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"It's past time to expand community care for Veterans with mental health and substance use disorders. To do otherwise will perpetuate America's catastrophic suicide crisis among our heroes."

We are grateful for the opportunity to submit written testimony about the need to expand access to community care under the MISSION Act for Veterans and their loved-ones suffering with mental health and substance use disorders.

It is estimated that since 2008, more than 70,000 veterans have died by suicide – more than the total number of deaths from combat during the Vietnam War and the Global War on Terrorism combined. Risk of suicide is significantly higher among Veterans who have a mental health and/or substance use disorder.[1] More than 18% of all Veterans say they experience high levels of difficulty when transitioning to civilian life. Amongst combat Veterans, over 45% describe a difficult transition.[2] After service, many Veterans describe a sense of loss of the camaraderie, honor, duty, and service that inspired them for years or even decades, leaving them alone and without purpose. This serves as a stark reminder that many of America's warriors need mental health and addiction treatment on this side of the uniform.

Approved, in-network community care providers have immediate capacity, expertise, experience, and resources to rapidly and effectively provide medical and clinical care for anxiety, depression, substance misuse, and other known drivers of suicide among Veterans.

For example, All Points North (APN) is an approved substance misuse and behavioral health treatment provider for Veterans with TriWest. With 77 residential beds, APN combines innovative neurotechnology and interventional psychiatry – such as Hyperbaric Oxygen Therapy (HBOT), Deep Transcranial Magnetic Stimulation (dTMS), Stellate Ganglion Block (SGB), Neurofeedback, and Ketamine-assisted treatment – with proven talk and experiential PTSD treatment modalities, extensive group therapy, individual therapy, and medically assisted treatment for substance use disorders, anxiety, and depression. APN's specific Veterans' treatment track creates a safe and specialized environment for Veterans with significant mental health, trauma and substance use disorders. To further support Veterans in an acute condition, APN also has walk-in detox and behavioral health assessment and stabilization facilities in Colorado and California with more facilities opening soon in Texas and Florida.

[1] . Tanielian, Terri, et al. Invisible Wounds: Mental Health and Cognitive Care Needs of America's Returning Veterans. RAND Corporation, 2008.
[2] Parker, Kim, et al. The American Veteran Experience and the Post-9/11 Generation. Pew Research Center, 10 Sept. 2019.

Because APN focuses on outcomes and transparency, it participates in the ACORN collaboration, a large database of psychotherapy treatment outcomes. ACORN measures APN's client outcomes against 3,000 other providers and 3 million other patients. APN is in the top 5% of provider outcomes, with six-times better client engagement and only 7.3% of clients returning for additional care post-treatment. ACORN categorizes APN's Change in Patient Condition as "Significantly Improved".

APN is the only community care provider of its kind for the approximately one million Veterans who live in the VA Rocky Mountain Network (VISN 19), a 10-state region covering Montana, Wyoming, Utah, Colorado, Oklahoma, and portions of North Dakota, Nebraska, Kansas, Nevada, and Idaho.

Despite its innovative services and excellent outcomes, the VA has rarely referred a Veteran to APN for community care under the MISSION Act. Instead, the VA consistently delays approval for Veterans who meet the Eligibility Standards for Access to Community Care under the MISSION Act and ask to be treated at APN. Instead of efficiently and quickly approving a Veteran for life-saving community care, the VA makes them wait for authorization, leaving them to languish in a dangerous "VA decision-limbo" for many weeks and even months without treatment.

To further delay a Veteran's access to community care, the VA often rejects the diagnosis and level of care recommended for a Veteran by a non-VA licensed clinical or medical professional. Instead of accepting the assessment and recommended treatment plan of a licensed clinical or medical professional, who is a specialist trained to diagnose and treat mental health and substance use disorders, Veterans are instead required by VA policy to first see a Primary Care Physician (PCP). This step alone oftentimes and tragically results in the Veteran giving up seeking treatment altogether, putting the Veteran at high risk of suicide or overdose.

Rather than turn them away, APN has consistently admitted and treated any Veteran at risk of suicide or overdose and provided anywhere from thirty to sixty days of intensive, residential care, free of charge. Currently, seven combat Veterans are receiving care at APN's residential facility. Their diagnoses range from severe PTSD and opioid dependence to anxiety and depressive disorders. Less than half of the seven at APN have currently been approved by the VA for community care under the MISSION Act.

Changing the culture of resistance to community care within the VA ranks remains the largest and most time-sensitive challenge to ending Veteran suicide and overdose. A hand-in-hand partnership with its in-network community care providers is something Congress has encouraged, authorized, and advocated through multiple statutory and budget approvals. After nearly a decade of efforts, starting with the Veterans Choice Program, the tools are in place for the VA to engage community care providers as a much-needed extension of mental health and addiction treatment in the life-saving care of Veterans and their families.

Community Care Under the MISSION Act of 2018

Under the MISSION Act of 2018, Veterans may request, and are eligible for, community care when they meet one or more of the MISSION Act Eligibility Standards for Access to Community Care. These eligibility standards were intentionally designed by Congress to accelerate care for Veterans whose condition would otherwise worsen unless treated quickly, and when a Veteran needs a service not available at a nearby VA medical center; a Veteran lives more than a 30 minute drive to their nearest VA medical center; a VA medical center cannot schedule an appointment for the Veteran within 20 days; a Veteran determines that community care is in their best interest; or a Veteran does not feel they are receiving the best care they need at the VA.

For Veterans seeking treatment for a mental health and/or substance use disorder, these access standards rightly prioritize the urgent conditions under which community care treatment services are needed to prevent another Veteran suicide or overdose.

Considering the shocking reality that we are now in our 20th consecutive year with 6,000 or more Veteran suicides per year, there is no rational or humane justification to delay or deny an eligible Veteran efficient and effective mental health and substance use disorder treatment by an approved community care provider.

Community care under the 2018 MISSION Act should be a seamless alternative for Veterans who can't quickly or easily access care at a VA medical center. Unfortunately, there are currently significant obstacles to overcome in order to ensure Veterans can access community care under the law.

The VA's Own Guidance Has Dissuaded Veterans from Community Care Options.

The Americans for Prosperity Foundation (AFPF) has reported extensively on documents obtained under the Freedom of Information Act about the VA's willingness and efficiency in approving Veterans for community care. According to the AFPF, the VA regularly fails to refer, while delaying and denying eligible Veterans for community care under the MISSION Act and its own regulatory requirements.[3]

According to AFPF, the VA Veterans Health Administration's own Referral Coordination Initiative Implementation Guidebook (Updated: October 28, 2021) describes the VA's strategy to reduce utilization of community care because of "more Veterans being referred to the community than expected."[4] The VA's solution to the higher-than-expected access to community care among Veterans was to shift the responsibility of referring to community care

[3] "More Evidence the VA Is Improperly Delaying or Denying Community Care to Eligible Veterans." Americans for Prosperity, AFPF, 28 Jan. 2022.
[4] "Veterans Health Administration: Referral Coordination Initiative Implementation Guidebook." U.S. Department of Veterans Affairs, 28 Oct. 2021, pp. 92.

from health care providers to "dedicated clinical and administrative staff" who the VA calls "Referral Coordination Teams." This additional process of decision-making was implemented in part because "Veteran feedback suggests many Veterans prefer to receive internal/direct VA care."[5] The AFPF also uncovered a VA training document that creates an additional barrier for a Veteran already eligible for community care. It states, "After eligibility has been confirmed, clinical review is performed to determine if the requested services are clinically appropriate to be authorized for delivery in the community." This extra step is not required in the MISSION Act or implementing regulations, but it could lead to longer wait times or denial of community care.[6]

Sadly, some may think that these VA cost-saving measures are justified for fiscal reasons However, in the face of a two-decades-long suicide crisis, these decision delays leave Veterans languishing in "VA decision-limbo", putting them a grave risk of suicide and overdose. Delaying an eligible Veteran from receiving community care for mental health and/or addiction treatment it's nothing short of inhumane, not to mention, unlawful.

Delays to Access Community Care

Long delays veterans face when attempting to access life-saving mental or behavioral health care through the Veterans Administration (VA) betrays America's Promise by Abraham Lincoln "*To care for him who shall have borne the battle, and for this widow and his orphan.*"
According to the VA's own internal data, veterans waited an average of 41.9 days for an appointment, starting from the time he or she requested an appointment until the date they actually were seen by the VA.
Outside audits of appointment delays at the VA are far more damning. On July 24, 2019, Debra Draper, Director of Health Care at the United States Government Accountability Office (GAO), delivered shocking testimony before the House Committee on Veterans' Affairs. When considering all factors, veterans are typically waiting up to 70 days for an appointment for care at the VA.

This limbo period, between when a veteran in a mental health or behavioral health crisis first asks for help, and the moment they access care, has become a "Valley of Death." Consequently, many veterans lose hope, give up, and tragically take their own lives or suffer a lethal overdose.

It is acutely problematic when a veteran seeks non-VA "Community Care" under the MISSION Act of 2018. There are two primary VA policies that create delays which can contribute to suicides for veterans seeking Community Care.

[5] Veterans Health Administration: Referral Coordination Initiative Implementation Guidebook." U.S. Department of Veterans Affairs, 28 Oct. 2021, pp. 90.
[6] "More Evidence the VA Is Improperly Delaying or Denying Community Care to Eligible Veterans." Americans for Prosperity, AFPF, 28 Jan. 2022.

First, veterans are required by VA policy to first see a VA Primary Care Physician (PCP) prior to accessing community care. If and when the veteran finally sees their PCP, many weeks or months later, and secures a referral for Community Care, the VA often overturns the PCP referral and requires the veteran to be treated within the VA's own health care system. More appointments are then required, and the process starts all over again.

Second, the VA often rejects the diagnosis and level of care recommended for a Veteran by a non-VA licensed clinical or medical professional. Instead of accepting the psychiatric assessment, diagnosis, and recommended treatment plan from a licensed clinical or medical professional, who is a specialist trained to diagnose and treat mental health and substance use disorders, the VA requires the veteran to be assessed by their physician.

These steps and delays don't make clinical or economic sense for someone with any other life-threating condition such as cancer, heart disease, or a severe allergy. Why then is it acceptable to slow-play and disregard veterans who need immediate intervention and treatment for depression, anxiety, post-traumatic stress, or addiction? Have we not learned anything from the now two-decade-long veteran suicide crisis where we have lost over 6,000 Veterans year over year? The solution is simple. Veterans must have the same rights and access to life-saving mental health and behavioral health care that every other insured American is afforded.

Mental and Behavioral Health Treatment for Non-Veterans

The Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2018 (a.k.a., mental health parity law or federal parity law) requires any insurance company to treat mental and behavioral health and substance use disorder coverage equal to, or better than medical/surgical coverage. The law also requires that insurers treat financial requirements equally and lift all limits on the number of mental health visits allowed by an insurance company per year.

The federal parity law applies to all employer-sponsored health coverage, for companies with 50 or more employees, coverage purchased through health insurance. It also applies to exchanges that were created under the Affordable Care Act, the Children's Health Insurance Program (CHIP), and most Medicaid programs.

Unlike the delays a Veteran has to endure with VA care, under commercial PPO health insurance coverage in the United States, an individual can walk into any in-or out-of-network provider and receive treatment for a mental or behavioral health disorder. Under even the most basic HMO plan, the policy-holder can typically get an appointment and referral from their PCP in less than a week. In the case of a mental or behavioral health referral, approvals are oftentimes expedited due to the emergent nature of the diagnosis and the liability the PCP shoulders if they delay getting their patient into the proper level of care.

Furthermore, under commercial insurance plans, the insurer accepts the psychiatric assessment and diagnosis, performed by the patient's chosen healthcare provider.

Policy Recommendations

Therefore, to eliminate delays in life-saving services and to reduce Veteran suicide and overdose:

1) Congress should ensure that all Veterans who meet one or more of the MISSION Act Eligibility Standards for Access to Community Care should be afforded both the same choice of when and where they receive treatment that is given under the Urgent Care exception in the MISSION Act and the same choice afforded to every American under the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008.

2) Congress should ensure that all Veterans who self-refer to Community Care, and who meet one or more of the MISSION Act Eligibility Standards for Access to Community Care, are quickly assessed by a licensed clinical or medical Community Care professional, and promptly approved for the indicated level of care by the VA, without the requirement that a Veteran must first see their Primary Care Physician. Congress should consider imposing a 7-day maximum waiting period for mental health care attendant to a finding of suicidal crisis/ideation or any assessment that is deemed life-threatening.

3) Congress should ensure that diagnostic assessments conducted by any licensed clinical or medical professional (whether at the VA or in the community) are the standard for diagnosis and level of care placement for Veterans.

4) Congress should pass HR 3520 the Veteran Care Improvement Act of 2023 as it addresses barriers that are preventing access to mental health care via Community Care for veterans in crisis and recognizes the difficulties that veterans and clinicians are facing in rapidly providing assessment and care to prevent suicide.

5) Congress should pass HR 3554, the Protecting Veteran Community Care Act as it provides much needed reforms to the Community Care program at VA specific to mental health and can make a measurable difference in preventing veteran suicide.

About the Author

West Huddleston has been advocating for and helping Veterans who have substance misuse and/or behavioral health treatment needs for 30 years. As the former CEO of the Washington, DC-based National Association of Drug Court Professionals (NADCP) and founder and Executive Director of Justice For Vets, he led the only national organization dedicated to transforming the way the justice system identifies, assesses, and treats justice-involved Veterans. Due in part to his effort, there are now over 700 Veterans Treatment Courts across the United States, significant federal and state funding, as well as engagement by the VA, national and state Veteran Service Organizations, and a vast network of volunteer Veteran Mentors. West is on the Advisory Boards of the Harvard Medical School CHA Division on Addiction and All Points North (APN). He is the former Vice Chairman of the Board of The Independence Fund, granting

mobility to our nation’s catastrophically wounded combat Veterans and the proud dad of an Active-Duty son in the United States Armed Forces.