AMERICAN PSYCHIATRIC ASSOCIATION

800 Maine Avenue, S.W.
Suite 900
Washington, D.C. 20024



**Statement of the**

**American Psychiatric Association**

**Submitted for the record to the**

**U.S. House of Representatives Veterans Affairs Committee**

**In advance of the**

**SEPTEMBER 10, 2020 FULL COMMITTEE LEGISLATIVE HEARING**

The American Psychiatric Association (APA) appreciates the opportunity to submit testimony to the U.S. House of Representatives Committee on Veterans Affairs in advance of its hearing on comprehensive mental health expansion and Veteran suicide reduction legislation. As the largest professional association for mental health physicians representing 38,800 psychiatrists, and the umbrella organization for state societies across the country, the APA recognizes the importance of this hearing to address persistent challenges our nation's Veterans face in accessing quality mental health care and suicide prevention services. We are grateful to the Committee for your attention to the mental health of our nation's Veterans.

In response to the increasing Veteran suicide rate, the House Veterans Affairs Committee has made suicide prevention a top priority. As described below, APA supports many of the bills under consideration today, several which have companion provisions in S.785, the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019*, which the Senate passed earlier this year. These standalone bills and provisions would better coordinate efforts within the U.S. Department of Veterans Affairs (VA) to reduce Veteran suicide through investments in suicide prevention programs and mental health resources, develop VA clinical practice guidelines for Veterans with serious mental illnesses, support innovative research, and increase the overall availability and accessibility of mental health care for Veterans.

Though the APA supports several of the provisions being discussed at today's hearing, **we strongly oppose Section 505 of the House package that would authorize an experimental pilot program to allow clinical psychologists to prescribe and manage medication for patients in the VA system**. With limited time left in the 116thCongress, APA is hopeful that Congress will act swiftly to move forward legislation that will improve quality access to and resources for VA mental health services and specialized programs for our nation's Veterans, while excluding such controversial and counterproductive proposals.

**Veteran Suicide**

Suicide is the 10th leading cause of death in the U.S. and Veterans are at a high risk for suicide when compared to the rest of the US population. In 2017, the suicide rate for Veterans was 1.5 times the rate for non-Veteran adults, with approximately 17 Veterans dying by suicide each day and over 6,000 Veterans dying by suicide each year.[1,2] This means that despite accounting for just 7.9% of the population, Veterans account for 13.5% of all suicide deaths in the United States. However, research indicates that Veterans who used services provided by the Veterans Health Administration (VHA) had much lower suicide rates than Veterans who did not use those services. [3]

In the present COVID-19 pandemic era, like many Americans, Veterans are now grappling with one of the worst unemployment rates in recent history. Social isolation to comply with physical distancing recommendations may add to feelings of hopelessness, anxiety, depression, and despair. Each of these factors alone would generally increase feelings of anxiety, depression, and other mental health disorders

[1] https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf
[2] https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf
[3] https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf

as well as SUDs for many Americans. However, when these elements are combined and added to the stressors Veterans and active duty military members experience pre-deployment, during deployment and post-deployment, pandemic stressors can exacerbate mental health conditions in this population.

In August, the Centers for Disease Control and Prevention released a report finding a considerable increase in anxiety and depressive disorders compared to this time last year.[4] This spike in mental health needs requires comprehensive action to increase quality of care while reducing the barriers to accessing mental health and suicide prevention services. To this end, we are pleased the Committee has chosen to focus this hearing on legislation aimed at helping Veterans manage their mental health conditions and decreasing the Veteran suicide rate.

To that end, the APA supports **H.R. 8033, the *Access to Suicide Prevention Coordinators Act*** introduced by Representatives Brindisi (D-NY), Bost (R-IL), and Banks (R-IN) and included in **Section 101 (Expansion of health care coverage for Veterans) of the *Veterans COMPACT Act,*** which is a companion to S. 785; **Section 102 (Review of records of former members of the Armed Forces who die within one year of separation from the Armed Forces) of the *Veterans COMPACT Act***, a companion to S. 785; **Section 403 (Comptroller General management review of mental health and suicide prevention services of the VA) of the *Veterans COMPACT Act***, which also has a companion provision within S. 785; and **Section 404 (Comptroller General report on efforts of the VA to integrate mental health care into primary care clinics) of the *Veterans COMPACT Act***, which also has a companion provision in S. 785. The APA believes that each of these provisions are essential for inclusion in a comprehensive package of complementary, suicide-focused improvements to our nation's Veteran suicide prevention efforts.

**Evidence-based Care for Serious Mental Illness**

APA has endorsed and is pleased to see the Committee consider **H.R. 8108, the VA Serious Mental Illness Act** introduced by Representatives Dunn (R-FL) and Malinowski (D-NJ) on today's list of legislation for consideration. This bill includes policies that require the VA and the Department of Defense to develop clinical practice guidelines for the treatment of Veterans and service members presenting with a serious mental illness. **This standalone legislation is a bipartisan companion to Section 304 of S. 785,** which is vitally important to facilitating the appropriate delivery of mental health care to Veterans with serious mental illnesses. Clinical practice guidelines offer a way of bridging the gap between policy, best practices, local context, and patient choice. Such guidelines provide evidence-based recommendations and are intended to assist in clinical decision making by presenting systematically developed patient care strategies in a standardized format. APA is encouraged to see the alignment between the House and Senate provisions.

[4] Czeisler ME, Lane RI, Petrosky E, et al. Mental Health, Substance Use, and Suicidal Ideation During the COVID-19 Pandemic – United States, June 24-30, 2020. MMWR Morb Mortal Wkly Rep 2020;69:1049-1057. DOI: http://dx.doi.org/10.15585/mmwr.mm6932a1external_icon

**American Indian/Alaska Native Veterans**

The American Psychiatric Association appreciates the work Congress has done to ensure access to vital health services for all communities. However, health disparities are still prevalent among racial/ethnic, gender, and sexual minorities that often suffer from poor mental health outcomes due to the inaccessibility of quality mental health care services, cultural stigma surrounding mental health care, discrimination, and overall lack of awareness about mental health.

Systematic review of racial and ethnic disparities in the VA health care system have consistently noted findings that black and Hispanic patients were more frequently diagnosed with and treated for serious mental illness than non-minority patients.[5] These reviews also found that American Indian/Alaska Native (AI/AN) populations experience disproportionately higher rates of substance use disorders (SUDs), posttraumatic stress disorder (PTSD), suicide, and attachment disorders than the general US population.[6] Additionally, mental health service utilization rates for AI/ANs are low, which is likely due to a combination of factors, including stigmatization of mental health, lack of culturally trained providers, and lack of available services.[7] That is why **the APA strongly supports H.R. 8068, the *American Indian and Alaska Native Veterans Mental Health Act,*** introduced by Representatives Brownley (D-CA), Cole (R-OK), and Torres Small (D-NM). This critical piece of legislation would establish targeted outreach to American Indian/Alaska Native (AI/AN) communities and implement practices for the delivery of culturally appropriate mental health and suicide prevention services.

**Proposed Pilot Program Expanding Psychologist Prescriptive Authority**

The **APA strongly opposes the experimental pilot program proposed in section 505 of the draft *Veterans COMPACT Act*.** This provision puts patient safety at risk by allowing clinical psychologists to prescribe and manage medications for Veterans, despite psychologist's lack of medical training. This provision does not address the shortage of mental health clinicians within the VA. In fact, the pilot project has the potential to further silo health care clinicians instead of encouraging and increasing collaboration between providers.

Psychologists are not allowed to prescribe and manage medication independently without collaborating with a medical doctor in any setting, including the VA, because they do not have the requisite training or medical background to do so. To date, no Federal program including Medicare, Medicaid, TRICARE, or the VA allows psychologists to have independent prescriptive authority. Medicare expressly states that the program does not reimburse for evaluation and management or pharmacologic management by prescribing psychologists, specifically citing psychologists' lack of knowledge and ability.[8] No state allows for clinical psychologists to independently prescribe, and only 5 states allow any type of prescribing authority under collaboration or the supervision of another medical provider or physician. **For the two**

[5] Jones, Audrey L., et al., "Racial/Ethnic Differences in Primary Care Experiences in Patient-Centered Medical Homes Among Veterans with Mental Health and Substance Use Disorders." Journal of General Internal Medicine 31, no. 12 (2016): 1435, 1436, 1443.

[6] Bassett, D., Buchwald, D., & Manson, S. (2014). Posttraumatic stress disorder and symptoms among American Indians and Alaska Natives: a review of the literature. *Social psychiatry and psychiatric epidemiology*, *49*(3), 417–433. https://doi.org/10.1007/s00127-013-0759-y

[7] Kaufman, C. E., Kaufman, L. J., Shangreau, C., Dailey, N., Blair, B., & Shore, J. (2016). American Indian veterans and VA services in three tribes. American Indian and Alaska Native Mental Health Research, 23(2), 64-83. doi:10.5820/aian.2302.2016.64

[8] CY 2013 Medicare Physician Fee Schedule Final Rule with Comment, CMS-1590-FC.

**percent of United States residents who live in states that allow psychologists to prescribe, there has not been an increase in access to care.**

Allowing psychologists to prescribe medication in the VA system jeopardizes the safety of our nation's Veterans, one of the most vulnerable populations. This population is frequently diagnosed with not only acute mental health illnesses, but also has a high rate of co-morbid physical health conditions. In fact, more than half of patients living with a mental illness also have an underlying physical illness. The complex interactions between mental and physical health conditions – and the medications used to treat them – require advanced medical training that psychologists do not possess.

While clinical psychologists are highly trained members of the behavioral health team, they are not trained to prescribe for acute and serious mental illness that often requires medication management given prevalent co-morbid physical illnesses, such as diabetes, heart disease or hypertension. Medications, of all forms, can affect internal organs and the body's physiological process. Side effects and contraindications with other prescribed medications may be numerous and only initially detectable if the right symptoms are noted and the correct medical tests, or batteries of testing, are ordered. Any missed side effect or misstep in these complex and interrelated processes could lead to adverse outcomes, or even death. This evaluation, testing, diagnosis and management of medication to treat co-morbid conditions cannot be mastered without years of medical training and then further years of medical residency. It is simply not possible to learn all of this during a graduate psychopharmacology program and a single year of supervised practice.

Given the prevalence of over-prescription in the VA, we believe that nothing is more important than ensuring that Veterans are given high quality mental and physical health care by qualified, appropriately educated and trained medical clinicians, not more prescribers and more prescriptions. ***Veterans have gone above and beyond by serving our country and should not be subjected to a lower standard of care than other patients across the country.***

Instead of considering an ill-conceived experiment to expand psychologists' scope of practice putting our Veterans at risk, the Committee should focus on improving access to quality mental health care and treatment in the VA. The APA strongly supports access improvement strategies that alleviate very real workforce shortages across the mental health provider continuum including increasing recruitment, training and retention of psychiatrists, psychologists and other mental health providers in the VA system. We believe that the VA can work towards this goal by enhancing integrated care, further expanding telehealth, and examining in-depth the impediments to recruiting and retaining these providers within the VA system. Accordingly, **APA has endorsed, and is pleased to see the Committee considering H.R. 8144, the *VA Mental Health Staffing Act***, introduced by Representatives Steube (R-FL) and Hayes (D-CT) on today's list of legislation for consideration. A companion to section 501 of S. 785, the bill would assess VA's mental health workforce and develop a plan to address staffing requirements and appropriate delivery of essential mental health care. **APA also supports H.R.7879, *VA Telehealth Expansion Act,*** introduced by Representatives Lee (D-NV) and Banks (R-IN), which is a companion to section 701 of S. 785. This bill would expand telehealth capabilities in rural and remote areas of the country. Prior to COVID-19,

telehealth was underutilized with only about 12 percent of Veterans receiving elements of their care via telehealth in fiscal year 2016 with the number growing 3.6 percent the following year.[9] These proposals, along with consideration of access improvement strategies are vitally important to better our understanding of the mental health needs throughout the VA health system.

The APA also has **concerns with Section 504 of the *Veterans COMPACT Act*** and is unclear why the change to the Title 38 statute would be necessary. The provision would amend the VHA appointment of psychologists to designate them in a category with medically trained health care professionals.

## Additional Recommendations

*Collaborative Care and Team-based Care*

As the VA confronts workforce shortages in mental health, we encourage the Committee to work on a long-term recruitment plan that proposes new ways to recruit, train and retain more mental health providers across the continuum of care. Given the current care shortage, the APA commends the VA for instituting team-based practices such as the Primary Care-Mental Health Integration program and the VA collaborative chronic care model as mechanisms for ensuring Veterans receive immediate, collaborated services. We specifically encourage the VA to build on its effort to improve the integration of care through greater implementation of the Collaborative Care Model, a population-based model with over 90 randomized control trials showing its effectiveness. The model uses a psychiatric consultant to support a primary care provider (PCP) as well as a care manager to coordinate care for the PCP and among providers. The VA was one of the first systems to use this model to enhance team-based care and integration; however, it is underutilized despite having effectively improved access to treatment, patient satisfaction and outcomes while reducing costs.[10,11]

Although enhanced integration efforts, like the Collaborative Care Model, can benefit the VA now, the APA does not recommend delaying enactment of the many important Veterans mental health proposals under consideration to do so. We would gladly work with the committee on this and other additional solutions after Congress dispenses with the legislation that is currently under consideration.

In closing, the APA wishes to stress how vital it is that the Committee address the mental health needs for Veterans, transitioning service members, and their families as quickly as possible. We hope that the Committee will work quickly to move bipartisan, bicameral legislation that avoids new, controversial provisions. We support the Committee's goal of improving underlying suicide prevention legislation and are hopeful that any necessary adjustments can be made quickly to accommodate enactment of S.785. We stand ready to work with you during this process and offer our association and its members as resources as the Committee continues its work on this important issue. Thank you again for the opportunity to submit this testimony on today's slate of bills and for your leadership on this important issue.

[9] Department of Veteran Affairs (FY 2018) Telehealth Factsheet. Retrieved from https://www.va.gov/anywheretoanywhere/docs/Telehealth_Services_factsheet.PDF

[10] Archer J et al. "Collaborative care for people with depression and anxiety". Cochrane Review. October 2012.

[11] AIMS Center (Advancing Integrated Mental Health Solutions). "Collaborative Care Evidence Base."