TESTIMONY

OF

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BEFORE THE

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HOUSE OF REPRESENTATIVES

ON

VA PROVISION OF MENTAL HEALTH CARE

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

I am honored to have the opportunity to speak to you today regarding VA mental health care.

I proudly served as a United States Army Infantryman for 5 1/2 years, and was medically retired due to severe injuries from a mortar blast in Iraq. Working now with a non-profit in Washington state, I assist service members, veterans and their families who are struggling due to deployment-related trauma. I have a great deal of experience with VA medical facilities and VA mental health care – not just as a patient, but as an advocate for many other warriors I've mentored, and through dialogue with veteran leaders from across the country. Recently VA leadership invited me to participate in an online learning session through VA's eHealth University to share my perspective as a veteran accessing VA care, so VA clinicians and staff could have the opportunity to learn from my experience.

That experience with the VA health care system began in 2008. As I explained in testifying before the Subcommittee on Health last year, that experience began badly. At the time I was being treated for anxiety, sleep problems, migraines, pain, and seizures, and it had taken Army doctors 3 years to determine the right medications and dosages to treat those conditions. Because several of those 8 different medications were not on the VA formulary, my primary care provider at the American Lake VA Medical Center substituted different medications, despite the urging of my wife due to the failure of these medications in the past. The side effects caused me so much difficulty that I began to backslide in my recovery. I was soon on 13 medications (some to simply counter the effects of others); and soon all my conditions worsened and I had a severe panic attack at work.

Since then, with my multiple medical and surgical issues and my work with other warriors, I've had extensive experience with VA care. As to VA mental health care in particular, I've benefitted from excellent care at a VA medical center that for a period of time made that care a

priority and staffed it accordingly. The facility provided easy one-stop access to OEF/OIF/OND veterans through a "Deployment Health Team" that brought together in one spot medical, mental health, pharmacy and social work providers. Unfortunately, medical center leadership concluded that providing this excellent, well-staffed interdisciplinary care was too costly. With budget considerations trumping patient-centered care considerations, the team's providers were reassigned. (While the facility still has a unit called the "deployment health team" it now provides only primary care and social work services. Having only a skeleton staff, the team manages a huge caseload and, as a result, has long wait times and shorter appointments.) Instead of seeing an interdisciplinary team, GWOT veterans now go through an impersonal intake/assessment process. From there they are channeled into a conventional system where providers do not work as a team, and where veterans have to navigate their way to the different services scattered across the sprawling, complex campus to get the care they need. For many of the warriors with whom I've worked, just navigating around the many buildings housing different treatment services in this complex facility is anxiety-provoking.

Interdisciplinary, Team-Based Care: Key to Mental Health Care and Suicide Prevention

I cite my and other veterans' very positive experience with this interdisciplinary, team-based-care approach (and the effective demise of that program) because it highlights some very important points. First, veterans with mental health issues are seldom going to open up to a clinician they've never met and begin discussing painful, private issues. They're more likely to skirt those deeper issues and simply report that they're experiencing difficulty sleeping, having headaches, or some more general problem, with the hope that there's medication to provide relief. It takes time to build trust to open up to deeper problems or even to recognize them. And not every clinician is necessarily skilled at eliciting that trust or insightful enough to gauge from a veteran's demeanor that there are deeper issues, and to ask the probing questions that might begin to identify them. Working with a team increases the likelihood that one or more will see things that others missed.

Interdisciplinary care has profound implications for suicide-prevention. Veterans will rarely volunteer to clinicians that they're contemplating suicide, and there aren't obvious signs by which a mental health provider can reliably identify a veteran as a suicide risk. And we certainly won't prevent suicides by having physicians go down a mandatory checklist and mechanically asking a veteran-patient a series of questions like "have you thought recently about harming yourself?" While people who commit suicide often have a mental health condition, that alone is seldom an explanation for a suicidal act. Life events and problems are often important catalysts.[1] But in a treatment system, where, for example, I'm sent to Building 3 to see the neurologist for severe back pain, to Building 61 to see a psychiatrist for medication to help with sleep problems, and to Building 81 to see my social worker for serious relationship problems, no one is getting a full picture and no one can see and put together the red-flag signs that may point to the fact that

[1] Keith Hawton, "Suicide prevention: a complex global challenge," 1(1) The Lancet (June 2014), 2.

my life is spinning out of control. This isn't just a problem in VA. But as an integrated health care provider, VA can provide the kind of care I got from the interdisciplinary deployment health team in the past. There, the team members shared observations, and could see potential problems as they had begun to develop and question veterans about issues before they became explosive. In my view, therefore, it is much less fruitful to press VA to establish or re-design "suicide prevention programs" than to improve VA health and mental health care delivery.

"Access" Is Only Half the Equation

When we discuss mental health care, it's not enough to talk about "access." One has to get to the question, "access to what?" Access to a system in which I go to three different buildings to see three different providers for health issues which are all related to my mental health – pain, lack of sleep, and relationship issues – is a real problem when those providers aren't working as a team, and aren't even given the needed time to coordinate their observations and treatment approaches with one another. In other words, access to mental health care isn't enough unless that mental health care is also effective.

This is particularly important as it relates to combat veterans; having been trained to tough it out and soldier through pain, they often come into treatment hesitantly and even distrustfully. A provider needs to understand that warrior mentality, and often must work hard to win that veteran's trust. A clinician who doesn't understand that warrior culture or isn't permitted the time needed to develop that relationship of trust is unlikely to have success in helping that warrior overcome his or her demons. In my experience, veterans have a greater likelihood in the VA of working with a clinician who has some understanding of that warrior experience and of working with combat-related mental health problems than they would "outside." But a veteran who has to work with a provider who lacks cultural awareness or whose patient care load doesn't allow time will inevitably become frustrated (whether in the VA or outside) and often drop out of treatment. Similarly, many veterans who aren't ready for an often very traumatic exposure-based therapy have dropped out of these intense multi-week treatment programs, even though they are hailed as an "evidence-based therapy." I question the wisdom of evaluating facilities, as VA does, based on the percentage of veterans with PTSD who complete these evidence-based therapies. While the underlying intent has merit, there are many reasons that veterans don't complete those programs: for some, they're just too intense, for others, it's too difficult to come in for treatment that often. The bottom line is that this performance requirement, like others, can not only be "gamed," it fails to take the patient's preferences into account. VA has often cited the importance of a veteran-centered approach to mental health care. But if care is to be veteran-centered, as it must be, it's critical to recognize each veteran's unique situation, and their individual treatment preferences, and build systems to meet their needs and preferences, not the other way around. That seems to me, to be essential to providing effective care, whether in the VA or elsewhere.

The warriors I'm describing – and I've worked with many of them – very often don't come into treatment for PTSD or anxiety or depression when the textbooks say they should, at an early stage when the problems can be most easily dealt with. They finally come into treatment when things have gotten really bad. Sometimes that's when their spouse is threatening to leave. In some cases, it's when they've gotten into trouble with law enforcement, often involving substance abuse. Or it might be when the veteran has experienced a panic attack or overwhelming thoughts of self-harm, to cite some common examples. Timeliness is obviously critical in those kinds of instances, and they're not at all isolated occurrences among OEF/OIF veterans. Clearly a veteran in distress who finally asks for help for a combat-incurred mental health condition needs to get into treatment. VA policy did establish the expectation that veterans were to be afforded initial appointments for mental health care within 14 days. But – just as with the challenges many VA facilities faced in meeting that requirement for primary care appointments, limitations in mental health staffing at many facilities have made provision of timely mental health care either very challenging or impossible to meet. What I saw facilities do was to reconfigure their staffing to meet the technical requirement of the 14-day rule. At these facilities, warriors with mental health issues were assessed within the 14-day window; in that way they were "seen," even though facility staffing wouldn't permit an initial treatment appointment itself until many weeks later. Understandably, warriors who are at the end of their rope and finally seek help at a VA medical facility often experience deep frustration and even despair if they are told to wait six weeks or longer to begin therapy. Deferred treatment can set the stage for potentially tragic outcomes.

I do believe that there are VA facilities that are providing veterans timely access to effective, patient-centered mental health care. But that's certainly not the case systemwide. Unfortunately there are no measures in place to assess patient outcomes. (In that regard, I would suggest that the Committee look into the rates at which OEF/OIF veterans drop out of PTSD treatment programs, surely one relevant indicator). But with what appear to be widespread disparities in the timeliness of VA care (but not necessarily the same focus on care-effectiveness), I understand that some have called for expanding veterans' access to care from non-VA providers.

Purchased Care: No Silver Bullet

It seems doubtful that that step by itself can be the "silver bullet" solution for veterans' mental health care. For one thing, it assumes first that the private sector holds a key to meeting VA's mental health workforce "supply" problem. But a 2013 report to Congress warns of "an already thinly stretched [behavioral health] workforce."[2] The report points to longstanding concerns about a national shortage of behavioral health workers, cited in previous publications, including the following:

[2] Hyde, P., "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues," Substance Abuse and Mental Health Services Administration (Jan. 24, 2013), 5. Accessed at http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf

- A 2009 study that found that 77 percent of counties had a severe shortage of mental health workers, both prescribers and non-prescribers and 96 percent of counties had some unmet need for mental health prescribers;
- A 2012 government report that found there were 3669 areas of the country with shortages of mental health professionals;
- A 2007 report that 55% of U.S. counties, all rural, had no practicing psychiatrists, psychologists or social workers; and
- A 2010 government report finding that more than two-thirds of primary care physicians who tried to obtain outpatient mental health services for their patients reported they were unsuccessful due in part to shortages in mental health care providers.[3]

Not only is there a real issue in terms of a national mental health workforce shortage, but there are real quality of care issues to contend with. According to the 2003 report of a presidential commission on mental health care in this country, "not only is there a shortage of [mental health providers, but those providers who are available are not trained in evidence-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in modern medicine."[4] The Commission found that "too few benefit from available treatment" because "state-of –the-art treatments vital for quality care and recovery…are not being used."[5] A later report by the Institute of Medicine that focused on improving the quality of behavioral health care cited "numerous studies [that] document the discrepancy between the [mental health and substance use] care that is known to be effective and the care that is actually delivered."[6]

A Better Purchased-Care Model

Years ago, Washington State's Department of Veterans Affairs, recognized the unique needs of Wartime Veterans and their families and established a PTSD Counseling Program to provide access to best practices of care for those who otherwise couldn't get that care through VA because of service-unavailability or distance. Under the Department's program, 30 licensed practitioners across the state provide counseling services at State expense; importantly each has a minimum of 24 years of experience and all providers are veterans or are trained to be military and veteran culturally competent. Veterans need only contact the program director who will determine the best practitioner for the individual situation and connect the Veteran with that office. Given the counselor's experience and backgrounds, the veterans I've referred to the program have found it very helpful. (For the same reasons, veterans with whom I've worked

[3] Id., 10.
[4] "Achieving the Promise: Transforming Mental Health Care in America," The President's New Freedom Commission on Mental Health (July 2003), 70. Accessed at http://store.samhsa.gov/shin/content//SMA03-3831/SMA03-3831.pdf.
[5] Id., 68.
[6] Institute of Medicine, "Improving the Quality of Health Care for Mental Health and Substance-Use Conditions," National Academies Press, 2006, 35.

and whom I've met around the country have similarly positive experiences with VA's Vet Centers.) But in the most recent instance, the veteran I referred to the Washington State program was informed that all the providers in his area had full case loads and were not taking new clients.

I don't want to suggest that VA could not benefit from greater use of purchasing care, where that care is available and where it offers promise of being effective. But it would not be particularly helpful simply for veterans to be "seen" outside the VA by a provider who is not equipped to provide effective care – for lack of training in treating combat- or MST-related PTSD, for lack of "cultural competence," or any other shortcomings. In short, it is pretty clear that providing an avenue to mental health care, even if there is a source, does not assure that veterans will get effective care.

Improving VA Mental Health Care

So what's the answer? It's important to appreciate that the VA health care facilities do have caring, dedicated providers. I know, for example, that some of my own health care providers are coming in on weekends and staying late at night to keep up with their work. I don't believe the answer to improving VA mental health care is to demand more of those clinicians.

But I think we have to demand that VA mental health care – especially for veterans with service-incurred mental health conditions -- become a top priority. VA leaders have, of course, repeatedly stated that it is. But if that were so, why would my VA medical center in Washington State have effectively eliminated -- for reasons of cost -- the one program through which OEF/OIF veterans got excellent mental health care? Why, given strong policies on PTSD care would there be variability on PTSD management from facility to facility, and why would it be "unclear whether VA leaders adhere to [VA PTSD] policies," as a recent Institute of Medicine study reported.[7] And why would veterans in facilities across the country be having problems getting timely and effective VA mental health care?

From this veteran's perspective – with staggering numbers who have come back from war with psychic wounds and PTSD -- the starting point for improving VA mental health care lies with VA leadership at all levels embracing the principle that providing timely, effective mental health care for those with service-incurred mental health conditions – whether due to combat, military sexual trauma, or otherwise -- MUST be a top priority! These are not just words. We've seen with the example of VA's efforts to combat veteran homelessness, that this Department can have a real impact when the direction and priority are clear, when artificial performance requirements don't create distortions, and when clinicians have latitude to provide good care. Improving mental health care may be as or more complex a challenge, but it surely requires a comprehensive approach. I don't think legislation is necessarily the path through which to meet the challenge, although there are important steps Congress can take. These might include:

[7] Institute of Medicine, "PTSD in Military and Veteran Populations," National Academies Press, 2014, 6.

- providing incentives to help increase the mental health workforce;
- funding training programs for non-VA mental health providers on treating service-incurred PTSD and on military culture to improve clinicians' expertise and cultural competence in working with military and veteran populations; and
- increasing VA funding for research to find better treatments for PTSD.

But I believe that there is much that VA should, and with the right leadership, can do itself. First, I would reiterate the point I made above about instituting interdisciplinary, team-based treatment. While VA's PACT program employs that approach in the primary care arena, it shouldn't end there. There is also much to be learned from the Vet Center program, and why veterans -- who have to feel safe and trust their provider if they are to engage in mental health care -- are comfortable in that setting. Vet Center counsellors are typically veterans, and often combat veterans. Having a connection with peers is critical. And Vet Centers engage family members as well. I believe VA medical centers and clinics would have far greater success in treating veterans for PTSD and other mental health conditions – and keeping them in treatment -- if they routinely engaged the family at the same time.

Many of the problems with which this Committee has wrestled in overseeing VA seem to relate to management practices. Perhaps it's time for VA to change course and rely more on the dedicated clinicians in this health care system, and less on arbitrary performance requirements and metrics. As the ones who are closest to the patients, the clinicians are probably best able to develop veteran-centered programs – like the Deployment Health Team I described earlier.

Finally I would draw on my own experience working with other warriors as a peer-mentor. As a former infantryman who was badly injured and experienced psychic wounds too, I can say things to other warriors that a clinician can't and I can assure those warriors from my own experience that mental health treatment can work. To its credit, VA has hired and provided for the training of more than 800 peer-specialists, to work as members of VA mental health treatment teams. That is a great concept, but with the numbers of veterans coming to VA for mental health care, I would recommend that that number be greatly expanded.

I hope my experiences, observations, and recommendations are of some help, and would be pleased to answer your questions.