STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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Mr. Chairman and Members of the Committee:

Thank you for inviting Disabled American Veterans (DAV) to testify at this important hearing. We appreciate the opportunity to offer our views on the problems confronting the Department of Veterans Affairs Veterans (VA) and its Veterans Health Administration (VHA) in meeting the critical mental health needs of some of our nation's veterans—particularly newer veterans now struggling with post-deployment mental health challenges. As requested by the Committee, we focus this testimony on mental health care staffing; barriers to access; quality of care; reliability of data; and, systemic issues impeding care, wellness and recovery.

Over the past five years both the House and Senate Committees on Veterans' Affairs have held numerous hearings on VA mental health. Topics included access to care; closing the gaps; waiting times; invisible wounds; suicide and its prevention; treatment of post-traumatic stress disorder (PTSD); and, VA's Mental Health Strategic Plan and its Uniform Mental Health Services Handbook.[1] Both the Government Accountability Office (GAO) and VA's Office of Inspector General (OIG) have evaluated and examined many of these issues, sometimes at the request of Congress, including the latest report, issued on April 23, 2012 *–Review of Veterans' Access to Mental Health Care*. Likewise, for over a decade the print and electronic media has widely and repeatedly covered the many challenges new war veterans face with physical and mental health—including the perception that VA seems unable or has failed to help some of them. Predictably, this coverage focuses predominantly on veterans who have fallen through the cracks, taken their own lives, or has highlighted gaps in VA and DOD care, documented particular mistakes and failures in individual cases, cited the ever-present bureaucracy, and made observations examining barriers to care, including mental health stigma that prevents some veterans from even seeking VA care. It is rare to see media coverage of VA mental health in a positive light although over the past five years it has made remarkable progress in establishing a strong foundation of mental health services. DAV continues to be concerned about the constant negativity of the reports on VA mental health. Without proper balance in reporting we fear many veterans who need care the most may not come to the system designed to meet their unique needs.

As noted, the unprecedented efforts made by VA over recent years to transform itself and improve consistency, timeliness, and effectiveness of VA's mental health programs, provide evidenced-based treatments and care that bring veterans hope for recovery, and reduce stigma associated with mental health, are rarely discussed and virtually never applauded. Likewise, published reports and research on the tens of thousands of dedicated VA health care

professionals and staff who provide specialized mental health services to troubled and ill veterans frequently go without any recognition, thanks or gratitude. Unfortunately, in the current environment it is difficult to shift public perception to the positive gains VA has actually made. Compared to the private sector, VA's mental health and substance abuse system gets high marks. However, given the troubling findings of the Senate's informal July 2011 mental health query of mental health providers[2] and the most recent OIG report[3] pointing out lingering and significant flaws and limits, VA seems to have fallen short of its own goals to provide the best possible accessible care to veterans, many of whom are in desperate need of receiving VA's specialized mental health services. VA is not meeting its access standards and has not provided the needed services consistently to every veteran in every VA facility across the country. While not true in most cases, VA bears the brunt of this perception and consequently pays a high price in the minds of the public and the veteran community.

The informal query VA conducted at the request of your counterparts in the Senate found that mental health care providers did not agree that veterans' ability to schedule timely appointments matched data reported by VA's performance management system and identified a number of constraints on their abilities to best serve veterans, including inadequate staffing, space shortages, limited hours of operation and competing demands for scarce appointment slots. Seventy-one percent of those survey respondents indicated that their medical centers had inadequate numbers of mental health staff. VA recently testified that it was taking two major actions as a result of the findings of this survey. VA developed a comprehensive action plan to enhance services and to address the VA staffs' concerns and it conducted an external focus group to better understand the issues raised by front-line providers. VA also stated it is conducting site visits to each VA medical center this year to evaluate mental health programs.[4]

The OIG was asked to determine how accurately VHA documents waiting times for mental health services for new and established patients, and whether the data VA collects is an accurate depiction of veterans' ability to access needed services. VHA policy requires new patients who are referred to, or who are requesting, mental health services, to receive initial evaluations within 24 hours of request, and be provided a more comprehensive diagnostic and treatment planning evaluation within 14 days of request. VA has reported that 95 percent of its first-time patients receive a full mental health evaluation within VA's 14-day goal. Nevertheless, the OIG report found that VHA's mental health performance data is not accurate or reliable and that VHA's measurement of first-time access to a full mental health evaluation was not a meaningful measure of waiting times.

The OIG conducted its own analysis and projected that in VHA only 49 percent of patients (versus 95 percent) received full evaluations, to include patient history, diagnosis, and treatment plan, within 14 days and for the remainder of patients, it took 50 days on average. Additionally, VHA could not always provide existing patients their treatment appointments within 14 days of their desired dates. DAV began an informal, anonymous online survey for veterans in December 2011, asking about their experience seeking and receiving VA mental health services. To date, nearly 1,050 veterans from all eras of service have responded to the survey, and our findings were close to those reported by the OIG on waiting times for follow up appointments. A complete report of DAV's survey results can be found on line at http://www.standup4vets.org. The OIG report also noted that several mental health providers

whom inspectors interviewed had requested desired dates for patients for follow up care based on their personal schedule availabilities rather than the patients' requests, or based on observed clinical need in some cases. Likewise, VHA schedulers did not consistently follow VHA policy or procedures but scheduled return clinic appointments based on the next available appointment slots, while recording the patients' "desired" and actual dates as if they were compliant with VA policies. Since the OIG had found a similar practice in previous audits nearly seven years earlier, and given that VHA had not addressed the long-standing problem, OIG urged VHA to reassess its training, competency and oversight methods and to develop appropriate controls to collect reliable and accurate appointment data for mental health patients. The OIG concluded that the VHA "…patient scheduling system is broken, the appointment data is inaccurate and schedulers implement inconsistent practices capturing appointment information." These deficiencies in VHA scheduling system have been documented in numerous reports. After more than a decade, VA's Office of Information and Technology has still not completed development of a state-of-the-art scheduling system that can effectively manage the scheduling process or provide accurate tracking and reporting.

The OIG also recommended that VHA conduct a comprehensive analysis of staffing to determine if mental health provider vacancies were systemic issues impeding VA's ability to meet its published mental health timeliness standards. Most importantly, the OIG report noted that meaningful analysis and decision making required reliable data, not only related to veterans' access but on shifting trends in demand for services, the range of treatment availability and mix of staffing, provider productivity and treatment capacity of the facilities. References were provided by the OIG to VHA on managing a better response to a number of shifting dynamics, through "dashboard reports" used in the private sector that incorporate patient demand, clinic capacity and provider productivity in a consistent set of business rules in which to assess and respond quickly to changes in access parameters. The OIG made four major recommendations to VHA on the above noted issues. Similar to previous external reviews, the VA Under Secretary for Health has agreed with all these recommendations and stated that a number of measures are currently underway.[5]

As we noted earlier in this testimony, despite obvious progress, it is clear to us that much still needs to be accomplished by VHA to fulfill the nation's obligations to veterans who are challenged by serious and chronic mental illness, and particularly to those with post-deployment mental health and transition challenges. VA's duty is clear—all enrolled veterans, and especially service members, Guardsmen and reservists returning from current or recent war deployments, should be afforded maximal opportunities to recover and successfully readjust to civilian and domestic life. They must gain 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 in the post-Vietnam period, that psychological reactions to combat exposure are not unusual: they are common. If they are not readily addressed at onset, they can easily compound and become chronic and lifelong. The costs mount in personal, family, emotional, medical, financial and social damage to those who have honorably served their nation, and to society in general. Delays or failures in addressing these problems can result in self-destructive acts, including suicide, job and family loss, incarceration and homelessness.

Currently, we see the pressing need for mental health services for many of our returning war veterans, particularly early intervention services for substance-use disorder and evidence-based care for those with PTSD, depression and other consequences of combat exposure. As we have learned from experience, when failures occur, the consequences can be catastrophic. We have an opportunity to save a generation of veterans, and help them heal from war, but decisive action is essential.

Mr. Chairman, in mental health, VA is now at a crossroads, and its next steps are critical ones. This issue is extremely serious—and everyone wants to ensure that VA gets it right. We observe that Congress is frustrated, as are we. Billions of new dollars and personnel for improving VA mental health services have been pumped into the system over the past five years—and despite the significant number of new hires, a 46 percent increase in staff between 2005-2010,[6] VA recently reported it still needs to hire 1,600 additional mental health clinical and 300 support staff.[7] Many have pointed out[8] this increment alone will not fix the problem. So, the question is what can and should be done at this critical juncture? What are the best solutions to solve the existing problems? Within the next couple of years, more combat veterans will be returning home and many will need VA's services. We concur with remarks made by Deputy Under Secretary for Health for Operations and Management, William Schoenhard, at the April, 25, 2012, Senate Veterans' Affairs Committee Hearing that sending these veterans out of the system en masse is not the answer—this group particularly can benefit from VA's expertise in treating post-traumatic stress, PTSD, substance-use disorders, traumatic brain injury and other post deployment transition issues. To that end, it is essential that VHA address and resolve the issues that tolerate variable provision of mental health and substance abuse care and prevent consistent, timely access to care at VA facilities nationwide.

Unfortunately, the problems in VA's mental health programs are complex, and cannot be resolved within any single dimension. The VHA is facing systemic challenges that are similar in nature to the organizational problems that the Veterans Benefits Administration (VBA) is facing with respect to its seemingly intractable backlog of disability claims. The root causes are multiple, systems-based, longstanding, and complex. DAV has been a staunch advocate for correcting the *root* problems in VBA—not just managing a symptom of the problem by reducing the backlog on a crash basis. We believe the same holds true for VA's mental health clinical programs.

One of the most troubling barriers that prevents VA from being more effective in many of its programs is VA's own human resources (HR) policies and the practices surrounding them. Practitioners and clinical program leaders across the VA system have told DAV for years that recruitment of new professionals is a vexing and frustrating challenge that contributes to VA's failings and deficits. Even when new candidates are plentiful, well-qualified, and eager to join VA employment, the process that leads to offers of VA employment can linger for months, and in rare cases, years, before an employment commitment can be made. Many excellent candidates wait for months without feedback from VHA and simply move on to other opportunities. Delays of such magnitude are due to a variety of factors, but one principal reason for them is that human resources personnel are accountable only to their program officials in HR, but not to clinical selecting officials. In our opinion, they do not treat recruitment as an urgent process requiring the highest level of customer service to both the internal and external

customers. This is especially ironic, given that about 100,000 health professionals train in VA facilities annually. Many of these young professionals may want to stay in VA but their personal and financial circumstances prevent them from waiting months or years for a VA job offer.

As a part of the *Independent Budget* (IB), DAV has been calling for reform in VA's human resources policies.[9] Recent hearings on VA mental health in the Senate confirm that the lack of responsiveness of human resources offices and management policies are contributing to deficits in VA's mental health programs. Sadly, unresponsive HR practices are also affecting all of VA's key missions. We urge the Committee to carefully examine VA and Office of Personnel Management appointment authorities in statute and how they are being applied within VA to determine whether additional legislation would offer any helpful resolution. VA should develop and track measures of performance in HR recruitment, on-boarding and retention of clinical staff. Almost as important, the Committee should provide targeted oversight in examining why VA human resources programs are so weak and unaccountable at a time when they should be acting forcefully and supportively to ensure VA programs in VHA, VBA and Memorial Affairs are properly staffed to meet their missions. With help from Congress, we believe this aspect of VA's challenges can be solved with better leadership and more responsiveness, beginning at the local level and extending throughout the system.

I must also report that many VA facility executives seem to tacitly support current bureaucratic practices in HR as a means to conserve facility funding and stretching health care budgets. Almost every VA facility operates a "resources committee" or similar function to examine every vacancy occurring and then to require selecting officials to justify in writing (and sometimes by making personal appearances and appeals before the Committee) why vacancies should be filled at all. This grueling process that constitutes a "soft freeze," can consume months, all the while allowing the facility to "save" the personal services funds that would have been paid in salary and benefits associated with those unencumbered positions. It is common practice for resource committees to deny authorization to fill mental health and substance positions, creating "ghost" positions that are listed in the Service FTEE allocations but can never be recruited. We understand that in many locations, the 1,600 newly allocated FTEE will not even be sufficient to fill these vacancies. We believe, certainly now in the face of inadequate mental health access, that such practices should be halted. With the massive and rising unmet needs being reported today, VA must become very sensitized and make every effort to quickly fill all mental health provider vacancies and their support staff positions as a high priority in HR offices. VHA Central Office and VA Medical Center leadership should be accountable to ensure that this occurs.

Despite all these staffing challenges, the transformation of the VHA's mental health program over the past decade has been revolutionary. As the wars in Afghanistan and Iraq were raging, VA inaugurated its internal reforms in the beginning of 2004 and developed a Mental Health Strategic Plan rooted in the principles of recovery-oriented care. In 2008, VA instituted a national Uniform Mental Health Services Handbook to ensure consistency of available services throughout the health care system's 1,400 sites of care. Full implementation of the Handbook is still ongoing, and now a patient-centered care model has been added to the mix for all of VA health care. Likewise, state-of-the-art approaches to care, evidenced-based treatments and new technologies have been validated by research for some mental health challenges, including

PTSD. All of these activities have occurred during a time of steadily increasing patient care workloads and rising demand for services. Despite the addition of thousands of new mental health staff, demand for these services by tens of thousands of new veterans has obviously overwhelmed the system and made it difficult for VA mental health providers to translate transformational mental health policies and cutting edge clinical services into consistently delivered clinical practices.

Today's wars are truly different, and accompanied by multiple and longer deployments than any previous experience of military service members, National Guard or reserve personnel. Additionally, the VA must not only contend with a new generation of war veterans but continue longer term treatment of a significant number of veterans from prior eras of military service with mental health challenges and a large, older population with debilitating chronic and serious mental illnesses. We believe the clinical policy changes VA has made over the past eight years are positive and will ultimately equate to better patient care and improved mental health outcomes—but significant challenges have arisen now on a daily basis, and these will need continued attention, intensity, resources and oversight—and the development of sound and workable solutions to ease the pressure while meeting veterans' needs. The VHA must develop a number of short and long range goals to resolve existing problems identified by the OIG, Congress and the veterans service organization (VSO) community. However, even those gains will not be enough unless VA conquers the challenge of making its own transformational cultural change across the health care system and at every service delivery point nationally. The HR function discussed is but one significant challenge that cries out for immediate reform.

VHA must develop reliable data systems; fix the flaws in its appointment and scheduling system with effective policies and IT systems that fill the current gaps, and is responsive to mental health needs; develop an accurate mental health staffing model that accounts for both primary and a multitude of complex specialty mental health capacity demands; revolutionize its hiring practices and eliminate the barriers that obstruct timely hiring of mental health providers and support staff; adjust its practices to address the complexities of co-occurring general health, mental health and psychosocial problems of veterans in a truly patient-centered manner, and re-establish credibility and trust with the veterans that VA is charged to serve.

In addition to these general principles we have recommended to guide VA reforms, DAV also makes the following specific recommendations for additional oversight or legislation, as warranted:

- There is an immediate need for VHA to implement a National Tele-mental Health Program, modeled on the National Tele-radiology Program, that provides the infrastructure, professional expertise and staff support needed to deliver consistent, evidence-based mental health services at all VA health care facilities. Facilities could access the program to address surge demand for services and meet the challenges of staffing shortages. If sites were established on the East Coast, West Coast and in Hawaii, extended evening clinic hours could be offered that would ease the burden on veterans for time off work and child care. An effective tele-mental health program could also help ease the recruitment challenges being reported by smaller and more rural VA facilities

that have difficulties recruiting and retaining mental health professionals.

- With Congressional oversight, VA should institute a Secretary's Task Force or Commission on Mental Health and Substance-Use Services, composed of VA and non-VA mental health and policy leaders and with participation by VSOs. This body should be given a broad directive, the staff, resources and mandate to provide comprehensive analysis and advice on the organization and delivery of VA mental health, substance abuse, and suicide prevention programs.

- The VHA should institute an external Mental Health Assessment and Site Visit Program to evaluate local fidelity and adherence to national mental health and substance-use disorder policy in the Uniform Services Handbook, as well as become a monitor for access, satisfaction, and quality of care issues. An external assessment will increase the objectivity and visibility of the site visit process. The current internal, VA staff review should serve as a pilot for this external comprehensive program evaluation and reporting process.

- The recent VHA reorganization divided the mental health program management responsibility and organized them under two different Deputy Under Secretaries—the the Deputy Under Secretary for Operations and Management and the Deputy Under Secretary for Policy and Services. This management change was implemented to ostensibly increase "integration" but, in our opinion, instead has increased VA Central Office staff redundancy, reduced responsibility and accountability, and removed valuable professional staff resources from coordinated care delivery. Given the deteriorating performance of mental health programs and the difficulties now being highlighted, the wisdom of this reorganization should be reexamined and full authority returned to the Patient Care Services and the Office of Mental Health.

- As a high priority, VHA should address the co-morbidity of mental health and chronic pain syndromes in Operation Iraqi Freedom/Operation Enduring Freedom veterans in order to provide better treatment guidance and reduce the epidemic of prescription drug misuse and the use of high risk opioid prescriptions.

- The VHA should revise the Veterans Equitable Resource Allocation (VERA) funding model to account for, and fund, the rising cost and complexity of comprehensive mental health and substance-use care in VHA.

- The Committee on Care of Veterans with Serious Mental Illness, which was authorized by law as a monitor on the quality of mental health care in VHA, and has been staffed by VHA, does not meet the original congressional intent, functions, and responsibilities. Congress should re-charter this committee to ensure that it provides input from expert advisors in the mental health, substance abuse, and veterans communities, receives staff support and access to data in order to assess the performance of the program and health care facilities, present its findings to VHA and VA leaders, and advocate for all veterans who need outreach and anti-stigma, mental health, substance use, and especially suicide

prevention programs. The VSOs should be active, full members of the Committee, rather than be part of its external consumer liaison group.

Mr. Chairman and Members of the Commiittee, in closing we applaud VHA for its focus on providing veteran-centered care and changing to a recovery-based model of care with the goal of not only symptom control and reduction but a goal of helping veterans achieve improvement in their overall wellness and functionality in society. Likewise, we appreciate the Committee's continued oversight efforts in VA mental health and for continuing to insist that VA dedicate sufficient resources in pursuit of comprehensive mental health services to meet the needs of veterans VA serves—particularly the post-deployment mental and transition readjustment needs of returning war veterans. DAV recognizes this strong support and progress, but it is eclipsed and obscured by the problems we are discussing here today, and happening at the worst possible moment when expectations are highest. VA should expeditiously work toward real reforms to make the system stronger, while properly prioritizing and addressing the urgency of the current findings. We believe the recommendations provided by the OIG and the VSO community, along with VA's measures, can collectively be used to solve these challenges.

Chairman Miller, this concludes my prepared statement. I am pleased to address any questions you or other Members of the Committee may wish to ask.

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[4] Senate Veterans Affairs Committee, "VA Mental Health Care: Evaluating Access and Assessing Care," April 25, 2012. http://veterans.senate.gov/hearings.cfm?action=release.display&release_id=b030f350-2b9f-4e85-9903-0731e03be8e1

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