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Before the
Institute of Medicine of the National Academies
Keck Center of the National Academies
June 5, 2014, Public Meeting

Evaluation of the Department of Veterans Affairs Mental Health Services

Distinguished Members of the Committee –

I am pleased to appear at your meeting today on behalf of DAV (Disabled American Veterans) and our 1.2 million members, who were wounded, injured or made ill due to their wartime military service, to discuss your current objective: evaluation of the Department of Veterans Affairs (VA) mental health programs and whether they meet the needs of veterans who served in Iraq and Afghanistan.

Your tasking document indicates the purposes of this study are to examine the barriers and the range of services available to newer and younger veterans who may be struggling with their transitions after serving in war. DAV acknowledges the importance of the Committee's task and believes this topic is a worthy one for the Institute to consider.

DAV has testified before Congress numerous times on topics related to your planned study. Also, as a partner organization of the *Independent Budget* www.independentbudget.org, we have written for years on these matters. My statement today will summarize our views from these sources, and I am providing a thumb-drive copy of the latest *Independent Budget* (IB) to each Committee member for your use. Printed copies of the document are available on request.

The wars in Iraq and Afghanistan have taken a heavy toll on the mental health of American military forces. Research suggests combat stress, post-traumatic stress disorder (PTSD), and other mental health conditions are prevalent among veterans of Operations Enduring and Iraqi Freedom, and Operation New Dawn (OEF/OIF/OND) and some of these veterans have been severely disabled. The IBVSOs believe that all enrolled veterans—particularly service members, National Guardsmen, and reservists returning from combat deployments—should have the maximum opportunity to recover and successfully readjust to civilian life. They must have user-friendly and timely access to VA mental health services that have been validated by research evidence to offer them the best chance for full recovery.

Experts note that if post-deployment mental health issues are not readily addressed, these problems can easily compound and become chronic and impact the personal well-being, family relationships, educational and occupational performance, and social and community engagement of those who have served. Delays in addressing these problems can culminate in self-destructive behaviors, including substance-use disorders and suicide attempts, and can lead to incarceration or death. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those diagnosed with PTSD, depression, and other consequences of combat deployments.

It was noted that the mental health toll of these conflicts is likely to grow over time for those who

have deployed more than once, those who do not seek or receive needed services, or those who face increased stressors in their personal lives following deployments.[1] The VA Office of Mental Health Services (OMHS) introduced a public health model for meeting the mental health needs of OEF/OIF/OND veterans with the knowledge that most war veterans will not develop mental illness if proper focus is concentrated in primary and secondary prevention, early treatment intervention, and the use of effective mental health models, along with increased outreach efforts with this population and efforts to de-stigmatize seeking VA's help. The Department indicated its goal is to promote healthy outcomes and strengthen families, with a particular focus on resilience and recovery. This initiative required VA to shift from its more traditional "medical model" approach to earlier non disease-based models and complementary and alternative models of care that focus on coping, readjustment to civilian life, and helping veterans and their families retain or regain an overall balance in their physical, social, and mental well-being. Most important, it called for VA to reach out to veterans in their communities, adjust its message, make access easy and on these veterans' terms, and reformat programs and services to meet the individual needs of veterans and their families, rather than expecting veterans to fit into its traditional array of available services.[2]

Applying lessons learned from earlier wars, VA mounted earnest efforts early on to identify and treat post-deployment behavioral health problems experienced by returning OEF/OIF/OND veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies in PTSD and other conditions associated with combat exposure. VA's readjustment counseling Vet Centers were expanded and enhanced as well as mental health related research. Nevertheless, critical gaps in timely access to mental health services were identified and additional mental health and support staff had to be hired.

Much debate has occurred about VA's ability to manage the new wartime population and provide timely access to the variety of VA's specialized mental health services. A key question has been whether VA should outsource or partner with community mental health resources to provide this care when local waiting times exceed VA's own policies and standards. VA has the authority to send veterans to the private sector to receive mental health services in the community if it cannot provide such care or provide it in a timely manner. However, we note that when a veteran acknowledges the need for mental health services and agrees to engage in treatment, it is important to establish a consistent, continuous-care relationship with that individual. Once a trusting therapeutic relationship is established, it should not be disrupted because of a lack of VA resources or for the convenience of the department.

Clearly, VA has the highest number of mental health providers with the expertise in successfully treating post-deployment-related mental health conditions in veterans, such as PTSD. VA is also able to coordinate a comprehensive set of primary and specialty services for substance-use disorders, traumatic brain injury (TBI) and other co-occurring disorders that are designed to meet veterans' complex medical and mental health needs. VA has initiated a Patient Aligned Care Team (PACT) approach and Patient-Centered Community Care (PCCC) in its mental health service delivery system to maximize utilization of its integrated health care and delivery of high-quality, accessible care to

[1] Brett T. Litz, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs, "The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq," A National Center for PTSD Fact Sheet (January 2007); http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf.

[2] Harold Kudler, VA/DOD/State and Community Partnerships: Practical Lessons on Implementing a Public Health Model to Meet the Needs of OEF/OIF Veterans and Their Families, VA Course on Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans, PowerPoint presentation, Baltimore, MD (July 28, 2010).

meet the dynamic needs of veterans. We know VA has implemented new systems of care and technology such as telemedicine and mobile applications for PTSD, as well as ensuring that it has expert mental health and substance-use disorder programs to treat co-occurring conditions such as traumatic brain injury (TBI), PTSD, and substance-use disorder. The IBVSOs prefer VA to be the provider of such services when possible, but timely access to care is the most critical factor for a veteran in crisis and therefore VA should use its community partners when necessary. We believe VA should properly triage and make a determination for each patient based on the unique findings presented, and develop a mental health treatment plan that is supported by the veteran and meets those needs.

To address the needs of veterans living in rural communities VA established pilot projects with 24 community-based mental health and substance abuse providers across 9 states and 7 VISNs. Pilot projects are varied and may include provisions for inpatient, residential, and outpatient mental health and substance abuse services. Sites may include capabilities for telemental health, staff sharing, and space utilization arrangements to allow VA providers to provide services directly in communities that are distant from a VA facility. The pilot project sites were established based upon community providers' available capacity and wait times, community treatment methodologies available, veteran acceptance of external care, location of care with respect to the veteran population, and mental health needs in specific areas.[3] DAV recommends the Committee request VA provide a report on the success and status of these rural care pilot models, and whether VA is making any plans to expand them further.

DAV recognizes the significant efforts made by VA since the start of the wars to improve mental health services and access to those services for our nation's veterans. However, despite the Department's obvious efforts and progress, DAV believes there is still much to be accomplished to fulfill the nation's obligations to veterans who are affected by post-deployment mental health readjustment issues and sexual trauma. That said, we acknowledge that through its national Mental Health Strategic Plan and the President's August 31, 2012 Executive Order, to improve access to mental health services for veterans, service members, and military families, that the OMHS has been steadily working to improving services and access to mental health care throughout the system.

In fiscal year (FY) 2012 VA provided specialized mental health services to more than 1.3 million veterans. These services were integrated into the basic care of veteran patients as a part of VA primary care.[4] Additionally, 37% percent of veterans returning from service in Iraq and Afghanistan have enrolled for VA care, sought health care services, and received mental health diagnoses.[5] Although ready access to mental health care may still be an issue at some VA facilities, the Department has made notable progress in hiring additional staff to meet increasing demand. Last year, pursuant to the 2013 Presidential Executive Order, the Secretary announced a goal of hiring 1,600 new mental health clinical providers and 300 administrative support staff to fill new and vacant existing positions. As of May 31, 2013 VA announced it had hired 1,607 mental health clinical providers, 223 support staff, and 2,005 mental health clinical providers to fill existing vacancies.[6,7]

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[3] Robert Petzel, MD, Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs. Testimony before the Senate Veterans Affairs Committee Field Hearing: "Ensuring Veterans Receive the Care They Deserve - Addressing VA Mental Health Program Management." Atlanta. 7 Aug. 2013.
[4] Department of Veterans Affairs, "VA Mental Health Care Fact Sheet." July 2013.
[5] Department of Veterans Affairs, HSR&D's Quality Enhancement Research Initiative (QUERI). "QUERI Mental Health Fact Sheet." Little Rock, Arkansas. June 2013.
[6] Department of Veterans Affairs. Press Release. "VA Hires More Mental Health Professionals to Expand Access for Veterans." 11 Feb. 2013.
[7] Department of Veterans Affairs. Press Release. "VA Hires Over 1600 Mental Health Professionals to Meet Goal." 3 June 2013.

VA also committed to hiring and training at least 800 Peer Support Specialists by the end of December 2013 and to develop partnerships between the Department and community mental health providers to improve overall access to care. As of November 2013, the Department exceeded its goal by hiring 815 Peer Specialists and Peer Apprentices with a goal of having all of them trained by the end of 2013.[8] In talking with mental health providers we found that, in their opinion, this program has been extremely beneficial and successful, especially in coaching veterans into care and helping them stay in treatment. Peer specialists are considered part of the mental health treatment team.

Despite the progress in hiring additional staff, the IBVSOs remain concerned about how VA plans to resolve its mental health staffing issues to meet demand and provide timely access for these critical services. VHA indicated in March 2013 that it had begun work on implementing provisions in the FY 2013 National Defense Authorization Act (NDAA), (Public Law 112-239), including developing measures to assess mental health care timeliness, patient satisfaction, capacity and availability of evidence-based therapies, as well as developing staffing guidelines for specialty and general mental health. VA also began developing a contract with the National Academy of Sciences to assess the quality of mental health care resulting in the establishment of this Committee.[9] Additionally, according to VA promotion of mental health research and development of more effective treatment methodologies in collaboration between VA, the Department of Defense (DOD), HHS, and Department of Education has also been established.[10] DAV recommends the Committee also ask VA for a report on the success and status of these pilot agreements, partnerships, and inter-agency collaborations. In this regard, we believe it is essential that VA develop a proper mental health triage and staffing model to help clinicians better manage their patient workloads and meet the unique treatment needs of each veteran. VA must be flexible and creative in its approach to solving its access issues and use the wide range of treatment options from nontraditional complementary and alternative care to traditional comprehensive evidence-based therapies for those who need them.

We are pleased that VA has placed special emphasis on suicide prevention efforts, an aggressive anti-stigma and outreach campaign, and services for veterans involved in the criminal justice system. Peer-to-peer services, mental health consumer councils, and family and couples services have also been evolving and spreading throughout VA. VHA provides a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings and has trained over 4,700 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD: Cognitive Processing Therapy and Prolonged Exposure Therapy. [11]

But despite all of VA's efforts over the past several years timely access to VA mental health services and the quality of that care have been the topic of numerous Congressional hearings and government reports, with intense media scrutiny, indicative of the recent explosion of press and media coverage on veterans' lack of access to care. VA indicates that it is developing methods to improve access and address barriers, but veterans who seek VA assistance while struggling with mental health challenges too often face difficulty gaining timely appointments, despite VA official policies governing 24/7 access for emergency mental health care and scheduling of mental health specialty visits within 14 days of initial contact.

As a consequence of a July 2011 Senate Veterans' Affairs Committee oversight hearing, and pressed

[8] Department of Veterans Affairs. Press Release. "VA Meets President's Mental Health Executive Order Hiring Goal." 5 Nov. 2013
[9] Robert Petzel, MD, Under Secretary for Health, Veterans Health Administration, Department of Veterans Affairs. Testimony before the House Veterans Affairs Committee, "VA Mental Health Care: Ensuring Timely Access to High-Quality Care." 20 Mar. 2013.
[10] Ibid.
[11] Ibid.

to reconcile the disparity between VA policy and practice on waiting times, VA surveyed mental health providers across the system. Nearly 40 percent responded they could not schedule an appointment in their own clinics for new patients within 14 days. A startling 70 percent responded that their sites lacked both adequate staff and space to meet current demands, and 46 percent reported lack of off-hour appointments to be a barrier to care. In addition, more than 50 percent reported that growth in patient workloads contributed to mental health staffing shortages and one in four respondents stated that demand for compensation and pension examinations diverted clinical staff away from direct care.[12] Based on the results of this internal VA survey and continuing reports from veterans themselves, it was clear that despite significant progress in enhancing VA mental health programs—access to care was an issue.

In October 2011 the Government Accountability Office (GAO) issued *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, a report that covered veterans who used VA from FY 2006 through FY 2010. Approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, the GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, and 88 percent (1,064,363) were veterans of earlier military service eras. The GAO noted that services for the OEF/OIF/OND group had caused growth of only 2 percent per year in VA's total mental health caseload since 2006. Given these findings, the IBVSOs believe there is a misperception that the majority of the recent mental health resources are needed to care for the OEF/OIF/OND population. We understand from VA officials that the overall improvements in VA mental health services over the past five years have benefited *all* eras of veterans—particularly older veterans and Vietnam era veterans, many of whom are accessing VA mental health services for the first time. Increased resources from Congress have been beneficial for all VA patients and should be sustained. One of the more obvious benefits is universal mental health screening in primary care with direct access to services within that care setting.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care differed from the barriers that VA found in its August 2011 query; these included stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. VA indicated it was aware of these barriers and would continue to implement efforts to increase veterans' access to mental health care. It is our hope that the Committee's charge can bear out if VA's efforts since the 2011 GAO report and informal survey have in fact improved access and reduced barriers to mental health services in VA.

Members of the Committee, to put a human face on the issues we are discussing, let me quote from a letter DAV received from a recently-discharged, decorated, senior non-commissioned Army veteran of Iraq and Afghanistan (with over 26 years of military service) who wrote to us an unsolicited message highlighting his experience in seeking help for PTSD during and following his military service and several wartime deployments. Some of his comments expressing concern about the existing system of mental health care may be helpful to your work. His comments are primarily about his experiences as an Army soldier, and the circumstances of his discharge from active service, but they offer greater insights about the transition of service members into civilian life, with implications for both DOD and VA. In part, his letter states:

[12] Veterans Health Administration, *A Query of VA Mental Health Professionals: Executive Summary and Preliminary Analysis* (Washington, DC: September 9, 2011).

Within a few days of my redeployment from Iraq I had a five-year physical that was due. During this physical I mentioned to the doctor that I had trouble getting to and staying asleep. Without a word the doctor grabbed me by my arm and physically escorted me down to mental health; his actions did not make me feel normal as a matter of fact it was very humiliating. I met with a mental health provider and told him that I was there because I had trouble getting to sleep, he told me that it was just adrenaline from the deployment and it would soon subside. It has been 11 years and I still have trouble getting to and staying asleep even with prescribe[d] medication.

In about a year's time after Iraq I was transferred from [an overseas station] to a stateside assignment teaching military science at a university for ROTC students, [and] after nearly 18 months I had a rare supervisor that identified my need for PTSD treatment. He insured [sic.] that I made appointments and had ample time to attend them. In my first session with my mental health care provider I was diagnosed with moderate to severe Post Traumatic Stress Disorder. I started regular weekly treatments. But after a short time I was on orders again for a combat tour in Afghanistan. This is just an example of how little emphasis is placed on PTSD. My PTSD treatment was put on hold while I was deployed.

In combat arms units each unit takes a specific amount of time to inspect and fix, [and] refit all of their combat equipment, but there is no system in place to inspect and or fix ours soldiers. This seems to say that our equipment is more valuable and important than the service member.

As it came to light that I was going to be medically retired for PTSD and other issues, my chain of command ridiculed and harassed me. The professor of military science at the [ ] University [ ] told me that he was more interested in getting my replacement then [sic.] assisting me. He consistently asked when I was going to be out of the Army. He told me over and over he needed to know so he could get a replacement as soon as possible, because he had no concern for me and just wanted me gone.

We pride ourselves as committing to the future and winning the next big fight with the best and newest equipment. What we have for the care and benefit of our Service members, in regards to PTSD is as dated as a tourniquet and saw. We are requiring all that a service member has to give, and in return they are given enough time to be labeled as being unfit, when the Country owes them as much as was asked of them.

Service members either ignore the issues or are locked up in mental wards, sent from one program to the other, and then sent to the Medical Review Board where it is then over. With the treatment of a service member who has PTSD, getting fixed is the worse [sic.] experience in the military. Having the courage to take care of your issues is hard enough. Having to deal with a lack of support, and the stigma of acting or playing the system leaves a service member with a new found hate for his service, command, and members of his profession. After all the new obstacles one faces to get help, most choose to get out. Forever changed by the actions of his service, a realization of a new life, and a lonely future with a long fight ahead. With environments like this, other Service members are less likely to seek any assistance with PTSD. Unlike a physically injured such as a broken arm where the chain of command ensures one will recover, this is not the case with PTSD.

The military is very good at making young boys and girls into warriors but it makes no attempt to make warriors, men and women into civilians.

In the closing of his letter the veteran makes a call for action—to fix "…the broken PTSD care system." These are the men and women who have gone to war and served our nation honorably. As a result of military service and their wartime deployments they are in need of mental health services to recover and gain back their health and well-being. Clearly there is a disconnect in the system of care that currently exists. Although the Committee's charge is limited to VA mental health services and the transition from warrior to civilian falls primarily to VA—we cannot ignore the experience of veterans who seek help during military service. We ask, are there ways VA can better assist these veterans who reach out for care—and those that may not reach out but are in need of specialized post-deployment mental health services? Are there opportunities to address the apparent disconnect between DOD and VA in this regard? Finally, we look forward to the Committee's assessment of existing barriers and access to VA mental health services given VA's efforts to date.

Thank you for this opportunity for DAV to provide our views to the Committee. I would be pleased to address any questions from your members related to this statement.