. The Richmond VA has stated it will implement evening hours, but that "plan" has been promised to patients for over three years now.

Treatment must be tailored to the individual. VA speaks often of being a "veteran-centered" system. But a system that put its patients first would not insist that veterans conform with VA's preferred care-models. Instead it would be open to providing treatment options that work for its patients. Individual psychotherapy may meet the needs of one veteran, but another might be better served in a group setting. The veteran must have a voice in treatment decisions. Too often in VA, patients are channeled into programs where every veteran is given the same program regardless of their needs. A system that presupposes what a veteran needs does not truly serve the veteran and ultimately takes him out of actively pursuing the path to recovery. As the VA did in my husband's case, every veteran in his clinician-led group therapy session was relegated to a community-based group without individual evaluation of the veteran's preparedness for this move.

The current MH model risks a similar checklist mentality. Channeled veterans through a series of modules (explaining what PTSD is, what changes it creates in the chemicals of the body, what changes it creates in thinking patterns, a series of modules on coping skills) lends itself to an standardized shuffling without the quality assessment to see if veterans have mastered the skills. Once a module is completed it is checked off whether or not the veteran feels he has mastered the skill. The veteran can become frustrated by this lack of recourse especially if he must have to wait months for a requested follow-up appointment. While education is good, this model cannot become so metric based that veterans will be pushed through. They will, and to date have, quit because they do not see it as quality therapy that is individually tailored or focused on making a difference, not to mention the time it takes away from the occupational arena.

To encourage a veteran to seek and complete treatment, VA must ensure that each individual veteran is not lost in a maze of completing treatment that is not relevant to him as an individual patient. PTSD veterans like all other veterans with health conditions need to be seen as patients first and diagnoses second. The patient's individual symptoms should determine his type of treatment, not a predetermined course of treatment that does not account for individual variances.

Treatment must be culturally competent. As Ranking Member Burr commented during the hearing, VA must transform at every level to ensure every employee is committed to the notion of keeping veterans engaged in treatment. This means that when veterans call to make appointments, the person on the other end of the line should be committed to serving the veteran. When the first interaction veterans have with the VA mental health system is a negative one, they aren't likely to come back for more. VA must also do more to ensure that administrative employees and clinicians alike have an understanding of the combat experiences of OEF/OIF veterans. Imagine the frustration of a veteran who finds that the clinician has no real understanding of the experience of being in a combat zone, or even empathy for the veteran's experience. VA health facilities should be places where staff have a baseline understanding of the combat experience and military culture, and clinicians are uniquely suited to meet their treatment needs.

Most VA clinicians seem familiar with PTSD as a clinical diagnosis, but many do not seem to understand the difference veterans experience with combat PTSD verses military sexual trauma (MST) verses a routine car accident. Veterans are routinely frustrated by having to stop and explain language/command structure/nature of combat jobs/basic military language to clinicians. In one instance, my husband was explaining to a clinician the damage done to a body by an IED. She got a very puzzled look on her face and asked how a contraceptive device could have caused limbs to be blown off. The difference between an IED (improvised explosive device) and an IUD (a female contraceptive device) had to be pointed out to her. At that point, that clinician had lost all credibility. Therapy was over for the day.

In another instance, a female veteran whose PTSD rating is, in part, due to an MST and who still experiences horrific flashbacks, was placed in an all-male PTSD coping skills group. She was placed with mostly Vietnam-era men, who, as was the case in this group, had little respect for female servicemembers, and certainly no understanding of or empathy for a veteran suffering from MST. Eventually she

stopped going to the group as it caused her more trauma listening to the comments of her fellow group participants than the symptoms she already experienced.

VA should engage in a program similar to the Navy's Civilian Familiarization for all employees. This program allows members of the public to experience a small taste of a sailor's occupation. Also a continuing education class in military terms is necessary. This could be easily added to the required continuing education classes that already exist in the VA.

VA should support the implementation of modified evidence-based treatments. VA currently recommends two evidence-based therapies for PTSD—Cognitive Processing Therapy and Prolonged Exposure Therapy. The idea is that a veteran needs to have 9 or more sessions spaced weekly or biweekly. This therapy itself is emotionally difficult and draining, requiring a veteran to re-experience the trauma again and again to desensitize himself to the emotion associated with the trauma. While completing treatment does improve the severity and recurrence of symptoms, the therapy itself is traumatizing and lends itself to discouraging a veteran from completing treatment. Recognizing this, the incorporation of complementary and alternative therapies within this course of the treatment, such as coping skills sessions, exercise/yoga, or lower intensity therapy could be useful to help motivate continued engagement in the more intense mental health treatment regime.

Treatment through community based partnerships for should be available to a veteran as a choice not a requirement. There is a trend in VA to form community partnerships for purposes of offering wider support for veterans and for expanding options for veterans. This is a good trend when considering the numerous challenges faced in providing a menu of services for this population. But in doing this, VA cannot abdicate responsibility—it is necessary for there to be some kind of oversight process. In the case of Richmond changing the therapy groups to support groups and moving them off campus, the community group supposedly tapped by VA to facilitate the group has yet to attend a meeting. Furthermore, in this case, the community group selected does not have the appropriately trained staff to lead this group. Also, in the instance of Richmond, veterans were not consulted about the change, it was simply dictated, without evaluation to ensure that each individual was ready for leaving a clinical therapeutic setting and transitioning to a non-clinical supportive setting.

For purposes of treatment and compensation, administrative data collection to support the evidence that treatment is being provided must be worked out in advance. Support groups do not normally keep attendance records, so it is difficult to prove that a veteran is receiving treatment through a support group. Also, community support groups or community clinicians need to provide evidence-based treatment. It is not fair to do away with a treatment at the VA because it is not evidence-based only to send veterans out into the community to receive other non-evidence based treatments while leaving them no options at the VA.

VA should use a Memorandum of Agreement (MOA) with community partners and fee-basis providers to ensure that veterans with PTSD may have the option, at the veteran's discretion, of receiving evidence-based treatment in their home communities. This scenario would make treatment for veterans more accessible geographically, more time sensitive to the onset of the symptoms, and more practical from a standpoint of the availability of evening and weekend hours. Using MOA's would allow VA to ensure that all treatment remains evidence-based and set a clear expectation about the administrative practices it requires to document a veteran's treatment regimen for purposes of compensation.

VA should use peer support (firmly backed by clinical treatment) to outreach and provide support to warriors struggling with PTSD. VA must focus on more effective outreach to draw veterans needing treatment into the system. VA can accomplish this by meeting a long-overdue requirement of law—implementing provisions in the Caregivers and Veterans Omnibus Health Act of 2010 that requires the establishment of a peer-outreach program through VA medical centers pertaining to OEF/OIF mental health. As demonstrated by the success of the Vet Centers' approach, peers are powerful tools to not only draw veterans into the system, but to keep them engaged in their treatment when things are difficult. VA must make an earnest attempt to harness peers as partners to clinical treatment by establishing this program and formalizing these relationships by creating permanent staff positions for this type of work. Communication and referral between VA medical centers and Vet Centers must become routine and a recognized partnership within VA.

VA should also take the opportunity to engage veterans and draw them in to mental health treatment at every point in the system. A recent survey of warriors conducted by the Wounded Warrior Project found that 1 in 5, or 20%, of all mental health compensation and pension examinations lasted less than 30 minutes. For some veterans, this might be their first interaction with a clinician. This is a real

opportunity for VA to conduct a warm handoff and ensure that veterans seeking compensation also know where to turn for treatment. Yet the evidence suggests that this does not occur.

Chairman MURRAY. Mrs. Sawyer, thank you very much for sharing that story and for your tremendous courage as well as those of your husband and your family helping us understand what you are going through. So, thank you to both of you.

Mr. David Underriner, please proceed.

STATEMENT OF DAVID THOMAS UNDERRINER, CHIEF EXECUTIVE, PROVIDENCE HEALTH & SERVICE, OREGON REGION

Mr. UNDERRINER. Chairman Murray, Ranking Member Burr, and Members of the Committee, I really respect what Daniel and Andrea and Loyd have been going through. And in the context of what we do at Providence, I will go through it in my testimony to reflect the concern that we have in caring for individuals in our communities.

My name is David Underriner. I am currently serving as Chief Executive, Delivery System for the Oregon Region of Providence Health and Services. Providence Health and Services is a Catholic-sponsored, not-for-profit health care system serving communities across Oregon, Washington, Montana, California, and Alaska.

It was founded by Mother Joseph of the Sacred Heart in 1856 in Vancouver, WA. Providence Health and Services comprises 27 hospitals, more than 34 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 50,000 employees, and numerous other health, housing, and educational services.

I am here today to describe the steps taken by Providence Health and Services in Oregon to improve clinical integration of behavioral health in to our broader health care delivery system over the past 25 years, including our current work to fully incorporate behavioral health into the care provided to the patient-centered health home. We thank you for the opportunity to present today and share what we have learned over the past quarter century.

First, I would like to provide some context as to why behavioral health is so important to Providence. Our mission cause us to provide high-quality compassionate care to all people with a special emphasis on serving the poor and vulnerable in our communities. Those dealing with mental health conditions are amongst the most vulnerable of those we serve, often suffering from physical challenges directly connected to an underlying behavioral health condition.

As such, Providence has striven for 150 years to ensure that people suffering from mental illness are able to access the care they need regardless of their circumstances. In fact, in 1861 the Sisters of Providence opened the first mental health facility in what was then the Washington territory.

We believe effective behavioral health care is a key component of improving the health status of our communities. To that end, Providence developed a vision statement that guides our day-to-day operation and provides a roadmap for our strategic initiatives and planning.

Our vision for behavioral health is as follows: "Providence Behavioral Health Services will be an advocate and leader in developing a patient-centered system of care for people with mental health and substance needs. The system of care will be evidence-based, focus on recovery and work in partnership with our community of providers, educators, consumers, and families. This connected experience of care will achieve superior outcomes and patient satisfaction."

That is what drives us.

This vision is pursued through a comprehensive organizational structure led by physician and administrative leadership focused on patient outcomes, population health, care coordination, patient satisfaction, strategic partnerships in the community, advocacy, clinical transformation and physician integration, research and education.

More than 25 years ago, as part of Providence's development of an integrated delivery system in Oregon, the decision was made to include behavioral health as a distinctive, service-line program due to its importance as a clinical area of excellence.

Providence Health and Services in Oregon has eight service lines, including heart and vascular, cancer, brain and spine, and behavioral health. Each of these service lines has defined leadership and strategic plans for delivery of services and programs in a coordinated, efficient, high quality, and cost-effective fashion.

This decision, perhaps more than any other, facilitated the integration of behavioral health services into the larger delivery system by elevating it as a key clinical program that requires overarching leadership and strategic focus. It also set forth the path toward full integration of behavioral health into our regional delivery system.

The decision led to a series of initiatives which were outlined in our written testimony.

I would like today to focus on the patient-centered medical home. Consistent with our vision of a connected patient experience through a coordinated model of "team based" behavioral health services, Providence in Oregon has set about to fully weave behavioral health into our patient- centered health home model for primary care.

This not only includes adding a behavioral health specialist in our primary care clinics; it also includes standardization of how we identify patients in need of assistance, development of clinical guidelines and creation of a team-based model of holistic care for patients being served in our clinics.

This model involves the entire care team in the primary care clinic, with the primary care provider in the oversight role in the management of the patient, both in terms of his or her medical and behavioral health needs.

The Providence medical group has developed a tiered approach to the assessment and treatment that is both standardized and flexible. Specifically, the tiered approach in behavioral health includes the use of a patient behavioral health screening packet which focuses on using comprehensive diagnostic methods to identify specific behavioral health issues concerning the patient.

A behavioral health care plan is developed and implemented and improvement is measured. If the patient requires a higher level of

care, appropriate referrals are made within the community or within the system.

As you can see, for the patient the team approach provides for a comfortable, connected experience in which his or her whole person can be addressed in the clinic visit. The team knows them, cares for them, and eases their way.

Despite the significant challenges resulting from lower reimbursement and inadequate numbers of mental health providers in the communities, we remain committed and steadfast in our commitment to behavioral health as a priority service line.

Integrating behavioral health and medical home model provides an important, seamless point of access for patients, particularly those whose medical concerns are intertwined with a mental health condition.

We thank you for the opportunity to speak today. I am happy to answer any questions that you may have.

[The prepared statement of Mr. Underriner follows:]

PREPARED STATEMENT OF DAVID UNDERRINER, CHIEF EXECUTIVE, DELIVERY SYSTEM, PROVIDENCE HEALTH & SERVICES, OREGON REGION

INTRODUCTION

Chairwoman Murray, Ranking Member Burr and Distinguished Members of the Senate Committee on Veterans Affairs: Thank you for providing me, on behalf of Providence Health & Services, the opportunity to offer testimony on the very important topic of behavioral health care for American Veterans and how the Veterans Administration can take steps to improve access to behavioral health services through increased integration of care delivery. My name is Dave Underriner and I currently serve as Chief Executive, Delivery System for the Oregon Region of Providence Health & Services. In this role I am responsible for management and oversight of our eight hospitals in the state, as well as statewide functions including nursing, pharmacy, information systems, ethics and foundations.

Providence Health & Services is a Catholic-sponsored, not-for-profit health system serving communities across the states of Oregon, Washington, Montana, California and Alaska. Founded by Mother Joseph of the Sacred Heart in 1856 in Vancouver, Washington, Providence provides health care across the full continuum. Today, Providence Health & Services comprises 27 hospitals, more than 34 non-acute facilities, physician clinics, a health plan, a liberal arts university, a high school, approximately 50,000 employees, and numerous other health, housing, and educational services.

Our mission calls for us to place a special emphasis on serving the poor and vulnerable in our communities. As such, Providence has striven since our founding to ensure that people suffering from mental illness are able to access the care they need, regardless of their circumstances. In 1861, the Sisters of Providence opened the first mental health facility in the Washington Territory. The sisters ran the hospital for five years and were commended by the territorial Governor for their humane, conscientious and compassionate care of the mentally ill. This commitment continues today across our system.

Our vision for behavioral health is as follows: "Providence Behavioral Health Services will be an advocate and leader in developing a patient-centered system of care for people with mental health and substance use needs. The system of care will be evidence-based, focus on recovery and work in partnership with our community of providers, educators and consumers. This connected experience of care will achieve superior outcomes and patient satisfaction."

This vision is pursued through a comprehensive organizational structure led by physician and administrative leadership focused on patient outcomes, population health, care coordination, patient satisfaction, strategic partnerships in our communities, advocacy, ongoing clinical transformation and physician integration, research and education.

INTEGRATING BEHAVIORAL HEALTH WITH PHYSICAL HEALTH CARE
IN THE STATE OF OREGON

More than 25 years ago, as part of Providence's development of an integrated delivery system in Oregon, the decision was made to include behavioral health as a distinct service line/program due to its importance as a clinical area. Providence Health & Services in Oregon has eight service lines, including heart and vascular, cancer, brain and spine, and behavioral health. Each of these service lines has defined leadership and strategic plans for delivery of services and programs in a coordinated, efficient, high quality and cost-effective fashion through development of a continuum of programs and care models.

This decision, perhaps more than any other, facilitated the integration of behavioral health services into our larger delivery system by elevating it as a key clinical program that requires overarching leadership and strategic focus. It also set us on the path toward full integration of behavioral health in our regional delivery system.

Among the noteworthy integrated behavioral health models developed over the past two decades include:

1. *Consult Liaison Team:* The Consult Liaison Services (CLS) team has long been seeing patients who are admitted to Medical/Surgical floors in both Providence Portland Medical Center and in Providence St Vincent Medical Center. In 2005, the team was expanded to include Psychiatrists, Nurse Practitioners, Social Workers and Counselors. These practitioners meet with patients who have been admitted for physical medical procedures, but who have been identified as having some related mental health or chemical dependency care needs. The CLS assess the patient's symptoms or problems and make recommendations regarding "next steps" in the treatment of the behavioral health issues. Often times, the CLS is able to connect the patient with follow up care for these needs within Providence Health and Services or in the community.

2. *Access Triage Call Center:* Since 1997, this service has been staffed by masters prepared social workers and counselors and is available to members of the community including referred patients, potential patients, concerned family members and primary care physicians or other healthcare providers. The call center staff have these primary roles:

- Assess the caller's current situation, including risk for harm to self or others;
- Facilitate the involvement of other agencies (police, crisis team, EMTs) as needed;
- Triage to the next level of care needed;
- Whenever possible, engage the caller in an intake process for one of the Mental Health or Chemical Dependency services offered at PH&S.

In 2007, the Access Triage Call Center initiated a "pilot" program with the Providence Medical Group (PMG) Clinic in Sherwood, Oregon as a mechanism to respond to medical care providers concerns about depressed patients who may be thinking of suicide. The call center supported a dedicated line that PMG health care providers could utilize either in consultation, or to have the patient speak directly to a behavioral health clinician.

In 2010, the Access Triage Call Center piloted a project to provide follow up calls to people who visited the Emergency Department at Providence Portland Medical Center for mental health or chemical dependency reasons. The goal of the project is to reduce the frequency of visits by individuals who presented repeatedly for care. Call center staff call out to the identified individuals and offered support for the person in completing their discharge plan.

3. *Behavioral Health Interface with PMG*—In 2004, one of the masters-prepared counselors from Access Triage was placed in the PMG Gateway Clinic in Portland as a pilot. The counselor's appointment times were quickly booked up by the health care providers who had active patients that needed counseling support. This position has continued through the current time as a result of the pilot. It also has laid the foundation for a current plan which PMG has recently launched.

In 2010, the Access Triage Call Center provided telephone support to PMG patients who were participating in an on-line depression study. Patients were identified by their primary care physician, invited to participate, and then began the study. Patients were able to contact Access Triage for support and/or intervention, if needed, at any time during the study.

In 2011, seven clinics were identified for a project which would staff each of the chosen clinics with a Behavioral Health Specialist. The specialist is tasked with assessing the level of care needed by the PMG patient and facilitating the patient's entry into treatment, particularly into the Partial Hospital or Intensive Outpatient

levels of care, before the patient's symptoms develop to a level that requires a hospital admission.

Both individually and collectively, these initiatives support improving access for mental health patients such that they can receive the right level of care when they needed—to be directed to the "right door" the first time. This goal of creating a single point of access has evolved to provide points of access from other settings within the Providence delivery system and allows Providence providers to act in concert to ease the way of patients in need of behavioral health services.

CURRENT INTEGRATION EFFORTS: PATIENT-CENTERED MEDICAL HOME

Consistent with our vision of a connected patient experience through a coordinated model of "team based" behavioral health services, Providence in Oregon has set about to fully weave behavioral health into our Patient-Centered Health Home model for primary care. This not only includes adding a behavioral health specialist into our primary care clinics; it also includes standardization of how we identify patients in need of assistance, development of clinical guidelines and creation of a team-based model of holistic care for patients being served in our clinics.

This model involves the entire care team in the primary care clinic, with the primary care provider (PCP) in an oversight role in the management of the patient, both in terms of his or her medical and behavioral health needs. Providence Medical Group has developed a tiered approach to assessment and treatment that is both standardized and flexible:

1. The patient is referred to the clinic's behavioral health provider by his/her PCP to address any behavioral health issues that may be exacerbating a current physical health condition.
2. The patient, with a behavioral health provider and medical assistant, completes a questionnaire and screening packet;
3. The behavioral health provider then determines the intensity of the necessary intervention based on the screening;
4. The Care Team, led by the PCP, is activated—treatment is planned and implemented, including facilitating connection to the community and specialty care if needed. This also includes consultation on drug therapy management with a pharmacist who is also part of the team.

The behavioral health provider also educates members of the care team on documentation, coordination and treatment support for behavioral health concerns. Providence began developing the fully integrated PCMH model at four of our PMG clinic sites, with three additional clinic pilot sites scheduled to be on line by September 2011.

The PCMH integration initiative will measure effectiveness using a variety of metrics, including:

- Improvement in patients' Patient Health Questionnaire (PHQ–9) scores from first to last session with their behavioral health provider;
- Patient and provider satisfaction improvement;
- Reduction of Emergency Department (ED) visits for patients seen by the behavioral health provider;
- Reduction of hospital visits for patients seen by the behavioral health provider
- Improvement in chronic care conditions for those patients seen by the behavioral health provider;
- Process and other measures, such as number of handoffs to behavioral health specialist, average time to initial appointment with behavioral health specialist, percentage of use of community support networks and medication adherence.

For the patient, the team approach provides for a comfortable, connected experience in which his or her whole person can be addressed in the clinic visit: the care team knows them, cares for them and eases their journey to improved health.

CONCLUSION: IMPLICATIONS FOR THE VA HEALTH CARE SYSTEM

Despite the significant challenges resulting from low reimbursement and inadequate numbers of mental health providers in the communities, Providence has remained steadfast in its commitment to behavioral health as a priority service line program in Oregon. Integrating behavioral health into the medical home model will provide an important, seamless point of access for patients—particularly those whose medical concerns are intertwined with a mental health condition, in some cases one that is undiagnosed.

The VA health system, in our view, has both an imperative and unique opportunity to fully integrate behavioral health care into its delivery models. According

to recent statistics, 48 percent of veterans returning from duty in Afghanistan and Iraq are diagnosed with a mental health condition.[1]

Over the past two decades, the VA has greatly strengthened its primary care capacity and has taken important steps by developing integrated health networks across the Nation and re-focusing the system on population-based care delivery, rather than a hospital-oriented system. From 1995 to 2005, the VA expanded its primary care access points by 350 percent. The VA has been a leader in the use of electronic medical records (EMRs) and automating care processes.[2]

Additionally, the VA health system's utilization of employed physicians provides a key structural component that allows the system to integrate its service lines more rapidly—including behavioral health. By emphasizing the primary care clinic setting as the focal point of diagnosis, care planning and referral for veterans' health concerns, there is a strong opportunity to create a more comfortable, safe and efficacious environment to meet their needs.

It is our hope that the Providence experience in clinically integrating behavioral health with physical health in our Oregon region can offer some perspective that will benefit the VA health system as it moves forward in redesigning care systems and structures in order to better serve the current and future health needs of America's military veterans.

Thank you for the opportunity to speak to you today.

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[1] Veterans Administration, "Analysis of VA Health Care Utilization Among US Global War on Terrorism Veterans, 4th Quarter, Fiscal Year 2009," March 1, 2010.

[2] Thomas L. Garthwaite, MD, Presentation to Federal Trade Commision workshop, "Clinical Integration in Health Care: A Checkup, The Veterans Health Administration Experience," May 29, 2008

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO DAVID UNDERRINER, CHIEF EXECUTIVE, DELIVERY SYSTEM, PROVIDENCE HEALTH & SERVICES, OREGON REGION

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August 3, 2011

The Honorable Mark Begich
United States Senate
111 Russell Senate Office Building
Washington, D.C. 20510

Re: Coordination of services in Alaska between the VA and Providence Health and Services

Dear Senator Begich:

Thank you for your interest in Providence Health & Services' efforts to integrate behavioral health services into our care models in Alaska. In response to your question, I want to present you with an overview of the integrated health care services that Providence Alaska provides to its patients, which benefit both Veterans and active duty members.

At Providence, we offer a full continuum of behavioral health services in Anchorage as well as some targeted services in Wasilla, Valdez and Kodiak. In Anchorage the following services are available through Providence:

Psychiatric Emergency Department
Located towards the back of the main ED at Providence Alaska Medical Center, this secure section of the ED sees approximately 4000 admissions per year. Patients present to the ED themselves or are brought in by friends or family members or by the police. About 60% are treated and are able to return home after several hours. Approximately 20% are hospitalized either at the Alaska Psychiatric Institute or in Providence's mental health unit. Veterans can and do make use of this service.

Adult Mental Health Unit and Adolescent Mental Health Unit
Patients who need acute care services are admitted to the appropriate mental health unit. Patients may come in through the Psychiatric Emergency Department or they may be directly admitted if the referring physician works directly with the inpatient unit's medical director. For example, if a veteran living in Kenai or in Talkeetna is known to the medical director (perhaps through a previous admission) then the veteran's physician can call the medical director and have the patient admitted without going through the Psychiatric Emergency Department. The average length of stay on the adult unit is 5-7 days. These units are unlocked, voluntary units.

Patients must have the ability to give informed consent for admission and need to be able to benefit from cognitive/behavioral therapy.

Crisis Respite Center

Patients who have been screened in the Psychiatric Emergency Department may be referred to the CRC as a way to avoid hospitalization. CRC clients tend to be those who are grappling with recurrent and/or chronic conditions. They are encouraged to use the CRC proactively rather than wait until their symptoms are out of control necessitating a trip to the emergency room. CRC clients may have diagnoses of schizophrenia, borderline personality disorder, PTSD among others. Clients generally do not stay in the CRC longer than two weeks. It is a voluntary, unlocked program.

Consultation/Liaison Services

Patients who are in medical or surgical units of PAMC due to significant medical needs, may also need mental health services. These are provided by the Consultation/Liaison service. Either a psychiatrist or a psychiatric nurse practitioner will evaluate and provide follow up care to patients on medical or surgical floors of the hospital.

Providence Behavioral Medicine Group

PBMG is a large outpatient psychiatric clinic with branches in Anchorage and Wasilla. These clinics provide traditional outpatient therapy as well as medication review and management.

Breakthrough Chemical Dependency Program

The Breakthrough program offers a variety of outpatient chemical dependency programs which can be tailored and combined to meet many needs. There is a day treatment option for those with more intensive needs, an evening outpatient treatment option, a family treatment component and an aftercare component.

Providence Adolescent Residential Treatment

This is a small, highly structured program for adolescent girls who have experienced multiple treatment failures in a hospital setting and need long term therapy. Often, these young women have extensive abuse histories and the average length of stay in this program is approximately one year.

Kodiak and Valdez Counseling Centers

These two community mental health centers provide outpatient therapy for mental health and chemical dependency issues.

Psychiatric Residency Development

Alaska has a significant shortage of only two physician specialties – internal medicine and psychiatry. Providence has a very successful Family Medicine Residency program and is now working to add a pediatric residency and a psychiatric residency to the mix. The VA is one of the partners in a coalition of federal and state agencies, hospitals, providers, the University of Alaska and the University of Washington who are trying to develop a psychiatry residency program to resolve this critical shortage.

All of the services offered by Providence welcome veterans as well as active duty members. Providence serves veterans and active duty members every day, and the coordination between Providence and both services is generally very good. For example, the VA routinely provides case management services and discharge planning for any veterans who are receiving inpatient care.

We have heard veterans in Valdez and Kodiak say they wish they could be approved to get services in their home community rather than have to travel into Anchorage to the VA. This comment applies to medical as well as mental health services. One service currently needed is a longer-term PTSD treatment program, possibly an inpatient one.

Providence is working daily on methods that will increase care coordination and benefit the VA health system as it moves forward in redesigning care systems and structures in order to better serve the current and future health needs of America's military veterans.

Sincerely,

Dave Underriner
Chief Executive, Delivery Systems
Providence Health & Services, Oregon Region

Chairman MURRAY. Thank you very much for your testimony. Dr. Daigh.

STATEMENT OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY MICHAEL SHEPHERD, M.D., SENIOR PHYSICIAN

Dr. DAIGH. Madam Chairman, Ranking Member, Members of the Committee, it is an honor to be here to represent the work of the Inspector General to you today.

I would like to first thank Andrea and Daniel for their courage, for the statements they made as prior to me giving this testimony.

There are two gaps in the delivery of mental health care that I would like to emphasize in my oral statements with you. The first has to do with what I would call coordination of care. We have looked at a number of cases over the years in detail where veterans either committed suicide or had other untoward outcomes.

It has been almost a constant in those cases that at the level of the patient trying to get his care coordinated either between CBOCs, Vet Centers, and VA medical centers, but also between VA-owned facilities and civilian facilities.

Veterans that we have looked at closely almost never get their care entirely from the VA. They get it both from the community and from private practitioners.

And third, the family of these veterans who are adults often feel left out at the end of the day when bad things have happened.

So, I think that the coordination of care between the communities involved in these veterans is a very important issue.

I think that the patient-aligned care teams, as I understand them, offer an opportunity, and I hope will address this problem over time. So, I think that is hopefully a good way to begin to look at that problem.

The other gap that I would like to talk about would be access to who I would call mental health specialists, and for me that would be those psychiatrists, psychologists, and in the VA system, I would also include in that group pain management experts since so many of our veterans return from war with physical disabilities, have substance-abuse disorders and/or have pain syndromes that are really quite complex to deal with.

When we looked at residential rehab programs in the report we recently published where VA had established staffing guidelines for physicians, PAs, and nursing practitioners, they had in these programs 73 percent of the individuals they thought they should have. For psychiatrists, they had 68 percent. For psychologists, they had 49 percent. And for social workers, they had 65 percent.

In the recent report we published on Atlanta waiting times, one of the problems that complicated the issue in Atlanta, from our point of view, is that there was inadequate mental health staffing at CBOCs, not that the VA did not try to put mental health providers there but they were not there; and I think that diminished the flexibility of Atlanta to deal with the issues that they had.

So, I guess, I would make the point that when you have extremely complex patients presenting with very complex mental health conditions, I think they need to see rather quickly the captain of the team who, for me, would be a psychiatrist or an experienced provider.

And that individual then needs to lay out a plan that the rest of the team, the patient-care aligned team and all the support staff can then follow. So, I am less comfortable that the patient-aligned care team will directly get individuals to the specialist that they need to see. It might do that. I am just skeptical as to whether it will do that.

So, I think that given the staffing issues that we see, I think the VA ought to consider, in areas where there are a relative wealth of mental health providers, establishing arrangements with those providers that are beyond the fee-basis arrangement, arrangements where a medical record can easily be shared, where the coordination of patients is easily seen and easily understood and a common activity.

Where VA does not have primary care outposts, which is a large part of the country, and where the communities might be small enough that there really is not a demand for mental health providers, I think VA needs to sit down and talk with the State and local leaders, mental health providers, to see if they cannot pool pa-

tients to create the demand and pool resources to provide the clinics that might then take care of those individuals where they live.

With that, I would end my oral statement, and Dr. Shepherd and I will be happy to answer questions. Thank you.

[The prepared statement of Dr. Daigh follows:]

PREPARED STATEMENT OF JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Madam Chairman and Members of the Senate, Thank you for this opportunity to testify on the delivery and the quality of mental health care provided by the Department of Veterans Affairs. My statement is based on the many reports issued by the Office of Inspector General (OIG) including reports on system-wide reviews and reports on the care provided to individual veterans. Accompanying me today is Michael Shepherd, M.D., Senior Physician in the OIG's Office of Healthcare Inspections.

BACKGROUND

The Veterans Health Administration (VHA) has been a national health care leader for many years due to the quality and dedication of VA employees, their use of the electronic medical record, their national patient safety program, and their commitment to use data to improve the quality of care. VHA's decision to provide public access to extensive data on quality and process measures is a further step forward as is the decision to limit the surgical procedures at facilities based on the facility's ability to handle follow-up care.

The delivery of mental health care to veterans is a significant challenge for VA, especially due to the growing number of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans seeking care and their often coexisting complex medical conditions. According to VA, more than 1.2 million of the 5.2 million veterans seen in 2009 in VA had a mental health diagnosis. This represents about a 40 percent increase since 2004.

The percentage of OEF/OIF veterans enrolled in VA is historically high compared to prior service eras. Among VA-enrolled OEF/OIF veterans, 51 percent have received mental health diagnoses and rates of Post Traumatic Stress Disorder (PTSD) and depression have steadily risen as the contemporary nature of warfare increases both the chance for injuries that affect mental health and the difficulties facing veterans upon their return home. In addition, mental health issues are often contributing factors to veterans' homelessness.

UTILIZATION OF VA CARE

One area that many perceive as a gap is in mental health services for women veterans. The OIG was asked to review VA's capacity to address combat stress in women veterans (*Review of Combat Stress in Women Veterans Receiving VA Healthcare and Disability Benefits*, December 16, 2010). We assessed women veterans' use of VA health care for Traumatic Brain Injury (TBI), PTSD, and other mental health conditions. To conduct this review, we analyzed integrated data from almost 500,000 male and female veterans who separated from the military from July 1, 2005, to September 30, 2006, for their experience transitioning to VA and using VA health care and compensation benefits through March 31, 2010. Nearly half of these veterans served in OEF/OIF before their separation. Using this data, we described veterans' experience transitioning to VA and using VA health care and their compensation benefits through March 31, 2010.

We found the following:

• *Female veterans generally were more likely to transition to and continue using VA health care services*—As of March 31, 2010, 199,301 (40 percent) veterans in the study population and 52 percent OEF/OIF veterans used or transitioned to VA health care. Higher proportions of female veterans transitioned to VA care than their male counterparts, except for the non-OEF/OIF reserve component cohort in which proportions of females and males were the same. In addition, 23 percent used Department of Defense care (including TRICARE), although they did not use VA care. Among veterans who transitioned to VA health care, female veterans generally were more likely to use VA health care and used it more frequently than male veterans. We examined individuals' numbers of VA outpatient visits by year for the 3 years after military separation to assess whether veterans continued their use of VA health care after their initial decision to use VA. Female veterans continued more

frequent use of VA care than their male counterparts by years after separation. Increasing trends of utilization were observed for male and female veterans diagnosed with mental health issues, PTSD, TBI, and veterans with military sexual trauma.

• *Higher proportions of female veterans generally were diagnosed with mental health conditions by VA after separation, but lower proportions were diagnosed with PTSD and TBI*—VA diagnosed about 22 percent of the study population with mental health conditions, with higher proportions of female veterans generally diagnosed than their male counterparts. Overall, VA diagnosed more than 9 percent of the study population with PTSD. The proportion of OEF/OIF veterans VA diagnosed with PTSD was at least 3 times higher than those of their non-OEF/OIF counterparts. However, VA diagnosed fewer female veterans with the specific mental health condition of PTSD except for the veterans in the non-OEF/OIF active duty cohort. VA diagnosed over 2 percent of the study population with TBI. The proportion of OEF/OIF males diagnosed with TBI was twice as high as those of females across military components. The proportion of OEF/OIF veterans diagnosed with TBI was more than 3 times greater than their non-OEF/OIF counterparts.

• *In keeping with the results of the VA diagnosis, higher proportions of female veterans generally were receiving disability benefits for mental health conditions, but a lower proportion for PTSD and TBI*—As of March 31, 2010, nearly 126,500 (26 percent) veterans in the study population were receiving compensation for their service-connected disabilities. Among the veterans awarded disability compensation, 30 percent of them were receiving some disability award for mental health conditions. Higher proportions of female veterans were receiving service-connected disability compensation and receiving some compensation for mental health conditions, except for the OEF/OIF reserve duty component cohort in which the corresponding proportion of females was about 1 percentage point lower than that of males. However, lower proportions of females generally were awarded disability compensation with a component for the specific mental health condition of PTSD.

For OEF/OIF veterans, PTSD was the most common disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. Higher proportions of female veterans received some disability compensation than their male counterparts for each of the five prevailing mental disability award components, except for PTSD. Less than 1 percent of the veterans in the study population were awarded service-connected TBI disability, with lower proportions of females than their male counterparts.

PROGRESS MADE, BUT MORE WORK REMAINS

VA Mental Health Residential Rehabilitation Treatment Programs

The OIG issued a follow-up report to a comprehensive 2009 review of VHA residential health care facilities (*A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs*, June 22, 2011). The 2009 report contained 10 recommendations based on identified areas of concerns (*Healthcare Inspection—Review of Veterans Health Administration Residential Mental Healthcare Facilities, June 25, 2009*). Our 2011 review evaluated any improvements made or problems remaining in these areas since our 2009 report.

The 2011 review found that progress was made in many areas, but in one key area, VHA made little interim progress—ensuring contact with patients during the time interval between acceptance into a mental health residential rehabilitation program and the start of the program—indicating an ongoing challenge with continuity during care transitions. Also, we found two other areas of concern: the actual staffing in place despite core mental health clinician staffing guidelines and, in light of the emphasis on a recovery based model, the 4 percent of patients referred to vocational rehabilitation services. We also remain concerned about the provision of more than a 7-day supply of narcotics to veterans in residential programs. We made 7 recommendations to the Under Secretary for Health; we will monitor VHA's implementation of those recommendations through the OIG's Follow-Up Program.

Post-Traumatic Stress Disorder Counseling Services

We conducted an inspection of the Readjustment Counseling Service (RSC) Vet Centers' PTSD counseling services to determine how Vet Centers screen for PTSD; if documentation of clients' treatment is in compliance with policy; and if providers are trained to provide PTSD counseling services according to policy (*Healthcare Inspection—Post-Traumatic Stress Disorder Counseling Services at Vet Centers*, May 17, 2011).

In a previous OIG review of the RCS Vet Centers' operational services provided during FY 2008, we found that documentation in client treatment records and staff PTSD counseling training was in need of improvement (*Healthcare Inspection—Re-*

adjustment Counseling Service Vet Center Report, July 20, 2009). As part of the 2011 review, we evaluated whether any improvements had occurred in these areas.

Our 2011 review found that RCS Vet Center counselors utilized appropriate tools to screen clients for PTSD. Client treatment case file documentation improved from our FY 2009 report. While staff training has improved, approximately 15 percent of Vet Center providers have not attended RCS' required training on PTSD, and 47 percent of the providers have not attended VHA-sponsored PTSD training. In addition, some Vet Center providers received supplemental training in Evidence-Based Therapy (EBT), and most Vet Centers were providing EBT to PTSD clients.

Although RCS made improvement from our previous review, we found that Vet Center Directors were not consistently providing supervision and consultation to the Vet Center providers in accordance with RCS policy. We made two recommendations which the Under Secretary for Health concurred with and provided an acceptable implementation plan. We will continue to follow up until all actions are complete.

Suicide Prevention

Veteran suicides remain an important focus of VA's mental health delivery plan. VHA estimates that there are approximately 1,600 to 1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans.

At the request of VHA, we reviewed VHA facilities' suicide prevention safety plan (SPSP) practices at 45 facilities as part of the OIG Combined Assessment Program reviews from January 1 through September 30, 2010 (*Combined Assessment Program Summary Report—Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities*, March 22, 2011). Our report found the VHA facilities recognized the importance of developing comprehensive and timely SPSPs for high-risk patients. Additionally, VHA issued appropriate timeframes for initiating SPSPs. However, despite VHA's efforts to comply with suicide prevention program requirements, problems with SPSP development continue to occur. We reviewed the medical records of 469 inpatients and outpatients placed on the high risk for suicide list. We found that 12 percent of these records did not have documented SPSPs. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that mental health providers develop and document timely SPSPs that meet all applicable criteria.

Additional areas that would benefit from increased VHA attention include: ensuring follow-up contact with veterans who have been discharged from a mental health ward within 7 days of discharge to check on their mental health status because this is a time of high suicide risk (in FY 2010, only 4 of 111 medical centers met VA's 85 percent goal for this indicator); and efforts to facilitate ongoing engagement and retention of OEF/OIF veterans in mental health treatment.

Coordination of Care

We reviewed the quality of a veteran's care at a VA Medical Center to determine if the events leading to the veteran's death were connected to any issues with the quality of care (*Healthcare Inspection—Review of Quality of Care at a VA Medical Center*, December 9, 2010). Our review identified three areas that the medical center could improve on. Specifically, the medical center needed to ensure smooth transitions when there are changes in veterans' providers and/or care settings. The medical center also needed to improve internal communications between providers and external communications with veterans and other parts of the VA system to ensure that significant information is communicated timely and with individuals who have a need to know. Last, the medical center needed to review the procedures of the Disruptive Behavior Committee to ensure clear and consistent messages about patient risk and to promote patient-centered solutions when risks are identified. Whether addressing these three issues previously would have resulted in a different outcome for the veteran is unknown.

While this report focused on one veteran's care, it follows a series of reports on individual veterans' care that continue to indicate that for those veterans with a complex interplay of mental health, medical, and psychosocial issues, VHA needs to better coordinate care internally among providers and clinics, between VBA and VHA, and when possible between private sector health care providers, families, and VA.

TOPICS AFFECTED BY MENTAL HEALTH CARE

Homeless Veterans and the Relationship to Mental Health

The Secretary has committed to reducing the number of homeless veterans. In many instances, VHA has provided compassionate care to a most challenging popu-

lation. We conducted a review of allegations that VHA staff discharged a homeless veteran to a shelter without the ability and appropriate supplies to care for himself, and against his will (*Healthcare Inspection—Alleged Continuity of Care Issues VA Greater Los Angeles Healthcare System Los Angeles, California*, March 4, 2011). We did not substantiate the allegations.

At the time of discharge, system staff determined that the patient had capacity to make decisions, was medically stable, and was able to care for himself. Discharge planners explored and offered appropriate disposition options. However, the veteran refused all available options because each required behavioral agreements and/or Social Security contributions. Throughout the discharge planning process, the veteran often told staff he intended to return to being homeless. Staff negotiated plans for him to go to a homeless shelter (which he agreed to do), and provided him with instructions on self-care, medication that did not require refrigeration, medical supplies, follow-up appointments, and transportation to a shelter. We found that staff made multiple and reasonable efforts to negotiate acceptable and safe disposition plans with the veteran while also respecting his right to make his own decision. VHA is challenged to determine which sub-population of veterans is most at risk of becoming homeless, and of placing homeless or at risk veterans into programs that are demonstrated to be effective.

Pain Management Program Impact on Mental Health Treatment

Pain management programs remain a difficult problem for VA to manage and appear to have an uneven impact upon patient care across the country. The OIG has published a number of hotline reports on this topic and is in the process of a national review of issues related to pain management (*Healthcare Inspection—Prescribing Practices in the Pain Management Clinic, John D. Dingell VA Medical Center, Detroit, Michigan, June 15, 2011, and Healthcare Inspection—Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia*, October 12, 2010).

The combination of physical injury, medication dependence, and mental illness make this an extremely difficult but important aspect of VA care that requires improved outcomes to assist veterans in their re-entry into civilian society.

CONCLUSION

VA continues to make progress in their mental health programs despite increasing numbers of veterans with significant mental health disorders, particularly among women veterans. Continued attention must be given to improving staffing and access to care, providing continuity during integral care transitions, coordinating care for individual veterans with mental health issues, and linking pain management, mental health, and substance use programs.

Madam Chairman, this concludes my statement. Dr. Shepherd and I would be pleased to answer any questions that you or other members of Committee may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO JOHN D. DAIGH, JR., M.D., ASSISTANT INSPECTOR GENERAL FOR HEALTH CARE, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

VA OFFICE OF INSPECTOR GENERAL RESPONSE TO A QUESTION FOR THE RECORD FROM SENATOR MARK BEGICH FROM THE JULY 14, 2011, HEARING BEFORE THE COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES SENATE ON VA MENTAL HEALTH CARE

Question: Dr. Daigh, in your prepared testimony, you stated that 12 percent of the 469 medical records you reviewed belonging to patients on the high risk for suicide list did not contain the required suicide prevention safety plan (SPSP). Measures such as these seem like simple, yet effective mechanisms for ensuring high-risk individuals receive proper care and attention.

i. What can be done to ensure these SPSPs are completed in a timely and accurate manner?

Answer: In response to the recommendations in the Office of Inspector General (OIG) report, *Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities*, the Under Secretary for Health stated that the Veterans Health Administration's Office of Mental Health Services will identify facilities that have a safety plan completion below 95 percent. The Deputy Under Secretary for Health for Operations and Management (DUSHOM) will require facility directors to submit an action plan that outlines the steps necessary to ensure providers develop and document timely SPSPs, and require each facility director to certify that the action plan has been completed. The OIG will continue to monitor VHA's actions to comply with this recommendation.

ii. Are there other measures that can be taken to help high-risk patients receive proper care and attention?

Answer: There are a number of suggestions that could help high-risk patients receive proper care and attention both in the short term and the long term:

- Ensure follow-up contact with veterans who have been discharged from a mental health inpatient unit within 7 days of discharge. The post discharge time frame is a period of high risk. In fiscal year 2010 only 4 of 111 medical centers met VA's 85 percent goal for this performance indicator.
- Develop innovative efforts to retain Operation Enduring Freedom/Operation Iraqi Freedom veterans in a sustained course of evidence-based mental health treatment once they have engaged mental health services.
- Facilitate the involvement of family members in patients' treatment within the bounds of existing privacy laws.

Chairman MURRAY. Thank you very much for your work on this. Dr. Daigh, let me start with you. As you mentioned, you heard the testimony. The stories that we have heard before the Committee today are not unique. I hear them everywhere I go, and Congress has been listening to this. We have responded with the resources, with legislation, new programs. The IG has provided the oversight.

Yet, here we are, and these stories are still here and they are relevant again today. You mentioned a little bit in your testimony about problems in the coordination of care. I heard you talk about Atlanta, that they needed more clinicians but it is not that they did not try, I think you said. It is just that they were not there.

Is it lack of providers? Is it lack of resources? Tell us what we need to be doing in order to make sure that the VA has what it needs, or what we should be telling the VA what it needs to do.

Dr. DAIGH. I think that from my understanding of the situation in Atlanta and looking at the data, there was a tremendous growth in the demand for mental health services over a relatively short period of time.

Some of the assumptions that they made about how they would provide care, their inpatient ward for example, they thought it would be functional and it was not. So, they had to adjust.

I think they could have made better decisions about how they adjusted. Our report says that we think they could have made better decisions about how they adjusted.

But part of the problem is that if you have prearranged relationships with universities or private practices or clinics of specialists that you know you need and you can easily call on them as opposed to fee basis where you say I cannot meet your demand, here is a chit, go get care, if you have an organized way, the records are shared, they expect to see patients.

Chairman MURRAY. Which goes to be closed system that I think Mrs. Sawyer was referring to, is that it?

Dr. DAIGH. I think it is along the lines of what she was saying where she was able to go outside the system and get some help that was coordinated with it but maybe not. I am not sure. We can talk.

Chairman MURRAY. Mrs. Sawyer, tell me what your experience was.

Ms. SAWYER. We actually were not able to use the fee-basis system in the VA as fee-basis was not an option offered. Because my is medically retired, we have TRICARE and so we just simply chose to exercise the TRICARE benefit. It was not in conjunction with the VA.

Even requesting a fee basis at Richmond even for physical medical care is a labor-intensive process. It takes months. It is not easy to get done. It is really kind of a broken system.

So, even though there has been a directive that people should be able to use fee-basis care, in terms of wait, you still have to get it approved and it almost takes, pardon the pun, and an act of Congress to get it done.

Chairman MURRAY. Mrs. Sawyer, in your testimony, let us talk about that. I mean, you just told us time and time again that you were fighting everything to get appointments, to get attention. Dr. Daigh mentioned needing a captain of the team.

Did you ever feel like there was a captain of the team?

Ms. SAWYER. Quite honestly, I feel like I am the captain of the team. I feel that I monitor symptoms. I see the increase in symptoms, the decrease in his quality-of-life, and that at that time I activate the chain as it is.

I call the FRC. I call the clinic. I call the OIF case manager. I do everything that I can. The problem with the VA is that we have found is time and time again I have gone in and said, "We are seeing the civilian counselor." I have said it to neuro-psychiatrist. I have said it to the person he was seeing in the PTSD clinic. I have said it to his OIF case manager. It is in his records.

And yet, again and again, I get comments from the PTSD clinic, "We did not know he was seeing anyone else." I am sorry. You can Google it and find that he is seeing someone else. We have not stayed quiet about it.

We just cannot get them to pay attention. I hand the number over. I ask them to call his counselor. I am his health care power of attorney. There is a flag on his chart. I am supposed to coordinate his medical information because of a cognitive processing disorder. I constantly say, "Please call his counselor," and they do not.

Chairman MURRAY. This is a full-time, 24/7 job for you.

Ms. SAWYER. Yes, ma'am, I gave up my job. In order to keep him alive—that is what I had to do.

Chairman MURRAY. I hear that all the time, and it has to have a huge impact on you and take a tremendous amount of courage. I think about all the men and women out there who do not have a Mrs. Sawyer as the captain of their team. I appreciate what you have been doing.

Ms. SAWYER. Thank you.

Chairman MURRAY. Mr. Williams, again thank you for your service. All of what you are talking about is echoed in many other stories as well. You mentioned getting a hard time geting an appointment. I was curious whether any of the mental health care you receive is offered after hours or on weekends.

That is another thing I hear from a lot of people who have a job, do other things, and cannot get care because of lack of after hours or weekend services.

Is that something that you have been able to access or see a need for?

Mr. WILLIAMS. There needs to be a larger amount of this care, yes. The access, the only access I have to this is the Vet Center, which is not communicating with the VA actual facility.

This is a center where they do after-hours counseling. They do marriage counseling. They are really not communicating to be honest with you. They have no idea what is going on. There needs to be more of it. There needs to be more advertised that there is these after-hours care that can be used when, you know, you have, you get off at six o'clock, well, they have sessions at seven or eight o'clock at night.

You know, the family members need this care too because the family members have the same or gain the same PTSD or whatever the diagnosis may be as the veteran does.

I know, as Mrs. Sawyer said, she gave up her, pretty much her life, to take over, to help her husband. And this is what happens not only to her but I think just about every family either the spouse leaves or the spouse stands behind them.

And I know if it was not for the woman behind me, I would not have any care that I have today because she has given up her job to take care of me.

And there does need to be some more after hours. I know NAMI is partnering with the VA to do family to family. Family to family is a program that helps the servicemember's family understand why they are doing the things they are doing, why they are trying to get an adrenaline rush, why they are doing these little quirks that may not make sense to the family.

Chairman MURRAY. This may be a rhetorical question, but it seems to me like people like both of you know the system really well. Your family has really borne the burden of this silent disorder of Post Traumatic Stress Disorder and Tramatic Brain Injury. We have a country that says they are there for our soldiers, but you alone have borne this.

Does the country understand PTSD? Do your neighbors and employers and people in the community know what you are going through? Or do you feel pretty alone?

Mr. WILLIAMS. To be honest with you, I feel very alone. The only other people that understand is my family; and when I say my family I mean my wife, and other soldiers or other veterans. They are the only ones that understand the actual pain, the invisible pain that we live with every day.

It is very, very hard to try to express to the Nation. We get condolences. Thank you for your service. We hear that very often. But when was the last time someone actually said, all right, we need to make a change in the VA center. You need more services.

That is the type of thanks that I believe, I take more to heart action than I do words, because like I said, it is not only I suffer from this mental illness of Traumatic Brain Injury, my wife has to go through it. My kids have to go through it.

So, this is a never-ending cycle. My kids will have PTSD because of my actions. If we could put peers together, family members, like Mrs. Sawyer and my wife together, more times the support for one another not only for themselves but for us it would be a stronger VA system. They have got to start looking at family-oriented stuff.

It is such a just the veteran that half the time the veteran cannot even get stuff done. I mean, it literally takes my wife getting to the point of being arrested by VA police to be able to see my psychiatric doctor because people are sitting on the phones, talking on their cell phones during business hours, telling me to hold on a minute and I am having a crisis where I am fixing to honestly have a breakdown.

And it takes people like these two women to have, not every veteran has that, not everyone is fortunate enough, and I think that needs to somehow be a mentorship to veterans that do not have the support system.

Chairman MURRAY. Mrs. Sawyer, do you want to add anything?

Ms. SAWYER. Truly I do not feel that the community understands. We spend a lot of time at the VA. Going to the VA is never just go-for-an-hour-for-an-appointment. It is go; you sit. You have a nine o'clock appointment, and you might get seen by eleven. Then the doctor says, "Oh, well, we are only running 2 hours late today. That means we are on time."

Then we sit for an hour. Sometimes it is not a good appointment. Then it takes hours for him to wind it down, and we get home and the neighbors say, "What do you do all day?"

I talk to a lot of other caregivers who are in my situation. I have attempted to mentor some of the other caregivers because I do have a lot of time to deal with caregivers that I have met through the Wounded Warrior Project here at different stages in their recovery.

I have been privileged that they trust me to call and ask, "OK, we are stuck; what do we do?" We needed to build our own strong network outside of the VA and that is really what I use to survive.

We have a community kind of all to ourselves. We have been ostracized from the community. I left my job teaching. I had great scores for the "be all to end all" test at the end of the year that all teachers are judged by whether we say they are or not, great scores.

But I had missed a lot of work. It was my fourth year, my tenure year, and it was Loyd's first year after he was retired. We were spending a lot of time at the VA, which meant I was spending a lot of time out of the classroom, and my principal came to me and told me I had to choose between getting my husband better and teaching.

So, I left. So no, the community does not understand.

Chairman MURRAY. Thank you very much for sharing that with us.

Mr. Williams, I know your wife is sitting directly behind you. We want to thank her for her being here as well and for all she does for you.

I have gone way over my time. Senator Burr, I apologize. But I felt what they had to say was extremely important for the Committee. So, I will turn it over to you.

Senator BURR. I was interested in your questions and more importantly the answers and, for as grateful as I am that all of you are on this panel, and I have got questions, I am going to forgo all but one because, quite honestly, I do not want anything to stand in the way of the VA coming to that table while your testimony is fresh on their minds and share with us where there is not a problem.

But I will ask you, Andrea, with the exception of your recovery officer, was there anybody in the VA that attempted to solve any of the problems that you had or went the extra mile to try to facilitate some type of remedy to the health challenge?

Ms. SAWYER. We actually have a fabulous OEF/OIF team that is a part of our VA. Our team at Richmond is wonderful. We have a patient advocate, the team leader, and then OEF/OIF case manager social worker. They have since added a couple of people to the office.

Two of them are OEF/OIF vets, and the social worker is the wife of a vet. It is truly personal to them, and they take it personally. They have intervened countless times.

I have watched my OEF/OIF case manager storm down and say, "You had 14 days to act on this referral. It is now day 30. What is your problem?" She has been my champion.

I could not have done without her, but we did not get introduced to that team until a year and a half into the VA; but once we were, they have been absolutely fabulous. They have done everything that they can.

The problem is that they file complaints, and then they do not have the authority to act when nothing is done. So they do, I mean they literally do everything that they can, complain, marched down there, attempt to hold people accountable to see what they can get

done. But then when they cannot get anything done, there is no remedy for the situation. And so, it does necessitate me calling DC.

The other thing that has been helpful for me personally as a family member, the Memphis VA did a pilot study, a telehealth group for caregivers, where there are 10 of us that all knew each other and so we asked to be in a special group. We were spread across the country, and they talked with us once a month on a group call and really tried to give us advice as a group and really to just help us heal and find resources within the system.

The problem with that was it was a year-long pilot and, of course, our year has ended and we are back floundering on our own again.

So, a lot of times I feel like the VA has some great things inside of it, but there is a time limit and when your time limit is done it does not matter if your condition is done. They are done with you.

Senator BURR. You have given us a number of avenues to look at from the standpoint of this Committee, and I am grateful to you for that.

Ms. SAWYER. Thank you.

Senator BURR. I thank the Chair.

Chairman MURRAY. Senator Brown.

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair. I kind of concur with Senator Burr. I am curious, I mean, the stories are not unlike the ones that you have seen, Madam Chair, and others throughout the country.

In Massachusetts, we have very similar problems. They are working on them. With the Guard and Reserve, we have I think a better handle on it than the regular Army folks.

I just had one question of Dr. Daigh. The VA has increased the number of mental health staff by more than 6,800 and are training another 4,000 since last October. Yet, we continue to hear stories like this.

Where do you think the breakdown is?

Dr. DAIGH. I am going to be a little bit of a pessimist here. I think that people will try very hard. I am not sure that all of these stories will ever end. I think there will always be disappointments in the delivery of care between patients, their needs, and providers.

Senator BROWN OF MASSACHUSETTS. But this seems just so egregious, these stories.

Dr. DAIGH. I understand that. I am not disagreeing at all, and I think that the limit that I would see is that I think there is sort of a finite number of practitioners out there.

And when you are in a city where there are mental health resources outside of what the VA owns, I think that an arrangement with those groups that are able to see veterans through a contracted or a regular occurring use would make it easier for the access issues that I think are at the heart of much of what people are talking about to be addressed where people can then see the experts that they need to see.

Senator BROWN OF MASSACHUSETTS. So, is there a breakdown that we can help with? For example, I am in the military still, and I understand there is always rules and regulations.

Is there a breakdown where you are not able to go and seek those outside entities? Is there something that we need to tweak and fix to make that easier?

Dr. DAIGH. I would defer to experts——

Senator BROWN OF MASSACHUSETTS. Is a territorial?

Dr. DAIGH. I would defer to experts on contracting. But my message to you is I do not think fee basis which is, in my view, a blow-off valve for a temporary increase in demand that you cannot meet with the resources you have is working.

And I think a more concerted effort to build relationships within the communities where they exist would alleviate some of what we hear here. And the other piece I think, I do hope that the patient-aligned care teams are better able to deal with the coordination, both within VA and with VA.

So, that would be my view as to what we need to consider.

Senator BROWN OF MASSACHUSETTS. Great. I will defer to the next panel.

Chairman MURRAY. Mrs. Sawyer.

Ms. SAWYER. Senator Murray, if I may, I guess, Senator Brown, what I would like to say about those hiring numbers, with the 7,500 new staff. I heard Dr. Zeiss say in a hearing on the House side a couple of weeks ago that not all of that new staff are actually clinicians. They are techs.

So, they are not all people who are available to actually treat patients. Some of them are support staff. The other thing that I have seen in my experience at the VA is that a lot of people are hired on as only part-time clinicians and the rest of the time they are doing admin or research. They are not boots on the ground 100 percent of the time.

And quite frankly, we have a crisis. They need to be there treating. I am not saying that research is not needed and is not necessary, but at this point we need people seeing patients.

Senator BROWN OF MASSACHUSETTS. Madam Chairman, maybe there is an opportunity for you to inquire like what are the actual boots-on-the-ground numbers so we understand who is working part-time and who is working full time, how many people they are seeing, what is the breakdown so we can get a better handle on that sort of thing.

Chairman MURRAY. I think we will have that opportunity with the next panel. So, we will definitely follow-up.

Mr. Williams, do you have a comment?

Mr. WILLIAMS. Yes, ma'am, I would like to make one more statement. Two things. A better way to see veterans not only with their crisis of not having a lot of doctors and also covering rural areas would be telemedication. I do not think that is an avenue that has been seriously looked at that would help a lot.

Two, you can, right now it is hard to change things if there is a hiring freeze for the VA system, and you could hire peers or veterans that are making great progress in their recovery.

I am not saying for lesser pay. The same thing you can spend on a psychiatrist or a psychologist when we can work together as a team to make a lot better place to save lives.

Chairman MURRAY. All right. I may have additional questions to submit for the record, particularly for Mr. Underriner and Dr. Daigh.

I want to thank all of you for your testimony today, and I concur with Senator Burr: I think it is important for us to get the VA up here. They had just heard your testimony. We want to hear their response.

So again, thank you to each and every one of you for being here today and your continued input to this Committee. It is extremely valuable.

With that, I want to call our second panel up for their testimony. We will pause for just a minute in order to change seats here.

While they are getting seated, I will go ahead and introduce the second panel.

We are pleased to have Mr. William Schoenhard, Deputy Undersecretary for Health for Operations and Management at the Department of Veterans Affairs.

Mr. Schoenhard is accompanied today by Dr. George Arana, Assistant Deputy Under Secretary for Health for Clinical Operations; Dr. Zeiss, Acting Deputy Chief Consultant for Mental Health; and Dr. Schohn, Acting Director for Mental Health Operations.

Mr. Schoenhard, I believe you are going to testify for the panel today. So, if you will proceed please.

STATEMENT OF WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GEORGE ARANA, M.D., ASSISTANT DEPUTY UNDER SECRETARY FOR HEALTH FOR CLINICAL OPERATIONS; ANTONETTE ZEISS, Ph.D., ACTING DEPUTY CHIEF CONSULTANT FOR MENTAL HEALTH; AND MARY SCHOHN, Ph.D., ACTING DIRECTOR FOR MENTAL HEALTH OPERATIONS

Mr. SCHOENHARD. Yes, ma'am. Before I begin, I would like to thank Mrs. Sawyer and Mr. Williams for their testimony. I for one, as a veteran, was very moved by their testimony. I talked to them briefly during this exchange and would very much like to personally follow-up with them and learn more of their story and what we can learn.

But to these people who serve our country, whether they have served in uniform or as spouses of those who have served, their service is appreciated, and I want to express regret for any difficulty that they have had and a pledge to get better.

We have, since 2005, addressed a number of gaps in mental health thanks to the support of the Congress with budget enhancements. As already has been mentioned, a number of staff have been hired.

We have put together a comprehensive mental health strategic plan in a landmark mental health services handbook that was developed in 2008.

As Madam Chairman acknowledged, with the wars our volume of patients served has increased significantly. In 2005 we served 905,000 veterans for mental health services. In fiscal year 2010, that had risen to 1¼ million.

If you consider the number served in mental health in our integrated setting in primary care, the number in fiscal year 2010 was 1.9 million. So, there is a great, great need.

Suicides are obviously of tremendous concern to all of us. One suicide is one too many. A crisis line was established in July 2007. To show you the importance of this, over 400,000 calls have been received on that crisis line since it was initiated with over 15,000 rescues. There is a great need.

Suicide prevention coordinators are now in every of our facilities. We have teams that work in our larger ones to be able to work with our rural and other clinics and CBOCs.

One of the advances this year under Dr. Petzel's leadership, our Undersecretary for Health, is a reorganization, and that is represented here in this panel where a number of clinical leaders have been added to operations in management, where I sit.

We have been, I think, particularly blessed to have a psychiatrist as the assistant deputy, Dr. Arana, who is next to me. And with the addition of Dr. Schohn, who has been in mental health operations working to deploy our uniform mental health handbook, we have more boots on the ground in operations to have consistent deployment, monitoring, and improvements as we go forward.

It is extremely important that mental health be integrated into primary care if for no other reason than the worry that many fellow veterans of mine have and that is a stigma around accessing mental health services.

So, I know the Committee has already received testimony regarding the development of patient-aligned care teams in the effort to integrate better the captain of the ship and the team to be able to forge coordinated care.

I could not agree more with Dr. Daigh from my private-sector experience or in VA so far that improved coordination is needed.

We have made progress. In 2008, 77,000 veterans were treated in primary care settings for mental health. That rose to 155,000 in 2010, but much more is needed as we go forward.

Earlier testimony spoke to Vet Centers. This is another important element of care for veterans because some veterans may be reticent to access traditional VHA services.

These Vet Centers that will number some 300 in 2011 and include 39 rural Vet Centers, 70 mobile clinics are important in terms of outreach. They provide professional readjustment counseling for those who have suffered military sexual trauma, and they provide bereavement counseling for families with servicemembers who have lost their life while on active duty.

In fiscal year 2010, we served 191,000 veterans in these Vet Centers. That is about 1.2 million visits. It is important also to understand that, while there were 120,000 referrals from Vet Centers to our facilities for mental health, 39 percent of those who were seen in Vet Centers do not access traditional VHA services.

So, that is another source of outreach to those who, for whatever reason, may be reluctant to access traditional services. Particularly in my era, the Vietnam era veteran.

Let me just conclude by saying, there is no more important work we could be about than the provision of mental health services. I have seen firsthand, as a veteran on the deployment during war-

time, the impact of the extended deployment. Mental health is integral to the quality of care and the quality-of-life for our veterans.

I come with 34 years of private sector experience. This is the most mission-driven organization I have ever been a part of. I came too from a Catholic system, but this is an area where one suicide is one too many. We can do better and we will do better. Learning from people like Mrs. Sawyer and Mr. Williams today is an important activity for us, and I would again thank the Committee for its focus, its leadership, its support of our efforts. I am happy to answer any questions.

[The prepared statement of Mr. Schoenhard follows:]

PREPARED STATEMENT OF WILLIAM C. SCHOENHARD, FACHE, DEPUTY UNDER SECRETARY FOR HEALTH OPERATIONS AND MANAGEMENT VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Murray, Ranking Member Burr, and Members of the Committee: Thank you for the opportunity to appear and discuss the Department of Veterans Affairs' (VA) provision of mental health care to America's Veterans. I am accompanied today by my colleagues Dr. George Arana, Assistant Deputy Under Secretary for Health for Clinical Operations; Dr. Antonette Zeiss, Acting Deputy Chief Consultant for Mental Health; and Dr. Mary Schohn, Acting Director for Mental Health Operations.

Mental health care is an important component of overall health care and well being. VA recently realigned the Veterans Health Administration (VHA) to enhance effective oversight and to better support VA's health care programs, including mental health. By establishing the Office of Mental Health Operations in the Office of the Deputy Under Secretary for Health for Operations and Management, VA ensures that there is a structure for implementing policies developed by VHA under the guidance of the Office of Mental Health Services. The Office of Mental Health Operations reports to me, and I work closely with the Directors of all of the Veterans Integrated Service Networks (VISNs), thereby making one entity responsible for ensuring that organizational priorities concerning mental health are met. The Office of Mental Health Operations will monitor compliance and provide technical assistance to networks to support implementation of national policies. Priorities will continue to be guided by the Office of Mental Health Services, which serves as the locus of policy development for mental health care in VA. The Offices of Mental Health Services and Mental Health Operations work very closely, supporting each other's efforts fully. This realignment is expected to reduce variance across clinical specialties, including mental health, and to promote an integrated approach to the delivery and management of health care for America's Veterans.

My testimony today will discuss our initiatives to improve access to and the availability of mental health services, and our initiatives to enhance the quality of mental health care VA delivers.

IMPROVING ACCESS

Access to care is the first step toward treatment and recovery. One particularly important barrier to accessing care is the stigma that some believe comes from seeking mental health care. To reduce this stigma and improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions, when appropriate. Mental health services are incorporated in the ongoing evolution of VA primary care to Patient Aligned Care Teams (PACT), an interdisciplinary structure to organize holistic care of the Veteran in a single primary health care team. Between fiscal year (FY) 2008 and FY 2010, the number of unique individuals receiving mental health care in a primary care setting increased by 102 percent, from 77,041 to 155,554. Recent program evaluation studies demonstrate the integration of mental health services into primary care settings has increased access to large numbers of younger, elderly, and women Veterans; these cohorts do not typically access specialty mental health services to the same degree as other populations. In parallel with the implementation of these programs, VA has been modifying its specialty mental health care services to emphasize psychosocial as well as pharmacological treatments and to focus on principles of rehabilitation and recovery. In addition, VA is designing and will deploy this fall important public messaging campaigns to com-

bat stigma and emphasize the strengths of Veterans and the invaluable contributions they make to our country.

VA has responded aggressively since FY 2005 to address previously identified gaps in mental health care by expanding our mental health budgets significantly with the support of Congress. In FY 2011, VA's budget for mental health services, not including Vet Centers, pharmacy, and primary care, reached over $5.7 billion, while the amount included in the President's budget for FY 2012 is $6.15 billion. Both of these figures represent dramatic increases from the $2.4 billion obligated in FY 2005. This funding has been used to greatly enhance mental health services for eligible Veterans. VA has increased the number of mental health staff in its system by more than 7,500 full time employees since FY 2005. There has been recent concern over the use of resources to fill vacant positions, and we share this concern. We will discuss these vacancies with VISN leadership and ask for reports to determine if recent evidence is simply an aberration or a part of a larger trend. If the latter, we will develop strategies and action plans to rapidly address this issue.

For Veterans under VA care, identifying and treating patients with mental health conditions is paramount. VA's efforts to facilitate treatment while removing the stigma associated with seeking mental health care are yielding valuable results. VA screens any patient seen in our facilities for depression, Post Traumatic Stress Disorder (PTSD), problem drinking, and a history of military sexual trauma, usually on their first visit. Thereafter, screenings for depression and problem drinking are repeated annually throughout the time the Veteran comes for care. PTSD screening is annual for the first 5 years and subsequently is done every 5 years. Screening for MST is only formally done once, though the response on the electronic health record screen can be changed at any time if the Veteran volunteers new information suggesting a past history that was not reported on the initial screen. Any positive screen must be followed by a full diagnostic evaluation; if the screening is positive for PTSD or depression, an additional suicide risk assessment is conducted. This screening and treatment have been incorporated into primary care settings, resulting in the identification of many Veterans who benefit from early treatment, before they may have reached the point of initiating discussion of mental health difficulties they are facing.

VA's enhanced mental health capabilities include outreach to help those in need to access services, a comprehensive program of treatment and rehabilitation for those with mental health conditions, and programs established specifically to care for those at high risk of suicide. VA has a full range of sites of care, including inpatient acute mental health units, extended care Residential Rehabilitation Treatment Programs, outpatient specialty mental health care, telehealth, mental health care in integrated physical health/mental health settings such as the PACT, geriatrics and extended care settings, and Home-Based Primary Care, which delivers mental health services to eligible home-bound Veterans and their caregivers in their own homes. VA also offers "after hours" clinics that make services available to Veterans during non-regular hours, such as evenings and weekends.

Our efforts to improve access and provide the full range of needed mental health services have increased the numbers of Veterans receiving mental health care in VA. In FY 2010, VA treated more than 1.25 million unique Veterans in a VA specialty mental health program within medical centers, clinics, inpatient settings, and residential rehabilitation programs; this was an increase from 905,684 treated in FY 2005. If including care delivered when mental health is an associated diagnosis in integrated care settings, such as primary care, VA treated almost 1.9 million Veterans in FY 2010, an increase of almost a half million Veterans since FY 2005.

The policy guiding VA's significant advances in mental health services since 2005 was developed by the Office of Mental Health Services, beginning with the VA Comprehensive Mental Health Strategic Plan, which was implemented utilizing special purpose funds available through the Mental Health Enhancement Initiative. In 2008, implementation of the strategic plan culminated in development of the VHA *Handbook on Uniform Mental Health Services in VA medical centers and Clinics*, which sets mental health policy for VA by defining what mental health services should be available to all enrolled Veterans who need them, no matter where they receive care. Current efforts focus on fully implementing the Handbook, and continuing progress made, emphasizing additional areas for development, and sustaining the enhancements made to date. These implementation efforts have the promise of being even more fully successful, with the reorganization described in my opening comments that created the office of Mental Health Operations.

According to VHA policy guidelines, all new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days. These guidelines help support VA's Suicide Prevention Program which is based on

the concept of ready access to high quality mental health care and other services, and is discussed in more detail later in this testimony. Data closely monitored by VA confirm that our established standards for access to mental health care have generally been met through FY 2010 and the first half of FY 2011; however, we have noted some concern that the system may not be fully meeting this requirement in the most recent month. Up to the most current data, over 96 percent of all Veterans referred for new mental health care receive an appointment leading to diagnosis, and when warranted a full treatment plan, within 14 days. Similarly, data showed that over 95 percent of established mental health patients were receiving appointments for continuing care within 14 days of their preferred date, based on the treatment plan. As successful as this appears, we note that the waiting time data is starting to show some decline, with the percentage of patients meeting the requirement falling from a high of 96 percent in 2010 to just over 95 percent in 2011. Because of the importance of this indicator, and because the Uniform Mental Health Services Handbook is not yet fully implemented, the Office of Mental Health Operations is developing a comprehensive monitoring system to identify problems proactively in conjunction with the VISNs and to develop action plans to ensure that full implementation occurs. Based on assessments already conducted, current efforts at improving implementation are targeted toward increasing utilization of the psychosocial and recovery model across all areas of mental health service delivery, increasing development and integration of mental health into primary care, geriatric and specialty care services, and increasing the utilization of specialty substance abuse services.

The VA Suicide Prevention Program builds on all of the components described above; it is based on the concept of ready access to high quality mental health care and other services. VHA has added Suicide Prevention Coordinators (SPC) at every facility and large community-based outpatient clinics (CBOC); these are an important component of our mental health staffing. The SPCs ensure local planning and coordination of mental health care and support Veterans who are at high risk for suicide, they provide education and training for VA staff, they do outreach in the community to educate Veterans and health care groups about suicide risk and VA care, and they provide direct clinical care for Veterans at increased risk for suicide. One of the main mechanisms to access enhanced care provided to high risk patients is through the Veterans Crisis Line, and the linkages between the Crisis Line and the local SPCs. The Crisis Line is located in Canandaigua, New York, and partners with the Substance Abuse and Mental Health Services Administration National Suicide Prevention Lifeline. All calls from Veterans, Servicemembers, families and friends calling about Veterans or Servicemembers are routed to the Veterans Crisis Line. The Crisis Line started in July 2007, and the Veterans Chat Service was started in July 2009. To date the Crisis Line has:

- Received over 400,000 calls;
- Initiated over 15,000 rescues;
- Referred over 55,000 Veterans to local VA SPCs, who are available in every VA facility and many large CBOCs, for same day or next day services;
- Answered calls from over 5,000 Active Duty Servicemembers; and
- Responded to over 16,000 chats.

VA also has put in place sensitive procedures to enhance care for Veterans who are known to be at high risk for suicide. Whenever Veterans are identified as surviving an attempt or are otherwise identified as being at high risk, they are placed on the facility high-risk list and their chart is flagged such that local providers are alerted to the suicide risk for these Veterans. In addition, the SPC will contact the Veteran's primary care and mental health provider to ensure that all components of an enhanced care mental health package are implemented. These include a review of the current care plan, addition of possible treatment elements known to reduce suicide risk, ongoing monitoring and specific processes of follow-up for missed appointments, individualized discussion about means reduction, identification of a family member or friend with the Veteran's consent (either to be involved in care or to be contacted, if necessary), and collaborative development with the Veteran of a written safety plan to be included in the medical record and provided to the Veteran. In addition, pursuant to VA policy, SPCs are responsible for, among other things, training of all VA staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with Veterans, so they know how to get immediate help when Veterans express any suicide plan or intent.

So far, I have been describing mental health care provided in VA facilities and their associated CBOCs. VA also offers important services through the national system of Vet Centers. Vet Centers provide a non-clinical environment that addresses the needs of Veterans as individuals and as members of families and communities.

Vet Centers are community-based counseling centers that provide a wide range of social and psychological services, including professional readjustment counseling, military sexual trauma (MST) counseling, and bereavement counseling for families of Servicemembers who died while on Active Duty.

A core value of the Vet Center program is to promote access to care by helping Veterans and families overcome barriers that impede them from utilizing other benefits or services. A recent survey found that 97 percent of Vet Center clients would refer a fellow Veteran to a Vet Center. Vet Centers remain a unique and proven component of care not found in any other government or private sector organization by providing an alternate door for combat Veterans not ready to access the VA health care system. By the end of 2011, VA will operate 300 Vet Centers across the country and in surrounding territories (the U.S. Virgin Islands, Puerto Rico, Guam, and American Samoa). Thirty-nine (39) of these Vet Centers are currently located in rural or highly rural areas. Seventy (70) Mobile Vet Centers provide early access to returning combat Veterans through outreach to a variety of military and community events, including demobilization activities.

Vet Centers are designed to be both accessible and welcoming. Veterans who walk into a Vet Center will talk to a Counselor on the same day, and Vet Centers frequently maintain evening and even weekend hours to better serve Veterans. Approximately 72 percent of all Vet Center staff are Veterans, and almost one-third have served in Iraq or Afghanistan. The Vet Center Combat Call Center (1–877-WAR-VETS, or 1–877–927–8387) is available for Veterans and their families to speak confidentially to a fellow combat Veteran about their military experience and transition home. Family members are central to the combat Veteran's readjustment, and every Vet Center is adding a licensed family counselor to help meet the specialized needs of the readjusting family.

In FY 2010, Vet Centers provided more than 191,500 Veterans and families support through 1.2 million visits. While Vet Centers annually make approximately 120,000 referrals to VA medical facilities and collaborate with these facilities to enhance the continuum of care available to those who have served, more than 39 percent of Veterans did not access service at any other VA facility.

Vet Centers maintain a trained and professional workforce consisting of mental health and other licensed counselors. More than 60 percent of Vet Center direct readjustment counseling staff members are VHA-qualified mental health professionals (licensed psychologists, social workers, and psychiatric nurses). If a Veteran requires more complex mental health care, Vet Centers actively refer Veterans to VA medical facilities. Each Vet Center also has an assigned external clinical consultant, who provides peer consultation services for complex and emergent cases. External clinical consultants are VHA-qualified mental health professionals who support referrals to VA medical facilities.

IMPROVING QUALITY OF CARE

Improving access is important to ensuring more Veterans receive our care, but VA is equally focused on continuing to improve the quality of care Veterans receive. In addition to general mental health care services, VA offers a range of specialty care programs for Veterans with substance use disorders, PTSD, depression, homelessness, or other mental health conditions. It is essential that mental health professionals across our system provide the most effective treatment for PTSD, once the diagnosis has been identified. In addition to use of effective psychoactive medications, VA supports use of evidence-based psychotherapies. VA has conducted national training initiatives to educate therapists in two particular exposure-based psychotherapies for PTSD that have especially strong research support, as confirmed by the Institute of Medicine in their 2008 report, *Treatment of Posttraumatic Stress Disorder: Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE)*. To date, VA has trained over 3,400 VA clinicians in the use of CPT and PE. For both of these psychotherapies, following didactic training, clinicians participate in clinical consultations to attain full competency in the therapy. VA is also using new CPT and PE treatment manuals developed for VA, with inclusion of material on the treatment of unique issues arising from combat trauma during military service.

VA has developed Staff Experience and Training Profiles (STEP) criteria to establish the qualifications of family counselors working in Vet Centers. All Vet Center clinical staff are trained in relevant evidence-based practices to better serve the needs of Veterans and their families. Recently, 100 Vet Center staff participated in Cognitive Processing Therapy (CPT) training, and many more are working toward certification. Eleven (11) Vet Center counselors have received training that will allow them to train fellow staff on CPT. Vet Center counselors are also trained to help identify and refer Veterans who are at risk for suicide. VA will continue to

train and prepare these professionals to ensure they provide the highest quality readjustment counseling to combat Veterans.

With the publication and dissemination of VHA Directive 1160.01, *Uniform Mental Health Services in VA medical centers and Clinics*, in September 2008, VHA required that all mental health services must be recovery-oriented, with special emphasis on those services provided to Veterans with serious mental illness. VA has adopted the definition of recovery as developed by the Substance Abuse and Mental Health Services Administration (SAMHSA), which states: "Mental health recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential." It is important to note that this definition does not refer to the individual being "cured" of mental illness. Rather, it is a functional definition that describes an improved quality of life—often while managing ongoing symptoms of mental illness—as a result of engaging in recovery-oriented services.

Recovery-oriented services are strengths-based, individualized, and person-centered. These services strive to help the Veteran feel empowered to realize his or her goals and to engender hope that symptoms of mental illness can be managed and integration into the community can be achieved. They rely on support for the Veteran from clinical staff, family, and friends and allow the Veteran to take responsibility for directing his or her own treatment, within the range of viable, evidence-based approaches to care.

Although reducing the symptoms of mental illness that the Veteran is experiencing is important, the goal of recovery-oriented treatment services does not focus solely on symptom reduction, as symptoms may wax and wane over the course of the individual's life. While reducing the symptoms of mental illness the Veteran is experiencing is important, the reduction of symptoms alone does not mean that the Veteran has the skills necessary to lead a meaningful life. The goal of recovery is to help Veterans with mental illness achieve personal life goals that will result in improved functioning, while managing the symptoms they experience to the extent possible. It is important to emphasize that the path to recovery is not necessarily linear. Periods of significant growth, improvement, and stability in functioning are sometimes interrupted by periods of increased difficulty that may be accompanied by a worsening of symptoms or other setbacks. Such setbacks may have a significant effect on Veterans' ability to reach their goals. In addition, while life events or environmental stressors might cause a relapse, there are many times when there is no identifiable cause. Because experiencing a relapse can be significantly disruptive, and because relapses are often unpredictable, Veterans with serious mental illness are sometimes hesitant to engage in recovery-oriented activities without assurance that their basic needs can be met during times when they are unable to work.

Evidence indicates our mental health programs are successful. We have seen a continuing decline in the number of homeless Veterans over the last several years. Our suicide prevention efforts have saved hundreds of Veterans, and our programs are reaching those in greatest need. A recent research study found that evidence-based psychotherapies for PTSD are more effective approaches to treatment and are more cost effective in the long run as well.[1] VA participated from FY 2006 through FY 2010 in a Government Performance and Results Act review, which was recently submitted to Congress. That review, conducted by RAND/Altarum, concluded that VA mental health care was superior to other mental health care offered in the United States on almost all dimensions surveyed. These data speak to the great strides made in the mental health care VA provides.

CONCLUSION

While we have made progress in improving the availability and quality of our mental health services, new information suggests we can strengthen and sustain the growth we have accomplished. In addition, we continue to follow research, best practices, and other emerging information that can guide policy development and focused concurrent implementation efforts. No matter how strong our mental health programs are, they can and should continually strive for constant, evolving improvement. We will continue to monitor the outcomes and utilization of our programs and will regularly update the Committee on any changes in conditions. We appreciate your attention to this matter and look forward to working with the Committee to ensure Veterans receive the quality mental health care they deserve.

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[1] See Beau Kilmer, et al., *Invisible Wounds, Visible Savings? Using Microsimulation to Estimate the Costs and Savings Associated with Providing Evidence-Based Treatment for PTSD and Depression to Veterans of Operation Enduring Freedom and Operation Iraqi Freedom*, 3 American Psychological Association, 201 (2011).

Thank you again for this opportunity to speak about VA's efforts to improve access to quality care for Veterans with mental health concerns. My colleagues and I are prepared to answer any questions you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. The Air Force has a program for suicide prevention in which they identify high risk events (i.e. servicemembers under investigation), and then track individuals affected by those events. Does VA have any similar suicide prevention program that tracks high risk events in veterans' lives, such as arrests or domestic disputes?

Response. The Veteran population is different from the Air Force population, so our programs differ, but retain some similarities. In the Department of Veteran Affairs (VA), we identify risk factors as a part of all suicide risk assessments, mental health intake forms and medical evaluations, but it is solely dependent on the Veteran revealing this information to VA voluntarily. For example, Veterans (as with members of the general population) are under no obligation to tell their health care providers about arrests, a significant stressor, and often do not. We encourage Veterans to share with us the stressors in their lives so that we can work with them to deal effectively with these issues. We closely track Veterans who have been identified as being at high risk (e.g., those who have expressed suicidal thoughts, have demonstrated suicidal behaviors, or who have multiple risk factors), and we have developed an intense suicide prevention strategy for these Veterans, including an enhanced care package and safety planning. That enhanced care includes mandatory frequent follow-up visits, a flag in the Veteran's medical record to ensure immediate assistance, follow-up for missed appointments, and strict attention to the Veteran's treatment plan. In addition, all of our high risk patients develop Safety Plans in collaboration with their health care providers. This is a plan designed to help the Veteran stay safe when under stress or when the Veteran otherwise has increased suicidal thoughts or urges. It may include the use of a mobile application for the reduction of PTSD symptoms, the use of gun locks, emergency service information, the identification of a support system, or whatever is useful to the Veteran. We constantly track the development of these plans.

Question 2. How many staff in Central Office, as defined by the 101 stop code, are in the mental health program? Please break this down into how many staff are devoted to mental health policy, and how many are devoted to mental health operations (implementation of policy)?

Response. The total number of permanent full-time employee equivalents (FTEE) assigned to the Office of Mental Health Services and devoted to mental health policy is 159.08; 17 FTEE are Station 101 employees, and the balance are decentralized employees.

The total number of permanent FTEE assigned to the Office of Mental Health Operations and devoted to mental health operations is 267.11; of that number, 10 FTEE are Station 101 employees, and the balance are decentralized employees.

Question 3. In response to a QFR following the Committee's 2010 hearing on suicide and mental health, VA stated that, in accordance with Title I, Section 107 of the Veterans' Mental Health and Other Care Improvements Act of 2008, three pilots would be implemented in Veterans Integrated Service Networks 1, 19, and 20 to assess the feasibility and advisability of providing mental health services to OEF/OIF Veterans who reside in rural areas and do not have ready access to mental health services through VA facilities. VA said at that time all the pilot programs would be operating by October 2010. Please provide an update on these pilot programs.

Response. VA completed the contracting process for the Section 107 pilot program in fall 2010. The pilot programs began in January 2011 and will run for a period of 3 years. The three Veterans Integrated Service Networks (VISNs) in which the pilot programs are taking place are in regular contact with the chosen contractors who have hired peer outreach workers, arranged for training of the peer outreach workers, and conducted outreach events in a wide variety of venues. These workers are making referrals for mental health services. The pilot programs have been supported by funds from VA's Office of Rural Health. The VA Acquisitions and Logistics Center in Denver, Office of Rural Health, and the Office of Mental Health Services are monitoring implementation of Section 107 and providing guidance to the pilot sites.

Question 4. How many CBOCs in VA currently offer tele-mental health services? How many total CBOCs that VA directly operates or contracts with offer mental health services in general (defined for this purpose as those provided using a mental health stop code)? How do wait times compare between facilities offering tele-mental health services and those that do not?

Response. Tele-mental health services are currently provided at 394 community-based outpatient centers (CBOCs) from 96 parent facilities. A total of 683 (94 percent) out of 728 VA CBOCs that coded any care in the fiscal year (FY) 2010 National Patient Care Data base offered mental health services, defined as services coded with a mental health stop code.

Mental health wait times are similar among facilities that offer tele-mental health services and those that do not. There was no difference in the percentage of new mental health patients that received a mental health evaluation and initiation of mental health services within 15 days of referral between facilities that offer tele-mental health services at their CBOCs from those who do not. We did not expect that availability of tele-mental health services would have a large impact on wait time for mental health services; tele-mental health has been primarily used for delivering group psychotherapy, facilitating transitions between levels of care in rural communities, and for monitoring and aftercare inpatients following intensive treatment. Thus, tele-mental health services are generally used for purposes other than for initial visits for assessment and treatment planning with a new, acute mental health patient, and we would instead expect to see improvements in care transitions, aftercare, and treatment completion rates at facilities with tele-mental health services. For example, facilities that offer tele-mental health services with their CBOCs show significantly better rates of follow-up within 1 week of medically managed withdrawal from alcohol or opioids. Specifically, facilities with tele-mental health services successfully transition 42.3 percent of patients completing alcohol or opioid detoxification into outpatient mental health services in the first week compared with 37.4 percent of facilities without tele-mental health services available.

Question 5. Residential care is a critical part of VA's safety net for veterans with PTSD and other invisible wounds of war. As you know, the Inspector General released a report in 2009, which found these facilities were not meeting staffing requirements. They also found that medications were not being managed properly. Recently, the IG released a follow-up report and found that VA has not fixed these problems. Please explain why these issues have not been fully addressed, and also discuss how the Department will ensure that the Inspector General's recommendations are implemented. When will corrective actions be complete?

Response. In 2007, the Veterans Health Administration (VHA) National Leadership Board—Health Systems Committee charged VHA's Office of Mental Health Services (OMHS) with reviewing the current status of care delivery in Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) to improve and enhance services to Veterans. Subsequently, OMHS developed a MH RRTP Transformation Plan, which included a full review of all MH RRTPs and the development of a unified VHA MH RRTP Handbook. In May 2009, OMHS finalized VHA Handbook 1162.02, *Mental Health Residential Rehabilitation Treatment Programs*. The Handbook was further amended in December 2010 to address issues identified in the OIG's initial MH RRTP report dated June 25, 2009.

As recommended by the initial OIG review, VHA developed specific requirements for minimum staffing for all MH RRTPs in May 2009, with the initial publication of VHA Handbook 1162.02. The OIG noted in the recent follow-up inspection that most sites met requirements for 24/7 coverage by staff; however, there were identified gaps in discipline-specific staffing. Since publishing the Handbook in May 2009, programs have made some progress in addressing identified staffing gaps with 145 additional FTEE hired in FY 2010; however, as noted by the OIG, gaps in meeting the minimum staffing requirements remain. VHA concurred with the OIG's recommendation and the initial findings concerning staffing were shared with the Network Directors, who were asked to assure that these staffing gaps are closed. At this point, given continued difficulties in filling these positions, the Office of Mental Health Operations is taking specific steps to address staffing. All MH RRTPs are required to:

(1) submit a detailed staffing plan that includes required staffing levels as specified in the Handbook as well as current program FTEE by discipline; and

(2) provide an action plan where staffing gaps are identified that will be updated quarterly until minimum staffing requirements are met.

All staffing plans will be reviewed and approved by the medical center and VISN Director and are due to the Office of Mental Health Operations by September 15, 2011. Senior leadership will also review the staffing and action plans and these will

be discussed with the Network Directors at an upcoming VISN Director meeting later in September. It has been made clear that this is not an optional component of the Handbook and that routine staffing assessments will be made by both VHA and the VA's external review consultants, Mathematica. Specific timeframes will be set for each Network by which the staffing requirements will be met.

The Handbook outlined significant changes in how medications are to be managed on residential units, with a transition from "Self-Medication Management" to "Safe Medication Management." This includes specific requirements for documentation, as well as administration of controlled substances. The OIG follow-up report noted moderate progress in meeting initial recommendations, noting in particular that compliance with prescribing requirements for controlled substances was high but not yet at 100 percent. This was disappointing and since the initial OIG review, we have focused on educating providers and program leadership on requirements for safe medication management. These education efforts have included development of a Web-based training curriculum specific to medication management in the MH RRTPs. We are continuing our efforts to further educate program, medical center, and VISN leadership about the recent OIG findings and recommendations, along with the specific requirements for safe medication management. Our external consultant (Mathematica) will continue to monitor medication management procedures on these units.

Question 6. Given that symptoms of PTSD can manifest months or even years after veterans return home, what is VA doing to proactively reach out to those veterans who have been home a year or more?

Response. VHA has employed various mechanisms to reach out to recently returned/released Servicemembers. Since 2006, VHA has coordinated referrals from the National Guard and Reserve Components for Veterans who have completed the Post Deployment Health Reassessment (PDHRA), a Department of Defense (DOD) program, which requires assessments at 90 and 180 days post-deployment. The PDHRA is a global health assessment, with an emphasis on behavioral health and service-related conditions, conducted between 90 and 180 days post-deployment. The intent of the PDHRA is to identify deployment-related physical health, mental health, and readjustment concerns, and to identify the need for follow-up evaluation and treatment. VA has supported over 2,200 PDHRA events and the DOD PDHRA 24/7 Call Center since November 2005, resulting in over 94,000 referrals to VAMCs and nearly 37,000 referrals to Vet Centers.

In addition to these outreach activities for new Veterans there are programs that continue far beyond the first year when Veterans are very involved with re-adjustment issues and concerns and may not recognize their need for services. VA regularly screens all of its patients and all new Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans to determine if they may have PTSD, are at risk of suicide, or in need of additional mental health counseling. VA's nearly 3,000 community-based Vet Centers also provide mental health screening and PTSD counseling. To reduce the stigma of seeking care and to improve access, VA has integrated mental health into primary care settings to provide much of the care that is needed for those with the most common mental health conditions, when appropriate.

VA also uses internet Web page http://www.mentalhealth.va.gov/PTSD.asp to provide a self-assessment tool to screen for PTSD. The screen is a very short list of questions to determine if the Veteran needs to be assessed further. A positive screen instructs the Veterans to see their physician or a qualified mental health professional immediately for a complete assessment and for advice about different treatment alternatives.

VA has also developed the PTSD Coach smart phone app which can help Veterans learn about and manage symptoms that commonly occur after trauma. Features include:

- Information on PTSD and treatment options;
- Tools for screening and tracking symptoms;
- Convenient, easy-to-use skills to help the Veteran handle stress symptoms; and,
- Direct links to support and help.

Focusing on Veterans that have returned at any point in the past several years a new anti-stigma campaign has been developed to provide outreach at various points in their readjustment. The next question and response address this also.

Question 7. What is VA doing to reduce the stigma associated with seeking mental health services? How is it working with DOD on this issue?

Response. VA is working to reduce stigma associated with seeking mental health services through a number of strategies, many of which include collaboration and coordination with the DOD. First, VA will launch a public awareness and outreach

campaign this fall aimed specifically at reducing the stigma Veterans may associate with seeking mental health treatment. The campaign will target specific audiences, tailor messaging, and optimize communications channels for a comprehensive, integrated stigma reduction communications and outreach campaign. This effort will engage Veterans and their families and friends, key community-based groups, Veterans Service Organizations (VSOs), traditional and online media, and internal VA stakeholders. The overall goal of the outreach campaign is to reduce the stigma Veterans and their loved ones associate with seeking mental health services and increase the number of Veterans with mental health needs who seek mental health care. For this campaign, as well as for VA's ongoing suicide prevention communication efforts, VA has contracted with an experienced public relations firm that understands the need to project these messages in a way that does not stigmatize mental health services. Veterans' groups have been consulted and messages crafted to demonstrate that seeking mental health care when needed can lead to improved life functioning. This campaign is complementary to the DOD Real Warriors campaign that was previously launched to reduce stigma associated with seeking mental health treatment among active duty Servicemembers.

Second, to further reduce perceived stigma related to Veterans seeking mental health care, VA is integrating mental health into primary care settings across the country. Mental health services are also incorporated in the evolution of VA primary care to Patient Aligned Care Teams (PACT), an interdisciplinary model to organize a site for holistic care of the Veteran in a single location. In parallel with the implementation of these programs, VA has also spent several years enhancing its mental health care services to emphasize a positive, recovery-oriented model of care. All of these efforts are aimed at engaging Veterans in effective mental health services across a variety of treatment settings.

In addition, VA is using new technological solutions to help reduce the stigma associated with seeking mental health services. For example, the VA National Suicide Hotline has been re-branded as the Veterans Crisis Line and provides anonymous services to Veterans and Servicemembers who do not want to be identified. Further, the Veterans Chat service is completely anonymous and provides a way for Veterans and Servicemembers to seek help in a completely non-stigmatizing way. Another example of technological approaches VA and DOD are utilizing to address stigma-related barriers is the launch of the PTSD Coach, which has been downloaded over 20,000 times in 51 countries since its launch in April 2011. The smart phone app is one of the first in a series of jointly designed resources by VA's National Center for PTSD and DOD's National Center for Telehealth and Technology to help Servicemembers and Veterans manage their readjustment challenges and receive just-in-time assistance.

All of the efforts described above are supported by the DOD/VA Integrated Mental Health Strategy (IMHS). This level of collaboration between VA and DOD is providing unique opportunities to coordinate stigma reduction efforts across the two Departments, for the benefit of all of our Servicemembers, Veterans, and their family members.

Question 8. In the Committee's 2010 hearing on suicide and mental health, VA said there were a total of 237 operational Mental Health Residential Rehabilitation Treatment Programs (MH RRTPs) providing more than 8,440 treatment beds, which included 252 beds dedicated to women veterans in 35 of the programs (NEPEC). Of those, there were six MH RRTP dedicated to serving women veterans in a setting where no male patients would be receiving care on the same unit at the same time, with a total of 50 beds. In light of GAO's report on sexual assault complaints, do you intend to increase the number of women-only units in MH RRTPs?

Response. There were seven MH RRTPs dedicated to serving women Veterans with an additional 30 programs with specialized tracks for women Veterans as part of mixed-gender MH RRTPs. These programs are considered regional or national resources, not just a resource for the local facility. Clinically, there are advantages to models where treatment occurs in an environment where all Veterans are of one gender. Mixed gender programs also have advantages, including helping survivors challenge assumptions and confront fears about the opposite sex, fostering respect for appropriate boundaries in relationships, and promoting an emotionally corrective experience. Given the advantages associated with both models, VA does not promote one model as universally appropriate for all treatment settings and is focusing attention toward ensuring the safety, security, and comfort of women Veterans admitted to all residential units, rather than increasing the number of women-only MH RRTPs.

Question 9. Medical literature has clearly identified risk factors for certain diseases, like coronary artery disease, and can therefore predict a veteran's risk of get-

ting coronary artery disease. Is VA pursuing any similar research for risk factors associated with suicide or suicide attempts? If so, what is its status?

Response. VA's research portfolio includes studies focused on identifying risk factors for suicide, prevention, and treatment. Risk factors under study include co-morbid disorders, medications, and behaviors. A few specific study examples include:

• In one study, VA researchers seek to determine the prevalence of suicide ideation, plans, and attempts resulting in medical treatment among Veterans currently enrolled in VA's health care system. The researchers will also collect data on a limited number of established risk factors and characteristics unique to military service that can be used to understand correlates of non-fatal suicidal behaviors.

• A VA Suicide and Self-Harm Classification System (SSHC) and Clinical Tool is being evaluated to determine the feasibility for implementation in diverse VA treatment settings and to assess its impact on health care system processes pertaining to the assessment and management of suicide risk.

• The VISN 2 Center of Excellence, in collaboration with the National Center for Homelessness among Veterans, is conducting a study of risk factors for suicide among Veterans with a history of homelessness or housing instability. Characteristics of service utilization, the independent effect of homelessness, and differences in risk associated with psychiatric diagnoses are being studied through the use of homeless intake assessments, non-fatal suicide event data (SPAN), and data obtained from the National Death Index.

• VA researchers are determining the role of a brain chemical called serotonin in suicide and seek to discover whether alterations in levels of this chemical impact suicide.

• *The Suicide Assessment and Follow-up Engagement:* Veteran Emergency Treatment Project (SAFE VET) is a clinical demonstration project that focuses on providing a brief intervention and follow-up for suicidal Veterans who present to the Emergency Department (ED) and Urgent Care Services and who do not require hospitalization. This study also permits us to longitudinally follow risk factors in Veterans identified as being at moderate risk for suicide.

• Motivational Interviewing to Prevent Suicide in High Risk Veterans is a study to test the efficacy of an adaptation of Motivational Interviewing to Address Suicidal Ideation (MI-SI) on the severity of suicidal ideation in psychiatrically hospitalized Veterans at high risk for suicide. The researchers also are examining the impact of MI-SI on risk factors for suicide in Veterans, such as treatment engagement and psychiatric symptoms.

• Many completed studies addressing suicide epidemiology have been published by VA investigators, providing important information related to risk factors.

VA is also doing extensive work in Traumatic Brain Injury (TBI), including how Veterans with a TBI may be at risk for mental health issues and suicide. Our work in TBI will also give us a broader knowledge about suicide in general. A few examples of ongoing studies investigating the risk factors for suicide in those with TBI include:

• *Executive Dysfunction and Suicide in Psychiatric Outpatients and Inpatients:* The goal of this project is to maximize recovery in those with TBI by potentially: 1) increasing clinicians' ability to identify neuropsychological correlates of suicidal behavior for those with TBI; 2) identifying measures of executive functioning that correspond to real-life behaviors that impact treatment response and recovery; 3) facilitating the creation of innovative assessment techniques and psychosocial interventions (e.g., safety planning) to minimize complications in the management of suicidal behavior due to TBI-related impairments; and 4) creating a basis for further and much-needed research in this area.

• *Neurobiology of Suicide Risk in Traumatic Brain Injury and Substance Abuse:* Veterans with TBI are often co-morbid for substance abuse, and it has been shown that use of alcohol and illicit drugs can further compromise executive mediated functions known to depend on the frontal cortex. It has been proposed that these functional deficits may lead to cognitive rigidity and psychological distress and thus may serve as markers for suicidal risk. Using functional and white matter brain imaging techniques, the investigators will test the hypothesis that reduced white matter integrity and reduced activation in frontal regions in both substance abusing and non-substance abusing TBI Veteran groups is significantly correlated with suicidal ideation, and that the correlation will be stronger for the TBI plus substance abuse cohort.

Recently published research on suicide risk factors in those Veterans with TBI include:

• *Suicide and Traumatic Brain Injury among individuals seeking Veterans Health Administration services.* VA researchers found that those Veterans who sustained a

TBI were almost twice as likely to die from suicide when compared to those Veterans that had no diagnosis of TBI.[1]

• *Neuroimaging Correlates of Traumatic Brain Injury and Suicidal Behavior.* VA researchers examined the relationship between the integrity of major frontal white matter systems on measures of impulsivity and suicidality in Veterans with TBI. Results indicated that white matter damage was present in 2 frontal white matter areas. The damage to these white matter tracts was correlated with impulsivity and suicidal ideation. These data demonstrate a significant reduction in frontal white matter integrity in Veterans with mild TBI that was associated with both impulsivity and suicidality. These findings may reflect a neurobiological vulnerability to suicidal risk related to white matter microstructure.[2]

Additionally, other studies incorporate suicide assessment measures to determine whether there are risks identified during the course of a study that require preventative measures. While not focused directly on suicide, these studies will also provide important information about risk factors.

Question 10. CARES underestimated future outpatient demands for mental health care by more than 30 percent because of the differences in utilization of mental health care services between veterans and the general population. How is VA projecting future demands for mental health services?

Response. VA employs several techniques to forecast Veteran enrollee needs for VA mental health services including: the incorporation of the latest scientific evidence about effective mental health interventions; data analysis of Veteran demographics; access to care data; national trends in service utilization projections; and staffing levels at each facility. With input from VHA's OMHS, VA's Enrollee Health Care Projection Model (Model) projects future demand for mental health services and accounts for: enrollee age; gender; morbidity; and the unique utilization patterns of specific cohorts such as OEF/OIF/OND.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

According to VA's testimony "all new patients requesting or referred for mental health services must receive an initial evaluation within 24 hours, and a more comprehensive diagnostic and treatment planning evaluation within 14 days." However, testimony before the Committee by Veterans has communicated instances of long wait times for follow up mental health appointments at VHA facilities.

Question a. What metrics does VA use to ensure the Veterans Health Administration's (VHA) guidelines are complied with at VHA facilities?

Response. There are two metrics that VA uses to ensure VHA guideline compliance with respect to mental health patient appointments: a performance measure for "new" patients, and a timeliness measure for "established" patients.

The Mental Health (MH) performance measure: "Percent of Eligible Patient Evaluations Documented within 14 days of New MH Patient Index Encounter" is the metric used to assess the requirement that new patients to mental health (new patient defined as a Veteran not having been seen in any mental health program in the last 24 months) are seen, assessed, and have treatment initiated within 14 days.

VHA also has a timeliness measure for all patient appointments such as primary care and specialty care; these include mental health clinics. The timeliness standard is that patients be seen within 14 days of the desired date. This timeliness standard applies to both new and established patients. Desired date is defined as the date determined by the Veteran and the provider as the date the Veteran should be seen. The timeliness measure is a quality indicator for facilities.

A new patient under the timeliness measure is any patient who has not been seen in the last 24 months in the particular stop code for which the appointment is requested. This differs from the definition of new patient in the performance measure "Percent of Eligible Patient Evaluations Documented within 14 days of New MH Patient Index Encounter," as patients who have been seen in one of the mental health

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[1] Brenner, L., Ignacio, R. V., & Blow, F. C. (2011). Suicide and Traumatic Brain Injury among individuals seeking Veterans Health Administration services. *Journal of Head Trauma Rehabilitation*. 26:4, 257–264.

[2] Yurgelun-Todd, D.A., Bueler, C. E., McGlade, E. C., Churchwell, J. C., Brenner, L. A., Lopez-Larson, M. P. (2011). Neuroimaging correlates of Traumatic Brain Injury and suicidal behavior. *Journal of Head Trauma Rehabilitation*. 26:4, 276–289.

clinics will not be "new" by the performance measure but will be "new" in the timeliness measure, if they are being referred to a different mental health clinic.

Question b. When it is found that a VHA facility is not meeting the access guidelines, what steps does VA take to bring that facility back into compliance?

Response. Access guidelines are monitored at the facility and Veterans Integrated Service Network (VISN) level. If there are access delays, facilities and VISNs will identify the problems associated with those delays and then determine an appropriate action plan. The range of problems identified may include data issues (scheduling errors); a temporary shortage of providers due to vacation, family leave or staff loss; inefficient scheduling or clinic processes that may need to be redesigned; seasonal spikes in appointment demand; or more ongoing provider shortages. The action plan developed by the facility will address the root cause of the problem and indicate the timeline for achieving compliance with VHA access guidelines. For example, action plans associated with provider shortages usually include strategies such as the use of fee basis care, locum tenens mental health staff, per diem, or contracted providers, or the use of overtime while recruiting for more permanent staff.

Question c. What are VA's access standards to provide an established patient with follow up appointments for mental health visits?

Response. See response to "a" above. VHA timeliness standards for all clinics state that patients should be seen within 14 days of the desired date for established patients.

Question d. When access standards for established patients are not met to what extent does VA use fee basis care to ensure veterans receive mental health care in a timely fashion?

Response. Decisions to use VA versus non-VA care are determined on a case-by-case basis and in concert with the most appropriate clinical decision for providing the services. Factors such as the extent of the Veteran's eligibility, patient's ability to travel, the urgency of the care required, and other VA capacity issues are considered in these decisions. VA does not record and calculate fee basis use on each of the various factors involved in addressing access issues.

Question e. Please provide the Committee with the average wait time by facility type (VAMC's, CBOC's and Vet Centers) and by VISN, for follow up mental health appointments.

Response. Please see attached list of Fiscal Year 2011 year-to-date (YTD) wait times by VISN and by facility for mental health appointments. Included are both new and established patients. Wait time data is not kept by Vet Centers, however, context is provided below.

[The extensive list was received and is being held in Committee files.]

Vet Center Response: Per VHA Handbook 1500.01, Readjustment Counseling Service Vet Center Program, September 8, 2010, the Vet Center service mission, by Congressional intent, is designed to remove all unnecessary barriers to care for combat Veterans and family members. One of the means by which this is accomplished is for Vet Centers to maintain non-traditional appointment schedules, after normal business hours during the week and on weekends, to accommodate working Veterans and family members. Non-traditional appointment scheduling is a quality performance criteria that is reviewed during every Vet Center's annual quality site visits. Within this context, Vet Centers welcome Veteran callers and walk-ins, who are provided with an assessment by a qualified counselor on the same day. The Vet Center Program standard for scheduling follow-up appointments is from 24 to 48 hours contingent upon the severity of need.

Community outreach services outside of the Vet Center also facilitate Veterans' access to care via staff making strong empathic connections with Veterans and family members, and by providing them with the information needed to access the full range of VA services. Effective outreach services indirectly reduce waiting times for services by overcoming Veterans' post-combat stigma and trauma induced alienation. Vet Centers also help Veterans access other needed VHA care by providing over 100,000 referrals every year to VA medical facilities for primary and mental health care.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. DANIEL K. AKAKA TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Several veterans who testified on the first panel hearing expressed concern over a lack of communication and coordination among VA care teams and centers regarding the overall awareness of patient treatment plans.

What steps, if any, has VA taken to address this concern?

Response. The Uniform Mental Health Services Handbook requires the identification of a Mental Health Treatment Coordinator (MHTC) for every Veteran receiving mental health services. The role of the MHTC is to ensure coordination and development of the Veteran's treatment plan and communication with the Veteran (and the Veteran's authorized surrogate or family or friends when appropriate). To assist in implementation of, and compliance with this role, the OMHS has two initiatives to support treatment planning and easy identification of the MHTC.

First, VHA has purchased and installed a treatment planning software program on every facility server. We are training providers in the use of the software, which will assist MHTCs in coordinating mental health services and ensuring that each Veteran has one treatment plan that provides a single place in the medical record documenting the Veteran's individualized mental health treatment plan across programs and disciplines.

Second, VA's Office of Information and Technology is working with the OMHS to develop a software upgrade for the Computerized Patient Record System that will easily display the MHTC in the medical record. Similar to the identification of the primary care provider, the MHTC will be visible for all providers to see in the medical record, so that the MHTC can be contacted by any provider seeking information about the treatment plan or wishing to add information to the treatment plan. The software allows for reports that will enable managers and the Office of Mental Health Operations to track assignment of the MHTC and to monitor compliance to further ensure Veterans needing mental health services will have coordinated care.

Question 2. The Healthcare Inspections Office in the VA Office of Inspector General found at several VA mental health clinics in Georgia, that some patients who had been waitlisted for an extended period of time attempted suicide or had to be hospitalized. The findings indicate that the clinics were not resourced to handle the increase in the demand for services.

As you look to the future, do you see other regions of the country that might see an increase of new patients? What are some lessons learned from the Atlanta situation that can be applied in a similar situation?

Response. VA employs several techniques to forecast Veteran enrollee needs for VA mental health services including: the incorporation of the latest scientific evidence about effective mental health interventions; data analysis of Veteran demographics; access to care data; national trends in service utilization projections; and staffing levels at each facility. With input from VHA's OMHS, VA's Enrollee Health Care Projection Model (Model) projects future demand for mental health services and accounts for: enrollee age; gender; morbidity; and the unique utilization patterns of specific cohorts such as OEF/OIF/OND Veterans.

Across VHA from FY 2009 to FY 2010, there was an 8.9 percent increase in patients with mental health diagnoses, and all VISNs noted an increase in the number of patients with mental health diagnoses who were treated (range of 4.78 percent to 14.34 percent increases). Those VISNs with an increase of over 10 percent in patients with mental health diagnoses include VISNs 4, 6, 7, 11, 19, 20, and 21. In a projection of overall enrollment growth from 2010–2020 (including all patients), we estimated that the VISNs with greatest projected increase in enrollment include VISNs 6, 7, 9, 16, 17, 18, 19, and 20. However, when reviewing performance indicators, increases in the number of patients seen do not uniformly co-occur with problems in access.

To improve our ability to identify and respond to mental health access problems like those observed in Atlanta, we examined VA performance and administrative tracking data for signs that might have predicted the problems. It was difficult to identify an individual measure that would have conclusively highlighted Atlanta as problematic; however, we found that there was a pattern of generally lower than average performance across administrative measures of staffing, wait-time and access to specialty care at the facility.

These analyses suggest the need for comprehensive, multi-measure monitoring of a broad array of administrative and clinical mental health measures, including tracking of both absolute levels and trends over time to adequately detect and address concerns. To facilitate cross-administrative and clinical assessment of perform-

ance and trends in mental health care, the Office of Mental Health Operations is developing a dashboard and technical assistance program that will look both broadly and specifically across administrative and clinical care delivery measures to assess access to mental health care within each VHA facility and VISN. Evaluation of VHA facility and VISN status based on this dashboard will guide collaborative development by Veterans Affairs Central Office (VACO) Mental Health staff, and VISN and facility leadership of action plans to address gaps in services. The Office of Mental Health Operations will then monitor progress on VISN/facility action plans and provide technical assistance to resolve barriers to implementation of services to ensure on-demand access to high-quality mental health care at all VHA facilities.

Question 3. According to the VA's National Registry for Depression, 11 percent of veterans over the age of 65 have been diagnosed with a major depressive disorder, which is twice the rate found in the general population of adults in the same age group.

What steps has the VA taken to address the unique mental health needs of our older veterans?

Response. VHA has implemented several initiatives designed to promote mental health care access and treatment for older Veterans. These new initiatives incorporate innovative and evidence-based mental health care practices, as well as person- and family-centered care approaches.[3] One major national initiative has involved the integration of mental health care into VA's Home-Based Primary Care (HBPC) Program, which provides comprehensive, interdisciplinary primary care services in the homes of primarily older Veterans with complex and chronic, disabling disease. The HBPC Mental Health Initiative involved the placement of a full-time mental health provider on each of the more than 130 VA HBPC teams, establishing a new model of care to best meet the significant mental health needs of older and younger homebound Veterans. The VA HBPC Mental Health Provider functions as an integral member of the HBPC team and provides a full range of psychological assessment and intervention services to HBPC patients and their families. This initiative has received overwhelmingly positive response from HBPC patients and their families. VHA Handbook 1160.01, *Uniform Mental Health Services in VA medical centers and Clinics*, now requires that all Community Living Centers (CLC) and HBPC teams have fully integrated mental health providers, sustaining and further expanding the successful initiatives described above.

In addition to the geriatrics settings identified above, VA has also integrated mental health services in Hospice and Palliative Care settings, Spinal Cord Injury Disability (SCID) Centers, and Blind Rehabilitation Centers, who each serve a large proportion of older Veterans. VA has also implemented a national initiative to integrate mental health services in general primary care settings, incorporating evidence-based integrated care models, which have been shown to increase mental health care access, utilization, and quality, including specifically with older patients.[4]

Furthermore, VA has developed a pilot initiative to disseminate and implement an evidence-based approach to managing challenging dementia-related behaviors of Veterans in VA CLCs. The intervention was adapted by VA staff and implemented in 21 CLCs. Program evaluation data are being analyzed and results will be available by the end of FY 2011.

In addition, VA's OMHS and Office of Geriatrics and Extended Care have developed a training program and materials related to suicide risk assessment and safety planning with older Veterans, specifically. This training program has been launched nationally and is intended for use by a wide variety of VHA staff. Representatives of the Office of Geriatrics and Extended Care and geriatrics field-based staff also serve on VHA's Suicide Prevention Steering Committee. Furthermore, leaders from the OMHS are regular members of VHA's Dementia Steering Committee, which is chaired by the Office of Geriatrics and Extended Care.

Question 4. A recent Government Accountability Office report indicated that there were 284 alleged sexual assaults from January 2007 through last July. The report

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[3] Karlin, B. E., & Zeiss, A. M. (2010). Transforming mental health care for older Veterans in the Veterans Health Administration. Generations, 34, 74–83.

[4] Bartels, S. J., Coakley, E. H., Zubritsky, C., Ware, J. H., Miles, K. M., Areán, P. A., et al. (2004). Improving access to geriatric mental health services: A randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *American Journal of Psychiatry*, 161, 1455–1462. See also: Hedrick, S. C., Chaney, E. F., Felker, B., Liu, C., Hasenberg, N., Heagerty, P., et al. (2003). Effectiveness of collaborative care depression treatment in Veterans' Affairs primary care. Journal of Internal Medicine, 18, 9–16.

made a number of recommendations to help make VA facilities more secure and reduce the chances of offenses occurring.

What is the Department's position on these recommendations? Please provide an update on those recommendations the VA plans to implement.

Response. In response to the Government Accountability Office (GAO) report highlighting the need for the VHA to improve its data reporting streams, we plan to extract data from three sources:

1. The Police Service Management Information System. This is the most comprehensive and timely data source for the initial report of sexual assault and other safety incidents.
2. The Automated Safety Incident Tracking System (ASISTS) is an Employee Accident Reporting package with data and information about employee accidents and incidents.
3. The issue brief is used by the field to report to management in VA Central Office. One type of incident reported in the issue brief is sexual assault. VA is currently developing an automated system for submitting issue briefs. This system is being tested in 9 VISNs and will be tested in all 21 VISNs in September 2011.

Merging and evaluating data on sexual assault incidents from these three sources will allow VHA management to trend and track sexual assault incidents more accurately and precisely in the future.

A more detailed timeline is below:

Action	Target Date	Status
Design and implement manual system for recording and reporting	July 2011	Complete
Consolidate and reconcile data from the three sources	September 2011	On Schedule
Determine new report requirements	September 2011	On Schedule
Roll out the automated Issue Brief to all VISNs	September 2011	On Schedule
Determine technology to combine SharePoint Issue Brief data with data from the Police Application data and ASISTS	October 2011	On Schedule
Determine report needs for clinical and administrative leadership	October 2011	On Schedule
Combine the data and build the report	December 2011	On Schedule
Test the report	January 2012	On Schedule
Make final enhancements and implement system-wide	February 2012	On Schedule

On June 16, 2011, VA's Assistant Secretary for Operations, Security and Preparedness issued a Memorandum to all VA Under Secretaries, Assistant Secretaries, and other key officials re-emphasizing the requirements of VA Directive 0321, which requires all serious incidents, including incidents on VA property that result in serious illness or bodily injury, be reported as soon as possible, but no later than 2 hours after the incident. The Deputy Under Secretary for Health for Operations and Management issued a Memorandum to all Network Directors on July 7, 2011, directing them and their subordinate managers to ensure that all allegations of sexual assault on VA property (or off-property in the execution of official VA duties) involving a Veteran, VA employee, contractor, visitor, or volunteer be reported within 2 hours, in accordance with VA Directive 0321.

Question 5. The VHA Handbook 1160.01, Uniform Mental Health Services in VA Hospitals and Clinics, was published in 2008, but, as Doctor Zeiss' testified, has yet to be fully implemented. Dr. Zeiss stated that part of the reason for not fully implementing the policies within the handbook was based on the VA's organizational structure.

What internal oversight mechanisms do you have in place now to ensure that official policies are being implemented and are effective? How will VA's reorganization affect implementing policies?

Response. VHA's internal oversight mechanisms include: the Executive Career Field performance system and the Transformation–21 (Transformation for the 21st Century) VISN performance review process that identify key areas for regular review between the Deputy Under Secretary for Health for Operations and Management (DUSHOM) and VISNs or facilities; follow-up on data generated by external bodies such as the Joint Commission and Commission on Accreditation of Rehabili-

tation Facilities (CARF); governmental reviews through the Office of the Inspector General and the GAO; and internal reviews such as System-wide Ongoing Assessment and Review Strategy (SOARS) that assess compliance and identify areas needing improvement.

VHA's reorganization effectively places clinical expertise under VHA Operations to allow clinical review of policy implementation in the field. This aligns responsibility with authority and resources in the implementation of policy. Currently, the Office of the Assistant Deputy Under Secretary for Health for Operations and Management (ADUSHOM) for Clinical Operations is developing a comprehensive dashboard monitoring system that will help identify gaps in the implementation of policies. This information will also be valuable in identifying ways to increase consistency in performance across facilities. The ADUSHOM for Clinical Operations has staff dedicated to the provision of technical assistance to VISNs and facilities. Technical assistance may be provided in the form of consultation, site visits, connection with subject matter experts, and follow-up on strategic plans to address key areas of concern.

Question 6. It has been estimated that almost 200,000 veterans may be homeless on any given night. Additionally, about half of all homeless veterans suffer from mental illness with more than two-thirds suffer from alcohol or drug abuse problems. It is believed that the lack of a permanent address contributes to the problem, because of the inability to receive needed medication. Federal agencies abroad are currently using facial recognition, or retinal scanning technologies as a way to identify citizens for a variety of purposes.

Is the VA looking at alternative solutions such as facial recognition or retinal scanning to verify homeless veteran's identification as a way to provide needed medicines to help counter their illness or addictions?

Response. VA is not presently considering facial recognition or retinal scanning technology to verify the identities of homeless Veterans. VA does, however, recognize the importance of incorporating technology into the Homeless Program Office's work in the field. For example, VA has initiated a handheld device project to design and implement a software system on mobile devices that can be used by VA outreach workers in capturing and securely transmitting homeless Veterans' information to and from the Homeless Operations Management and Evaluation System (HOMES). HOMES is a centralized information management system designed to consistently measure and monitor homeless Veteran information and program outcomes throughout VA's continuum of care. The application and device design have the capability to capture the Global Positioning System coordinates of the encounter with the homeless Veteran as well as to photograph the Veteran.

The handheld device project will be a proof-of-concept system to be evaluated by VA for the efficacy of using mobile communications in assisting outreach workers and the Veterans they serve.

Question 7. VA has identified that Prolonged Exposure (PE) is one therapy that is effective for many people who have experienced trauma. It also has been shown to be one of the most effective treatments for PTSD. VA has indicated that they are rolling out a national plan using PE.

Please describe the VA's plans to make this program available nationally.

Response. As part of its strong commitment to make evidence-based psychotherapies available to Veterans with PTSD, VA has implemented a national initiative to disseminate and implement Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT) for PTSD. PE and CPT are recommended in VA/DOD Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." Moreover, in 2007, the Institute of Medicine (IOM) conducted a review of the literature on pharmacological and psychological treatments for PTSD and concluded in its report, *Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence*, that there was sufficient evidence to support the efficacy of these therapies. As part of its efforts to disseminate PE and CPT, VA has implemented national programs to train mental health staff in the delivery of PE and CPT. As of July 1, 2011, VA has provided training to more than 3,500 VA staff in the delivery of CPT or PE, and many of these clinicians have been trained in both therapies.

VA's PE and CPT training programs are competency-based training programs that involve intensive, highly experiential learning opportunities. The training model for these initiatives involves two key components designed to build skill mastery and promote successful implementation and sustainability: (1) participation in an in-person, experientially-based, workshop; followed by (2) ongoing telephone-based clinical consultation on actual therapy cases with a training program consult-

ant who is an expert in the psychotherapy, lasting approximately 6 months. The average timeline for completion of the overall training is 7–9 months.

The PE and CPT training workshops provide educational and experiential training on the theoretical basis of PTSD and the specific therapy being trained, assessment of PTSD and trauma-related symptoms prior to and during treatment, implementation of therapy components and processes (e.g., imaginal and in-vivo exposure for PE, cognitive restructuring for CPT), recommended session structure, and logistical and practical implementation issues. The consultation phase that follows the training workshop provides in-depth training and experience with the application of the therapy to actual therapy cases with an expert in the treatment who serves as a training consultant. The consultation further provides an opportunity for training participants to receive extensive feedback on their implementation of the therapy. Initial program evaluation results indicate that the PE and CPT training and implementation of the therapies have resulted in significant positive patient outcomes.[5]

In addition to training, VA has developed other mechanisms to support the implementation of PE, CPT, and other evidence-based psychotherapies. This includes the appointment of a Local Evidence-Based Psychotherapy Coordinator at each VA medical center to serve as a champion for evidence-based psychotherapies at the local level and provide longer-term consultation and clinical infrastructure support to allow for the full implementation and ongoing sustainability of evidence-based psychotherapies at each VA site. VA has also developed a national evidence-based psychotherapy public awareness campaign. As part of this campaign, VA's OMHS has developed evidence-based psychotherapy brochures, fact sheets, and posters designed to provide education on and promote awareness of evidence-based psychotherapies among staff and Veterans at VA facilities and community agencies. This is designed to promote requests for evidence-based psychotherapy, by encouraging Veterans to ask informed questions to their providers (e.g., primary care providers) and other staff that ultimately will promote engagement in treatment. Furthermore, VA is also working to promote initial and ongoing engagement in evidence-based psychotherapies for PTSD by promoting the implementation of these therapies through tele-mental health modalities. Evidence-based psychotherapy for PTSD using tele-mental health services offers an opportunity to overcome physical and related access barriers (e.g., physical distance, transportation costs and difficulties, job responsibilities) to initial and ongoing participation in evidence-based psychotherapy.

Question 8. Researchers at the Yale University School of Medicine found that of the more than 1 million U.S. veterans who have been diagnosed with a mental disorder, the rates of substance abuse among them is between 21 and 35 percent. Also, DOD separately reported that between 25 and 35 percent of patients assigned to special wounded-care units are addicted or dependent on drugs.

How are the Department of Veterans Affairs (VA) and the Department of Defense (DOD) collaborating to address the issue of substance abuse within care facilities as servicemen and women transition to veteran status?

Response. Until Servicemembers receive a DD 214 releasing them from active duty, DOD is responsible for providing substance use disorder care. Nevertheless, individual VA medical facilities may choose to develop local memoranda of understanding with military installations to provide substance use disorder and other mental health services prior to release from active duty.

At the national level, the InTransition program is one part of the VA/DOD Integrated Mental Health Strategy. The InTransition program is designed to address the care needs of Servicemembers with mental health problems during the process of leaving active duty. An InTransition coach, typically a master's level social worker, is assigned to work with Servicemembers enrolled in the program to sustain their motivation and engagement in the treatment regimen until they come under VA care. The coach also provides healthy lifestyle information, answers questions about treatment modalities, and suggests community resources. The program is voluntary and confidential. Coaches thus "close the loop" between DOD and VA care by following up with the receiving VA case manager to ensure that the patient has arrived at the VA health care facility and has successfully engaged with a new care provider.

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[5] Karlin, B. E., Ruzek, J. I., Chard, K. M., Eftekhari, A., Monson, C. M., Hembree, E. A., Resick, P. A., & Foa, E. B. (2010). Dissemination of evidence-based psychological treatments for Post Traumatic Stress Disorder in the Veterans Health Administration. *Journal of Traumatic Stress*, 23, 663–73.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Alaska's veterans need additional mental health services. The Alaska VA system's participation in the Alaska Psychiatry Residency would improve access to mental health care for Alaska's veterans. What financial and political support is necessary for the Alaska VA system to participate in the Alaska Psychiatry Residency? Can you report any progress?

Response. The Alaska VA Healthcare System has agreed to participate in the Alaska Psychiatry Residency program, which is operated by the State of Alaska. VA can provide funds to cover the salary costs of a resident while the resident is providing care at a VA facility; when the resident is providing services elsewhere, his or her salary will be covered by the facility where the resident is working. VA understands there have been issues with securing funding from the State of Alaska for this initiative, which has contributed to the delay in implementation. VA refers you to officials from the State of Alaska for additional information concerning these issues.

Question 2. Rural veterans are a major concern in my state and across the country. With a push from me, I am glad to see plans to coordinate with the IHS and Community Health Centers in rural areas to provide "seamless" services for rural vets. For example, veterans should be able to go to the clinic in their village and receive mental health care and not have to worry about paperwork or denials or to travel over 500 miles for an appointment. Are the plans to include in the MOU mental health services?

Response. VA, in consultation with the Indian Health Service (IHS), has established a workgroup specific to Alaska for the implementation of the VA/IHS Memorandum of Understanding (MOU) signed by the two agencies on October 1, 2010. Alaska is home to nearly half (229 of 565) of the federally-recognized tribes with unique characteristics and needs. The initial face-to-face meeting of this group is scheduled to take place September 30, 2011, in Anchorage. This meeting will be co-chaired by VA and the Alaska Area Native Health Service, IHS, and the Department of Health and Human Services. The Alaska Native Health Board is facilitating the selection of volunteers for tribal representation. The workgroup will follow the VA Tribal Consultation process and will be driven by consensus as MOUs are established with the tribal entities. The workgroup will establish guidelines identifying what it believes should be included in the MOUs; mental health services may be one of the areas identified.

Question 3. In states such as Alaska, where psychological health, TBI, and suicide resources are minimal and there is a workforce concern, is there a mechanism to encourage VA to work with state/community leaders that are working hard to develop the same care in the civilian sector and having similar workforce, access, or outreach/identification challenges?

Response. The Uniform Mental Health Service Handbook requires that each VISN and VA medical center have liaisons identified for state, county, and local mental health systems. This allows for coordination of VA mental health activities with the private sector and includes informing community providers about VA services, coordinating with Vet Centers and DOD, building VA awareness of community-based mental health programs for Veterans and their families, including sharing agreements and co-location of staff, providing service on States' council on suicide prevention, providing spokespersons for mental health, coordinating outreach efforts, and creating Consumer-Advocate Liaison Councils which include the National Alliance on Mental Illness, Veterans Service Organizations, local employment and housing representatives, and other mental health advocacy groups from the community. Additionally, the OMHS encourages regular engagement with state and community leaders in addressing the mental health needs of the Veteran population. One endeavor includes outreach efforts to community organizations with the provision of training in Veteran and military culture, readjustment issues, and deployment-related mental health concerns. VA facilities report quarterly to OMHS on the number and types of outreach programs provided to community organizations. For example, in the first two quarters of FY 2011, VA mental health staff provided 28 outreach programs in Alaska to community organizations, such as DOD, community medical facilities, universities, the Salvation Army, Alaska Coalition on Housing and Homelessness Annual Conference, various mental health conferences where community providers participated, probation offices, and police services. A variety of topics were addressed including suicide prevention, violence prevention, substance abuse treatment, PTSD treatment, readjustment concerns, Traumatic Brain Injury and home-

lessness concerns. These provided opportunities for exchange of best practice information and sharing of resources for the improved treatment of Veterans both in VA and for those served by community providers. Another example is the provision of the Flex Rural Veterans Health Access Program (RVHAP), a 3-year grant program recently funded to improve service access for rural OEF/OIF/OND Veterans in Alaska, Montana, and Virginia. Program activities include crisis intervention, including screenings for PTSD and TBI, referral services to VA, and telehealth enhancement to support care for rural Veterans.

Question 4. How will (or can) telemedicine be used to increase access to psychological health, TBI, and suicide services and support? What are the detail steps you are taking to increase access and services for veterans?

Response. VA has systematically adopted tele-mental health as a means of enhancing access to care for Veteran patients since 2002. In FY 2010, this ongoing process of development resulted in 49,531 Veteran patients receiving 112,332 consultations via tele-mental health. VA routinely uses tele-mental health between 96 VA medical centers and 394 community-based outpatient centers (CBOC) for the assessment and management of Veterans with mental health disorders, psychological conditions and suicide risk. In appropriately assessing and managing the risk of suicide via tele-mental health, VA has established processes and procedures that ensure the "at risk" patient is linked to VA's comprehensive program for suicide prevention. In addition to tele-mental health services provided via videoconferencing between hospital and clinics, VA currently supports 12,870 Veterans with mental health conditions with services directly in their own homes using home telehealth monitoring and messaging devices. This number includes 664 patients with substance abuse disorder, 8,571 with depression, and 3,635 with PTSD.

VA is aggressively expanding its capacity to support tele-mental health with both general and specific initiatives. VA's general support of telehealth takes the form of its FY 2011 and FY 2012 Telehealth Expansion Initiative, which will ensure nationwide availability of the technology, support staff, and telecommunications requirements needed for all VA medical centers to undertake clinical videoconferencing with all their associated sites of care, thus making all specialty care services, including tele-mental health and assessment of Traumatic Brain Injury, more widely available. Specific initiatives for tele-mental health in VA include: (1) Current integration of tele-mental health, and other mental health care interventions into VA's patient aligned care team model (PACT); (2) VA's current implementation of telehealth technology that enables Internet Protocol (IP) videoconferencing directly to Veteran patients' homes by VA providers, which will increase the capacity for tele-mental health services provided via videoconferencing directly into the home; and (3) a FY 2012 initiative to systematically implement the delivery of evidence-based psychotherapy services for PTSD into tele-mental health services across VA.

Question 5. Are there telemedicine options for specialty therapies for TBI, such as physical therapy, speech therapy, occupational therapy, or counseling?

Response. VHA tele-rehabilitation utilizes telehealth technologies to connect Veteran patients with rehabilitation providers separated by distance or time. Tele-rehabilitation services that involve clinical videoconferencing make specialist expertise available across VA medical centers and from VA medical centers to CBOCs. The advantage of these services is that they increase the timely access of Veteran patients to specialist services and reduce their need for avoidable travel. Tele-rehabilitation services that are routinely provided via clinical videoconferencing in VHA cover the provision of care for: audiology, speech pathology, management of Traumatic Brain Injury, physical therapy, occupational therapy, recreation therapy services, spinal cord injury, post-amputation care, polytrauma, and provision of durable medical equipment. In FY 2010, 1,168 Veteran patients received care via tele-rehabilitation. There was a 49 percent growth of tele-rehabilitation encounters between FY 2009 and FY 2010. VHA recorded a 96 percent growth of tele-rehabilitation encounters through the second quarter of FY 2011.

In addition to tele-rehabilitation services provided via clinical videoconferencing, VA supports the care of Veteran patients with complex care needs in their own homes using home telehealth technologies. The home telehealth technologies employed by VA include: videoconferencing directly into the home that replicates a face-to-face visit; and messaging and monitoring devices that monitor symptom progression and vital signs.

Question 6. I continue to hear about the value of Assistance Dogs/Service Dogs with respect to our service men and women as well as our veterans who are experiencing mental health and/or mobility issues. Considering the Pilot Program in place

within the VA and the funding that has been allocated to that program, what are we doing to make this valuable resource available to those who would benefit?

Response. VA has a number of efforts in place to increase awareness of the benefits of obtaining a Service Dog or Guide Dog (SDGD). VA has published numerous articles in national Web sites, and has participated in public affairs articles across the Nation. VA is currently working with a number of the VSOs and National Service and Guide Dog Organizations to gather and disseminate accurate information regarding the benefits of obtaining a service dog or guide dog, the processes and requirements that must be met to obtain a trained dog, and what it takes to sustain a long-term Veteran and SDGD partnership. These dialogs have served the organizations, VA, and the Veterans.

One product of this collaboration has been the development and completion of two video presentations which will be made available during the fourth quarter FY 2011 to all VA facilities and clinics. One of the videos is a short film targeted for use in lobbies, clinic waiting areas, and other sites where Veterans congregate. This short film introduces the concept of SDGDs, talks about the benefit of having a SDGD, and encourages viewers to ask about this benefit at their local medical center or CBOC. The second video's target audience is VA staff and provides education on the benefits of SDGDs, provides general information about the cohort of Veterans that might want to consider obtaining a SDGD, and encourages the staff to learn more about the VA SDGD Program. Fact Sheets will be made available to the staff and Veterans along with the videos, providing additional information about SDGDs and contact information. VA plans for FY 2011 and FY 2012 include additional education, publication, communication, and advocacy efforts targeting Veterans, dog organizations, DOD, and VA clinical and benefits staff. VA's efforts will support the increase in the number of Veterans interested in obtaining SDGDs, and provide a mechanism to promote VA staff support and advocacy resulting in improvement to the overall provision on SDGDs for all Veterans needing the services of a SDGD.

In FY 2010, VA spent $180,410 from the prosthetics budget to support Veteran/SDGD teams through provision of veterinary services, prescribed medications, and needed equipment such as harnesses, leashes, vests, etc. In 2010, VA provided veterinary care and equipment to 254 Veterans in support of their SDGDs. In 2010, that number included payment to provide care and equipment for 66 new Veteran/SDGD teams. In May 2011, with over 4 months of the year remaining, VA has provided veterinary care and equipment to 224 Veteran or SDGD teams, 41 of these teams were new to the VA in 2011, at a cost of $161,643 It is important to remember that SDGDs do not require services every year, and this being the case, the numbers provided (254 and 224) include only those dogs that required a service during the fiscal year reported. At this time, the number of unique Veteran or SDGD teams who have already received services and are currently eligible for VA services is estimated to be slightly over 450.

VA welcomes the possibility of expanding the use of trained dogs to provide appropriate services to Veterans diagnosed with certain mental illnesses. At this time, valid and reliable scientific evidence is not available to determine, from a clinical standpoint, whether or when SDGDs are most appropriately provided to Veterans with mental illness, including Veterans diagnosed with PTSD.

The National Defense Authorization Act (NDAA) for Fiscal Year 2010, Public Law 111–84, Sec. 1077 authorized VA to conduct a 3-year research study to assess the benefits, feasibility, and advisability of using service dogs for the treatment or rehabilitation of Veterans with physical or mental injuries or disabilities, including PTSD. Passage of this measure provided VA with an excellent vehicle to examine the issues and possibly accumulate valid and reliable clinical evidence necessary to proceed.

We are pleased to report that VA's implementation of Public Law 111–84, Sec. 1077, is underway. VA's Office of Research and Development's study proposal completed all of the development and preliminary review required for a research study. The study received approval from the Institutional Review Board for human subjects on January 10, 2011, and from the Institutional Animal Care and Use Committee for animal subjects on January 28, 2011. VA's Privacy Officer and Chief Veterinarian completed the review and granted approval shortly thereafter.

This is a fairly complex and novel study involving advanced design and statistical analyses. The research study is specifically designed to evaluate use of service dogs for individuals who have been diagnosed with PTSD. The study objectives include: (1) Assess the impact service dogs have on the mental health and quality of life of Veterans; (2) Provide recommendations to VA to serve as guidance in providing service dogs to Veterans; (3) Determine costs associated with total health care utilization and mental health care utilization among Veterans with PTSD; and (4) Ex-

plore meanings and perceptions of roles that service dogs fill in the lives of the Veterans and their caregivers.

The study will involve the partnering of approximately 200 PTSD-diagnosed Veterans with specially trained dogs. The number of dogs involved required contracting with more than one vendor. VA has successfully completed blanket purchase agreements with three vendors, ensuring an ample number of dogs will be available when and where they are needed. Per the requirements of the NDAA, two of the vendors are accredited by Assistance Dogs International (ADI), and the third vendor demonstrated adherence to standards comparable to those of ADI. Veterans are now being recruited for enrollment in the study, and two Veterans were partnered with dogs in July 2011. These first two Veterans served in the Vietnam era, and the OEF/OIFOND era; one Veteran is female, and one is male.

It is very important to note that, based on previous studies in which Veterans were matched with dogs, we can anticipate that recruitment may take longer than one might expect because of the unique needs of each Veteran with mental health issues, and the logistics of finding the best possible service dog match. This study is of the utmost importance to VA as we continue to work toward providing top quality care to our Nation's Veterans. The study is expected to be completed by March 2014.

If the results of the research study demonstrate the clinical effectiveness of this effort, VA will then evaluate how best to modify existing regulations to ensure Veterans can access this benefit.

Question 7. What are you doing to ensure that veterans are being provided the best possible psychiatric care? Statistics show that a large percentage of those servicemembers who die by suicide had previously been seen at behavioral health.

Response. Please see the response below to question 13.

Question 8. What are you doing to reach out to families, especially parents, to provide education on emergency mental health issues, how to identify them, and what to do about it?

Response. Please see the response below to question 15.

Question 9. How does one diagnose, treat and prevent depression and mental health disturbances in remote areas for veterans or civilians? This is a difficult task. The use of telepsychiatry and methods of selecting high risk populations after discharge are important. What methods are being used? Any evidence they are successful?

Response. VA has been studying and implementing a variety of tele-mental health programs to increase access to mental health specialty treatment for patients in rural areas or areas lacking specialty providers. These include videoconferencing-based consultation and training for specialty care delivery by primary care providers, telephone-based care management for mental health patients, videoconferencing-based psychotherapy at CBOCs, and in-home mental health visits via videoconferencing. Many of these programs have been studied in clinical trials and have been adopted based on evidence that outcomes of care delivered by these mechanisms are at least as good as outcomes delivered in face-to-face modalities, and that Veterans and other patients are satisfied by care delivered using telehealth. Brief summaries of some of these programs and evidence of their success follow:

- Videoconference-based Specialty Care consultation and training program for primary care clinicians allows rural primary care providers to provide specialty treatments with specialist expertise and success rates—Project Extension for Community Health Outcomes/VA Specialty Care Access Network (ECHO/VA SCAN)

To address the difficulties associated with access to specialty care services in rural areas, a video-teleconferencing based system named Project ECHO was developed at the University of New Mexico for training primary care providers through video-based consultation with specialists in treatment of high prevalence disorders for which medical specialists may not be available in rural areas. Project ECHO focused initially on primary care training and consultation for Hepatitis C treatment. Outcomes for Project ECHO patients did not differ significantly, demonstrating that the treatment model is as successful as specialty care for treating Hepatitis C in underserved communities

Based on these impressive results, Project ECHO has expanded to improve care for 19 other disorders including psychiatry, and VA is being trained in and adopting this model in a nationwide project. The VA SCAN project will initially focus on four types of disorders: chronic pain, Hepatitis C, cardiology and diabetes mellitus. Using high-resolution video equipment provided by VA SCAN, participating sites will be able to access real-time video consultations with specialists regarding high priority conditions, as well as free, formalized, accredited, continuing education credits. Par-

ticipating sites will also benefit from enhanced connectivity, equipment, and the training necessary to successfully build and maintain a telemedicine consultation program through participation with VA SCAN. Notably, chronic pain problems are extremely prevalent and complicate treatment for substance use disorders, depression, PTSD and suicidality, and non-optimal chronic pain care can increase risk for abuse and misuse of prescription medication. The disorders covered will be expanded as implementation progresses and will provide a mechanism for increasing mental health specialty access in rural areas.

• Delivery of evidence-based psychotherapy for PTSD by videoconferencing is as effective as in-person counseling

VA psychologists conducted the first randomized controlled trial investigating the effectiveness of using video-teleconferencing (VTC) to deliver cognitive behavioral group psychotherapy.[6] The study delivered anger management therapy to rural combat Veterans with PTSD. Using a highly rigorous methodology, the study found that delivery of psychotherapy via VTC was as clinically effective as traditional face-to-face delivery.[7]

Additionally, research has found that attrition, treatment adherence, satisfaction, and group cohesion were comparable between the two modalities.[8] The only significant difference was in therapeutic alliance or the level of perceived connection between the therapist and the patient. Although alliance was strong in both conditions, alliance with the therapist was lower in the VTC condition. However, the relatively lower alliance was not sufficiently powerful to result in substantially lower clinical outcomes for participants in the VTC condition.

Both clinical and process outcomes of this trial indicate that delivering cognitive behavioral group psychotherapy via VTC is an effective and feasible way to increase access to evidence-based care for Veterans residing in rural or remote locations. In addition, further analyses supports that therapist fidelity to a manualized cognitive-behavioral group psychotherapy is similar whether the treatment is delivered via a VTC modality or the traditional in-person means, and VTC does not compromise a therapists' ability to effectively structure sessions and build rapport with patients.[9]

There are currently three additional trials underway testing the clinical effectiveness and cost-effectiveness of video-teleconferencing-based cognitive processing therapy for the treatment of PTSD in male and female Veterans. Additionally, a VA task force is beginning a roll-out of video-conferencing based PTSD psychotherapy across the country.

Finally, the Portland VAMC began a home-based mental health videoconferencing program which allows Veterans to receive treatment from mental health providers via Web-cameras on their personal computers in their own home. While this has not been studied in a clinical trial, based on the acceptability and successful patient and provider experiences with this mode of mental health treatment, this program has been expanded throughout VISN 20.

• Substance use disorder (SUD) aftercare following intensive services via telephone is acceptable and at least as effective as face-to-face care

McKay and colleagues compared telephone-based continuing care to two more intensive face-to-face continuing care interventions for patients with alcohol or cocaine dependence who had just completed 4 week intensive outpatient substance use disorder treatment programs. The trial included 359 patients from either a VA or a community based treatment program and compared: (1) 12 weekly monitoring and brief counseling calls plus 4 weekly supportive group therapy sessions, (2) 12 weeks of twice-weekly cognitive-behavioral relapse prevention sessions, and (3) 12 weeks of twice-weekly standard group counseling. Participants who received the telephone-based continuing care had better substance use outcomes over the next 2 years including higher rates of abstinence, better alcohol biomarkers levels, and lower rate of cocaine-positive urine samples. Higher risk patients did better in face-to-face treatment, but lower risk patients had better outcomes with telephone aftercare.

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[6] Morland LA, Greene CJ, Rosen CS, Mauldin PD, Frueh BC. (2009). Issues in the design of a randomized noninferiority clinical trial of telemental health psychotherapy for rural combat veterans with PTSD. Journal of Contemporary Clinical Trials 30(6): 513–522.

[7] Morland LA, Greene CJ, Rosen CS, Foy D, Reilly P, Shore J, He Q, Frueh BC. (2010) Telemedicine for anger management therapy in a rural population of combat veterans with Posttraumatic Stress Disorder: A randomized non-inferiority trial. Journal of Clinical Psychiatry 71(7): 855–863.

[8] Greene, C.J., Morland, L.A., McDonald, A., Frueh, B. C., Grubbs, K.M. & Rosen, C.S. (2010). How does telemental health affect group therapy process? Secondary analysis of a noninferiority trial. Journal of Consulting and Clinical Psychology 78(5): 746–750.

[9] *Supra* note 3.

A second VA-funded study randomized 667 drug and alcohol disorder patients to telephone treatment versus face-to-face continuing care at two VA facilities (one urban, one rural). One year after entering the treatment study, patients receiving telephone care reported rates of recovery that were equal to those receiving face-to-face treatment. Veterans found the telephone treatment to be highly satisfactory and the benefits of telephone treatment were not diminished for Veterans with an additional psychiatric disorder or for those who lived farther from a VA facility.

Based on the success observed in these trials, 126 of 140 VA facilities have incorporated telephone-based SUD treatment services into their specialty SUD treatment programs to reach more patients and keep patients engaged in care.

• Telephone case monitoring for patients with PTSD is feasible and improves continuity of care and detection of emergent mental health problems

A quasi-experimental cohort study looked at whether continuity of mental health care following residential PTSD care could be improved by adding telephone care, using bi-weekly telephone calls, to standard referral to outpatient mental health care. This study found that telephone monitoring was feasible, reaching 95 percent of patients, and successful for improving outpatient treatment engagement and improving patient satisfaction with care. Specifically, patients receiving telephone support were twice as likely (88 percent versus 43 percent) to complete an outpatient mental health visit within 1 month of discharge and 85 percent wished the intervention could continue beyond the 4-month study.[10] A multi-site randomized controlled trial is currently underway testing this intervention, and full results will be available soon. Preliminary findings confirm that VA was able to reach most patients by phone (76 percent completed at least three of six planned calls) and that calls are helpful in detecting and alerting clinicians about emergent clinical problems.

Question 10. There are cases in which family members have been encouraged to seek help for their spouse or child when they fear they may be suicidal as a result of combat related PTSD. Is there a plan to provide families with a safe place to call where they can access care for their loved ones?

Response. VA has implemented a call center to coach family members and friends on how to talk to a Veteran about mental health issues, particularly when that Veteran is not receiving care. The program, Coaching Into Care (1–888–823–7458), receives calls actively from 8am to 8pm (EST). After hours, a Veterans Crisis Line responder will take a message from callers to be returned the next business day. The Veterans Crisis Line and Veterans Chat service are available to family members and friends 24 hours a day, 7 days a week, to assist with any crisis or emotionally challenging situation and can make direct referrals and mobilize immediate help if needed. This new service provides information and problem solving regarding mental health issues free of charge to callers. There is no limit to the number of calls. The service is designed to connect the family member caller and his or her Veteran to their local VA facility and other resources in their community.

Question 11. What are the staffing levels in VA facilities in Alaska and how do you see that growing and sustaining? For example, the Kenai Peninsula has had a need for clinicians for over a year.

Response. The Alaska VA Healthcare Care System (AVAHS) has continued to increase the size of its staff to meet the growing number of Veterans accessing care. Since FY 2009, AVAHS has added three new sites of care: the Mat-Su VA CBOC, the Homer VA Outreach Clinic (an extension of the Kenai CBOC), and the Juneau VA Outreach Clinic. These clinics are staffed with Primary Care and Mental Health staff.

As of July 28, 2011, current staffing levels at VA facilities in Alaska are:

- Anchorage VA Outpatient Clinic: 475.3
- Fairbanks CBOC: 7
- Kenai CBOC: 8
- Mat-Su CBOC: 12
- Juneau CBOC: 5

In addition, the Anchorage VA Outpatient Clinic and Fairbanks CBOC are augmented by on-station fee basis, VA Locum Tenens Program, and contract staff.

Recruitment and retention are ongoing challenges in Alaska, particularly for specialty care. The total number of full time employees has increased by 42 between FY 2010 and FY 2011. As of July 28, 2011, AVAHS currently has 57 positions approved for recruitment and hire, with 10 tentative offers pending. AVAHS recently

[10] Rosen CS, DiLandro C, Corwin KN, Drescher KD, Cooney JH, Gusman F. (2006) Telephone monitoring and support for Veterans with Chronic Posttraumatic Stress Disorder: A pilot study. Community Mental Health Journal 42(5): 501–508.

selected two primary care physicians for the Fairbanks CBOC. These recruitments had been ongoing since 2006 and 2010.

At the Kenai CBOC, the first psychiatrist recruitment resulted in a selection; however, the individual decided not to accept the offer. The position was re-posted and a psychiatric nurse practitioner was selected; however, human resources staff members were not able to reach her after the selection. The mental health positions have been re-posted for recruitment effective July 26, 2011. While the Kenai CBOC mental health positions have been vacant, coverage has been provided by telehealth using video-teleconference from the Anchorage VA Outpatient Clinic, as well as the Mat-Su and Juneau clinics.

Recognizing potential retirements during the next 2 years, AVAHS is developing succession planning for key positions.

Question 12. Should the mental health professionals who are working with DOD transition with their patients to VA? For example, the professionals (case manager, etc.) follow the person as they go from DOD to VA (continuity of service provider).

Response. No, mental health professionals, such as case managers, should not transition with their patients from DOD to VA. Although both VA and DOD professionals work for the Federal Government, they are hired to each work within a specific Department and cannot transition schedules, locations, pay, and benefits back and forth between the two. Furthermore, there are several reasons why this kind of movement of staff from one care system to another is not needed to ensure continuity of care and a "warm hand-off" of care for the patient.

Each VA medical center has an OEF/OIF/OND Care Management team in place to coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits. Members of the OEF/OIF/OND Care Management team include: a Program Manager, Clinical Case Managers, and a Transition Patient Advocate (TPA). The Program Manager, who is either a registered nurse or licensed social worker, has overall administrative and clinical responsibility for the team and ensures that all OEF/OIF/OND Servicemembers/Veterans are screened to see if they require case management. Those severely ill or injured are provided with a case manager, and other OEF/OIF/OND Servicemembers/Veterans are assigned a case manager as indicated by a positive screening assessment or upon request. Clinical Case Managers, who are either registered nurses or licensed social workers, coordinate all patient care activities, using an integrated approach across all systems of care. The TPA helps the Servicemember/Veteran and family/caregiver navigate the VA system by acting as a communicator, facilitator, and problem solver. VA case managers maintain regular contact with Servicemembers/Veterans and their families/caregivers to provide support and assistance to address any health care and psychosocial needs that may arise based on an agreed upon and clinically appropriate contact plan. The OEF/OIF/OND Care Management program now serves over 53,000 Servicemembers and Veterans, of whom over 6,400 are severely ill or injured.

In addition to the comprehensive and coordinated work of DOD and VA case managers cited above, there are other supports available to enhance continuity of care. Servicemembers with mental health problems who are moving from DOD to VA care can also take advantage of the InTransition program. The InTransition program is a component of the VA/DOD Integrated Mental Health Strategy in which Servicemembers are assigned a coach to work with them during this period of change to keep them motivated and engaged in their treatment regimen. The coach will assist in bridging the gap from their current/referring provider to the new/gaining mental health provider. The coach is also available to provide healthy lifestyle information, answer questions about treatment choices, and provide community resources to the Servicemember. The program is voluntary and confidential. The telephonic coaching generally takes place at least weekly, but more often if deemed appropriate. The coaches all have experience working with the military and understand military culture. At minimum, each coach has a master's degree in social work.

It is important to recognize that an InTransition coach does not provide clinical treatment, does not provide therapy, and is not a case manager. Coaches differ from case managers because they enhance care that is already in place. They do not make assessments or develop new treatment plans, but rather serve to complement the plans already established by the DOD provider or case manager. Also the coaches work to "close the loop" between DOD and VA care by following up with the receiving VA case manager to ensure the patient has arrived at the VA health care facility and is engaged with a new care provider.

Question 13. Statistics show that 40 percent of those servicemembers who die by suicide had previously been seen at behavioral health.

a. What are we doing to ensure that Veterans are being provided the best possible psychiatric care?

Response. VA is strongly committed to providing the best mental health care available. Our suicide prevention strategy is based on the premise of ready access to quality mental health and other health care. All Veterans who are identified as being at high risk for suicide receive an enhanced level of care that includes frequent visits with their mental health provider, safety planning and treatment planning that must address the suicidality, attention to means restriction and medication management as well as ongoing treatment for any mental health conditions. VA has instituted Suicide Prevention Coordinators (or Suicide Prevention Teams) at each VA medical center and the largest CBOCs to monitor the care of high risk patients, provide training and outreach concerning risk factors and warning signs, and to track suicidal events.

In an effort to provide the best possible psychotherapy, VA has developed national initiatives to disseminate and implement evidence-based psychotherapies (EBPs) for PTSD, depression, serious mental illness, and other mental health conditions and behavioral health conditions (e.g., insomnia). For example, VA has implemented a national initiative to disseminate and implement Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT) for PTSD. PE and CPT are recommended in VA/ DOD Clinical Practice Guidelines for PTSD at the highest level, indicating "a strong recommendation that the intervention is always indicated and acceptable." As part of its efforts to disseminate EBPs, VA has implemented national programs to train mental health staff in the delivery of specific EBPs, including PE, CPT, Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for depression, and other therapies. As of July 1, 2011, VA has provided training in one or more EBPs to more than 4,500 out of 21,000 eligible VA staff. VA has also instituted the Local Evidence-Based Psychotherapy Coordinator at each VA medical center to serve as a champion for evidence-based psychotherapies at the local level and provide longer-term consultation and clinical infrastructure support to allow for the full implementation and ongoing sustainability of evidence-based psychotherapies at each VA site.

VHA's system of National Mental Health Centers of Excellence and Mental Illness Research, Education and Clinical Centers (MIRECCs) focuses on specific solutions to mental health problems such as PTSD, serious mental illness, suicidality, and women's mental health. They are continually developing and disseminating new and promising interventions for mental health treatment and are, in fact, leading the Nation in developing strategies for treating PTSD and other conditions.

b. Are the treatments appropriate, timely, and effective?

Response. As noted above, VHA is committed to the use of evidence-based practice in providing mental health care for Veterans. The psychotherapies being promoted throughout VHA were chosen based on their effectiveness as shown in clinical trials in improving patient outcomes for the specific diagnoses being targeted. VHA monitors access to care through evaluation of performance metrics. At this time, it is not possible to directly track national access to the evidence-based psychotherapies, although software improvements to allow this to happen are being developed. However, all patients new to mental health must be seen and evaluated within 24 hours and seen for full evaluation and treatment initiation within 14 days. VHA reports on this measure monthly; current data show that 95.4 percent of patients are seen and evaluated within this timeframe, which is slightly lower than the 96 percent benchmark. The Office of Mental Health Operations is currently looking at additional methods of evaluating access to mental health care.

Question 14. Why do suicide investigations take so long? Why they are not made a priority in the labs when we know that families need this information in order to fully grieve their loss?

Response. Suicide investigations can vary considerably as to the time needed for completion. Non-VA entities have initial responsibility for investigations under their authority. They conduct a thorough review that can include forensics, autopsies, and post mortem psychological reviews. There will be variability among these non-VA entities in accomplishing a suicide investigation, given the processes and procedures that they utilize.

Likewise, suicide investigations under VHA's authority have similar requirements for review. VHA's commitment is to provide a timely review of the Veteran's medical care prior to the Veteran's death and disseminate the results of this review as appropriate. VHA provides a number of services to family members. Meeting and exceeding the needs and expectations of our Veterans and their families is a priority. VHA will continue to make every effort to ensure that every applicable resource is made available at the time of need.

Question 15. What are we doing to reach out to our families, especially parents, to provide education on emergency mental health issues, how to identify them, and what to do about it?

Response. VA Suicide Prevention Coordinators include family and community groups and organizations in their outreach efforts on a monthly basis to make sure everyone knows how to get help in an emergency situation. We have developed an overarching information program concerning the Veterans Crisis Line and Veterans Chat service to make sure that everyone knows that 24/7 help is available for any emotional crisis. We have developed a community-based program titled Operation SAVE that teaches family members and friends the signs of emotional distress and suicide risk. Each Suicide Prevention Coordinator is required to present this educational program in the community a minimum of five times per month. OEF/OIF/OND coordinators also reach out to families of returning Servicemembers to make sure they are aware of available programs, and all new enrollees receive an information letter about the warning signs of crisis and available crisis intervention services from the Under Secretary of Health. In addition, the *Coaching into Care* line is available for more general help to family members when needed.

Question 16. Servicemen and women consistently tell me that they want peer based support to help them with their behavioral health issues. Is there anything we are doing to try to build that peer based support? Is the VA utilizing peer-based support to help them with their behavioral health issues? What are you doing to try to build peer-based support for veterans?

Response. VHA's OMHS strongly supports the use of peers in its mental health programs and has implemented several efforts to provide peer services nationwide. As part of the overall effort to transform VHA's mental health programs to the recovery model, peer support services are an integral adjunct to the clinical services provided by degreed professionals.

Peer support services have a long history in the substance use disorder programs in VHA. In addition, as a result of the Mental Health Enhancement Initiatives, over 250 peers have been hired, most of whom deliver services to Veterans with a serious mental illness. Programs like the Psychosocial Rehabilitation and Recovery Centers and Mental Health Intensive Case Management teams now have peers providing services. OMHS has been working with the Office of Human Resources Management to develop a career ladder for peers that will recognize their valuable services and compensate them fairly for the work they provide.

As authorized by Public Law 110–387, Section 107, OMHS is conducting a pilot program of peer-provided outreach and support services to rural OEF/OIF/OND Veterans. These pilot projects are currently active in VISNs 1, 19, and 20, all of which have large rural populations. In addition, Public Law 111–163, Section 304, authorizes access to peer outreach and peer support services for all OEF/OIF/OND Veterans and specifies that VA develop a contract with a national organization to carry out a program of training for Veterans to provide peer outreach and peer support services. VA is currently in the contract development process for that effort.

Furthermore, VHA has developed the Buddy-to-Buddy peer support program jointly with the University of Michigan and in partnership with the Michigan Army National Guard and Michigan State University. This program addresses the unique challenges facing returning National Guard citizen soldiers, who are often isolated from those with whom they served once they return to their home communities and who face challenges reintegrating into civilian communities and returning to the civilian work force. The primary goal of the program is to intervene early so that identified concerns and stressors do not escalate into PTSD, family disruption, or suicidal crises. This program is now implemented throughout the Michigan National Guard.

Chairman MURRAY. Thank you very much. Dr. Zeiss, I wanted to ask you. I noticed that you were shaking your head during Mr. Williams' and Mrs. Sawyer's testimony.

Do you have anything you want to say to them?

Ms. ZEISS. I respect and really appreciate what they say, and I am shaking my head only in the sense of listening and trying to incorporate and understand the issues that they are raising for us.

Chairman MURRAY. I think you have been with the VA system longer than anybody on this panel, and you have made some great strides, and I know you are writing the policies. Do you think the facilities are listening to what you are telling them to do?

Ms. ZEISS. I think that there has been tremendous progress in all of the facilities but inconsistent, and I very much support the reorganization that Mr. Schoenhard was just describing.

I think that we have come to a much clearer delineation of what policy offices, like the office of mental health services, can do and can accomplish. To be able to work in a much more interwoven fashion with operations and management is going to be very powerful I believe.

Ms. Schohn and I work very closely together in terms of looking not only at how policies are being implemented, but I think the other part of the question is, are we in central office listening to the facilities, and are we learning from them about the challenges they are having in implementing policy, and how do we do a much more coordinated job of coming up guidance for the field that really can be implemented in a consistent way throughout. And I think this organization is going to be very, very helpful.

Chairman MURRAY. Mr. Schoenhard, we heard from the IG that Atlanta was not prepared to handle the influx of new veterans who needed mental health.

This is not the beginning of this war. It has been going on for a very long time. We have been talking on this Committee for a very long time about PTSD and TBI and the invisible wounds of war and the high number of soldiers coming back who need this access.

How can it be that the VA was not prepared for this?

Mr. SCHOENHARD. Madam Chairman, that is a tremendously important question. In Atlanta, and it is true of VISN–7 where Atlanta is part. This is one of our fastest growing areas for veteran enrollment. We have there 7 to 8 percent increase.

We concur with the IG, and I have talked with Mr. Clark, who is the director there. We were not as quick as we should have been, and we are going to learn from this. We are taking this report, not just for Atlanta but for other facilities particularly in high-growth areas. We need to improve the process that occurred in VISN–7, but I think with delay, to secure additional funding from the VISN in order to observe the growth.

Every opportunity we have to learn from this and especially apply those lessons across is important. I do not know if Dr. Arana may want to elaborate on that a little bit or Ms. Schohn because I am looking to them for help with this.

Dr. ARANA. Madam Chairman, before I make my comments, I would like to thank Mr. Williams and Mrs. Williams, Mrs. Sawyer and Mr. Sawyer for being here.

I have been a practicing psychiatrist for over 30 years. Their stories are just unacceptable in terms of practice. I have been in the VA system for over 28 years. I know we can do better. I have treated hundreds of PTSD patients.

And so I am very sorry that you have had the experience you had. I am sure hopeful that we can be able to make that better in the next few months and the next few years.

To the point of the reorganization, over the past 4 months realigned in VA particularly in terms of operations, and one of the key areas that we have realigned is mental health.

The idea of the realignment is to have more clinical muscle in operations so that we can better implement the policies that Ms. Zeiss has developed over the past few years, and the plan is very much to do that in an aggressive way.

Our hope is to get out to the facilities in the very regular way. In fact, much the way the IG does with on the ground visits with experts who know the business, who know how to ask the questions, who know how to find out where the gaps are.

Our hope is to deploy this effort very strongly over the next six to 8 months and hope to come back and tell you about our progress with that.

Chairman MURRAY. As you have heard, the wait times for appointments have a huge impact not only on veterans, but on their entire family and the stress that they are going through.

I know we do not even know the scope of all this from the VA itself because they are only measuring the wait times for the first time mental visit. We are not seeing data for the second time or the third time, and I know that is what both of our witnesses before were talking about. It is not just the first appointment. It is when you called yesterday and you were told: well, because you are going to be at this hearing it is going to be 4 months before you get in. Unacceptable.

How are we or you, how are you empowering managers to be more flexible with their money to do what they need to do to make sure that that is not what veterans hear on the first, second, third, or hundredth time that they call?

Mr. SCHOENHARD. Madam Chairman, I am going to ask Dr. Schohn perhaps to add to this if it is OK.

But what I would begin with is that the performance measurement that we have for new patients is important. We already heard testimony this morning that in this case a new patient presenting was not served in a timely fashion. And while that is necessary, I do not believe it is sufficient.

The performance measures that we work with facilities on and understand their difficulties with is an evolving methodology. I think from the Atlanta IG report and from other indications we have, we need to look at what support needs to be given to being able to insure that timely appointments are made for existing patients as well.

We do measure that, but what I am hopeful for in terms of the deployment of Uniform Mental Health Handbook is that all of this is laid out there for existing and new patients.

What we need to do is to get better deployment, do the site visits, and as you infer in your question, understand what, if any, barriers exist, what difficulties the facilities are having, the clinicians are having, what are the root causes of any gaps in that care and address those whether they be staffing, facility, or whatever.

Chairman MURRAY. Are you doing that or are you just identifying that as a problem?

Mr. SCHOENHARD. Yes, we are doing that. And if I could ask Ms. Schohn to elaborate.

Chairman MURRAY. And then I need to turn it over to Senator Burr so if you can answer quickly.

Ms. SCHOHN. Yes. We are in the process of developing a comprehensive monitoring system that looks at all of the issues, the implementation rates, really combining the date for all into one place so that we can red-flag quickly based on our available data.

By the same token, we are also looking to develop new databased on our site visits that might give a more accurate reflection of what is really going on in the facilities, and finally, we are going to be——

Chairman MURRAY. When will you see that? How long does it take to collect all of this data?

Ms. SCHOHN. We hope to have the full package in place by the end of the year. We are looking at pieces of the data right now so we can again begin to address it as it comes up but we hope to have the full package available by the end of the year.

Chairman MURRAY. And then you will have to analyze it and then go back to the facilities?

Ms. SCHOHN. No, no. It will be put together as an analysis that we can work with the VISNs.

Chairman MURRAY. My question is: does everybody have to wait another year?

Ms. SCHOHN. No, no. We will be working on this, as I said, concurrently with putting the information together.

Chairman MURRAY. If you see information coming in that second, third, fourth, fifth visits are taking too long, can you do something immediately about that?

Ms. SCHOHN. Yes, we can.

Chairman MURRAY. OK. Senator Burr.

Senator BURR. Mr. Schoenhard, how do you define "timely" for a veteran with a gun in his mouth?

Mr. SCHOENHARD. Instantaneous, sir.

Senator BURR. So, is that the directive that comes out of the VA Central Office to all individuals at all locations that would come in contact for the first time with a veteran with mental health needs?

Mr. SCHOENHARD. Well, we do have a requirement that those who present with serious issues, and I might ask Dr. Zeiss to elaborate on this, be seen within 24 hours. But to your question specifically, a veteran with a gun in his or her mouth, our expectation would be immediate help starting with whatever would be available on the crisis line and any other intervention that could be provided.

Senator BURR. Does the VA have written access standards for behavioral health care for both urgent care and routine care?

Mr. SCHOENHARD. Yes, sir, we do.

Senator BURR. And what are those?

Mr. SCHOENHARD. Could you elaborate, Dr. Zeiss?

We do, for urgent care, require an appointment within 24 hours, and 14 days for other new patients. But you may want to elaborate on that.

Ms. ZEISS. There are a number of components. I will try to lay it out, but we can also give you some additional information later. We do have very clear directives about having mental health providers in emergency departments where many of these issues might come up, having 23-hour observation beds in those emergency departments. We also have requirements, as Mr. Schoenhard

said, that if there is a referral for a new individual who has not been seen in mental health in the last 2 years they require a contact within 24 hours.

Senator BURR. Dr. Zeiss, where is our problem? Is our problem that the VA really does not put these directors out? Is the problem that the VISNs really do not read the directives that you put out and do not share it with the facilities? Is the problems that individuals that comprise the medical staff at the facilities believe that the guidelines that come from the VA Central Office are not enforceable?

Let me just ask this. Has anybody involved in the mental health delivery of care around the country in the VA been fired because of some of the issues that have arisen from veterans like the two that we heard today?

And, Mr. Schoenhard, I have to tell you. Your opening statement, I had heard it before. I just had not heard it from you.

So, now that we have gotten that out of the way, the purpose of this Committee is hopefully to partner with the VA to solve the problem, and we keep going back to the things that are in place.

If you only take one thing away from this, please understand it does not work. There are gaps. There are holes. There are veterans that are falling through the cracks with mental health problems that I do not think were on detected. I think there is a professional on the other end who works for the VA that really did not give a damn whether they got the care in a timely fashion or not.

So, I fear that your definition of "timely" and the front line's definition of "timely" is extremely different. Yours is genuine and theirs is whenever I have time to deal with it versus the human face on the other end of a phone.

I have complained to the Secretary before. If the relationship between the VA and veterans is going to change, it starts with hiring somebody that answers the phone and makes appointments that actually cares about whether the appointment is made or not, because when you get that bad taste in a veteran's mouth to begin with, no matter where you navigate through the system, the fact is that that is always going to stick in your craw if the first person you talked to really could care less who you were or what your problem was.

Now, let me ask, Ms. Zeiss, you stated that the VA Central Office continually updates guidelines. I am paraphrasing, but I think that is what you said. As we update those, should it not eliminate some of the things we constantly hear?

Ms. ZEISS. That is certainly our goal and that is the intent of any guideline that we develop because we have seen a problem or have been asked by the field for more clear guidance. The guidance is developed and disseminated, and I will again say what I did before. I think that this new organization so that we in policy now have a clear team to turn to who will be working directly with the network directors is a tremendously positive step.

Senator BURR. My time has expired. I will have some written questions for the panel.

Let me just make this statement because it is highlighted in every hearing that we have on mental health, and it is how well

the suicide prevention hotline works, and I applauded that when it was added. I think it is absolutely a necessity.

But I want to suggest to you that the ultimate prevention of suicide is to supply the treatment in a timely fashion that our veterans need. To walk away and feel good because somebody can pick up the phone when they want to kill themselves, I am worried about the ones that never pick up the phone. I am worried about the ones that naturally we are not going to affect the outcome of what they intend to do.

And the only assured way that we can make sure that we minimize the number of people that call that line is to make sure that, in fact, the service we provide is effective.

So, as we hear about the numbers increasing on the hot line, understand with as many hearings as I have been in and with all of the new programs that I hear we are going to start, with an increasing number who call the hotline, it tells me that everything that we are trying really is not working for the ones who need it the most.

And as long as we have veterans who come before the Committee and tell us their horror stories, it is the responsibility of this Committee to remind you that everything we have in place is not perfect.

We have got a lot of work to do. And I might say, just for the record, this year we budgeted $5.7 billion to mental health; in 2012 it is $6.1 billion to mental health.

Trust me, if you look at the last 9 years in the VA, if increasing funding solved the problems, this would be the model of government. But the challenges exist in every area of the VA, and they are not limited by how much money we have been willing to pump into the program.

I thank you, Madam Chairman.

Chairman MURRAY. Thank you very much, Senator Burr, for your passionate statement. The only thing I would add, and I share everything you said, is that the VA is the receiver of all of this and ends up having to deal with it.

We have to go back to the Department of Defense and the military itself and make sure that we are doing the right thing for our servicemen and women while they are on the ground to make sure that they know where to go so that they do not get into some of the gaps that we hear that end up in the laps of this Committee as well.

Senator Brown.

Senator BROWN OF MASSACHUSETTS. Thank you, Madam Chair.

You know, listening to and reflecting on what you just said, there needs to be a top-to-bottom review from the minute the soldier is getting out to determine what their status is; how they are mentally and physically. I know we do a pretty good job on that depending on what branch of service you are in, depending on whether you are Guard, Reserve, active Army.

But I will tell you what. You know, like I said, I have been here only a year and a half and I have heard these stories more than any other Committee, any other Committee that we have had these are the most consistent stories I have heard is the complete break-

down between the soldier when they get out, when they are in such desperate straits that they would think of taking their own life.

I do not understand where the breakdown is. And I know that you are in a tough situation. I understand that. But when you are dealing with people's lives, you know, the response rate needs to be perfect because every lack of perfection equals a death—bottom line.

Interestingly, it was commented on about video links, video treatment, to have a video treatment for some of these areas that are out in kind of the boonies, so to speak. It makes sense if they can get to a facility and at least speak to somebody.

I am finding from everything that has been told to me—and I am still serving, 32 years in. I deal with this regularly, and it is just having a warm body on the other end, a smile, a handshake, a hug to say, hey, we care, we may not be able to help you right now but, you know, to have the cold, calculating statement, it is 4 months, sorry, we do not really give a crap, that is where the breakdown is.

There is a complete lack of trust between the veteran and the Department. As a result, there is so much desperation right now in this area that I do not know what you have to do to shift assets and resources and bodies and whatever, but you have got to get a handle on this stuff or you are going to be back here every month, every week answering to us.

And the amount of money that is being sent forth to the Department to solve these problems needs to be fixed, and it is going to take draconian efforts and Herculean efforts I should say on your part to send the message out that this is unacceptable, these stories are unacceptable.

That being said my question is: if the VA is placing an emphasis on recovery-based models, then why are only 4 percent of its patients referred to vocational rehabilitation services?

I am curious as to why that is such a low number.

Mr. SCHOENHARD. Senator, before I answer that, could I just say to your very, very important point regarding transition from active duty or Reserve or Guard service: there is a lot of collaboration. I was in a meeting over at the Pentagon this week working this issue between DOD and VA, and this is an area where we need to continue to work together to improve.

Senator BROWN OF MASSACHUSETTS. How do these people then come to us? It has been years. It is not like you could Google them and find out. How does it take them screaming with MPs breaking down doors to come to this point? If that is the case, there is all this amazing coordination, everything is great, great, great; I love Washington; everything is great here but outside it is not. People are hurting.

So, how do you get there?

Mr. SCHOENHARD. In my view it is what we are working on in terms of OEF/OIF reach, outreach. It is the warm handoff between active duty——

Senator BROWN OF MASSACHUSETTS. It is not only a handoff, it is a continuation.

Mr. SCHOENHARD. That is right.

Senator BROWN OF MASSACHUSETTS. It is not the handoff. The handoff. You can give a box of candy and flowers and a big hug. The handoff is great; boy, what a great experience. That is not where the breakdown occurs. The breakdown is from the handoff to the actual treatment that follows.

Mr. SCHOENHARD. Yes, sir.

Senator BROWN OF MASSACHUSETTS. That is the problem.

Mr. SCHOENHARD. And that is how I intend—what I am saying is that we get visibility of these folks, that there is not that kind of delay in what we have for those who have served this country, particularly in multiple deployments in the current wars, an excellent transition going forward. And that requires, I mean, is in place right now, and present in cooperation and work. But it is an area where we are focused and where we are going to continue to improve.

As it relates to the vocational rehabilitation, if I could yield to Dr. Zeiss or Dr. Schohn. That may be a question we would have to take for the record, sir.

Senator BROWN OF MASSACHUSETTS. Yes. I have a whole lot of questions for the record. But I am concerned and I will just tell you where my mind is.

I am concerned about the process for follow-up consultations, what are the procedures and standards in place to contact the individuals who have been discharged that are still at risk.

I mean, the fact that, the testimony we heard that they were even allowed to go home, it just mystifies me. How is VA going to improve its coordination in partnership with local community organizations and really just have everybody in the ballgame, everyone has some skin in the game.

Listen, I know this has not been just your problem. I understand that. I am not just going to come in and throw bombs. That is why the Chairwoman is having this hearing. And I have often said, if there is a problem and you need help, we need to know about it.

Where is the breakdown? You give them the money. Is it regulatory help you need? Are there roadblocks that you are seeing that we can kind of push the doors opened a little bit? Is it the Administration that needs to do something? Is it we in Congress? What is it?

Because all I hear are the stories and stories. Oh, yeah, we are working on it, we are working on it, were working on it, we are working on it. It is like, OK, it is 10 years now. We have known about this for at least seven. So where are we?

Mr. SCHOENHARD. Well, sir, I think we are going to have greater visibility with the site visits and targeting clinicians in a more focused way than we have had before in talking with veterans and in talking with other providers, and we certainly will brief the Congress on any barriers that require your help.

Senator BROWN OF MASSACHUSETTS. Thank you. I will submit questions for the record, Madam Chair. Thank you.

Chairman MURRAY. Following up on Senator Brown, Mr. Schoenhard, I would like you to go back to each one of the VISNs to survey the clinicians on the ground that are dealing with wait lists that we are hearing about and report back to this Committee on your findings.

I think it is really imperative that we hear directly from the VA's mental health care providers who are on the front lines treating our veterans. We need to know if the providers, not the administrators, but the providers think that they have sufficient resources to manage the waiting lists that they have.

So, I would like you to commit to doing that for this Committee.

Mr. SCHOENHARD. We will do that, Madam Chairman.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. PATTY MURRAY TO WILLIAM SCHOENHARD, DEPUTY UNDER SECRETARY FOR HEALTH FOR OPERATIONS AND MANAGEMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

A Query of VA Mental Health Professionals
Executive Summary and Preliminary Analysis
September 9, 2011

Background:
Secretary Shinseki has placed the highest priority on providing our Veterans living with mental health issues with timely, responsive and quality care. Under the President's budgets, VA has seen one of the largest increases in the past 30 years, which has allowed VA to hire more staff, treat more patients, and provide benefits to more Veterans. Under the President and Secretary Shinseki's leadership, VA has recently hired more than 3,500 mental health professionals, and our mental health staff now totals almost 21,000. Last year, 408,167 Veterans with a diagnosis of post-traumatic stress disorder (PTSD) received treatment at VA medical centers and clinics. More than 1.2 million Veterans received care from the VA for a mental health problem – a caseload level that increases each year. All of this work to fully implement the Uniform Mental Health Services Handbook is moving the VA mental health care system forward; yet VA knows that more can and should always be done to improve the access to and quality of VA mental health care for Veterans.

VA recently received the results of a report for which VA had contracted with Rand Altarum to complete a "Program Evaluation of Veterans Health Administration (VHA) Mental Health Services." These results indicated that across the country, VHA facilities report substantial capacity for treating Veterans with mental illness. Moreover, VHA capacity has increased since the implementation of the Mental Health Strategic Plan. In addition, overall, the quality indicators assessed suggest that in most instances, the performance of VHA care is as good as or better than that reported in the literature by other groups or by direct comparisons conducted in the study. However, important gaps remain, and VHA has not yet fully met its aspirational goals.

Query Summary:
As requested at the July 14th Senate Veterans' Affairs Committee (SVAC) Hearing "VHA Mental Health Care: Closing the Gaps," the VHA queried selected VA frontline mental health professionals for their perceptions on mental health issues as requested by SVAC staff. VHA expedited SVAC's request to meet their deadline and quickly developed a Web-based query that was administered from August 10 to August 17, 2011. Given more time, VHA would have sought the assistance of a professional trained in survey development, who may have provided different recommendations on the wording of specific questions, the size of the population contacted, and other factors related to survey methodology.

In this effort, VHA queried 319 general outpatient mental health providers from each facility within five Veterans Integrated Service Networks (VISNs) that were selected by SVAC staff. A total of 272 professionals responded for a response rate of 85 percent. Approximately one-third (31 percent) of the respondents were social workers, about a quarter (25 percent) were psychologists, 22 percent were psychiatrists, and 22 percent were nurses. Appendix A provides the raw data captured by the query, and below we have summarized our initial findings, relevant facts, and potential actions.

VHA leadership is taking the findings of this query seriously and is working to better understand where service gaps exist. Although the results and analysis presented in this summary are preliminary, many of our actions are underway. VHA is aggressively filling current mental health vacancies, is reviewing current performance measures related to access to mental health

services, and plans to follow up on these findings by directly engaging mental health leadership, frontline staff and Veteran patients regarding how to best meet the mental health needs of Veterans. In this effort, VHA leadership will hold focus groups in which both Veterans and mental health clinicians will be asked to provide their feedback. VA places the highest priority on providing Veterans with timely, responsive, and high quality mental health care.

Key Findings from the Query, Related Facts and Action Plans:

Key Findings:
Of the respondents, 63 percent reported they can schedule a new mental health patient appointment within 14 days in their own clinics, and 48.1 percent believe that Veterans they refer for mental health specialty appointments for conditions such as PTSD or substance use disorder will be seen within 14 days. Moreover, 61 percent of respondents reported that they can see established patients within their own clinic in 14 days of the desired date. However, 70.6 percent reported that in their opinion, their facility does not have adequate mental health staff to meet current Veteran demands for care.

Related Facts:

1) VHA has collected data on waiting time for these same clinics within the sampled VISNs. That data, based on valid performance measures, show a 30 percent discrepancy with these results; i.e., VHA waiting time data indicate that 96.7 percent of new patients referrals to general mental health clinics are seen within 14 days, and 97.1 percent of new patients for specialty mental health appointments are seen within 14 days. Similar findings emerged for established patients. VHA waiting time data shows that 97.4 percent of established patients are seen for general mental health appointments within 14 days of their desired date.
2) In attempting to understand this discrepancy, we reviewed the narrative responses to the questions. Some provider responses focused on an inability to provide mental health care as they would like; for example, not being able to provide the type of treatment indicated by the treatment plan, such as evidence-based psychotherapy, which may not be as readily available as needed. Other providers cited a shortage of a specific type of provider function, such as a case manager. We also noted that approximately 24 percent of the respondents were located in community-based outpatient clinics (CBOC). To understand the specific challenges in those settings, VHA will need to carry out further evaluation.
3) Of note, the providers are not ordinarily the individuals who actually schedule appointments. In our ongoing discussions with providers and their staffs, we hope to gain the input of additional staff, including schedulers.
4) As of May 2011, VHA vacancy data for mental health positions showed a vacancy rate of 13.6 percent across the country.

Action Plans:

1) The Deputy Under Secretary for Health for Operations and Management (DUSHOM) has reinforced to network and facility Directors to aggressively recruit for all mental health vacancies. VHA is also exploring additional mechanisms to audit the scheduling practices of mental health clinics.
2) VHA is revising our access metric and performance measures for waiting times and further refining metrics that take into account specific types of care such as

evidence-based treatment, to include in the fiscal year (FY) 2012 Performance Contract for network directors.

3) VHA is reviewing the Mental Health Staffing Plan in every Network and developing a national staffing model in conjunction with the Mental Health Executive Councils of each Network.
4) VHA will directly engage mental health leadership and mental health frontline staff to gain additional understanding of staffing patterns and barriers to access.

Key Finding:
Almost 70 percent of providers replied that their sites had shortages in mental health space.

Related Facts
We have no comparative data available.

Action Plan
VHA will directly engage with mental health leadership and mental health front line staff to discuss their reports of space shortages. Based on those discussions, VHA will explore ways to maximize the use of clinical space.

Key Finding:
Of respondents, 46 percent reported that the lack of off-hour appointments was a barrier to care.

Related Facts
1) The DUSHOM memo of June 1, 2007, required medical centers to provide mental health/substance abuse clinics at least one evening a week, and preferably more, by August 2007.
2) Some Veterans Affairs Medical Centers (VAMC) that established after hours clinics found that appointment slots were not used or did not appear to be meeting Veterans' needs.

Action Plan
VHA will continue to explore possible barriers to care and develop new policies to address this issue and better meet the needs of the Veterans seeking mental health services.

Key Finding:
Of respondents, 26.5 percent reported that the demand for Compensation and Pension (C&P) exams pulled clinicians away from direct care.

Related Facts
Demand for C&P exams has risen dramatically from FY 2009 to FY 2011. Data as of May 2011 suggests that the rate of growth during this period is about 148 percent. Many VAMCs are using existing mental health clinicians to meet this demand.

Action Plans
1) VHA will work with other offices such as the Office of Human Resource Management and Veterans Benefits Administration to review these workload issues and develop options.

2) The VHA tele-mental health program is developing models of regional centers to provide support for C&P exams.
3) The VA Office of Disability and Medical Assessment is working to ensure every facility has a separate C&P service.

Key Finding:
Of respondents, 50.1 percent reported that growth in patient numbers contributed to mental health staffing shortages.

Related Facts
From 2005 to 2010, the number of patients (uniques) seen in VA in mental health specialty settings rose by 39 percent. At the same time, the number of Veterans Affairs mental health staff increased by 46 percent.

Action Plan
VHA will continue to be aggressively recruit mental health providers to ensure access to our growing patient population.

Veterans Health Administration
September 9, 2011

Appendix A
Query Results (August 10 to August 17, 2011) – Raw Data

Discipline of respondent?	**N**	**%**
Psychiatrist	59	21.7%
Psychologist	67	24.6%
Nursing – APH	36	13.2%
Nursing – RN	25	9.2%
Social Work	85	31.3%
Total Responses	**272**	

1. How long does it take you on average to schedule a new mental health patient appointment in your clinic?

No wait – can see Veteran immediately or at their earliest preferred date	57	21.0%
Can see Veteran within 14 days of their earliest preferred date	114	41.9%
Can see Veteran within 30 days of their earliest preferred date	49	18.1%
Cannot see Veteran until 30-60 days of their earliest preferred date	33	12.1%
Cannot see Veteran until more than 60 days after their earliest preferred date	19	7.0%

2. How long does it take you on average to schedule an already established mental health patient relative to the desired date?

No wait – can see Veteran immediately or at their earliest preferred date	64	25.3%
Can see Veteran within 14 days of their earliest preferred date	97	35.7%
Can see Veteran with 30 days of their earliest preferred date	61	22.4%
Cannot see Veteran until 30-60 days of their earliest preferred date	31	11.4%
Cannot see Veteran until more than 60 days after their earliest preferred date	19	7.0%

3. If you need to refer a Veteran to a mental health specialty appointment such as for PTSD or Substance Use Disorder, how long on average does it take for the Veteran to be seen?

No wait – can see Veteran immediately or at their earliest preferred date	15	5.5%
Can see Veteran within 14 days of their earliest preferred date	116	42.6%
Can see Veteran with 30 days of their earliest preferred date	91	33.5%
Cannot see Veteran until 30-60 days of their earliest preferred date	34	12.5%
Cannot see Veteran until more than 60 days after their earliest preferred date	16	5.9%

4. Does your site have adequate mental health staff to meet current Veteran demands for care?

Yes	80	29.4%
No	192	70.6%

- **If you answered No to #4, indicate the discipline and number of vacancies for all under-staffed positions.**

Psychiatrist	91	33.5%
Psychologist	79	29.0%
Nursing	45	16.5%
Social Work	71	26.1%

- **If you answered NO to #4, what are the causes of these staff shortages? {Check all that apply}**

Difficulty in recruitment	48	17.6%
Increase in volume of Veterans seen for mental health care	138	50.7%
Unfilled vacancies	96	35.3%

Narrative responses – problems with HR, lack of ability to replace staff that leave, not enough case managers, psychiatrists or therapists. In process of developing coding system to better characterize these responses.

5. Does your site have mental health space shortages?

Yes	189	69.5%
No	83	30.5%

6. Are there other system barriers that delay access to care?

Yes	148	54.4%
No	124	45.6%

- **If you answered YES to #6, please describe these barriers in the space provided below:**

Veterans need off hour appointments (evenings, weekends)	124	45.6%
Shortages of Clerical/Scheduling staff	67	24.6%
Demand for C&P exams that pulls clinical staff away from direct care	72	26.5%
Other –*in process of coding responses*	49	18.0%

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Chairman MURRAY. OK. I have a couple of more questions that I want to ask and I will have some I will submit for the record. But, Mr. Schoenhard, while you are here, I wanted to ask you about this issue of sexual assaults.

I was very troubled by the GAO's recent report on sexual assaults. They started this work because clinicians were not referring female patients or veterans to inpatient PTSD treatment because of safety concerns.

I am paraphrasing but the GAO found that clinicians were concerned about the safety of women veterans in residential mental health programs. Part of this was that a program housed both women veterans and male veterans who had committed sexual crimes in the past.

Clinicians expressed concerns about inadequate safety precautions in place to protect those women that were admitted to the units.

Now, I am shocked that this would happen at even one medical center. It is entirely unacceptable, and I am afraid that there may be other places in the VA that this could be true as well.

So, I want to know this morning what you are doing to correct that problem at this unnamed medical center and what you are doing to make sure this is not happening anywhere else in the system.

Mr. SCHOENHARD. I am going to ask Dr. Arana to add to this, but let me begin. This report from GAO had eight recommendations that we fully concur with, four that had to do with prevention which gets to your question, Madam Chairman, and four which had to do with reporting.

Just as with the case of suicide, one sexual assault, one instance where someone feels victimized, is one too many. We take this report extremely seriously. The Under Secretary for Health, Dr. Petzel, has chartered a workgroup chaired by Dr. Arana and Dr. Patty Hayes, who is the Chief Consultant for Women's Services at VA.

We wanted both operational and program leadership to address these recommendations, particularly having to do with prevention. And there are a series of findings that are coming out of the Committee, out of the workgroup, that are due July 15.

We have been in touch with the facility that was addressed. Again, as I mentioned earlier in my testimony, when we have a report like we did in this case of sexual assault where they visited five of our facilities, what is it that we learn from that that we apply systemwide, not just to answer compliance with that.

Dr. Arana, if you could please give some update on your work.

Dr. ARANA. Madam Chairwoman, what we are doing is essentially taking the GAO report and have extracted six major areas that we are going to pursue. One of the criticisms was we do not have a clear definition for sexual assault. That we have done.

Chairman MURRAY. We do not have a definition?

Dr. ARANA. A clear definition for all of VA for sexual assault. GAO has a definition. CDC has a definition. So, the VA has——

Chairman MURRAY. You talk to any of the women. They can define it for you.

Dr. ARANA. Yes, ma'am.

So, the VA has used the definition that the GAO used. Going forward, we will be using their definition for the VA.

We are also relooking at our databases and our report structures. Right now they are imperfect. That was pointed out by the GAO. The plan is to have police reports and management reports basically integrated and have 100-percent coincidence so that we know that they agree with each other. That we are also doing right now.

The other thing is we are doing behavioral surveillance education. We are working, we are partnering with DOD. They have a very strong program with us. The hope is to learn from them about how to educate all staff and all patients and all visitors at our health care centers and also all of our care areas about vigilance and prevention.

And the fourth point is what we call technical surveillance which goes to cameras, panic buttons, locks on doors, adequate staffing of police.

So, we are looking at those four areas aggressively and hoping to be able to report back here and tell you about progress.

Chairman MURRAY. OK, look. I have to tell you in terms of sexual assault, I am deeply concerned about this. This has been a hidden problem coming home from our veterans for far too long.

Part of the work that I have done on this Committee is to put in place a new focus on women's veterans so that all of our facilities have a place for women to go to. I have been out looking at many of the women's facilities, talking to the caregivers on the ground. A high number, much higher than I thought, are reporting military sexual trauma, definition or not.

We cannot leave this as a hidden problem or something we are looking at and report back a year from now and hear the same things are going on. We have to all take this as a serious issue, bring it out into the light and deal with it. These kinds of reports to me are very, very troublesome, and I am angry about it.

So, I do not want this to be a report back to this Committee months from now. I want to know immediately what is being done, immediately what is being done to make sure that this is not happening to anybody.

Mr. SCHOENHARD. Madam Chairman, if I could just clarify as it relates to the definition, that had to do with the reporting. Any

time, anyone—visitor, patient, employee—anyone, feels that they have been victimized in some way that is where we need a report. We need an immediate follow up, and we need intervention.

Chairman MURRAY. And that needs to be systemwide in the VA.

Mr. SCHOENHARD. Yes, ma'am.

Chairman MURRAY. Immediately.

Mr. SCHOENHARD. Yes, ma'am.

Chairman MURRAY. I have a number of questions, but we have run out of time, so I am going to submit them for the record.

I want to know about the peers—the use of veterans' peers in particular. We heard that from our veterans today.

I would like you to get back to this Committee on what you are doing on that.

The wait times, as you heard from this Committee, are a huge concern. VA reported that 95 percent of the veterans seeking mental health were seen within 14 days. That is not what we are hearing on the ground. So again, that is going to be an issue we want to follow up on and several others.

You are hearing the frustration from the Members of this Committee. You are all wonderful people. I know you work hard every day. I know you work with people who care. But I have to tell you this war has been going on a long time. There are not surprises about the number of people out there suffering from PTSD and TBI.

We, as a country, cannot allow this to be a report or a report back or to have it be hidden in a corner. We have to bring it out in the open. If we need more resources, if we need, you know, America to stand up taller, if we need more clinicians, boots on the ground, we need to know that because this Committee is going to make sure that we do not continue to hear these stories year after year.

We need your help to find out the real answers to this so we can have the right policies and resources in place. That is why you are hearing the passion from this Committee.

With that, we have run out of time this morning, and I do want to thank all of our witnesses for being here today to share their views and experiences.

Some steps have been taken. This Committee knows that and we appreciate what the VA has been doing. But it is very clear: a lot more needs to be done; and it is really crucial that we have the resources, that we have the personnel in the right places.

As Senator Burr has reminded us time and time again, that first person who answers the phone has to be responsive because that is how our veterans feel that they are treated. So it goes across the board.

With that, I look forward to working with the VA in the months ahead to address these issues and appreciate again all of you being here.

Thank you very much, and this hearing is adjourned.

[Whereupon, 11:46 a.m., the Committee was adjourned.]

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