**WOUNDED WARRIOR PROJECT**

**STATEMENT FOR THE RECORD**

**COMMITTEE ON VETERANS AFFAIRS**

**U.S. HOUSE OF REPRESENTATIVES**

**Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans**

**FEBRUARY 13, 2013**

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

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

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

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

Engagement in Treatment as a First Step

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

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

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

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

With projections of only 1 in 5 veterans receiving adequate treatment, the importance of early intervention and consequences of delaying mental health care, and the rising rates of suicide and MST, we must heed growing evidence that a majority of soldiers deployed to Afghanistan or Iraq are not seeking needed mental health care.[[9]](#footnote-9) While stigma and organizational barriers to care are cited as explanations for why only a small proportion of soldiers with psychological problems seek professional help, soldiers’ negative perceptions about the utility of mental health care may be even stronger deterrents.[[10]](#footnote-10) To reach these warriors, we see merit in a strategy of expanding the reach of treatment, to include greater engagement, understanding the reasons for negative perceptions of mental health care, and “meeting veterans where they are.”[[11]](#footnote-11)

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

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

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

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

Need for Outcome Measurements

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

*“Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment.”[[18]](#footnote-18)*

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

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

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

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

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

Need for Continued Congressional Oversight

WWP welcomes the Department’s acknowledgment of a “need [for] improvement” in its mental health system.[[26]](#footnote-26) While there has been movement in response to recent critical congressional oversight, the VA’s actions have often lacked needed transparency. To illustrate, the VA testified to having conducted a “comprehensive first-hand assessment of the mental health program at every VA medical center,”[[27]](#footnote-27) but it would not afford advocates the opportunity to participate in such visits (despite a request to do so) and has not disclosed its site-visit findings, the expectations for each such facility, or facility remediation plans. The VA also cited its adoption, on a pilot basis, of a prototype mental health staffing model, without meaningful explanation of the foundation or reliability of its model. VA Central Office recently also surveyed mental health field staff; but while its survey effort could represent a healthy step, officials have neither disclosed the survey findings nor indicated how the data might be used, if at all.

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

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

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

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

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

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

* Given new statutory requirements to work with the NAS to establish new staffing guidelines and measures to assess timeliness and effectiveness of mental health care, the VA must give high priority to expeditiously contract with NAS to conduct the necessary assessments and establish the framework for reforms required by law;
* DoD and the VA must work collaboratively, not simply to improve access to mental health care, but to identify and further research the reasons for -- and solutions to – warriors’ resistance to seeking such care;
* As provided for in law and Executive Order, the VA in 2013 must carry out large-scale training and employment of at least 800 returning warriors (who have themselves experienced combat stress) to provide peer-outreach and peer-support services as part of VA’s provision of mental health care to wounded warriors, and DoD must support that initiative by referring servicemembers to be considered for such employment;
* The VA should partner with and assist community entities or collaborative community programs in providing needed mental health services to wounded warriors, to include providing training to clinicians on military culture and the combat experience;
* The VA must implement provisions of law that require it to provide needed mental health services to immediate family members of veterans whose own war-related mental health issues may diminish their capacity to support those warriors;
* The VA should improve coordination between its medical facilities and Vet Centers, and increase both Vet Center staffing and the number of Vet Center sites, with emphasis on locating new ones near military facilities; and
* The VA should provide for Vet Center staff to participate in VSO-operated recreational programs that are designed to encourage veterans’ readjustment, as provided for by law.

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

1. Franklin, et al, 2012 Wounded Warrior Project Survey Report, ii (June 2012). WWP surveyed more than 13,300 warriors, and received responses from more than 5,600. (Hereinafter “WWP Survey”). [↑](#footnote-ref-1)
2. Id. at 105. Studies document widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, and the finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. D. Leslie, S. Mohamed, and R. Rosenheck, “Off-Label Use of Antipsychotic Medications in the Department of Veterans’ Affairs Health Care System” 60(9) *Psychiatric Services*, 1175-1181 (2009); John Krystal, et al., “Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service–Related PTSD: A Randomized Trial,” 306(5) *JAMA* 493-502 (2011). [↑](#footnote-ref-2)
3. Charles W. Hoge, MD, “Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are,” *JAMA*, 306(5): (August 3, 2011) 548. [↑](#footnote-ref-3)
4. http://articles.washingtonpost.com/2013-02-01/national/36669331\_1\_afghanistan-war-veterans-suicide-rate-suicide-risk [↑](#footnote-ref-4)
5. Rachel Kimerling, et al., “Military-Related Sexual Trauma Among Veterans Health Administration Patients Returning From Afghanistan and Iraq,” 100(8) *Am. J. Public Health*, 1409-1412 (2010). [↑](#footnote-ref-5)
6. U.S. Dept. of Veterans' Affairs and the National Center for PTSD Fact Sheet, “Military Sexual Trauma,” available at <http://www.ptsd.va.gov/public/pages/military-sexual-trauma-general.asp>. [↑](#footnote-ref-6)
7. See Donna Washington, et al., “Women Veterans’ Perceptions and Decision-Making about Veterans Affairs Health Care,” 172(8) *Military Medicine*  812-817 (2007). [↑](#footnote-ref-7)
8. M. Murdoch, et al., “Women and War: What Physicians Should Know,” 21(S3) *J. of Gen. Internal Medicine* S5-S10 (2006). [↑](#footnote-ref-8)
9. Paul Kim, et al. “Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care Among Soldiers,” 23 *Military Psychology* 66 (2011). [↑](#footnote-ref-9)
10. Id. at 78. [↑](#footnote-ref-10)
11. Hoge, supra note 14. [↑](#footnote-ref-11)
12. National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239, §730, (Jan. 2, 2013). Additionally, the President issued an Executive Order in August 2012 which included among new steps to improve warriors’ access to mental health services, a commitment that VA would employ 800 peer-specialists to support the provision of mental health care. Exec. Order No. 13625 “Improving Access to Mental Health for Veterans, Service Members, and Military Families” (Aug. 31, 2012) [↑](#footnote-ref-12)
13. WWP Survey, at 54. [↑](#footnote-ref-13)
14. Sec. 304, Public Law 111-163. [↑](#footnote-ref-14)
15. Khaylis, A., et al. “Posttraumatic Stress, Family Adjustment, and Treatment Preferences Among National Guard Soldiers Deployed to OEF/OIF,”176 *Military Medicine* 126-131(2011). [↑](#footnote-ref-15)
16. *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Ralph Ibson, National Policy Director, Wounded Warrior Project). [↑](#footnote-ref-16)
17. Dept. of Veterans’ Affairs Press Release, “VA to Increase Mental Health Staff by 1,900,” (Apr. 19, 2012), available at: <http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302>. [↑](#footnote-ref-17)
18. Id. [↑](#footnote-ref-18)
19. *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm, on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Nicole Sawyer, PsyD, Licensed Clinical Psychologist). [↑](#footnote-ref-19)
20. *VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans’ Affairs*, 112th Cong. (Apr. 25, 2012) (Testimony of Nicholas Tolentino, OIF Veteran and former VA medical center administrative officer). [↑](#footnote-ref-20)
21. *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Ralph Ibson), supra note 21. [↑](#footnote-ref-21)
22. WWP Survey of VA Mental Health Staff (2011). [↑](#footnote-ref-22)
23. As one WWP-survey respondent explained in describing practices at a *VA facility*, “Unreasonable barriers have been created to limit access into Mental Health treatment, especially therapy. Vets must go to walk-in clinic so they are never given a scheduled initial appointment. Walk-in only provided medication management, but Vets who just want therapy must still go to walk-in. After initial intake, Vets are required to attend a group session, typically a month out. After completing the group session, Vets can be scheduled for individual therapy, typically another month out. Performance measures are gamed. When a consult is received, the Veteran is called and told to go to walk-in. The telephone call is not documented directly (that would activate a performance measure)…Then the consult is completed without any services being provided to the Veteran. Vets often slip through the cracks since there is no follow-up to see if they actually went to walk-in. Focus of the Mental Health [sic] is to make it appear as if access is meeting measures. There is no measure for follow-up, so even if Vets get into the system in a reasonable time, the actual treatment is significantly delayed. Trauma work is almost impossible to do since appointments tend to be 6-8 weeks apart.” [↑](#footnote-ref-23)
24. U.S. General Accountability Office, “Reliability and Reported Outpatient Medical Appointment Wait Times and Scheduling Oversight Need Improvement,” GAO-13-130 (Dec 2012). [↑](#footnote-ref-24)
25. VA Office of Inspector General, “Review of Veterans’ Access to Mental Health Care’” (Apr 2012). [↑](#footnote-ref-25)
26. *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcomm. on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (May 8, 2012) (Testimony of Eric Shinseki, Secretary of the Dept. of Veterans’ Affairs). [↑](#footnote-ref-26)
27. Id. [↑](#footnote-ref-27)
28. See Lt. Col. Paul Dean and Lt. Col. Jeffrey McNeil, “Breaking the Stigma of Behavioral Healthcare,” U.S. Army John F. Kennedy Special Warfare Center and School, 25(2) Special Warfare (2012), available at: <http://www.soc.mil/swcS/SWmag/archive/SW2502/SW2502BreakingTheStigmaOfBehavioralHealthcare.html>. [↑](#footnote-ref-28)
29. National Defense Authorization Act for Fiscal Year 2013, supra note 18, at §§ 580-583 and 723-730. [↑](#footnote-ref-29)
30. Id. at § 726. [↑](#footnote-ref-30)