CHARTING THE U.S. DEPARTMENT OF VETERANS AFFAIRS' PROGRESS ON MEETING THE MENTAL HEALTH NEEDS OF OUR VETERANS: DISCUSSION OF FUNDING, MENTAL HEALTH STRATEGIC PLAN, AND THE UNIFORM MENTAL HEALTH SERVICES HANDBOOK

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS
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THURSDAY, APRIL 30, 2009

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

The Subcommittee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Michael Michaud [Chairman of the Subcommittee] presiding.

Present: Representatives Michaud, Brown of Florida, Snyder, Rodriguez, McNerney, Perriello, Brown of South Carolina, and Moran.

OPENING STATEMENT OF CHAIRMAN MICHAUD

Mr. MICHAUD. I would like to call the Subcommittee on Health to order. I would like to thank everyone for coming today. We are here today to talk about the U.S. Department of Veterans Affairs' (VA's) progress on meeting the mental health needs of our veterans. Specifically, we will be discussing issues of funding and implementation of the Mental Health Strategic Plan and the Uniform Mental Health Service Handbook.

Many in this room are familiar with the daunting statistics on mental health from the April 2008 RAND Corporation Report on "Invisible Wounds of War." The RAND Report estimated that of the 1.64 million Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) servicemembers deployed to date, about 18 percent suffer from post-traumatic stress disorder (PTSD) or major depression, and about 20 percent likely experienced a traumatic brain injury (TBI) during deployment. In addition, the report showed that despite our current efforts about half of our servicemembers are not seeking and receiving the mental health treatment that they need. This raises serious concerns about the long term negative consequences of untreated mental health problems, not only for the affected individuals but also for their families, their communities, and our Nation as a whole.

To address this problem the VA has focused their efforts on improving mental health care for our veterans. For example, the VA has set aside substantial funding for mental health care, which amounts to $3.8 billion in fiscal year 2009. The VA also approved a Mental Health Strategic Plan in November of 2004, which is a 5-year action plan with distinct mental health enhancement initiatives. Additionally, I am aware of the 2008 Uniform Mental Health Service Handbook, which defines standards and minimum clinical requirements for mental health services that the VA will implement nationally.

I applaud the VA on these efforts, and it is important for the Committee to ensure proper oversight. Today's hearing will explore the concern raised in the 2006 U.S. Government Accountability Office (GAO) Report which found that the VA spent less on mental health initiatives than planned and lacks the appropriate mechanism for tracking the allocated mental health funding. We will also seek a better understanding of the successes and the challenges faced by the VA in implementing the Mental Health Strategic Plan and the Uniform Mental Health Service Handbook. Today we will hear from various experts in the field, including the Disabled American Veterans (DAV), the Wounded Warrior Project (WWP), the Office of Inspector General (OIG), and the VA, and I look forward to the different panels today and their testimony.

I now would recognize a distinguished Member of this Committee, Ranking Member Brown, for any opening statement that he may have.

[The prepared statement of Chairman Michaud appears on p. 24.]

OPENING STATEMENT OF HON. HENRY E. BROWN, JR.

Mr. BROWN OF SOUTH CAROLINA. Thank you, Mr. Chairman. I appreciate you holding this hearing today. Mental health is a critical component of a person's well-being and essential to the mission of the Department of Veterans Affairs, "To care for those who have borne the battle is to effectively intervene and to care for the invisible wounds of war." The psychological toll of war is not always apparent and sadly has not always received the attention it should. However, I think we can all agree that the VA has come a long way, especially in the past few years, to improve mental health services and encourage veterans in need of care to get help.

Even though significant progress has been made, there is no doubt that we must still do more, as we continue to hear about veterans facing barriers and gaps in service. We must ensure that when a veteran needs and seeks help, that veteran gets the right care at the right time. In the past decade, we have made a substantial investment in VA mental health, increasing funding by 81 percent from $2.1 billion in fiscal year 2001 to no less than $3.8 billion in fiscal year 2009. That is why it was very disturbing when the Government Accountability Office, in November of 2006, reported that VA had not allocated all available funding to implement the Mental Health Strategic Plan.

It is our responsibility to see that the funding we provide is spent as intended to support a complete array of mental health prevention, early intervention, and rehabilitation programs for our Nation's veterans. I look forward to hearing from our witnesses and

having the opportunity to take a look at where we stand in taking care of the mental health needs of our veterans. With that, Mr. Chairman, I yield back.

[The prepared statement of Congressman Brown appears on p. 24.]

Mr. MICHAUD. Thank you very much, Mr. Brown. We will start off with panel two. Congresswoman Kaptur is going to be delayed so we will move directly to panel two, Adrian Atizado from the Disabled American Veterans and Ralph Ibson from the Wounded Warrior Project, I would like to thank both of you for coming here this morning to talk about this very important issue that our veterans are facing. And we will start off this morning with Mr. Atizado.

STATEMENTS OF ADRIAN ATIZADO, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND RALPH IBSON, SENIOR FELLOW FOR HEALTH POLICY, WOUNDED WARRIOR PROJECT

STATEMENT OF ADRIAN ATIZADO

Mr. ATIZADO. Thank you, Mr. Chairman, Members of the Subcommittee. I would like to thank you for inviting the DAV to testify today. We appreciate this opportunity to discuss our views on meeting the mental health needs of our veterans.

We, as an organization, strongly believe that all enrolled veterans, and particularly every servicemember returning from war, should have maximum opportunity to recover and successfully readjust to life. We recognize the unprecedented effort made by VA, as you had mentioned in your opening statement, Mr. Chairman, over the past several years to improve the consistency, timeliness, and effectiveness of mental health services in VA. We also appreciate Congress' continued support to help VA achieve this momentous goal. Nevertheless, we believe much still needs to be accomplished to fulfill our obligations to those who have serious mental illness and post-deployment mental health challenges.

The development of the Mental Health Strategic Plan by VA, as well as the Uniform Mental Health Services Handbook, provide an impressive and ambitious roadmap for the Veterans Health Administration's (VHA's) mental health transformation. However, we have expressed, and continue to express, our concerns about the oversight of the implementation phase. VA specifically developed its new policy so that veterans nationwide can be assured of having not only accessible but timely access to the full range of high quality mental health and substance use disorder services at all VA facilities.

On April 6, 2009 the OIG issued two reports focused on VA mental health services. We had expected that these reports' would provide an in-depth nationwide assessment. Unfortunately, they fell far short of this expectation. We note that the report on the VA Handbook predominantly relies on self-reports from leadership at various VA facilities as to whether they have a particular program, and generally without any clear criteria on services offered, their intensity or capacity to provide such services.

The report does note that evidence-based services for PTSD are labor intensive, but that VA has no current means of tracking the

true accessibility of such services. Moreover, the recent OIG report makes no attempt to calculate the intensity of PTSD services although OIG quoted VA research reports that raised concerns that intensity levels have been falling despite the fact that effective services for PTSD require very intensive services.

We are pleased that VA plans better tracking of true access to evidence-based PTSD therapies in its response to the report, and believe that this is an achievable goal and should be accomplished as soon as possible. We are pleased the OIG reported that Central Office, the Department of Veterans Affairs Central Office, had adequately tracked funds allocated for the mental health initiative in fiscal year 2008, and that the funds allocated were used as intended. While it is encouraging that the funds allocated are being predominantly utilized for the purposes intended, the report does not address two of the most pressing issues regarding true augmentation of VA mental health services. First, it does not calculate the actual increase in the number of providers. It merely audits the hiring of new staff. Second, their funds have been allocated as time limited or special purpose, although the need for additional services will clearly extend into the foreseeable future. We are concerned that if all mental health funds move into Veterans Equitable Resource Allocation (VERA) and are mixed with other funds allocated to medical centers, mental health and substance use disorder programs will, again, erode over time.

Based on the two recent OIG reports it is unclear if sufficient resources have been authorized given the comprehensive requirements outlined in VA's Handbook. While we agree with OIG that implementation of the Handbook is ambitious, it must be approached with clear recognition that delays in immediate implementation inflict heavy costs on veterans.

The oversight process we envision, and which we recommend in mental health, is one that is data driven, transparent, and includes local evaluations and site visits to factor in local circumstances and needs. And empowered VA organization structure is needed to carry out this task. Such a structure would require VHA to collect and report data at national, network, and medical center levels.

We believe the recommendations further outlined in our written testimony, Mr. Chairman, could provide the architecture for effective oversight and improvement in VA programs. In summary, comprehensive, independent oversight is necessary to assure the current policy and new funding result in immediate access for all veterans who need such services.

Mr. Chairman, this concludes my testimony. I would be happy to answer questions that you or other Members may have.

[The prepared statement of Mr. Atizado appears on p. 26.]

Mr. MICHAUD. Thank you very much. Mr. Ibson.

STATEMENT OF RALPH IBSON

Mr. IBSON. Chairman Michaud, Ranking Member Brown, Members of the Subcommittee, thank you for inviting Wounded Warrior Project to offer our views on VA's progress in meeting the mental health needs of our veterans. Wounded Warrior Project brings an important perspective to this issue given our founding principle of "Warriors Helping Warriors" and the organization's goal of ensur-

ing that this is the most successful, well-adjusted generation of veterans in our history.

This Committee has recognized that mental health care is a key VA mission and has provided critical leadership over the years. Your oversight efforts have been invaluable.

VA has taken important steps toward improving mental health care, beginning particularly in 2004 with its development of a strategic mental health plan and last year in establishing minimum clinical requirements for mental health services with its Uniform Mental Health Services Handbook. This hearing asks timely questions as we approach the 5-year mark since adoption of the strategic plan, and as VA is apparently moving toward ending a special funding initiative that had supported the plan and Handbook's implementation.

VA has clearly made strides toward realizing its strategic mental health goals but in our view large gaps and wide variability in programs remain. Let me illustrate. While the strategic plan acknowledges the importance of specialized PTSD services for returning veterans, our warriors are experiencing both long waits for inpatient care and a dearth of OIF/OEF-specific programs. For the first time, VA policy calls for ensuring the availability of meeting mental health services, to include providing services through contracts and similar arrangements, but VA facilities have made only limited use of that contracting authority. Mental health care is increasingly being integrated into primary care clinics, but at any given VA Medical Center or large clinic, mental health may be integrated into only a single primary care team. Further, VA facilities have yet to fully incorporate a recovery orientation into their care delivery programs. And VA, while it has trained clinicians in two evidence-based therapies for PTSD, has no comparable initiative to ensure integrated or coordinated care of co-occurring PTSD and substance use disorders. Integrated treatment of these often co-occurring health problems appears to be the exception rather than the rule.

In our view, a strategic plan by its very nature should be revisited periodically, and while the current plan provides a credible foundation, we encourage the Committee to press the Department to reexamine that blueprint and take account of what has changed in the 5 years since the plan's adoption. For example, it is not clear that the plan anticipated the increased prevalence of PTSD and other behavioral health conditions affecting this and other generations of veterans. The plan also emphasizes screening as a tool to foster early intervention, but fails to address the problem of veterans who are identified in screening as needing follow up but who elect not to pursue further evaluation or treatment. The plan also includes initiatives to foster peer-to-peer services, but only in the context of veterans with severe mental illnesses such as schizophrenia. In our experience, peer support can be powerful in helping OIF/OEF veterans with PTSD as well.

Whether we gauge VA's progress through the lens of its 2004 strategic plan, or as we recommend in the context of an updated plan, we share DAV's view that the transformation of VA's mental health delivery system remains a work in progress. Accordingly, we believe it is critical to sustain robust funding for VA mental health

programs. Without question, VA's special mental health funding has supported a very substantial increase in staffing and expanded services at many facilities. But we understand that special funding will be phased out next year, with 90 percent of those special funds reverting to VA's general health care funds to be allocated through the VERA system. The implications of that shift could be very detrimental, given that funding for veterans mental health care during a still evolving major transition would be allocated primarily based on the numbers of veterans under treatment rather than on improving the intensity of care provided current patients. Absent a special funding mechanism, there is real risk that critical mental health policy goals will not be realized, and that prior gains may be eroded.

Given that concern, we urge continued strong oversight to ensure that the Department does have a sound funding plan to support and sustain its still evolving transformation of mental health care. Let me emphasize, funding alone will not achieve strategic goals. Leadership is equally important. Finally there is a keen need for close monitoring and evaluation. We must bring each of those elements to bear to ensure that VA programs are meeting veterans' mental health needs.

Mr. Chairman, that completes my statement. I will be happy to answer any questions.

[The prepared statement of Mr. Ibson appears on p. 33.]

Mr. MICHAUD. Thank you very much. I have one question. Mr. Atizado, in your testimony you recommended that the VA develop an accurate demand model for mental health and substance use disorder services. Can you explain this point a little further, as far as what factor the VA should look at when developing a demand model?

Mr. ATIZADO. Well, much like VA's overall health care demand model I believe it has to reflect that. It has to be very comprehensive. It has to take into account this new paradigm of care that VA has embraced and wants to provide. The amount and the intensity of service that is required under this transformation is much different from their previous way of caring for serious mental illness and post-traumatic stress disorder, as well as substance abuse disorder. And I think the current model does not accurately capture that, and doing so does not necessarily provide the bottom line that would allow VA in the field to implement these initiatives.

Mr. MICHAUD. Mr. Ibson, the Wounded Warriors Project is a great organization, and we appreciate all the work that you do. My question is, when you look at PTSD or TBI, how much concern do you hear from family members as far as the lack of service? Are the family members out there really more prevalently than the soldiers in looking at services, particularly relating to TBI or PTSD?

Mr. IBSON. Mr. Chairman, I think you hit on an important point. That these are not issues of the veteran alone. They are very much family issues. We do have very active engagement with our families. And they do bring those concerns to us. Concerns regarding the variability in service, concerns regarding the lack of inpatient programs, particularly for PTSD, and the dearth of programs that are specific to OIF/OEF veterans. Concerns around the challenges facing a young veteran who, in seeking treatment, may find himself

or herself in a program with older veterans who have continued to suffer with these problems and have not made the progress that a young veteran might hope to make. That can be a real disincentive to, or impede the kind of progress that the veteran and family would hope to expect from a program. And it underscores the need for age appropriate services.

Mr. MICHAUD. The next question is actually for both of your organizations. In 2004, VA came forward with their Capital Asset Realignment for Enhanced Services (CARES) process, which looked at where there is a need for access points, particularly in the rural areas throughout the country. Have either of you heard concerns about lack of services in areas where there is supposed to be an access point, but currently is not an access point because the VA and Congress has not appropriated the funding needed for those access points? Is there more of a concern in those areas where you have not even kept track of the areas that you are hearing concerns in both the Wounded Warrior Project as well as the DAV?

Mr. ATIZADO. Well Mr. Chairman, we do not know specific instances. We do have written, in fact, in our testimony that the VA's Office of Inspector General did a combined assessment report on Montana. And in there, and that is obviously a highly rural area. And in there it does talk about the inability for that facility to attract and retain mental health provides. Not only that, that also impinges on the availability of services as well as the quality of services that can be provided. If a facility does not have enough direct mental health providers the intensity may not be provided, or not enough veterans can be served. So at least in that one report we know that there is a direct impact.

Mr. IBSON. I am not sure that I can speak to the implications of the issue as it relates to the CARES process, sir. But I think the Montana report is interesting as it goes to concerns you have spoken to, with regard to rural veterans and the success in Montana of working with the private sector to make access points for mental health care available. So I think in some marked contrast to the experience in other parts of the country, the underlying theme of equity of access I think continues to be a challenge for the Department.

Mr. MICHAUD. Thank you. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Yes, thank you, Mr. Chairman. In fact, I am going to just kind of throw this question out and either one can respond or both. Given the scope of the Mental Health Handbook that was last updated in September of 2008, do you think it is realistic for VA to implement all of the initiatives by the end of the fiscal year?

Mr. ATIZADO. Well Mr. Chairman, as I have stated, it is a very ambitious goal. I think that if things go the way they are now, how it is currently being implemented, I think VA will be seriously challenged to meet that deadline. Which is why we are very hopeful that something will come of this hearing. That better metrics will be provided to the field so that they have better guidance to meet the over 400 services that the Handbook is supposed to require.

Mr. IBSON. I think that is an excellent question, sir. And it is important to appreciate, I think, that underlying that Handbook is a

vision of a real transformation in the way care is delivered, and the philosophy underlying that care. And emphasis on a recovery orientation is intended to supplant a focus on simply managing symptoms. And that is not simply a matter of funding. It is not simply a matter of programs. It is a real culture change that mirrors a change going on in the health care system generally, but one that has not preceded with great speed. And it is difficult to imagine that transformation reaching a culmination by the end of this year.

Mr. BROWN OF SOUTH CAROLINA. Okay, thank you both. Let me throw out another question and I would ask for a similar response. For a person to seek mental health services they must recognize that they need help. To what extent do you think the stigma associated with mental health care is affecting veterans' willingness to seek help?

Mr. IBSON. I think there is no question but that, notwithstanding public education efforts to diminish stigma, it continues to play a role, and that it does play a role among returning servicemembers and to some extent among veterans as well. At the same time, I think we do see larger numbers of veterans turning to VA for mental health care. And this Committee, I think, certainly can take pride in the work that it has done to underscore the importance of mental health and to diminish somewhat the still lingering stigma.

Mr. ATIZADO. That is an excellent question, sir. I would like to first make a comment about what is being done upstream to sensitize servicemembers to the fact that mental health is just as important as physical health, that the U.S. Department of Defense (DOD) is doing. And I think it is providing some impact. I think VA's outreach, while excellent and they have done quite a bit, requires a little bit great customer service. We are aware of a program that was instituted in Veterans Integrated Service Network (VISN) 12 called the Vet Advisor Program. And what that does, sir, is it actually contacts veterans who have self-identified, or who have been screened positive, such that they have the intention of seeking mental health services and they, for whatever reason, did not come back to VA to do so. And what this program does is it, VA trains these individuals specifically on the screening tools and verbiage, the culture. And they seek out these veterans. They call them. They make person contact. And they are very clear. The idea is to make sure that veterans are provided the greatest amount of an offer. Because if it is a very good offer, one tends not to ignore it. Not only that, they also walk them through what they can expect once they contact their VA Medical Center, what should happen next. And it really empowers them and educates them on a very personal level. And it has turned out to be a very successful program.

Mr. BROWN OF SOUTH CAROLINA. I know that if we let them fall through the process then they will end up homeless someplace, and that is a major concern of mine. Thank you both.

Mr. PERRIELLO [presiding]. Thank you. We will turn now to Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman. Mr. Atizado?

Mr. ATIZADO. Adrian.

Mr. MCNERNEY. Adrian? Adrian, thank you. You know, I am going to sort of follow up a little bit on some of the prior questions.

Many veterans service organizations (VSOs) have noted a slow start in implementing new mental health services and substance abuse programs. What do you think would be beneficial in terms of speeding up the VA's response to these needs?

Mr. ATIZADO. Sir, that is a good question. I think one of the things that really hampered the speed of the implementation that we were hoping was that the Mental Health Handbook did not have objective metrics that the field would have to comply with. In other words, the perfect example is this OIG report. It did a survey based on self-reports and it did not dig any deeper than that. So when I am a mental health chief, or medical center director, and OIG calls me up and says, "Do you have this program?" I will say, "Oh, yes." But they never really quite asked what services do you have available in that specific program? How many people do you expect to need to meet the demand in your facility? And that never really was provided to the field at the outset. And I think the strict monitoring and oversight really needs to get ramped up in order for these challenges to be met.

Mr. MCNERNEY. So, I mean, when you use the word "metric" in my mind that means results, or outcomes, rather than facilities or services?

Mr. ATIZADO. Yes, sir. For example, when the Handbook was issued publicly, and the field was asked, service chiefs in local facilities were asked, "What do you need to make this happen?" That was the only question, really, that was asked. There was not clear guidance on these new initiatives, these new intensive programs. Some places did not even have a program that is included in the Handbook and they had to start from scratch. With very little guidance it is extremely hard for the field to be responsive and provide the data needed at the highest levels in the VA for them to provide the resources and the support.

Mr. MCNERNEY. Thank you. Mr. Ibson, I am going to sort of paraphrase something you said. I did not have time to write it down word for word. Funding alone is necessary but not sufficient. You also need strong leadership and good oversight. Are we having, are we seeing the strong leadership that you refer to? And is the oversight that this Committee is supplying sufficient? Or do you have recommendations on how to improve on those two issues?

Mr. IBSON. Well I think your earlier question is an illustration of the point, sir. We saw leadership exercised at the VA in terms of adoption and issuance of a very forward looking and aggressive policy, a policy that could well be applauded. But what was missing, I think, as your question suggested and as Adrian's response indicated, was a sufficient architecture or mechanisms to ensure that the broad policy directive could and would be implemented in an appropriate and timely way. I do think there has been a real focus on establishing broad policy and to get funding out to the field, and the challenge of how and when to get the policy fully implemented has been something of a catch up. And I think this hearing is certainly an important step to continue to underscore the importance of moving beyond policy and to realization of those goals and very specific measures.

Mr. MCNERNEY. So one of the things I am hearing is that the element of leadership that is missing as a clear, concise metrics, or

both in terms of what facilities should provide in detail and also metrics in terms of what the outcomes are. If you are having good outcomes then you are going to get a good mark. If you are not having good outcomes you are not going to get a good mark.

Mr. IBSON. I think that is right, sir.

Mr. MCNERNEY. Thank you, Mr. Chairman.

Mr. PERRIELLO. Thank you. Mr. Moran, do you have questions?

Mr. MORAN. Mr. Chairman, thank you very much. I apologize for not hearing your testimony. If this is not a question for you, I would be happy to have you tell me that. One of the concerns I always have about the provision of health care services for our veterans is the geographic disparity, and from my perspective a rural disparity. I wondered if you have thoughts about the services different between urban, suburban areas of the country and the ability to access mental health services in rural America?

Mr. IBSON. I think there is no question but that that is the case, sir. And as we have discussed a little bit earlier there is still significant disparity across the country. I think there are important efforts in the VA's Strategic Plan and the Uniform Services Handbook that we have been discussing to try and narrow that gap. One of the elements in the recently issued Handbook is an effort to ensure that there is service availability without regard to where the veterans may be living. And indeed, a directive for the first time for facilities if they cannot provide services in-house to provide them through contract or similar mechanisms.

Two problems with that: one is that there is no real requirement to assure that that private sector provider has the capability, the expertise, to provide, for example, care for individuals with posttraumatic stress disorder or a combat-related condition. And secondly, the facilities have not taken particularly aggressive steps to use that mechanism, even where capable providers might exist in the community. So I think it is yet another illustration of a transformation or a work in progress.

Mr. MORAN. In Kansas we have a reasonably comprehensive mental health delivery system with a series of mental health area agencies covering a very rural State. On numerous occasions those mental health centers have indicated a strong willingness to figure out how to connect with the VA system to provide services. I guess part of what you may be telling me is that they may not be totally trained in some of the needed aspects of mental health care that are required for our veterans, for our servicemen and women. I am looking for the ability to put those to use. We do not, I do not think we need to reinvent the system. Maybe we need to augment it. I think there is a delivery system that exists, at least in our State, that perhaps is underutilized.

I also know that we have been successful in Kansas of having a second Vet Center. We have had one in Wichita for a long time, and one now in Manhattan. Their plan is to place mobile vans in which they provide family counseling mental health services out to rural areas of Kansas. I am interested in your thoughts of whether those kind of services can be provided in that kind of setting. Is that something that is going to be effective?

Mr. IBSON. I think from my perspective, the jury is still out as to whether that is an optimal means of providing care. But cer-

tainly, given the needs across the system and given the needs of rural America, it is important that one explore all alternatives.

Mr. MORAN. This Congress has seen in the past significant improvements on our funding for health services. One of the common themes when I talk to those who provide services at home is, despite the additional money, we still cannot attract and retain the necessary professionals to provide the services. So, it is nice of you to give us the additional resources, important, but there is a general shortage of health care professionals, particularly in the mental health area, that the private sector is not meeting. They cannot come up with the necessary folks as well. So, it is a very broad issue that needs broad attention about attracting, retaining, and educating a necessary workforce. The demands are great; the numbers of people in the profession are too shy.

Mr. IBSON. Yeah. It is not a complete answer to your point, sir. But I think one of the themes reflected in VA's planning, and a theme that I think can be continued, is greater reliance on peer-provided services. Not as a substitution for clinician services but as a complement to them, and as an important element of a system that, in philosophy, is moving toward recovery, toward enabling individuals to lead productive, fulfilling lives. And peer mentoring, which is a program Wounded Warrior Project fosters and runs, is an illustration of that kind of program. You know, veterans helping veterans——

Mr. MORAN. Thank you for that reminder. One of the ironies of the expansion of mental health services at one of our military installations in Kansas is that the neighboring hospital, the public hospital, closed its mental health facilities. Again, the inability to compete with the number of professionals. It sort of works both ways in the private sector. I do appreciate the idea that there are other possibilities. This mentoring program may be an opportunity, at least, to provide a level of services that would not otherwise be there. I am sorry, I have allergies. I can hardly talk. Thank you for your response. Thank you, Mr. Chairman.

Mr. PERRIELLO. Yes. Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman. I would like to ask permission to be able to submit some comments for the record, if possible. Thank you.

Let me first of all also take this opportunity to thank you for your testimony, and thank you for the written comments that you made. I am extremely pleased with the things that you stressed in terms of the importance of peer-to-peer. And if you have an opportunity after I stop talking, maybe you might suggest as to how we might go about making that happen.

Secondly, the other issue that was brought up regarding staffing. There is no doubt that looking at the vacancies, it is something that is essential and important, and how to best do that. I know we have a lot of great staff working for the VA. But I also know that we have a lot of staff that maybe should not be there now. And some that have been burned out because of the workload, and especially mental health services. They tell me that in England in mental health they work for a certain period of time then they are

off for a good chunk of time because of the burn out factor. And I do not know if you want to make comments on that.

The third area that, and I am going to give a case on this one at the end, is the issue of working with the families, and how critical it is to reach out to those families of those soldiers and those veterans. And how important that is, especially when we deal with post-traumatic stress disorders. And there is one over with Congressman Brown, who talked about when they suffer from mental health problems the soldier is not going to say, you know, when they come out, they are going to say, "Hey, I am okay. I do not have a problem." And part of the fact is that they have not acknowledged that and that is a serious situation. But the ones who catch on to this is the family. The family knows sometimes, "Hey, my son has a problem." You know? "He is not the same young man that was here and has come back." And so that somehow making some kind of outreach also to those soldiers that are out there is really important.

I wanted to also just kind of stress, I think it was mentioned, preventative maintenance and checking services that is also so, I think it is important in the process. I had gotten testimony in San Antonio from a psychiatrist. And there was some basic questions that were asked then about post-traumatic stress disorder. And he gave us a beautiful presentation about the fact that we have always had it. We have just called it Gulf War Syndrome. We have called it adjustment reaction. We have called it other things. And he said all you have to go back in history and read the Iliad. And I said I had not seen that since high school, but that you can, you know, that we have always had some of those difficulties. So I know that we are going to have to kind of push forward and see what we can make happen.

Congressman Moran also mentioned the importance of community health centers that we have back home. We have some great ones in San Antonio, where they are ready to provide access to services. And they have some great community mental health people out there that could be utilized, and that is not happening. And so I wanted to, you know, see if you might be able to make some comments on that. But before I do I want to, if Mr. Chairman, I want to be able to read this comment that I have. Because it is an incident that just occurred right outside that district. But the family lives in my district and, anyway, please allow me, you know, for a minute.

I wanted to bring up a situation that occurred Friday at Fort Bliss, Texas. And this is DoD, not VA, but DoD. A soldier who returned fifteen months ago from deployment then immediately relocated to new assignment, had Post Traumatic Stress Disorder. And I do not know exactly, you know, how much services he was provided with. What I do know is that the family, his mother lives in my district, cried out for help, you know, for a long time, for assistance. They had repeatedly raised concerns that the soldier had Post Traumatic Stress Disorder and needed some immediate attention. And again, I am not sure how much attention he received. But the family indicates that it was insufficient. The last call for help was last Wednesday and Thursday to the unit there in El Paso. And Friday morning the soldier turned himself into the mili-

tary police after allegedly having shot and killed an eighteen-year-old on his way to school and having also shot and wounded another soldier. And I just wanted to make it, you know, clear that the ultimate victims on this, of course, the young people that were killed and the soldier. But that soldier, a lot of times, it was the result of the Post Traumatic Stress Disorder, is also a victim in a lot of ways.

But I do not, you know, I wanted to kind of mention that particular case because it just happened. And we are kind of helpless. You know, these families are calling us for help and assistance, and we try to call, and I know it is, you know, that it is difficult. But yet, you know, they are becoming too numerous. And that is just one incident. We have soldiers right now committing suicide while in service. If they do that we know that they do not get any compensation whatsoever. In fact, I had a soldier commit suicide and was almost treated very poorly, you know, when the body came into the community. And so somehow we have got to do more. And so I wanted to get some feedback from you in terms of how do we make this happen?

[The prepared statement of Congressman Rodriguez appears on p. 25.]

Mr. IBSON. Congressman, thank you for raising those issues. Wounded Warrior Project certainly works closely through our service teams, with military personnel. And if your caseworkers come across problems that we can help with, our doors are certainly open. We are certainly happy to engage.

You posed a question earlier about the peer-to-peer services and I want to acknowledge the work of this Committee and the Congress in passing legislation last year that authorizes VA to employ peer specialists. I believe they have begun to do so, though primarily to work with individuals with the most severe mental illnesses. And our testimony is to the effect that there are opportunities to expand those programs, in our view, to work effectively with younger veterans with other diagnoses, particularly PTSD. And we would see that as an area that VA could pursue, the Committee as well.

I want to cite your important remarks on the role of the families and I would very much like to underscore on behalf of Wounded Warrior Project the importance of family caregiver legislation, which we have discussed informally with the Committee staff, and to mention S. 801, a bipartisan bill introduced by Senator Akaka and Senator Burr, which would establish a foundation for supporting family caregivers of severely wounded servicemen and veterans as a very important step toward sustaining the caregiving that is enabling severely wounded warriors to remain at home rather than becoming institutionalized.

Mr. RODRIGUEZ. Mr. Chairman, I apologize for taking more than my time. Thank you.

Mr. PERRIELLO. Next we will go to Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman. Thank you for your testimony. And I have to tell you, I am very concerned about the mental health situation with VA. When you gave your testimony you indicated that some of the agencies, or some of the hospitals, you did not know whether or not they were qualified to

work with the veterans' situation. Well, that is what I am finding, that VA does not want to contract out mental health services. But we are not serving the population. All we have to do is look at the homeless. I mean, one-third of them are veterans. They either have drug problems, or they have alcohol problems, and we are not addressing them. Yes, it is a role for peer counseling. But these people need professionals. And we do not have enough professionals in VA. And they resist, they resist farming out, partnering with agencies that do mental health services. And I do not know why. The situation can only get worse. And if you have certain standards, certain guidelines, that is where you could bring in these agencies and work with them, and partner. But there is no role for peer counseling for severe problems. I am, that is my training. I am a counselor, at least back in my real life. So, I mean, what are we going to do?

Mr. IBSON. I certainly share your view that there is an important role for partnerships. And I would not want to represent that VA fails to partner. Certainly, there are some core VA homeless programs that had their genesis in this very hearing room which represent very fine partnerships. I think there is an opportunity for VA to employ its contracting authority. At the same time, it is important to recognize, I think, that when we are dealing with the very specialized condition like post-traumatic stress disorder it is important for VA to be assured that community providers have the capacity and training and expertise to do that. But——

Mr. IBSON [continuing]. There is an opportunity for VA to do that kind of training, I think.

Ms. BROWN OF FLORIDA. Right. But the problem is, VA has resisted contracting out, working with agencies. If the VA, puts out a contract and say, "We want this, this, and this, and you want this training," I do not see why we cannot work more with community agencies and community groups that provide these mental, they are doing it anyway, they are just not getting paid for it.

Mr. IBSON. I share your view. There certainly is an opportunity for greater partnership here. And particularly in areas of the country, as Mr. Brown was indicating, where there is a dearth——

Ms. BROWN OF FLORIDA. Well, he is a rural area, I am in the inner city. But the question is, the problem exists in both places. What can we do to encourage VA to expand their mental health services working with other agencies? Because it is not happening, and the veterans are not getting served.

Mr. IBSON. Well certainly a hearing like this one today will be a very rich opportunity and a first step toward that. There is a certainly an opportunity to do more.

Ms. BROWN OF FLORIDA. Well, I believe that you are correct. Because failure is not an option. We are going to have more suicides, more problems in our community, if we do not address the problem with this new group that is coming back. And VA is just not geared up to handle it. We just need to, and I am not, it is not negative. VA has good services. But we need to expand what we are doing. We need the partnership.

Mr. IBSON. I would agree.

Ms. BROWN OF FLORIDA. Does VA have the authority to do it?

Mr. IBSON. Yes. I believe VA has very expansive contracting authority. And particularly, most particularly in areas where they either lack the capacity in-house to provide needed services or where geographic distance is a barrier. But I think this Committee has given VA very broad authority and there is certainly opportunity to use it.

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman.

Mr. PERRIELLO. Thank you very much, Mr. Atizado and Mr. Ibson for your testimony and for your service. And with that, let us call up panel three. Panel three will be Dr. Michael Shepherd, Senior Physician from the Office of Healthcare Inspections, Office of the Inspector General, U.S. Department of Veterans Affairs. He is accompanied by Larry Reinkemeyer, Division Director, Kansas City Office of Audit, Office of the Inspector General, U.S. Department of Veterans Affairs. Thank you, gentlemen, for being here today and sharing your comments with us. Dr. Shepherd?

STATEMENT OF MICHAEL L. SHEPHERD, M.D., SENIOR PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY LARRY REINKEMEYER, DIVISION DIRECTOR, KANSAS CITY OFFICE OF AUDIT, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MICHAEL L. SHEPHERD, M.D.

Dr. SHEPHERD. Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today regarding VA's progress toward meeting the mental health needs of our veterans. I will focus on our report, Implementation of VHA's Uniform Health Services Handbook, and my colleague, Larry Reinkemeyer, will be able to answer questions related to another OIG report, "Audit of VHA Mental Health Initiative Funding."

In 2004, VHA developed its 5-year mental health strategic plan which included more than 200 initiatives. Because the plan is organized by the broader goals and recommendations of the 2003 "President's New Freedom Commission Report," rather than specific mental health programs, some initiatives do not delineate specific actions——

Mr. PERRIELLO. Excuse me, doctor, could you move the microphone closer?

Dr. SHEPHERD. Sure. Is this better?

Mr. PERRIELLO. Yes.

Dr. SHEPHERD [continuing]. That should be carried out to achieve these goals and are not readily measurable. The Handbook notes that when fully implemented these requirements will complete the patient care recommendations of the mental health strategic plan. Overall, medical facilities are expected to implement the Handbook requirements by the end of fiscal year 2009.

Because there are over 400 items in the Handbook we limited the scope of our review to the Medical Center level, where full implementation is more likely to occur prior to community-based outpatient clinic (CBOC) level implementation. Based on clinical judgment we chose 41 items from throughout the Handbook to evalu-

ate. OIG inspectors agreed on what criteria constituted a positive response and affirmative responses were queried for demonstration of their validity.

We believe the items chosen reasonably estimate the present extent of implementation at the Medical Center level. Although it is an ongoing process, the data presented do not credit partial implementation. We found that 31 of 41 items reviewed were implemented at more than 75 percent of Medical Centers. For example, a mental health intensive case management program is in place at all facilities with more than 1,500 seriously mentally ill veterans.

We identified items indicative of areas in which VHA is at risk for not meeting the implementation goal, including timely outpatient follow up after mental health hospitalization; provision of intensive outpatient treatment for substance use disorders; provision of psychosocial rehabilitation and recovery programs at centers with more than 1,500 seriously mentally ill patients; and the provision of sufficient clinical psychologist staffing for VA community living centers.

Additionally, we are concerned that while a section of the Handbook addresses access to specific evidence-based psychotherapies for PTSD, it appears that VA does not have in place a national system to reliably track provision and utilization of these therapies. A national system would allow for a population-based assessment of treatment outcomes with implications for treatment of other veterans presenting for PTSD-related care. While VA has relevant process measures in place to monitor program implementation, we believe that VA should develop more outcome measures where feasible to allow for dynamic refinement of program requirements in order to meet changes in mental health needs and to optimize treatment efficacy.

Although this inspection contains some items related to suicide prevention, as a component of OIG's CAP review process, in January 2009 we began a separate medical record-based review of suicide prevention items. We will conclude our inspection in June 2009 and then issue a roll up report on our findings.

In conclusion, the Handbook is an ambitious effort to enhance the availability and provision of mental health services to veterans. VHA has made progress in implementation at the medical center level. Because our review was limited to medical centers, we plan to conduct an inspection in fiscal year 2010 on implementation at the CBOC level where factors such as geographic distance and the ability to recruit mental health providers may pose greater obstacles to implementation.

In regard to mental health initiative funding, we found that VHA adequately tracks and uses mental health initiative funding as intended. Mr. Chairman, thank you again for this opportunity to appear before the Subcommittee. We would be pleased to answer any questions that you or Members of the Subcommittee may have.

[The prepared statement of Dr. Shepherd appears on p. 38.]

Mr. PERRIELLO. Thank you very much for being with us today, and thank you for your thoughts. What would you say at this point are the main limiting factors for you to be able to produce the kind of metrics that you have in mind?

Dr. SHEPHERD. For this report—limiting factors for us to produce the metrics, or for VA to produce, for VA? Well, one of the issues, again, which we cited and the previous panelists cited is, for example, in terms of provision of evidence-based treatments for PTSD. In the absence of knowing who you have provided these treatments to, whether they have done part of these treatments, completed these treatments, whether they have opted not to pursue these treatments, in the absence of a data system that is able to capture that, you really down the road do not have the structure you need to make outcome judgments in terms of evidence-based therapies for PTSD. And so I think, as we say in the report and in the San Diego report that we issued, we think there is a real urgent need for VA to adjust their data system, or their electronic medical record system, to allow for capture of what type of services are provided, not just that a service was provided.

Mr. PERRIELLO. Thank you. Your written testimony includes a list of VA mental health services and the extent of implementation of the Uniform Mental Health Services Handbook for each of these services. How do you respond to DAV's concerns that this data is based on self-reports from VA leadership? And did the OIG consider other ways of assessing the implementation which are perhaps more objective?

Dr. SHEPHERD. We provide independent oversight in response to questions we are asked. In terms of the method we chose, I point out, again, that this was mostly a structured interview, not a purely passive survey. That we had developed and agreed upon among the inspectors, criteria we were looking for that constituted an affirmative response. When we asked mental health directors a question if we had an affirmative response, we basically kept pushing them with further queries to try to get demonstration of the criteria we were looking for. In addition, if someone gave an affirmative response but in response to queries, the affirmative response did not match what we were hearing, we took that to be a negative response.

Again, if there were further systems in place to allow for better capture within, the electronic medical record, or through the administrative sources, the types of services and not just that services are performed, that would also enhance the oversight ability.

Mr. PERRIELLO. Let me turn to the Ranking Member Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much for your testimony, and I know that maybe you might have emphasized some of these questions before. You described the Uniform Mental Services Handbook as an ambitious effort that may require ongoing adjustment based on patient utilization and needs. In your opinion, is there a section of the Handbook that may require adjustment in the near term?

Dr. SHEPHERD. In looking at the Handbook, it does seem that two sections that I think are going to need adjustment in the near term are: as baby boomer veterans age and we start to see a growing number of older veterans coming into VHA for care, I am concerned that the part of the Handbook that addresses services to older veterans may need further adjustment in the near term to meet the changing utilization patterns. In addition, in the Handbook there is not much in the way of addressing the concomitance of recent

veterans with both traumatic brain injury and PTSD. And I think that bears looking at further.

Mr. BROWN OF SOUTH CAROLINA. Thank you very much for your testimony.

Mr. PERRIELLO. Mr. McNerney?

Mr. MCNERNEY. Thank you, Mr. Chairman. And I want to thank you, Dr. Shepherd, for sitting in front of us this morning. In your written testimony, well, and your written testimony includes a list of the VA mental health services and the extent of implementation in the Uniform Mental Health Services Handbook for each of these services. Now, the DAV's testimony was that some of these reports are generated within the VA and so they might be self-serving. Can you respond to that? Do you think there is a better way to go about finding, you know, finding what the outcomes are of these services?

Dr. SHEPHERD. Well, again, part of the data that was presented was from our structured interviews of all of the medical center mental health directors. Some of the data was performance measure data from VHA. One example of other ways, as mentioned in our look at suicide prevention initiatives from the Handbook, that is ongoing. That is a chart-based review from patient records. We have an ongoing review right now of residential treatment programs that has extensive chart-based review as part of it.

Mr. MCNERNEY. So you feel these are objective enough, then, to be valuable?

Dr. SHEPHERD. I think this report reasonably reflects the state of the system at this point.

Mr. MCNERNEY. Well, I mean, we have heard a lot about outcome measures here this morning in this panel and the prior panel. Could you elaborate on how these measurements are taken? And how you would use the information in a specific setting to improve the performance at that location?

Dr. SHEPHERD. You are referring to outcome measures in terms of outcomes of treatment?

Mr. MCNERNEY. Yes.

Dr. SHEPHERD. One of the reasons I think we really need to keep prodding for further development of outcome measures is if your outcomes at some facilities really vary when you take into account risk adjustment, it would tell you that you need to look closer at what is happening at that facility, such as who is getting services, the fidelity of the treatment going on. In addition, at the facility level every facility may have different patient subpopulations. Certain facilities may have a greater proportion of patients with certain needs. And outcomes at those facilities would help to better tailor what you are doing at those sites to the specific needs at that site.

Mr. MCNERNEY. So you may not use that to adjust funding for a specific site, but you may use that to direct more services of a certain kind?

Dr. SHEPHERD. And the quality of the services provided.

Mr. MCNERNEY. And the quality. But we always want to see good quality. I mean, that is always an issue. And another thing that the DAV mentioned was that in the Handbook there is not specific enough guidelines in terms of what should be provided in terms of the services. Do you have any comment on that?

Dr. SHEPHERD. I think that would probably better responded to by VHA.

Mr. MCNERNEY. Okay. All right. Thank you for your testimony. I yield back.

Mr. PERRIELLO. Mr. Brown.

Mr. BROWN OF SOUTH CAROLINA. I have no further questions for this panel.

Mr. PERRIELLO. Thank you very much for your time. Thank you for traveling. And we appreciate your testimony today. We will call up the next panel. Our next panel will include Dr. Ira Katz, M.D., Ph.D., Deputy Chief of Patient Care Services Officer for Mental Health Services, Veterans Health Administration, U.S. Department of Veterans Affairs; accompanied by Dr. Antonette Zeiss, sorry if I got the name wrong, Deputy Consultant for Mental Health Services; and James McGaha, Deputy Chief Financial Officer. Thank you very much, and we will begin. Dr. Katz?

STATEMENT OF IRA KATZ, M.D., PH.D., DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ANTONETTE ZEISS, PH.D., DEPUTY CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION; AND JAMES MCGAHA, DEPUTY CHIEF FINANCIAL OFFICER, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. KATZ. Good morning, Mr. Chairman, and Members of the Subcommittee. I would like to request that my written statement be submitted for the record. Thank you for the opportunity to discuss VA's progress on meeting the mental health needs of our veterans. With the support of Congress, VA has received record increases in funding over the past several years, almost doubling our mental health budget from the start of the War in Afghanistan to today. During the same time, VA developed the VHA Comprehensive Mental Health Strategic Plan and the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics. My testimony will address these advances, recognizing that VA's overall mental health programs include strengths in other areas, including research and the Vet Center program, but focusing on mental health services in medical centers and clinics.

The mental health strategic plan was developed in 2004 to incorporate new advances in treatment and recovery, and to address the needs of returning veterans. It was based on the principle that mental health was an important part of overall health. Its 255 elements could be divided into six key areas: enhancing capacity and access for mental health services; integrating mental health and primary care; transforming mental health specialty care to emphasize recovery and rehabilitation; implementing evidence-based care with an emphasis on evidence-based psychosocial treatments; addressing the mental health needs of returning veterans; and preventing veteran suicides.

In 2005, VA began allocating substantial funding through its mental health enhancement initiative to support the implementation of the plan. We are now in the 5th year of implementation,

and it is a critical time to review progress. Currently, substantially more than 90 percent of the items in the plan are now part of ongoing operations and clinical practice. Therefore, it is a time for us to move from a focus on rapid transition to one of sustained delivery. This was the impetus for the new Handbook on Mental Health Services in VA Medical Centers and Clinics, published in September 2008. It established clinical requirements for VA medical health services at the network, facility, and clinic levels, and delineated the essential components of the mental health programs that are to be implemented nationally. It consolidated requirements for completing and sustaining implementation of the mental health strategic plan by defining the services that must be provided in all facilities and those that must be available to all veterans. It established standards for mental health programs, guides program plannings, and serves as a tool for treatment planning. Most significantly, the Handbook represents a firm commitment to veterans, families, advocates, and Congress about the nature of the mental health services VA is providing.

At present, VA's goals must be to consolidate the gains of the past 4 to 5 years by implementing the Handbook and sustaining the operation of mental health services meeting this new standard. To achieve these goals VA will ensure implementation through a stringent series of monitors and metrics. They will, first, evaluate the development of new clinical capacities. Second, monitor the access and utilization of new capacities by facilities and by increasing numbers of veterans. Third, evaluate the quality of new services, including monitors for the fidelity of delivery of evidence-based interventions. And fourth, evaluate the impact of enhanced programs on the clinical outcomes of care. The first two sets of monitors will be implemented later this calendar year and the latter two during the following year. It is through these measures that VA leadership will hold itself, and its facilities, responsible for mental health services.

Thank you again for this opportunity to speak. Along with my colleagues, I am prepared to answer any questions you have.

[The prepared statement of Dr. Katz appears on p. 42.]

Mr. PERRIELLO. Thank you very much for your testimony, Dr. Katz. We have been called to vote so Mr. Brown and I are going to be submitting our questions for the record. But we are going to go to Mr. Moran to ask a question now.

Mr. MORAN. Mr. Chairman, thank you for your and Mr. Brown's courtesy. I have just one observation and one question. The question is, it has been nearly 2½ years since the Veterans Benefits Healthcare and Information Technology Act of 2006 was signed into law. That legislation added licensed marriage and family therapists, MFTs, and licensed professional mental health counselors, LPCs, to the list of eligible VA health care providers. I thought at the time that this would be a great opportunity for the VA to expand its ability to meet the needs of veterans, and I have championed this cause. But 2½ years later I am seeing little evidence that the VA has actually implemented the law. Is there a justifiable explanation for the delay? Or am I misunderstanding the situation?

Dr. ZEISS. Well we welcome the question. At this point, we have met extensively with the professional organizations that represent both licensed professional counselors and marriage and family therapists through our office in Mental Health, and have been very impressed with the potential to add these professionals to the team that would serve veterans. The issues are with human resources (HR). The law also stated clearly that new Hybrid Title 38 job series needed to be created for each of these. The law did not allow them to enter through the mechanisms of other existing series. So there are a number of licensed professional counselors and marriage and family therapists who work in VA under other series, and that has continued to increase. And we look forward, as you do, to HR reaching the point of having the qualification standards developed and having the Hybrid Title 38 job series in place so they can be hired directly under the auspices of their professions.

Mr. MORAN. So there is no impediment from the health care side of the VA? This is what I would describe as the bureaucratic process of bringing these people onto the payroll?

Dr. ZEISS. We do not, yeah, we certainly support this and have tried to be very available to these organizations, and to feed forward information to support the process of developing these new Hybrid Title 38 job series.

Mr. MORAN. Mr. Chairman, we have been through this numerous times that we have tried to add professional categories to the VA list of appropriate providers, the chiropractors are one. It is an enormous undertaking, apparently. I would welcome anyone on the Committee who would like to work with me to see if we cannot get the VA to move in a more expeditious manner. I think this is important. While we are sitting here talking about the lack of professionals, there is an opportunity for these services to be provided. Yet, because of the nature of the VA and its credentialing and accounting process, it is not happening. I think it is, it is not only disappointing to me, to the professionals who want to provide the services, but more important it means that there are veterans who could be served that are not because of the bureaucratic nature of the VA's process. If, particularly you, Doctor, if you are interested in my help in encouraging the other side of the VA to get on the dime, please consider me an ally.

The only other item I wanted to mention, Mr. Chairman, I know we are short of time, is that Kansas and a number of other States were designated in a pilot program for services, health care services, to be provided through the private sector in the absence of a VA, or an outpatient clinic, or mental health services, in the absence of them being in close proximity to the veteran. We are in the process, the VA is in the process, of implementing this program this year. I just wanted to make sure that you are aware of it, because it covers mental health services as well. So in those pilot VISNs, in the absence of those services being available within a certain distance of where the veteran lives, the VA is now obligated to provide those services through contract with the private sector, local hospital, local mental health. I want to make sure that you all are participating in that process. Because mental health services needs to be a significant component. I thank you for your time, sir.

Mr. PERRIELLO. Thank you for keeping an eye on that issue. Mr. McNerney?

Mr. MCNERNEY. Thank you, Mr. Chairman. Dr. Katz, I certainly want to thank you for your service to our country through our veterans. The DAV, just a while ago, highlighted a need to collect more results-oriented data. And they have also spoken about the need for leadership in terms of providing a little bit more of a picture of how to provide services, a little bit more detail. Could you respond to those two? What might be in the works, or how we could best approach those two questions?

Dr. KATZ. Yes. Everyone agrees that metrics and measures of the implementation of the Handbook, and of completion of the implementation of the strategic plan are necessary. VA has an extensive quality program that has numerous metrics related to mental health. But I want to speak specifically to the Handbook.

I am a clinician, and was a practicing psychiatrist until I came to Washington. To be honest, the Handbook is written primarily to be understood by clinicians about the clinical services that should be available and the services to be provided. It is not meant primarily to be read by accountants, or inspectors. It is written to be read by providers. And this year is the time for implementation to be guided by clinicians to meet the needs of our veteran patients. There will be a time for metrics, and VA is committed to having the metrics available to assess implementation, by October 1st. To get them out concurrently with the Handbook would have been to encourage practice to the test rather than practice to address clinical standards and clinical visions. So the staging of clinical guidance, then accountability through quantitative metrics, is, I believe, the appropriate way to unfold this process.

Mr. MCNERNEY. Well, thanks for that viewpoint, Dr. Katz.

Dr. KATZ. Thank you.

Mr. MCNERNEY. And I am going to yield back in the interest of letting Mr. Snyder have a question.

Mr. PERRIELLO. Mr. Snyder?

Mr. SNYDER. Thank you, Dr. Katz. And in your statement you make reference to the need to perhaps add other employees to CBOCs to handle mental health issues. Did I read your statement right?

Dr. KATZ. Well, there have been extensive enhancements in VA mental health staffing, including staffing in CBOC.

Mr. SNYDER. How do you do that when those are private contractors that have got a set amount of overhead? I mean, you cannot just pick up the phone and say, "Hey, put on two more people."

Dr. KATZ. Some community-based outpatient clinics are contract-based, but most are VA-owned and operated with Federal employees.

Mr. SNYDER. So you do not do that to the ones that are contract-based?

Dr. KATZ. We are committed to enhancing services, ensuring we provide or make available the services that veterans need, whether we provide them by VA employees, by contract, or fee-based, or other mechanisms.

Mr. SNYDER. Maybe I will do that for the record, then. Why do you not respond to the question, how do you do an enhancement

of mental health services at a privately contracted CBOC, since they have a contractual arrangement with a set overhead?

Dr. KATZ. I will have to take that for the record, thank you.

[The VA subsequently provided the following information:]

Question: How does VA enhance mental health services at a privately contracted CBOC if the contractual agreement has already set an amount for overhead?

Response: The Department of Veterans Affairs (VA) includes clauses in contracts for community-based outpatient clinics (CBOCs) that allow the Department to establish quality monitors and to negotiate to amend the contract. Each facility arranging a contract for CBOC care includes provisions to ensure quality patient care, including medical record review, accreditation surveys by The Joint Commission and other bodies, and the collection of quality and performance data, similar to what we require for VA owned-and-operated CBOCs. This allows the agency to assess adherence to evidence-based standards of care and to investigate further if facilities fall short of requirements or expected standards.

Mr. PERRIELLO. Thank you so much, Doctors, for your time and testimony. We are truly sorry that we were not able to get all of the questions out, but know how important these issues are to this Committee and that we will continue to pursue your expertise and advice as we address these important issues. All other questions will be submitted for the record, and the hearing is now adjourned.

[Whereupon, at 11:25 a.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Michael H. Michaud, Chairman, Subcommittee on Health

The Subcommittee on Health will now come to order. I would like to thank everyone for coming today. We are here today to talk about the VA's progress on meeting the mental health needs of our veterans. Specifically, we will discuss issues of funding and implementation of the Mental Health Strategic Plan and the Uniform Mental Health Services Handbook.

Many people in this room are familiar with the daunting statistics on mental health from the April 2008 RAND Corporation report on the invisible wounds of war. The RAND report estimated that of the 1.64 million OEF/OIF servicemembers deployed to date, about 300,000 or 18 percent suffer from PTSD or major depression and about 320,000 or 20 percent likely experienced TBI during deployment. In addition, the report showed that despite our current efforts, about half of our servicemembers are not seeking and receiving the mental health treatment that they need. This raises serious concerns about the long-term negative consequences of untreated mental health problems, not only for the affected individuals but also for their families, their communities, and our Nation as a whole.

To address this problem, the VA has focused their efforts on improving mental health care for our veterans. For example, the VA has set aside substantial funding for mental health care, which amount to $3.8 billion in fiscal year 2009. The VA also approved a Mental Health Strategic Plan in November of 2004, which is a 5 year action plan with distinct mental health enhancement initiatives. Additionally, I am aware of the 2008 Uniform Mental Health Service Handbook, which defines standard and minimum clinical requirements for mental health services that the VA will implement nationally.

I applaud the VA on these efforts, and it is important for the Committee to ensure proper oversight. Today's hearing will explore the concerns raised in the 2006 GAO report which found that the VA spent less for mental health initiatives than planned and lacks the appropriate mechanism for tracking the allocated mental health funding. We will also seek a better understanding of the successes and the challenges faced by the VA in implementing the Mental Health Strategic Plan and the Uniform Mental Health Service Handbook.

Today, we will hear from various experts in the field including the Disabled American Veterans; Wounded Warrior Project; the Office of the Inspector General; and the VA. I look forward to hearing their testimonies.

Prepared Statement of Hon. Henry E. Brown, Jr., Ranking Republican Member, Subcommittee on Health

Thank you, Mr. Chairman.

I appreciate your holding this hearing today.

Mental health is a critical component of a person's well-being. And, essential to the mission of the Department of Veterans Affairs (VA) "to care for those who have borne the battle" is to effectively intervene and care for the "invisible wounds" of war.

The psychological toll of war is not always apparent and sadly has not always received the attention it should. However, I think we can all agree that the VA has come a long way, especially in the past few years, to improve mental health services and encourage veterans in need of care to get help.

Even though significant progress has been made, there is no doubt that we must still do more—as we continue to hear about veterans facing barriers and gaps in services. We must ensure that when a veteran needs and seeks help, that veteran gets the "right" care at the "right" time.

In the past decade, we have made a substantial investment in VA mental health, increasing funding by 81 percent, from $2.1 billion in fiscal year 2001 to no less than $3.8 billion in fiscal year 2009. That is why it was very disturbing when the Government Accountability Office (GAO) in November of 2006 reported that VA had not allocated all the available funding to implement the Mental Health Strategic Plan.

It is our responsibility to see that the funding we provide is spent as intended—to support a complete array of mental health prevention, early intervention and rehabilitation programs for our Nation's veterans.

I look forward to hearing from our witnesses and having the opportunity to take a good look at where we stand in taking care of the mental health needs of our veterans.

With that, Mr. Chairman, I yield back.

Prepared Statement of Hon. Ciro D. Rodriguez, a Representative in Congress from the State of Texas

I want to thank the Disabled American Veterans and the Wounded Warrior Project for their candid comments and specific recommendations for oversight. I think it is important to highlight that if mental health professionals are "feeling overwhelmed due to increasing numbers and mental health needs," it is a pretty clear indication that we don't have enough mental health professionals. I understand the VA not wanting to make conclusions about staffing needs, but if the mental health professionals are overwhelmed then we need to ask why and address that issue. I'd hate to see our mental health professionals needing mental health counseling because of work stress.

I think the Disabled American Veterans hit the nail on the head when it comes to staffing needs. We can't report staffing needs based on the offers we've made and the responses received. We must look at our manpower authorizations, vacancies of those positions, and then the workload that each of those professionals face to determine how many more mental health professional positions we still need beyond what is currently authorized.

The recommendation of an independent mental health advisory body with direct access to the Secretary is a great idea and we should explore that possibility.

The Wounded Warrior Project testimony touched on the fact that 60 percent of the returning troops who screened positive for PTSD never reached out for help. Yet at the same time the need is for early, preventative intervention being critical to identification and recovery. The dilemma is trying to identify the need for help in those that do not identify themselves as needing help.

The Army used to use a term (they may still use it): PMCS—Preventative Maintenance, Checks, and Services. We do PMCS on vehicles and equipment, but we need to do it on our people as well. Early screening and proactive, preventative treatment for PTSD is needed. It is simply post-operation PMCS on a returning troop. And you don't just check it once. You do daily, weekly, monthly PMCS. In this case it should be done by a team of individuals actively working together to include the therapists, chain of command (if they're active, guard, or reserve), family members, and peers. And the same must happen for the family members of returning troops. For some, being left alone to handle all the rigors of life and events that occur in a single-parent household can be traumatic as well. For family members of veterans, trying to be there through many years of undiagnosed or untreated PTSD can affect them as well. Many spouses and family members are overwhelmed and need PMCS. We have to find a way to help the family members of all our troops, active and veteran, and provide them counseling as well.

Counseling should be mandatory at regular intervals for every returning troop and should continue for months or years after returning from deployment. The family members should be actively involved in post-deployment counseling. The family often knows more than the doctors and may often identify more than the member themselves. The spouse knows if the servicemember is different. They know if something is wrong. Too often the family member may cry out for help to the military, normally the member's chain of command, and be ignored, not taken seriously, or in some cases even belittled. The spouses must be included and taken seriously when they identify a problem with the servicemember when identifying possible PTSD symptoms or other work-related stressors.

I want to bring up a situation that occurred last Friday at Fort Bliss, Texas. A soldier who returned 15 months ago from deployment, then immediately relocated to a new assignment, had PTSD. I do not yet know how much help he'd been given.

What I do know is that the family—his mother lives in my district—has cried out for help for a long time. They have repeatedly raised concerns that the soldier had PTSD and needed some immediate attention. Again, I am not certain how much attention he received, but the family indicates that it was insufficient. The last call for help was last Wednesday and Thursday to the unit. Friday morning the soldier turned himself in to the military police after allegedly having shot and killed an 18-year-old on his way to school and having shot and wounded another soldier.

I want to make it clear that the ultimate victims here are the young man whose life was cut short and the soldier who was wounded. I do not want to diminish their loss in any way.

But I do want to point out that this is a situation where intervention was needed . . . early and continual. . . . We cannot take "I'm okay" for an answer, especially if someone screens positive for possible PTSD, but even if they have not initially screened positive. It may harvest and grow over time, like when you put a frog in water and slowly raise the temperature. He won't jump out because he doesn't realize anything's wrong. This soldier needed PMCS and he wasn't getting it.

We, as a community, have to ensure our troops are being helped. We have to take their family seriously when they give us clues that there is something wrong. We have to pay attention. In this case, one innocent life was lost and countless lives were impacted forever because we, as a community, didn't pay attention.

Prepared Statement of Adrian Atizado,
Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and other Members of the Subcommittee:

Thank you for inviting the Disabled American Veterans (DAV) to testify at this oversight hearing of the Subcommittee on Health. We appreciate the opportunity to offer our views on progress by the Department of Veterans Affairs (VA), and the Veterans Health Administration (VHA) on meeting the critical mental health needs of veterans.

We recognize the unprecedented efforts made by VA over the past several years to improve the consistency, timeliness, and effectiveness of mental health programs for disabled veterans. We are pleased that VA has committed through its national Mental Health Strategic Plan (MHSP) to reform VA mental health programs by moving from the traditional treatment of psychiatric symptoms to embracing recovery potential in every veteran under VA care. We also appreciate the will of Congress in continuing to insist that VA dedicate sufficient resources in pursuit of comprehensive mental health services to meet the needs of veterans.

Despite obvious progress, we believe much still needs to be accomplished to fulfill the Nation's obligations to veterans who have serious mental illness, and post-deployment mental health challenges. Our duty is clear—all enrolled veterans, and particularly servicemembers, Guardsmen and reservists returning from war, should have maximal opportunities to recover and successfully readjust to life following military deployment and wartime service. They must have user-friendly access to VA mental health services that have been demonstrated by current research evidence to offer them the best opportunity for full recovery.

We must stress the urgency of this commitment. Sadly, we have learned from our experiences in other wars, notably Vietnam, that psychological reactions to combat exposure are common. If they are not readily addressed, they can easily compound and become chronic. Over a long period of time, the costs mount in terms of impact on personal, family, emotional, medical and financial damage to those who have honorably served their country. Delays in addressing these problems can result in self-destructive acts, including suicide. Currently, we see the pressing need for mental health services for many of our returning war veterans, particularly early intervention services for substance-use disorders and evidence based care for those with post-traumatic stress disorder (PTSD), depression and other consequences of combat exposure.

The development of the MHSP and the new Uniformed Mental Health Services (UMHS) policy (detailed in VHA Handbook 1160.01, dated September 11, 2008) provide an impressive and ambitious roadmap for VHA's transformation of mental health services. However, we have expressed continued concern about need for improved oversight of the implementation phase of these initiatives.

Although we realize that VA is faced with a significant challenge in transforming its mental health services, this is not a time for the usual barriers that frustrate change. This is a time for extraordinary action to fulfill our commitments, and we believe extraordinary action can overcome the usual time delays. Surely, just as we

owed it to our servicemembers to outfit them with the best possible protective equipment as they prosecute war, we now owe it to these same men and women to provide immediate access to the best VA evidence-based mental health treatments and early intervention services available so that they can quickly recover and successfully readjust to civilian life after war.

Historically, VA has been plagued with wide variations among VA medical centers related to the adequacy of the continuum of mental health services offered. To address these concerns, VA has provided facilities with targeted mental health funds to augment mental health staffing across the system. This funding was intended to address widely recognized gaps in the access and availability of mental health and substance-use disorder services that existed prior to the development of the MHSP, to address the unique and increased needs of veterans who served in Operations Iraqi and Enduring Freedom (OIF/OEF), and to create a comprehensive mental health and substance-use disorders system of care within VHA that is focused on recovery—a hallmark goal of the 2003 *New Freedom Commission on Mental Health.* In addition, VHA developed its UMHS policy so that veterans nationwide can be assured of having access to the full range of high quality mental health and substance-use disorder services in all VA facilities where and when they are needed. Timely, early intervention services can improve veterans' quality of life, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. We understand that these funds have been dispersed as part of a special Mental Health Initiative (MHI), with clear direction that they be used to augment current mental health staffing, not merely to replace vacant positions that facilities could not afford to fill without extra funding.

On April 6, 2009, the VA Office of Inspector General (OIG) issued two reports focused on VA mental health services: (1) *Healthcare Inspection: Implementation of VHA's Uniform Mental Health Services Handbook;* and, (2) *Audit of Veterans Health Administration Mental Health Initiative Funding.* In anticipation of them, we had expected these reports would provide an in-depth assessment of the consistency of mental health services, and access across the Nation to evidence-based treatments. Unfortunately, they fall far short of this expectation. The OIG report on the UMHS Handbook was intended to review progress on the implementation of the MHSP and specifically to assess whether the identification and treatment of PTSD was being uniformly accomplished across the system.

The OIG noted that given the dimension of the handbook, a comprehensive review of the extent of implementation is challenging. For these reasons, the OIG limited the scope of review to the medical center level and reviewed only a limited selection of items from the handbook. OIG states that the Office of Healthcare Inspections, the community-based outpatient clinic (CBOC) Project Group, will inspect implementation of mental health services at the CBOC level at a later date. In addition, it was noted that the implementation of the handbook is a dynamic and ongoing process during fiscal year (FY) 2009 and that data in its report do not capture partial implementation. The OIG was also required to present its findings on uniformity of identification and treatment policies for PTSD.

The UMHS handbook clearly defines specific requirements for services that must be provided and those that must be available when clinically needed by patients receiving health care from VHA. Overall, facilities are expected to implement handbook requirements by the end of FY 2009, less than 6 months from now. Modifications or exceptions for meeting the requirements must be reported to, and approved by, the Deputy Under Secretary for Health.

VHA Central Office and the Office of Mental Health Services (OMHS) staff, and several Veterans Integrated Service Network (VISN) mental health liaisons and directors were interviewed during the inspection. Reports and data on locations, clinical staffing, and caseload on the mental health case management program and other relevant mental health programs were evaluated, including data and information on dissemination of training in evidenced-based psychotherapies. The inspection also included a web-based survey sent to all VA medical centers, including questions related to availability of certain mental health clinical services, (i.e., OIF/OEF specialty clinics and evening mental health hours). Responses were received from 149 of the 171 medical center sites. In addition to the web-based survey, structured phone interviews were conducted with directors or designees at 138 VA medical centers, containing 39 index questions. The report noted that during the telephone interviews, OIG staff had an opportunity to obtain feedback and to hear about potential barriers to implementation of the UMHS handbook.

The OIG commented on the individual areas evaluated in the inspection, but made no recommendations because facilities have until the end of FY 2009 to fully meet the handbook requirements. However, the inspection report noted areas for

specific review to include community mental health; gender-specific care and military sexual trauma treatments; around-the-clock care and emergency department care; inpatient care; ambulatory mental health care; care transitions; specialized PTSD services; substance use disorders; seriously mentally ill and rehabilitation and recovery services; homeless programs and incarcerated veterans; integrating mental health into medical care settings; care of older veterans; suicide prevention; and uniformity of PTSD diagnosis and use of evidenced-based treatments. Findings in the report were tallied by the above-identified categories and displayed by facility in percentages of the extent of implementation.

We note that the report predominantly relies on self reports from leadership at each of the VA medical facilities as to whether they have established a particular program, generally without any clear criteria as to what minimal services the program must offer, the intensity at which services are offered, or facility capacity to provide services at required levels of intensity. Self-reported rates of the existence of programs were high. However, in the few cases where intensity of the service is included or implied (e.g. intensive outpatient services or Psychosocial Rehabilitation and Recovery Centers), compliance is significantly lower (71 percent and 51 percent, respectively).

The report notes that evidence-based services for PTSD are labor-intensive but that currently VA has no means for tracking the true accessibility of such services across the system. VA, in conjunction with the Department of Defense (DoD), has made important efforts in developing evidence-based guidelines for mental health treatments, including those used for PTSD. VA has also commissioned independent reviews to establish which PTSD treatments are most effective. Consequently, much is known about the types and intensity of treatments that are optimal and effective. In the case of PTSD, the evidence-based treatments require careful training of staff and must be delivered at a high level of intensity, specifically—multiple hours of intensive treatment over several weeks or months, with subsequent followup care.

The recent OIG report makes no attempt to calculate the intensity of PTSD services delivered, even those that are not evidence based; nevertheless, VA research reports cited by the OIG in other reports (e.g. OIG August 2008 report: *Healthcare Inspection: Post-traumatic Stress Disorder Program Issues, VA San Diego Healthcare System)* raise concern that intensity levels have been falling, even in the face of evidence that effective services for PTSD require much greater intensity of services. The OIG report on national implementation of the UMHS Handbook acknowledges that extensive training is required to deliver evidence-based PTSD care, and reported that it collected data on such training nationally; nevertheless, no data are presented on how many staff have been trained, how many still require training, or the timeline needed for training completion. The only data reported is self-reported by local officials on compliance questions.

Within the past 8 months, the OIG conducted two other detailed inspections (including the San Diego inspection cited above) that attempted to look in depth at the provision of evidence-based PTSD care, including the critical issues of the availability of fully trained staff and the availability of time for staff to provide the intensive services required. In both cases, the results are in contrast to the optimistic tone of the self-reported data from local officials in this new report. In the San Diego report it is noted that "it would be inappropriate to make conclusions about staff resource needs based on such inaccurate information"; that PTSD therapists reported "feeling overwhelmed due to increasing numbers and mental health needs" of patients; and that "only a few patients actually received" evidence-based therapies.[1] In a report on the Montana VA Health System, the OIG reported that: "specific evidence-based therapies for PTSD have limited availability for Montana veterans."[2]

The concerns expressed to the OIG in the San Diego reportby local PTSD providers, particularly that they do not have the resources or time required to provide evidence based care at the intensity it requires, resonate with feedback we have received from clinicians and veterans who complain that they are providing and receiving PTSD therapies and other services, respectively, at only a limited intensity level.

In VHA's response to the most recent 2009 OIG report, the Under Secretary for Health acknowledged that VHA lacks a system that reliably tracks the provision and utilization of evidence-based PTSD therapies. He noted in fact that no health

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[1] Department of Veterans Affairs, Office of Inspector General. Healthcare Inspection: Post-Traumatic Stress Disorder Program Issues, VA San Diego Health Care System. Report 08–01297–187. August 26, 2008.

[2] Department of Veterans Affairs, Office of Inspector General. Healthcare Inspection: Access to VA Mental Health Care for Montana Veterans. Report 08–00069–102. March 31, 2009.

system offers such a mechanism. This response might imply that the task is unachievable. Given the importance of combat-related PTSD to VA's core missions, we believe it should certainly be the first to do so and the evidence is ample that this task is an achievable goal.

Over twenty years ago, VHA began translating one of the best established evidence-based approaches for care of the severely and chronically mentally ill, specifically—Intensive Case Management (ICM)—into general VHA practices. It did so with clear guidelines for conducting interventions to assure that the results would be comparable to the results found in the research studies that established the efficacy of the intervention strategy. This included measures of intensity of services, frequency of services and caseloads for providers. It should be noted that, in the current OIG report, the inspection found 100 percent compliance to the standards for having intensive case management services across the system. Based on extensive, available data from national VHA performance monitoring sources, not simply self-reported sources, it was possible for the OIG to assess the intensity and adequacy of staffing at the sites with ICM programs and identify that 24 out of 111 programs were below required staffing levels. We understand that all VA ICM programs are required to report regularly to a central monitoring center on their staffing levels, the number of patients per therapist, and other measures of fidelity to the delivery of true ICM services. Therefore, we believe it is clearly possible to track the implementation of an evidence-based therapy if the will and resources exist to do so, since VA has already done so with regard to ICM services.

We are pleased that VHA reported plans for improving the tracking of veterans' access to evidence-based PTSD therapies, as detailed in the Under Secretary's response to the 2009 OIG report. Again, we believe this is clearly an achievable goal, and adequate resources should be devoted to the task to assure that it can be accomplished immediately.

Mr. Chairman, let me now address the second OIG report before the Subcommittee today. The purpose of the OIG audit of VA's Mental Health Initiative (MHI) funding was to determine if VHA had an adequate process in place to ensure that funds that were allocated for the MHI were properly tracked and used for these purposes. According to the report, in FY 2008, VHA allocated $371 million to fund mental health initiatives outlined in the MHSP and UMHS handbook. The OIG visited six randomly selected VA medical facilities and reviewed allocation records related to MHI funding. According to the OIG staff from the OMHS and the Office of Finance in VA Central Office were interviewed to determine the process for funding the MHI and the mechanisms for tracking and ensuring accountability of these funds. Interviews also were conducted with VISN and medical facility staff, including new mental health staff hired to determine if they were performing MHI-creditable duties. Award memorandum sent by the OMHS staff to the medical facilities were reviewed as well as MHI tracking reports, payroll reports and transfer of disbursement authorities (TDA). It was noted in the report that VHA had not developed performance metrics to identify the intended outcome(s) of each initiative. In a subsequent memorandum, VA commented that these metrics for monitoring implementation of the requirements listed in the UMHS handbook are currently under development.

The OIG concluded that at the six sites reviewed, the OMHS had adequately tracked funds allocated for the MHI in FY 2008, and that the funds allocated for the MHI were used as intended. The OIG confirmed that 94 percent of the funds allocated in the six sites reviewed were used for initiatives outlined in the MHI. It reviewed the remaining funds to confirm they were used by, or for, mental health services. The OIG evaluated mental health personnel costs for FY 2008 and reported that VHA spent approximately $16.4 million of the $17.7 million allocated for 225 positions at the six sampled sites. Medical facility personnel reported the remaining funds ($1.3 million) allocated for hiring mental health staff, were not expended for that purpose because of delays in the hiring process. Finally, $1.8 million of some additional $3 million in funds not related to personnel costs were determined to have been expended on the MHI specifically, and on other mental health-related activities such as purchasing equipment and furniture, and paying travel costs to provide home-based primary care.

While it is encouraging, based on this report, that the funds allocated are being predominantly utilized for the purposes intended, the report does not address two of the most pressing issues regarding true, long-term augmentation of mental services in VHA: the net increase in actual providers of care; and, the availability and accessibility of early intervention services.

First, it does not calculate the actual *increase* in providers of care; rather, it merely audits the hiring of new staff. In the past, mental health augmentations have been offset by reductions in other areas of mental health services, leaving a smaller

net gain than intended, or no gain at all. Secondly, the funds have been allocated as time-limited funds, although the need for additional services will clearly extend well into the foreseeable future. Supplementary mental health funds were allocated as time-limited, annual "special purpose" funding allocations that occurred outside of the usual Veterans Equitable Resource Allocation (VERA) process. Although there was a clear expectation by Congress that the services based on these funds would be maintained well into the foreseeable future, we understand that within VA the continued enhanced MHI funding has not been promised or assured. It is critical that these programs and the UMHS package be fully implemented and then maintained over time, since, as was learned tragically after Vietnam, many veterans of that era first sought care long after the conflict had ended. Furthermore, we understand that VHA now proposes to move funding for these programs into the VERA process. We are concerned that if all new mental health funds were moved into VERA and mixed with other medical care funds allocated to the VISNs, mental health and substance-use disorder programs will again be at risk for erosion. In fact this has been the case in the past when mental health and substance-use disorder funds were allocated under VERA and were required to compete directly with other acute care programs.

Based on these findings, it is still unclear if sufficient resources have been authorized given the comprehensive requirements outlined in the UMHS handbook (approximately 400 mental health services). In our opinion, there is still much to be done to assure equity of access to mental health services for all veterans enrolled in and using the VA health care system. According to the OMHS, following the development of the UMHS handbook, each facility mental health chief was asked to prepare an analysis comparing the services identified in the handbook to the services they already provided at their facility. We understand that this analysis (one that VA has not released to Congress or the veterans service organization community) did not reflect the full recommendations made by mental health staff asked to complete the survey with regards to the actual number of full-time employee equivalents (FTEE) needed, in their estimation, to implement and carry out the services required in the UMHS handbook. Furthermore, we understand it did not fully take into account many important factors such as the cost and effort required to provide newer evidence-based treatments for priority conditions such as PTSD, or the extra efforts required to hire, train and orient new providers to VA, and to launch the new programs they would be expected to then manage.

We also point out that the IG report does not specifically focus on the availability and accessibility of early intervention services. When combat veterans return from war, it seems there is a tendency to underestimate and ignore the early signs of psychological distress. At a recent Department of Defense (DoD) conference, we understand that one expert inferred that a significantly higher percentage than we are seeing in the current literature (70 percent, versus 30 percent or less), of servicemembers and veterans who were in harm's way during their deployments experience some level of residual stress and may incur resulting problems that need DoD or VA attention.[3] According to mental health experts, these problems often first surface and come to the attention of the veteran or family members and friends, and manifest as relationship and marital problems, problems at work or school, or newly uncharacteristic and hazardous use of alcohol or other substance-use disorders. A number of new research studies underscore this point.[4] These symptoms often indicate broader problems needing attention. When a veteran approaches VHA with one of these early signs, VA must have available a user-friendly, accessible early intervention program that immediately provides the services identified (e.g. early substance use disorder services or relationship counseling). Also, we believe VA should be able to use such opportunities to further assess the veteran for other health problems needing VA's attention. If the veteran encounters a complicated, bureaucratic system, where services are fragmented, complicated, delayed or not available, he or she will likely reject VA. Thereby, VA loses an opportunity to address such problems early on, when early interventions can have a long-term and even life-saving impact. At minimum, later interventions in chronic illness will be more expensive and even more complicated. Data from a newly published VHA national study of 1,530 users of VHA outpatient services underscores the challenge. While 40 percent of the sample screened positive for potentially hazardous alcohol use and 22 percent

[3] Castro C. Oral Remarks at the Combat Stress Intervention Program Research Conference on Post Deployment Challenges: What Research Tells Practitioners. Washington and Jefferson College. April 4, 2009.

[4] Scotti J, Crabtree M and Bennett E. Presentation at Combat Stress Intervention Program Research Conference on Post Deployment Challenges: What Research Tells Practitioners. Washington and Jefferson College. April 4, 2009.

screened positive for full alcohol abuse, only 31percernt of those who screened positive reported being counseled about their hazardous alcohol use.[5]

Although there are many programs that support OIF/OEF veterans, few are true outreach programs designed to motivate veterans to take action to address their behavioral health concerns. However, the DAV recently learned about one such program in VISN 12—the "VetAdvisor Support Program." VetAdvisor is a proactive, telephonic outreach program that employs techniques to identify veterans (rural, suburban, and urban) who may be in need of behavioral health care and then helps to connect them directly to their local VA facilities.

VetAdvisor provides "Care Coaches" who are licensed, trained and experienced behavioral health clinicians. Through a series of VA-approved screenings, the Care Coaches telephonically assess veterans for medical and behavioral health conditions associated with serving in combat. The results of such screenings are provided to the VA facility concerned for follow-up and further evaluation.

VetAdvisor also incorporates an extended solution-focused Care Coaching Program (i.e., non-medical facilitation) which is provided telephonically or through virtual collaboration technology. The program is designed to recognize behavioral challenges and empower veterans to successfully overcome setbacks. The Care Coaches employ motivational interviewing techniques, with an emphasis on encouraging change.

We understand that the VetAdvisor concept was piloted in VISN 12 to a population of over 5,000 veterans and after positive screenings, directed over 1,100 veterans to VA facilities for follow-up services. We see the expansion of this pilot program as one possible alternative to increasing outreach to OIF/OEF veterans who may otherwise fall through the cracks and go untreated. As we have learned from Vietnam, later on in life untreated sick and disabled veterans often discover VA, but are much more challenging cases for whom to provide assistance.

While we agree with the OIG that implementation of the UMHS handbook is an ambitious effort, it must be approached with a clear recognition that delays in immediate implementation inflict a heavy cost on those who have honorably served their country. We strongly believe that comprehensive and detailed oversight and monitoring is imperative at this juncture if immediate progress in filling critical gaps in mental health services across the nation is to be assured and recovery is to be fully embraced.

The oversight process we envision in mental health would be a constructive one that is helpful to VA facilities, rather than punitive. It should be data-driven and transparent, and should include local evaluations and site visits to factor in local circumstances and needs. Such a process could assure that immediate progress is made in achieving the goal of the VA MHSP and UMHS package to provide easily accessible and comprehensive mental health services equitably across the nation.

An empowered VA organizational structure should be established within VA to assure that this oversight process is robust, timely and utilizes the best clinical and research knowledge available. Such a structure would require VHA to collect and report detailed data, at the national, network and medical center levels, on the net increase over time in the actual capacity to provide comprehensive, evidence-based mental health services. Using data available in current VA data systems, such as VA's payroll and accounting systems, supplemented by local audited reports where necessary, could provide information down to the medical center level on at least the following from the period of fiscal year 2004 to the present fiscal year:

- the number of full-time and part-time equivalents of psychiatrists and psychologists;
- the number of mental health nursing staff;the number of social workers assigned to mental health programs;
- the number of other direct care mental health staff (e.g. counselors, outreach workers);
- the number of administrative and support staff assigned to mental health programs;
- the total number of direct care and administrative FTEE for all programs, mental health and others, and as a basis for comparison;
- the number of unfilled vacancies for mental health positions that have been approved, and the average length of time vacancies remain unfilled.

The current practice of reporting only the number of offers made to prospective new mental health staff members, and not the number who are actually on board, should be immediately halted, since we know there are often lags of several months

[5] Calhoun PS, Elter JR, Jones ER, Kudler H, Straits Troster K. Hazardous Alcohol Use and Receipt of Risk Reduction Counseling Among U.S. Veterans of the Wars in Iraq and Afghanistan. Journal of Clinical Psychiatry, 69, 1686–93. November 2008.

in actually bringing these new clinicians on board, getting them trained and finally seeing patients.

VA should also develop an accurate demand model for mental health and substance-use disorder services, including veteran users with chronic mental health conditions and projections for the unique needs of OIF/OEF veterans. This model development should be created in coordination with the VA mental health strategic planning process and include estimated staffing standards and optimal panel sizes for VA to provide timely access to services while maintaining sufficient appointment time allotments.

Assuming the creation of these resource tools, Congress should also require VA to establish an independent body, a "VA Committee on Veterans with Psychological and Mental Health Needs," (or a similar title) with appropriate resources, to analyze these data and information, supplement its data with periodic site visits to medical centers, and empower the Committee to make independent recommendations to the Secretary of Veterans Affairs and to Congress on actions necessary to bridge gaps in mental health services, or to further improve those services. Membership on the Committee should be made up from VA mental health practitioners, veteran users of the services and their advocates, including veterans' service organizations and other advocacy organizations concerned about veterans and VA mental health programs. The site visit teams should include mental health experts drawn from both within and outside VA. These experts should consult with local VA officials and seek consensual, practical recommendations for improving mental health care at each site. This independent body should be responsible for synthesizing the data from each of the sites visited and make recommendations on policy, resources and process changes necessary to meet the goals of the MHSP and UMHS Handbook.

In addition to these changes, VA should be directed to conduct specialized studies, under the auspices of its Health Services Research and Development Program and/or by the specialized mental health research centers such as the Mental Illness Education, Research and Clinical Centers (MIRECCs) in several sites, the Seriously Mentally Ill Treatment, Research Education and Clinical Center (SMITREC) in Ann Arbor; and the Northeast Program Evaluation Center in West Haven, among others, on equity of access across the system; barriers to comprehensive substance use disorders rehabilitation and treatment; early intervention services for harmful/hazardous substance use; couples and family counseling; and programs to overcome stigma that inhibits veterans, particularly newer veterans, from seeking timely care for psychological and mental health challenges.

As an additional validation, we believe that the Government Accountability Office (GAO) should be directed to conduct a follow on study of VA's mental health programs to assess the progress of the implementation phase of the MHSP, the status of the UMHS Handbook at the end of 2009, and to provide its independent estimate of the FTEE necessary for VA to carry out the above-noted program initiatives. Congress should also require GAO to conduct a separate study on the need for modifications to the current VERA system to incentivize VA's fully meeting the mental health needs of all enrolled veterans.

We believe the ideas above—ideas that we have gleaned from a number of mental health and research professionals both within and outside of VA, and from scientific literature, are necessary to fully ensure VA is moving its mental health policy and program infrastructure in a proper direction, and with the sense of urgency that the current shortfalls require. We believe it is essential that VA provide immediate evidence-based mental health services for all veterans returning from wartime deployments, including time-sensitive early intervention services before VA misses the opportunity to restore these veterans to a level of full functioning.

Also, we urge this Subcommittee, which would be the major recipient of this new approach to reporting true VA mental health capacity, to continue to provide VA strong oversight to assure VA's mental health programs, and the reforms it is attempting, meet all their promises, not only for those coming back from war now, but for previous generation of veterans who need these specialized services.

In summary, while much progress has been achieved toward reforming VA mental health care and the programs that provide it, many more challenges lie ahead for VA to achieve the level and scope of reforms VA has laid out as its near-term goal. We again call your attention to DAV's testimony[6] at your March 3, 2009, legislative hearing with respect to H.R. 784, a bill introduced by Ms. Tsongas. That testimony embraced many similar points that we raise again today. We believe comprehensive, independent oversight is crucial to assure veterans and their advocates, including

[6] Ilem, J Statement of the Disabled American Veterans before the Committee on Veterans Affairs, Subcommittee on Health, U.S. House of Representatives, 3–3–09 http://www.dav.org/voters/documents/statements/Ilem20090303.pdf.

DAV, that current mental health policy mandates outlined in the UMHS handbook and MHSP, with stable, predictable funding augmentations, truly result in appropriate high quality treatment and immediate access to critically important mental health services for all veterans who need them. This is as important for older generations of disabled war veterans with chronic mental health problems, as it is for our newest generation of veterans from Iraq and Afghanistan, some of whom are surely suffering from more acute forms of these mental health challenges and readjustment difficulties. We urge the Subcommittee to act with dispatch to address these responsibilities.

Mr. Chairman, this concludes my statement. I will be pleased to respond to any questions you may wish to ask with regard to these issues.

Prepared Statement of Ralph Ibson
Senior Fellow for Health Policy, Wounded Warrior Project

Chairman Michaud, Ranking Member Brown and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to offer our views on VA's progress in meeting the mental health needs of our veterans, with particular emphasis on VA's mental health strategic plan, its uniform mental health services handbook, and the funding to support those initiatives.

The Wounded Warrior Project brings an important perspective to these issues in light of the organization's goal—namely to ensure that this is the most successful, well-adjusted generation of veterans in our Nation's history. That perspective provides the framework for our testimony this morning.

Wounded Warrior Project was founded on the principle of warriors helping warriors, and we pride ourselves on outstanding service programs built on that principle. Our signature service programs include peer mentoring, adaptive sporting events, and Project Odyssey—a potentially life-changing program that engages groups of veterans with combat stress and post-traumatic stress disorder in outdoor adventure activities that foster coping skills and provide support in the recovery process. WWP aims to fill gaps—both programmatic and policy—to help wounded warriors thrive. We recognize, of course, the critical role that the Department of Veterans Affairs can and must play in providing needed health care services to wounded veterans. We welcome the opportunity, accordingly, to offer our views on VA's progress in meeting veterans' mental health needs.

That progress certainly owes much to this Committee's leadership over the years in highlighting the importance of veterans' mental health and pressing to reverse the underfunding of VA mental health programs. Oversight hearings like this one are vital to sustaining the gains that have been made, and realizing goals that have not yet been fully attained.

Mental Health: A Vital VA Mission

We have certainly come a long way in this country in understanding the importance of mental health, and in diminishing the stigma that for too long surrounded mental illness and mental health treatment. We have come to understand that mental health is integral to overall health. We know too that mental health problems are a leading cause of disability. Yet mental disorders can be readily diagnosed and treated. Those who do not get that needed treatment, however, likely face a more difficult reintegration into their communities, and are at increased risk for chronic illness, poor general health, and unemployment.

VA's role as a provider of mental health care is particularly important. Recently, the Institute of Medicine reported trends in the numbers of veterans receiving disability compensation for a primary rated disability (which is defined as either the condition rated as the most disabling or equal to the highest rated condition). From 1999 to 2006, of all veterans receiving disability compensation, the primary rated disability diagnosis category with the largest percentage increase was major depression (474-percent increase). Two other mental health categories—"other mood disorders" and PTSD—experienced increases of 264 percent and 126 percent respectively.[1] While some 5.5 million veterans use VA health care services annually, most veterans have other health care coverage and do not rely on the VA health care system. Veterans who need mental health care, however, generally do not have good alternatives. Neither Medicare nor most employer-provided health plans cover the

[1] Institute of Medicine and National Research Council of the National Academies, *PTSD Compensation and Military Service* (Washington, DC: The National Academies Press, 2007), 145.

broad range of mental health services recommended by the Institute of Medicine, the Surgeon General, and the 2003 report of the President's New Freedom Commission on Mental Health. As a system, VA provides a broad range of services not generally available through other programs, but its facilities are not easily accessible to all veterans. Given the limited mental health coverage available through non-VA sources, it is particularly important that VA maintain and indeed augment its capacity to provide veterans such needed services.

OIF/OEF Veterans

Recent research indicates that we face substantial mental health challenges as a result of our engagement in Iraq and Afghanistan. A widely cited longitudinal study reports that some 20 percent of active duty returning servicemembers and 42 percent of reserve component soldiers were found to need mental health treatment.[2] VA reports that mental disorders are among the three most common health problems experienced by new veterans who seek VA care. VA's experience and research data suggest that we can expect the number of OIF/OEF veterans with mental health problems to increase. While PTSD is especially prevalent among veterans seeking VA care, the literature also makes clear that PTSD often co-occurs with other mental health disorders, particularly depression, anxiety, and substance-use disorders. Indeed one study reports that there is an 80 percent likelihood that a patient with PTSD will also meet diagnostic criteria for at least one other mental health disorder.[3] These substantial co-morbidities have been linked to significant impairment in social and occupational functioning, as well as to suicide. As this Committee knows, there has been a dramatic increase in the number of soldiers who have attempted or committed suicide since 2003.

VA has acknowledged that it is experiencing an increase in the numbers of OIF/OEF veterans treated for mental health disorders, and expects a further increase. That trend is concerning. Yet VA officials have maintained that the increased workload associated with mental health problems among returning veterans is manageable. We question that view, given our understanding that there is already a significant vacancy rate in VA mental health staffing and a nationwide shortage of mental health clinicians. While VA policy has encouraged facilities to use community resources to obtain needed mental health care when VA cannot provide needed services or where VA care would be geographically inaccessible to the veteran, community providers rarely have expertise in addressing military trauma. Moreover, sources of community-based mental health care do not exist in many parts of the country. Half the counties in the United States do not have a single mental health professional, according to a recent Federal report.[4]

Compounding the challenges associated with the increasing numbers of OIF/OEF veterans with mental health problems, it seems clear that VA is not reaching all who need mental health care. It is striking, for example, that of the veterans RAND surveyed, only about half of those with a probable diagnosis of PTSD or major depression had sought help from a health professional.[5] Another study found that approximately 60 percent of all ground combat troops in Iraq who screened positive for PTSD, generalized anxiety or depression did not seek treatment.[6] RAND suggested a number of factors that may inhibit some returning veterans from seeking VA mental health treatment, including the stigma associated with seeking mental health treatment, concerns about confidentiality, perceptions about feeling out of place among older patients in VA facilities, attitudes about the effectiveness of mental health treatment and medications, and logistical barriers.[7] The experience of

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[2] Charles S. Milliken, Jennifer L. Auchterlonie, and Charles W. Hoge, "Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq War," *Journal of the American Medical Association 298*, no. 18 (2007): 2143.

[3] RC Kessler, A Sonnega, E Bromet, M Hughes and CB Nelson, "Posttraumatic stress disorder in the national comorbidity survey," Archives of General Psychiatry 52, 1995: 1048–1060. As cited in Matthew Friedman, "Posttraumatic stress disorder among military returnees from Afghanistan and Iraq," *American Journal of Psychiatry 163*, no. 4, 2006: 589.

[4] Annapolis Coalition on the Behavioral Health Workforce, "An Action Plan for Behavioral Health Workforce Development, Executive Summary," report prepared for the Substance Abuse and Mental Health Services Administration (SAMHSA), 2007.

[5] Terri Tanielian, Lisa Jaycox, Terry Schell, Grant Marshall, M. Audrey Burnam, Christine Eibner, Benjamin Karney, Lisa Meredith, Jeanne Ringel, Mary Vaiana, and the Invisible Wounds Study Team, *Invisible Wounds of War: Summary and Recommendations for Addressing Psychological and Cognitive Injuries* (Santa Monica, CA: The RAND Corporation, 2008), 13–14.

[6] Charles Hoge, Carl Castro, Stephen Messer, Dennis McGurk, Dave Cotting and Robert Koffman, "Combat duty in Iraq and Afghanistan, mental health problems, and barriers to care," *The New England Journal of Medicine 351*, no. 1, 2004:16.

[7] Terri Tanielian, Lisa Jaycox, Terry Schell, Grant Marshall, M. Audrey Burnam, Christine Eibner, Benjamin Karney, Lisa Meredith, Jeanne Ringel, Mary Vaiana, and the Invisible

some of our wounded warriors and their family care givers indicate some inconsistency in outreach efforts, and suggest that the goal of a "seamless transition" from DoD to VA has yet to be fully realized.

Also troubling are reports that veterans with a co-occurring substance-use disorder—a high risk category—are less likely to use VA mental health services than those who simply have a mental health disorder. One study found that only 3 percent of OIF/OEF veterans surveyed who had co-occurring PTSD and a substance-use disorder actually received chemical dependency treatment, although evidence-based care calls for integrated treatment of these co-occurring conditions.[8]

Veterans with untreated mental health problems can face long-term consequences both in terms of their ability to reintegrate successfully in their communities as well as to their overall health. PTSD, for example, is associated with reported reductions in quality of life across several domains, including general health, energy, emotional well-being, emotional role limitation, physical role limitation, and social functioning. Studies have shown a strong correlation between PTSD and physical health measures, including missed workdays, among this generation of veterans.[9] Studies have also linked PTSD with illnesses such as cardiovascular disease,[10] nervous system disease,[11] and gastrointestinal disorders.[12] Given the potential chronicity of mental health conditions, a failure to intervene early and effectively could have profound long-term costs for this generation of veterans as well as for society, including lost productivity, reduced quality of life, strain on families, domestic violence, and homelessness.

VA's Strategic Mental Health Plan

With those concerns as background, we acknowledge that VA has taken important steps toward refocusing the system to meet veterans' mental health needs. In 2004, VA developed a strategic plan to transform mental health care in the VA. The plan was built on the foundation of the President's New Freedom Commission on Mental Health, one of whose core principles remains vitally important to the mental health of our newest generation of veterans. That "blue ribbon" Commission emphasized that the goal of mental health care must be recovery—not simply the management of symptoms. By recovery, the Commission meant an individual's being able to live a fulfilling, productive life in the community—even with a mental health condition that may elude "cure."

VA became the first Federal department to embrace the Commission's recommendations, and VA's strategic plan was hailed for the breadth and boldness of its vision. Among its key elements were:

- Adoption of the recovery model, emphasizing each veteran's rehabilitation;
- Integration of medical and mental health care to ensure coordinated, comprehensive care;
- Providing veterans equitable access to a comprehensive continuum of mental health services; and
- Intervening early to identify and address mental health needs among returning OIF/OEF veterans.

Wounds Study Team, *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (Santa Monica, CA: The RAND Corporation, 2008): 282, 301, 278, 302.

[8] Christopher Erbes, Joseph Westermeyer, Brian Engdahl and Erica Johnsen, "Post-traumatic stress disorder and service utilization in a sample of servicemembers from Iraq and Afghanistan," *Military Medicine 172*, no. 4, 2007: 359.

[9] Charles Hoge, Artin Terhakopian, Carl Castro, Stephen Messer and Charles Engel, "Association of posttraumatic stress disorder with somatic symptoms, health care visits, and absenteeism among Iraq war veterans," *American Journal of Psychiatry 164*, no. 1, 2007:151–2.

[10] Laura Kubzanksy, Karestan Koenen, Avron Spiro III, Pantel Vokonas and David Sparrow, "Prospective study of posttraumatic stress disorder symptoms and coronary heart disease in the normative aging study," **Archives of General Psychiatry 64**, no.1, 1997: 112–3.

[11] J Boscarino, "Diseases among men 20 years after exposure to severe stress: Implications for clinical research and medical care," *Psychosomatic Medicine 59*, no. 6, 1997: 604–14. As cited in Jennifer Vasterling, Jeremiah Schumm, Susan Proctor, Elisabeth Gentry, Daniel King and Lynda King, "Posttraumatic stress disorder and health functioning in a non-treatment-seeking sample of Iraq war veterans: A prospective analysis," *Journal of Research & Development 45*, no. 3, 2008: 348.

[12] P Schnurr, A Sprio III and A Paris, "Physician-diagnosed medical disorders in relation to PTSD symptoms in older male military veterans," *Health Psychology 19*, no. 1, 2000: 91–97. As cited in Jennifer Vasterling, Jeremiah Schumm, Susan Proctor, Elisabeth Gentry, Daniel King and Lynda King, "Posttraumatic stress disorder and health functioning in a non-treatment-seeking sample of Iraq war veterans: A prospective analysis," *Journal of Research & Development 45*, no. 3, 2008: 348.

The plan documented large areas of unmet current and future need, and candidly acknowledged that closing those gaps and realizing its goals would require an expansion of facilities, services, and personnel—in short, vibrant funding—as well as fundamental changes in culture.

Last year, VA took its strategic mental health plan a step further in issuing a Uniform Mental Health Services Handbook. That far-reaching directive, for the first time, established a policy calling for a "Uniform Services Package"—a requirement that veterans must be afforded access to a specific array of needed mental health services, regardless of where they live.

The question underlying this hearing—what has been VA's progress in meeting the mental health needs of our veterans?—is critically important as we approach the 5 year mark since adoption of the strategic mental health plan. That question is also vitally important as the Department is apparently moving toward ending a several-year long special funding initiative that had supported the strategic plan's implementation.

The VA has clearly made major strides in carrying out many of the plan's near-term initiatives and in closing the size of the gaps that had been identified. But gaps and wide variability in programs remain. By way of illustration:

- While the strategic plan acknowledges the importance of specialized PTSD treatment services for returning veterans, our warriors have experienced both long waits for inpatient care and a dearth of OIF/OEF-specific programs. (Young veterans with acute PTSD understandably question how they can be expected to feel confident about treatment when placed into treatment programs with older veterans who have been struggling with chronic PTSD and other health problems for decades.)
- For the first time, VA policy—as reflected in the new 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. That policy has particular relevance to the large number of OIF/OEF veterans who live in rural areas and for whom VA facilities are often geographically accessible. We understand, however, that VA facilities have made only very limited use of this new authority. Moreover, the new policy makes no provision for assuring that community mental health professionals have appropriate expertise to effectively treat veterans with combat-related mental health conditions.
- VHA has employed special mental health funding to support major efforts to train VA clinicians in two evidence-based therapies for treatment of PTSD. But no comparable initiative has been mounted to ensure integrated or coordinated care of co-occurring PTSD and substance-use disorders, one of the many requirements of the uniform services handbook. Integrated treatment of these often co-occurring health problems appears to be the exception rather than the rule in VA facilities.
- Mental health care is increasingly being integrated into primary care clinics; but at any given medical center or large clinic, mental health may be integrated into only a single one of its primary care teams.
- VA facilities have yet to fully incorporate recovery-oriented services, including peer-support programs, into their care-delivery programs.

Re-examining VA's Strategic Plan

The overarching vision underlying VA's strategic plan is sound. But a strategic plan, by its very nature, should be revisited periodically. While the current plan continues to provide a credible foundation, we encourage the Committee to press the Department to re-examine that blueprint and take account of what has changed in the nearly 5 years since the plan's adoption. For example, it is not clear that the plan anticipated the increased prevalence of PTSD and other behavioral health conditions affecting this and other generations of veterans. Another example is that the plan emphasizes screening as a tool to foster early intervention services, but fails to address the problem of veterans who are identified in screening as likely needing follow-up, but who elect not to pursue further evaluation or treatment.

The strategic plan also includes initiatives to foster peer-to-peer services but does so only in the context of veterans with severe mental illnesses (such as schizophrenia and bipolar illness). In WWP's experience, peer support can be powerful in helping OIF/OEF veterans cope with PTSD, and there is ample research to suggest that peers' social support is an important influence on psychological recovery and rehabilitation. Moreover, we see evidence that this generation of veterans value peer-services. To illustrate, a recent WWP survey of wounded warriors with whom we have worked showed that:

- 75 percent of respondents reported that talking with another OIF/OEF veteran was helpful in dealing with mental health concerns;
- 56 percent expressed the belief that peer-to-peer counseling would be helpful in addressing their mental health concerns; and
- 43 percent reported that talking with another OEF/OIF veteran had been the one most effective resource in helping with mental health concerns.

In short, a revised strategic plan should, in our view, promote the use of such peer-to-peer supports for wounded warriors with mental health needs, without regard to diagnosis.

VA Mental Health Funding

Whether we gauge VA's progress in meeting the mental health needs of our veterans through the lens of its 2004 strategic plan, or—as we recommend—in the context of an updated strategic plan, WWP believes the transformation of VA's mental health delivery system remains a work in progress. Given that view, and given the unique importance of VA's mental health mission, it is critical to sustain robust funding for VA mental health programs.

As VA officials have previously testified, the Veterans Health Administration (VHA) has allocated special funding in the form of a "Mental Health Initiative" every year since Fiscal Year 2005 to implement the Mental Health Strategic Plan. It is our understanding that VHA allocated some $600 million in special funding for mental health this fiscal year. Funds supporting this initiative have supplemented the resources provided through VA's resource allocation system, VERA.

Without question, VA's special mental health funding has supported a very substantial increase in the Department's mental health workforce, the development of new programs at many facilities, and expansion of existing services at others—consistent certainly with a bold vision of system "transformation." It is our understanding, however, that special funding will be phased out next year, with 90 percent of those special funds reverting to VHA's general health care funds, to be allocated through the VERA process.

The implications of that shift could be profoundly detrimental, given that veterans' mental health care needs—during a still-evolving major strategic transition—would no longer be subject to a special funding mechanism. Instead, as the General Accounting Office and other oversight entities have reported, moneys would be allocated to the networks under the VERA process based primarily on the *numbers* of veterans under treatment without any new funding or fiscal incentives to improve the intensity of care provided current patients. Yet improved patient care is precisely what the Strategic Plan aims to achieve. It is not at all clear that any targeted funding mechanism has been devised to sustain the gains that have been made in VA mental health care and to support those initiatives that have yet to be completed. In short, VA network directors and facility directors—who are charged to continue implementation of the strategic plan and the uniform services handbook, but who face an end of special mental health funding—may well be left with an unfunded mandate. Given that conundrum, there is a great risk that critical policy goals will not be realized, and that prior gains will be eroded.

It seems clear that policy goals critical to meeting the mental health needs of current veterans, and any surge of new veterans likely to need VA care, will not be met or sustained without either changing the resource allocation system or revisiting prior decisions regarding special mental health funding. Given the profound transformation in VA mental health service-delivery still underway, we urge continued strong oversight to ensure that the Department has a sound funding plan to support and sustain its still evolving mental health transformation.

We recognize that funding alone will not achieve a real system transformation. Leadership is equally critical. With that in mind, VA must ensure adequate resources are allocated to mental health programming. At the same time, the Department must closely monitor and evaluate program implementation, and report at least annually to Congress on its progress. That combination of adequate mental health funding and keen oversight offer the best promise, in our view, for ensuring that we meet the mental health needs of our veterans, and fostering the goal of ensuring that this generation of wounded warriors is the most well-adjusted, mentally healthy generation of veterans in our history.

Prepared Statement of Michael L. Shepherd, M.D.
Senior Physician, Office of Healthcare Inspections
Office of Inspector General, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to testify today regarding VA's progress toward meeting the mental health needs of our veterans. I will focus on the results of two reports that we recently released in this area: *Healthcare Inspection—Implementation of Veterans Health Administration's Uniform Mental Health Services Handbook and Audit of Veterans Health Administration Mental Health Initiative Funding*. I am accompanied by Larry Reinkemeyer, Director of the Office of Inspector General's (OIG) Kansas City Audit Operations Division, who directed the audit project.

Background

The 2003 President's New Freedom Commission Report identified 6 goals and made 19 broad recommendations for transforming the delivery of mental health services in the United States. In 2004, the Veterans Health Administration (VHA) developed its 5-year Mental Health Strategic Plan (MHSP) that included more than 200 initiatives. Because the MHSP is organized by the goals and recommendations of the Commission's report rather than by a mental health program or operational focus, some MHSP initiatives do not delineate what specific actions should be carried out to achieve these goals and are not readily measureable.

The VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, issued in June 2008 and updated in September 2008, establishes minimum clinical requirements for VHA mental health services. The handbook outlines those services that must be provided at each VA Medical Center (VAMC), and services required by the size of community based outpatient clinics (CBOCs).

Although there is overlap between MHSP and handbook items, the handbook more clearly defines specific requirements for services that must be provided (i.e., those services that must be delivered when clinically needed to patients receiving health care at a facility by appropriate staff located at that facility) and those that must be available (i.e., those that must be made accessible when clinically needed to patients receiving health care from VHA). The handbook has an operational focus and is organized by mental health program areas (e.g., Homeless Programs) rather than by broader Commission goals. The handbook notes that "when fully implemented these requirements will complete the patient care recommendations of the Mental Health Strategic Plan and its vision of a system providing ready access to comprehensive, evidence-based care."

Overall, VA medical facilities are expected to implement the handbook requirements by the end of fiscal year (FY) 2009. Each Veterans Integrated Service Network (VISN) must request approval from the Deputy Under Secretary for Operations and Management for modifications and exceptions for requirements that cannot be met in FY 2009 with available and projected resources.

Healthcare Inspection—Implementation of VHA's Uniform Mental Health Services Handbook

Because there are over 400 implementation items in the handbook, we limited the scope of our review to the medical center level where full implementation is more likely to occur prior to CBOC level implementation. Accordingly, the extent of implementation presented in the findings represents the highest level currently attained for the system as a whole.

Given the dimension of the handbook, a comprehensive review of the extent of implementation is challenging. Based on our clinical judgment, we chose 41 items from the handbook to evaluate for implementation. We believe the items chosen reasonably estimate the present extent of handbook implementation at the medical center level. Implementation of the handbook is an ongoing process and the data presented does not capture partial implementation.

We found that 31 of the 41 items reviewed were implemented at more than 75 percent of VAMCs. For example, evening mental health clinic hours were in place at 99 percent of VAMCs. As another example, Mental Health Intensive Case Management programs were in place at 100 percent of facilities with more than 1,500 seriously mentally ill (SMI) patients from the VA National Psychosis Registry. A complete listing of items reviewed and implementation rates is included at the end of the statement.

We identified the following items indicative of areas in which VHA is at risk for not meeting the implementation goal:

- Ensuring a follow-up encounter within 1 week of discharge from an inpatient mental health unit.

- Accessing timely a VISN specialized post-traumatic stress disorder (PTSD) residential program.
- Providing Intensive Outpatient Services (at least 3 hours per day at least 3 days per week) for treatment of substance use disorders.
- Availability of 23-hour observation beds.
- Availability of substitution therapy for narcotic dependence.
- Providing a psychosocial rehabilitation and recovery center program at facilities with more than 1,500 SMI patients.
- Availability of peer support counseling for SMI patients.
- The presence of at least one full-time psychologist to provide clinical services to veterans in VA community living centers (formerly nursing home care units) with at least 100 residents.

Additionally, we are concerned that while a section of the handbook addresses access to specific evidence-based psychotherapies and somatic therapies, it appears that VA does not have in place a system to reliably track provision and utilization of these therapies on a national level. VHA's Office of Mental Health Services (OMHS) began a system-wide effort to train VA clinicians in core mental health disciplines in cognitive processing therapy for PTSD in the summer of 2007 and in prolonged exposure therapy in the fall of 2007. Evidence-based PTSD therapies are relatively time and labor intensive, requiring regular sessions for multiple and consecutive weeks. At a given facility, factors limiting provision and/or utilization of available evidence-based PTSD therapies may include the number of trained providers; availability of provider time, especially at medical centers in areas where there is a high concentration of returning Operation Iraqi Freedom/Operation Enduring Freedom veterans; geographic distance to care; availability of mental health providers in rural areas; and patient preference for other treatment choices. Implementation of a national system to track provision of evidence-based PTSD therapies and their utilization by returning veterans would allow for a population-based assessment of treatment outcomes with implications for treatment of other veterans presenting for PTSD-related care.

Program evaluation and development of mental health outcome measures can be challenging. While VA has relevant performance measures and systems in place to monitor handbook implementation, VA should develop outcome measures where feasible to allow for dynamic refinement of program requirements in order to meet changes in mental health needs and to optimize treatment efficacy.

While this review contains items related to suicide prevention, we began a separate review of implementation of suicide prevention items in the handbook in January 2009. During our combined assessment program reviews, OIG inspectors have been conducting a focused, chart-based review of implementation. We will conclude our review in June 2009 and then issue a roll-up report on our findings.

Audit of Veterans Health Administration Mental Health Initiative Funding

In the FY 2008 budget submission to Congress, VHA requested $27.2 billion for medical services which included $360 million for the mental health initiative (MHI). Congress appropriated $29.1 billion to VHA for medical services but did not specify an amount for the MHI. In FY 2008, VHA augmented the $360 million it requested for the MHI with funds received as part of its overall funding for medical services and allocated $371 million to medical facilities for the MHI.

OMHS refined their method of allocating the MHI funding over the years. In FYs 2005 and 2006, OMHS allocated MHI funds to medical facilities based on proposals that detailed the specific projects and how the facilities would spend those MHI funds. In FY 2007 and 2008, OMHS allocated funds to continue the initiatives started in prior fiscal years (primarily to pay the salaries of MHI staff already hired) and to implement selected new nationwide initiatives, such as having a Suicide Prevention Coordinator at each facility.

In the FY 2008 VA budget submission, VHA requested funding to provide resources to continue the implementation of the MHI. VHA allocated these funds to programs that covered the specific initiatives identified in the MHSP.

Our objective for this audit was to determine if VHA had an adequate process in place to ensure funds allocated for the MHI were tracked and used accordingly. We found that VHA staff adequately tracked $371 million allocated for the MHI in FY 2008. At the six locations reviewed (New York, NY; Miami, FL; Milwaukee, WI; Jackson, MS; Alexandria, LA; and San Diego, CA), medical facilities' fiscal staff established multiple fund control points and tracked salary and purchase order costs for the MHI. VHA's Office of Finance staff compared the amounts spent to the amounts allocated. OMHS staff used reports from medical facilities to track the hiring status of MHI positions. Although our review covered only FY 2008 processes, in FY 2009, the Office of Finance established standardized account classification

codes for MHI funds that could further enhance transparency and accountability over how MHI funding is spent in the future.

We also found that medical facilities used funds allocated for MHI as intended. VHA allocated $19.4 million for the MHI to the six medical facilities we reviewed and confirmed that $18.2 million (94 percent) of the $19.4 million were used for the MHI. The remaining $1.2 million consisted of numerous small dollar purchases; therefore, we reviewed those purchases only to the extent we were able to confirm the funds were used for mental health.

Conclusion

We believe that VHA Handbook, *Uniform Mental Health Services in VA Medical Centers and Clinics*, is an ambitious effort to enhance the availability, provision, and coordination of mental health services to veterans and that VHA has made progress in implementation at the medical center level. Because our review was limited to medical centers, we plan to conduct a review in FY 2010 on implementation at the CBOC level where such factors as geographic distance to care and ability to recruit mental health providers may pose greater obstacles to implementation. In regard to MHI funding, we found that VHA adequately tracks and uses MHI funding as intended.

Mr. Chairman, thank you again for this opportunity to appear before the Subcommittee. We would be pleased to answer any questions that you or Members of the Subcommittee may have.

VHA Mental Health Services	Extent of Implementation (%)
Community Mental Health	
Collaboration with Vet Centers for Outreach	87
Gender-Specific Care and MST	
Separate and Secure Sleeping and Bathroom	97
Tracking of MST Treatment	82
Availability of evidence-based care for MST	96
24 Hours a Day, 7 Days a Week (24/7) Care	
24/7 ED On-Call MH Coverage	98
Urgent Care On-Call Coverage	100
Availability of 23 Hour Observation Beds	54
Inpatient Care	
Onsite Inpatient Care	79
Ability to Admit Involuntary Patients	92
Ambulatory Mental Health Care	
Follow-Up for new MH Patients	97
Evening MH Clinic Hours	99
Care Transitions	
Set MH Appointment Provided at Discharge	97
Seen for Follow-Up within 1 Week Post—Discharge	57
Specialized PTSD Services	
PCT or Specialized Clinic for Patients with PTSD	91
OIF/OEF Outpatient Clinic Specialized MH Clinic	65
(or) Specialized PTSD Services for OIF/OEF	96
Access to a VISN Specialized PTSD Program	91

VHA Mental Health Services	Extent of Implementation (%)
Ability to Reliably Access the VISN Program	73
Efforts to Address Concomitant PTSD and SUD	90
Coordination of PTSD and SUD Care	76
Substance Use Disorders	
Available Motivational Counseling	76
Treatment of Patients Awaiting Admission to Residential SUD Settings	94
Inpatient Withdrawal Management	95
Intensive Outpatient Services for SUD	71
Buprenorphine Opioid Agonist Therapy	38
(or) Methadone Opiate Substitution Therapy	20
SMI and Rehabilitation and Recovery Oriented Services	
MHICM Program if More than 1,500 SMI Patients	100
At Least 4 FTE MHICM Team Members	88
Presence of a Local Recovery Coordinator	93
PRRC Program if More than 1,500 SMI Patients	51
Social Skills Training	74
SMI Peer Counseling	60
Compensated Work Therapy	90
Homeless Programs and Incarcerated Vets	
Arrangements with Community Providers for Temporary Housing	93
At Least One Grant and Per Diem Arrangement	87
VISN Health Care for Reentry Veterans Specialist	95
Integrating Mental Health into Medical Care Settings and in the Care of Older Vets	
Integrated MH in Primary Care Clinics	78
At least 1 FTE Psychologist for 100 Bed CLC	67
FT Psychologist /Psychiatrist HBPC Core Team Member	81
Suicide Prevention	
Documentation of a Formal Risk Assessment	95
Suicide Prevention Coordinator in Place	95
Evidence Based Treatment	
Availability of CPT for PTSD	89
Availability of PE for PTSD	63

Prepared Statement of Ira Katz, M.D., Ph.D.,
Deputy Chief Patient Care Services Officer for Mental Health,
Veterans Health Administration, U.S. Department of Veterans Affairs

Good afternoon, Mr. Chairman and Members of the Subcommittee. Thank you for the opportunity to discuss VA's progress on meeting the mental health needs of our Veterans. I am accompanied today by Dr. Antonette Zeiss, Deputy Chief Consultant for Mental Health Services in the Veterans Health Administration (VHA), and Mr. James McGaha, Deputy Chief Financial Officer for VHA. With the support of Congress, VA has received record increases in mental health funding over the past several years, doubling our budget from the start of the war in Afghanistan to today. During this same time, VA developed and implemented the VHA Comprehensive Mental Health Strategic Plan (MHSP), and produced the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics to guide the sustained operation of its enhanced program. My testimony will address each of these areas today.

I will discuss VA's recognition of its need to enhance its mental health services, and its implementation of substantial enhancements within a highly compressed period of time. VA was able to do this because of the insight of VHA's senior leadership on the importance of mental health and the mental health needs of returning Veterans; the allocation of needed funding; and the mobilization of the entire system. Unique in America, VA is a provider of health and mental health care services, a payer, a policy environment, and a research organization. Moreover, coordination throughout the system is supported through an electronic health record. It is by aligning actions of all of the components of this integrated care system that VHA was able to achieve such significant progress.

In discussing VA's mental health services, it is important to provide information on their scale. Of the 5.1 million individual Veterans VA treated last year in its medical centers and clinics, approximately 1.6 million or 31 percent had a mental health diagnosis and 1.1 million or 22 percent were seen in mental health specialty care. Last year, VA provided care in ambulatory, residential care, or inpatient settings to 442,000 Veterans with a diagnosis of Post-Traumatic Stress Disorder (PTSD), making care for this condition an important part of its mental health program. The scope of the mental health needs for returning Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans may be even greater. Of the 400,304 OEF/OIF Veterans who received care at VA medical centers and clinics through the end of the fiscal year 2008, 178,493 (45 percent) had a possible mental health diagnosis, and 92,998 (23 percent) had possible Post-Traumatic Stress Disorder (PTSD). Among Veterans using VA health care services, the rates of mental health conditions and the use of mental health services are higher than these rates in the population as a whole. This probably suggests that those Veterans who need these services are more likely to seek care from VA. These issues are discussed below in more detail with respect to Post-Traumatic Stress Disorder in Veterans returning from Iraq and Afghanistan.

My testimony will begin by describing the Mental Health Strategic Plan and the Uniform Mental Health Services Handbook. From there, I will discuss three additional topics: program funding and metrics; other components of VA's overall mental health program; and a sampling of success stories, each of which has been made possible because of the advances achieved as a result of the Mental Health Strategic Plan and the Uniform Mental Health Services Handbook. We recognize these accomplishments, but we remain committed to outreach to Veterans who continue to suffer from mental health conditions without seeking treatment. As a matter of public health, it is important to emphasize to those Veterans that VA offers world-class mental health services and that Veterans in need of care can and should come to us for safe, effective and compassionate care.

Mental Health Strategic Plan and Uniform Mental Health Services Handbook

The VHA Comprehensive Mental Health Strategic Plan was developed in 2004 in response to the Department's recognition that its mental health programs needed enhancement. This plan helped VA identify gaps in the mental health services provided at the local level and to identify additional initiatives needed at the national level by reinforcing the principle that mental health was an important part of overall health. The 255 elements of the Plan could be divided into six key areas: (1) enhancing capacity and access for mental health services; (2) integrating mental health and primary care; (3) transforming mental health specialty care to emphasize recovery and rehabilitation; (4) implementing evidence-based care, with an emphasis

on evidence-based psychosocial treatments; (5) addressing the mental health needs of returning Veterans; and (6) preventing Veterans' suicides.

In 2005, VA began allocating funding for its Mental Health Enhancement Initiative. We allocated funds to promote specific programs that supported the implementation of the Mental Health Strategic Plan. These included:

- extending the mental health services available in community-based outpatient clinics (CBOCs), both by increasing the staff assigned to these clinics and by promoting telemental health services;
- establishing programs integrating mental health services with primary care, and with other medical care services including rehabilitation, geriatrics, and other medical specialties;
- establishing clinical programs and staff training to support the rehabilitation of those with serious mental illnesses in ways that help them pursue their own life goals;
- supporting the implementation of evidence-based care with a focus on evidence-based psychotherapies for PTSD, Depression, Anxiety, and Problem Drinking; and
- developing comprehensive and innovative programs designed to prevent suicide.

VA is currently in the fifth year of the implementation of the Mental Health Strategic Plan, and it is a critical time for us to evaluate our progress. Substantially more than 90 percent of the items in the plan that were aspirations in 2004 and 2005 are now part of ongoing operations and clinical practice. Mental Health staffing has increased by approximately 4,000 Full Time Equivalents from 14,000 to 18,000 since 2004. The proportion of America's Veterans who receive mental health services from VA has increased by 26 percent, and, over the same time, the continuity and intensity of care has also increased. For example, VA has modified its standard of care to require immediate care in urgent cases and an initial triage evaluation within 24 hours after a new request or referral for mental health services, and a full diagnostic and treatment planning evaluation within 14 days. We are now meeting the 14-day standard more than 95 percent of the time. Additionally, the number of outpatient mental health or substance abuse visits during the first 6 months after discharge from a mental health, substance abuse or dual diagnosis hospitalization increased by 15 percent or more.

In 2008, as VA approached the fifth year of the implementation of the Mental Health Strategic Plan, its task was to move from a focus on rapid transition to one of sustained delivery of a comprehensive array of services. This was the impetus for the new Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics (the Handbook), published in September, 2008. The Handbook establishes minimum clinical requirements for VA mental health services at the Veterans Integrated Service Network (VISN), facility, and Community Based Outpatient Clinic (CBOC) level, and delineates the essential components of the mental health program that are to be implemented nationally, to ensure that all Veterans, wherever they obtain care from VA, have access to needed mental health services. The Handbook specifically requires VA to assign a principal mental health provider to every Veteran seen for mental health services. This principal provider is responsible for maintaining regular contact with the patient, monitoring each patient's psychiatric medications, coordinating, developing and revising the Veteran's treatment plan, and following-up to ensure that the course of treatment reflects the Veteran's goals and preferences, and that it is working. The Handbook further requires each VISN and medical center to appoint staff responsible for working with state, county and local mental health systems and community providers to coordinate VA activities and care. In this, the goal is to ensure that the each VA facility is functioning as a part of its community, as well as a part of the national VA system of health and mental health care.

Other important features of the Handbook include requirements:

- Integrating mental health care into primary care settings, other medical care settings, and providing services for older Veterans;
- Mandating screening for common mental health conditions, with follow-up clinical evaluations for positive screens;
- Expanding first line treatments for substance use conditions within primary care and general mental health services;
- Identifying requirements for specialized treatment programs for PTSD and for mental health conditions related to military sexual trauma;
- Recognizing the need for gender-specific care;
- Staffing for 24-hours-a-day, 7-days-a-week care within VA emergency departments;

- Establishing requirements for substance use disorder programs and care;
- Employing evidence-based psychotherapies, including Cognitive Processing Therapy and Prolonged Exposure Therapy for PTSD and Cognitive Behavioral Therapy and Acceptance and Commitment Therapy for Veterans with anxiety or depression disorders;
- Reinforcing clear guidelines for suicide prevention programs; and
- Addressing the concerns of rural mental health care.

The Handbook is an important step forward. It is a tool that defines the mental health services that must be provided in all facilities and must be available to all Veterans. It also consolidates requirements for completing and sustaining the implementation of the clinical components of the Mental Health Strategic Plan. The Handbook guides VISNs and facilities in planning mental health programs and for the system as a whole for estimating care needs. It documents standards of care that can be translated into monitors for the scope and quality of services at each facility and in the system as a whole, while also serving as a guide, for Veterans and their families, and as a tool for processing treatment planning. Most importantly, the Handbook represents a firm commitment to Veterans, their families, advocates, and Congress about the nature of mental health services VA is prepared to provide to Veterans who need them. It has served as a conceptual model to guide planning for an approach to defining uniform health care services for the VA system as a whole.

Funding and Metrics

As discussed above, the VA Mental Health Enhancement Initiative has been successful as a catalyst, accelerating the implementation of the Mental Health Strategic Plan by augmenting the core mental health program funding with a separate funding source of approximately 15 percent for program enhancements and to support rapid innovations. The use of the VA's Mental Health Enhancement Initiative has created a partnership between VA Central Office, the VISNs, and the Medical Centers to demonstrate our commitment to maintaining the strengths of existing programs while at the same time reconfiguring and expanding them to meet new standards.

VA has dedicated dramatically more enhancement funds for mental health since FY 2005, increasing from $100 million in FY 2005 to $557 million in Fiscal Year (FY) 2009. These enhancement funds have paralleled overall mental health spending.

While we are pleased with the increased level of funding, the most important concern, however, must be maintaining programs that are effectively serving Veterans. At present, VA's goals must be to consolidate the gains of the past 4 to 5 years by implementing the Handbook and sustaining the operation of mental health services meeting this new standard. To achieve these goals, VA will ensure the implementation of the requirements of the Handbook at each medical center and clinic through a stringent series of monitors and metrics.

As part of this process, VA is developing methods and metrics for assessing the implementation of the Handbook and the outcomes of enhanced mental health services. The implementation of the Handbook can be divided into four overlapping stages, each monitored through a distinct series of metrics.

The first stage is development of new clinical capacities. This will be accomplished through hiring, credentialing, and training new staff, and providing them with the space and related supports that they need to function. VA will monitor successful recruitment of new mental health staff positions and increases in the total number of positions. Other monitoring strategies will include identifying specific programs (including those for inpatient, residential, and outpatient care and those for PTSD, serious mental illness, substance abuse, psychosocial rehabilitation, and others) and ensuring they are adequately supplied with staff, space and other resources.

The second stage is the utilization of new capacities by the facilities and the use of new or enhanced services by increasing numbers of Veterans. VA will monitor this stage by following the number of unique Veterans, the number of encounters and access times for specific services, as well as overall mental health care.

The third stage is ensuring the quality of new services. For evidence-based interventions, this includes monitors for the fidelity of programs to the specifications for the interventions that have been found to be effective. In general, this component of the monitoring will build upon VA's current program for quality and performance monitoring. It will emphasize the integration and coordination of the components of care, as well as the quality of the services delivered within each component.

The fourth and final stage will evaluate the change in Veterans' treatment outcomes as a result of the impact of services. Increasingly, it is apparent that ongoing monitoring for critical outcomes with standardized instruments is necessary to both

guide clinical decisionmaking about the need for modifying care and to support program evaluation. VA is developing specific initiatives to establish processes for monitoring outcomes for PTSD, depression, substance abuse, and serious mental illness.

Over time, the strongest approach to ensuring ready access to high quality mental health services must be based on monitoring the structure, processes and outcomes of these services. This will be the basis by which VA leadership will hold itself and its facilities responsible for mental health services.

Other Components of VA's Overall Mental Health Program

Although direct mental health services provided in VA's medical centers and clinics include an extensive array of services, they are only one component of VA's overall mental health programs. Other key components include the Vet Center program and the research programs supported through the Office of Research and Development.

VA provides mental health care in several different environments, including Vet Centers. There are strong, mutual interactions between Vet Centers and our clinical programs. Vet Centers provide a wide range of services that help Veterans cope with and transcend readjustment issues related to their military experiences in war. Services include counseling for Veterans, marital and family counseling for military-related issues, bereavement counseling, military sexual trauma counseling and referral, demobilization outreach/services, substance abuse assessment and referral, employment assistance, referral to VA medical centers, Veterans Benefits Administration (VBA) referral and Veterans community outreach and education. Vet Centers provide a non-traditional therapeutic environment where Veterans and their families can receive counseling for readjustment needs and learn more about VA's services and benefits. By the end of FY 2009, 271 Vet Centers with 1,526 employees will be operational to address the needs of Veterans. Additionally, VA is deploying a fleet of 50 new Mobile Vet Centers this year that will provide outreach to returning Veterans at demobilization activities across the country and in remote areas. Vet Centers facilitate referrals to either VBA offices or VHA facilities to ensure Veterans have multiple avenues available for receiving the care and benefits they have earned through service to the country.

Collaboration between Vet Centers and VA medical centers at the local level is a long established VHA policy. Vet Centers will refer Veterans to medical centers or clinics when they have symptoms or signs of mental health conditions that have not responded to care in Vet Centers; likewise, medical centers and clinics will refer Veterans to Vet Centers after successful completion of medical center treatment programs to receive social support and after-care services. To address these issues, and to strengthen collaborations, the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics includes a requirement that, "Each facility must designate at least one individual to serve as a liaison with Vet Centers in the area (if any), to ensure care coordination and continuity of care for Veterans served through both systems."

VA's Office of Research and Development supports well-designed, scientifically meritorious clinical trials to examine effective treatments for PTSD and other mental health conditions, as well as other clinical, health services and pre-clinical research. For years, mental health research has been among its top priorities. VA continues to serve as a leader in advancing knowledge and treatment for psychiatric and behavioral disorders. In 2008, VA's Office of Research and Development convened an expert panel to consider the methodological issues raised by the 2007 Institute of Medicine report on PTSO treatment effectiveness. The VA, the Department of Defense (000) and the National Institute of Mental Health (NIMH) have worked together to disseminate the guidance offered by the panel for rigorous trial designs. VA has used related processes to establish suicide prevention as another priority for VA research and to coordinate research activities between VA and both DoD and the National Institutes of Health. In 2008, a central Data Monitoring Committee has been provisioned as a resource to ensure independent assessment and ongoing evaluation of clinical trials. Just recently (in 2009), VA jointly sponsored two national conferences—one to consider the research agenda for the co-morbid mental health conditions in veterans returning from Iraq and Afghanistan, and one to define common approaches for research in traumatic brain injury and psychological health. These overarching efforts will lead to even more significant scientific discoveries for mental health.

Successes

VA can report a number of recent successes in its overall mental health programs.

PTSD

Population-Based Care: The 2008 RAND Report, "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," estimated that approximately 14 percent of servicemembers who served in Iraq and Afghanistan experienced PTSD. Although there may be conches about this estimate, including the validity of using a single interview rather than progress over time, the accuracy of a screening interview rather than a clinical diagnosis, and the nature of the sample selection process. Nevertheless, the estimate is in the mid-range of other available figures. For example, it is comparable to Milliken's published 2007 findings of positive findings from Post Deployment Health Re-Assessment evaluations of Army National Guard and Reserve Personnel, but greater than his report from active duty servicemembers. It is less than Hoge's published 2004 survey findings for the Army or Marines in Iraq, but somewhat greater than his findings for the Army in Afghanistan. Finally, it is comparable to findings from the 2008 report from the Army's Mental Health Assessment Team V. In the absence of any definitive information on the prevalence of PTSD in the population of returning servicemembers and Veterans; it may be interesting to explore the significance of these estimates.

Given that 945,423 Veterans have returned from OEF/OIF through FY 2008, the 14 percent estimate corresponds to 132,359 returning Veterans who may have PTSD. If this is the case, the 92,998 returning Veterans with possible PTSD who were seen in VA medical centers and clinics represent about 70 percent of the total and the 105,465 who have been seen in medical centers, clinics, OJ Vet Centers represent about 80 percent of the total. If these estimates are correct, VA has already seen a significant majority of returning veterans with PTSD. Moreover, calculations using these estimates for the rates of PTSD, the total number of returning Veterans, and the number of Veterans with PTSD seen in VA programs suggest that OEF/OIF Veterans with PTSD are about twice as likely to come to VA than those without this condition.

Evidence-Based Psychotherapy: In 2007, a VA cooperative study provided evidence for the efficacy of prolonged exposure therapy for PTSD. The Institute of Medicine later included this research in a comprehensive review which concluded that the nest established treatments for PTSD were prolonged exposure therapy and cognitive processing therapy, a different therapy developed by VA investigators and classified by the Institute of medicine as also being exposure-based. Given the importance of PTSD treatment for Veterans, VA translated these research findings into clinical care as rapidly as possible. Even before the results of the prolonged exposure trial Were published, VA was developing large scale training programs for mental health providers in both cognitive processing therapy and prolonged exposure. To date, over 1,500 providers have been trained in these two evidence-based therapies, which are currently being delivered in all but eight VA medical centers. Six of these eight have formulated plans with milestones and timelines, and the remaining two are receiving technical assistance from VA Central Office about developing such plans. While experts often bemoan the delay in turning research into practice, VA as a health and mental health care system has been able to accelerate this process dramatically. In working to ensure these advances in clinical practice are translated into public health benefits, VA is meeting the needs of Veterans and contributing to mental health care everywhere. We have trained enough providers in these evidence-based psychotherapies to offer cognitive processing therapy or prolonged exposure to OEF/OIF veterans to complete a course of treatment. To facilitate this process, VA Central Office has asked each VISN to submit plans for making these treatments available to returning Veterans with PTSD. The goal is to provide these effective, evidence-based treatments already as possible to those Veterans who need them. Our hope is that we can prevent much of the chronicity from PTSD that has, all too often, affected Veterans from prior eras who served before these treatments were developed.

New Treatments: For years, Dr. Murray Raskin, a psychiatrist at the Puget Sound VA Medical Center, has been conducting research on the clinical care of older Veterans and on the effects of noradrenalin and other stress-related neurotransmitters. As a clinician scientist, he also treated Veterans. Based on his clinical wisdom and scientific knowledge, he began to suspect that medications that blocked the actions of noradrenalin could decrease nightmares and possibly other related symptoms in patients with PTSD. To test this hypothesis, he used resources from the VA Mental Illness Research Education and Clinical Center (MIRECC) in Seattle to conduct a small clinical trial; based on early evidence, he found prazosin, a noradrenalin-blocking drug already approved for treating hypertension and urinary difficulties, appeared to be effective in treating nightmares in PTSD. Based on his preliminary findings, he obtained approval from VA's Office of Research and Development for

a large-scale clinical trial of prazosin for PTSD; this study is currently underway. Meanwhile, because prazosin is already an FDA-approved drug, many providers are already making it available to informed patients with PTSD who continue to experience sleep disturbances not responsive to other treatments.

Suicide Prevention

Much has been said and written about Veteran suicides and VA's program for suicide prevention. As part of its overall program, VA has been publicizing the availability of the national suicide prevention Lifeline (1–800–273–TALK) through advertising and public service announcements. The Lifeline is supported by Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services.

Case Report: On April 7, a mother was using an Internet video conferencing service to talk to her son, who is currently a soldier serving in Iraq. During the conversation, the soldier placed a gun to his head and threatened suicide. The mother quickly called the National Suicide Prevention Lifeline, connected to the Veterans Call Center, and used the service to prevent her son's death. The Lifeline contacted Military One Source and the Red Cross and arranged for them to notify the soldier's unit who intervened while the mother was still watching on the Internet. The soldier was taken to an Army hospital in Iraq and is currently receiving care. The mother stayed on the line for additional counseling.

VA's strategy for suicide prevention is built upon the basic principle that prevention requires ready access to high quality mental health care plus programs designed to help those in need access care, plus programs designed to identify those at high risk and to provide intensified care. This case demonstrates that VA has created resources that can promote public awareness and respond to the needs of individuals at risk. Evidence for the impact of the overall mental health program comes from analyses of suicide rates across VA facilities.

Potential Impact of Mental Health Enhancements: VA has information on the causes of death for all Veterans who utilized VHA health care services between 2000 and 2006, and it will update its databases when new information is available through the Centers for Disease Control and Prevention. One significant finding is that there is significant variability in suicide rates across facilities; about half of the variability can be explained on the basis of the region, geographic size, and the nature of patients seen. When VA tested to see if differences in suicide rates across facilities could be explained, in part, by the nature of the mental health services provided, the closest association it found was an inverse relationship between suicide rates in a facility and the intensity of the follow-up provided for patients with dual diagnoses (both mental health and substance use conditions), after they were discharged from inpatient mental health care. This is important because this measure of the quality of mental health services was among those that were substantially improved in recent years through the Mental Health Enhancement.

Together, these findings begin to demonstrate the complex nature of VA's activities in suicide prevention. Prevention utilizes highly specific resources that can demonstrate dramatic case reports. But, most basically, it relies on a well-functioning health and mental health care system. Suicide as an issue demonstrates that mental health conditions are real illnesses that can be fatal. It is with this always in its mind that VA has been implementing the Mental Health Strategic Plan and the Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics. VA now and will always continue to enhance and sustain its mental health services.

Conclusion

Thank you again for this opportunity to speak about VA's progress in meeting the mental health needs of Veterans. I am prepared to answer any questions you may have.

Statement of Christina M. Roof,
National Deputy Legislative Director, American Veterans (AMVETS)

Mr. Chairman, Ranking Member Brown, and distinguished Members of the Subcommittee, on behalf of AMVETS, I would like to extend our gratitude for being given the opportunity to discuss and share with you our views and recommendations on "Charting the VA's Progress on Meeting the Mental Health Needs of Our Veterans: Discussion of Funding, Mental Health Strategic Plan, and the Uniform Mental Health Services Handbook."

AMVETS is privileged in having been a leader, since 1944, in helping to preserve the freedoms secured by the United States Armed Forces. Today our organization

prides itself on the continuation of this tradition, as well as our undaunted dedication to ensuring that every past and present member of the armed forces receives all of their due entitlements. These individuals, who have devoted their entire lives to upholding our values and freedoms, deserve nothing less, if not more.

Given the extent of the matters at hand, AMVETS has chosen to focus primarily on the *"Uniform Mental Health Services in VA Medical Centers and Clinics"* (Veterans Health Administration (VHA) Handbook 1160.01, September 2008) and its implementation. VHA Handbook 1160.01 was designed to incorporate the new minimum clinical standards and requirements for all VHA mental health services. It delineates the essential components of the mental health program that are to be implemented nationally by every Department of Veterans Affairs (VA) Medical Center and each Community-Based Outpatient Clinic (CBOC). These requirements are to be in place by fiscal year ending September 30, 2009. May it also be noted that any modifications or exceptions for meeting the requirements must be reported to, and approved by, the Deputy Under Secretary for Health. All facilities are expected to be in full compliance by the date set forth, however AMVETS was unable to acquire any data on what the consequences of non-compliance will be.

Although there is overlap between the *"Mental Health Strategic Plan"* (MHSP), developed in 2004 as a 5 year plan of action of over 200 initiatives, and *"VHA Handbook 1160.1"* VA has used the handbook as a more operational approach to organizing all aspects of veterans' lives affected by mental health issues, including, but not limited to, homelessness, substance abuse, and Post Traumatic Stress Disorder therapies. VA has stated that when the handbook is fully implemented and all patient care recommendations are in place, that every veteran will have ready access to comprehensive, evidence-based care. Mr. Chairman, AMVETS believes that VA should be held accountable for fulfilling that statement. Never has there been a time when such care has been needed. VA/VHA set forth and agreed to that promise of care and system improvement and AMVETS strongly believes that this Committee should do everything in their oversight to ensure all requirements are met by VA/VHA no later than the deadline VA set for themselves, year ending FY09.

AMVETS is fully aware that the handbook is an ambitious undertaking; however VA/VHA has had 5 years to implement these changes. It is in the opinion of AMVETS that the standards of care set forth by the handbook guidelines will dramatically increase the quality of mental health care and enhance VA's overall availability, provision, and coordination of mental health programs. But only if the handbook is implemented correctly, uniformly, and in a timely manner, can the result benefit the mental health well-being of our veteran community.

AMVETS would also like to notify Mr. Chairman and the Subcommittee on Health of several inadequacies within the system we have unearthed while researching the future of VA health care. These concerns range from minor errors to critical errors that we feel could be resulting in unnecessary deaths of veterans. Today I will impart to you an overview of our findings and recommendations to address each concern.

As the end of FY09 rapidly approaches, AMVETS fervently believes that VA must immediately augment the evaluations of current facilities, development and training of staff, and overall outreach efforts to all medical facilities and personnel to ensure the timely implementation of the handbook's requirements. These basic, yet fundamentally critical guidelines will provide the foundation for the stability and reliability of the entire VHA mental health care system. Moreover, while AMVETS believes that the measures laid out by the handbook should have already been uniformly implemented, AMVETS is still very hopeful on the success of the handbook and all the agencies involved in this undertaking. AMVETS does acknowledge the significant challenges that are inevitably faced when transforming a mental health care system. However this is not a time for hindrance or hesitations that will impede the implementation of a stable and successful uniform standard of mental health care.

On April 6, 2009 the Department of Veterans Affairs Office of the Inspector General (OIG) issued Report No. 08–02917–105 entitled, *"Healthcare Inspection: Implementation of VHA's Uniform Mental Health Services Handbook."* As required by the Military Construction, Veterans Affairs, and Related Agencies Appropriation Bill, fiscal year 2009, the OIG conducted a review on the progress of the implementation of VHA's Mental Health Strategic Plan. Additionally, the Committee was also concerned that the VHA policy on the diagnosis and treatment of Post Traumatic Stress Disorder (PTSD) had not been uniformly applied as directed. These concerns are what prompted this review, thus leading to Report No. 08–02917–105.

OIG affirmed that due to the given dimension of the handbook, a comprehensive review of the implementation would be challenging, and thus decided to limit their scope of the review to the medical center level. In addition, they chose selected items

from the handbook to evaluate for implementation, which did not include the review of suicide prevention-related items. AMVETS also noted that Community Based Outpatient Clinics (CBOCs) were not included at all in this review. OIG has stated that a separate review of CBOCs is occurring and the results of the review will be released in June 2009. AMVETS believes that these factors are very important to keep in mind when using the data of this review as an overview of the entire plan, and will address this later in our testimony.

The OIG report was compiled of data gathered from 149 of the 171 VA medical center sites. In addition, OIG administered web-based surveys, comprised of 39 index questions, to be completed by the individual medical directors of each of the 171 sites. Of the surveys mete out by OIG, they received 138 responses either from the directors themselves or a designee. OIG then performed telephone interviews to obtain further feedback on the potential barriers to the implementation of the UMHS handbook. AMVETS has thoroughly reviewed the OIG's final report and is very distressed by many of their findings.

According to the handbook, regarding community mental health care, Veterans Integrated Service Networks (VISNs) and facilities must collaborate with Vet Centers in outreach to returning veterans and their families. OIG found that 87 percent of the facilities they spoke with (138 of 171 or only 81 percent of total VA medical sites) had affiliated themselves with at least one Vet Center as laid out by the handbook. Unfortunately, OIG also found that 5 percent of facilities they interacted with had no affiliations what so ever to a Vet Center. AMVETS is very concerned that if OIG found non-compliance in their review (composed of only 81 percent of total VA medical facilities' and excluding CBOCs) of one of the most basic requirements set forth by the handbook, what is occurring at the facilities not included in the review? AMVETS finds it absolutely unacceptable that 100 percent of the facilities contacted by VA's OIG did not respond to the request for review, and respectfully asks the Committee why this was permitted to occur, and if it was not permitted what actions have been taken in regards to said facilities?

The handbook also requires that all VHA emergency departments have mental health coverage by an independent, licensed mental health provider either onsite or on-call, on a 7 day a week, 24 hours basis. Additionally, for level 1A medical centers: mental health coverage must, at minimum, be onsite from 7 am to 11 pm and VA facilities with urgent care centers must have onsite or on-call coverage during their times of operation. Of the facilities interviewed by OIG, only 79 percent had emergency departments. OIG reported that they had initially attempted to ascertain the extent of 1A facilities with onsite emergency department coverage from 7am to 11pm, but it became clear that that many (no specific number given) do not even have the required 1A emergency departments. Even more disturbing is that many of the mental health facilities' directors were not aware that there facility level had been changed to 1A. One director suggested to OIG that it would be helpful for central office to send all facility Mental Health Directors a list of up to date facility level designations so they could meet the handbook requirements. If VA/VHA is having difficulties in communicating the most basic, yet most critical, information to their own facilities as of March 2009, AMVETS respectfully inquires as to how VA/VHA plans on implementing an entire mental health care handbook? AMVETS also respectfully asks the Committee what steps it is taking to ensure the FY09 deadline is met and that veterans will have access to the mental health services they need?

One of the most glaring deficiencies AMVETS observed in OIG's report is in regards to *"Issue G: Specialized PTSD Services."* The handbook requires that all VA medical centers have specialized outpatient PTSD programs, either a PTSD Clinical Team (PCT) or PTSD specialists based on locally determined patient populations needs. It is also a requirement of the handbook that every facility have staff with training and expertise to serve the Operation Iraqi Freedom (OIF)/ Operation Enduring Freedom (OEF) team or PTSD program staff. OIG reported that of the VA medical centers surveyed 80 percent reported having a PCT and of those 65 percent reported having an OIF/OEF PTSD Specialty Clinic. However, AMVETS was made aware of the fact that in the smaller facilities a single PTSD specialist that is available in that facility was often classified as a "clinic or program." It should be noted that these are self reported numbers and AMVETS was unable to locate any documentation showing that the reported numbers were valid and accurate.

The handbook also requires that all VISNs must have specialized residential or inpatient care programs to address the needs of veterans with severe systems and impairments related to PTSD and that each VISN must provide timely access to residential care to address the needs of those veterans with severe conditions. According to OIG: *specialized inpatient PTSD programs are unusual, as most PTSD care was moved to residential and outpatient basis*. The Mental Health Directors surveyed reported having a residential PTSD program or inpatient PTSD program at

only 33 percent of all facilities. Several directors, not included in the 33 percent, pointed out that their facilities had reliable access to the VISN program, but did not mention the fact that the average waiting period before entry into a VISN program was 4–8 weeks, often longer. AMVETS finds this completely unacceptable and almost negligent due to VA's own evidence that untreated veterans suffering from PTSD are more likely to become suicidal or violent. AMVETS measured the success and suicide rates among veterans who have had extended waiting periods before admittance into a PTSD program versus those who had timely access to care and was astounded at the higher rates of suicide, substance abuse, and domestic violence among those who were put on VISN PTSD waiting lists. Upon further review AMVETS observed that OIG presented similar concerns in their May 10, 2007 "Review of the Care and Death of a Veteran Patient—VA Medical Centers St. Cloud and Minneapolis, Minnesota." AMVETS finds it unfortunate that these trends are continuing to be over looked or hindered by either lack of public knowledge or funds. What ever the hesitation reasoning is on behalf of VA AMVETS respectfully asks the Committee to again use all oversight and guidance to prevent any more losses of life, due to non-uniformed access to care and the non-compliancy of many VA medical facilities. AMVETS recommends the immediate formation of a task force on oversight and compliancy to help ensure the integrity and implementation of the handbook. Furthermore AMVETS believes that if VA/VHA desires to enact the handbook by their self set deadline they will fully support the formation of such actions. These are only a few of the observations and reports that AMVETS found unacceptable and no where near meeting the requirements set by the handbook.

It has always been the belief of AMVETS that to successfully implement change, we must understand the current policy and procedure to which change is needed. For without full knowledge and understanding all of our efforts are in vein. Our veterans deserve immediate action by all parties involved in the implementation of the handbook. We must all work together to ensure our veterans mental health care needs are fully met.

Mr. Chairman, this concludes my testimony. I thank you again for the privilege to present our views, and I would be pleased to answer any questions you might have.

Statement of Hon. Marcy Kaptur,
a Representative in Congress from the State of Ohio

I want to begin today by thanking Chairman Michaud and Ranking Member Miller for permitting me to join you today to discuss a matter that is near and dear to my heart—the mental health of our veterans.

I have worked on the issue of our veterans' mental health since I was a Member of this esteemed Committee during the eighties. I applaud your leadership in holding a hearing on this subject, which were few and far between during my tenure on the Veterans Affairs Committee.

Throughout my career, our Ohio office has been ably staffed by a Vietnam veteran, Dan Foote, who handles an enormous veteran's caseload among many other issues.

Dan shared this story with me, and I want to share it with you:

> It is not unusual to have 5–8 phone messages on his voice mail at least once a week. One constituent, Tom, a Vietnam veteran who was a mechanic and a door gunner, medicates himself with alcohol starting around 7 or 8 p.m. and will drink well into the night.
>
> Tom's first call usually is a thank you call for assisting him in obtaining his air medals from his 12-month service in Vietnam in the late 60's. As the night wears on, Tom's phone messages become garbled and unclear and around 3:00 a.m., his calls are incoherent. Tom finally sleeps and the messages end until next time.
>
> Tom is one of many Vietnam Vets treating their PTSD with alcohol. The trauma of war was so severe they use alcohol to numb the feelings in order to get through the day or night. Tom has told my staff, 'When you lay down at night the demons come.' Alcohol chases away the demons if only for a few hours or a night.
>
> In 1967, Tom, arrived in Vietnam. As a helicopter mechanic he was assigned to an Aviation Unit. Tom's first challenge was to learn to fire the 60 mm machine guns mounted in the cargo doors of the Bell Huey chopper. A crew took him over the South China Sea to practice shooting and on their

way back inland to their base the pilot spotted five Vietnamese running on the beach and into the jungle.

The pilot ordered the newest crewmember to open fire on the Vietnamese assuming they were Viet Cong (Communist Guerillas). The ship landed to search for weapons and intelligence only to find a mother, father and three children dead from the machine gun fire. This occurred in his first week in Vietnam.

Tom has never been the easygoing teenage auto mechanic that left Toledo, Ohio, in 1966. His life can best be described as a soldier who has never come home from Vietnam.

Tom receives VA services to include counseling and psychiatric services, but medical science still must do more. Tom's service to his Nation was 42 years ago. His treatment and suffering continue.

Tom, and every other Veteran in my district and across the country, inspires work we have championed to support research in the understanding and treatment of PTSD and other neuropsychiatric war wound that can onset at any time during or post conflict. We must give proper care to those who have valiantly served their Nation. I know the Commander of the Ohio Purple Hearts would not mind my sharing with you that he suffers from PTSD and tinnitus for going on 40 years. His best buddy took his own life.

From September 11, 2001, until March 2009, our Nation has asked new generation to American military service men and women to serve including 401,840 Army National Guard Soldiers.

Dr. Milliken, of Walter Reed Army Hospital, recently reported that of 88,000 soldiers returning from Iraq, 20 percent of the active component and 42 percent of the reserve component had mental health concerns requiring treatment within 6 months of returning from combat. Our men and women are returning with deep scars that are not seen.

Why people develop PTSD is clear—you have to experience a trauma. Why the majority who experience a trauma do not develop PTSD and appear resilient is not understood. In order to reduce the immediate and long-term human and economic costs of this disorder, additional research is essential. Furthermore, it is essential that neuropsychiatries are included on the VA's peer review panels that review VA mental health research proposals and that we increase the training and preparation of neuropsychiatric nurses.

Currently, a Congressionally directed, Department of Defense landmark assessment of Ohio Guard veterans and soldiers is underway to detect or prevent neuropsychiatric war wounds associated with modern warfare. This 10-year prospective follow-up study represents the first ever detailed long-term study of mental health of the same soldiers.

Associated with this research will be the largest epidemiological DNA sampling of our 3,000 veterans and family members known to this field of science.

Studies such as these are vital to the continued care of our Nation's service men and women and our veterans. We know that science can unlock hidden passages of the brain and nervous system. We must maintain a course of care for those who have borne the battle and pledged their lives to our Republic.

Thank you for your leadership in convening this critical hearing so America can provide the promised care they have so nobly earned.

Statement of Christine Woods, Hampton, VA,
Former Program Specialist and National Consultant,
Office of Mental Health, Veterans Affairs Central Office,
U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Subcommittee, thank you for the opportunity to submit a statement for the record regarding VA's progress toward meeting the mental health needs of America's veterans. My testimony will convey both broad and specific insights that I believe will ultimately assist the Department of Veterans Affairs. I will primarily focus on aspects of the Mental Health Strategic Plan (MHSP) designed to ensure that VA Mental Health is Veteran and Family Driven. Goal #2 of the MHSP calls for *transformation* of VA's mental health system to a recovery-orientation, based on recommendations of the President's 2003 New Freedom Commission Report, which itself, stemmed from groundbreaking findings of the 1999 Surgeon General's Report on Mental Health.

Background

As a bit of background from which my personal insights are gleaned: Prior to my retirement in 2007, I worked nearly 30 years for the Department of Veterans Affairs; the last sixteen of which were as a Program Specialist in the VACO Office of Mental Health Services (OMHS). In the early 1990's, I led the development of VA's most comprehensive and effective psychosocial residential rehabilitation program; followed by VA's conversion of traditional inpatient psychiatry units to residential rehabilitation and treatment programs. In response to the 1999 Surgeon General's Report on Mental Health, I began promoting (in 2000) the concept of "recovery" in the VA Mental Health System, which led to the establishment and recent funding of Psychosocial Rehabilitation and Recovery Centers, incorporation of Peer Support positions as VA staff, and plans for system-wide transformation to a recovery-orientation of VA mental health services. Most of these initiatives were often characterized as "can't be done in VA"; and it would be an understatement to say that promoting the "concept of recovery" for those with the most serious mental illnesses was "a tough sell" in the OMHS. But, the need was obvious; and with the support of the (then) VA Committee on Care of Veterans with Serious Mental Illness, the President's New Freedom Commission, and the Mental Health Strategic Planning process, the opportunity was within reach by 2005.

While in VACO, I also worked on a number of systems-related initiatives associated with mental health information management and quality improvement activities. Most directly related to this hearing, I served as the initial mental health liaison for CARF Accreditation of VA Mental Health programs, and as a key mental health representative for Decision Support System (DSS) mapping for capture of mental health workload and costs. I also chaired and/or was a member of Mental Health Strategic Planning workgroups on Employment, Family Psychoeducation, Peer Support and Residential Rehabilitation Services, as well as Anti-Stigma, Knowledge Management, and Recovery Transformation planning.

VA Progress to Date:

I wish for my testimony today to appropriately acknowledge the significant accomplishments of the Department of Veterans Affairs in initiating and funding a number of new mental health programs and initiatives over the past few years. VA's current Uniformed Mental Health Services Handbook (UMHSH) details expectations to fill many longstanding gaps in care. It describes more integrated care approaches, and more comprehensive rehabilitation services. Several evidence-based and emerging best practices are beginning to be implemented; and VA is even hiring people with a history of mental illness to incorporate peer support into more traditional mental health services. These efforts should by all means be roundly applauded.

Yes, despite these positive accomplishments, I believe the effectiveness of all mental health services remains at serious risk until the culture of VA mental health services is *transformed* to a recovery-orientation. Long-held attitudes, beliefs, and resulting clinical and administrative practices remain barriers, both to encouraging veterans to access mental health services, and to their achievement of the positive outcomes that should be expected. It is important to note that the true success of these new services should not be measured in their mere existence, or in the amount of funding distributed to make them operational. Their success should not even be exclusively measured by the degree to which they are evidence-based or recovery-oriented—although those measurements are necessary to chart VA's progress. But, the true measure of accountability for VA mental health services is the extent to which veterans actually experience recovery: that is, the extent to which each veteran with mental health challenges has the ability to live a fulfilling, productive life in the community, even with a mental health condition that may elude a full "cure."

Concern Regarding the Uniformed Mental Health Services Handbook Replacing the Mental Health Strategic Plan

I believe it is important to highlight for the Subcommittee some serious concerns regarding VA's Uniform Mental Health Services Handbook (UMHSH), and in particular, how this document states that *"when fully implemented, these requirements will complete the patient care recommendations of the Mental Health Strategic Plan. . . ."* It is my intention to demonstrate, through some specific examples, how the UMHSH lacks incorporation of many of the most important MHSP recommendations necessary to achieve the patient care goals of a recovery-oriented, veteran and family driven mental health system.

Important facility-level MHSP patient care recommendations not reflected in the Uniform Guidelines are in the key areas of:

- Mental health leadership composition,

- Issuance of policy and procedural guidance, and
- Use of standardized metrics to measure both VA's progress in meeting the recovery-oriented transformational changes called for in the MHSP, and for measuring the actual recovery outcomes of veterans served by the VA MH system.

These, and other, specific MHSP recommendations are not only inadequately conveyed in the UMHSH, but, in some cases are abandoned or even contradicted. One must question if unprecedented mental health enhancement funding for new recovery-oriented programs and initiatives can be expected to achieve desired outcomes without the associated leadership enhancement, new policy infrastructure, and perhaps most importantly, the charting of progress toward those outcomes.

Certainly, in any three to 5-year strategic planning process some recommendations may, over time, be determined to be unnecessary, or even ill-advised. Additionally, expansive goals which are as transformative as Goal #2 of the MHSP will generally require additional detailed planning to facilitate implementation. Indeed, a number of specific recommendations to further realize the goal of a Veteran and Family Drive Mental Health System were developed by the Recovery Transformation Workgroup in March of 2005. (RTWG 2005).

Ensuring that VA Mental Health is Veteran and Family Driven may well be considered the most transformative and over-arching goal of the MHSP. The Center for Mental health Services' premier issue of *Mental Health Transformation Trends* (March/April 2005) defines transformation as "a deep, ongoing process along a continuum of innovations." This document further emphasizes that "Transformation implies profound change—not at the margins of a system, but at its very core. In transformation, new sources of power emerge. New competencies develop. When we do transformative work, we look for what we can do now that we couldn't do before."

VA Mental Health Leadership Composition is perhaps the most obvious and critical example of incomplete mental health strategic plans. The MHSP recommendation to appoint a permanent veteran mental health consumer in the VACO Office of Mental Health Services, to represent the unique perspective of veterans served, remains a critical step not yet taken. In addition to *requirements* for Facility Consumer Councils, the Recovery Transformation Workgroup further recommended that, at the facility level, "veteran consumers and family representatives *should* participate in facility mental health leadership meetings and participate in decision-making about program changes." Leadership, after all, *drives* systems, and *transformational* change requires "buy in," clear messaging, and modeling from the highest leadership levels.

One must question how a Veteran and Family Driven System can be achieved if veteran mental health consumers and their family members have no seat at the leadership table. Yet, the Uniform Mental Health Services Handbook (UMHSH) only "encourages" Facility Consumer Councils, and fails to include any mention of veterans or their family members being represented on Facility Mental Health Executive Leadership Councils. Clearly, these Leadership Councils have an impact on patient care services. To quote from the UMHSH, these Councils are responsible for: *"reviewing the mental health impact of facility-wide policies that include but are not limited to policies on patient rights, privileges, and responsibilities; restraints and seclusion; management of suicidal behavior; and management of mental health emergencies,"* and *"proposing strategies to improve care and consult with management on methods for improving innovation in treatment programs."* Removing the requirement for veteran mental health consumers to be represented at the VACO and Facility levels represents a significant disregard for the most powerful means by which a Veteran and Family Driven System can be realized. This apparent indifference to the value of veteran/family participation in leadership suggests that the VA mental health system has still not made meaningful progress toward becoming a system that is *driven* by the expressed needs of veterans and their families—the individuals for whom the very system exists.

In fact, Veteran Services Organizations (VSOs) and other advocacy groups have actually lost influence in organizational oversight of VA's Mental Health Services since approval of the Mental Health Strategic Plan. Prior to December 23, 2005, VSOs, professional organizations, and consumer advocacy groups were generally considered full (although non-voting) members of the VA Committee on Care of Veterans with Serious Mental Illness, which met face-to-face, bi-annually, for 2–3 days each year. However, with the December 2005-appointment of the current SMI Committee Chair, and replacement of all VA Committee members (except one), VSO's and other advocates have since been afforded only a half day of participation in one meeting each year. This diminishing of veteran and consumer advocate participation has resulted in denial of their opportunity to participate in the Committee's full discussion of issues or even to observe formal decisionmaking.

Clear operational policies and procedures are required in all healthcare systems, especially to guide major cultural and operational changes. VA's Mental Health Strategic Plan included action items requiring the issuance of broad conceptual guidelines for new initiatives, to be further followed by detailed policies and procedures. Content for many such documents was outlined in the Recovery Transformation Work Group Report (RTWG 2005). In many instances these recommended policies even had targeted dates of issuance to chart a detailed course for strategic implementation. Yet, despite nearly 5 years and millions of dollars expended, these policies and procedures for totally new initiatives, such as the work of the Recovery Coordinators, and the integration of Peer Support services, have yet to be issued. While the Uniform Mental Health Services Handbook (UMHSH) details requirements for facility-level mental health services, these facilities lack the detailed policies, procedures, and other necessary infrastructure to actually meet these requirements.

Likewise, the new Psychosocial Rehabilitation and Recovery Center (PRRC) programs were carefully designed to not only minimize the well known "silos effect" of traditional VA mental health programs. They were intended to actually integrate fragmented services and incorporate the fundamental elements and guiding principles of recovery-oriented system, i.e., those of being truly person-centered, consumer empowered, self-directed, holistic, etc. Yet, without clear operational guidelines, these new Recovery Centers (while expanding needed services) run the risk of becoming "more of the same" rather than the hub of integrated, recovery-oriented services that demonstrate the transformational change envisioned by the President's New Freedom Commission.

Standardized metrics for baseline, continuous quality improvement monitoring, and ultimate goal attainment represents another standard tool used in systems transformation. Metrics for use by the Office of Mental Health Services (OMHS) were well delineated in the Recovery Transformation Work Group (RTWG) report. For example, recommendations to guide and monitor the utilization of Local Recovery Coordinator (LRC) positions included tracking methods and reporting requirements to facilitate national monitoring of LRC achievement of goals. These goals included, but were not limited to: appointment of "local champions", consumer-led anti-stigma and educational activities, veteran/family representation in mental health leadership, establishment of consumer/advocate liaison councils, implementation of individual recovery plans, etc.

Equally important, a rigorous professional review of validated recovery measures was conducted, resulting in the selection of measures to be used for charting VA progress. (See appendix for full references) These included measures of staff competency to deliver recovery-oriented services (CAI 2003), veteran and staff perceptions of the system's recovery-orientation, (ROSI 2005 & RSA 2005, respectively) and veteran self-reported measures (MHRM 1999) designed specifically to focus on his/her individual recovery. Some specific indicators encompassed in these measures include: degree of consumer choice and self-determination, activities geared toward expanding social networks and social roles, staff attitudes and philosophy toward recovery, etc. As noted in the RTWG report, "these attitudinal and structural changes are critical first steps in supporting a system wide transformation. . . . This major undertaking will only be successful when it is clearly coordinated by strong (OMHS) leadership . . . and local efforts are held accountable to the national implementation plan. . . ."

While different measures may have since been determined to be more suitable for use in charting VA systems transformation and veteran self-perception of recovery/quality of life, the UMHS Handbook makes no mention of these facility-level recovery assessment functions. No such measures have yet to be employed for even a baseline assessment of the recovery-orientation of the VA's mental health system.

As I acknowledged previously, I appreciate that times change, and so do specific strategic plans. However, if VA is to achieve its stated goals of the MHSP—indeed, to successfully achieve the Department's primary mission—then transformational change is required. The VA has had the opportunity to make profound change over the past decade—and has even had the mandate to do so over the past (nearly) 5 years. The MHSP charted a course for VA transformation to an evidence-based, recovery-oriented, veteran and family driven mental health system. Yet, contrary to VA's testimony before your Subcommittee, this transformational change appears to be far from "90 percent complete." Our Nation's veterans, and their families (as well as patriotic Americans indebted to them for their service and sacrifice) are seeing hope for VA transformational change slipping away. Regrettably, for some, whose lives or loved ones have been lost to the hopelessness that results in suicide, it is already too late. . . . But for millions, there is still time to "achieve the promise."

Suggestions for Moving Forward:

Changing the organizational culture of a huge bureaucracy is difficult work that takes years to achieve, even with the strongest leadership, the best infrastructure, and a carefully charted course that is closely monitored. Considerable resources have been directed toward VA mental health becoming a recovery-oriented, veteran and family driven system. However, the most essential infrastructure for transforming the system is missing. Absent these cornerstone elements, issuance of the UMHS Handbook may only complicate the way forward by its failure to adequately support the goal for a veteran and family driven mental health system. Given these circumstances, the following recommendations are offered to assist the Subcommittee in re-directing VA toward Goal #2 of the MHSP before the window of opportunity for true *transformation* closes completely:

1. Establish an Office of Mental Health Recovery and Resiliency Initiatives (suggested within the Office of the Assistant Secretary for Public and Intergovernmental Affairs—or similar to that of VA's Homeless Initiatives). This office would:
    a. Ensure that VA's Mental Health Recovery Transformation has the internal external priority, and public affairs visibility, to be effectively re-initiated, through the strength of leadership associated with the Office of the Secretary of Veterans Affairs.
    b. Ensure that VA's effective Federal Partnership Activities include equal inclusion of recovery and resiliency initiatives to facilitate full collaboration with other Federal Agencies, State and Local governments and broad community resources. This collaboration will maximize VA and community resources to foster successful community re-integration of newly returning OEF/OIF veterans as well as veterans of previous eras who have become psychologically dependent on the traditional VA mental health system.
    c. Assist the National Recovery Coordinator to convene an "expert panel" for revisiting (and updating) Mental Health Strategic Plans associated with stigma reduction and recovery-orientation. Immediate special attention should be directed toward:
        i. the involvement of veterans and their families in the design, delivery, and evaluation of mental health services,
        ii. national policy development for all new recovery programs and initiatives, and
        iii. the application of metrics to measure progress of system transformation as well as the progress toward meeting the individual and collective needs and outcome goals of veterans for whom the VA mental health system exists.
2. Realign the National and Local Recovery Coordinator positions to function as direct advisors to the highest levels of mental health leadership. In this capacity, they will serve as both a "recovery lens" for viewing the implications of all mental health clinical and administrative practices, and as a "recovery filter" for ensuring that any future impediments to transformational change are caught early, brought to the attention of mental health leadership and then addressed, as needed, by the (above-recommended) Office of Mental Health Recovery and Resiliency Initiatives.
3. Implement MHSP recommendations to recruit a permanent veteran mental health consumer as staff to the VACO OMHS to represent the unique veteran consumer perspective in all OMHS endeavors, and to require both Facility Consumer/Family Councils and veteran consumer and family representation on Facility Mental Health Executive Councils.
4. Conduct a serious inquiry into the multi-faceted organizational value of utilizing the clinical capabilities of VA's Decision Support System (DSS) to inform the Office of Mental Health Services (and ultimately the Subcommittee) on the provision of VA mental health services. In addition to capabilities briefly listed below, this suggestion proposes transitioning the OMHS' existing focus on mental health *program-evaluation* to a new focus on *veteran outcomes of an integrated healthcare delivery* system. VA's Decision Support System (DSS) could be utilized for mental health services to:
    a. Measure outcomes-based performance and the effectiveness of healthcare delivery processes,
    b. Benchmark VA comparative aggregate data at network or national levels,
    c. Provide information on a corporate roll-up of both financial and clinical information, to include (but not be limited to) monitoring the provision of evidence-based practices, through "products" delivered in accordance with clinical practice guidelines.

Indeed, these recommendations represent profound change— not at the margins, but at the core of VA Mental Health Services. I believe all are of equal importance, but they are listed in suggested priority order. Transparency for strategic plan im-

plementation and accountability for veteran mental health outcomes can no longer be bogged down by the "strongholds of the status quo." More than a great slogan, "Putting Veterans First" must *lead the way forward*.

Overcoming Current Barriers to Family and Peer Support Services:

New perceived barriers, such as requiring Title 38 provisions for the hiring of Marital and Family Therapists, and new clinic stop codes for peer and family services, are among the most recent examples of the Department seemingly resisting change, rather than facilitating it. These cited barriers to meeting the mental health needs of veterans and their families are either demonstrations of organizational reluctance, incompetence, or worse. . . .

It is true that Title 38 authorities should ultimately be sought for Marital and Family Therapists. However, as a rapidly increasing number of new veterans' families are experiencing unprecedented hardship and stress, these Congressionally mandated therapists can be employed by VA under Title 5 Position Classifications. Aggressive hiring could be well underway— a full 2 years after a law requiring it. As for clinic stop codes: VA's VERA system reimburses VISNs based on diagnosis and complexity of care required, not on workload capture in particular therapist or non-professional clinic stop codes. Adding new evidence-based services such as Family Psychoeducation or Peer Support are actually more likely to reduce costs in the 2-year VERA funding cycle than to increase them. Also, establishing unique clinics for delivery of each new mental health service is a process wedded to the Cost Distribution Reporting system that was replaced nearly a decade ago. Requiring new clinic stop codes for peer and family services only further invests the OMHS in the past, rather than ushering in the more transparent and clinically informative Decision Support System of the present and future.

Informing the Future: National Vietnam Veterans Readjustment Study (NVVRS) and Future VA Mental Health Oversight:

As VA charts progress on its efforts to improve current and future mental health care, it is my impassioned belief that as a society, our Nation can now best honor VA psychologically dependent Vietnam Veterans by fostering their community integration with the dignity and respect they've so often been denied. Congress should ensure that VA take immediate action to comply with PL–106–419, requiring completion of the National Vietnam Veterans Readjustment (aka "Longitudinal') Study to ensure that the lessons learned from their "Long Journey Home" are used to at least inform our Nation's moral response to newly returning OEF/OIF Veterans and their Families. Completing this study will not only assist Vietnam Veterans of America (VVA) in fulfilling their motto of "Never Again Will One Generation of Veterans Abandon Another," but it will forever document the true costs of modern warfare on our military personnel, their families, and American society as a whole.

Concurrently, VSOs and new veteran coalitions, family members, and consumer advocacy groups should have equal membership (in numbers and voting rights) on VA Oversight Committees such as VA's Committee on Care of Veterans with Serious Mental Illness. This long-overlooked need for system-wide veteran empowerment, self-determination, and oversight will ensure that VA's Mental Health transformation to a Veteran and Family Driven System actually occurs. *Now is the time for new sources of power to emerge; for new competencies to develop. It is the time to do transformative work.*

Summary:

My testimony brings me full circle to VA work I did back in the early eighties when, as a Personnel Staffing Assistant at the Hampton VA Medical Center, I began working daily with veterans, primarily of the Vietnam Era. Many of these veterans were not only unemployed, but by the 1980's they had poor employment histories, substance abuse and mental health problems, marital and legal issues, and were often homeless or at high risk of homelessness. Many were living in the Hampton Virginia Domiciliary, or cycling through the Inpatient Psychiatry Unit.

It was at that time I realized the VA mental health system needed to do more than reduce symptoms of mental illness, or help veterans achieve sobriety. The system also needed to assist veterans (and their families) with the complications of these disorders: problems with employment, housing, social, legal, financial issues, etc. And equally important, I've believed since then that if our country ever became involved in another Vietnam-like conflict, the VA needed to be a place where veterans would want to come—with their families—and to come as a first, rather than a last resort. It would be a place where they felt heard, empowered to determine their future; and a place with a track record of positive outcomes. Every war era is a bit different, but the many "lessons learned" from the Vietnam Era should inform the current VA mental health system—lessons about what worked, and what

didn't. The Vietnam Vet Centers brought veterans in, (in part) because they were designed by Vietnam Veterans and therefore offered convenient, relevant, veteran and family driven services that supported community-living, and offered empathy and hope. This important lesson, combined with the findings of renowned scientific studies and "blue ribbon" commissions should chart the course for the current and future VA mental health system. Such a system would go a long way toward reducing the long-term, intergenerational consequences of delayed post-deployment readjustment services for new OEF/OIF veterans and their families.

VA has made considerable progress with many aspects of the Mental Health Strategic Plan. As I stated earlier, this progress should be roundly applauded. Herein, however, I've provided only a sampling of mental health strategic plans seemingly gone awry; and only a few new recommendations for getting back on track 5 years later. The 2004/2005 concerted effort to impede VA's provision of evidence-based peer support services is perhaps testimony for another time or another Subcommittee. For now, I offer these insights to the Subcommittee on Health to help ensure the transformative work of the Mental Health Strategic Plan is, in fact, "90 percent completed." I admire the Subcommittee's commitment to ensuring VA mental health services facilitate recovery and build veteran and family resilience to face life's challenges. Much of the planning and initial work is already done. It will need review, minor refinement and stronger leadership. But we (largely) know the way. We have the tools. We need only the will—the moral compass—to transform the VA system to meet the mental health needs of America's Veterans and their Families.

The road ahead for today's Wounded Warriors and their families will also be a "Long Journey Home," and sadly some will not make it successfully. However, through full implementation of the Mental Health Strategic Plan, we have the opportunity to prevent another generation of wounded warriors from falling through the cracks of a fragmented VA mental health system that "is not oriented to the single most important goal of the people it serves—the hope of recovery" *(Interim Report of President's New Freedom Commission).*

Again, I extend my sincere appreciation to the Chairman, Members and Subcommittee staff for inviting my testimony on Charting VA's Progress on Meeting the Mental Health Needs of Veterans. I would be honored to be of further service as you pursue this important work. To quote from President Theodore Roosevelt: "This is work worth doing."

Appendix

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MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
Subcommittee on Health
Washington, DC.
May 5, 2009

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue NW
Washington, D.C. 20240

Dear Secretary Shinseki:

Thank you for the testimony of Dr. Ira Katz, Deputy Chief Patient Care Services Officer for Mental Health of the Veterans Health Administration at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Health Oversight Hearing on "Charting the VA's Progress on Meeting the Mental Health Needs of Our Veterans: Discussion of Funding, Mental Health Strategic Plan, and the Uniform Mental Health Services Handbook" that took place on April 30, 2009.

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers by June 16, 2009.

Sincerely,

MICHAEL H. MICHAUD
Chairman

HENRY E. BROWN, JR.
Ranking Member

Question for the Record
The Honorable Michael H. Michaud, Chairman,
The Honorable Henry E. Brown, Ranking Republican Member,
Subcommittee on Health, House Committee on Veterans' Affairs
April 30, 2009

Charting the VA's Progress on
Meeting the Mental Health Needs of Our Veterans:
Discussion of Funding, Mental Health Strategic Plan, and the Uniform Mental Health Services Handbook

Question 1: How does the VA develop the funding it needs for mental health services and the Mental Health Initiative? Specially, what factors are considered in developing the funding level that's required to meet the mental health needs of Veterans? And what are your thoughts on DAV's recommendation for the VA to develop an accurate demand model for mental health and substance-use disorder services?

Response: The Department of Veterans Affairs (VA) believes that it has an accurate demand model for mental health and substance use disorder services and a robust approach to developing funding for mental health services. In the fiscal year (FY) 2010 budget, VA requested $4.6 billion to expand inpatient, residential, and outpatient mental health programs. This represents an increase of $288 million over the FY 2009 funding level.

Each year, VA assesses the expected demand for inpatient and ambulatory medical services based on its most recent experience for both VA and fee-based care provided to enrolled Veterans. Projections are updated to reflect the changing demographics of the enrolled Veteran population, including factors such as aging, priority group transition and geographic migration. VA also conducts a rigorous review to understand health care trends in VA, which impact the number of services and the expected cost of providing these services to enrolled Veterans. VA has also conducted a detailed analysis to understand the expected impact of expanding Priority Group 8 enrollment eligibility.

The mental health modeling assumptions used by the VA enrollee health care projection model, which supports the VA budget development process, are developed annually by subject matter experts on a VA workgroup. This workgroup determines policy goals for VA mental health programs, which are then incorporated into the assumptions for the model. The adjustments to the model needed to achieve these goals are phased in over a multiple year timeframe, depending on the time needed to build the capacity for the particular service.

Since the beginning of FY 2009, a newly formed group of subject matter experts has been reviewing the adjustments that were incorporated into the model by ear-

lier workgroups. This review was guided in large part by anticipated changes in the delivery of mental health and substance use treatment services as articulated in the Veterans Health Administration (VHA) Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics.* The updated 2009 model will reflect the implementation of specific handbook guidelines including transition of day hospital/day treatment programs to the psychosocial rehabilitation and recovery center model in all medical centers with 1,500 or more patients on the National Psychosis Registry, access to residential rehabilitation treatment programs in every Veterans integrated service network (VISN), and adherence to evidence-based psychotherapy regimens in outpatient mental health programs. In addition, the updated 2009 model will propose a new approach to projecting demand for homeless program services that is tied to homeless population counts rather than the total enrolled Veteran population. Also, the updated 2009 model will incorporate higher costs per service due to increased case mix and staffing intensity as required under the handbook. The requirements for uniformity in mental health services throughout the system, as specified in the handbook, together with improved methods for projecting the number of homeless Veterans requiring care, should improve the reliability and precision of the estimates of the demand for services, and, therefore, the costs.

Question 2: What progress has the VA made in implementing the Mental Health Strategic Plan (MHSP)?

Response: The Mental Health Strategic Plan (MHSP) was developed in 2004 to incorporate new advances in treatment and recovery, and to address the needs of returning Veterans. This plan was based on the principle that mental health was an important part of overall health. In 2005, VA began allocating substantial funding through its mental health enhancement initiative to support the implementation of the MHSP. Currently in the 5th year of implementation, more than 95 percent of the items in the MHSP from 2004 and 2005 have now been implemented and are part of ongoing operations and clinical practice. VA has moved the focus from implementation, emphasizing rapid transition and enhancement of mental health services, to a focus on sustained delivery of the mode of care the MHSP generated. This shift in focus was the impetus for the new VHA Handbook 1160.01: *Handbook on Uniform Mental Health Services in VA Medical Centers and Clinics*, published in September, 2008. This handbook lays out the requirements for mental health services to be delivered consistently across the VA health care system and describes key elements of the recovery process requirements for all VA medical centers and clinics. VA plans full implementation of the handbook's requirements by the end of FY 2009.

Question 2(a): VSOs note that the recovery programs have had a slow, prolonged startup period; program managers have not made a consistent effort to involve Veterans and family members locally; and regulatory impediments to the recovery transformation process must be removed. What is the VA's response to these concerns?

Response: VHA officials are not aware of any specific regulatory impediments to the recovery transformation process. We welcome the Subcommittee's identification of specific regulatory impediments so that we may address any concerns at our next Veterans service organizations (VSO) quarterly meeting.

In spite of a firm commitment to recovery transformation by VA leadership, and the appointment of recovery coordinators at each medical center, transformation is, in fact a challenge. Of all of the elements of the MHSP, recovery transformation is the most distant from many of the usual practices of bio-medically oriented mental health care.

Recovery transformation requires a change in the culture for providing care, and this type of change is always challenging to achieve. For providers, it means changing from clinical strategies based on professional judgments of what is best for the patient, to strategies based on determining what goals are most important to the patient, and helping him or her achieve them. The transformations in programs that are needed to ensure that they follow recovery models are so profound that they will take time to achieve.

Question 2(b): What updates can the VA provide on integrating mental health into primary care in more than 100 pilot program sites? (e.g., duration of the pilot; planned evaluation; planned evaluation and funding).

Response: The overall purpose of the VA primary care-mental health integration (PC–MHI) program is to promote the effective treatment of common mental health

and substance use disorders in the primary care environment, and thus improve access and quality of care for Veterans across the spectrum of illness severity. This is consistent with the recommendations of the President's New Freedom Commission on Mental Health, which emphasizes that mental health and physical health problems are interrelated components of overall health and are best treated in a coordinated care system. To that end, one goal of the MHSP is to "develop a collaborative care model for mental health disorders that elevates mental health care to the same level of urgency/intervention as medical health care."

PC–MHI program funding began during FY 2007 under the mental health enhancement initiative, through a request for pilot program proposals that was issued to the VISNs. VA facilities were asked to implement co-located collaborative or care management programs, consistent with evidence-based best practices. Funding during FY 2007 was $23 million, representing 409 full-time employee equivalents (FTEE) throughout programs located in 94 facilities. These pilot programs continued with funding of $32 million during FY 2008, and program growth occurred at additional facilities through VISN and local initiatives. An additional 142 FTEE for the program are being funded during FY 2009. VA disseminated the Uniform Mental Health Services Handbook (VHA Handbook 1160.01) in September 2008. It sets clinical expectations and structural requirements for FY 2009 and beyond. For PC–MHI, the handbook directs that these programs continue as routine practice, and that full primary care mental health integration be delivered at all VA medical centers and large community-based outpatient clinics (CBOC).

Formative program evaluation has assisted implementation greatly, and is coordinated through the VA National Serious Mental Illness Treatment Research and Evaluation Center in Ann Arbor, Michigan. Upon the start of the initial program funding, a request for a new clinic stop code for PC–MHI was made effective beginning in FY 2008. This enabled tracking of pilot program activities through encounter data. From FY 2008 through 2nd quarter FY 2009, 103 of 139 VA facilities have posted an aggregate total of 308,035 PC–MHI encounters. All VISNs have facilities represented in the data. The prevalent diagnoses in these encounters are those consistent with the evidence base for collaborative, primary care-based mental health screening and care: depression and anxiety disorders, alcohol and other substance use disorders, and post-traumatic stress disorder (PTSD). Notable current activities include ongoing program evaluation; developing service delivery models combining co-located collaborative care and care management; identification and dissemination of best practices, tools and procedures; and education and training centered on both program implementation and training of frontline integrated care staff.

Question 3: How does the VA know that MHSP was a success and helped to improve mental health care for our Veterans?

Response: The MHSP and the mental health initiative led to increases in VHA mental health staffing from 13,950 FTEE in 2004–2005 to 18,844 at the end of the second quarter of FY 2009. This staffing has allowed a 26.2 percent increase in the number of Veterans receiving mental health services since 2004; this represents an increase from 3.1 to 3.9 percent of all of America's Veterans. Over the same time, the continuity and intensity of care also increased. For one example, VA modified its standard of care to require an initial triage evaluation within 24 hours after a new request or referral for mental health services, and a full diagnostic and treatment planning evaluation within 2 weeks, and it is now meeting that standard more than 95 percent of the time. Another example is the number of outpatient mental health or substance abuse visits during the first 6 months after discharge from a mental health or substance abuse hospitalization increased by 15 percent. Overall, these measures and others indicate that VA is now providing more services to more Veterans.

Question 4: What is the future of MHSP when the 5-year plan ends in November 2009?

Response: VA will use the 5-year anniversary as a milestone for evaluating progress. At present, considerably more than 95 percent of the recommendations of the MHSP are now parts of ongoing policy and practice. Activities related to the remaining items are being developed. Those components of the MHSP that are related to clinical care have been incorporated into VHA Handbook 1160.01, *Uniform Mental Health Services in VA Medical Centers and Clinics*, with a requirement for implementation of the handbook by the end of FY 2009. The purpose of the MHSP was to catalyze a rapid enhancement of VA's mental health care programs. Since the MHSP was adopted, these enhancements have occurred, and VA's goal is now to ensure the sustained operation of the enhanced system.

Question 5(a): There have been concerns raised here today and recently with the Subcommittee concerning the ongoing cost of implementation of the Uniform Services Handbook and the lack of resource support. What is the level of support and buy-in from decisionmakers at the VISN and local levels? Also, what roles have VA's stakeholders (e.g., Veterans themselves, Veterans Service Organizations, and mental health professional associations) had in the development of the plan? What is their anticipated role in the implementation of the plan?

Response: Implementation of the Uniform Services Handbook by the end of FY 2009 is VHA policy. It has the highest level of support from the Acting Under Secretary for Health, and from each level of leadership, nationally and regionally. The handbook was developed on the basis of extensive dialog and interactions with mental health consumers, advocates, providers, and researchers, both within VA and beyond.

Similar to all mental health care systems, VA relies on organizations and individuals in the community to be watchful for warning signs of mental health problems in Veterans, and when they are observed, to help guide Veterans to care. VA hopes that VSOs and other advocates for mental health services familiarize themselves with the publicly available handbook and use it as a resource in working with Veterans. Specifically, mental health staff from VA Central Office is in the process of working with VSOs, mental health advocacy organizations, and mental health professional organizations to ensure consumers, families, advocates, and community-based professionals are aware of the requirements for services that are included in the handbook. Working to align guidance from Central Office with local, patient-by-patient advocacy should enhance implementation.

Question 5(b): What are the prior resource commitments that VA has made to develop and initiate the implementation of the handbook? Also, can the VA quantify future resource levels needed to fully implement the handbook system-wide?

Response: VA has increased its overall mental health budget from approximately $2.1 billion in FY 2001 to about $4 billion in FY 2009. During FY 2009, $557 million from the mental health enhancement initiative was allocated to enhancing mental health services. Of this, $380 million was used to support the sustained operation of programs and positions in medical centers and clinics that were funded through the initiative in prior years, and $127.5 million was allocated specifically to support implementation of the handbook. The remainder of the Initiative was used to support national programming in support of implementation.

In addition, approximately $29 million from "no year" 2007 supplemental funding was allocated this year to the VISNs and medical centers to support implementation of the handbook, and other special purpose funding was allocated to enhance PTSD, substance use, and homeless programs.

Future resource levels needed to fully implement the handbook system-wide will be projected and allocated through the models discussed in the response to question 1.

Question 5(c): Are equipment, space, and personnel office needs accounted for in the budget and implementation plan? Have VISN and local authorities allocated those resources?

Response: In FY 2008, the Office of Mental Health Services used supplemental funding to allocate $42 million in non-recurring maintenance projects to assist in improving the space and the care environment for mental health and substance abuse programs. An additional $7 million was allocated from the mental health enhancement funding to support required equipment and supplies related to increased staffing. At the end of FY 2008, the field reported the obligation of all funds.

Question 5(d): Will other sources of funding be required at the VISN, medical center and local levels to fully implement the plan? If so, how much will be required? Will they be expected to absorb the funding using its annual VERA allocations or will there be special set-aside funding for this, such as funding through Mental Health Enhancement Initiative?

Response: During FY 2009, approximately $600 million of the total VA mental health budget of $4 billion (~15 percent) has been in the form of special purpose funds. The remaining (~85 percent) is derived from the Veterans equitable resource allocation (VERA). The mental health enhancement initiative and other special purpose funds have never represented more than a small component of the total funding required for mental health services.

For FY 2010, VA plans to include the initiative as a new element in the VERA allocation, to ensure the sustained operation of the programs that were established through the use of the special purpose funds, VA will require accountability for maintaining enhanced funding, programs, and staffing on a facility by facility basis.

Question 6: Are there challenges outside of funding, such as the lack of qualified mental health professionals, in implementing the handbook in a timely manner?

Response: The implementation of the handbook will be accomplished through the activities of current mental health staff, as well as recruitment for increased staffing. VA is making steady progress toward recruiting mental health staff. During the 1st quarter of 2009, VA added 991 FTEE in mental health staffing and in the 2nd quarter added 726 for a total this year of 1,717 FTEE. VA does not anticipate being limited in the implementation of the handbook by the lack of qualified mental health professionals. However, we do anticipate other challenges.

The handbook includes requirements to complete the implementation of the clinical components of the MHSP. It is a broad-based, far-reaching document with multiple requirements for the provision of evidence-based, Veteran-centric care. It is the sense of VA that in its requirements, it is establishing VHA as the most comprehensive mental health care system in America. In this, there are multiple challenges. Some of these are expected and inevitable. They are the sorts of challenges that occur whenever change is mandated in a large system. Some are related to the stigma associated with mental illness and its treatment. Others are related to difficulties for some providers and patients in transitioning from older, traditional approaches to mental health care to evidence-based treatments. Still others are related to the time and training that may be required to achieve the recovery transformation, with an appropriate balance between the ethical principles of beneficence and of autonomy in defining the goals for treatment, especially for patients with serious mental illness.

Finally, it may be important to recognize that the coordination of information technology (IT) with clinical services may present another series of challenges. Specific areas in which further advances in mental health services will depend on IT developments include organizing the activities of patients, families, and providers to develop and monitor individualized treatment plans; systematic assessments of the outcomes of clinical interventions; documentation of the session-by-session delivery of evidence-based psychotherapy; and tracking of patients in care management programs.

Question 7: In what ways might the implementation of the Uniform Mental Health Services Handbook contribute to reducing the barrier that stigma plays in keeping Veterans from seeking mental health and substance use services?

Response: The handbook has been designed to empower Veterans as consumers and to support Veteran-centric care. It requires Veteran input into treatment planning. It defines those services that must be available to all eligible Veterans who need them and those that must be provided in each VA medical center, and each very large, large, mid-sized and small CBOC. In this, the handbook is intended to empower Veterans, families, and advocates in dialogs with providers about setting the goals for treatment. By laying out alternative approaches to care, it is intended to encourage the expression of Veterans' preferences. By requiring the integration of mental health services with primary care, it is designed to make mental health care for the most common conditions available in those settings where Veterans are most comfortable. By requiring that services for Veterans with serious mental illness emphasize the principles of recovery, it works toward establishing the principle that care must be provided to all Veterans in a manner that enhances their sense of control over their own lives.

Question 8: There is heightened awareness on the increased need for Veteran access to behavioral health and substance abuse providers, yet there is an ever-present VA mental health provider shortage. Why is it that the VA has yet to show evidence of substantial increases to the provider pool, particularly when there are almost 150,000 readily accessible marriage and family therapists (MFT) and Licensed Professional Counselors (LPC) waiting in the wings for final VA implementation?

Response: There have been substantial increases in the pool of VA mental health providers. Over the past 4 years, VA has increased its core mental health staff by almost 5,000 FTEE from 13,950 in 2005 to 18,844 at the end of the 2nd quarter of FY 2009, an increase of over 35 percent. Certainly VA is working to add job series

for marriage and family therapists (MFT) and licensed professional counselors (LPC) and will welcome them into the VA mental health team. However, they have not been needed in order to accomplish dramatic growth in the number of mental health providers in the VA system.

Question 9: How can the VA justify the lack of readily available mental health services and the slow rate of provider increases, particularly in rural communities, when the need for this care is so great?

Response: VA does not agree with the premises that there is a lack of readily available mental health services and a slow rate of provider increases. With respect to the availability of services, VA requires that all new requests or referrals for mental health services must be evaluated within 24 hours to determine the urgency of the need for care, and, if there is no immediate need for services, a full diagnostic and treatment planning evaluation must be conducted within 14 days. At present, VA is meeting the 14 day standard for over 95 percent of cases. With regard to staffing, since 2005, VA has increased its mental health staffing by almost 5,000 FTEE.

Question 10: Where is proof that VA has made mental health services and substance abuse providers appropriately available for smooth and efficient readjustment of OEF/OIF Veterans?

Response: In addition to increases in mental health staffing in VA medical centers and clinics, VA has increased the number of readjustment counseling centers (Vet Centers), and the staffing for the readjustment counseling program. This has allowed VA to expand outreach to returning servicemembers, including VA participation in all scheduled post-deployment health reassessment events, outreach to National Guard and Reserve Units, and community programs. It has also allowed increased screening for mental health conditions in medical care settings, and the integration of mental health services with primary care.

One way to evaluate the availability of mental health services for returning Veterans is to compare estimates of the needs of the Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) population with the number of Veterans actually seen in VA. A recent publication by Milliken estimates the prevalence of PTSD as detected in Army National Guard and Reserve members at post-deployment health reassessments events is 14.3 percent. This figure is comparable to the estimate from last year's RAND study of 13.8 percent for servicemembers and Veterans. Although there may be reasons to question the precision and validity of any single estimate, these findings taken together support a prevalence of about 14 percent. It may be useful to use this figure to estimate the extent to which VA services address the needs of the population.

From the start of the war in Afghanistan to the end of calendar year 2008, 981,834 Veterans returned from deployment to Afghanistan or Iraq. An estimate of 14 percent for the prevalence of PTSD corresponds to approximately 137,457 cases. During this time, VA has seen 114,908 Veterans in its medical centers, clinics, and Vet centers who have received a diagnosis of PTSD on at least one occasion. This number of Veterans seen corresponds to about 84 percent of all of those with PTSD, suggesting that VA is addressing a substantial component of the needs of the population. Clearly, there is a need for continued outreach and related programs, but review of these estimates suggests that a majority of those in need for specific services for PTSD may be accessing care in VA.

Question 11: Now 7 years into war, how many VA mental health providers have been trained to provide evidence-based PTSD treatments? What is the average timeline for completing staff training nationally, and what are its elements?

Response: Since findings from VA research supported the effectiveness of evidence-based psychotherapy for PTSD, and since the Institute of Medicine's (IOM) review confirmed the power of the evidence, VA has trained more than 1,700 VA providers in the delivery of cognitive processing therapy and prolonged exposure therapy. All of those have been licensed and credentialed VA providers, experienced in providing psychotherapy and related clinical interventions. Training for a provider in these therapies takes approximately 4 to 6 months. The training can be divided into three phases:

- Workshops, usually lasting several days, with review of the principles underlying the treatments and demonstration of the techniques;
- Trainees provide treatment using these therapies to a number of cases over the course of several months with case by case, session by session mentoring from a therapist experienced in the specific treatment; at the successful conclusion

of these mentored treatments, the trainee will be considered to have mastered the skills needed for providing the treatment; and
- Ongoing discussion, communication, and peer supervision to maintain skills.

Question 12: Can any Veteran who needs VA care for acute PTSD receive that care immediately? Can you give the Subcommittee staff a report on the average waiting time for starting specialized therapy or counseling once it is requested?

Response: Yes, VA requires that every Veteran who comes to a VA medical center or clinic with a mental health concern is evaluated for urgent medical needs, including danger to self or others and if found to need care immediately; that care is provided. There is a requirement for initial assessment within 24 hours of requests for service or positive screens, and for a diagnostic and treatment planning evaluation within 14 days. At present, VA is meeting the 14-day standard for over 95 percent of cases.

Question 13: Early intervention services are critical to prevent chronic mental health problems among returning Veterans. Has VA increased its focus on early, accessible intervention services, such as relationship counseling, and motivational counseling to prevent hazardous alcohol or drug use, and made sure that they are available at all sites of care, including Vet Centers?

Response: An important part of VA's increasing emphasis on the integration of mental health services with primary care is a focus on early screening, early brief intervention, and the early implementation of treatment for problem drinking. VA currently requires annual screening for problem drinking in all primary care settings, and, when Veterans screen positive, provision of treatments. When the problem persists, the requirements are for motivational interventions, and, then for referral to specialty care. The same treatment and motivational intervention strategies are also used in Vet centers.

Question 14(a): DAV recommended that Congress should require VA to establish an independent body, with appropriate resources, to analyze data and information, supplement its data with periodic site visits to medical centers and make independent recommendations to the Secretary and to Congress on actions necessary to bridge gaps in mental health services, or to further improve those services. This sounds much like the "Committee on Care of Severely Chronically Mental Ill Veterans" that was mandated by Congress in 1996. Please answer the following questions on that: What is the current role of mental health consumer organizations, Veterans service organizations, and professional organizations in the ongoing work of the VA's Committee on Care of Severely and Chronically Mentally Ill Veterans ("SMI Committee")?

Response: In the authorization by Congress, membership of the Committee on Care of Severely Chronically Mentally Ill Veterans defined to include VA staff, and not mental health consumer organizations, Veterans service organizations, or professional organizations. To establish a mechanism for obtaining input about mental health services from these groups, VA established a Committee consumer council consisting of a representative group of mental health consumers, including representatives from major mental health professional and consumer organizations and VSOs. Membership on the consumer council allows them to share their views with the Committee. However, following the initial authorization, they are not members of the Committee and do not have a vote.

Question 14(b): Was there a change in the role of these stakeholder groups as a result of the SMI Committee's re-chartering in 2006? If so, why?

Response: There was no change in the role of these stakeholder groups as a result of the serious mental illness (SMI) Committee's re-chartering in 2006. The SMI Committee has always served as an internal work group, reporting primarily to the Under Secretary for Health. It was never intended to function as a Committee that would be subject to Federal Advisory Committee Act (FACA). Over time, there has been an ongoing need to review its processes to ensure that it had not taken on activities that would lead to FACA requirements.

Question 15: Concerns have been raised about VA plans to shift funding for the Mental Health Initiative from general health care to an allocation through the Veterans Equitable Resource Allocation process. How would you respond to these concerns? Do you believe VA's funding plan will support and sustain the Mental Health Initiative over the long term?

Response: The mental health enhancement initiative was established by VA as a funding stream outside of VERA to support the rapid implementation of the VHA comprehensive MHSP. It has led to rapid enhancements in staffing that have allowed increases in the number of Veterans with mental health concerns to be seen in VA medical centers and clinics and in the intensity of services provided to them. With the rapid enhancement of staffing levels that has already been accomplished, and with the handbook's establishment of requirements for the services that must be available to all eligible Veterans in need and those that must be provided in each facility, the focus for VA must shift. At this time, VA's focus should be on monitoring the mental health services that are provided in all facilities and those that are available to all Veterans rather than on spending of specific funds. FY 2010, VA will ensure that spending and staffing levels for mental health are maintained, while it implements measures and monitors to ensure that the handbook is fully implemented. The current level of VA funding for mental health as specified in the President's budget is adequate to support and sustain the goals of the mental health initiative; implementation of the MHSP through implementation of the handbook.

Question 16: Is there a timeframe for VISNs to request modification or exceptions for Uniform Mental Health Services (UMHS) Handbook requirements that cannot be met? Have any VISNs requested modification or exceptions, and if so, how many? What will be done to bridge the gap in services between requirements in the UMHS Handbook and facility capabilities?

Response: VISNs are required to implement the requirements of the handbook by September 30, 2009 unless they apply for and are granted exceptions. Thus, the deadline for submission, review, and approval of exceptions is September 30, 2009.

In this context, it is important to emphasize several of the key provisions of the handbook. It includes requirements for the services that must be available for each eligible and enrolled Veteran, and those that must be provided at each VA facility (medical centers, and very large, large, mid-sized, and small CBOCs). An application for an exception is for a waiver for the requirement to provide specific services at specific facilities. There is no provision for applications for exceptions for services that must be made available to all eligible and enrolled Veterans who need them. Accordingly, the handbook requires that facilities bridge the gap between requirements in the UMHS handbook and facility capabilities by referral to geographically accessible VA services, and referral to community providers by sharing agreements, contracts, or fee-basis services provided that requirements for eligibility are met.

Question 17: In their testimony, the DAV highlights the need for better outreach and the success of the "VetAdvisor" program being piloted in VISN 12. Do you have any plans to expand this pilot?

Response: VA agrees that early findings from the VetAdvisor program appear promising. In brief, VISN 12 contracted with Three Wire, a serviced-disabled Veteran owned business. Its initial pilot project on telephone outreach provided screening to over 5,000 OEF/OIF Veterans who were identified as not having previously contacted VA. Over 1,100 of those contacted screened positive on at least one measure and were referred to VA for services. Recently VISN 12 renewed the contract and extended the scope of work to go beyond outreach and screening to include telephone coaching to promote access to services. More detailed findings from an evaluation of this program are needed, and they are anticipated by the end of calendar 2010.

There are also a number of other promising programs being piloted in other components of the system, including Web-based services in Texas, family based services in VISN 4, and others. The Vet center program is developing a call center for returning Veterans, and VA is working with the Department of Defense (DoD) to design a "coaching" program to facilitate the continuity of care for servicemembers who received mental health care while on active duty. Other relevant activities include advertising, public services announcements, and educational programs in the community.

VA recognizes the importance of outreach to encourage returning Veterans (as well as those from prior eras) to engage in care when they need it. The specific programs for outreach, overall and at each location are continually under review. Given the number of promising programs, and the need for further evaluation of the VetAdvisor program, it would be premature to make decisions about the expansion of this program. Instead, VA has developed a number of pilot and demonstration projects and will decide which should be rolled out on a national basis when evidence on their effectiveness becomes available.

Question 18: The OIG testified to a number of items in which VA is at risk for not meeting its implementation goal, specifically concerned with VA's not meeting the goal to follow up with Veterans within 1 week of discharge from an inpatient mental health unit. What is VA doing to improve its follow-up practices?

Response: VA would like to clarify the fact that Report 08–02917–105 from the VA Office of the Inspector General, dated April 6, 2009, made no specific recommendations related to the implementation of the handbook. It stated: "Consistent with the handbook requirements for timely follow-up after discharge from a mental health inpatient unit, the VHA Office of Quality and Performance, Office of Patient Care Services, and Office of Mental Health Services introduced a new quality monitor for FY 2009. The monitor measures the percent of inpatient discharges that include at least a bed day of care in a mental health bed-section of care during which the patient received a face-to-face, telehealth, or telephone encounter within 7 days following the discharge date; and if the initial follow-up encounter was by telephone, a face-to-face follow-up encounter must occur within 14 days. VHA pulls the data for these measures from the VA National Patient Care Database Outpatient and Inpatient Workload files. In March 2008 prior to the handbook, 46 percent of total patient discharges were seen within 7 days. For February 2009, this increased to 57 percent. The monitor target is 85 percent."

By including follow-up after hospital discharge as a performance monitor, VA is bringing a high level of scrutiny and accountability to this area. With ongoing monitoring, feedback, and direction to the facilities VA anticipates that the target for follow-up will be met by the end of the fiscal year.

Question 19: How is VA using its contract authority to enhance its mental health services, especially in rural areas where it is hard to recruit mental health professionals?

Response: VA is currently in the process of implementing a number of pilot or demonstration projects for the delivery of services in highly rural areas, including a number that use contracting for mental health services. This includes the pilot project authorized under section 107 of Public Law 110–387.

More generally, the UMHS handbook requires that when enrolled Veterans requiring specified mental health services are beyond the geographic reach of the services provided at VA medical centers and clinics, these services should be provided by referral to other VA facilities, when these are geographically accessible, through telemental health services, or through sharing agreements, contracts, or fee-basis services when the Veteran is eligible.

Question 20: What lessons have been learned from implementing the Mental Health Strategic Plan?

Response: VA's lessons learned about translating the recommendations of the MHSP into requirements for specific services have been incorporated into the UMHS handbook. The handbook will serve as the vehicle for ensuring the sustained operation of those programs and services that were implemented under the strategic plan.

The 255 recommendations of the strategic plan can be summarized in terms of 6 principal components:

- Addressing the needs of returning Veterans;
- Ensuring that the access and capacity of mental health services is adequate;
- Integrating mental health with primary care;
- Transforming the specialty mental health care system to focus on rehabilitation and recovery;
- Implementing evidence-based practices with an emphasis on evidence-based psychosocial and behavioral interventions; and
- Preventing suicide.

The first of these is, more or less, specific to VA. The others are important goals for the enhancement of mental health services for America as a whole. In this context, the lessons learned by VA may be relevant to understanding the mental health services that should be available to the population as a whole under health care reform.