STATEMENT OF
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BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

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Good morning, Chairman Miller, Ranking Member Brown, and members of the Committee. Thank you for the opportunity to discuss the effectiveness of the Department of Veterans Affairs (VA) mental health programs. I am accompanied by Dr. Harold Kudler, Chief Consultant, Mental Health Services, and Dr. Caitlin Thompson, National Director, Suicide Prevention, Veterans Health Administration.

VA has developed the largest integrated suicide prevention program in the country. We have over 800 dedicated and passionate employees, including Suicide Prevention Coordinators, Veterans Crisis Line staff, epidemiologists, and researchers, who spend each and every day solely working on suicide prevention efforts and care for our Veterans. Our overarching strategy is based on enhancing Veterans' access to high-quality mental health care and implementing upstream programs designed to help prevent Veterans from even considering suicide. Losing one Veteran to suicide shatters an entire world. Veterans who reach out for help must receive that help when and where they need it in terms that they value.

Preventing Veterans Suicide – A Call to Action

The Department of Veterans Affairs (VA) hosted a summit on "Preventing Veterans Suicide – A Call to Action" on February 2, 2016, to bring together Veterans, families, other Federal agencies, community providers, subject matter experts, and other key partners to enhance our work on suicide prevention. VA continues to partner with more than 150 non-Federal mental health organizations around suicide prevention. Alongside these partners, we remain strongly committed to preventing Veteran suicide. We recognize that we can't do this alone, and we continue to develop and prioritize these partnerships.

Powerful for so many attendees were the stories shared both by Veterans and by families. The families of Clay Hunt and Daniel Somers have testified before this committee with us several years ago. What they shared then and in other settings and again at our Call to Action truly has been an extremely powerful and compelling message to us. We see them and other families as essential partners to help us continue to think through and develop our services.

In addition, we heard from two extraordinary Veterans, Mr. John Heitzman and Mr. Brent Rice, during the Call to Action. They told their stories of falling into significant crises and seriously considering suicide. They then spoke about the power of connecting with VA Suicide Prevention Coordinators and VA clinicians who were integral in helping them to recover and lead fulfilling and healthy lives. All these stories were videotaped and are available through the following links: Veteran - John Heitzman - YouTube and Veteran- Brent Rice - YouTube

The message from these Veterans was one that truly resonated with us. Just as preventing death from heart attacks does not begin in the Intensive Care Unit, likewise suicide prevention does not necessarily begin with our Crisis Line or our interventions when suicide is imminent. Instead, it's about finding hope, leading a high-quality life, developing strong, meaningful relationships, and celebrating our reasons for living. Engaging Veterans in VA care, and particularly in our whole system of care, is a key part of prevention. Also engagement with communities is essential. Just like preventing death from heart disease involves our efforts in promoting healthy living, addressing risk factors, intervening when blood pressure or lipid profiles signal problems, there are precursor steps we continue to take to prevent suicide. Focusing on the social aspects of Veterans lives, working to advocate for their benefits, to assist them with jobs and functioning in those jobs, screening for signs of depression to include screening for substance use disorders, Post-traumatic Stress Disorder which is strongly associated with substance use and dependence, Military Sexual Trauma, and Intimate Partner Violence, intervening with our Justice Outreach System, preventing homelessness, and providing a system of medical care for Veterans,--all of these are significant interventions in VA which are part of our comprehensive suicide prevention program. That is the message these two Veterans who spoke so eloquently communicated.

The summit generated a series of very clear recommendations for VA. One frequently voiced recommendation was for VA and the Department of Defense (DoD) to partner on improving the transition from military service to civilian life. This builds upon the Presidential Executive Action of August 26, 2014, requiring DoD to automatically enroll all service members identified as having a mental health problem into DoD's

inTransition program and, upon separation from the military, provide a warm handoff to VA care or community care. Research demonstrates that the time of transition out of military service is a time of significant stress and increased health risk for service members and their families. This includes being a time of increased risk for suicide.

VA research has indicated that rates of suicide among those who use VA services have not shown increases similar to those observed in all Veterans and the general U.S. population. This research suggests that an improved healthcare transition between DoD and VA could help mitigate suicide risk as well as other increased risks of morbidity. Focusing on this transition would advance the Departments to a proactive population health approach focused on prevention through early engagement. To accomplish this, VA must facilitate transitioning service members' enrollment in VA health care.

The Call to Action summit generated multiple additional recommendations and initiatives to strengthen VA's approach to Suicide Prevention. Significantly, a pilot project is underway to evaluate risk intervention strategies based on data that predict who would be at risk for suicide before these individuals reach a crisis. Also, VA continues to actively monitor suicide related behaviors through the Suicide Prevention Applications Network (SPAN). We are working to develop a dashboard that will allow ongoing surveillance to support the identification of possible clusters of suicide-related behaviors and to trigger meaningful responses or interventions. We are also working towards establishing a new standard of suicide prevention care by analyzing measures of Veteran-reported symptoms to tailor mental health treatments to individual needs.

On April 8, 2016, VA leadership strategized to elevate and enhance the Suicide Prevention Program, in order to ensure that VA is able to fulfill ongoing and new suicide prevention initiatives. Plans are underway to elevate VA's Suicide Prevention Program with additional resources and a new reporting structure in order to strengthen current programs and initiatives.

In addition, to continue our commitment to preventing deaths, intentional or inadvertent, from opioid overdoses, every VA facility provides naloxone, which prevents death by overdose. More than 20,000 kits have been provided to Veterans across VA. Veterans and families have been instructed in their use. Educating VA physicians about the importance of ensuring patients only have access to medications they need is essential to decreasing overprescribing.

Veterans Crisis Line

VA is committed to ensuring the safety of Veterans, but especially when they are in crisis. We have universal access for 24/7 emergency care through our Emergency Departments and VA's Veterans Crisis Line (1-800-273-TALK (8255), press 1, and www.veteranscrisisline.net). We know that when we diagnose and treat people, they get better. August 2015 marked 8 years since the establishment of VA's Veterans Crisis Line (VCL), which has expanded to include a Chat Service and texting option for contacting the Crisis Line. The program continues to save lives and link Veterans with effective ongoing mental health services on a daily basis.

The Military Crisis Line has also been added, branded to reach active duty service members. Since 2007, the VCL has answered over two million calls, nearly

490,000 of those during the last fiscal year. VCL has made over 267,000 chat connections and communicated with over 48,000 texts. VCL initiated the dispatch of emergency services to callers in imminent suicidal crisis over 11,000 times last year and over 57,000 times total. Finally, the VCL provided over 340,000 referrals to a VA Suicide Prevention Coordinator (SPC) ensuring Veterans are connected to local care.

To address this increased demand, many steps are currently underway. First among these is an increase in responders to 310 Full Time Employee Equivalent . Since January 1, 2016, VCL has brought on 29 administrative personnel to augment areas such as analytics, knowledge management, quality assurance, and training. In addition, 38 new responders have been brought on board during this same period of time, with another 23 in active and ongoing recruitment. New responders are also receiving newly developed training that will allow them to provide the best experience and services to Veterans. This training includes approximately 20 modules, both in person and online, on a wide variety of topics in crisis intervention, substance use disorders, Screening, Brief Intervention, and Referral to Treatment (SBIRT), motivational interviewing, and suicide prevention. In addition, training is now being implemented onsite by dedicated training staff who are all former VCL responders.

The Veterans Crisis Line continues to uphold their extraordinary commitment to Veterans in crisis, demonstrating a 97% satisfaction rating, reported by Veterans who call the VCL and complete an end-of-call survey. In an effort to further improve the quality of the Veteran experience at VCL, Quality assurance processes have been initiated. These began April 3 with the selection of six dedicated silent monitors. This along with recruitment of a Quality Management Officer expected to be on board by

May 15, 2016 will bring VCL in line with Quality Management processes that are considered best in industry practices

Expanding Mental Health Services

While focusing on suicide prevention, we know that preventing suicide for the population we serve does not begin with an intervention as someone is about to take an action that could end his or her life. We are aware of how we work to prevent fatal heart attacks. We must similarly focus on prevention, which includes addressing many factors that contribute to someone feeling suicidal. We are aware that access to mental health care is one significant part of preventing suicide. VA is determined to address systemic problems with access to care in general and to mental health care, including substance use disorders in particular. VA has recommitted to a culture that puts the Veteran first. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increased staff in mental health services. Between 2005 and 2015, the number of Veterans who received mental health care from VA grew by eighty percent. This rate of increase is more than three times that seen in the overall number of VA users over the same time period. This reflects VA's concerted efforts to engage Veterans who are new to our system and stimulate better access to mental health services for Veterans within our system. In addition, this reflects VA's efforts to eliminate barriers to receiving mental health care, including the stigma associated with receiving mental health care and treatment for substance use disorders.

Easing the way Veterans receive care from mental health providers also has allowed more Veterans to receive care. VA Telemental Health innovations provided

more than 380,000 encounters to over 122,000 Veterans in 2015. Telemental Health reaches Veterans where and when they are best served. VA is a leader across the US and internationally in these efforts. VA's MaketheConnection.net, Suicide Prevention campaigns, and the Posttraumatic Stress Disorder (PTSD) mobile app (which has been downloaded over 208,000 times) contribute to increasing Mental Health access and utilization. VA has also created a suite of award-winning tools that can be utilized as self-help resources or as an adjunct to active mental health services and substance use disorders.

Additionally, in 2007, VA began national implementation of integrated mental health services in primary care clinics. Primary Care-Mental Health Integration (PC-MHI) services include both co-located collaborative functions and evidence-based care management, a telephone based modality of care. By co-locating mental health providers within primary care clinics, Veterans are able to be introduced same day by their primary care team to a mental health provider present in the clinic, thereby reducing wait times and no show rates for mental health services. Additionally, integration of mental health providers within primary care has been shown to improve the identification of mental health disorders and substance use disorders and increase the rates of treatment. Several studies of the program have also shown that treatment within PC-MHI increases the odds of attending future mental health appointments and engaging in specialty mental health treatment. Finally, the integration of primary care and mental health has shown consistent improvement of quality of care and outcomes, including patient satisfaction. The PC-MHI program continues to expand and through

December 2015, has provided over 5.5 million PC-MHI clinic encounters, serving over 1.3 million individuals since October 1, 2007.

These efforts align with VA's interagency activities including the Cross Agency Priority (CAP) Goals and expanding VA mental health policy and practice. We anticipate that demand for VA mental health care, including treatment for substance use disorders, will continue to grow as active duty personnel separate from service. Importantly, in an effort to help Veterans who have not enrolled in VA for care, these applications are important lifelines to understanding their symptoms and helping them to overcome other barriers to care.

VA Mental Health Services and Suicide Prevention for Women Veterans

VA conducts annual, comprehensive assessments of suicide deaths that occur among Veterans using VA health services. These assessments evaluate gender differences in suicide rates. While the suicide rate among women Veterans are lower than the rate in male Veterans, suicide rate among women Veterans have increased in recent years.

Providing high-quality care specific to women Veterans is a priority and VA offers a full continuum of mental health services to women Veterans. Evidence-based therapies for PTSD, including prolonged exposure and cognitive processing therapy, have been shown to decrease suicidal ideation. These treatments are available at every VA medical center. Women Veterans have access to comprehensive mental health services at every VA medical center. VA has residential and inpatient programs that provide treatment to women only or, that have separate tracks for women and men.

These residential and inpatient programs are considered regional and/or national resources, not just a resource for the local VA facility. VA remains committed to ensuring that appropriate services are available to meet the treatment needs of women (and men) Veterans who have experienced Military Sexual Trauma (MST) and may be at risk for suicide.

Breakthrough Outcomes for 2016

We are looking to achieve three breakthrough outcomes for 2016. First, we remain focused to increasing access to health care. When Veterans call for a new mental health appointment, they receive a suicide risk assessment and immediate care, if needed. Veterans already engaged in mental health care identifying a need for urgent attention will speak with a provider the same day. Second, we will modernize our Contact Centers, including the Veterans Crisis Line. Veterans will have a single toll free phone number to access the VA Contact Centers, know where to call to get their questions answered, receive prompt service and accurate answers, and be treated with kindness and respect. By the end of this year, every Veteran in crisis will have his or her call promptly answered by an experienced responder at the Veterans Crisis Line. Third, we will staff critical positions. VA is looking to achieve significantly improved critical staffing levels that balance access and clinical productivity. This will increase the rate at which positions are filled.

Timely access to mental health care for our Veterans is of utmost importance to VA. We acknowledge that we have work to do in this area, and we are constantly working to increase access. We are in partnerships with other Federal agencies, community providers, and through the use of tele-mental health, we are increasing

access. There are many entry points for mental health care, including 168 VA medical centers, 1,035 Community Based Outpatient Clinics and Outpatient Services sites, 300 Vet Centers providing readjustment counseling, 80 Mobile Vet Centers, a national Veterans Crisis Line, VA staff on college and university campuses, and a variety of other outreach efforts.

Community Provider Pilot Program

In 2013, 12 VA Medical Centers (VAMCs) developed agreements with 24 Community Mental Health Clinics (CMHCs) across the country to establish Community Mental Health (CMH) pilots. These pilots were created in response to section 3(a) of Executive Order 13625, “Improving Access to Mental Health Services for Veterans, Service Members, and Military Families,” which focused on the creation of “Enhanced Partnerships between the Department of Veterans Affairs and Community Providers” designed specifically to decrease wait times and assist in areas where VA has faced challenges in hiring and placing mental health providers. Pilot sites were able to select a model of care to best meet the needs of local Veterans. All sites used one of two broad approaches: Community Care or VA telemental health (TMH), with most sites choosing to provide Non-VA care to Veterans. Non-VA care uses community providers that are paid by VA. TMH care utilizes technology to deliver mental health services via modalities such as video conferencing and allows for real-time (or "synchronous") encounters between health care providers and patients who are not in the same location. During the VA/Community Mental Health Care Pilot partnerships, TMH

services enabled Veterans to receive care at designated community clinics that were closer to their homes than the nearest VA medical facilities or clinics.

VA and CMHC staff worked together in determining roles and responsibilities within each pilot partnership. Partnerships using telemental health required space, equipment, a technician, and a protocol for handling emergencies (e.g., a Veteran becoming distressed during a TMH session). For Non-VA care partnerships, there were other responsibilities that needed to be addressed: coordination of care (between VA and CMHCs), billing, and payment. While some pilot site VAMCs developed strong systems for coordinating care, monitoring patients, and billing, other sites, especially smaller ones, experienced challenges in these areas.

Evaluation of the pilots included both gathering data from not only Veterans about their experiences, but also from key staff at each of the participating Veterans Integrated Service Networks (VISN) and VA Central Office (VACO) and a review of key documents associated with the pilots. Results from follow up surveys indicate that Veterans were very satisfied with the services they received via these pilots. When the pilots concluded, each participating VAMC was allowed to determine whether to continue the partnership.

Additional Efforts to Improve Access

VA has also moved to Patient Centered Community Care, a centralized contracting mechanism, and has implemented the Veterans Choice Program. Regardless of how such care is provided, the growing need for mental health services for Veterans will increase the need for efficient leveraging of Non-VA community

providers when access to care is not available within the VA system of care. VA is rising to the challenge through its Community Mental Health Summit program which engaged over 11,000 individuals at 144 sites in FY 14 and continues annually to bring together DoD, VA, State, and Community providers and stakeholders for vital conversations at the local level.

VA and DoD developed a joint Military Cultural Competence Training Program as part of the Integrated Mental Health Strategy which is now housed on the public facing TRAIN website, vha.train.org, and which, to date, has provided free training to over 2,000 providers. Whether mental health care is delivered directly by Non-VA mental health care providers, through TMH care at Non-VA sites, or any other means, it is critical for VA to continue to provide Veterans with access to high quality mental health care in coordination with other VA services.

In addition, VA is addressing access through the following efforts:

- Veteran-centered operating hours: Extended hours help increase capacity when space is limited and improve the match between available staff hours and the needs of Veterans who are employed or have other competing responsibilities during day-time hours.

- Leveraging trainees and fellows: These professionals provide substantial amounts of clinical care under the direct supervision of appropriately licensed and privileged mental health staff. Training programs also provide ready access to well-qualified candidates for recruitment into vacant positions.

- Support staff, adjunct professions, and peer support staff: VA has hired over 900 peer specialists and is developing a pilot program in response to the

President's August 2014 Executive Actions to expand the role of peer specialists into primary care settings.

VA's efforts to increase access to mental health care for Veterans face many challenges. These include overcoming stigmas that Veterans may associate with seeking care for mental health, the need to address co-occurring substance use disorders, and fears that associated medical records documenting their care may have an adverse impact on their lives. Additionally, VA struggles to attain and retain a sufficient mental health workforce capacity, establish a competency-based practice, and have adequate systems to support improving care nationwide. In the face of these challenges, we continue to focus our efforts on ensuring Veterans receive timely access to mental health care.

Hiring Practices

In 2012, VA began a two-part hiring initiative under Executive Order 13625 issued in August 2012. The first part focused on recruiting 1,600 new mental health professionals, 300 new non-clinical support staff (such as scheduling clerks), and filling existing vacancies as of June 2012. The second part was the hiring of 800 peer specialist positions by December 31, 2013. As a result of this initiative, VA hired approximately 5,300 new clinical and non-clinical mental health staff. VA hired 932 peer specialists as well. The Government Accountability Office found that VAMC officials reported local improvements due to the additional hiring, such as more evidence-based therapies offered, mental health care provided at new locations, and a variety of benefits provided by the new peer specialists such as modeling effective coping,

engaging Veterans who are resistant to discussing mental health issues, and providing peer-to-peer counseling.

VAMC officials also cited several challenges to hiring mental health care providers such as pay disparity with the private sector, competition among VAMCs, the lengthy hiring process, lack of space and support staff, and an underlying nationwide shortage of mental health professionals. VA has increased its mental health hiring through outreach events at medical schools, through Mental Health professional groups and other means of active recruitment in order to develop the workforce needed to meet the needs of our Veterans who need mental health care. At a national level, VA outpatient mental health staff totals increased from 11,138 full-time equivalents in 2010 to more than 14,000 in FY 2015. Over the same time period, the number of Veterans receiving outpatient mental health care increased from 1,259,300 to more than 1,600,000.

The recent rapid growth in the number of Veterans seeking mental health treatment in VA has posed challenges in the area of staffing. In Figure 1 below, the solid black line shows the growth in numbers of Veterans using mental health services, from 897,600 in 2005 to more than 1,600,000 in 2015. The number of patients is expressed in terms of hundreds to show staff and patient numbers on the same graph. For example, 10,000 on the vertical axis represents 1,000,000 patients and 10,000 full time equivalents employees (FTEs).

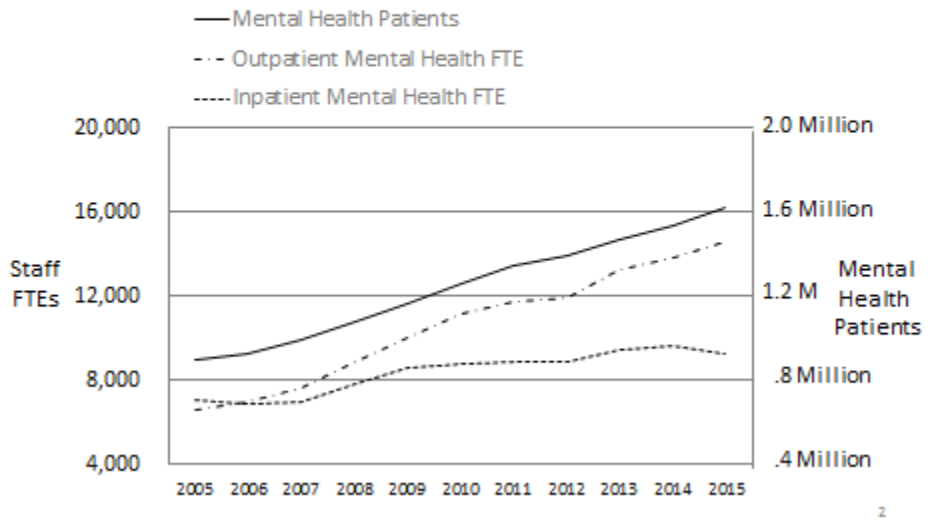

Figure 1. Growth in annual numbers of patients using mental health services and in outpatient and inpatient FTE levels, 2005 to 2014.

This graph also shows the growth in numbers of mental health clinical staff, measured in terms of the FTE providing outpatient and inpatient treatment. Consistent with a shift to outpatient care, the inpatient mental health FTEs began to level off after 2009. Outpatient mental health FTEs began to lag behind the growth in patient numbers in 2012, but as part of the President's 2012 Executive Order 13625, VA hired more than 1,600 new clinical providers by the June 30, 2013, target date.

In the absence of any national benchmark related to mental health staffing, VA continues to refine our model that is intended to inform local facility decision-making about the number of staff necessary to meet local demand for mental health services.

Clay Hunt Implementation Accomplishments

The Clay Hunt Suicide Prevention for American Veterans Act (Public Law 114-2) gives VA additional authority to advance suicide prevention efforts for Veterans within the Department and in partnership with the community. As of March, 2016, VA has taken steps to implement each of its requirements, including the Call to Action collaboration previously discussed. To conduct an independent evaluation of Mental Health and suicide prevention programs, VA has contracted with an independent third party, Enterprise Resource Performance, Inc. (ERPI). VA mental health program evaluation centers are collecting self-report outcome data from Veterans newly receiving mental health care. Funding has been provided to cover the programs included in the Clay Hunt evaluations. The Program Evaluation Centers will support ERPI's request for data to conduct the independent evaluation. The full report by ERPI is due to Congress in 2018, and the first VA interim report that provides descriptive data on specific mental health programs is due in September of 2016. The Office of Mental Health Operation (OMHO) is working with the independent 3rd party evaluator to ensure coordination for these reports.

We are working towards the publication of a website that provides easily-accessible information about mental health services for Veterans. The current VA Facility Locator tool includes information regarding PTSD, Substance Use Disorder, and Vet Center programs and contact and resource information. This tool is currently accessible on several sites, including the VA homepage, VA Mental Health page, and the Make the Connection website. The vets.gov team has developed a prototype for a website to provide a facility locator that includes both services and facilities for

Veterans. VA product team and mental health subject matter experts are reviewing the prototype with a planned launch of these enhancements on vets.gov in fall 2016 (Note: this capability is dependent on the existence and availability of required VA data. The VA team is currently working to determine if the necessary data will be available for this enhancement).

To address critical VA health care workforce needs in the area of mental health, VA is establishing a pilot program for the repayment of educational loans (PREL) for certain psychiatrists seeking employment in VA. The program secures a service commitment to a VA health care facility from program participants who are either licensed or eligible for licensure to practice who are enrolled in their final year of a post-graduate physician residency program leading to either a specialty qualification in psychiatric medicine or a subspecialty qualification of psychiatry. In return, VA will pay up to $30,000 a year in qualifying student loan debt for each year of obligated service.

VA has also developed a pilot program using community outreach and peer support to engage Veterans in care. Five Veterans Integrated Service Networks (VISNs), 6, 7, 16, 17, and 22, began implementing the pilot program, with support from the VISN 3 VA Mental Illness Research, Education Clinical Center to conduct the program evaluation component of this initiative.

VA has also implemented an expanded period of eligibility for recent combat Veterans. This resulted in the new enrollment of about 995 Veterans who discharged between January 1, 2009, and January 1, 2011, and who did not enroll in the VA health care during their initial 5 year period of eligibility.

Legislative Priorities

VA is grateful for your continuing support of Veterans and appreciates your efforts to pass legislation enabling VA to provide Veterans with the high-quality care they have earned and deserve. As the Department focuses on ways to help provide access to health care across the country, we have identified a number of necessary legislative items that require action by Congress in order to best serve Veterans.

Flexible budget authority would allow VA to avoid artificial restrictions that impede our delivery of care and benefits to Veterans. Currently, there are over 70 line items in VA's budget that dedicate funds to a specific purpose without adequate flexibility to provide the best service to Veterans. These include limitations within the same general areas, such as health care funds that cannot be spent on health care needs and funding that can be used for only one type of Care in the Community program, but not others. These restrictions limit the ability of VA to deliver Veterans with care and benefits based on demand, rather than specific funding lines.

VA also requests your support for legislation that would allow VA to enter into agreements with providers on an individual basis in the community outside of Federal Acquisition Regulations, and includes explicit protections for procurement integrity, provider qualifications, price reasonableness and employment protections. Such legislation will ensure that VA is able to provide local care to Veterans in a timely and responsible manner. VA would support language that addresses concerns related to employment nondiscrimination and equal employment protections. We would have strong concerns with any legislative language, such as that currently being considered by this committee that rolls back employment protections. VA further requests your

support for our efforts to recruit and retain the very best clinical professionals. These include, for example, flexibility for the Federal work period requirement, which is not consistent with private sector medicine, and special pay authority to help VA recruit and retain the best talent possible to lead our hospitals and health care networks.

Conclusion

Mr. Chairman, VA is saddened by the crisis of suicide among Veterans, but committed to the work we have done in implementing and expanding upon the expectations of this Committee. We remain focused on providing the highest quality care our Veterans have earned and deserve and which our Nation trusts us to provide. Our work to effectively treat Veterans who desire or need mental health care continues to be a top priority. We emphasize that we in VA remain committed to preventing Veteran suicide, aware that prevention requires our system-wide support and intervention in preventing precursors of suicide[1]. We appreciate the support of Congress and look forward to responding to any questions you may have.

[1] https://www.drugabuse.gov/sites/default/files/drugfacts_subabusemilitary.pdf