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VA MENTAL HEALTH CARE: ADDRESSING WAIT TIMES AND ACCESS TO CARE

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES SENATE

ONE HUNDRED TWELFTH CONGRESS

FIRST SESSION

NOVEMBER 30, 2011

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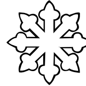

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VA MENTAL HEALTH CARE: ADDRESSING WAIT TIMES AND ACCESS TO CARE

WEDNESDAY, NOVEMBER 30, 2011

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 9:57 a.m., in room 418, Russell Senate Office Building, Hon. Patty Murray, Chairman of the Committee, presiding.

Present: Senators Murray, Rockefeller, Akaka, Tester, Burr, Isakson, Wicker, Johanns, Brown of Massachusetts, and Boozman.

STATEMENT OF HON. PATTY MURRAY, CHAIRMAN, U.S. SENATOR FROM WASHINGTON

Chairman MURRAY. Good morning. We will begin this hearing today on examining barriers that our veterans are facing in seeking mental health care.

We have a number of Senators who are going to be joining us today. I am getting started a minute or two early. My Ranking Member, Senator Burr, will be hear in just a few minutes, but we are going to have votes in an hour. We have two panels today and a lot going on. So, we are going to go ahead and getting started.

Today's hearing builds upon our July hearing on the same subject. At that hearing, the Committee heard about two servicemembers who, even after attempting to take their own lives, had their appointments postponed and difficulties getting through red tape in order to access the care that they needed.

I know that like me many on this Committee were angered and frustrated by their stories, and I am glad that today that we are going to have the opportunity to both get more information and answers on why these delays persist.

Today, we are going to be hearing from providers about the challenges that they face getting patients into care, including from Dr. Michelle Washington, who has been brave enough to come forward to give us a true sense of the daily frontline barriers at our VA facilities.

We will also hear about the critical importance of access to the right type of care delivered on time by qualified mental health professionals.

At our hearing in July, I requested that the VA survey their frontline mental health professionals about whether they have sufficient resources to get veterans into treatment. The results that came back to me shortly after that were not good.

Of the VA providers that were surveyed, nearly 40 percent said that they cannot schedule an appointment in their own clinic within the VA mandated 14-day window. Seventy percent said that they did not have adequate staff or space to meet the mental health care needs of the veterans that they served. And 46 percent said the lack of off-hour appointments prevented veterans from accessing care.

The survey not only showed that our veterans are being forced to wait for care, it also captured the tremendous frustration of those who are tasked with healing our veterans.

That hearing also identified wide discrepancies between facilities in different parts of the country, including the difference between access in urban and rural areas, and it provided a glimpse at a VA system that 10 years into war is still not fully equipped for the influx of veterans that are seeking mental health care.

VA can and must do much better, and I am pleased to say that since I asked for the survey, they had taken some steps in the right direction. They worked to hire additional mental health staff to fill vacancies. They have increased their staffing levels at the Veterans Crisis Line and Homeless Call Center, and they have made VISN directors accountable for more standards of access to care. These are positive steps, but there is much more to be done as we will undoubtedly see today.

Just yesterday before this hearing, I looked through the most recent statistics on PTSD that VA had provided the Committee, and they really showed what all of us know: this problem is not going anywhere.

As thousands of veterans today return from Iraq and Afghanistan, you can see the number of PTSD appointments steadily rise over time. With another announcement yesterday of 33,000 troops coming home by the end of next year from Afghanistan, the demand for care will only swell.

This should not come as a shock to the VA, and it should not cause the waiting lines for care to grow, especially at a time when we are seeing record suicides among our veterans.

We need to meet the veterans' desire for care with the immediate assurance that it will be provided and provided quickly. We cannot afford to leave them discouraged because they cannot get an appointment. We cannot leave them frustrated. We cannot let them down. We need to fix this now.

The VA has had a decade to prepare. Now is the time for action and for effective leadership.

I look forward to hearing from all of our witnesses today, and I hope that this hearing is another step to increased accountability of our efforts to provide timely mental health care.

I do want to mention that Loyd and Andrea Sawyer, who testified at our July hearing, are here today, and I want to thank them for all they have done to help us understand this challenge.

Even after coming before this Committee, they are continuing to have trouble navigating the system. I understand that Dr. Schohn has been personally working to help them get past some of the barriers, and I want to thank you, Dr. Schohn, for your help in this.

But I think that they continue to highlight for all of us the continuing issues with the VA mental health care and the challenge

that this Committee is going to continue to pursue and to follow and make sure that we are taking care of the mental health needs of our soldiers who are returning home or who have been home for some time.

We have two panels this morning. We are going to have a vote at 11 o'clock which will interrupt the Committee.

So, I am going to turn it over to my Ranking Member as soon as he is ready with his opening statement. I would ask any other Committee Members to try and keep their statements short.

But before I turn it over to the Ranking Member, I understand it is his birthday today. [Laughter.]

So, welcome. I am glad that you are spending it with all of us. I am sure you have other ideas, but we are glad that you are here with us today.

So, Senator Burr, if you want to go into your opening statement.

STATEMENT OF HON. RICHARD BURR, RANKING MEMBER, U.S. SENATOR FROM NORTH CAROLINA

Senator BURR. Thank you, Chairman Murray. It is good to have you back. I wish the outcome of the Super Committee had been different, but I know that on both sides Members committed a lot of hours to try to complete that process and it shows how daunting the task is.

And I thank you for the kind birthday remarks, but I have now reached the point where I enjoy this versus the alternative but I just as soon not count the numbers as they add up.

I want to thank you for holding this important hearing today to examine the barriers that veterans face in receiving the mental health services from the VA.

I welcome all of our witnesses. It is insights from people like you that help this Committee truly do our oversight duties.

As you know, this hearing is a follow-up to the July 14 mental health hearing where serious issues were raised by two of our witnesses, Andrea Sawyer and Daniel Williams, about problems assessing appropriate mental health care.

VA told Daniel and Andrea's husband Loyd that they would have to wait months to see a provider. Then, when Loyd was finally able to get treatment from the VA, we were told there was no coordination of care among his providers.

Unfortunately, their stories are not unique. I continue to hear from veterans about the problems they run into trying to get mental health care.

As the Chairman mentioned after the last mental health care hearing, she requested that the VA conduct a survey of the mental health care providers to try to get to the root of the problem.

The results of the survey confirmed what we already knew, that some veterans have a very difficult time in getting an appointment scheduled. This is simply unacceptable. The men and women of the Armed Forces suffering from the invisible wounds of war deserve better.

So, today we will again look at what is causing these problems, why they have not been fixed, and more importantly, when veterans will be able to get the appropriate and timely care that they need and deserve.

At a hearing in May, Dr. Zeiss indicated that the VA does have the resources it needs to meet the mental health care needs of our veterans. In fact, in fiscal year 2011, Congress appropriated $5.7 billion for mental health care services, a 25 percent increase over the previous year's budget and a 136 percent increase since 2006.

What has VA been doing with the resources Congress has provided over the years?

Also, as the VA's testimony points out, there has been a 47.8 percent increase in mental health staffing since 2006. Yet, in a VA Inspector General's report published earlier this year, the IG reported that only 16 percent of the sites they visited met their staffing requirements for mental health care.

Why have not the staffing increases been affected?

To top it all, the VA's response to the survey was to put together an action plan to develop a plan to address the issues raised by VA clinicians.

What is the plan of action the VA outlines? Focus groups, audits and publishing yet more policy guidelines. The question is how does this help our veterans in need of mental health care services today? How does this action plan help veterans waiting to get follow-up treatment?

As Dr. Hoge will testify today, 70 to 80 percent of the patients diagnosed with PTSD can get better. We stress that. Seventy to 80 percent can get better if the patients are able to get the care and continue with the treatment over the long term.

At VA, however, veterans may get their initial visit but many are not able to get the ongoing treatments that they need.

What is really troubling is the problems we will hear about today are not different from what we have discussed at the July 14 hearing.

I had expected that four and a half months would have been enough time for the VA to come up with solutions but it appears that that is not the case.

As we will hear today, aggressive steps must be taken, and they must be taken now. If VA is not able to provide the appropriate care to veterans in a timely fashion, VA should consider sending veterans to someone who can help them promptly, using their fee-based authority.

Madam Chairman, I am confident today that this is not something we are going to let get away from us; and if VA believes that this is going to be a once-a-year topic of a hearing, let me assure you: it is not going to be.

The fact that we are four and half months down the road, and the response is to do focus groups and to put out new guidelines to me is unconscionable, given the fact that every medical professional that has come before us says that the most important thing is to get these servicemembers into treatment, keep them in treatment for as long as it takes, to take that disability and to drive it as close to zero as we can possibly get it.

My hope is that the Committee will recognize the fact that we have funded and now it is a process of execution that we have got to seriously look at, and I pledge to the Chairman to work side-by-side with her on this.

I thank the Chair.

Chairman MURRAY. Thank you very much. I appreciate it.
Senator Akaka.

STATEMENT OF HON. DANIEL K. AKAKA, U.S. SENATOR FROM HAWAII

Senator AKAKA. Thank you very much, Madam Chairman. I appreciate you and Senator Burr holding this very important hearing. I want to add my welcome to the witnesses and thank you for all you have been doing for our veterans.

Through the efforts of the VA and its many stakeholders, our country is doing a better job for caring for veterans. While we continue to improve educational benefits such as the G.I. Bill, job training, and other opportunities through legislation spearheaded by the Chairman, we must keep working to improve the mental health provided to our veterans.

Over the last decade, the men and women of our Armed Forces have bravely served in two wars. Now, it is our turn to look after them and to get them access to the care they need.

Many of our men and women currently in uniform will be returning to the civilian world and seeking VA services in the coming years. Hopefully, the stigma which once discouraged some veterans in need from seeking mental health treatment will continue to decrease and there will be a welcome increase in demand for these services.

I know that Secretary Shinseki and his team have made strides and will continue to do so, but I have concerns as we all do. And as we look to the future and consider the capacity and projected requirements for mental health care, I think that this hearing is another vital step as we work to improve the services our veterans have earned and deserve.

So, I look forward to hearing our witnesses' testimony and how we are doing and how we might improve in meeting the needs of veterans and their families and we will continue to look forward to working with the Chairman and the Committee on this.

Thank you very much, Madam Chairman.

Chairman MURRAY. Thank you very much.
Senator Tester.

STATEMENT OF HON. JON TESTER, U.S. SENATOR FROM MONTANA

Sen Tester. Thank you, Madam Chairman, and I want to thank you and Senator Burr for convening this hearing today. I want to thank the witnesses in this panel and the next panel that is going to be up.

You know, the work that we did before the Thanksgiving break was employment opportunities for veterans. I know the Chairman is very proud of and I am very proud of, and this Committee should be very proud of that work. Working together to get that done was important.

This is another one of those issues that is going to require a bipartisan effort to move forward because we have got a steady flow of returning veterans to this country.

The signature injury from those folks from Iraq and Afghanistan is one that deals with mental health. They need care. There are no

ifs, ands, or buts about it. I can tell you that that care can only happen if we work together: Democrats, Republicans, and policymakers with the VA.

I think the VA has made some strides but not enough. They have hired a lot of folks in the mental health arena, but because of the number of folks we have got coming back, because of the stigma I believe that is attached to issues that revolve around mental health, it is critically important that we work together.

If Senator Burr is correct, if the response to the folks that come back with unseen injuries is to develop focus groups and guidelines, that ain't good enough.

But if the response is to get more mental health professionals in the field, if the response is looking to the private sector when necessary to be able to contract out some of these services, if the response is to make sure that we have the VA facilities available to those veterans, if the response is making sure that we have Vet Centers around this country where vets can talk to vets, then we are moving in the right direction.

We have done a lot of good work on this issue as a Committee. It continues to be a huge issue. It continues to be a big concern because I think—we have three docs up here and a civilian. I can tell you that from my perspective if we can get treatment earlier, we can help save a ton of money and improve quality-of-life for a ton of folks that deserve every benefit that we can give them because they put their lives on hold and their lives on the line for this country.

So, with that, I look forward to this hearing. I look forward to further hearings after this. Ultimately, in the end, I think that if we work together with the VA and amongst ourselves we can do a lot of good work and satisfy some of the needs that are out there.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you very much.

With that, we would like to welcome our first panel. Thank all of you for being here and for your testimony. We are going to start with Dr. Michelle Washington, who is representing the American Federation of Government Employees.

Then, we will hear from retired U.S. Army Colonel, Dr. Charles Hoge. Next, we will hear from Dr. Barbara Van Dahlen, founder and president of Give an Hour.

And finally, we will hear from Mr. John Roberts, who is the Executive Vice President of Mental Health and Warrior Engagement, with the Wounded Warrior Project.

So, we will start with Dr. Michelle Washington.

Just before she proceeds to her testimony, I do want to say how important it is for us on this Committee to hear from providers who are dealing with this issue firsthand.

If we cannot hear their accounts, none of us is going to learn what we need to do to improve help for our veterans, and I expect that as always our witnesses will be treated appropriately. No witness who comes before this Committee or one of our hearings should be treated unfairly just because they did the right thing in bringing us the issues and responding to this Committee and telling us the truth so that we can make sound policy decisions.

So, Dr. Washington, we will begin with you.

STATEMENT OF MICHELLE WASHINGTON, PH.D., COORDINATOR, PTSD SERVICES AND EVIDENCE-BASED PSYCHOTHERAPY, WILMINGTON, DELAWARE, VA MEDICAL CENTER, REPRESENTING AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL–CIO, AND THE AFGE NATIONAL VA COUNCIL

Ms. WASHINGTON. Chairman Murray, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to testify before you on behalf of AFGE.

As the coordinator of PTSD services and evidence-based psychotherapy at Wilmington VA, my role is to provide specialty care to veterans with severe and complex PTSD as well as the new onset.

Due to chronic short staffing at my facility and the inability to manage my patients appointments based upon their individual needs, I am frequently frustrated in my ability to provide that care.

Why do I work at the VA? For me, it is very personal. My father is a Korean War veteran as where my uncles. My brothers are veterans, and my niece and her husband are both veterans, and my nephew just recently returned from Iraq.

Timely treatment is critical in evidence-based psychotherapies including two methods I frequently use to treat PTSD. First, with prolonged exposure, the patient reexperiences rather than avoids the trauma.

The second approach, cognitive processing therapy, treats PTSD as a disorder of non-recovery where we address erroneous beliefs about the traumatic events so that the patient can better process the trauma memory.

These treatments have been demonstrated to be highly effective in treating trauma through a limited number of sessions, but patients must be seen weekly during the treatment period which is very difficult at my facility.

When I determine that a patient is suitable for this type of treatment and motivated to receive it, I ask the scheduling clerks to book out 10 to 12 weekly appointments at a regular time.

Too often, I am told that that the patient will have to wait as long as 6 weeks for the first appointment. But after waiting that long, many patients lose the motivation for treatment or their PTSD worsens while they are waiting. So, sometimes I find it better not to start evidence-based psychotherapy because the harm of waiting outweighs the benefit of treatment.

Also, because scheduling clerks are under great pressure to bring new veterans in within 14 days, they may take one of my PTSD patients regular appointments for a new patient appointment which hurts the effectiveness of my patient's treatment.

It is also extremely difficult to make timely referrals for ongoing mental health services. So, these patients stay on my caseload even though they do not need specialty treatment any longer. This, in turn, further delays for speciality treatment for veterans who could benefit from it.

Even though the Uniform Mental Health Services Agreement and the PTSD handbook clearly state that PTSD treatment should be reserved for veterans with severe PTSD and complex cases and new onset, I am frequently assigned patients with only minor forms of PTSD or only a history of PTSD with no current symp-

toms; and I have no means of referring them back to general mental health because they are booked solid. So, those patients stay with me indefinitely.

As long as scheduling continues to be driven by clerks pressured by management to make the numbers look good and as long as mental health providers have little or no say about where and when to best serve their patients, this will keep happening.

Patients are also harmed by the pervasive shortage of primary care providers at my facility. Even though assignment to a primary care provider is a requisite treatment to a mental health provider and the DSM clearly states that you rule out a medical condition first, some of the patients end up with me or in general mental health when they actually need medical treatment.

For example, Graves' disease, a hyperthyroid condition, sometimes mistaken for ADHD, similarly patients with dementia with Lewy Bodies that include a symptom of visual hallucinations, HIV medication can cause a brief period of psychosis at the onset.

When these patients are referred to mental health treatment without a comprehensive primary-care assessment, the mental health provider is forced to carry out treatment without critical information.

Also, the patient could end up worse because his medical condition is not treated, or he may receive antipsychotic medication he does not need.

The Wilmington VA has not filled a vacant primary care physician designated for OEF/OIF/OND veterans since March. As a result, OEF/OIF/OND staff cannot get primary care appointments for these patients, and no one is doing poly-trauma consults or related-injury referrals or monthly treatment review of poly-trauma veterans.

When veterans cannot get appointments with their primary care provider they sometimes end up in the ER to get their medication, which is not the best way to treat them or the best use of resources.

The VA would also make better use of its resources by timely treatment. Research shows that patients more effectively get better at the outset with fewer mental health or medical services in the long run when they received treatment early.

Another barrier to comprehensive care is the absence of a full PTSD treatment team. I developed and proposed a PTSD clinical team; but due to lack of staff, among other requirements, the program has not been implemented. Instead, management creates the appearance of a team by counting staff located at CBOCs.

What else do I think would help the medical conditions or the mental health conditions, first, it would be true that treatment teams that include regular meetings with mental health, medical, and nursing, panel sizes for mental health providers which are long overdue, and we have been waiting several years for VA central office to establish parameters for maximum number of patients for each mental health provider to carry.

Finally, as I noted, mental health providers must have a say in when their patients need to be seen and to ensure that our patients receive integrated care so all their medical and mental health conditions are treated as a whole.

That is good care. That is good resource allocation, and that is the way to get the most care for veterans and which is our goal every day.

Thank you very much.

[The prepared statement of Ms. Washington follows:]

PREPARED STATEMENT OF MICHELLE WASHINGTON, PH.D., COORDINATOR, PTSD SERVICES AND EVIDENCE BASED PSYCHOTHERAPY, WILMINGTON VA MEDICAL CENTER ON BEHALF OF AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO AND THE AFGE NATIONAL VA COUNCIL

Chairman Murray, Ranking Member Burr and Members of the Committee: Thank you for the opportunity to testify on behalf of the American Federation of Government Employees (AFGE) and the AFGE National VA Council (NVAC) (hereinafter "AFGE") about VA mental health care wait times and access to care. AFGE represents more than 205,000 VA employees, including roughly 120,000 Veterans Health Administration (VHA) employees providing direct services to veterans.

My testimony addresses mental health access at the Wilmington VA Medical Center, where I work as the Coordinator of PTSD Services and Evidence Based Psychotherapy. My testimony also includes reports from other AFGE members providing mental health services. Please note that at the request of these employees, none of the reports are identified by name or location. All these employees expressed serious concerns about job loss or other workplace retaliation for speaking up for patient care and employee rights. In fact, several employees turned down AFGE's request to testify because of the risk of retaliation.

I also fear retaliation by management for participating in this hearing. Nonetheless, I took the risk of testifying today because of the importance of speaking out about the growing barriers to providing mental health care to my patients. Like my colleagues, I work at the VA because of an intense dedication to serving this unique patient population, and their service-connected mental health conditions.

I have reviewed the VA's survey questions about access and sadly, my own experiences confirm that my facility lacks adequate staff to allow me to treat patients on a timely basis in order to maximize the effectiveness of treatment.

I was hired as a specialist in Post-Traumatic Stress Disorder (PTSD) to treat veterans with severe and complex PTSD as well as veterans newly diagnosed with PTSD. However, due to staffing issues I am called upon to treat veterans with any mental health condition. As a result, there are significant time delays in my ability to provide requested PTSD assessments and services including evidence-based psychotherapies for PTSD.

Additionally, once specialty services have been provided, poor staffing in the general mental health clinic makes it difficult if not impossible to refer veterans for ongoing general mental health services. Consequently, veterans remain on my caseload for extended periods of time causing delays in providing treatment to other veterans in need of specialty PTSD care.

More specifically, veterans in need of new and established patient appointments usually have to wait far longer than fourteen (14) days and often as long as two months before they can begin evidence-based trauma-focused treatments. Often after such a delay, patients have lost the motivation for treatment and therefore cannot benefit from these highly effective treatments. In addition, without clinicians having control of their schedules, scheduling consistent weekly 60–120 minute appointments is difficult and especially harmful for patients receiving various evidence-based psychotherapies.

As previously stated, these treatments have been demonstrated to be the most effective treatment approaches I use to treat Post-Traumatic Stress Disorder (PTSD) and depression. The mental health community, both inside and outside the VA, is very excited about these forms of treatment because they are so highly effective in treating trauma and other disorders within fairly short timeframes.

Timely treatment is critical for both evidence-based psychotherapies for PTSD: Prolonged Exposure and Cognitive Processing Therapy. Prolonged Exposure therapy (PE) is a form of cognitive behavioral therapy designed to treat Post Traumatic Stress Disorder, characterized by re-experiencing the traumatic event through remembering it and engaging with, rather than avoiding, reminders of the trauma (triggers). Cognitive Processing Therapy (CPT) conceptualizes PTSD as a disorder of "non-recovery" in which erroneous beliefs about the causes and consequences of traumatic events produce strong negative emotions and prevent accurate processing of the trauma memory and natural emotions emanating from the event. Patients in evidence-based psychotherapies must be seen at least weekly, in order to effectively

treat PTSD. If patients have to wait longer between appointments, the treatment loses its efficacy.

Recently, the new Chief Psychologist mandated that all psychologists set up a "new patient clinic" and see four new patients per week in order to meet the fourteen (14) day requirement. However, no provision has been established to see these new patients for follow-up care. They will have to wait four to six weeks for a follow-up appointment. In addition, taking away four clinical hours per week further delays follow-up care for established patients.

The Wilmington VA does not currently have a full PTSD treatment team despite the VA's current commitment to patient-centered, team-based care. As the coordinator of PTSD services, my duties include development of a PTSD Clinical Team (PCT). I have in fact developed and proposed such a program but due to a lack of staff, among other requirements, the program cannot be implemented. Instead, management claims to have a PTSD program by including staff located at CBOCs, even though a clear requirement of a PCT is that team members be co-located at a separate and distinct location. AFGE has reported this to the Office of the Inspector General.

Mental health access is also impacted by a shortage of primary care providers in the hospital and CBOCs. Even though assignment to a primary care provider is a prerequisite to assignment to a mental health provider, our hospital has not filled a primary care position designated for OIF/OEF/OND veterans that has been vacant for since March of this year, and previously, was only covered two days a week intermittently. OIF/OEF/OND staff was sending consults to primary care for appointments, but were recently told the consults did not go anywhere.

The previous provider in this position had a panel of 1,038 veterans to cover with two days per week in a variety of shielded and different named panels. These veterans are still assigned to that provider even though she no longer has clinical privileges or access to CPRS. Since March, no provider is been doing polytrauma consults, War Related Injury referrals, or monthly treatment review of polytrauma veterans.

One of our CBOCs does not have any primary care provider, causing even longer waits for mental health treatment at the other CBOC.

Veterans who cannot get timely assignments to primary care provider sometimes end up in the emergency room to obtain medication.

Access to primary care is also essential for detecting medical conditions, such as a thyroid disorder, that may be contributing to a veteran's mental health problems. While patients wait many months for their first primary care appointment, we try to proceed with treatment even though we are missing a "big piece of the puzzle * * *."

Evening and weekend appointments should be available at the medical center and the CBOCs, but additional clinic hours are simply not possible due to chronic short staffing.

At the Wilmington VA, space shortages interfere with our ability to provide appropriate care. Mental health services are not all provided on the same floor, making it more difficult for clinicians to consult with each other regarding patient needs.

The chronic shortage of medical clerks at our facility also hurts the ability of our mental health clinics to run smoothly. Management is unwilling to hire more clerks, consequently, the clerks we have are always getting pulled away to work in other short staffed areas, without management consulting the affected BH providers.

The clerks have been told that if a patient does not arrive by one minute before the scheduled appointment time, that they should cancel the appointment; they are disciplined if they fail to do so and have more than three "no shows."

Sadly, new measures for timeliness have encouraged more, not less, management gaming. When a veterans asks for the first available appointment that week, he or she is told that the first available date is "X" and when they ask for date "X," it is recorded as a desired appointment.

Social workers at my facility universally feel extremely overworked and overwhelmed. When a new position is posted, such as HUD VASH or SUD, the position is only posted internally, and instead of hiring additional staff, social workers are simply transfer from one critical area to the new position.

Our new social work chief has created a very negative work environment, and recently, more than a dozen social workers resigned after being unfairly targeted and being admonished for speaking up for patients.

The new social work chief recently instituted thirty minute therapy sessions, and is ordering social workers to cease providing more time with patients, unless he has been notified. The clerks have been directed to change all appointments to thirty minutes; social workers were never consulted.

The chief has not informed staff of the guidelines he will apply to determine whether longer sessions are appropriate. Our social workers feel as if these major changes are being made based only on anecdotal evidence, rather than a solid justification for reducing patient access to therapy, resulting in a lower quality of care.

Workplace morale is also harmed by management's practice of passing over existing social work staff for internal promotions, and, instead, hiring new clinicians with no VA experience for higher positions and chief positions. When internal promotions do occur, management does not backfill the vacant position, yet they expect other fully assigned social workers to take over other one or two vacated positions in addition to their own full time responsibilities.

Our social workers report that there is an overreliance on group therapy for substance abuse treatment, noting that some veterans have more intense needs or are too introverted for group treatment but are not offered other options.

Social workers at our CBOCs are forced to place patients on long wait lists. At the CBOCs, one social worker may have to handle all therapy, including substance abuse treatment, as well as case management—a growing need in communities that have lost other resources for veterans and their families.

Our patients also face long waits for substance abuse treatment. Our clinicians are very frustrated; a two month wait for services does not work for these patients. If a veteran is ready to quit, we have to get them into the VA now or the window may close!

REPORTS FROM OTHER VA FACILITIES

Psychiatrist in general mental clinic:

This clinician recently transferred to Comp & Pen because he could no longer handle the stress and frustration of trying to provide BH treatment with severe staff shortages. He feels as if staffing levels will "never catch up" with the growing demand for services, and that at his medical center, trying to keep up with patients' needs is like "a finger in the dike."

His panel sizes were enormous, and he and other psychiatrists had to carry the entire onus of developing suicide prevention plans and working with Suicide Prevention Coordinators. He felt pressured to care more about deadlines than patients

This psychiatrist's patients had to wait two months for new appointments. Although he preferred setting up frequent appointments (within a month) for his established patients, they usually had to wait at least six months. He was "absolutely" unable to make timely specialty appointments for his patients with PTSD; he would do a consult and get no response.

When medical school residents stopped covering overnight calls a few years ago, VA clinicians were required to cover weekend rounds without any compensatory time. Compensatory time was restored only after AFGE filed a grievance.

This psychiatrist also noted although many residents want to work at the VA, new hires frequently quit the VA because of poor human resources practices and heavy caseloads.

He sees his former colleagues rushing around as if in a "rat race" with thirty minute visits that leave no room for emergencies or walk-ins. As he noted, "a walk-in is never quick." (As other clinicians noted, management is pressuring clinicians to cancel patients with non-urgent needs, and advise them to come in on a walk-in basis instead.)

He could no longer handle intense pressure of having to squeeze too many patients into shorter sessions. "I am not a 30 minute psychiatrist," he noted; "lots of veterans don't tell you they are suicidal until minute 41!" He felt that his only choice if he ended up with a suicidal emergency was to take time away from next patient.

He had too little time to write adequate notes after each session; the "smart" clinicians survive by seeing patients for only twenty minutes and then writing up quick notes by hand.

In his view, a shortage of clerical and scheduling staff also contributes to mental health access limitations, but Central Scheduling for Psychiatrist "just doesn't get it." It is the clinician who knows whether a patient needs to come back sooner. He felt strongly that patients need localized attention for proper scheduling.

CBOC Psychologists:

Report #1: As the only mental health provider in her CBOC, this psychologist reported that she has to "do it all because you are it" including all individual and group appointments, walk-ins, call-ins, as well as some C&P exams.

She is "overbooked every day." Her caseload of more than 200 patients, including many high risk patients, is simply "unrealistic."

She has no control over new patient appointments but is always "booked out solid two to three months ahead." This provider feels strongly that fifty minutes for intake is simply "not enough."

Management has repeatedly pressured her to go into CPRS and change the "desired date" even though doing so would be a clear violation of VHA directives.

She is also usually booked two months out for established patient appointments. Even though she has patients that she should be seeing weekly, "there are no openings."

This psychologist struggles to keep up with her charting because of her caseload. If she takes even one day of annual leave, it puts her further behind. Management has refused her repeated request to assign a social worker to her CBOC. Yet, when her charting fell behind because of her patient caseload, management invoked the threat of not assigning a social worker!

She never takes her fifteen minute breaks because she is booked back to back, and her supervisors regularly take her lunch hour to meet with her. She does not complain because "I am here for the vets" but it is demoralizing when management responds by failing to support her and refusing to approve the compensation time she rightfully earned.

This provider agrees that C&P exams hurt access by pulling clinical staff away from routine patients. To perform a C&P exam properly takes time. "They are like forensic exams" and she likes to do psychological testing and go through the C file to provide what VBA needs.

The workplace environment at this psychologist's facility is extremely unsupportive, and often hostile to providers already under great stress for carrying extremely heavy caseloads that include many high risk patients. When a patient attempts suicide or other at-risk behavior without warning, management routinely blames the provider and refuses to recognize that the provider also is under stress. It seems as if "all management cares about is numbers because that's what their bonuses are based on."

The CBOC's psychiatrist recently quit because the work environment was too stressful and management wore her down with false allegations, and by refusing to let her order sleep studies. Management has refused to fill that vacancy.

Veterans in her area wanted evening and weekend appointments. When a psychiatrist was still at the CBOC, this would have been possible. To find a way to accommodate veterans, this psychologist proposed to management that an alternative work schedule be instituted to provide evening and weekend appointments. Sadly, her request was denied, even though it would have complied with the Uniform Services mandate and the recovery model for veterans in school or working.

A disabled veteran herself, this provider states that she will continue to speak up every time patients are not getting the care they need. Her patients give her a great deal of positive feedback. However, she is seriously considering jobs outside of the VA and only stays because she really wants to work with veterans.

Report #2: Another clinical psychologist working at a CBOC concurred that it is very difficult to see patients on a more frequent basis. Four years ago, he could see his established patients twice a month, but the standard is now once a month. While he can make exceptions for some crises and evidence-based treatment for weekly or bi-weekly appointments, this can only occur for a short time period. Even if patients want to go through evidence-based weekly psychotherapy (an intense experience that not all veterans want to go through), he simply could not keep up with a weekly schedule, even though it is dangerous to space it out more infrequently. As he noted, "One time a month is simply not quality of care."

More generally, he felt that resources are not properly distributed; his county has a large number of veterans and too few providers, whereas the adjoining county is far better staffed. He acknowledges that it is hard to fill vacancies in rural areas and recommends rotating staff to less desirable locations to cover these gaps.

He also felt that the C&P exams pull clinicians away from direct BH care. At his facility, C&P exams are now performed at a different location so he and other clinicians who do C&P on a part-time basis have to spend more time traveling, further diminishing therapy time.

He agrees that there is a shortage of clerical and scheduling staff and that when new providers were hired, there was no corresponding increase in support staff.

Report #3: This provider stated that her work environment is so stressful that "everyone I work with is trying to leave and we are losing really good people who could be an asset to the VA."

She is usually able to make new patient appointments within 14 days, and the next two follow up appoints within three weeks. Patients have to wait from about four to six weeks for subsequent appointments.

Her managers regularly manipulate the wait list numbers in numerous ways, including requiring veterans to choose between being on a wait list for two week appointments and taking a four week appointment.

This clinician is very frustrated that she cannot set appointments based on her own clinical judgment, even though management assured her that she could. It concerns her that she is required to see some OIF/OEF/OND patients for eight weekly sessions when older veterans with more serious BH problems have to wait longer between appointments.

Management also regularly pressures providers to give up their administrative days to see patients.

This provider is worried about keeping her job because she insists on maintaining her own wait list to get her patients in sooner. She noted: "If you see some patients only four to five times a year, they don't get better and there is a greater chance they will get suicidal." In her view, therapy every five weeks "is like fake therapy." She feels that current limitations on access prevent BH providers from "keeping up with our veteran's lives much less their coping skills."

Clinical Nurse Specialist at a Domiciliary

Homeless veterans typically have not accessed VA BH services in the past, despite rampant problems with depression and anxiety. Thus, getting them a timely initial appointment is critical.

Sadly, this clinician, a 26 year veteran herself, is extremely frustrated that the homeless veterans she works with have to wait 45 to 60 days for their initial BH evaluation. In addition, access at her facility has deteriorated since the psychiatrist who split his time between the domiciliary and substance abuse clinic left; that had been a "wonderful, wonderful arrangement."

Because she is a veteran who "does not take no for an answer," she tries to get her clients intake appointments sooner, by calling scheduling clerks daily, despite her own heavy caseload. Sometimes, she has to send homeless veterans to the emergency room instead for short term medication needs. (An emergency room doctor at another facility recommends that all ERs follow the example at his facility of having 24/7 psychiatrist coverage.)

In urgent cases, she goes to the acting Chief of Psychiatry, who may make an exception but often tells her there are simply no available appointments.

Her facility has lost eight psychiatrists recently because management interfered with their work assignments. Management's solution was to pull psychiatrists from other units to cover inpatient vacancies. But many inpatient staff vacancies remain, and many patients, including those at risk of suicide and homicide, have to be diverted to non-VA hospitals.

More generally, the new OIF/OEF/OND initiatives are good and new veterans are receiving better debriefings on MH issues. She is concerned that the veterans already in the VA system are the ones not getting the help they need.

In closing, I again thank the Committee for the opportunity to testify on behalf of AFGE and share the perspective of BH clinicians on the front lines. I hope that in the future, our members can share their suggestions about ways to improve patient care with the Committee without fearing for our jobs or experiencing other forms of retaliation.

SUMMARY OF AFGE CONCERNS

- **The inability to make timely new patient, established patient and specialty appointments is rampant and directly related to provider short staffing:** In all VA behavioral health (BH) settings (inpatient, outpatient, domiciliary), the lack of providers has resulted in widespread failure to provide timely appointments, including specialized care where frequent sessions are critical, such as evidence-based psychotherapies.
- **Providers are regularly required to "rob Peter to pay Paul."** In order to see higher risk patients more frequently, BH providers must shorten sessions with other patients, delay care for other patients, and cut into time needed for preparation of patient notes and other administrative responsibilities.
- **Residents and other potential new hires who are very interested in working at the VA are deterred by poor H.R. practices** including delays and lost applications.
- **BH providers with valuable experience are leaving the VA** due to management pressure to cover up delays in treatment, failure to promote from within, unsupportive, stressful and hostile work environments and interference with clinical judgment about what patients need.

- **Central scheduling results in "one size fits all" appointments** that fail to take into account provider recommendations and individual patient needs.
- **Rural CBOCs lack sufficient BH staff** to provide the growing number of rural veterans with clinical care and case management who depend on the VA because of a severe lack of other resources in their communities for veterans and their families.
- **Short staffing of clerical and scheduling personnel diverts clinical time away from patients.** The VA's failure to hire more medical support staff to back up recent expansions in its clinical staff also interferes with providers' ability to focus on patient needs. *AFGE strongly opposes VA's ongoing campaign to downgrade medical support personnel without a thorough analysis of the duties of impacted employees.*
- **Greater management flexibility** could expand BH access, such as alternative work schedules to cover evening and weekend sessions, and rotation of staff to rural CBOCs, as mandated by the Mental Health Uniformed Services Act of 2008.
- **Managers should be held accountable for violations of laws and regulations**, including through the application of the Title 38 Table of Penalties, for instances of wait list data manipulation, pressuring providers to change appointments, and for retaliating against employees who use appropriate avenues to advocate for patient needs.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO MICHELLE WASHINGTON, PH.D., COORDINATOR, PTSD SERVICES AND EVIDENCE BASED PSYCHOTHERAPY, WILMINGTON, DELAWARE VA MEDICAL CENTER, REPRESENTING THE AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES

Question 1. We have heard some concerns about the transition to mental health care teams occurring as part of the Department's implementation of the Patient Aligned Care Team (PACT) model. The Department tells us that this is a more appropriate model and one the private sector uses. They also say that the veteran will need to establish good relationships with each of the providers on the team, and we discussed the importance of truly establishing those relationships. Can you please explain how providers decide which team member is most appropriate to see a veteran seeking care?

Response. According to the Patient Centered Medical Home Model Concept Paper from the VA Patient Centered Primary Care Implementation Work Group, the core team of the Veteran patient is his/her provider, an RN care manager, a clinical staff assistant, and an administrative staff member who are responsible for the central functions of a medical home model. Although care management functions reside within the core team, specialized services are provided on an episodic basis when the Veteran patient can benefit from additional expertise such as that of mental health providers, medical/surgical specialties, pharmacists, dieticians, chaplains, etc.

Some VA facilities have a mental health provider (not including a social worker who may serve solely as a case manager) as part of that team. On those teams, if mental health services are needed the veteran would be sent to that team's provider (for example, psychiatrist for medication, psychologist/social worker for psychotherapy). On teams that don't have mental health providers such as here at Wilmington VAMC, the team sends a consult (requesting evaluation for services) to the Behavioral Health Service. The veteran is randomly assigned to a provider to collect background information. Following that appointment the veteran is assigned to the next available mental health provider.

The "team" approach in behavioral health is not functioning because the teams do not have all of the people needed to make it multidisciplinary per the original design. It never did. Therefore, on paper the idea looks great but in practice it is failing. So the administration simply tells everyone we have teams but never reveal that they are not functioning (same for PACTs).

Question 2. Dr. Washington, in your experience, has VA been able to schedule appointments in a way that encourages those personal relationships to develop?

Response. My training and experience has taught me that for mental health treatment to be most effective you start with weekly sessions and taper off as the patient improves and hopefully eventually no longer needs mental health services. Heavily loading treatment at the front end encourages good treatment rapport which leads to better and often faster treatment outcomes. Since coming to the VA, it has been difficult to follow this process. Seeing people every four to six weeks means that rapport takes longer to build and progress in treatment is substantially slower if it occurs at all. Please also note that in behavioral health, clerks will schedule any new

patient in any open slot. (In contrast, existing patients are scheduled with their usual provider.)

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO MICHELLE WASHINGTON, PH.D.

Question 1. In your testimony, you state that veterans at the Wilmington, Delaware VA Medical Center usually have to wait much longer than 14 days for an appointment. Has the mental health clinic at Wilmington used other options, such as fee-basis care, to ensure veterans get the care they need? If not, why?

Response. For mental health services we will refer to the Vet Centers if the veteran meets their criteria for treatment. Otherwise, they are scheduled with the next available provider. To my knowledge, fee basis is not used because we can provide the service at our facility. Therefore, the veteran will have to wait for the next available provider appointment. For emergency inpatient mental health care only, we have contracts with two community hospitals.

Please note that Vet Centers have access to our records but we are not able to view theirs. So when patients are seen there as well as here we don't know how they are doing in treatment. Also, related to the social worker/veteran who was recently terminated, her PTSD group will be taken over by a Vet Center employee and will be held at the Wilmington VAMC. Vet Center employees cannot document in our medical record (CPRS), so we will cannot see how our patients are doing in that setting.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO MICHELLE WASHINGTON, PH.D.

Question 1. How can we meet the overwhelming demands for mental health care among all our veterans, in this climate of cuts and calls for spending caps?

Response. a. One suggestion would be to start psychotherapy first, and then refer for psychiatric medications once the therapist has been able to conduct a proper assessment of the patient's condition. This is what is frequently done in private practice psychotherapy offices. Here at Wilmington, the practice is frequently the opposite which often serves to discourage patients from engaging in psychotherapy. The veteran "feels better" with the medication and thus, the cause of the problem is never addressed. Please note that this is not a universal statement; some patients with acute/urgent issues, chronic conditions, etc. may need immediate psychiatric assistance.

b. Engage veterans in treatment with weekly sessions earlier and taper off as they improve. This encourages good treatment rapport which leads to better and often faster treatment outcomes.

c. Another suggestion would be to have mental health imbedded in primary care. That provider could conduct the initial assessment and determine if more in depth mental health services are needed. Please note also that when the administration talks about integration of mental health into primary care they cite that we have a health psychologist. However, the scope of duties for that position is limited and not true mental health/primary care integration.

Question 2. How do we encourage and recruit VA nurses and mental health professionals in times of pay freezes and calls for overall cuts in our Federal Government?

Response. a. Reallocate funds from administration to direct care staff. By shrinking the size of the administrative staff, those funds could be used to hire additional direct care staff. In addition, you would not have one direct care staff member doing three jobs. Therefore, more patients can be seen.

b. Accountability of administration's use of time and distribution of resources.

c. Communication with direct care staff regarding patients' needs when developing performance measures and/or compliance with these measures.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO MICHELLE WASHINGTON, PH.D.

Question 1. When servicemembers are separating from the military and DOD has identified them as being in need of behavioral health care, is there any formal communications between DOD and VHA behavioral health care providers with regards to continuity of behavioral health care for those veterans after separation from active-duty?

Response. Once there is a discharge date, the DOD's Military Treatment Liaison sends a referral packet to the OIF/OEF/OND program manager at the facility.

Question 2. Is there any effort by DOD to set up an initial interview with local VHA behavioral health providers for servicemembers, who DOD has identified in need of behavioral health care, prior to separation from active-duty?

Response. Not prior to discharge but once the referral packet is received, we are mandated to set up an appointment within 30 days of discharge.

Question 3. Is there any effort by DOD providers to collaborate with local VHA providers with regard to servicemembers, who DOD has identified in need of behavioral health care, after separation from active-duty?

Response. No. VHA providers may get a referral packet but there is generally no direct communication with DOD providers.

Question 4. Are servicemembers, who DOD has identified in need of behavioral health care, discharged from active-duty prior to successfully completing behavioral health treatment coming to VHA for additional behavioral health services?

Response. The only information VHA gets is what is in the referral packet. Therefore, the status of their mental health care may not be clear.

Chairman MURRAY. Thank you very much, Dr. Washington.

Dr. Hoge.

STATEMENT OF CHARLES W. HOGE, M.D., COLONEL, U.S. ARMY (RET.)

Dr. HOGE. Good morning, Chairman Murray, Ranking Member Burr, Members of the Committee, thank you for the honor of allowing me to be here today to talk with you about access, which is a very critical issue.

I kind of in my testimony, my written testimony, I sort of broaden the discussion a little bit to look a little bit beyond appointment access and to consider other barriers to care and barriers to recovery because it is not just about appointments.

We know that the majority of veterans and servicemembers who need mental health care do not come in initially or upwards of half come in to see us and another half do not.

And then of those who come in, a large percentage drop out of care after they touch mental health care one or two times and then they drop out of care. There are a variety of factors. There are a variety of considerations in why this occurs some of which has to do with appointment availability or follow-up availability.

Sometimes it has to do with negative perceptions of mental health care or interactions within, you know, at the first session in which the veteran felt as if their needs were not met and they leave care.

I have been involved in studying stigma and barriers to care since the beginning of the war, and one of the things that we learned more recently is that there are negative perceptions of mental health care that actually drive utilization of services or drive the willingness to come in to see us in the mental health clinic and that some of those perceptions are actually stronger than some of the traditional stigma concerns that we have had for a long time.

Those are things, perceptions that mental health care does not work, or that it is not going to be effective for me, or it is a last resort, for instance, or some of the things that veterans voice.

In terms of, I want to echo a few of the comments that were made. Treatment is 70 to 80 percent effective for combat-related PTSD. If the veteran comes in to get care and receives a sufficient

number of sessions for recovery to occur, and clearly early treatment, as Mr. Tester mentioned, is a very important factor in that.

I also want to echo the comments that Dr. Washington mentioned about the importance of integration with primary care because PTSD is really not solely an emotional or psychological condition.

I really view it as a physical condition that has generalized health effects. It affects the endocrine system. It affects the autonomic nervous system, the part of the nervous system that controls automatic functions like heart rate, breathing, and so forth.

A lot of veterans—there are a number of studies showing that veterans with PTSD have significantly higher rates of physical health problems in almost all categories of physical health problems compared with veterans without PTSD.

So, the coordination of care in primary care and having access both to mental health care within primary care and having good coordination of services with the primary care team is really critical in the treatment of veterans.

Some of the other things that I mentioned in my testimony have to do with the stigmatizing PTSD, combat- related PTSD by considering it from the occupational perspective and not always from the medical perspective, and that is, to understand how some of the reactions that servicemembers and veterans have after coming back from a combat deployments are, in fact, very adaptive for the combat environment.

So, many of the reactions that individuals have that we label symptoms were, in fact, beneficial and adaptive in the combat environment.

Talking about it this way can sometimes help to reassure veterans that, you know, they are not crazy and that, you know, their condition, their reactions have a physiological basis. They are not something in their head, and that, you know, the medical system is there to do something to help them with those physiological reactions.

The other thing that I mentioned in my testimony has to do with the importance of peer-to-peer support. I think that there is a real critical role, because a lot of veterans are very reluctant to speak with civilians, including civilian mental health professionals who have not been deployed, and sometimes they need that veteran peer-to-peer connection in order to kind of encourage them to come in to get the help that they need.

And finally, I just want to put in a plug for research. There are a number of areas where we could improve the research particularly in primary-care interventions, particularly in understanding more about why veterans, why there is still a reluctance to seek care and drop out of care and what specific interventions we might be able to do to improve retention in treatment.

Thank you very much.

[The prepared statement of Dr. Hoge follows:]

PREPARED STATEMENT OF CHARLES W. HOGE, M.D., COLONEL (RET.), U.S. ARMY

Chairman Murray, Ranking Member Burr, and Members of the Committee, thank you for the honor of addressing the Senate Committee on Veterans' Affairs. I served on active duty for 20 years as an internist and psychiatrist. My experiences have included deployment to the war zone, treating servicemembers and their families at

Walter Reed, and directing research to improve post-deployment mental health care. I also wrote a book for veterans and their families titled *Once a Warrior—Always a Warrior: Navigating the Transition from Combat to Home*, which Max Cleland described as "the guide to surviving the war back here."

Ensuring that veterans have access to quality mental health treatment is a high priority. Of veterans who experienced direct combat in Afghanistan or Iraq, an estimated 10–20% struggle with PTSD, similar to rates after Vietnam. Depression, alcohol/substance abuse, suicidal behaviors, and other mental health concerns are also prevalent. In addition, large numbers of veterans experience readjustment challenges of a less severe nature (sometimes this is referred to as "PTS"). These problems can affect the veteran's spouse, children, and other family members, and can impact the ability to find meaningful work and enjoy life.

Access to care has been defined in various ways, and it is helpful to distinguish between an organization's ability to provide medical services, and the many barriers to care and recovery experienced by individuals in need of these services. In other words, even when an organization makes care accessible in the form of readily available appointments with qualified personnel and short wait times, this does not mean that individuals will be able to utilize these services or that the quality of care will be adequate to achieve recovery. My interest has increasingly been focused on the veteran's perspective and the many barriers veterans encounter navigating the transition home from the combat environment.

Mental health treatments have improved dramatically over the last two decades, and there are many more resources now that were not available to veterans of previous conflicts. Studies have shown that treatment for PTSD can be 70–80% effective, as long as individuals are able to access the care and continue with treatment long enough for it to be effective.

Unfortunately, the marked improvements in evidence-based treatments have been offset by continued gaps in access and other barriers to recovery. Despite extensive stigma-reduction efforts over 10 years of war, it is estimated that only approximately half of servicemembers and veterans in need of mental health treatment seek these services out; of those who do begin treatment, many receive less than optimal care or leave before achieving recovery. The actual effectiveness of PTSD treatment is estimated to be closer to 40%, not 70–80%, because of high rates of withdrawing from care.

Stigma, negative perceptions of mental health care, and other barriers influence whether a veteran will initially access or continue to utilize services. Stigma is pervasive in society, not just in the military, and involves concerns of how others might view the veteran who seeks mental health care. Negative perceptions include lack of trust or confidence in mental health professionals, or considering mental health treatment ineffective, unhealthy, or a "last resort." Other barriers include difficulty obtaining appointments, lack of availability of the same provider over time, poor coordination of care, distance from the treatment facility, transportation costs, or work or child care responsibilities that interfere with appointments.

The question is, how do we meet veterans where they are, and foster a climate that minimizes the many barriers they face to recovery? Here is a partial list of considerations grouped into broad categories:

APPOINTMENT ACCESS

Appointments for veterans (initial and follow-up) need to be readily available at convenient times and locations, with options to assist veterans with evening or weekend appointments to minimize interference with work. This includes addressing any specific barriers that impede getting to appointments (e.g., transportation availability and costs). Outreach is essential to ensure that veterans are aware of available resources.

STIGMA AND WILLINGNESS TO SEEK CARE

More research is needed to better understand and guide interventions to improve willingness to seek care when needed. There are numerous potential opportunities to affect change in this area, and I will comment on two that I have been particularly interested in: (a) fostering greater understanding of PTSD from the warrior's perspective to reduce stigmatizing attitudes, and (b) veteran peer-to-peer initiatives to enhance transition and readjustment.

Considering PTSD from the warrior's perspective within the military occupational context, rather than always from a medical perspective, is an important normalizing step for everyone (veterans, family members, health care professionals, and society at large). Warriors are professionals trained to work in some of the most inhospitable environments and they respond to combat events according to their training

as part of cohesive teams. This is similar to other first responders (e.g., police, firefighters), and very different than the experiences of civilian victims of trauma. There is a paradox that responses that sometimes interfere with functioning back home (and may be labeled "symptoms") can also be beneficial in the military occupational context, reinforced through rigorous training and deployment. For example, "hypervigilance" can equate to sharply tuned threat perception in combat. Anger and numbing of emotions can stem from skills the warrior developed in channeling anger and controlling other emotions to focus on accomplishing combat missions. These responses have a physiological basis. They are not "psychological" or "emotional" per se.

I think there is also a critical role for veteran peer-to-peer counseling, mentoring, readjustment, and outreach efforts, partnered with traditional mental health services, since many veterans report feeling much more comfortable talking with peers about their war-related concerns than with others.

NEGATIVE PERCEPTIONS OF MENTAL HEALTH CARE AND WILLINGNESS TO CONTINUE WITH TREATMENT

No matter how good evidence-based treatments may be, they will not be effective if offered in ways that drive veterans away. Mental health care needs a makeover to correct negative perceptions which appear to be pervasive. Research is needed to better understand veterans' perceptions of their health care experiences, with feedback to ensure the health care system is responsive. Veterans frequently report dissatisfaction with care, and disconnect between their experiences as warriors and situations they encounter when they access the medical system. This can take many forms, such as: "I'm tired of answering the same questions over and over to different providers." "The doctor kept looking at the computer screen." "I felt misunderstood and judged." "The doctor only offered medications." "The doctor told me she understands what I went through, but never deployed." "The doctor said there were only two talk therapy options for PTSD supported by the VA, neither of which I want." "The doctor told me that I have to think differently about something that happened in combat that I don't want to see differently."

When a veteran takes the difficult step to overcome obstacles and seek mental health care, they are looking for a professional who is accessible, caring, competent, non-judgmental, and attentive to their concerns. Patient-centered care is important. Veterans should be provided with as wide a range of evidence-based treatment options as possible, and actively participate in selecting those they are most comfortable with.

Clinicians must know how to tailor the core components of evidence-based treatments to individual patient preferences. For example, in PTSD treatment, narration is one of the most therapeutic components, and research indicates that narration can be conducted in many different ways, including oral (past or present tense), written, as part of a life narrative review, or combined with specific eye-movements (as is done in a therapy called *Eye Movement Desensitization and Reprocessing* or EMDR). Clinicians must also have sensitivity and knowledge in attending to difficult military-specific topics, such as grief, survivor's guilt, ethical dilemmas from combat, and other unique transition and readjustment concerns. The bottom line is that one size does not fit all, and policies aimed at standardizing care across health care systems must not lose sight of this.

STRUCTURE AND COORDINATION OF HEALTH CARE

I am encouraged by efforts in both the DOD and VA to enhance mental health treatment in primary care, and build collaborative patient-centered systems within primary care that address all deployment health concerns. However, more research, particularly clinical trials, is needed in this area.

Health care should be structured with an understanding of PTSD as a physical condition that affects physical, cognitive, psychological, and emotional functioning, and co-exists with other health concerns. There is an unrealistic expectation that the physiological effects of combat can quickly reset upon return home, which is not how the body functions. The extreme physical stress of combat, sleep deprivation, injuries (including concussions/mild TBIs) and PTSD can all interact to affect health, including the functioning of the endocrine and autonomic nervous systems (the part of the nervous system that controls heart rate, breathing, digestion, and other automatic or reflexive functions). Veterans with PTSD have significantly higher rates of physical health problems compared with veterans without PTSD, including chronic pain, headaches, sleep problems, concentration/memory problems, fatigue, cardiovascular problems, hypertension, and other concerns. Several of these problems are also linked to "self-medication" with alcohol or other substances.

This means that PTSD (and other war-related health concerns) cannot be treated in isolation or strictly within specialty clinics. Treatment needs to attend to all post-war health effects holistically, with careful coordination of services through primary care to avoid problems, such as adverse interactions between medications prescribed by different providers.

I believe there is also a role for complementary and alternative medicine modalities to help, for example, with modulating physiological reactivity, improving sleep, and assisting with pain control. Program evaluation and research is needed in all these areas.

SUPPORT FOR FAMILIES

Last, more attention needs to be given to supporting spouses, partners, and other family members who are the most important and healing connections that veterans have. Family members should be actively involved in the treatment process. Sometimes the most effective intervention the medical system can provide to veterans is to simply support and strengthen their connections with others.

Once again, I thank you for inviting me to share my perspective and for your attention to the critical topic of access to care, and I look forward to your questions.

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RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO CHARLES HOGE, M.D., COLONEL (RET.), U.S. ARMY

Question 1. In your testimony you list a number of barriers to a veteran seeking mental health care such as scheduling issues, continuity of providers, poor coordination of care, travel and transportation issues, and responsibilities such as work or child care that keeps the veteran from getting to appointments.

a. In your opinion, what role can the private sector play in helping to ease some of these barriers veterans face?

Response. There are many ways that the private sector can help, particularly in the areas of outreach, clinical treatment, and research. In terms of outreach, I am particularly encouraged by peer-to-peer programs that involve fellow veterans reaching out to other veterans in need of services. Veterans are often more willing to talk with their peers, and I think there is an important role for peer-to-peer outreach partnered with traditional mental health services. In terms of treatment, many veterans access civilian health care systems, and there is a need for better education of civilian providers on how to effectively communicate with and provide treatment to the veteran population. The private sector is also important in conducting research to improve evaluation and treatment of war-related mental health problems.

b. What immediate steps would you suggest VA take to help veterans needing mental health care today?

Response. To expand on the recommendations provided in my testimony, I believe that enhancing willingness to engage in and continue with mental health treatment is the most important thing that can be done to improve the overall effectiveness for care for veterans. Research and program evaluation in this area is a very high priority. Strategies that I believe are particularly important to consider include: (1) better integration of mental health services in primary care, given the strong association of combat-related mental and physical health problems; (2) establishing peer-to-peer outreach programs partnered with traditional mental health services; (3) having strong marital and family therapy capability within treatment facilities; (4) integrating PTSD and other mental health services, given the high co-existence of conditions (e.g., depression, alcohol/substance misuse); (5) ensuring that all veterans with PTSD have access to a wider range of evidence-based trauma-focused psychotherapy options than just Cognitive Processing and Prolonged Exposure therapies, following the current VA/DOD Post-Traumatic Stress (PTS) Clinical Practice Guideline (2010); (6) better education and support for clinicians in delivering evidence-based trauma-focused psychotherapy in a patient-centered manner; (7) evaluation and dissemination of strategies to improve negative perceptions of mental health care, such as incorporating immediate patient feedback into treatment sessions; and (8) enhancing research and dissemination of adjunctive treatment modalities, including complementary and alternative medicine approaches, following the current VA/DOD PTS Clinical Practice Guideline. Please also review my written testimony for additional information regarding these recommendations.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO CHARLES HOGE, M.D., COLONEL (RET.), U.S. ARMY

Question 1. Dr. Hoge, your testimony talks about the stigma of seeking mental health care, and I agree this is a huge challenge and one I hear about at private veteran's roundtables. But seriously how do we change military culture and public understanding about mental health care and veterans?

Response. Stigma is pervasive in society, and I'm not sure stigma perceptions will change very much until there is broader acceptance and understanding of mental health issues. However, I think we can still make a significant difference in veterans' willingness to utilize mental health services by looking beyond stigma at the many factors that influence veterans' decisions to access care or stay in treatment, as well as the key factors that predict recovery. These include, for example, how care is structured and delivered, the specific treatment strategies that are most acceptable to veterans, the rapport between the veteran and provider, and negative perceptions of care. Please see my responses above and written testimony for additional comments.

Question 2. Getting a job is an important part of the transition, but how do we educate employers that a veteran has transferable skills and is a good hire, rather than a mental health risk?

Response. This is such an important issue. Veterans have unique professional skills and values that they developed through their military training and deployment experience, and even PTSD symptoms can sometimes be considered adaptive and beneficial skills in certain professional situations (e.g., military, law enforcement, other first responders). There needs to be an active effort to combat negative stereotypes and improve general understanding of what it means to serve in the military, including the many benefits of military service and positive qualities that military training and experience bring to the civilian workplace.

Question 3. How can we meet the overwhelming demands for mental health care among all our veterans, in this climate of cuts and calls for spending caps? How do we encourage and recruit VA nurses and mental health professionals in times of pay freezes and calls for overall cuts in our Federal Government?

Response. I'm not sure I have a ready answer for this, but I know that there is nothing more rewarding than working with veterans, and that this sentiment is universally shared by my colleagues devoted to providing outstanding care. It is very important that funding priorities continue to be directed toward ensuring that there are sufficient mental health personnel and resources to support the growing demand for services resulting from over a decade of war (in addition to the demand from prior wars). It is important that health care policy decisions be strongly informed by feedback from mental health professionals who are working every day "in the trenches" with our veterans, even if this feedback is not what the organization wants to hear. It is important that mental health professionals have healthy work

environments that are conducive to wanting to stay in those positions, and that health care leaders strive to protect mental health professionals from unnecessary or burdensome policies or administrative requirements that may be well intentioned but actually detract from patient care. For example, there needs to be a serious relook at the multiple existing screening processes in terms of whether they are truly patient-centered with potential benefits outweighing risks.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO CHARLES HOGE, M.D., COLONEL (RET.), U.S. ARMY

Question 1. Do active-duty servicemembers, who are identified with behavioral health care needs, have greater access to effective treatment and fewer barriers to receiving treatment, while still on active-duty?

Response. Some studies have suggested that active duty servicemembers have more ready access to care than Reserve/National Guard servicemembers, who may be living in locations distant from military or VA treatment facilities. However, this is a question that may be best asked directly to the military services.

Question 2. Do active-duty servicemembers receiving behavioral health care treatment have similar withdrawal rates to veterans in VHA treatment programs?

Response. The rate of dropping out of treatment has not been studied as extensively in active duty servicemembers as it has in the VHA, but the limited data that are available suggest that dropping out of mental health care is also a critical problem for active duty servicemembers.

Question 3. Are you aware of any peer-to-peer counseling, mentoring, readjustment and outreach efforts currently underway in DOD for active-duty servicemembers and National Guard personnel?

Response. A program that immediately comes to mind is the Army Embedded Behavioral Health program, which received a very favorable program evaluation. It would be best to ask the Army directly for information on this and other programs.

Chairman MURRAY. Thank you very much.
Dr. Van Dahlen.

STATEMENT OF BARBARA VAN DAHLEN, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR™

Ms. VAN DAHLEN. Thank you. Good morning, Chairman Murray, Ranking Member Burr, and Members of the Committee. Thank you for this opportunity to provide testimony regarding veterans access to care through the Department of Veterans Affairs.

It is an honor to appear before the Committee, and I am proud to offer my assistance to those who serve our country. As the founder and president of Give an Hour, a national nonprofit organization providing free mental health services to our returning troops, their families, and their communities, I am well aware of the mental health issues that now confront our military and veterans community.

As a licensed clinical psychologist who has practiced for over 20 years, I am certain of the importance of ensuring that those in need are able to access effective care, care that fits their needs, care that fits their schedules, care that guarantees the opportunity to develop a relationship with a provider that they can trust.

As the daughter of a World War II veteran, I share your commitment to ensure that all veterans in need of mental health services receive the care that they deserve.

The Department of Veterans Affairs is the principal organization in our Nation's effort to ensure that all of those who wore the uniform receive the mental health services they require.

But no organization, agency, or department can provide all of the education, support, mental health treatment that every veteran and family need.

Indeed, I would argue that it is more helpful to those who serve and their families to see numerous endeavors coordinated on their behalf so that they understand that our country, not just our government, supports them and is committed to their health and well-being.

Give an Hour is one example of a community-based effort designed to complement the work of the VA. We are honored to do our part.

The idea behind Give an Hour is really quite simple. Ask civilian mental health professionals to provide an hour each week of mental health support or treatment to any OEF/OIF servicemember, veteran, or family member in need free of charge.

Give an Hour provides mental health care and support to those that are active duty, members of the Guard, reservists, veterans, and their families. We define family members as anyone who loves someone who has served since 9/11.

Our clients find their way to us through a number of channels. Many find us on the web and contact our providers directly. We have excellent relationships with other nonprofits and VSOs, all of which make regular use of our services.

Further, we have very good relationships within the Department of Defense and often receive referrals from our colleagues there. And although we do not have an official relationship with the Department of Veterans Affairs, we received many referrals from the VA.

Our mental health professionals remain in our network for at least 1 year. They are required to be licensed in good standing and to carry their own malpractice insurance.

We have developed excellent relationships with all of the major mental health associations. Our network includes psychologists, psychiatrists, social workers, psychiatric nurses, pastoral counselors, licensed professional counselors, substance abuse counselors, and marriage and family therapists.

Give an Hour has over 6000 professionals in our network. We are in every State and territory. Our providers offer face-to-face direct care. They provide phone support to those who are unable to attend a session in person. And this month, we began offering telehealth capability first in Virginia and North Carolina and then to the rest of our network in 2012.

Give an Hour providers offer a wide range of options with respect to available appointments including evenings, weekends, and home visits. In addition, they bring a wealth of treatment options and areas of expertise to their work.

We know that one size does not fit all with respect to this population or any. Flexibility and treatment based on individual needs are critical elements if we are to successfully address the mental health needs of veterans and their families.

There is no limit to the number of sessions the client receives and all of our services are free. Give an Hour providers have provided over 42,000 hours of care, and we have reason to believe that many more hours have actually been given. Regardless, we are pleased that we can count $4.2 million in mental health services provided to those who have served our country.

Our capacity for providing care has not yet been reached. We can currently offer 6,000 hours of care each week to provide support, education, information, and assistance. Our goal is to enlist 40,000 professionals to assist in this effort so that someday we hope to offer 40,000 hours which translates to $4 million of mental health care per week.

Give an Hour is a virtual organization. Because we are not a bricks and mortar operation, we have minimal overhead and are able to provide our services efficiently and inexpensively. We are currently able to provide 1 hour of care for $17.88.

Give an Hour cannot provide all of the services that our veterans and families need. But neither can the VA. Working together, we have a much greater likelihood of ensuring that no veteran in need suffers or fall through the cracks of a poorly coordinated and overly burdened system. Thank you.

[The prepared statement of Ms. Van Dahlen follows:]

PREPARED STATEMENT OF DR. BARBARA VAN DAHLEN, PSYCHOLOGIST, FOUNDER AND PRESIDENT OF GIVE AN HOUR™

Thank you for this opportunity to provide testimony regarding veterans' access to mental health care through the Department of Veterans Affairs. It is an honor to appear before the Senate Committee on Veterans' Affairs, and I am proud to offer my assistance to those who serve our country.

EFFECTIVE MENTAL HEALTH CARE

As a psychologist and the Founder and President of Give an Hour™, a national nonprofit organization providing free mental health services to returning troops, their families, and their communities, I am well aware of the mental health issues that now confront the men, women, and families within our military and veterans community. As an American I share your commitment to ensure that all veterans in need of mental health services receive the care and treatment they deserve.

Many issues affect our ability to effectively and successfully deliver mental health treatment and support to our military and veterans communities. While we are here to focus specifically on the critical elements of wait time and access to care, our efforts must address all of the factors that enhance or interfere with the delivery of services if we are to ultimately succeed with our mission. First, we must have adequate numbers of mental health professionals appropriately prepared and available in all communities to serve those in need. In addition, we must effectively educate military personnel, veterans, and their families so that they understand the full range of mental health issues that can affect those who serve our country. Education is critical if we are to prevent the development of disabling and costly conditions and disorders. Finally, and most important, we must work together across organizations and agencies to ensure that our messaging is consistent and our approaches are complementary.

The failure to provide effective mental health education, support, and treatment to military personnel, veterans, and their families will have dire consequences for generations to come. As a mental health professional I have witnessed the impact on the families of Vietnam veterans of the failure to provide effective and appropriate care to those in need. Many of these veterans—who returned from an unpopular war to an unsupportive Nation—were never properly identified as having significant mental health concerns. As a result, they and their families suffered for years—some for decades—from the invisible wounds of war.

Indeed, we are already seeing the consequences of the failure to identify and provide treatment to those OIF/OEF veterans in need as they come home from war. Over the last 10 years we have seen a rise in suicide among our servicemembers and veterans from the current conflicts. This generation of veterans is entering the homeless population at an alarming rate. And we need only look at the rise of divorce within the military community as well as an increase in mental health services being delivered to children of our warriors to understand the far-ranging and significant consequences of the mental health issues affecting those who serve.

Without a doubt, the Department of Veterans Affairs is the principal organization in our Nation's effort to ensure that all of those who wore the uniform and their families receive the mental health care they need to ensure they are able to lead

healthy and productive lives once they complete their service. Clearly the VA has worked hard to keep up with the changing landscape and the growing demands over the last decade as a result of the wars in Iraq and Afghanistan. The VA has increased the number of mental health professionals providing services since 2006. It now employs 21,000 clinicians. It has increased the number of Vet Centers across the country to 292 and has added 70 mobile Vet Centers in its effort to serve those who live in rural communities. Similarly, the VA has expanded its call centers to help connect veterans in need with counseling services and launched the Veterans Crisis Line, which allows veterans and their families to call 24 hours a day, seven days a week for assistance. Finally the VA has begun integrating mental health care into its primary care settings.

But no organization, agency, or department can provide all of the education, support, and mental health treatment that every veteran and his or her family needs. Indeed, I would argue that it is more helpful to those who serve and their families to see numerous endeavors coordinated on their behalf so that they understand that our country—not just our government—supports them and is committed to their health and well-being. Give an Hour™ is one example of a community-based effort to complement the good work of the Department of Veterans Affairs. We are honored to do our part.

GIVE AN HOUR™

I founded Give an Hour™ in 2005. As the daughter of a World War II veteran, I became concerned about the stories coming home about those who were serving. Although the Departments of Defense and Veterans Affairs were doing more than ever before in their efforts to care for the invisible injuries of war, servicemembers were clearly struggling and their families were suffering. Early studies by Charles Hoge and others indicated that significant numbers of servicemembers would continue to come home with post-traumatic stress, Traumatic Brain Injury, depression, anxiety, and other understandable consequences of exposure to the brutality of war.

The idea behind Give an Hour™ is really quite simple: ask civilian mental health professionals across the country to provide an hour each week of mental health support and/or treatment to any OIF/OEF servicemember, veteran, or family member in need, free of charge. Our plan continues to be to organize the civilian mental health community so that we might offer additional critical mental health services to the Departments of Defense and Veterans Affairs to aid them in our Nation's efforts to assist returning troops and their families.

Give an Hour™ provides mental health care and support to those who are active duty, members of the National Guard, Reservists, veterans, and their families. We define family members very broadly—as anyone who loves someone who has served since 9/11.

Our clients find their way to us through a number of channels. Servicemembers and veterans tend to be technologically skilled, and many find us on the Web and contact our providers directly. We have excellent relationships with a number of nonprofits and VSOs, all of which make regular use of our services by referring individuals to our providers. In addition, we have a successful marketing campaign, with frequent articles about our efforts appearing in numerous magazines and newspapers. And we have been fortunate to receive free advertising from publications such as *Time* magazine and *USA Today*. I am also a frequent guest on local and national television and radio programs. Further, we have very good relationships within the Department of Defense and often receive referrals from our colleagues there. Finally, although we do not have an official relationship with the Department of Veterans Affairs, we have received many referrals from the VA.

Our mental health professionals commit to remain in our network for at least one year. Mental health professionals accepted into our network are required to be licensed in good standing in their state and to carry their own malpractice insurance. We have developed excellent relationships with all of the major mental health associations, and we accept mental health professionals from all of the major disciplines. Our network includes psychologists, psychiatrists, social workers, psychiatric nurses, pastoral counselors, licensed professional counselors, and marriage and family therapists. Though not required, servicemembers, veterans, or family members who receive care through GAH are asked to give back by volunteering in their own communities. We currently have great relationships with a number of organizations—including The Mission Continues and Service Nation—that assist us with this element of our model.

Give an Hour™ has over 6,000 mental health professionals in our network. We have providers in each of the 50 states and U.S. territories. Our providers offer face-to-face direct care to servicemembers and/or their families, they provide phone sup-

port to those who might be unable to attend a session in person, and this month we will begin offering tele-health capability first in Virginia and North Carolina and then to the rest of our network in 2012.

Give an Hour™ providers offer a wide range of options with respect to available appointment times to those who seek services including evenings and weekends. In addition, they bring a wealth of treatment options and areas of expertise to their work. We know that one size does not fit all with respect to this population or any. Flexibility and treatment based on individual needs and preferences are critical elements if we are to reach and successfully support the mental health needs of veterans and their families. There is no limit to the number of sessions that servicemembers receive, and all services are free.

In addition to providing direct service, GAH also offers free mental health consultation to other organizations that provide services to the military community. For example, we have enjoyed a long-standing relationship with organizations such as TAPS (the Tragedy Assistance Program for Survivors) and SVA (Student Veterans of America), providing direct assistance with referrals and assisting at their events. We are also regularly asked to participate in Yellow Ribbon events and similar community gatherings across country. Our staff members present at conferences and are key members of advisory groups addressing the needs of those in our Armed Forces. We are proud that Give an Hour™ is successfully harnessing the knowledge, wisdom, skill, and compassion of our civilian mental health professionals and offering these resources to those who serve, our veterans, and their families in communities across the country.

Give an Hour™ surveys our mental health professionals quarterly to determine the specific services they have provided. Typically about 25% of our mental health professionals respond to our surveys. Our last survey was completed at the end of August 2011: those who have answered our surveys over the last five years report having given 42,000 hours of care since we began providing services. Given that only a quarter of our respondents provide information, we can assume that many more hours have actually been given. Regardless, we are pleased that we can count $4.2 million in mental health services provided to the men, women, and families who serve our country.

And we know that our capacity for providing care has not yet been reached. We can currently offer 6,000 hours of care each week, to provide support, care, education, information, and assistance. Our goal is to enlist 40,000 mental health professionals—approximately 10% of the 400,000 mental health professionals in our country—to assist in this effort. Someday we hope to offer 40,000 hours, which translates to $4 million, of mental health care per week.

Give an Hour™ is a virtual organization. Although most of our 12 staff members live and work in the Washington, DC, area, we also have employees in Virginia, New Jersey, North Carolina, and Pennsylvania. Five of our staff members are either veterans themselves or military family members. Because we are not a bricks and mortar operation, we have minimal overhead and are able to provide our services efficiently and inexpensively. In addition to our 6,000 mental health volunteers, we also appreciate the efforts of approximately 300 general volunteers, who assist us throughout the country with a variety of tasks and efforts. Because of our organizational efficiency and the generosity of the mental health professionals who have stepped up to assist with this critical effort, Give an Hour™ is able to provide one hour of care to servicemembers, veterans, their families, and their communities for $17.88.

As a clinical psychologist I am aware of the importance of proper training for the members of our network. Indeed focus groups conducted with our mental health volunteers indicate their interest in being well prepared to serve those in the military community. Since our inception, Give an Hour™ has been dedicated to providing a variety of training opportunities—both online and through conferences and workshops—to those who offer their services to assist returning troops and their families. We are fortunate to have collaborative relationships with a variety of organizations and associations, many of which have provided training tools and opportunities. Indeed, because of our knowledge and commitment to training and education, Give an Hour™ has also been commissioned to create training tools for educators and employers. We look forward to continuing to explore and offer new and creative tools to assist our talented mental health professionals with their important work.

And we look forward to working with our colleagues at the Departments of Defense and Veterans Affairs as we continue to develop opportunities to offer the considerable resources available within the civilian mental health community to returning troops, veterans, their families, and their communities.

BEYOND MENTAL HEALTH CARE

As critical as effective and accessible mental health care is to servicemembers, veterans, and their families, these men, women, and families who serve our Nation need and deserve much more as they return to our communities. And while good mental health forms the basis for every other aspect of a satisfying and productive life, without a good job or a quality education, it is difficult to imagine how those who serve can move forward and carry on.

Over the past six years through my work and travel with Give an Hour™, I have had the pleasure of meeting numerous community leaders—leaders who care deeply for our military families. I have also had the honor of working with many leaders within the nonprofit community as well as leaders from a variety of Veterans Service Organizations, all of whom work tirelessly to support servicemembers, veterans, and their families. And I am pleased that I now have many good friends and respected colleagues in the Department of Defense who are committed to providing opportunities and care to servicemembers.

I have had numerous conversations and frequent discussions with these colleagues regarding the importance—and indeed the necessity—of creating a comprehensive and integrated system of care for those who serve and their families. These conversations consistently focus on the need for collaboration, coordination, and communication among all organizations, agencies, and departments. And while everyone seems to agree that a concerted effort is required to coordinate Federal, state, local, and community-based efforts, implementation of such an effort has been difficult to achieve.

Fortunately, several efforts seem to be under way across the country to tackle this most difficult challenge, and many of the leaders of these efforts are now working to connect these critical models to one another. I am proud of my association with and contribution to one of these efforts, the Community Blueprint Network.

COMMUNITY BLUEPRINT NETWORK

As Adm. Mullen noted so many times during his tenure as chairman of the Joint Chiefs of Staff when he coined the phrase "The Sea of Goodwill," there is universal public support for veterans, servicemembers, and their families. Federal, state, and local governments, as well as nonprofit, private, and philanthropic resources and services, have grown and improved in communities across America. But supporting veterans, servicemembers (active duty, Reservists, and National Guardsmen), and their families is about ensuring that communities are prepared to organize the resources, services, and support that help those in the military community lead healthy, successful lives. There remain significant gaps in services and a great deal of untapped potential for providing effective and sustainable care through focused planning and coordination.

To address these needs by leveraging the combined experience and expertise of collaborating organizations, volunteers from several leading nonprofits created an initiative and an online tool called the Community Blueprint, which is already helping local community leaders assess and improve their community's support for veterans, servicemembers, and their families. The initiative is now formally being administered as the Community Blueprint Network Initiative by Points of Light Institute and is being implemented in several communities across the country. Plans for a national launch of the initiative are currently under way.

The Community Blueprint Network Initiative includes several key components:

- The Blueprint assists each community in assessing and fulfilling its role in supporting those who have borne the price of battle—veterans, servicemembers, and their families.
- The Blueprint helps community leaders and citizens gain a more precise and locally focused understanding of how they can contribute to an improved support matrix including offering opportunities for civilians, veterans, servicemembers, and their families to volunteer and serve alongside each other.
- The Blueprint provides community leaders with information about the primary challenges returning veterans, servicemembers, and their families may face.
- The Blueprint offers advice based on practices worthy of replication and experience about setting priorities, adopting strategies that work, and building coalitions to implement those strategies.
- The Blueprint is user-friendly and focuses on eight key areas: Behavioral Health, Education (both K–12 and higher education), Employment, Family Strength, Financial Management and Legal Assistance, Housing Stability and Homelessness Assistance, Reintegration, and Volunteerism. Under each of these impact areas the Blueprint offers up to six topics that stakeholders (community leaders, civic leaders, VSOs, etc.) can address. For example, under Higher Education, stakeholders will

find the topic "Welcome and Integration: Strategies to identify and support military-connected students and families." Each topic will have tabs for additional information and resources.

- The Blueprint provides communities with a forum to learn and share best practices and to bring key stakeholders and community leaders together to collaborate behind the common goal of assisting our Nation's veterans, servicemembers, and their families.

In the summer of 2010, the Bristol Myers-Squibb Foundation (BMSF) approached Give an Hour™ with an interest in funding our efforts to provide free mental health care to returning troops and their families. After learning of our involvement in the Community Blueprint Network Initiative—and the need for a more comprehensive and integrated system of care to support those who serve in communities across the country—BMSF agreed to fund Give an Hour™ to develop a model that can be used to assist communities in their efforts to organize support for military personnel, veterans, and their families. The result was a two-year grant for a demonstration project in two communities: Norfolk, VA, and Fayetteville, NC. This grant is enabling GAH to support, assist, coordinate, and convene community stakeholders as we develop a model that will be shared with the national Community Blueprint Network Initiative and with communities across the country involved in this critical endeavor.

Thus far, we have been impressed with and pleased by the response to our efforts in Norfolk and Fayetteville. Multiple community-based organizations have joined our meetings and our working groups, and we have received assistance from colleagues at the Department of Defense so that we now have developing relationships with installations and military partners in each of these communities. We have begun implementing programs and events in each community to highlight what we are doing in each of the eight areas of focus within the Blueprint.

On November 17 Give an Hour™ joined with the consulting firm Booz Allen Hamilton to host a summit in Fayetteville, on the needs of women veterans. The event was well attended by stakeholders and community leaders, including the mayor and officials from the local VA. This summit resulted in the development of three initiatives focused on ensuring the health of women veterans in Fayetteville and the commitment of those who attended to ensure the implementation of these initiatives. Give an Hour™ will continue to work with Booz Allen Hamilton over the coming months to support and coordinate these and other initiatives in this community as part of our work on the Community Blueprint demonstration project.

Clearly, the development of the Community Blueprint Network Initiative provides an unprecedented opportunity for all Federal and state agencies and departments to coordinate with community-based organizations and efforts to ensure that military personnel, veterans, and their families receive the type of comprehensive and coordinated care they need and deserve as they move forward in their lives as healthy Americans. We look forward to joining our efforts with those of the Department of Veterans Affairs in this worthy effort.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO BARBARA VAN DAHLEN, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR™

Question 1. We often hear that VA is the best place to treat veterans because VA providers better understand the veterans' experiences. Dr. Hoge's testimony echoed that sentiment when he says that the experience of a veteran with PTSD is very different from a civilian's experience with trauma. How does your organization make sure your providers understand the effect military service has on the course of treatment for PTSD?

Response. Indeed, it is very important to ensure that all mental health professionals working with servicemembers, veterans, and their families are properly trained and prepared for the critical work with this population. Many of our providers join Give an Hour™ because they have expertise in treating those who have experienced trauma, but they may not be familiar with the military culture. Others join because they are in some way connected to the military through family members or their own service, but they may not have experience in treating trauma victims. All seem to join because they are patriotic Americans, with excellent clinical skills, who want to do their part even though they may not be skilled in the treatment of trauma or have experience with the military culture.

Fortunately, there are many good training tools currently available to assist civilian mental health professionals who are interested in learning more about this population and the issues they bring home. I am regularly asked to review these programs and frequently make our providers aware of good programs. Sometimes work-

shops or conferences are available in specific geographical regions, so we send out notices to our providers in those areas. Often we are notified about online training tools that have become available and we pass on this information to all of our providers. In addition, we have worked with our mental health association partners to provide information through Webinars and we have created and collected tools and primers that can be downloaded from our Web site.

Give an Hour™ is also working with a number of partners to identify—and when needed—create training tools and opportunities. We are also crafting a project with one of our VSO partners to bring servicemembers/veterans together with GAH providers in communities across the country so that both groups can better understand each other.

Finally, we would welcome the opportunity to partner with the VA to provide training to our providers. I was recently approached by some of my colleagues at the National Center for PTSD to participate in a research study to train civilian mental health professionals. We provided a letter of support for this DOD-funded project and are hopeful that the project will go forward and that Give an Hour™ providers will become part of the study. I will be meeting with Deputy Sec. Gould on January 12 and look forward to discussing how Give an Hour™ and the VA might work together to provide training to the community-based mental health professionals in our organization and elsewhere who will be treating our Nation's veterans for decades to come.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO BARBARA VAN DAHLEN, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR™

Question 1. How can we meet the overwhelming demands for mental health care among all our veterans, in this climate of cuts and calls for spending caps? How do we encourage and recruit VA nurses and mental health professionals in times of pay freezes and calls for overall cuts in our Federal Government?

Response. The current demand for mental health services for veterans and their families will certainly continue to increase over the coming months and years. We can successfully meet this growing demand if we create a comprehensive and integrated system of care—one that incorporates all of the excellent services available through the VA system but also goes far beyond what the VA can provide. Such a system must include community-based mental health resources, primary care physicians, and other professionals in our communities who interact with veterans and their families. Such an approach must coordinate the efforts of state, Federal, and local governmental agencies in addition to nonprofit and VSO initiatives and resources. Mental health professionals from all involved organizations can and must play a primary role in educating our civilians—our physicians, our faith-based leaders, our first responders, our educators, and our employers—about the issues affecting those who serve and their families. Such a public health approach will ensure that those in need of treatment will be identified early and that all who can play a role in the healing and support of those who are suffering are knowledgeable and well prepared for the task at hand.

There is no silver bullet when it comes to treatment and healing. During this time of budget cuts and limited resources we must look for creative and innovative approaches to address the mental health needs of our returning warriors. For some veterans, a stable and meaningful job is as important—if not more so—to their mental health as a weekly session with a mental health professional. Increasing community awareness and increasing options for care and support increase the likelihood of success in ensuring that all military personnel, veterans, and their families receive the care and support they need and deserve. By creating an "all hands on deck" approach to this problem, we increase the number of potential supports in a community, despite the fiscal challenges of our era, and we create opportunities for skilled professionals to join the effort through volunteer work even if funding is cut or limited.

The awareness that no one organization, no one profession, and no single approach can meet all of the needs of our servicemembers, our veterans, and their families led to the development of the Community Blueprint Network Initiative. As I described in my written testimony, volunteers from several leading nonprofits created the Community Blueprint, which is already helping local community leaders assess and improve their community's support for veterans, servicemembers, and their families. The initiative is now formally being administered as the Community Blueprint Network Initiative by the Points of Light Institute and is being implemented in several communities across the country. Plans for a national launch of the initiative are currently under way.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY SENATOR SANDERS TO BARBARA VAN DAHLEN, PH.D., FOUNDER AND PRESIDENT, GIVE AN HOUR™

Question 1. Do you and your volunteers provide servicemembers and veterans you provide behavioral health services to documentation that they can submit to VA in support of a service-connected disability claim?

Response. Give an Hour™ provides confidential free mental health services to servicemembers, veterans, and their families. As an organization we do not collect information about the clients who make use of our provider network. However, all of our mental health professionals keep records just as they would when seeing any client in their practice. Therefore any veteran can request documentation of the services they receive—just as any client can from any mental health professional. They are entitled to those documents when and if needed.

Chairman MURRAY. Thank you very much.

Mr. Roberts.

STATEMENT OF JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND WARRIOR ENGAGEMENT, WOUNDED WARRIOR PROJECT

Mr. ROBERTS. Thank you, Chairman Murray, Ranking Member Burr, and Members of the Committee. Thank you for allowing me the time to come before you today on this important issue and provide testimony.

As the Executive Vice President of the Wounded Warrior Project, I interact daily with wounded warriors. Not only am I an executive with WWP, a former VA supervisor, but I am also a wounded warrior myself who has struggled with PTSD since my injuries in 1992.

Every day I come across men and women that served this country. Their stories echo the story that I once told. They are very similar in nature. The stories have not changed from one generation to another.

Earlier this month, Wounded Warrior Project sent out a survey to our alumni or our warriors we serve. We got 900 responses back. Out of those 900, 62 percent of those individuals had attempted to obtain treatment through the VA. Half of those individuals have had difficulties getting that treatment, and one out of three of those individuals got no treatment at all.

You know, these are real-life individuals that have served their country proudly and are struggling to get the care that they need and deserve. But I want to share a couple of statements from three of those individuals that wrote in written comments.

"I cannot get an appointment for 3 months, and then they canceled and rescheduled three times. Once I was able to see a counselor, I was told I cannot get repeat care in a group setting more frequently than once a month. Even though group counseling was not ideal for my situation, I was told that they would not pay for me to see a private counselor even though they could not fill my appointments at the frequency they said I required. That is when I gave up on the VA health care. As a result, I put off getting treatment for almost 2 years until I got private insurance from my new job."

The second statement is, "In Columbia, South Carolina, there is one doctor, two counselors. I have been off active duty since July 2011 and I have had one appointment for PTSD. They are so short staffed it is like trying to put a Band-Aid on an amputation."

And the last statement is, "While it would be great to have the ability to have more frequent visits than every two to 3 months, I am actually limited to the frequency anyways due to the limited sick leave from work and the VA CBOC not offering evening counseling."

All the stories are different. They have a very similar theme, and unfortunately, they are very troubling. Warriors may be able to get in for their initial appointment and screening; but when a veteran who is struggling with PTSD, with depression, substance abuse, and is coming to the VA for help and is told that the next available appointment is months away, why are we surprised when somebody kind of loses hope and turns to more desperate measures—suicide, for example.

Let me ask some questions. Why, after 10 years, do warriors have to struggle to get effective care for the signature wound of this war? Why has not the Undersecretary for Health and the Secretary moved beyond measuring baseline access to initial mental health evaluations to systematically tracking access to sustained follow-up care?

In fact, if leaders spent more time speaking with the veterans and their own clinicians, they would realize that the problems with the VA's mental health system run far deeper than even their data suggests.

In that regard, why have not those leaders instituted concrete medial measures rather than offering so-called action plans that promise nothing more than the possibility of future plans.

And when will VA leaders actually enforce central office policies and end the disconnect between national directives and what is actually taking place in the medical centers across the country?

I recently spoke to a VA psychologist in a large urban VA medical center. He described the VA's ability to handle the current caseload as completely inadequate.

VA has placed great emphasis on providing evidence- based mental health care to include sessions of cognitive behavioral therapy. The clinician I spoke with is trained in this technique and thinks it is effective for veterans with PTSD.

Unfortunately, he is not able to provide this time- consuming treatment. This individual talked to me about working 10 to 12 hour days just to keep up. So, the veterans that he treats are not able to get that treatment that they deserve.

This clinician operates a crisis center which currently has a waiting list for veterans who need care and then he indicated to me that there are other clinicians in his medical center that have caseloads up to 300 veterans.

I am not the smartest math guy around but I did a little calculation. If one doctor had 300 patients, never took lunch, phone calls, breaks, went to the bathroom or went to meetings, they could give 30 minutes a month to each patient.

To me, as was said, I am the civilian up here. I do not know if 30 minutes a month is actually adequate or quality care. I will leave that up to the professionals.

These caseload levels result in many veterans being seen no more than once every 4 weeks; and when they go to those appoint-

ments, the sessions often are focused on medication management but not much of the needed therapy.

Appointments to manage medication may check the box and fulfill access to timeliness standards but this is not the type of care that will ultimately lead veterans to successfully manage their mental health conditions.

Meeting numerical benchmarks is not good enough if the care the warriors receive is of poor quality. VA's recent action for improving timeliness and mental health care does not reflect the urgency needed to address the situation.

While the issues of impact and access to care are complex, this is also a leadership issue. It is time to move beyond characterizing these issues as perceived challenges and acknowledge them head on.

VA's insistence on studying these issues is simply unacceptable. Veterans need a meaningful, aggressive strategy the same way that they are currently tackling homelessness which is often a direct result of an underlying mental health issue.

While there is a lot to be done, WWP as three recommendations. First, better utilize VA's Vet Centers and allocate more resources to those centers. Second, mount a meaningful peer support program to help engage and retain veterans in mental health treatment. And last, utilize the fee-basis care in situations where VA resources do not allow a veteran to be seen in a timely manner.

VA officials speak of transforming the VA mental health care system, but a real transformation must dramatically improve the timeliness and access to effective quality mental health care.

In our view, VA leadership has fallen short in meeting that challenge, short on urgency, short on commitment, short on vision, and short on action. We urge the Committee to demand more.

Thank you, Chairman Murray, Ranking Member Burr, and the other Members of this Committee. Your continued oversight is essential in getting Secretary Shinseki and Undersecretary Petzel to embrace this challenge. Too much is at stake to move forward with business as usual. Thank you.

[The prepared statement of Mr. Roberts follows:]

PREPARED STATEMENT OF JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND FAMILY SERVICES, WOUNDED WARRIOR PROJECT

VA MENTAL HEALTH CARE: ADDRESSING WAIT TIMES AND ACCESS TO CARE

Chairman Murray, Ranking Member Burr and Members of the Committee: Wounded Warrior Project (WWP) applauds this Committee's continued focus on Department of Veterans Affairs (VA) mental health care. Thank you for conducting this hearing as a follow-up to your July 14th hearing. During that hearing you heard testimony from Daniel Williams, a wounded warrior, and Andrea Sawyer, a caregiver for her husband Loyd. Chairman Murray, the survey of VA mental health professionals you requested during that hearing clearly shows that Daniel's and Loyd's struggles are not isolated anecdotes but representative of a systemic gap in care. More does need to be done.

The survey's findings should serve as a stark call-to-action. Instead, the Veterans Health Administration provided the Committee an "Action Plan" (dated November 7th), which outlines a series of timid half-steps for improving VA mental health care. This vague plan-to-develop-plans falls far short of the immediate, aggressive action that is needed to assure that warriors receive timely, effective mental health care. Our experiences in working with wounded warriors overwhelmingly verify the fact that access to appropriate mental health care is a real and dire issue that war-

rants immediate, aggressive action. Admittedly, the factors impacting access to care are complex, but this is also a leadership issue—and that leadership is failing.

TIMELINESS OF VA MENTAL HEALTH CARE

Earlier this month we asked wounded warriors to participate in a survey that asked about their experiences with VA mental health care. Of more than 935 respondents, 62% had tried to get mental health treatment or counseling from a VA medical facility; some 2 in 5 of those indicated that they had difficulty getting that treatment. And of those reporting that they had experienced difficulty, more than 40% indicated that they did not receive treatment as a result. Getting timely appointments was a frequent problem.

The following comments from warriors responding to the survey were not unusual:

> "I could not get an appointment for 3 months, and then they canceled/rescheduled me three times. Once I was able to see a counselor, I was told I could not get repeat care [in a group setting] more frequently than every month, even though group counseling was not ideal for my situation. I was also told they would not pay for me to see a private counselor, even though they couldn't fill my appointments at the frequency they said I required. That's when I gave up on VA health care. As a result, I put off getting treatment for almost two years until I got private insurance through a new job."
>
> "The wait time to see my mental health provider is way too far between appointments and I am tired of having to go inpatient to have my immediate needs met. I just think that the VA is overwhelmed."
>
> "Timeliness of my appointments with my primary care provider and psychologist can be 3–6 months depending on how busy they are. The providers are grossly understaffed. How can veterans receive quality care if they only schedule a visit with their providers 2–3 times a year?"
>
> "I felt the care provided by the caregivers was top notch. However through no fault of their own, the system has set them up for failure in that they have too many people to see in such periods of time."
>
> "While it would be great to have the ability to have more frequent visits than every two to 3 months, I am actually limited to this frequency anyways due to limited sick leave from work and my VA [CBOC] not offering evening counseling."
>
> "It took over 6 months from retirement date to even be scheduled for mental health treatment. The local VAMC has only one mental health provider for ALL OIF/OEF veterans."

WWP outreach and alumni support staff routinely assist in referring warriors who have combat stress issues to Vet Centers and VA medical facilities. Our staff often encounter difficulties in securing timely mental health appointments for warriors. That experience certainly led us to question the reliability of VA data indicating near-uniform adherence to its 14-day scheduling policy, and VA's recent clinician-survey findings were not altogether surprising. Unfortunately, VHA's response to those findings suggest little real action. The operative words describing VHA's plans—"reviewing," "exploring possible barriers," "working with other offices," "engaging leadership and staff," and "developing policies"—suggest a response that amounts to little more than studying the problem. As we advised Secretary Shinseki in an October 6th letter that urged him to take bold leadership, VHA's emphasis on studying and discussing issues at a time when veteran suicides continue at alarming rates, suggests a plodding bureaucracy out of touch with a very real crisis.

Consider how just three warriors describe their own mental health status:

> "I've been dealing with PTSD/Depression for many years now and it just seems to never go away. It affects my day to day activities. I seem to have lost my self-purpose and interest."
>
> "My main problems are being emotionally numb, isolation, freezing up in social environments, drugs and not having the desire or energy to put toward changing my situation any more. It has been over 5 years, and I am still just as bad as and even worse than when I came back."
>
> "My greatest challenge is the feeling of uselessness and helplessness."[1]

Warriors facing such serious mental health problems need timely, effective mental health care. But we routinely encounter very different experiences with VA mental

[1] Franklin, et al., "2011 Wounded Warrior Project Survey Report," (July 2011) pp. 83–4.

health care. Some of the very common problems warriors experience are the following:

- Delays in obtaining appointments;
- Inability to have input on appointment times, and resultant inability to attend a scheduled appointment because of work or school commitments;
- Lack of available mental health providers;
- Having to go to an emergency room because a therapist wasn't available to see the veteran;
- Not seeing the same therapist twice;
- Overmedication or inability to have meds adjusted when needed;
- Lack of support or understanding;
- Distance to available VA clinics or hospitals.

QUALITY CARE

VA mental health care should not only be of exceptional quality but should be tailored to meet the unique needs of our warriors. Ten years of war have taken a toll on the mental health of American fighting forces. Too many warriors are still battling demons. WWP is somewhat encouraged that the Veterans Health Administration, in responding to the survey of its mental health providers, acknowledged with respect to its mental care delivery system that "important gaps remain, and VHA has not yet fully met its aspirational goals."

But we are also concerned that VA is highlighting a recent RAND assessment suggesting that its mental health care is as good as or better than that reported in the literature by other groups or by direct comparisons.[2] In our view, veterans suffering from the stress of combat deserve timely, effective mental health care—not just "as good as." In 2006, an Institute of Medicine panel assessing mental health care in this country, observed that despite what is known about effective care for mental-health/substance-use conditions, numerous studies have documented a discrepancy between mental-health/substance-use care that is known to be effective and care that is actually delivered. Reviewing studies assessing the quality of care for many different behavioral health conditions, IOM found that only 27 percent of the studies reported adequate rates of adherence to established clinical practice guidelines.[3] Pointing to departures from known standards of care, variations in care in the absence of care standards, failure to treat mental health and substance use conditions, and lack of care-coordination, IOM found that poor behavioral health care in this country hinders improvement and recovery for many.[4]

For veterans confronting such problems, the observation that VA mental health care may be "better" than poor care elsewhere offers little comfort.

Consider, in that regard, the experience of a veteran named Angie, who was medivaced back from Iraq in 2003, developed PTSD, and soon after spiraled into a deep depression. After an 8-month wait to get care at the St. Louis VA medical center, Angie turned to TRICARE. But complicated medical problems led to her becoming dependent on pain medication. Finally, feeling suicidal, she again sought VA help, going to a VA medical center emergency room. She credits a dedicated VA physician's response to her crisis to her finally being admitted for care and to successful recovery. In this case, the care provided was apparently excellent. But that care almost came too late. For a facility or system to provide good care that cannot be readily accessed can hardly be classified as an achievement.

ACCESS TO CARE

It is not enough, in our view, for VA to assure this Committee that it is providing veterans access to mental health care. "Access" must mean more than simply that a veteran can get "through the door" or can "be seen." Important questions include "access to what?" and "how is that access maintained?"

We know that many veterans are being helped by dedicated clinicians at VA medical facilities, but others have had less positive encounters. Too often OEF/OIF veterans cite experiences reflected in a recent response to a WWP survey, "the VA is overwhelmed at this point and [it is] discouraging for young troopers seeking care. Too much medicine gets thrown at you. Each provider thinks they can solve the complex issue of PTSD/Combat Stress with meds."[5]

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[2] Katherine E. Watkins and Harold Alan Pincus, "Veterans Health Administration Mental Health Program Evaluation," RAND Corporation, 2011.

[3] Institute of Medicine, "Improving the Quality of Health Care for Mental and Substance-use Conditions," The National Academies Press (2006), 5–6.

[4] Id., 35–6.

[5] Franklin, et al., 2011 Wounded Warrior Project Survey Report, (July 2011), 90.

We must move beyond the "access to care" paradigm to a standard of "access to effective care." It is not clear that VA has genuinely identified the critical elements of what constitutes effective mental health care, particularly as it relates to treating our returning warriors. Notwithstanding the recent extensive RAND Corporation attempt to evaluate VA mental health care, RAND's study seems ultimately to pose as many questions as it is able to answer in terms of meaningful qualitative judgments regarding VA mental health care. As RAND notes, the current state of quality assessment in mental health is still limited by many barriers.[6]

RAND's acknowledgement that VA outperformed private plans on seven of nine quality measures should also be tempered, in our view, by the fact that those quality measures all relate to reliance on medication. In contrast, RAND found that VA clinicians fall far short in providing a range of evidence-based practices, many of which involve talk-therapy. RAND specifically cited the low percentage (20%) of veterans receiving cognitive-behavioral therapy for PTSD. A relatively recent comprehensive study found even lower rates in that regard among OEF/OIF veterans. There VA researchers found that of nearly 50,000 OEF/OIF veterans with new PTSD diagnoses, fewer than 10 percent appeared to have received evidence-based VA mental health treatment for PTSD (defined by researchers as attending 9 or more evidence-based psychotherapy sessions in 15 weeks).[7]

But even if VA adherence to evidence-based practices were greater, applying tested treatment models and techniques do not necessarily ensure effective treatment.[8] Treatment must also be "culturally competent"—that is, it must be responsive to the values, experiences, and language of the patients it serves.[9]

In our experience, the success that Vet Centers have in counseling warriors stems in significant part from their staff's understanding of both the combat experience and warriors' ethos and language. A high percentage of Vet Center staff are themselves combat veterans; they and their clients share a common "culture," so to speak. Many warriors also report that they feel understood when seen at Vet Centers and that their traumatic experiences and responses are viewed as normal responses to the combat experience rather than being pathologized.[10]

While the RAND's report lacks all the answers, one of the leading clinician-researchers in the field, Dr. Charles Hoge, has it right, in our view, in offering the following perspective with respect to helping veterans with war-related PTSD:

> "Improving evidence-based treatments * * * must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors * * * Matching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the veteran's healing process and also need their own support."[11]

There is much to this advice, and it illustrates the gaps in VA's approach. With a dogged adherence to a medical model, VHA leaders seem insistently and narrowly focused on evidence-based treatments—closing the door to promising practices or even veterans' preferences. As discussed in WWP's testimony before the Committee on July 14, VA insisted on pursuing evidence-based practice as a rationale for disbanding a group-therapy program at the Richmond VA Medical Center over the objections of the veterans who had not only been actively participating in their treatment but also benefiting from the therapy. While promoting tested practices may seem laudatory, the rigidity of VA's approach has tended to ignore the veteran and what "works" for him or her.

In striking contrast, Hoge wisely emphasizes that reliance on evidence-based treatments alone is not enough. As he notes, VA must also work to improve its clinician's cultural competence—their understanding of, and rapport with, warriors. And

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[6] "Veterans Health Administration Mental Health Program Evaluation," RAND Corporation, 149.

[7] Karen Seal, Shira Maguen, Beth Cohen, Kristian Gima, Thomas Metzler, Li Ren, Daniel Bertenthal, and Charles Marmar, "VA Mental Health Service Utilization in Iraq and Afghanistan Veterans in the First Year of Receiving New Mental Health Diagnoses," Journal of Traumatic Stress, 2010.

[8] Sandra J. Tanenbaum, "Evidence-Based Practice as Mental Health Policy: Three Controversies and a Caveat," Health Affairs, vol. 24, No. 1 (January/February 2005).

[9] The President's New Freedom Commission on Mental Health, 52.

[10] See Charles W. Hoge, "Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home," Globe Pequot Press (2010).

[11] Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," JAMA, 306(5): (August 3, 2011) 551.

success is not solely about clinician-patient relationships. Peer-support has a critical role to play, as he advises. It is noteworthy that when WWP surveyed our alumni, nearly 30% identified talking with another OEF/OIF veteran as the most effective resource in coping with stress—the highest response rate of all the resources cited, including VA care (24%), medication (15%) and talking with non-military family or friend (8%).[12]

Finally, greater attention should be given to the metrics being employed to gauge the effectiveness of VA care. The goal should not be simply to alleviate or manage symptoms or to have the veteran complete a 14-session evidence-based therapy program. Rather, the goal should be to help these wounded warriors rebuild their lives.

THE WAY AHEAD

Given the urgency of the issues raised during the Committee's July 14th hearing and VA's clinicians' survey, WWP asked Secretary Shinseki to take three immediate steps to improve timeliness and access to care: better utilize VA's more than two hundred Vet Centers and allocate more resources to those centers, integrate peer-to-peer support to help sustain warriors in mental health treatment, and cover private-care options if VA resources are so limited and taxed that a warrior in need cannot be seen within a reasonable timeframe.[13]

Immediate action is imperative. VA has embraced an all-out effort to end homelessness; they must do the same to address the growing mental health crisis before it is too late. Our newest generation of veterans must not be allowed to fall into the gaps that lead to addiction, homelessness, or suicide.

Congress has already specifically mandated or authorized several steps in law, directing VA to provide needed mental health services to OEF/OIF family members whose own stress may diminish their capacity to provide emotional support for returning warriors as well as to implement a peer-support program at VA medical facilities.[14] The VA is capable of providing "the best care anywhere." That care needs to include timely, effective mental health care.

Thank you Chairman Murray, Ranking Member Burr, and the other Members of this Committee—your continued oversight is essential in getting the Department to embrace this challenge. Too much is at stake for business-as-usual to be the watchword.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND WARRIOR ENGAGEMENT, WOUNDED WARRIOR PROJECT

Question 1. You recommend that VA better utilize Vet Centers to improve timeliness and access to care. One of the key factors in the success of Vet Centers has been the strict privacy protections they have in place. How do you believe VA can effectively expand the use of Vet Centers while maintaining these protections?

Response. We would not anticipate any diminution in the strict confidentiality afforded veterans who receive Vet Center services as it relates to our recommendation that VA expand Vet Center services.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND WARRIOR ENGAGEMENT, WOUNDED WARRIOR PROJECT

Question 1. John, your remarks highlight some disturbing instances of individual veterans not getting timely mental health care. Are these isolated instances unique to a relatively limited number of facilities, or something more?

Response. The responses to our survey strongly suggested that, with isolated exceptions, the problems veterans encountered regarding access to timely care and getting the right type of care, for example, were widespread and existed at many facilities across the country. Those survey responses were in alignment with the observations and experiences of WWP staff at our field offices who work closely with warriors. The troubling pattern documented by our survey raises a related issue—VA's relative lack of transparency regarding its provision of mental health care. For example, while VA has been eager to share data that highlight the number of OEF/

[12] Wounded Warrior Project Survey, p. 54.

[13] According to the RAND evaluation report, only 1.3% of FY 2008 mental health encounters were paid for by VA but not provided by it.

[14] See sections 304 and 401 of Public Law 111–163.

OIF veterans who have been seen for mental health conditions, there has been little to no transparency regarding other important issues and indicators—how extensive has been VA facilities' use of fee-basis mental health care, how long on average have VA mental health position-vacancies gone unfilled, what are VA's mental health staffing criteria, etc. Rather than exhibiting openness and candor as it relates to providing mental health care to returning veterans, the Department has been too quick to assert that "all's well," and to reject suggestions for improvement.

Question 2. Your testimony contrasts the experience veterans have at Vet Centers with their encounters at VA medical centers and clinics. How different are those experiences, and are there lessons the VA medical centers can take from the Vet Centers?

Response. Wounded Warriors who are experiencing problems associated with combat stress or readjustment consistently report having very different experiences at Vet Centers than at medical centers and clinics. Wounded Warrior Project explored this issue with warriors in-depth over the course of a three-day "Warrior Empowerment Summit" in September 2010. Despite the Summit participants' varied backgrounds and unique personal journeys, they reached remarkable agreement on what VA assistance had "worked" for them and what hadn't, and what needs to change to help those warriors coming behind them. What was strikingly evident was how helpful Vet Centers have been to participants, and, with only limited exceptions, the frustrating and even negative experiences many had at other VA medical facilities. Several important themes—and avenues for change (already either authorized or required by law)—emerged from these discussions, relating to key differences between Vet Center services and those provided at other VA facilities. What is significant about these observations is that other VA facilities can adopt and incorporate into their operations critical features that make the Vet Center experience attractive to, and successful for, warriors. In particular, the Summit participants identified the following Vet Center elements as important to them: (a) peer-to-peer services; (b) working with clinical staff who understood the military and combat experience; (c) the availability of family services; and (d) outreach.

Peer-to-peer support: In describing highly positive experiences at Vet Centers, warriors emphasized the importance of being helped by peers—combat veterans on the Vet Center staff who (in their words) "get it"—something too seldom encountered at other VA facilities. Given the inherent challenges facing a patient in an acute-care setting, it is all the more important to have the support of a peer who, as a member of the treatment team, can be both an advocate and support. Section 304 of Public Law 111–163 requires VA to provide peer-support services to OEF/OIF veterans at its health care facilities along with mental health services, a requirement it was to have implemented within 180 days of enactment. It is very troubling that VA has not implemented that long-overdue requirement.

Cultural competence: Health care providers, to be effective, must be "culturally competent"—that is, must understand and be responsive to the diverse cultures they serve. Our Summit participants expressed frustration with VA clinicians and staff who, in contrast to what most have experienced in Vet Centers, may appear not to understand the experience of combat, or the warrior culture. In essence, these warriors found that VA health care often was not "culturally competent." Rather than winning trust and engaging warriors in treatment, some clinicians and staff were perceived as ignorant of military culture. Warriors reported frustration with clinicians whose only experience with PTSD was in treating patients whose trauma was a vehicular accident or domestic violence, but who were inexperienced with PTSD stemming from combat. Warriors can accept the explanation that their PTSD is a normal human (physiological) response to extreme stress, but may not trust a clinician who pathologizes them or characterizes PTSD as a "disorder" rather than an expected reaction to combat.[1] Moreover, VA health facilities are in many respects "foreign" to warriors, who complain of difficulty navigating the system and lack of information regarding their health or treatment plans. It is not surprising, given warriors' frustrations with VA staff insensitivity and difficulty in navigating or understanding their VA care, that very high percentages of OEF/OIF veterans fail to complete the recommended 15-session evidence-based treatments for PTSD.[2] Dramati-

[1] C.W. Hoge, *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home*, (Globe Pequot Press, 2010) 5, 51.

[2] Karen Seal, Shira Maguen, Beth Cohen, Kristian Gima, Thomas Metzler, Li Ren, Daniel Bertenthal, and Charles Marmar, "VA Mental Health Service Utilization in Iraq and Afghani-

Continued

cally improving the cultural competence of clinical AND administrative staff who serve OEF/OIF veterans through training, standard-setting, etc.—and markedly improving patient-education—would be a valuable step.

Family mental health services: Research indicates that one of the strongest factors that help warriors in their recovery is their level of support from loved ones.[3] Yet the impact of lengthy, multiple deployments on those loved ones may diminish their capacity to provide the depth of support the veteran needs. One survey of Army spouses, for example, found that nearly 20 percent had significant symptoms of depression or anxiety.[4] While Vet Centers have provided counseling and group therapy to family members, VA medical facilities have long offered little more than "patient education" despite broad statutory authority to provide not only counseling but mental health services. It took nearly two years for VHA to disseminate information on section 301 of Public Law 110–387, which requires VA to provide marriage and family counseling to family members of veterans under treatment for a service-connected condition (though we are finding that such services are, in fact, not widely available).[5] Section 304 of Public Law 111–163 directs VA to go further—requiring VA (within 180 days of enactment) to provide support, counseling and mental health services to members of the immediate family of veterans when such services would assist in the veteran's readjustment, the family's readjustment, or the veteran's recovery from an injury or illness. WWP finds it troubling, particularly given its durational "window," that this provision—covering the three year period beginning on return from an OEF/OIF deployment—has still not been implemented.

Outreach: Warriors reported that VA's general "outreach" was not particularly helpful as related to their combat stress issues. Post-deployment briefings that encourage veterans to enroll for VA care tend to be ill-timed, or too general and impersonal to address the warrior's issues. While generally aware of the existence of a treatment option, many Summit participants cited a reluctance to seek VA care, often attributed to a perception (or experience) that pursuing VA treatment would be more stressful than helpful. Several acknowledged self-medicating; others sought isolation as their "drug of choice." Warriors identified VA health care facilities as "passive"—as placing the burden on the warrior to seek treatment rather than reaching out to engage the veteran in his or her community, and providing little or no support, encouragement, or helpful information for navigating that system. While a significant percentage of OEF/OIF veterans have enrolled for VA care, an almost equally large percentage has not. Given the prevalence of PTSD among OEF/OIF veterans and the implications of its going untreated, Web sites and public service announcements are insufficient to get warriors to seek help. Section 304 of Public Law 111–163 now directs VA to carry out such one-on-one peer outreach, though VA has not implemented that peer-outreach directive.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND WARRIOR ENGAGEMENT, WOUNDED WARRIOR PROJECT

Question 1. How can we meet the overwhelming demands for mental health care among all our veterans, in this climate of cuts and calls for spending caps?

Question 2. How do we encourage and recruit VA nurses and mental health professionals in times of pay freezes and calls for overall cuts in our Federal Government?

Response. We appreciate the concern underlying those questions, and would highlight that the deep and immediate concern is that today those returning from often multiple deployments with war-related mental health conditions are not getting timely effective mental health care at many VA health care facilities. Rather than tight budgets, VA has in recent years enjoyed significant budget increases, but it appears to be doing a poor job of managing those resources to meet veterans' needs for mental health care. Our experience mirrors the Committee's findings that veterans are experiencing unreasonably long waits for needed mental health treatment. But the Department has failed to be at all transparent about these problems. What

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stan Veterans in the First Year of Receiving New Mental Health Diagnoses," *Journal of Traumatic Stress*, 2010.

[3] Hoge, *Once a Warrior*, 28.

[4] Hoge, 259.

[5] Veterans Health Administration, IL 10–2010–013, "Expansion of Authority to Provide Mental Health and Other Services to Families of Veterans," August 30, 2010.

has become increasingly clear is that VA performance measures are fueling pressures to "see" increasing numbers of OEF/OIF veterans. But VA has not established performance measures to assess treatment outcomes. Moreover, VA's failure to deploy its resources to ensure that OEF/OIF veterans are actually receiving the timely effective treatment they need is resulting in too many veterans falling through the cracks. Under such circumstances, it is not surprising that some VA clinicians have expressed frustration and that VA finds it difficult to recruit. In sum, we are justifiably concerned that VA has not made a sufficient priority of ensuring timely effective care of those bearing the psychic wounds of war.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO JOHN ROBERTS, EXECUTIVE VICE PRESIDENT, MENTAL HEALTH AND WARRIOR ENGAGEMENT, WOUNDED WARRIOR PROJECT

Question 1. In your testimony, the Wound Warrior Project recommended to VA, "* * * that Secretary Shinseki better utilize VA's more than two hundred Vet Centers." Could you elaborate on how Vet Centers could be "better utilized"?

Response. It has been our experience that VA medical centers do not necessarily have close working relationships with Vet Centers, and that veterans who are seen at either Vet Centers or other VA facilities cannot necessarily rely on what should be easy, reliable referral patterns to and from VA medical centers. One step toward better utilization of Vet Centers, therefore, would be to establish more consistent coordination and collaboration between the two. And, given that veterans generally report highly positive experiences at Vet Centers and have generally encountered greater difficulty accessing timely, effective mental health at other VA medical facilities, we see benefit in expanding the number of Vet Centers, and in that sense, better utilizing those services.

Question 2. Could you discuss what happens when DOD identifies an active-duty servicemember is in need of behavioral health services before the servicemember is either separated from active-duty or determined to be fit for duty?

Response. In our experience, if a servicemember is referred to a treatment facility and is found to need behavioral health treatment, that individual would often receive treatment. This is the expected action. But such a hypothetical servicemember might mask or minimize symptoms out of fear that getting needed treatment might result in ending a military career, or might be given only a superficial assessment resulting in the judgment that no treatment is needed. That servicemember might be referred to a Medical Evaluation Board and in some instances rushed through a process where needed treatment is deferred for later treatment under VA auspices.

Question 3. How much collaboration is there between DOD and VA with regard to addressing the behavioral health needs of wounded warriors prior to and following separation from active-duty?

Response. We have seen little evidence of significant collaboration between the military services and VA in terms of meeting warriors' behavioral health needs prior to and following separation.

Chairman MURRAY. Thank you very much, Mr. Roberts. I think every Member of this Committee agrees with you that we need an aggressive strategy; and hopefully, this hearing will highlight that and our second panel will be able to really begin to talk to the VA about that.

So, thank you to all of you.

Dr. Washington, I wanted to start with you. As I mentioned, the survey that I requested of mental health providers really highlight the disconnect between VA policies and practice.

The VA claims that about 95 percent of our veterans get an appointment within that mandated 14-day window. The survey from VA staff found that only 63 percent of providers can schedule patients for mental health appointments within 14 days.

So, I wanted to ask you as the provider, and I am sure you talk with other providers throughout the system, how often have you and those you talk to been able to really schedule appointments for patients within that 14-day window?

Ms. WASHINGTON. I would agree with probably the survey's findings. It is fairly inconsistent. It is very low numbers, meaning that they may be able to come in for the initial consultation which is just getting background information within the 14 days; but then actually getting a face-to-face physical appointment to start actual therapy could be a month, 6 weeks easily.

Chairman MURRAY. So, the disconnect then could possibly be what that initial appointment actually is about?

Ms. WASHINGTON. Yes, because initially when a consult is sent in, usually from primary care or sometimes the individual is self-referred; they come in and then we just get their background history, and it could be anyone who actually takes that.

So, I think what is happening is sometimes they are accounting that as the initial appointment when, in reality, it is really just getting the background information, getting their history versus an actual appointment to sit with a counselor to then determine what a good treatment plan will be for that person.

Chairman MURRAY. Because I think most of us think when somebody is seen within the first 14 days, they are actually seeing you or another provider who is beginning treatment.

Ms. WASHINGTON. That is not the case.

Chairman MURRAY. But that counts under the VA's 14-day window if they just get that.

Ms. WASHINGTON. Yes.

Chairman MURRAY. OK.

Dr. Hoge, you recently wrote an article in the Journal of the American Medical Association and found that a very high percentage of veterans dropped out of their PTSD treatment, and you found that VA efforts at providing PTSD therapy was only reaching about 20 percent of the veterans who needed it.

I am really troubled by that finding that only about half of our veterans actually complete a full course of mental health treatment. From where you sit, what do wait times and scheduling problems play in veterans dropping out of care and not getting their full treatment?

Dr. HOGE. I think that is one of many factors because there is not good research to really tell us exactly, you know, how important that is versus other factors. But it is clearly a critical and important, one critical and important factor along with others.

Sometimes it is stigma. Sometimes it is, you know, sort of structural or physical barriers like transportation or distance from the treatment facility or appointment times, not being able to get appointment times that conflict with work, work priorities and so forth.

And then I have been very interested recently in the sort of new domain of perceptions, negative perceptions of mental health care. I was actually surprised by some of the recent research that has looked at that and the high percentage of individuals who report having negative perceptions of mental health care, not trusting mental health professionals, feeling as if mental health care is not going to be effective.

And so, I do not know what to do about it exactly but I think that it opens the question of, you know, how do we better market mental health care.

And I think that some of the answers to that lie within the domain of integration with primary care, better peer-to- peer support because veterans are very responsive to their peers, in communication with peers, and family support also because the family also is critical often in helping the veteran get into care. So, it is not just peers but family members.

Chairman MURRAY. I think that the stigma issue that you talk about plays into the wait time. If you are reluctant to call anyway and ask for help and then you call and you cannot get help right away or you cannot get an appointment at a time that works for you, that just plays right into your own thought that this is not something that is acceptable.

Dr. HOGE. I agree completely.

Chairman MURRAY. Dr. Van Dahlen, first of all, thank you for everything your organization has done and continues to do for our veterans. Give an Hour and a lot of other organizations played really an important part in making sure that our veterans get access. So, we really appreciate what you do.

You mentioned that you do not have a relationship or you do have a relationship with the DOD but not with the VA.

Ms. VAN DAHLEN. Yes.

Chairman MURRAY. What is the barrier in establishing a relationship with them?

Ms. VAN DAHLEN. I do not really know. We have had many conversations and meetings; but unlike with the Department of Defense where there has really been an openness and an interest toward collaborating with community-based resources, there is clearly a belief in DOD that I have watched evolve over the last 6 years since founding Give an Hour that, a recognition that we cannot do it all from the military perspective, the military organizations. It has to be coordinated effort in communities because many of these veterans go home to communities where there may not be a VA or Vet Centers nearby.

And so, why not coordinate with the community mental health professionals whether it is fee-for-service or, in our case, mental health professionals who do not want to be paid. They want to give their time.

So, the Department of Defense seems to have moved in a cultural way, in a perspective that we need to look at and they are doing a lot of work. I have not had that experience in conversations with the VA.

Chairman MURRAY. Thank you very much. I am out of time. So, I will have to go to my second round.

Senator Burr, I will turn it over to you.

Senator BURR. Thank you, Chairman, and I am going to be brief and focus just with Dr. Washington but I would ask unanimous consent that all Members be allowed the opportunity to send questions to our witnesses today as part of the record because I think we could spend a half a day here quite honestly.

Chairman MURRAY. Absolutely. We will do that.

Senator BURR. Dr. Washington, very quickly, what are you told when you raise the barriers that you have painted for us to your management? What do they tell you?

Ms. WASHINGTON. They tell me we are working on it. We are developing a new blueprint for services, and that is usually the response. There is nothing really substantive given to me other than they are looking at it. They are aware of certain things, and then in some cases, there is flat out denial that there is an issue.

Senator BURR. You testified that there are mental health positions that, at the Wilmington Medical Center, have not been filled.

Ms. WASHINGTON. Yes.

Senator BURR. Let me ask you. In the last 2 years, how many positions have been filled?

Ms. WASHINGTON. The exact number? I could not tell you. But I know some positions once they were vacated were then eliminated. So, the exact number of how many are left vacant——

Senator BURR. Do you have any idea right now how many are open and how long they have been open?

Ms. WASHINGTON. I could not give you exact numbers.

Senator BURR. I think these are all things that we will follow up in detail. Again, I think it gets at the heart of the level of commitment to structurally solve the problem, and I hear from each one of our witnesses the most disturbing thing is that appointments still are the most difficult thing for a veteran, whether they are seeking mental health treatment or primary care. The actual appointment is the toughest thing for them to accomplish. Forget the fact that it may only be for the purposes of collection of records, and I think the Chairman and I will get into that with the Secretary if, in fact, we have got a little scam going on.

I thank the Chair.

Chairman MURRAY. Senator Akaka.

Senator AKAKA. Thank you very much, Madam Chairman.

Dr. Washington, first, thank you for testifying before us today despite your fear of retaliation. Enacting stronger protections so whistle blowers can come forward without fear of retaliation is one of my top priorities. I believe it is important to have many viewpoints so that we can continue to improve the services we are providing to our veterans.

In your opinion, what are the top two priorities that should be addressed in order to better treat veterans who need mental health care services?

Ms. WASHINGTON. I would say the top two from my perspective would be, first of all, getting them into care much more quickly. That seems to me, as I said in my testimony, that if you get them into services quickly and you get them in intensive services quickly, you can get the treatment, they can get the treatment that they need and then they can go on with their lives because ideally, I mean, that is the goal is for them to get better and to live their lives rather than having to come to the VA constantly for the rest of their lives.

So, it is definitely, you know, getting access to both mental health and medical care. Numerous, many numbers of my patients have extensive medical conditions because their PTSD was the result of a physical trauma as well.

I have had people who have serious back injuries and they are in chronic pain and they are not able to get the medications that

they need to treat those chronic conditions or any other treatments without a long delay.

So, I would say my top two things would be helping them to get quick appointments for both medical and mental health care.

Senator AKAKA. Thank you.

Dr. Hoge, left untreated many health conditions can lead to an increased risk of unemployment, homelessness, and suicide. Stigmas prevent some from seeking the mental health treatment they need. This has been a huge problem over the years.

DOD has also faced this issue; but according to the leaders I have spoken to, the situation is improving. My question to you is is the stigma situation improving amongst the veterans and can the VA leverage some of the DOD's successes to help further break down the stigma in the veteran community?

Dr. HOGE. I think stigma has improved; but because that is not the whole story, it has not led to the robust numbers that we would like to see in terms of utilization of services and access. So, it is not the whole story but they are clearly has been improvements in perceptions of stigma.

I think that looking at things, looking at PTSD, for instance, from the physiological and physical perspective and its relationship to combat physiology, how combat changes the way the body functions is important in destigmatizing this condition and treatment and also looking at it from the occupational warriors perspective so that when a veteran comes in for treatment or a servicemember comes in to treatment in DOD and they sit down with the health professional or mental health professional, they are not automatically, they do not automatically get the sense that they are being labeled as having a mental disorder when, in reality, their body is reacting the way it has been trained to react in a combat environment, if that makes sense.

It is a little bit long-winded response.

Senator AKAKA. Thank you.

Dr. Van Dahlen, I want to thank you and your staff for all that you do to support the mental needs of veterans. Your partnering with communities across the country to provide needed support is to be commended.

From your viewpoint, if there is one thing that we in Congress could do better to support the needs of veterans and their families, what would it be?

Ms. VAN DAHLEN. That is a big question. I really do believe that the answer, and there are some great efforts currently underway, the answer is in encouraging and sometimes perhaps using the power of the Congress to push where it is not happening.

Integration, coordination, collaboration. That is the way we are seeing forward in many communities that we are now working in. There are some good efforts underway nationally to do just that. And it requires the VA and DOD and Department of Labor, those agencies have critical roles in those communities but it is at the community level because that is where people live.

Senator AKAKA. Thank you.

Mr. Roberts, part of your organization's focus is to ensure injured servicemembers stay connected with one another through both a

peer mentoring and robust alumni program. You mentioned peer-to-peer programs.

How important is it for veterans in your programs to be able to connect with other veterans through peer-to-peer programs?

Mr. ROBERTS. In the survey that I mentioned when I spoke, the biggest response I got back of what these individuals want and what they think is effective for them is that peer-to-peer support and it is easier. I have run a program called Project Odyssey since 2007 which is basically a peer-to-peer recreational outdoor retreat with a therapeutic aspect to it.

And that Loyd, who is behind me, Loyd Sawyer, whose wife testified on the 14th, was a benefactor of that program. I think Loyd can to speak the fact that being around other peers and being able to talk openly and honest about what is going on back home and how they are affected by this PTSD and how their families are affected makes a great impact on it. It also encourages many of them to get that treatment to get better because we do put peers that we have trained that are being successful with their recovery, we train them, give than 8 hours of training, put them into our programs, and they are out there basically to be that peer mentor for those young men and women who are still struggling.

Senator AKAKA. Thank you very much.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you.

Senator Isakson.

STATEMENT OF HON. JOHNNY ISAKSON, U.S. SENATOR FROM GEORGIA

Senator ISAKSON. Mr. Roberts, thank you very much for your service to our country. Have you had any experience with the Federal Recovery Coordinator Program at VA that has been established for severely wounded warriors?

Mr. ROBERTS. We have many experiences with them, yes, sir.

Senator ISAKSON. Is it improving the coordination of care to veterans?

Mr. ROBERTS. From the messaging I am getting, yes, it is. I think to the credit of the VA, the establishment of that program has begun to help. We are understaffed in terms of the number we need but that is a step, I think, in the right direction.

Senator ISAKSON. Have any of you others had experience with the Federal Recovery Coordinator Program?

Dr. Van Dahlen.

Ms. VAN DAHLEN. Just from hearing that it is a positive experience for veterans who access that. So, I would say the same thing as Mr. Roberts.

Senator ISAKSON. Dr. Van Dahlen, you mentioned the telemedicine or telehealth program you are initiating. Could you elaborate with regard to mental health how you deliver, what you are delivering? Are you delivering counseling? Are you delivering consulting? What are you delivering?

Ms. VAN DAHLEN. Yes. We are using that capability to do all of the services that we are now providing, and one of the things that I would like to say is that one of the ways that I think organiza-

tions like ours can really work collaboratively with the VA is to have our professionals providing education and information.

To the Dr. Hoge's point, the issue is to try to change the perceptions, change the stigma, change the expectations. If you harness the mental health professionals across the range—VA, community-based—you can help put information out to communities, to faith-based leaders, to schools about these issues, about the needs, about what is available.

So, in terms of what we are going to telehealth we will be providing direct service for folks in rural communities who cannot access a clinic or mental health professional. We will be providing consultation to schools and to employers and to other primary care doctors or pediatricians who do not have access to a mental health professional.

So, we plan to use that technology. It is not the answer, but it is another tool to provide information, support, and treatment where we cannot get live providers out to those areas.

Senator ISAKSON. Yeah. That makes a very good point. Interestingly enough, on the stigma issue, which is a huge issue, and another national problem which is illiteracy, we found that by delivering via the Internet Web-based literacy training in the State of Georgia we have greatly improved the number of people coming in to learn to read and learn to write because the stigma is removed since they are dealing with a computer versus a human being. And I would think telecounseling would be somewhat the same thing.

Ms. VAN DAHLEN. Actually, there have been some interesting initial reports that this generation of servicemembers, because they have grown up with technology, often feel more comfortable having that telehealth conversation.

It is an issue of training some of the providers who are older that it is OK to engage in that kind of relationship. But I think we are moving again toward finding no one-size-fits-all solution, but for this generation I think that can be a very important tool to add.

Senator ISAKSON. I am a little bit miffed with the fact that DOD is very engaged with your program and VA has been distant. I guess distant is the right word; perhaps not engaged any way.

Ms. VAN DAHLEN. There have been, I would say at the local levels there had been some wonderful folks through the VA who have found out about what we do, and we work together. But on the national conversation, it is not happening yet; and hopefully that will come. It is what we want.

Give an Hour was built to offer those services in whatever way they make sense to assist the efforts with the VA and DOD. That is the purpose.

Senator ISAKSON. Madam Chairman, I think we ought to have an engagement with the VA on that very subject because if there are community-based free services, mental health services for veterans, with the number of veterans coming back from Iraq and from Afghanistan we can use every professional available for our veterans, and coordination of that would be very helpful.

Thank you, Madam Chairman.

Chairman MURRAY. Thank you very much.

Senator Tester.

Senator TESTER. Well, thank you, Madam Chairman, and I want to thank all of the folks for testifying today. We will start with you, John. I, too, want to echo my thanks for your service to the country, and you are an incredible asset in this particular unit because you have been there and done that, and obviously had some successes. I think that your perspective is critically important.

I want to talk about peer-to-peer for a second and vet-to-vet.

Mr. ROBERTS. Yes, sir.

Senator TESTER. From your perspective, you talked about the retreat that was done. There is a program in Montana called Healing Waters. We take fishermen out and do a little fly fishing. It is a little different than what you visualize sitting in a room and talking.

But how can we enhance peer-to-peer or vet-to-vet stuff? But more importantly, how can VA enhance it?

Mr. ROBERTS. I have got to tell you that most of my comments probably sounded very negative toward the VA. I was a VA supervisor. I know there are a lot of good people in that system that want to do the right thing.

One of them, Dr. Batres, with the Readjustment Counseling Services, actually partnered with me on Project Odyssey when we started in 2007, which provided culturally competent counselors from the Vet Centers to go on these retreats.

Because it is a little bit out-of-the-box—not sitting in a room around, you know, a circle with a bunch of chairs pouring out your feelings—it was actually taking the counselors out, being engaged with the warriors on an active level where they were doing an activity, whether physical or whatever we were doing, and then at night having that trust built up where you could sit around the fire and just kind of talk about everything.

And the individuals did not know they were actually in a group session, but they were. I think it is being creative. I think it is engaging in these warriors that are being successful.

Myself, I am very proud of the fact that I overcame PTSD; and if my wife was here, she could testify how bad I was. Just like Andrea could testify how bad Loyd was or is. It impacts the families.

Honestly, it is doing something more than my experience with the VA. I went for one appointment. I got screened, and the doctor sat me in a room. He had no military experience and had a very short time to talk to me; he did not want to know what was going on.

My marriage at that time was falling apart. I was self-medicating like many of the warriors I treats or I help today. And quite frankly, he wanted to teach me how to breath. And I thanked him kindly, left the room, and never went back for treatment.

I was lucky. I had another Marine reach out to me that I was injured with and kind of pulled me out of the gutter. I think that it is a critical part of the recovery process, having that support and having those individuals that have been successful dealing with it.

And not every treatment is perfect. You cannot put everybody in a box and expect one treatment to fit everybody.

Personally, I am not a believer in medication. That may work for others—I cannot say what works or does not work—but I think the treatment has to be tailored to the individual, so they are going to

go through trials and errors. Sometimes things are going to work, but if it does not work they have to try something else.

Senator TESTER. I appreciate the perspective. I can tell you that I do not think any of us around here think the VA are bad people. They are doing the best I think they can do but there are some areas they can do better.

You actually made some comments during your opening remarks that I hope the VA can respond to, access to follow-up care, the fact that we are doing medication management.

I mean, the days of warehousing folks who have mental health problems should have been long, long, long gone. When I see that kind of structure, sure there needs to be some medication management, but that should not be the entire emphasis of the visit.

I want to talk with either one of the two docs. In the private sector, and I do not know if you guys can answer this or not, but as far as highly qualified mental health professionals that are out there, the information that I have got is that there is not a lot of folks out there, not enough, let us put it that way.

And if that is your own opinion, do you have any ideas on how we can enhance it so that we can get more highly qualified folks out there from your perspective being in the business?

Dr. HOGE. I mean, clearly, there is a shortage of mental health professionals nationally that is also in DOD and VA. And so, you know, more training of mental health professionals, more programs to train mental health professionals might be of benefit.

I think there are ways also in the discussion, for instance, of peer-to-peer counseling to leverage the skills of mental health professionals in ways that have partnerships with lay peer-to-peer counselors that may extend mental health professionals.

And so, for instance, there may be ways to incorporate peer-to-peer mentoring and counseling into traditional mental health clinics within the VA structure, within DOD and other clinics.

So, short of going out and training and hiring more mental health professionals, there may be ways to extend the treatment in other ways through other types of professionals that work with the mental health professionals.

Ms. VAN DAHLEN. I completely agree, and there are several programs now underway that Give an Hour is partnering with that are peer-based programs and what someone taught me very early on who is a vet, who had developed a peer-to-peer, you know, peer-lead, clinician-guided, to have a clinician involved to assist, to provide the mental health information can really facilitate the delivery of peer-to-peer support. So that is one.

And what we are finding in the communities we are very involved in—Fayetteville, NC, and the Hampton Roads area of Virginia in a community-based effort—the mental health professionals want to be trained. And there are so many great tools; the VA has many, as do others, like DOD.

It is working, again collaboratively, to create systematic programs to offer the kinds of training online, in workshops. It is out there. It is poorly coordinated. There are good tools but they are not available.

But clinicians want it. Our providers when we surveyed them they do not want to join TRICARE. They do not want to be paid

but they want training. They want the cultural information they need, the appropriate training to give the good services.

So, they are there but it is packaging them and providing them.

Senator TESTER. Thank you.

Thank you, Madam Chair.

Chairman MURRAY. Senator Boozman.

STATEMENT OF HON. JOHN BOOZMAN, U.S. SENATOR FROM ARKANSAS

Senator BOOZMAN. Thank you, Madam Chairman. And we appreciate you all being here very much.

Mental health is just a huge problem. We can go to, I think, county jails all over the country where you have people who have tried to commit suicide, that literally there is no room in the State hospitals. It is just a tremendous problem.

We can look at the suicide among our youth, and then we have this significant problem among the military. You know, we have created this problem. So, it is just something. It is just a very, very difficult problem.

I would like to talk a little bit more about the peer- to-peer in the sense that, you know, your testimony is such that, you know, the Marine helped you and where would you be without that.

So let us talk a little bit about how, you know, how we can do a better job of instituting that. I am familiar with the Rivers to Recovery Program. We actually have a dog training bill in the sense that we have a lot of dogs that need to be trained, using veterans to interact with that, and, you know, the fact that you are caring about something else.

And I heard a story of a guy that had amputations, was laying in a hospital, and a golf pro told him that he was going to teach him how to play golf, and the guy who was actually suicidal laughed at that thought inside. And sure enough, it is very frustrating because, you know, he could thrash me without any problem at all now.

So, I think those are great things. The question is, from your perspective, you know, recognizing that again this is not just a problem with the VA. I mean, we have got, you know, this tremendous mental health problem going on throughout the country especially in rural areas which is a great concern.

Much of Arkansas, much of our country, you know, especially the National Guardsmen, you know, come from small communities, go back. They do not have the resources even of being with their buddies.

You know, it is not like being overseas or, you know, being theater. You come back as a group. These people come back and they are just dispersed to the small towns they are from.

But I guess what I would like is some suggestions. Most of the studies that we have seen are based on medication and, you know, how do we think outside the box perhaps and maybe do things a little differently.

Go ahead, sir.

Dr. HOGE. If I could make a comment. One of the most feeling components of what happens inside that mental health office, mental health treatment office is narration, the ability to narrate the

events that happened downrange in combat and really talk through the details and connect with the emotions.

Often times, there is underlying issues of grief, for instance, and the loss which have never been dealt with, just as one example.

And there are also some interesting data on that narration, as you mentioned, one size does not fit all. Each individual, you know, each individual has a distinct way in which they need to go through their readjustment process.

Sometimes there are some good data, for instance, on written narration. There is some very interesting data from European investigators working with war-torn refugee populations where they train lay counselors to go in and do narrative therapy, life-narrative therapy, and achieve essentially equivalent results in recovery from PTSD.

So, I think that opens the door for narrative, you know, treatment strategies done by peer-to-peer, you know, lay peer counselors but supervised and coordinated and done in conjunction with traditional mental health professionals.

So, I think that would be one area that we could think outside the box among others. The other big area would be primary care, really integrating care within that primary care structure in a collaborative way.

Ms. VAN DAHLEN. Another piece that we should put out here is we know from studies, a really excellent study that was done a few years ago by civic enterprises that our veterans and their families, they volunteer at a higher rate. They come home and take continue to serve.

And I think we are not taking advantage of their desire to continue to serve, to take care of their own. So, if you want to think about thinking outside the box, here we have a population that those who are coming through programs like ours, like the VA, like others, if we, from the beginning, create almost an expectation but a need that they understand that if they make it through, then we want them to join an effort to become a peer support person.

I think we have a pool of ready-made folks who we could ask to engage in that kind of help for those who are coming behind them.

Mr. ROBERTS. It is hard to argue with both their comments. I think these young men and women do have still that service desire; and once they do come through the recovery and they are successful, do want to give back and want help others that are struggling still.

I like the peer-facilitated group that has to be supervised. That is kind of the key, that supervision is key to it.

Senator BOOZMAN. The Marine that you mentioned.

Mr. ROBERTS. Yes.

Senator BOOZMAN. What was his role? Was he a friend or an acquaintance, or how did you come into contact him?

Mr. ROBERTS. We served together. We were blown up together, and he was actually, at that time, being successful in his recovery. I, at that time, was more severely injured and quite frankly struggling and not doing very well. And he happened to reach out to me and pulled me back up and got me on the right path.

Senator BOOZMAN. Which would be hard to replace.

Mr. ROBERTS. It is very hard to replace. I had more trust in that individual than I did in a VA mental health clinician. So, yeah, there was a lot of trust built up and somebody I knew I could talk to and not be judged for what I was doing.

Senator BOOZMAN. Thank you, Madam Chairman.

Chairman MURRAY. Thank you to all of our panelists. I think your insight is very helpful to our Committee as we continue to move forward on this critical topic.

I do have a number of Senators who want to ask additional questions. They will commit them to you in writing; and if we could get your responses that way, I would appreciate it.

We do have a vote that is coming up shortly. So, I want to get our second panel up here. Again, thank you to all of you. Would our second panel please come forward.

The vote has just been called so as the second panel comes up I would like all of us to go vote. We will come back and then we will hear the testimony and have a chance to ask questions.

[Recess.]

Chairman MURRAY. I am going to bring the Committee back to order here. Our Senators will be returning but I want to get this panel started. I appreciate everybody's patience.

I want to welcome representing the VA, Dr. Mary Schohn. She is the Director of the Mental Health Operations, Veterans Health Administration, Department of Veterans Affairs. She will be testifying today and is accompanied by Dr. Zeiss and Dr. Kemp.

So, Dr. Schohn, if you want to go ahead and begin your testimony.

STATEMENT OF MARY SCHOHN, PH.D., DIRECTOR, MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ANTONETTE ZEISS, PH.D., CHIEF CONSULTANT, OFFICE OF MENTAL HEALTH SERVICES; AND JANET KEMP, R.N., PH.D., NATIONAL DIRECTOR, SUICIDE PREVENTION PROGRAM

Ms. SCHOHN. Chairman Murray, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to appear before you to day to discuss the Department of Veterans Affairs' commitment to providing responsive, accessible, and effective mental health services that meet the needs of our Nation's veterans.

I am accompanied by my colleagues, Dr. Antonette Zeiss, Chief Consultant for Mental Health; and Dr. Jan E. Kemp, the National Mental Health Director for Suicide Prevention.

I also want to thank the first panel. We are pleased to hear of their recommendations to improve VA's mental health services. We agree with their suggestions and, in fact, have begun implementing many of them.

VHA takes seriously our responsibility for meeting the mental health care needs of veterans. For the past several years, we have focused on enhancing this care by improving both the availability and quality of our services.

As Chairman Murray noted in her October letter, we have written state-of-the-art policies, begun integrating mental health into

primary care, and created groundbreaking new programs to meet the needs of veterans.

Moreover, we have expanded our mental health staffing levels by almost 50 percent since fiscal year 2006. During this same time, VHA saw a 34 percent increase in the number of veterans receiving mental health care.

To extend our reach to veterans in rural or hard-to-reach places, we have expanded and continued to expand the use of technology, including the use of telemental health and mobile apps most recently.

We have recognized the essential role family members and friends play in each veteran's personal support network. To help spouses and other family caregivers address the many challenges associated with the transition from active duty, VHA has launched a spouse telephone support intervention and we have implemented the Coaching into Care Program to help family members in supporting veterans in accessing needed care.

The VHA's efforts to improve mental health care have been many and yet we are aware that there is still much more for us to do. To this end, we have implemented a set of near-term actions informed by the August 2011 query of field staff requested by this Committee.

Respondents to the query perceived deficiencies in performance measurement and mental health staffing, and expressed concerns about space shortages for mental health care. They also mentioned inadequacy of off-hour services and the need to balance demand for C&P and IDES examinations with the delivery of mental health services. Our action plan addresses each of these areas of concerns.

First, we are auditing mental health scheduling practices and using the findings from these to improve practices.

To ensure that appointments reflect veterans' needs and scheduling desires, we are developing a team-based staffing model that enables VHA to carefully monitor mental health staffing levels at business and facilities and to assess efficiency and value across the system.

We have strengthened the performance measures to provide us with information beyond timeliness. We have added measures to assess three additional things, access to follow-up care for veterans recently discharged from inpatient treatment, access to enhanced care for veterans at risk for suicide, and access to specialty appointments for the treatment of PTSD.

We continue to reach out to providers for their perceptions on problems and solutions in delivering the best quality mental health care. By the end of January 2012, we will have completed 10 focus groups on providers to help us better understand the concerns cited in the survey and to follow-up as needed.

As more veterans seek and receive mental health care and VHA augments staffing to provide their care, we have encountered space challenges. We have asked sites to update their facility-based base plans to address these challenges in both the short and long-term.

VHA's off-hour capability for mental health services depends on primary care availability, especially at our community-based outpatient clinics.

The Undersecretary for Health has commissioned a workgroup to review and develop a systemwide policy for off-hours clinic times and to report on these findings by tomorrow.

In addition, because C&P/IDES exams may be for many veterans their first introduction to VA, we want to ensure a positive experience and timely access to care.

To that end, VHA's Office of Mental Health Services and the Office of Disability and Medical Assessment have partnered to identify facilities highly impacted by these exams, and we have begun pilot programs to mitigate the issues.

We know that veteran demand for mental health care will continue to increase as our servicemembers return from deployment and discharge from service. We have done a great deal to address these needs and I promise you we will continue to do more.

I thank you for the opportunity to discuss our efforts. We are now prepared to answer any questions you may have.

[The prepared statement of Ms. Schohn follows:]

PREPARED STATEMENT OF MARY SCHOHN, PH.D., DIRECTOR OF MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Chairman Murray, Ranking Member Burr, and Members of the Committee: Thank you for the opportunity to appear before you to discuss the Department of Veterans Affairs' (VA) commitment to providing responsive and effective mental health services that meet the needs of our Nation's Veterans. In particular, I will address wait times for mental health appointments and implementation of our mental health policies. I am accompanied today by my colleagues, Antonette Zeiss, Ph.D., Chief Consultant for Mental Health; and Jan E. Kemp, Ph.D., National Mental Health Director for Suicide Prevention.

Let me state clearly at the outset that we take very seriously this Committee's concerns regarding needed improvements to VA's mental health care services. We are diligently and quickly working to make changes identified by this Committee and through our own review. We look forward to continued dialog and partnership with this Committee and Congress on our shared mission.

The Veterans Health Administration (VHA) places a high priority on providing timely, quality care to our Nation's Veterans living with mental health issues. While we have made marked improvements in the mental health services available to Veterans, we continue to experience rapid increases in demand. We have seen a 34 percent increase in the number of Veterans using VHA mental health services, from 897,129 Veterans in FY 2006 to 1,203,530 Veterans in FY 2010. During the same period, mental health staff levels increased by 47.8 percent, from 14,207 to more than 21,000.

In addition, VHA has been implementing major improvements for Veterans since 2006, including expanding the availability of telemental health services; establishing VA's National Center for PTSD Consultation Program available by toll free number (866–948–7880) or online to assist VA clinicians with questions about PTSD, its symptoms and treatment; developing, in collaboration with the Department of Defense (DOD), a mobile smartphone app for tracking and self-management of PTSD symptoms, the PTSD Coach, which has been downloaded over 30,000 times in over 50 countries worldwide and has been awarded the 2011 Federal Communication Commission's Chairman Award for Advancements in Accessibility; and launching a national messaging campaign, "Make the Connection," designed to connect Veterans and their family members to the experiences of other Veterans, and connect them with information and resources to facilitate the transition from service to civilian life. VA appreciates Congress' support, which enabled enhancement of these important mental health services.

In October 2011, the Government Accountability Office (GAO) issued a report on "VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access." GAO made no recommendations to VA in the report, and recognized the extensive efforts VA is making to increase access. The report stated:

> VA has implemented several efforts to increase Veterans' access to mental health care, including integrating mental health care into primary care. VA

also has implemented efforts to educate Veterans, their families, health care providers, and other community stakeholders about mental health conditions and VA's mental health care.

Moreover, VA recently received the results of a report for which VA had contracted with the RAND Corporation and the Altarum Institute to complete a "Program Evaluation of Veterans Health Administration (VHA) Mental Health Services." These results indicate that across the country, as of FY 2009 (the last date of data collection) VHA facilities reported substantial capacity for treating Veterans with mental illness, with reported substantial increases between original measurement and 2007. Capacity has continued to increase since the RAND/Altarum data collection as VHA transitions toward full implementation of the Uniform Mental Health Services Handbook. For example, they reported after-hours availability of mental health care at VA medical facilities at 81 percent, and our internal data monitoring show 100 percent of facilities having this availability in 2011.

In October 2011, the journal Health Affairs published an article referencing the RAND/Altarum study. The study authors claim that this is the largest and most comprehensive assessment of a mental health system ever conducted. The report, which was based on a review of administrative data from 2007, concludes that most quality indicators showed good care compared to privately insured mental health patients not seen in VA. While there are numerous differences demographically between the private plan patients and VA patients, this is the most comparable data source available. The demographic differences would tend to work against VA, which has a generally older, sicker, poorer population. However, on nine administrative measures used to evaluate important processes in mental health care, VHA performance on seven of these performance indicators is higher than that reported in the literature for non-VA providers. VA is not as good as non-VA care on the other two, but these are measures of care for Substance Use Disorder care patients. The RAND/Altarum researchers point out ways in which the population differences could bias results against VA, for example, saying, "Performance on the SUD indicators within VHA may lag private plan performance due to the significantly higher prevalence of SUD in our cohort (57 percent) than in the privately insured population (19.1 percent). The study's authors also noted that a major issue to further improve VA mental health services is to reduce variation across Veterans Integrated Service Networks (VISN) and facilities. VA agrees with this analysis and has made reducing such variation a major focus of our efforts. Despite the strengths and improvements noted in the GAO and RAND/Altarum study, we recognize we have much more to do. Put simply, our work to care for America's Veterans' mental and overall health can never stop and we must continually improve.

I want to provide you with a brief summary of the results of the query of VA mental health staff requested by Chairman Murray at the July 14, 2011, hearing titled, "VA Mental Health Care: Closing the Gaps." Then, I will discuss a set of actions VA is implementing to further determine what gaps still exist, and finally, the actions VA is taking to deliver measurable improvements in our mental health care for Veterans.

After the request from Chairman Murray at the July hearing, VHA queried selected VA front-line mental health professionals for their perceptions on the adequacy of staffing and resources to serve Veterans with mental health needs. To meet the Committee's deadline, VHA developed a Web-based query that was administered from August 10, 2011, to August 17, 2011. VHA queried 319 general outpatient mental health providers from each facility within five VISNs selected by Senate Veterans' Affairs Committee staff. A total of 272 professionals responded (a response rate of 85 percent). Approximately one-third (31 percent) of the respondents were social workers, about one quarter (25 percent) were psychologists, and a similar percentage were psychiatrists and nurses (22 percent each).

The Mental Health Query was not a formal survey, but rather an informal tool designed to provide a quick assessment of a small sample of provider perceptions. VHA views it as one step in its ongoing commitment to assessing and addressing providers' perceptions and needs. The survey recorded providers' perceptions relating to performance measurement, mental health staffing, space availability in medical and mental health facilities, off-hours mental health clinics, and balancing demand for Compensation & Pension/Integrated Disability Evaluation System (C&P/IDES) examinations. Specifically, many front-line providers believe that Veterans' ability to schedule timely appointments as measured by the VA performance system does not match providers' experience and that mental health staffing at their facility is inadequate. They also believe that space shortages, inadequate off-hour clinic availability, and competing demands for C&P/IDES examinations are barriers to providing access.

Based on these perceptions, VHA leadership has already taken a number of actions. Since the query was completed, VHA has:

- Disbursed $13 million in funding to hire new mental health staff, which will provide telemental health psychotherapy services to areas where there is lower staffing, such as small community-based outpatient clinics.
- Hired additional staff for our Veterans Crisis Line and the Homeless Call Center, given that needs continue to expand for these services. In addition, VHA is aggressively filling existing vacancies for mental health staff.
- Implemented a Spouse Telephone Support Intervention as part of our Caregiver Support Program after Veterans participating in pilot programs reported decreased symptoms of depression and anxiety. The spouse support program builds spouses' ability to cope with the challenges that reintegration to civilian society can bring, helps them serve as a pillar of support for returning Veterans, and eases the transition for families post-deployment.

In addition, to supplement the preliminary survey findings, VHA will continue to reach out to providers for their perceptions on mental health care. By the end of January 2012, we will have completed 10 focus groups of providers to better understand their concerns. Based on the findings of the focus groups, VISN leadership will conduct a formal staff survey at every facility, and a sampling of their associated community-based outpatient clinics, to generate facility-based plans. Surveying will begin in the second quarter of FY 2012, and we expect we will complete the survey by the end of the third quarter of FY 2012.

As always, VHA's goal and focus is to have mental health services closely aligned with Veterans' needs and tightly integrated with VA health care facility operations. To this end, VHA leadership has developed and is implementing an action plan with aggressive timelines for completion. Some of the actions outlined above are part of this action plan. The results-oriented action plan pursues five key objectives: (1) improve the accuracy of the mental health scheduling process to improve our performance measurement system; (2) measure the adequacy of mental health staffing through development of a consistent national staffing model; (3) systematically identify and address space shortages in mental health areas; (4) increase off-hours access; and (5) balance the demand for C&P/IDES examinations. These actions have already been initiated, with deliverables scheduled throughout FY 2012.

To address mental health access, VHA has put in place a new four-part mental health measure that will be included in the FY 2012 performance contract for VHA leadership. This performance contract forms the basis for evaluation of VHA leadership, including VISN Directors. Thus, the measures in the performance contract define what leadership is accountable to accomplish, and the evaluation based on their performance defines various outcomes for them, including bonuses.

The new performance contract measure holds leadership accountable for meeting the following objectives:

(1) The percentage of new patients to mental health who have had a full assessment and started in treatment within 14 days of seeking an appointment.

(2) Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) patients newly diagnosed with Post Traumatic Stress Disorder (PTSD) receive at least eight sessions of psychotherapy within a single 14 week period;

(3) Follow-up by a mental health professional within seven days after discharge to the community; and

(4) Four visits within 30 days for any patient flagged as a high suicide risk.

We are combining these actions with the overarching mandate articulated in the VA strategic effort known as "Improving Veterans Mental Health (IVMH) Major Initiative" and VHA Handbook 1160.01, "Uniform Mental Health Services in VA medical centers and Clinics." VHA's actions prescribe mental health teams; staffing plans based on approved patient panel sizes; and measureable improvement of patient-centered outcomes for depression, PTSD, suicide, substance use, and mental health recovery. In addition, VHA recognizes that accountability for delivering improved performance rests squarely with VA facility and VISN leadership. VHA is using its management and oversight processes to ensure that all facilities and VISNs have appropriately prioritized the improvement of mental health care and are making measureable progress. A critical function of VHA Central Office and VISN oversight includes identification of facilities with high performance on mental health access and dissemination of high performing practices to other facilities and VISNs.

VA greatly appreciates Congress' continued support of VA's mission. VA has worked hard to increase Veterans' access to mental health services through non-traditional settings such as primary care and community living centers, community

outreach programs, and telemental health services. We have made significant improvements in the range and quality of services offered by providing state-of-the-art psychotherapy and biomedical treatments to cover the full range of mental health needs. We are pleased that these efforts have been recognized in recent external reviews by GAO and separately by RAND/Altarum study. As I said earlier, our work is and will never be complete. We must be focused on constant improvement and excellence. VA continues to implement Veteran and family education and is training other community stakeholders about mental health conditions experienced by Veterans. We remain committed and will continue to provide all services to meet the needs of our Veterans and to provide them the quality care they so richly deserve.

I appreciate the opportunity to discuss VA's ongoing efforts in delivering quality mental health care. My colleagues and I are prepared to answer any questions you may have.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. PATTY MURRAY TO MARY SCHOHN, PH.D., DIRECTOR, MENTAL HEALTH OPERATIONS, VETERANS HEALTH ADMINISTRATION, DEPARTMENT OF VETERANS AFFAIRS

Question 1. Section 304 of Public Law 111–163 required the Department to establish a program providing OEF and OIF veterans with mental health services, readjustment counseling and services, and peer outreach and support. This provision also authorized the Department to contract with community mental health centers and other qualified entities in areas not adequately served by VA. When asked about the status of this provision's implementation, the Department did not sufficiently respond to the question.

a. Please provide the Committee with an update on the Department's progress in implementing Section 304 of Public Law 111–163.

Response. An internal Veterans Affairs (VA) group supplemented by external members from the Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Services Administration (SAMHSA) and the Department of Defense (DOD) Office of Reserve Affairs is monitoring the implementation of this legislation. Please see Attachment A: Section 304 Elements, Plan, and Timeline; which provides the most recent update of each Section 304 element. Site visitor teams, comprised of a lead consultant from the Veterans Health Administration's (VHA) Office of Mental Health Operations (OMHO) and mental health subject matter experts from the Office of Mental Health Services (OHMS), Veterans Integrated Service Network (VISN) Mental Health Directors, Office of Homeless Programs, Program Evaluation Centers, Mental Health Research Centers, Centers of Excellence, mental health leadership from the field, and/or experienced mental health front-line providers are currently gathering site-by-site information on the implementation.

Readjustment Counseling Service's Vet Center Program also has some involvement with Section 304 of Public Law (P.L.) 111–163. A portion of this section requires the provision of, "readjustment counseling and services described in section 1712A of title 38, United States Code." The Vet Center Program has provided these services, without time limitation, to eligible Veterans since the program's inception in 1979. Furthermore, Vet Centers have been authorized, through the Secretary of Veterans Affairs approval, to provide the full range of readjustment counseling services, including working with families, to Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans and families since April 2003 (OEF) and June 2003 (OIF/OND).

ATTACHMENT A: SECTION 304 ELEMENTS, PLAN, AND TIMELINE

Attachment A
Section 304 Elements, Place, and Timeline

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Plan and Timeline to Implement Section 304 of P.L. 111-163

Element of §304	How VA Has Met This Requirement	Status
Required Services to Veterans of OEF/OIF:		
- Peer outreach services	The Vet Center Program has provided outreach services to this cohort since the Secretary of Veterans Affairs authorized the program to do so in August 2003. Currently, the Vet Center Program's 100 Veteran Outreach Specialists proactively contact their fellow returning Veterans at military demobilization sites, including National Guard and Reserve locations, and in the community. These individuals, all of who served in recent combat zones, provide information and referral to Vet Center services.	Currently being provided
- Peer support services	Vet Centers provide a full range of psychosocial services under the umbrella of readjustment counseling and are able to facilitate the Veteran-to-Veteran connection due to the high percentage of Veterans employed by the program.	Currently being provided
- Readjustment counseling	Vet Centers have been authorized to provide the full range of readjustment counseling services, including working with families, to Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND) Veterans and families since April 2003 (OEF) and June 2003 (OIF/OND).	Currently being provided

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- Mental health services	VHA provides a full range of general and specialty mental health services to Veterans of all eras including evidence based psychotherapy, residential treatment programs, and crisis intervention services.	Currently being provided
Services related to members of the immediate family to assist in:		
- The readjustment of such Veterans to civilian life	As stated above, Vet Centers have been authorized to provide the full range of readjustment counseling services, including working OEF/OIF/OND Veterans and their families since April 2003 (OEF) and June 2003 (OIF/OND).	Currently being provided
- In the case of Veterans who have an injury or illness incurred during deployment, the recovery of such Veterans	VA has a robust system in place to provide transition assistance and care management for wounded, ill and injured OEF/OIF/OND Veterans. Each VA medical center has an OEF/OIF/OND Care Management team that is highly experienced and specially trained in the needs of returning combat Servicemembers. These teams coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits. OEF/OIF/OND clinical case managers screen all returning combat Veterans to identify Veterans who may be at risk so VA can intervene early and provide assistance before the Veteran is in crisis. In addition to identifying prevalent	These services are currently being provided and additional training will be provided by mid-January 2012 to improve screening. The goal is that while screening Veterans for psychosocial risk factors, the OEF/OIF/OND case management team will include questions regarding mental health, substance abuse or other psychosocial issues associated with immediate

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	medical and mental health issues related to deployment, this screening includes the risk factors for psychosocial issues such as homelessness, unemployment, family issues and substance abuse. Severely ill or injured Servicemembers and Veterans are provided a case manager and other OEF/OIF/OND Servicemembers and Veterans are assigned a case manager, as indicated by a positive screening assessment, or upon request. Case management needs are identified early, a plan of care is developed, and follow-up is provided as long as needed. OEF/OIF/OND case managers are experts at identifying and accessing resources within the VA health care system and the local community to help Veterans recover from their injuries and readjust to civilian life. The OEF/OIF/OND case managers are well positioned to offer support and assistance to families in need of mental health services as well.	family members. OEF/OIF/OND case managers will receive training from the Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA) regarding use of their mental health provider locator available on the SAMHSA Web site. Training is set up for OEF/OIF/OND case managers who work with family members to assist them in identifying and accessing mental health and community resources for families and children that are not available through VA.
	A Caregiver Peer Mentoring Support program is under development in which new caregivers will be matched with experienced caregivers for support, guidance, and the sharing of experiences following similar paths in their caregiving journey. Caregivers interested in being a mentor will be registered as volunteers at their local VA medical center and complete an orientation program with the Caregiver Support Program. After orientation, caregiver mentors will be matched with an appropriate	VA will begin the roll-out of the Peer Mentoring Support program in January 2012.

	caregiver mentee with the expectation that they will contact each other regularly to discuss issues, provide support, and solve problems together. Mentors will receive ongoing support from the Caregiver Support Program including monthly calls with all of the mentors participating in the program to provide support and guidance for the mentors. **Caregiver Core Curriculum Training:** Caregiver Training and Education are an important component of VA's Caregiver Support Program. Family caregivers of eligible seriously injured post-9/11 Veterans are required to complete a Core Curriculum prior to approval for the Program of Comprehensive Assistance for Family Caregivers, which provides additional services and benefits to those eligible, including a stipend and health insurance, if the family member is not already eligible for health insurance under another program. The Core Curriculum is designed not only to ensure the proper care of the Veteran, but also to support and minimize the physical and mental health consequences of long-term caregiving on the caregiver and other family members. VA has contracted with Easter Seals to develop a comprehensive caregiver training curriculum to address these needs. The curriculum is offered in three formats: self-instruction with a workbook and CD/DVD, Web-based online course, or a classroom setting. The caregiver may choose the option which best meets their needs and	 As of December 6, 2011, 2,610 family caregivers have completed training; 731 family caregivers have completed training via the Web-based, online course, and 84 family caregivers have completed training via classroom training.

	learning style.	
- The readjustment of the family following the return of such Veterans	In addition to the services above provided by the OEF/OIF/OND teams, there are a variety of family programs available through Mental Health Services. These include: • Family consultation, family education and family psychoeducation for Veterans with serious mental illness. • Family education and training, brief problem-focused consultations, more intensive family psychoeducation, and marriage and family counseling. • The Support and Family Education Program (SAFE), which is an 18 session workshop for families of Veterans living with PTSD or serious mental illness . • The NAMI Family-to-Family Education Program (FFEP), a 12-week program developed by the National Alliance on Mental Illness and taught by trained family members (peers). • Talk, Listen, Connect: Deployment, Homecoming, Changes, which is a joint VA-Department of Defense (DoD) and Sesame Street Workshop bilingual educational outreach initiative. • Integrative Behavioral Couples Therapy (IBCT)	Although all of these services are currently being provided, availability varies across the VA health care system. A memorandum has been sent to the field to remind them that these services are authorized and should be provided on an ongoing basis. The current Mental Health Operations site list Check List will be revised to include these services, and we will assist sites on an individual basis to implement these services if they are not already in place. This fiscal year, training will be available to VA clinicians in Behavioral Couples Therapy (BCT) for PTSD and Substance Use Disorders. VA tracks the number of family

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		services provide. In FY 2008, more than 41,000 unique Veterans received family services and this has increased to more than 55,000 in FY 2011.
Contracts with Community Mental Health Centers and Other Qualified Entities	Authority for contract care already exists to provide mental health services to Veterans who are remote from VA services. In the absence of accessible peer outreach services, peer support services, and readjustment counseling services, Veterans Integrated Service Networks (VISN) will utilize these contracting options and explore alternative opportunities in surrounding communities, utilize telehealth options, or encourage the use of online applications and options.	Beginning with the memorandum to the field listed above, reminders to VISN leadership about the need to identify and utilize these options will be provided on an ongoing basis. This item will also be added to the Mental Health Operations Check List. VA will assess the local need for these contracts in light of the plans that are in place, and will identify any additional needs through site visits this year. All sites will be visited by the end of FY 2012. Technical assistance will be provided to those sites needing to develop contracts.
Availability of Community Services and Referrals	VA is working with SAMHSA to identify community-based referrals, resources, and options for Veterans and family members to access these referral services. Developing system-wide solutions to this issue has been difficult, but VA is building a Web-based resource directory populated with available options for use by	VA anticipates having a model that we can test in approximately 3 months; and will complete this referral project by June 30, 2012.

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	OEF/OIF/OND coordinators, social work staff, and other VA providers to ensure that appropriate referrals for care are made.	
Training of Veterans for Provision of Peer-Outreach and Peer-Support Services	Staff have been added to programs which provide ongoing peer outreach and peer support through VA's Office of Mental Health Services. In 2008, there were 127 staff. By the end of 2010, there were an additional 237 as well as 130 training volunteers. To increase these numbers, VHA plans to finalize a national contract with a not-for-profit mental health organization to provide such training to VA staff. Vet Centers provide their own staff training on peer-related issues and will not be included in this contract. VHA-contracted community mental health providers that employ Veterans providing peer outreach and peer support services will also require training of those peer Veterans.	A complete package of contracting documents was sent to Contracting from the Office of Mental Health Services on November 25, 2011. The packet has been assigned to a procurement specialist, who will review it to ensure that it is complete. VHA anticipates the Request for Proposals will be placed out for bid in 4th Quarter FY 2012.
Training of Clinicians for Provision of Services	VA medical centers currently do outreach to community providers to educate them about Veterans and mental health issues. Outreach efforts include (but are not limited to) expanding knowledge of Veteran mental health issues to college and university campuses, supporting organizations serving Native Americans, working with Veterans involved in the criminal justice system, and improving connections with community homeless programs. Notable among these efforts is VA's suicide prevention program which includes collaboration with community providers.	Currently being provided.

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	For contracted community mental health care providers, Web-based training currently exists (such as the Post-Traumatic Stress Disorder 101 series) and will be augmented by training on best mental health care practices developed by the Center for Deployment Psychology and training on military culture that is being developed as part of a joint effort between the Center for Deployment Psychology and VHA.	Augmentation will be provided as developed throughout FY 2012 with anticipated completion by the end of the fiscal year.
Early identification of Veterans and families needing services	As part of the implementation plan of Section 304, VA's Planning and System Support Group has created VISN level maps that identify the location of enrolled and non-enrolled OEF/OIF/OND Veterans and the travel distance for them to existing VA medical centers, Community Based Outpatient Clinics, and Vet Centers. These maps can be used by VISNs for planning purposes. We are also creating a list of current Guard/Reserve members that are nearing the end of an active duty phase in order to provide outreach to them and their families about services. This is a collaborative effort with the DoD Office of Reserve Affairs.	Maps will be rolled out to facility staff no later than February 1, 2012. Specific guidelines on how to use these maps in the strategic planning process will be developed and disseminated to the field with the maps. We anticipate completion of this list by March 2012. The list will be provided to OEF/OIF/OND coordinators and Vet Center staff. Outreach strategies using the list will include mailings and phone calls to invite Veterans and their families to specific events and to encourage them to come to VA medical centers and Vet Centers for services. A specific plan for the use of this

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		information will be developed by March 1, 2012.

b. According to Dr. Kemp, VA is in the process of providing training to train more "peer type support counselors." Please provide more details regarding this effort.

Response. For each of the past 3 years, VA has supported the certification process for VA Peer Support Technicians. In fiscal year (FY) 2012, OMHS and OMHO will be working with the VHA Business Office and the VHA Contracting Office to award a contract to train Veterans to be peer support specialists by a single not-for-profit

organization, as directed by section 304(c) of Public Law 111–163. Contracting received the materials for the contract at the end of November. We anticipate being able to award the contract no later than the fourth quarter of FY 2012. The Contractor shall provide the required labor and materials to develop and present a peer support specialist training and certification program for VA employees nationwide. The contract will require Peer Support Certification Training (including didactic, experiential, and multimedia modalities) covering the 34 competencies VHA has designated as required for peer support staff. The training for the competencies that do not require the face-to-face experiential modality may be provided through in-person training or through completion of workbook materials, manuals, or online learning conducted prior to the experiential training. The Contractor will also demonstrate that competencies and skills have been mastered through both demonstration and written testing.

Question 2. According to the RAND study entitled "The Cost and Quality of VA Mental Health Services," evidence-based practices were reported as being widely available throughout VA, but the Department's records did not demonstrate that they were being widely delivered to veterans. What should the Committee make of this disparity and what actions is the Department taking in response to the report?

Response. There are straightforward explanations for the apparent discrepancy between the RAND study and VA self-reported data. VA survey and administrative data support the RAND study finding that evidence-based treatments for mental health disorders are widely available throughout VA. VA survey and administrative data also agree with the RAND study finding that these treatments are not currently delivered to all of the Veterans who could potentially benefit from them.

One reason for the apparent discrepancy between treatment availability and delivery is that delivery of evidence-based treatments for mental health requires substantial teamwork between a patient and his or her clinicians and health care system. Having an evidence-based treatment available is a first step, but for that treatment to be fully delivered, the patient must be made aware of the available treatment, be motivated to try it, and be able to navigate logistical barriers to attend or adhere to treatment. Moreover these conditions must continue to be met over the course of care to ensure that a full dose of treatment is obtained. For example, a patient might be motivated and logistically able to attend evidence-based psychotherapy sessions for major depression while suffering from severe depression and unemployment, but early treatment response and a job offer might reduce motivation and make it more difficult to continue attendance to obtain a full course of therapy.

Studies of patient behavior within and outside VA indicate that, even when evidence-based treatments are available, only a subpopulation of patients with relevant diagnoses will use and complete these treatments. Even in carefully selected cohorts of interested patients in clinical trials, where patients are closely tracked and typically provided incentives and assistance to complete the trial treatments, patient adherence to evidence-based mental health treatments is far from perfect. For example, in a large randomized clinical trial of psychotherapy for depression, 23 percent of patients who began psychotherapy did not complete the 12 week treatment program (Arnow et al., 2007). Similarly, a detailed longitudinal study of patients receiving treatment for obsessive compulsive disorder found that among those whose clinicians recommended a course of evidence-based cognitive behavioral therapy, only 74 percent initiated treatment, and only 21 percent completed a full course of the treatment (Mancebo et al., 2001). Patients also do not consistently use their medications even after receiving prescriptions. For example, estimates of medication nonadherence for depression and bipolar disorders range from 10 to 60 percent (median: 40 percent), and attitudes and beliefs have been shown to be as important as side effects for determining adherence (Pompili et al., 2009).

Given these difficulties in motivating patients to use and adhere to evidence-based treatments, VA expects a disparity between available treatments and their use. Knowing that patients are likely to have difficulty with motivation and adherence to recommended treatments for mental health problems, VA recognizes the importance of creating care systems and encouraging patient-provider interactions that increase patient motivation and facilitate adherence to treatment. VA has designed programming to be more accessible (e.g., offering evening or weekend hours, care via telemedicine, providing transportation assistance), provided reminders or organizers for Veterans, and trained staff in communication techniques that improve motivation (e.g., motivational interviewing or message framing). VA has also created performance measures that assess success in 1) getting patients to try evidence-based psychotherapy and pharmacotherapy, and 2) getting patients to complete a substantial course of treatment.

These measures have spurred projects across VA to improve use of mental health services and highlighted the need to address patient motivation and adherence in health care delivery. For example, VA Palo Alto implemented a program to train primary care providers in motivational interviewing techniques that have been shown to encourage behavior change and treatment engagement in numerous clinical trials, and VA Portland has implemented a telepsychiatry program to allow patients to follow up with mental health providers without leaving their homes. OMHO is currently identifying promising programs through their site visits and program evaluation and will disseminate these interventions to other facilities.

Another significant issue that contributes to the low rates of documented delivery is a lack of standardized methods for recording information about use of evidence-based practices (EBP) in the VA electronic health record and administrative databases. The RAND report states "Documented delivery of EBPs in the medical record and administrative databases is infrequent, even when they are reported to be available." Because of lack of standardized documentation methods, these services may not be accurately identified in program evaluations even when they do occur.

VA administrative databases rely on clinician coding using standardized procedure codes. These codes indicate only that patients received, for example, some sort of psychotherapy. They do not indicate what was discussed during the session and whether the session utilized evidence-based procedures or content. Moreover, these codes may not be consistently entered. While clinicians consistently enter notes about patient encounters into the electronic health record, these notes often focus on patient symptoms or concerns and treatment plans and frequently do not include information about the techniques, processes or manual treatment content used during the session. To improve documentation of use of evidence-based psychotherapies in medical record and administrative data systems, HVA's OHMS is creating psychotherapy session note templates and information technology solutions to help clinicians consistently document their use of evidence-based psychotherapies and program evaluators accurately track use of these treatments.

Arnow BA, Blasey C, Manber R, Constantino MJ, Markowitz JC, Klein DN, Thase ME, Kocsis JH, Rush AJ. (2007) *Dropouts versus completers among chronically depressed outpatients*. Journal of Affective Disorders 97 (2007) 197–202.

Mancebo MC, Eisen JL, Sibrava NJ, Dyck IR, Rasmussen SA. (2011) *Patient Utilization of Cognitive-Behavioral Therapy for OCD*. Behavior Therapy 42 (2011) 399–412.

Pompili M, Serafini G, Del Casale A, Rigucci S, Innamorati M, Girardi P, Tatarelli R, Lester D. *Improving adherence in mood disorders: the struggle against relapse, recurrence and suicide risk.* Expert Rev Neurother. 2009 Jul;9(7):985–1004.

Question 3. In the Department's query of mental health professionals almost half of the providers reported that the lack of off-hour appointments is a barrier to care. However, the Department claims that after-hours mental health care is available at all VA medical facilities and large CBOCs. The Department also claims that evening hours are less preferred by veterans compared to weekend or early morning availability.

a. Please explain the disparity between the provider responses and the Department's assertions.

Response. The sampling methodology of the query of mental health professionals was developed to identify concerns of frontline providers in response to the Senate Veterans' Affairs Committee (SVAC) request. However the methodology was not sufficiently rigorous to provide an estimate of the size of the problem, or to identify where access problems are occurring. VHA administrative data provides specific information about the location of off-hours care for mental health and shows that this is available as required at facilities and large community-based outpatient clinics (CBOC). The data also showed that medium to small CBOCs are not routinely offering off-hours care.

VHA did not mandate off-hours care for these smaller CBOCs, as there is often limited logistical support for off-hours care. However, the newly developed Extended Hours Access for Patients policy, which requires facilities to use local data on utilization, no-show, and cancellation rates to determine which extended hour option(s) best meet the needs of the facility's patient population, strongly encourages both primary care and mental health to provide services in these clinics during extended hours.

b. Additionally, please describe how the Department will ensure that the off-hours care it provides will be most responsive to the preferences of veterans.

Response. Based on the query data and concerns, VA's Under Secretary for Health commissioned a workgroup to expand access to off-hours care, including primary

care. The workgroup looked at the administrative data of use of off-hours care and gathered additional information through discussions with Veterans. Data showed that in-person extended hours were most heavily used in urban areas; extended telehealth hours were more frequently used in rural areas. No-show rates were highest for clinics schedule after 4:30 p.m. and were lower for clinics scheduled before 8:00 a.m. and on weekends. Veteran feedback was mixed, citing concerns about driving at different times of the day, the need for consolidating all visits into one trip, availability of parking, and so on. Given the wide variety of feedback, much of it site-specific, the new Extended Hours Access policy requires facilities to use "local data on utilization, no show and cancellation rates to determine which extended hour option(s) best meet the needs of the facility's patient population."

Question 4. Testimony from the hearing's first panel indicated that scheduling evidence-based psychotherapy treatment sessions at short and regular intervals is necessary for it to be effective. Is VA able to schedule mental health appointments according to the frequency the treatments prescribe?

Response. VHA Handbook 1160.01, Uniform Mental Health Services in VA medical centers and Clinics requires that facilities have capacity to provide these therapies and that Veterans have full access to evidence-based psychotherapy (EBPT) services "as designed and shown to be effective." VA is not able to precisely track specific wait times for EBPTs and how they may influence Veteran dropout of therapy as the Current Procedural Terminology codes used for tracking health care services do not distinguish types of psychotherapy, nor do they provide information about the number of therapy sessions received as compared to the number recommended within a given therapy protocol. OMHS has developed and is nationally disseminating documentation templates for the EBPTs that enable precise tracking of EBPT delivery and treatment completion, as well as facilitate documentation of session activity, promote fidelity to therapy protocols, and capture data elements to help track more detailed information about participation in evidence-based psychotherapy activities than is available through standard encounter form data. The templates have been piloted at several facilities and are scheduled for full system deployment in FY 2012.

A national survey of VA facilities evaluating the extent to which these therapies are provided indicated that all facilities are providing Cognitive Processing Therapy (CPT) or Prolonged Exposure (PE) Therapy for PTSD, and 98 percent of facilities were providing both of these therapies, which have been found to be equally effective. Survey results further indicate that capacity to provide these therapies varies throughout the system. To address variations in capacity, OMHS, in coordination with OMHO, developed additional national guidance on how to deliver EBP with the appropriate level of intensity and session frequency that has been shown to be effective. In addition, VA's national competency-based staff training programs in CPT and PE Therapy implemented a targeted training approach this FY 2012, placing important focus on sites that have fewer trained staff to ensure adequate numbers of trained staff are available.

VA also appointed a Local Evidence-Based Psychotherapy Coordinator at each VA medical center to serve as a champion for EBPTs at the local level and to help establish local clinical infrastructures necessary for successfully implementing EBPTs at the local level. VHA has also developed a performance measure that evaluates sites on their ability to deliver a minimum of 8 sessions of psychotherapy within a 14-week period for OEF/OEF/OND Veterans with PTSD.

VA is promoting implementation of these therapies through telemental health. Evidence-based psychotherapy for PTSD using telemental health offers an opportunity to overcome physical and other access barriers (e.g., physical distance, transportation costs and difficulties, job responsibilities) to initial and ongoing participation in evidence-based psychotherapy. Funding has been provided to the field to place approximately 100 EBPT for PTSD Telemental Health Providers at carefully selected sites throughout the system. Moreover, VA has developed an EBPT for PTSD Toolkit to help program managers and front-line staff to implement these services. An all-day workshop on the delivery of CPT and PE via telemental health was conducted at VA's national mental health conference in August 2011.

Question 5. What new quality assurance measures will VA implement regarding mental health appointments to account for wait times, appropriate types of care needed, and ability to see the same provider to encourage good patient-provider relationships?

Response. VA is committed to developing quality measures to help ensure that Veterans are able to receive timely access to mental health care as well as to developing measures to ensure that Veterans have continuity in their same provider(s) throughout their course of mental health treatment. During FY 2012, the Network

Director's Performance Plan added a composite of five measures of behavioral health access. It includes a measure to monitor timely access among Veterans initiating specialty outpatient care for PTSD. The measure will track the percentage of Veterans seen for a new appointment to initiate PTSD treatment within 14 days of their desired date. This measure complements the following other access measures in the composite (1) completion of a comprehensive mental health evaluation within 14 days of an initial visit, (2) follow-up within 7 days after discharge from an inpatient psychiatry hospitalization, (3) frequent contact and follow-up during the 4 weeks after identification of risk for suicide, and (4) engagement in sufficient intensity of evidence-based psychotherapy for PTSD among returning Veterans.

During FY 2012, a major implementation effort continues to identify the Mental Health Treatment Coordinator (MHTC) for each Veteran receiving mental health services. Over the course of mental health treatment, Veterans may receive care from a variety of clinicians. The MHTC role is intended to ensure that each Veteran has continuity through his or her mental health care and its transitions. Having a MHTC assigned ensures that each Veteran can maintain an enduring relationship with a mental health provider who can serve as a point of contact, especially during times of care transitions. Planned release of software enhancements in the 2nd Quarter of FY 2012 will facilitate the process of identifying and tracking the assigned MHTC for each Veteran. Currently, implementation is being tracked through electronic record review, but the capacity to aggregate information electronically is anticipated later in the fiscal year as sites shift to utilizing the new software tool. Decisions about clinically appropriate care are also documented in the Mental Health Suite (MHS) Treatment Planning software being implemented nationally in FY 2012. The software will systematize individualization of care and facilitate comprehensive care planning.

Question 6. Dr. Charles Hoge estimated that, in 2010, only 20 percent of the veterans who needed PTSD specific treatments were effectively reached by VA.

a. What role do waiting-times and scheduling difficulties play in veterans dropping out of treatment?

Response. Dr. Hoge's estimate, in his article of August 3, 2011 in the Journal of the American Medical Association, estimates that, "* * * current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment." However, that estimate is based primarily on extrapolations from published, randomized, controlled trials, not from actual VA evidence. Further, he assumes that the 50 percent of OEF/OIF/OND Veterans who seek VA care are representative of the larger population of Veterans. However, VA knows from data on those who have completed the Post Deployment Health Reassessment (PDHRA) process that Veterans who report mental health concerns on the PDHRA are much more likely to come to VA for health care than those who do not report mental health concerns. Thus, the 50 percent he cites (actually currently 53 percent) who come to VA include a majority of those who are likely to seek mental health care.

This is supported in VA's data. For example, 28 percent of those who seek VA health care have at least a possible diagnosis of PTSD, compared to 15–20 percent estimated for all military personnel who have combat experience, in the study of OEF/OIF/OND Servicemembers and Veterans by RAND. Further, in VA's annual review of mental health services actually delivered, of the 408,142 OEF/OIF/OND Veterans who received some VA care in FY 2011, 99,610 had at least one visit recorded with a PTSD diagnosis. Of those, over 98 percent (a total of 94,414 individuals) were actively involved in VA mental health care during FY 2011.

At another level, VA shares Dr. Hoge's concern. Although VA is serving a large and increasing proportion of those Veterans who need PTSD specialty care, Veterans are not always able or willing to participate in a full course of evidence-based treatment. VA continues to strive to make such services more readily accessible, as detailed in the following responses. Such efforts will continue and expand in FY 2012. For example, in addition to the scheduling efforts documented below, improved access through expansion of delivery of evidence-based psychotherapies for PTSD via telemental health is already underway. VA is fully committed to constantly striving to improve on the extensive mental health enhancement efforts already made in VA.

In addition, waiting times and scheduling difficulties are two important considerations, among many, which could affect dropping out of treatment. Although there is no empirical basis to determine statistically what percent of drop out may be related to such issues, even one dropout because of such problems would be too many. Therefore, continued focus on ensuring that waiting times meet our policy requirements and that scheduling difficulties are minimized are a focus of VA efforts to improve mental health services. Certainly as a part of that, efforts are directed at

waiting times meeting VA's timeliness standards, as lengthy waits can discourage Veterans from seeking treatment. Moreover, clinic hours outside normal business hours (8–4:30 on weekdays) are essential for reducing difficulties in scheduling appointments. All VA facilities and CBOCs serving over 10,000 unique Veterans already have after-hour or other extended hour mental health clinics, and an expanded array of extended hour services is being planned.

There are other considerations, as well, concerning simplifying scheduling to ensure delivery of a coordinated course of evidence-based psychotherapy, which are reviewed in the following paragraph.

Scheduling practices must be appropriately flexible to enable clinicians to deliver full courses of any PTSD treatment, including EBPT. At some sites, less flexible scheduling practices have resulted in some challenges in implementing the weekly 60–90 minute sessions that EBPs typically require. As noted above, the OMHS, in coordination with the OMHO, has developed national guidance on fully implementing EBPs at the local level, which includes specific guidance and identified best practices related to meeting scheduling requirements for EBPs. A number of facilities have developed scheduling procedures that support EBPs, and that have included clinic profiles with a default time increment of 30 minutes. The 30-minute default increment allows the clinician to specify to the scheduler whether a 30-, 60-, 90-, or 120-minute session is required. Another scheduling strategy that can be useful is to schedule an entire course of weekly EBP sessions (or a significant number of sessions for the therapy protocol) prior to the initiation of treatment (e.g., Cognitive Processing Therapy typically requires 12 weekly 60-minute sessions). This can be accomplished using the "multibook" (multiple appointment booking) function in the VistA scheduling package. This practice ensures that the weekly appointment time is not inadvertently scheduled with a different patient. The consistency of date and time from week to week increases the likelihood that the patient will remember the appointment, with fewer failures to show, and also supports the patient's commitment to completing the entire course of psychotherapy.

As noted above, other factors also impact Veteran dropout rate, as emphasized by Dr. Hoge, including stigma about receiving mental health treatment or belief that mental health care is not required. VA also is addressing these issues and has a variety of outreach programs to address these issues. Most recently, VA launched a national messaging campaign called "Make the Connection" to provide Veterans with information from other Veterans about the benefits of treatment. Make the Connection helps Veterans and their family members to connect with the experiences of other Veterans—and ultimately to connect with information and resources to help them confront the challenges of transitioning from service, face health issues, or navigate the complexities of daily life as a civilian.

b. What specific steps can VA take to improve adherence to treatment?

Response. VA has taken specific steps to increase Veterans' access to mental health care in general, which can lead to improved adherence, beginning with specific attention to availability of evidence-based PTSD treatment and to support the receipt of specialized PTSD services. These steps are outlined below.

- VA has implemented, and keeps updated, a PTSD Program Locator that allows Veterans, their family, or other concerned parties to search for the availability of specialized PTSD programs in their geographic area. The locator is available on the Internet and provides information about the types of programs available (e.g., outpatient, residential care, etc.) and gives information about how to contact programs. The Web site is linked to the National Center for PTSD (www.ptsd.va.gov), which also has extensive information for Veterans and their families that can educate them about PTSD, treatment options, and the resources that VA has to offer Veterans. This information is designed to increase access to appropriate care for PTSD.
- VA has implemented extensive efforts to integrate mental health care into primary care. These services include screening, assessment, and treatment of PTSD in primary care settings. This helps reduce wait times for receipt of care for PTSD, reduces the stigma that may be associated with seeking care for PTSD symptoms, and ultimately improves adherence.
- Screening, referral, and follow-up care are the first important steps in providing care to those Veterans who need it. VA has set standards for these measures in several domains and monitors them quarterly.
- VA has set standards for the appropriate screening of Veterans for PTSD. Nationally, 99 percent of all Veterans who should be screened for PTSD are screened at appropriate intervals.
- Additionally, 97 percent of Veterans are screened for Military Sexual Trauma (MST), and more than half of the female Veterans who screen positive for a history of MST go on to receive MST-related treatment services.

• More than half (57 percent) of Veterans with a diagnosis of PTSD receive at least some psychotherapy care. VA has made EBPs such as Prolonged Exposure Therapy and Cognitive Processing Therapy widely available, in addition to a number of other treatment options for Veterans with PTSD. Evidence-Based Therapy coordinators are present in 97 percent of VA medical centers to coordinate access to these types of care.

• Of those Veterans with a diagnosis of PTSD, 15.7 percent receive a full course of psychotherapy treatment, defined as at least eight psychotherapy visits within a 14 week period. A course of psychotherapy is not appropriate for every Veteran at every stage of his or her recovery.

Question 7. What specific actions is VA taking to reduce variation in mental health services across VISNs and facilities?

Response. Although mental health services and service utilization may vary across sites as a function of differences in population treatment needs, marked variation raises concerns regarding mental health access. On September 11, 2008, VHA defined essential elements of its mental health program, to be implemented to ensure that all Veterans have access to mental health services, wherever they receive VHA care.

Recently, VHA has taken a number of specific actions to reduce variation across VISNs and facilities. For example, on March 27, 2011, VHA established the OMHO to enhance monitoring, collaboration, support for mental health field operations, and engagement with VISNs and facilities. Addressing variation in mental health services is a major OMHO focus. OMHO is part of VHA Operations and collaborates closely with policy leadership in the Office of Mental Health Services. OMHO staff has been trained to provide technical assistance to VISNs and facilities and engage in ongoing close support, assessment and evaluation of the effectiveness of their interventions.

In addition, VHA has developed new tools for assessment of variation in mental health services. OMHO has developed a comprehensive new tool for assessment of VHA mental health services and variation across VISNs and facilities, the Mental Health Information System (MHIS). The MHIS includes over 200 indicators that are based on ongoing surveys and health system administrative measures. These provide an essential tool for evaluating variation in mental health services. Indicators of services availability and utilization are calculated for specific items and item domains, by facility, VISN, and nationally. The MHIS enables assessment of variation in key aspects of VHA mental health services. Facilities are flagged for focused review and implementation support if their scores on specific measures are not consistent with policy expectations. Where specific policy guidelines are not available, thresholds for indicators were based on distributional attributes, with low performing outliers flagged for immediate review and assistance. MHIS is being updated quarterly.

VHA has also ensured the availability of these resources, including the MHIS, for leadership throughout VHA. In September and October, the MHIS was introduced in conference calls to VISN mental health leadership. In addition, VHA has initiated ongoing consultation and review meetings with VISN mental health leadership. For each VISN, OMHO consulted with VISN mental health leadership regarding the MHIS and VISN- and site-specific results. These consultations also served as an introduction to the mission of OMHO and the specific role of OMHO Technical Assistants.

To further ensure that VA reduces variation across VISNs and facilities, VHA has initiated ongoing site visits, comprised of a lead consultant from the Office of Mental Health Operations and mental health subject matter experts from the Office of Mental Health Services, VISN Mental Health Directors, Office of Homeless Programs, Program Evaluation Centers, Mental Health Research Centers, Centers of Excellence, mental health leadership from the field, and/or experienced mental health front-line providers to assess mental health services. Based on the VISN-level consultations, specific sites were identified for immediate site visits.

Twenty-one (21) site visits will have been conducted by the end of December 2011. Visits focus on those sites and those domains that have been flagged for close review. Visits include assessment of strengths and barriers of specific programs and development and review of VISN and site-specific plans to address concerns and reduce variation in mental health services. Technical Assistants are assigned to specific VISNs and provide ongoing support and engagement to address concerns. In addition, VHA has initiated development, review and ongoing assessment of VISN level mental health Strategic Action Plans. Each VISN has provided a Strategic Action Plan to address marked variation in mental health services. Noted above, these are an important element of the dialog between VHA OMHO and VISNs and facilities.

Question 8. In response to the survey's findings, VA provided the Committee an action plan with concrete steps the Department is taking to resolve longstanding issues with mental health care. Specifically, VA tasked focus groups (potentially ten groups) with the mission of assessing in more detail the key themes from the initial query on scheduling, staffing, space, office hours, and C&P/IDES in mental health services.

Please share with the Committee, the findings from each focus group.

Response. The ten focus groups are being conducted by Altarum under a contract with VHA and are due to be completed with an aggregated report of the findings by January 31, 2012. The ten sites include Boise, Boston, Iowa City, Memphis, Minneapolis, Nashville, San Antonio, Waco, Walla Walla, and White River Junction. To ensure confidentiality, VA has not requested a facility-specific report of the findings. VA will provide the final report to the Committee when it is available.

Question 9. The Department has transitioned to a composite mental health access metric that includes several different wait time standards. Are there other metrics that were not included, which would be beneficial to developing a comprehensive picture of access to care?

Response. Although the Department has transitioned to a composite mental health access metric for use as a performance measure to prioritize and incentivize specific quality improvement efforts system-wide across VA, these are by no means the only mental health access metrics that the Department tracks. In fact, OMHO has created the Mental Health Information System (MHIS) which includes well over 200 measures that examine facility- or VISN-level access to specific treatments or elements of mental health programming that will provide a more comprehensive picture of access to care and other measures of quality of care delivery. This MHIS was designed to allow comprehensive monitoring of mental health care elements as described in the Uniform Mental Health Services Package and other VA policies and initiatives, and thus is highly beneficial for developing an overall picture of access to care. These measures typically look at the percentage of patients in a relevant diagnostic or demographic cohort who receive a specific treatment or service. For example, one measure looks at the percentage of patients with an opioid dependence diagnosis who receive opioid agonist treatment in VA or by contract. Another looks at the percentage of Veterans with a mental health service connection living within the VISN catchment area that receive VA specialty mental health services. While the absolute percentage of patients that should receive a specific treatment or service depends on clinical factors and patient preferences and is thus unknown, we believe based on past experience that these patient factors will be relatively uniform across facilities. This information system allows us to identify facilities where fewer patients are receiving a specific type of mental health service for targeted intervention and to improve local access to that service or treatment.

In addition, the VISN Support Service Center produces several reports designed to assist facilities in adapting programming and services to improve access for patients. These reports quantify how many people waited, how long they waited, as well as how many are currently waiting for mental health care. The "Access List" report was designed to help reduce the number of future appointments with long waits. The report shows the number of patients and appointments in the queue waiting, but gives the most attention to those patients who have already waited more than 14 days for an upcoming visit. Another access metric is the "Electronic Waitlist (EWL)" report, which provides information on Veterans on the EWL, including those waiting for mental health care. The "Pending Future Appointments" report was designed to provide information on Veterans who have pending appointments, including mental health appointments, as of a given date. Demographic information about the Veterans with pending appointments allows for detailed monitoring. The overall goal in the use of these reports is to help reduce the number of appointments with long waits.

a. Does the Department have standard requiring patients who are prescribed new antidepressants to be seen within one month of starting the prescription in order to be reevaluated?

Response. Although VA does not have a policy requirement that patients who are prescribed new antidepressants be seen within one month of starting the prescription in order to be reevaluated, page 80 of the VA/DOD Clinical Practice Guideline for the Management of Major Depressive Disorder (2009) does recommend that clinicians follow up and reassess patients at 2 weeks following initial treatment with a new antidepressant, and then, if the patient has not responded to initial treatment, again between 4–6 weeks to adjust treatment as needed. This guideline provides recommendations for clinicians making practice decisions regarding the treatment of patients for major depressive disorder based on existing evidence and expert con-

sensus, but these recommendations are not meant to set policy or supplant clinical judgment regarding what is appropriate clinical care for an individual patient. This is explicitly stated at the start of the guideline in the following statement "The Department of Veterans Affairs (VA) and The Department of Defense (DOD) guidelines are based on the best information available at the time of publication. They are designed to provide information and assist in decisionmaking. They are not intended to define a standard of care and should not be construed as one. Also, they should not be interpreted as prescribing an exclusive course of management.

Variations in practice will inevitably and appropriately occur when providers take into account the needs of individual patients, available resources, and limitations unique to an institution or type of practice. Every healthcare professional making use of these guidelines is responsible for evaluating the appropriateness of applying them in any particular clinical situation."

Thus, while the Department recommends that patients prescribed new anti-depressants be seen within one month of starting the prescription, this is not a standard (see Guideline link: https://www.qmo.amedd.army.mil/depress/depress.htm).

b. If so, what is the compliance with this standard?

Response. As stated in the above response, VA has no policy requirement or standard that patients who are prescribed new antidepressants be seen within one month of starting the prescription in order to be reevaluated. VA does, however, have a guideline for clinicians making practice decisions regarding the treatment of patients for major depressive disorder.

c. If not, why is this not tracked?

Response. Because this is not part of the current VA performance measurement set, follow-up after new anti-depressant prescription is not currently included in our main mental health measure tracking system. However, VA is able to track receipt of VA care following new prescriptions on demand. Nationally, 69.7 percent of the 187,781 VA patients with a new anti-depressant prescription in the 4 quarters ending in FY 2011 Quarter 2 had another VA encounter within 30 days. Across VA facilities, the rate of 30 day follow-up after a new anti-depressant prescription ranged from 57.2 percent to 83.6 percent.

Question 10. Please provide an update of the wait time data provided by the Department in response to the question for the record (Question one: c & e) requested by Senator Burr following the Committee's mental health care hearing in July.

Response. Please see Attachment B, which provides the wait time data for completed mental health appointments by VISN for FY 2011 through November, FY 2012. Within each VISN page, the listing is by facility and then by clinic.

[Attachment B was received and is being held in Committee files.]

Question 11. VISN 3 utilizes a PTSD software based program named "Family of Heroes" that allows veterans and their families to readily access a web-based, interactive roll playing simulation. Please provide the Committee with more details regarding this effort, including utilization and an evaluation of its efficacy.

Response. VISN 3 (the New York metro area) contracted with Kognito Interactive, a New York City-based developer of role-play training simulations, to design and make available to the families of Veterans—particularly those who have returned from combat—an online training simulation called Family of Heroes. Family of Heroes is designed to teach family members critical skills to support their Veteran's transition to post-deployment life.

This training simulation provides users with the opportunity to engage in simulated conversations with fully-animated Veteran avatars who exhibit signs of PTSD, Traumatic Brain Injury (TBI), and depression. Each "virtual Veteran" possesses his or her own personality, emotions, and memory, thus replicating real-life interactions with individuals experiencing post-deployment stress. This unique learning experience provides a hands-on experience wherein users learn and internalize best practices for approaching and talking with at-risk Veterans and, if necessary, motivating them to seek help at the VA. The training includes three simulated conversations:

In the first conversation, users assume the role of the wife and learn to de-escalate an argument with her husband Dave who is experiencing PTSD and mild TBI. In the second, users assume the role of the husband and learn to re-negotiate family responsibilities with his wife Alicia who is experiencing post-deployment stress. Finally, in the third, users assume the role of the mother and learn to motivate and refer her son Chris, who is exhibiting signs of depression and thoughts of suicide, to support services.

The program was presented at the poster session of the DOD/VA Suicide Prevention Conference in Boston in March 2011, where it won the first place award of excellence for Best in Quality and Originality. The program was also presented at the National VA Mental Health Conference in Baltimore in August 2011.

The program was rolled out to VISN 3 VA medical centers and VA community partners in September, 2011, and formally launched the week before Veterans Day. To date, 52,792 users have accessed the Family of Heroes Web site. The Web site has a Contact Us (VA) option and this user information is provided to the VISN 3 VA medical center closest to the address provided. To date, no referrals have come to any VISN 3 VA medical centers from this Contact Us option on the Web site.

In order to better understand the impact of the Family of Heroes program, VA researchers are conducting a study, using funding from the VISN 3 Mental Illness Research Education and Clinical Center. Recently returned Veterans from the conflicts in Iraq and Afghanistan who are living with PTSD will be invited to participate in this study. In total, 120 of these Veterans from the New Jersey area will be invited to have their spouse or a close family member participate with them in the study. Half of these Veterans will have their spouse/family take the web-based, Family of Heroes program, while the other half will not complete the Family of Heroes program. This will allow the researchers to compare these two groups. By understanding the differences between the groups, the researchers can pinpoint the ways in which participating in Family of Heroes helps family members and spouses support their Veterans. The research study will pay special attention to whether the program will help improve PTSD symptoms and relationship health. The researchers will also determine whether the program increases the use of mental health services in the VA or elsewhere.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. In VA's testimony and the action plan VA developed, VA states that mental health staffing has increased by 47.8 percent since 2006. However, staffing shortages were identified by the mental health providers you surveyed and confirmed by testimony we heard at the hearing.

a. Please provide the Committee with a breakdown of the providers that have been hired in mental health since 2006.

Response:

Discipline or Professional	Increase in Mental Health Clinicians since 2006	% increase
Nurse	2115.53	34
Physician Assistant	333.79	30
Physician	741.37	41
Psychologist	1409.63	87
Social Work	2767.10	125
Therapist	456.90	34
Total*	7824.33	55

*Total includes staff hired for the Homeless program as well as mental health.

b. How many of those additional staff are actually engaged full-time in clinical care?

Response. Nationally aggregated data shows eighty-seven (87) percent of mental health Full-Time Employee Equivalents (FTEE) are providing direct clinical care.

c. How does VA decide what type of providers are needed at VA facilities?

Response. Although some programs such as Residential Rehabilitation programs and Mental Health Intensive Case Management have specific standards for type and amount of staffing based on either number of beds or number of Veterans served, many other outpatient programs do not currently have national standards. For these programs, facilities develop staffing standards based on the range and type of services provided and the volume of care provided. Staffing decisions are also developed locally based on the types of providers that are available in the local area. VA mental health is currently working to develop national guidance on staffing to assist facilities in determining their staffing needs.

d. How many positions for mental health providers does VA currently have open?

Response. The number of open positions for mental health providers is approximately 1,500 positions as of December 2011. This is a constantly changing number as positions are filled and vacated through normal processes. However, based on the survey VA conducted in December, sites reported filling 870.82 FTEE that were vacant in May. This December survey was a follow-up to the May 2011 survey which

asked all medical centers and VISNs to complete a full staffing report on all mental health vacancies.

Question 2. VHA has placed considerable priority on having its mental health clinicians provide evidence-based psychotherapy to treat PTSD, but that therapy calls for intensive treatment involving 12–15 sessions. Yet, as we heard from Dr. Washington, some VA facilities place emphasis on seeing new patients within 14 days, but cannot provide the timely follow-up care.

a. For the most recent fiscal year for which you have data, what percentage of OEF/OIF patients with mental health diagnoses are actually receiving evidence-based therapy?

Response. VHA cannot currently provide administrative data on the number of OEF/OIF/OND Veterans receiving these treatments. This is due to the limitations of Current Procedural Terminology codes used for tracking health care services, which do not allow distinction of different types of psychotherapy. OMHS has developed documentation templates for each of the EBPs it is nationally disseminating; these templates will be added nationally into VA's electronic medical record. These templates will allow for precise tracking of EBP delivery and treatment completion, as well as facilitate documentation of the types of Veterans who engage in these treatments. The templates have been piloted at several facilities and are scheduled for full system deployment later in FY 2012.

While awaiting development of these new informatics processes, VA has conducted surveys of the field to obtain information on the extent to which OEF/OIF/OND Veterans with PTSD have been offered and provided EBPs for PTSD (specifically Cognitive Processing Therapy [CPT] or Prolonged Exposure Therapy [PE]), as well as the extent to which these Veterans have completed a full course of one of these treatments.

A national survey of VA facilities evaluating the extent to which these therapies are provided by facilities indicated that all facilities are providing CPT or PE, and 98 percent of facilities were providing both of these therapies, which have been found to be equally effective. Survey results further indicate that the level of capacity to provide these therapies varies throughout the system. OMHO is assessing this variability through the site visits that are ongoing, and VA continues to increase its capacity through training. Training in CPT and PE this fiscal year has involved a targeted approach placing important focus on sites that have fewer trained staff. The availability of clinics with weekly 60–90 minute sessions, as these therapies require, is also an important standard VA is working to ensure is consistently in place throughout the system.

Survey data have further indicated 30 percent of OEF/OIF/OND Veterans offered CPT or PE began treatment. Of those Veterans that initiated treatment, 51 percent completed a full course of therapy. It is important to note that these survey data are approximations reported by facilities based on locally available data collected by facility staff, since centralized administrative data for tracking specific types of psychotherapy are not available. These data are comparable to data in the literature that shows that the average completion rate for psychotherapy is 53 percent (average from a meta-analysis of 125 studies).

Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, 24, 190–195.

b. How does VA plan to address the lack of appointment availability for follow-up care?

Response. OMHS, in coordination with OMHO, has developed national guidance on fully implementing EBPs at the local level. This guidance provides detailed requirements for providing EBP with the appropriate level of intensity and session frequency with which they were originally designed to be delivered and shown to be effective. In addition, VA's national, competency-based staff training programs in Cognitive Processing Therapy and Prolonged Exposure Therapy have implemented a targeted training approach this fiscal year, placing important focus on sites that have fewer trained staff.

Furthermore, the OMHS and OMHO have developed and are now actively implementing in the field, a performance measure that requires that OEF/OEF/OND Veterans with PTSD receive a minimum of 8 sessions of psychotherapy within a 14-week period. OMHO has also developed a "dashboard" of metrics to monitor and provide feedback to the field on the delivery of courses of psychotherapy and a broad array of other services.

VA is also working to promote engagement in evidence-based psychotherapy for PTSD by promoting the implementation of these therapies through telemental health modalities. EBP for PTSD telemental health services offer an opportunity to overcome physical and other access barriers (e.g., physical distance, transportation

costs and difficulties, job responsibilities) to initial and ongoing participation in evidence-based psychotherapy. As part of this effort, VA has developed a Task Force that has issued recommendations for a national strategy to promote the implementation of evidence-based psychotherapy for PTSD telemental health services, which are already provided at some facilities and have been shown to be effective with Veterans. Funding has been provided to the field to place approximately 100 EBP for PTSD Telemental Health Providers at carefully selected sites throughout the system. Moreover, VA has developed an Evidence-Based Psychotherapy for PTSD Toolkit to help program managers and front-line staff implement these services. An all-day workshop on the delivery of CPT and PE via telemental health was conducted at VA's national mental health conference in August 2011.

Tuerk, Yoder, Ruggiero, Gros, & Acierno, 2010.
Wierzbicki, M., & Pekarik, G. (1993). A meta-analysis of psychotherapy dropout. *Professional Psychology: Research and Practice*, 24, 190–195.

Question 3. VA has the authority to use fee-basis care to meet veterans' needs if their needs cannot be met within VA. According to information VA provided my staff, on average about two percent of VA's mental health patients are referred to fee-basis care per year. When a VA provider decides fee-basis care is needed, it can take several months before the request is granted by the facility, leaving that veteran waiting for the needed care that is available in the private sector.

a. If VA has big staff shortages and long wait times to access care, why have only two percent of veterans in need of mental health care been referred for fee-basis?

Response. When VA facilities are unable to furnish cost-effective hospital care or medical services because of geographical inaccessibility or lack of required staff or equipment, VA may contract with non-VA facilities to furnish such care or services to certain eligible Veterans. A referral for non-VA care is a clinical decision, which may include consideration of VHA's ability to provide the required care in a timely manner, or to address eligible Veterans' clinical needs if a Veteran is not geographically accessible to a VHA facility. Referral to fee basis care does not always guarantee more timely care however, especially in accessing evidence-based psychotherapies. For example in facilities that have experienced problems with staff shortages or wait times, especially in rural areas, there is a limited provider pool for both VA and non-VA needs. Because of this, VA is expanding its telemental health services to provide coverage for areas that have difficulty locating either VA or fee basis providers.

b. Please describe the process for getting a request for fee-basis care approved.

Response. The referral process for non-VA care from a VA facility begins with a provider making the determination that the VA site is unable to provide the necessary clinical care for the Veteran at that facility, either because the facility lacks the clinical resources to provide that care timely, the VA facility is not available, or the Veteran is unable to travel to a VA facility to receive care. Once the determination is made, the facility staff determines the most appropriate location of care, and if all administrative eligibility requirements are met, a referral will be processed to provide these services in the community. If a contract is in place for the required service and that is the most appropriate clinical setting, Veterans will be referred to those contracted providers. VA is implementing standardized business practices in FY 2012 to ensure equity of access for services and appropriate care coordination, management, and oversight of these non-VA services. These new processes include standardized business practices such as deploying standardized non-VA consult/referral templates across all VHA medical centers, and Implementing new tools and Standard Operating Procedures (SOP) to improve the way we coordinate non-VA healthcare services for our Veterans.

The scope of this initiative encompasses the processes between the time when a VA provider generates a consult/referral for a Veteran until the time the Veteran receives the authorized services and fee program staff receives all required clinical documentation.

Question 4. At the hearing, VA testified that their facilities have off-hours appointments for mental health.

a. Please specify by facility type, how many facilities have off-hours appointments?

Response. Based on data through December 12, 2011, mental health (MH) off-hours appointments are provided at 152 VA medical centers and 376 CBOCs.

b. Please specify whether these hours are early morning, evening or weekend appointments, and the types of services available.

Response. Data from October 1, 2010 through December 12, 2011, indicate that during early morning hours 179, 880 MH appointments were provided at 152 VA

medical centers, and 32,020 at CBOCs; during evening hours 393, 825 MH appointments were provided at VA medical centers and 68,876 at CBOCs; and during weekend hours, 118,563 MH appointments were provided at medical centers and 9,692 at CBOCs. Each facility provides different MH services during off-hours. Attachment C contains a list of stop codes indicating the types of MH services provided nationally during off-hours.

ATTACHMENT C

Primary Stop Code	Primary Stop Code Name
502	MENTAL HEALTH CLINIC - IND
503	MH RESIDENTIAL CARE IND
505	DAY TREATMENT - INDIVIDUAL
506	DAY HOSPITAL - INDIVIDUAL
509	PSYCHIATRY - INDIVIDUAL
510	PSYCHOLOGY - INDIVIDUAL
512	MENTAL HEALTH CONSULTATION
513	SUBSTANCE USE DISORDER IND
514	SUB USE DISORDER HOME VST
516	PTSD - GROUP
519	SUBST USE DISORDER/PTSD TEAMS
522	HUD/VASH
522	HUD/VASH INDIV
523	OPIOID SUBSTITUTION
524	ACTIVE DUTY SEXUAL TRAUMA
525	WOMEN'S STRESS DISORDER TEAMS
529	HCHV/HCMI
529	HCHV/HCMI INDIV
532	PSYCHOSOCIAL REHAB - IND
533	MH INTERVNTION BIOMED CARE IND
534	MH INTGRTD CARE IND
535	MH VOCATIONAL ASSISTANCE - IND
539	MH INTGRTD CARE GRP
540	PTSD CLINICAL TEAM PTS IND
547	INTNSE SUB USE DSRDER GRP
548	INTNSE SUB USE DSRDER IND
550	MENTAL HEALTH CLINIC - GROUP
552	MHICM - INDIVIDUAL
553	DAY TREATMENT - GROUP
554	DAY HOSPITAL - GROUP
557	PSYCHIATRY - GROUP
558	PSYCHOLOGY - GROUP
559	PSYCHOSOCIAL REHAB - GROUP
560	SUBSTANCE USE DISORDR GRP
561	PCT-POST TRAUMATIC STRESS - GRP
562	PTSD - INDIVIDUAL
564	MH TEAM CASE MANAGEMENT
565	MH INTERVENTION BIOMED GRP
567	MHICM - GROUP
568	MH CWT/SE FACE TO FACE
571	SERV-MH INDIVIDUAL
572	SERV-MH GROUP
573	MH INCENTIVE THERAPY F TO F
574	MH CWT/TWE FACE TO FACE
575	MH VOCATIONAL ASSISTANCE - GRP
576	PSYCHOGERIATRIC - INDIVIDUAL
580	PTSD DAY HOSPITAL
582	PRRC INDIVIDUAL
583	PRRC GROUP
588	RRTP AFTERCARE IND
590	COMM OUTREACH HOMELESS VETS
591	INCARCERATED VETERANS RE-ENTRY
592	VETERANS JUSTICE OUTREACH
593	RRTP OUTREACH SERVICES
595	RRTP AFTERCARE GRP
596	RRTP ADMISSION SCREENING SRVCS
598	RRTP PRE-ADMIT IND
599	RRTP PRE-ADMIT GRP

c. What metrics are used by the facilities to decide what appointments to offer (early morning, evening or weekend) and what types of services will be available during those off-hours appointments?

Response. Facilities use various metrics for determining what services to offer and what times of the day to offer appointments, including wait time studies, patient focus groups and surveys, and staff focus groups and surveys. In addition, some types of services and appointment times are offered in response to VHA Handbook 1160.01: *Uniform Mental Health Services in VA medical centers and Clinics*.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. JOHN D. ROCKEFELLER IV TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. I mentioned a question from a recent call with West Virginia veterans, and a female veteran talking about access and making women veterans comfortable in VA facilities. I know that each facility should have a designated coordinator for women veterans, and that is important I understand why it is hard for female veterans who have survived Military Sexual Trauma (MST) to wait in a large area surrounded by men. But what has VA done to survey the VA facilities about space and privacy?

a. Has VA done a systemic review of VA facilities—both Medical Centers and Vet Centers—to access the needs of women veterans and privacy?

Response. Women Veterans Program Managers review structural, environmental, and psychosocial patient safety and privacy issues in all VHA outpatient care settings and conduct monthly environment of care rounds. Each facility must engage in an ongoing, continual process to assess and correct physical deficiencies and environmental barriers to care for all Veterans, particularly women Veterans. Currently,

every VHA health care system has in place a full-time Women Veterans Program Manager to improve women Veterans' access to care.

In addition, Women Veterans Program Managers and Deputy Field Directors conduct on-site visits to monitor compliance with correction of privacy deficiencies and communicate findings to local leadership. Other strategies include site visits by VISN Environment of Care Teams, random site visits, reviews by VHA's Office of Environmental Programs Service, as well as System-wide Ongoing Assessment and Review Strategy (SOARS) site visits. VHA Environmental Programs Service assists and ensures compliance with planning needs.

b. What has VA done to provide specialized programs for women instead of group counseling? How readily available is such personalized care?

Response. The Veterans Health Administration offers a full continuum of mental health services for women Veterans. Every VHA facility has mental health outpatient services for women. A wide range of services are available including formal psychological assessment and evaluation, psychiatry, and individual and group psychotherapy. Specialty services are available to target problems such as PTSD, substance abuse, depression, and homelessness. Many facilities have specialized, women's only outpatient services. These services enable women Veterans to stay at home, surrounded by family, friends, and other supports. Moreover, women Veterans can maintain employment and stay integrated into their community, which helps facilitate their recovery.

Women Veterans can also receive services through most of VA's residential/inpatient treatment programs. Specialized residential programming for women is a resource that is rare to non-existent in the private sector. There are 19 programs that are able to provide specialized care in a VA residential or inpatient setting for mental health conditions related to MST. When clinically indicated, Veterans may benefit from receiving residential treatment in women's only environments. VA has 11 residential or inpatient programs that provide treatment to women only or that have separate tracks for men and women. One (1) additional VA program provides women-only treatment in a non-VA residential setting in conjunction with a local non-profit program for homeless and at-risk Veterans. These programs are considered regional and/or national resources, not just a resource for the local facility. Some of these women-only programs focus on MST specifically, while others focus on specialized women's care in general (including MST).

VA recognizes that some Veterans will benefit from treatment in an environment where all of the Veterans are of one gender as this may help address a Veteran's concerns about safety and improve a Veteran's ability to disclose trauma details, address gender-specific concerns, and engage fully in treatment. However, VA also recognizes that mixed-gender programs have advantages, as they may help Veterans challenge assumptions and confront fears about the opposite sex and provide an emotionally corrective experience. Given these considerations, VA does not promote one model as universally appropriate for all Veterans. The needs of a specific Veteran dictate which model is clinically most appropriate.

VA policy requires that mental health services be provided in a manner that recognizes that gender-specific issues can be important components of care. All VA facilities must ensure that outpatient and residential programs have environments that can accommodate and support women with safety, privacy, dignity, and respect. All inpatient and residential care facilities must provide separate and secured sleeping and bathroom arrangements including, but not limited to, door locks and proximity to staff for women Veterans.

VHA facilities are strongly encouraged to give Veterans the option of a consultation from a same-sex provider regarding gender-specific issues when they are in a mixed gender program or group. Veterans being treated for conditions related to MST have the option of being assigned a same-sex mental health provider or an opposite-sex provider if the MST involved is a same-sex perpetrator.

Question 2. Another recent question by a West Virginia veteran was about the waiting period for "de-tox" in our state. When asked, VA facilities say they can provide care, but veterans in our state tell another story. How do we provide clear incentives for VA facilities to report and deal with shortfall in staff or care, rather than using creative ways to "count" care and visit to meet guidelines?

Response. As part of the action plan recently submitted to the SVAC, VA outlined a plan to develop a nationwide staffing model for mental health. The national staffing plan will ensure that VHA facilities to include the four Medical Centers in West Virginia are evaluating staffing in a consistent way across sites and will allow VA to monitor variations in practice. At the current time, staffing is determined locally. The ongoing site visits as noted in an earlier response will be assessing mental health staffing levels.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. BERNARD SANDERS TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. When DOD separates an active-duty servicemember, who has been identified as having behavior health needs, does DOD share that information with VHA behavioral health services in order to assure continuity of care and assist VHA in its outreach efforts?

Response. Over the last 10 years DOD and VA have expanded sharing of protected health information (PHI), including interfaces between their respective health information systems. The VA/DOD Bi-directional Health Information Exchange was initiated in 2008 and is designed to ensure that providers from both systems have access to information related to current treatments, which aims to improve continuity of care for the Servicemember or Veteran. The two Departments are currently developing next generation solutions, including a fully integrated electronic health record with a shared user interface. A joint VA/DOD task group is also currently examining policies for health information sharing between VA and DOD, including an analysis of legal, ethical, moral, and privacy issues related to VA/DOD health information sharing. The ultimate goal is to provide continuity and coordination of care while allowing Veterans and Servicemembers some measure of control over whether, how, and with whom their information is shared.

Currently, when a Servicemember is separated from DOD and transferred directly to a VA facility, for example, to an inpatient treatment program, that Servicemember's medical records are transferred to VA. When a separating Servicemember is referred to VA for care, such as following a Post-Deployment Health Reassessment (PDHRA), limited information may accompany the referral (e.g. name, diagnosis, reason for referral), and if the Veteran chooses to seek care at a VA facility, an authorization for release of information signed by the Veteran will allow for his or her records to be forwarded to VA.

Continuity of care is also facilitated through the DOD inTransition program, which provides counselors who are trained to assist and support Servicemembers making transitions from one location to another within DOD, as well as those who are transitioning from the DOD health care system to VA. Through telephone assistance, the Servicemember and family members work with a personal coach who provides advice, information about mental health care, location of resources, and assistance in connecting with new providers. The inTransition program operates 24 hours a day, 7 days a week, 365 days a year. VA is a partner with DOD on the program, which is one of the Strategic Actions included in the VA/DOD Integrated Mental Health Strategy.

With regard to sharing information to assist with outreach efforts, VA is working with DOD Reserve Affairs to explore the possibility of receiving both general and specific information that would assist VHA in reaching out to National Guard and Reserve members as they are preparing to separate and to families who are currently receiving behavioral health care through TRICARE.

Question 2. Will VA consider collaborating with Dr. Van Dahlen's Give an Hour program and its volunteer mental health providers?

Response. VA is already exploring opportunities to collaborate with Give an Hour. Most recently, our Veterans Crisis Line leadership has initiated conversations with Give an Hour about the development of a potential memorandum of agreement with Give an Hour concerning the ability of the Crisis Line to assist them with any Veteran their practitioners identify as being in crisis or needing immediate medical attention. Also, the memorandum of agreement would facilitate our ability to provide a referral to Give an Hour as a resource to those Veterans who contact the Crisis Line and are not willing or able to access VA services for any of a number of reasons (e.g., stigma, dishonorable discharge, physical distance from VA facilities). In addition, VA sees Give an Hour as a resource for family members of Veterans who could benefit from their own mental health treatment in ways that are not related to the treatment needs of the Veteran.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MARK BEGICH TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Alaska has a difficult time in recruiting and retaining mental health providers. Can you provide details on the VA Rural Health Coordinator's efforts to expand telemental healthcare, outreach, and training? Are there new initiatives to expand telemental health access, and can you expand on them?

Response. The Office of Rural Health (ORH) and the Office of Mental Health Services (OMHS) places a great emphasis on making telemental health services

more accessible to rural Veterans. A new initiative that ORH is funding in FY 2012 for approximately $1.1 million, the "Oregon Rural Mental Health Initiative," involves expanding home-based telemental health (HBTMH) services to rural areas in Veterans Integrated Service Network (VISN) 20. The goal is to train and to provide equipment to 70–100 providers in 30 facilities and community-based outpatient clinic (CBOC) sites throughout Oregon, Washington, Idaho, and Alaska. Rural Veterans will be able to receive mental health services (e.g., psychotherapy, medication management, psychiatric evaluations) from their homes by using inexpensive webcams attached to their computers to communicate with their providers. There is a special emphasis on expanding telemental health services in Alaska. Two mental health providers have been trained to initiate HBTMH with Veterans in rural Alaska. For parts of Alaska that lack high speed internet, the use of secure cellular notebook connectivity modalities will be explored. It is anticipated that by the end of FY 2012, 1,200 unique rural Veterans will have been impacted by this initiative.

In addition, VHA is initiating several Alaska-focused initiatives. Contact has been made with tribal officials who have a community health clinic in Talkeetna, a remote town about 2.5 hours driving time from Anchorage. They have agreed to allow VA to provide a pilot telemental health care program for Veterans into their clinic, and we are working to equip their clinic with secure telemental health equipment to initiate this care. They have offered to help VA establish a similar site in Willow, Alaska, where they are building a new community health clinic. Assuming these small pilots are successful, VA hopes to expand the ability to deliver such care to other rural and highly rural sites in the state. We have also been working to equip the main facility in Anchorage with the ability to deliver telemental health services from Anchorage to CBOC sites in Fairbanks, Juneau, Kenai, and Mat-Su, and to prepare them to expand their Home-Based Telemental Health capacity.

Following from the recommendations of a national VA Evidence-Based Psychotherapy for PTSD Telemental Health Task Force, VHA has developed a strategic plan that includes two core components to promote the delivery of EBP for PTSD telemental health services nationally: (1) Expansion of Cognitive Processing Therapy (CPT) and Prolonged Exposure (PE) Therapy clinical video teleconferencing services provided from medical centers to community-based outpatient clinics; (2) Piloting of regional CPT and PE clinical video teleconferencing clinics that will supplement the delivery of CPT and PE telemental health services provided by local medical centers and clinics and serve as regional sites of excellence and technical support. Alaska will be included in this effort.

Question 2. Do you have numbers on how many veterans are receiving psychotherapy and medication management using secure videoconferencing? Are there other similar arrangements? (Linda Godleski)

Response. In FY 2011, 55,305 Veteran patients received mental health services using secure videoconferencing; approximately 43 percent received a combination of Medication Management and Psychotherapy; 30 percent received Medication Management alone; 20 percent received psychotherapy alone; 7 percent were Other (e.g., Initial Diagnostic Evaluation).

Question 3. Can you describe the staffing process for a typical mental healthcare facility? Does each facility have a base staffing document detailing authorized positions, and is there a minimum required fill level for positions at the facility? Can a facility director make a decision to leave positions unfilled if they are authorized and there are qualified applicants?

Response. Every facility has a posted, approved organizational chart that includes authorized positions (ceiling). Facilities update their approved staffing routinely as new services are added to amend or to reflect other changes in service provision as well as to ensure that the numbers were supportable by their budgets. There are no minimum fill levels for positions established.

For specifically-funded positions, facility directors are required by the VISN Director to begin recruiting and hiring positions immediately. Requests for non-funded new positions or for filling vacant positions go to the facility Resource Management Board.

Resource Management Boards make decisions based on justification submitted for the request and balance it with all services in the medical center, taking into account the approved ceiling, clinical needs, current budget, and total FTEE.

In addition, the ongoing site visits, as noted in an earlier response, will be assessing mental health staffing levels across facilities and developing national standards to guide facility decisionmaking. These site visits serve as an additional check on how facilities are serving their Veteran population with current staffing on-board.

Question 4. What is the (plan/formula) about what the patient: psychiatrist ratio should be? (Follow-up corollaries: patient: psychotherapist (and what training level,

what types of psychotherapies) ratio? patient: psychiatric nurse? If so, what are these ratios, and on what evidence-based literature is this based? national, international?

Response. There currently is no well-developed literature on what mental health staffing levels should be as this will vary depending on the type and range of services provided. VA, as the largest integrated health care system, provides many services that are not offered in other types of health care systems and is therefore not comparable to other settings even if such guidance existed. Also, VA is not comparable to other settings in the level of qualifications required. Unlike many community-based clinics, VA hires primarily masters or doctoral level clinicians to ensure the workforce is adequately credentialed to meet the mental health needs of Veterans.

VA has examined the productivity of the mental health workforce based on existing community standards. VA providers tend to be more productive than their academic counterparts but less than private practice providers. Currently, VA is developing a staffing model. The timeline and process for development of the staffing model was submitted to SVAC as part of the mental health action plan, sent in November 2011.

Question 5. How do these ratios compare to the standard of care in the community (the standard of care vis-a-vis community mental health centers, as would be the most reasonable comparison)?

Response. Please see response to question 4 above.

Question 6. Is there a requirement/policy that VA SBH (social behavioral health) outpatient clinics (such as what exists in Anchorage) provide a program for the OEF/OIF (operation enduring freedom/operation Iraqi freedom) veterans? If so, what is the program intended to provide?

Response. VHA Handbook 1010.01, Care Management of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) Veterans, states that all "VA health care facilities must provide appropriate health and mental health services to Veterans who served in OEF and OIF. Coordination of those services is to be ensured by the OEF-OIF Care Management Team at each facility led by the OEF-OIF Program Manager." Each VA medical center or outpatient clinic (such as exists in Anchorage) must appoint a masters level social worker or registered nurse as the OEF-OIF Program Manager to ensure that these Veterans receive patient-centered and integrated care. Program requirements include:

- Ensuring that OEF-OIF Veterans are screened to determine the need for mental health care or case management services.
- Facilitating seamless transition from DOD military treatment facilities and transition units.
- Assignment of a case manager (RN or social worker) for all seriously ill or seriously injured OEF-OIF Veterans as well as others requiring case management services.
- A Transition Patient Advocate to provide outreach to Veterans and Servicemembers transitioning from DOD to VA care to smooth their entrance into the VA patient-aligned care teams and to assist with eligibility for VA benefits including those specifically targeting OEF-OIF Veterans.
- Close collaboration with specialty programs to address issues such as polytrauma, Traumatic Brain Injury, blindness, and PTSD to ensure care coordination.
- Assisting with accessing special benefits such as home modification, in-home services, and coordination with community resources.
- Providing a regularly scheduled interdisciplinary team review of the special needs of OEF-OIF Veterans (Integrated Post Combat Care Team).
- Keeping VA leadership abreast of new programs, Veteran needs, challenges, and resource requirements.
- Tracking and monitoring the OEF-OIF Veterans and the quality care measures that apply specifically to this group.
- Meeting new OEF-OIF Veterans in the VA Introductory Clinic to advise them of their specific benefits and to facilitate case management from the first encounter with the VA.
- Assessing the need for Post-9/11 Caregiver Support Program referral and ensuring this process is implemented.

Question 7. If this is a requirement/policy of VA, why does that not exist in Alaska clinic, let alone outlying CBOCs?

Response. The OEF-OIF Program has been in existence in Alaska as a formalized program since 2007, when a Transition Patient Advocate and a Program Manager were hired. Prior to that time, a case manager provided outreach and care coordina-

tion for these Veterans. The program expanded in 2009 with the addition of staff. In addition:

- OEF-OIF Program staff as well as other mental health providers from the Alaska VA have provided on-site training for community providers throughout the state on issues specific to OEF-OIF Veterans.
- OEF-OIF staff have traveled throughout the state with the National Guard for Yellow Ribbon events and continue to do so.
- OEF-OIF staff continue to provide community briefings, to brief transitioning servicemembers from Anchorage and Fairbanks military installations, and to coordinate care for Servicemembers and Veterans coming to Alaska from other states.
- They have cross-trained CBOC social workers to provide screening and case management for the OEF-OIF Veterans in their communities, and they consult with them on local Veteran issues, benefits, and concerns. They travel to the CBOCs to consult and assist as needed.
- In July 2011, the OEF-OIF Program Manger resigned from the Alaska VA. The service chief in Social and Behavioral Health, a seasoned psychologist with experience in the VA and in treating PTSD, has been serving as the acting Program Manager.
- The position was announced three times since July 2011. The first two announcements did not provide candidates with sufficient knowledge or experience for this position. The third announcement has closed and interviews are being planned.
- A Caregiver Support Coordinator, a retired Army RN, was appointed in the spring of 2011. He has fully implemented that program and continues to offer nursing expertise in collaboration with the social workers providing care for OEF-OIF Veterans.
- Integrated care delivery is ensured by the social workers in the Patient Aligned Care Teams who serve as case managers for the OEF-OIF Veterans on their teams.
- Anchorage and CBOC mental health providers have received training and are providing evidenced-based psychotherapies for the treatment of PTSD.

Question 8. What is the plan to expand Vet Centers in Alaska?

Response. VA's decision to establish new Vet Centers in 28 counties throughout the country in 2010 was based on consideration of county Veteran population and distance from the nearest Vet Center. The county Veteran population is identified in VetPop, which is VA's latest official estimate and projection of the Veteran population and their characteristics. VA's intent with this expansion was to extend access to Vet Center services to underserved Veterans in more rural areas. The criteria for establishing a new Vet Center is outlined below. These criteria were applied to a Nation-wide analysis of Veteran population by county:

- County with more than 40,000 Veterans and more than 30 miles to nearest Vet Center
- County with more than 20,000 Veterans and more than 60 miles to nearest Vet Center
- County with more than 10,000 Veterans and more than 100 miles to nearest Vet Center
- Two adjacent counties with more than 10,000 Veterans and more than 100 miles to the nearest Vet Center

Based upon these criteria, VA concluded that the size of the county Veteran population and distance to the closest Vet Center do not support the establishment of a new Vet Center in Alaska. The three counties with comparable Veteran population, Anchorage at 31,000, Fairbanks North Star at 11,700, and Matanuska-Susitna at 10,500, are covered by the Vet Centers in Anchorage and Fairbanks, and the Vet Center outstation in Wasilla. However, VA is augmenting the staff at the Vet Centers in Anchorage and Fairbanks by adding a qualified family counselor at each Vet Center.

Response to Posthearing Questions Submitted by Hon. Roger F. Wicker to U.S. Department of Veterans Affairs

Question 1. It has been nearly 5 months since the Assistant Inspector General testified before this Committee about the wait times between acceptance into a mental health residential program and the start of that program. Have things improved? What is the wait time now?

Response. During the July 14, 2011, hearing, "VA Mental Health: Closing the Gaps," the Assistant Inspector General for Healthcare Inspections testified about recommendations from the Office of the Inspector General's (OIG) recent follow-up review of the Mental Health Residential Rehabilitation Treatment Programs (MH

RRTP) (*A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs*, June 22, 2011). The follow-up review recommended that VHA ensure contact between MH RRTP staff and/or engagement in MH treatment for patients in the interim between their acceptance into and actual participation in a MH RRTP. In response to the recommendation, the Office of Mental Health (OMHS)—MH RRTP Section, along with the Office of Mental Health Operations (OMHO) reviewed policy and clarified guidelines and procedures. Guidance was provided during a series of national conference calls with VISN and medical center leadership, and Program Managers in August 2011. Additionally, the Office of the Deputy Under Secretary for Health for Operations and Management sent written guidance to the VISN and Medical Center Directors on August 8, 2011.

These efforts were designed to directly address the concern noted by the OIG. While the OIG report did not specifically identify concerns with average wait time for admission to residential mental health treatment, all MH RRTP programs are required to monitor wait times and ensure that admissions occur as quickly as possible. In FY 2010, MH RRTP program managers reported that the average number of days between screening and admission was 17.6, with 25 percent of programs admitting Veterans within less than 3 days between screening and admission. Preliminary review of administrative data for a subset of programs for FY 2011 indicates that the average number of days between screening and admission was 17.5. Complete information on the FY 2011 average wait time between screening and admission is not yet available, however it is being evaluated during our site visits.

Question 2. In July, only 4% of patients were referred to vocational rehabilitation services. What percentage of veterans is being referred now?

Response. We believe that this statistic is from Assistant Inspector General for Healthcare Inspections' written statement for a hearing before the Committee on July 14, 2011, and is a typographical error. The OIG report (10–04085–203) outlines that 92 percent of all Veterans admitted to a Mental Health Residential Rehabilitation and Treatment Program (MH RRTP) are assessed for Occupational Dysfunction, and that 60 percent are referred for vocational rehabilitation services.

Question 3. In July, the Assistant Inspector General testified about the shortcomings of readjustment counseling and Post Traumatic Stress Disorder. Have those shortcomings been resolved?

Response. OIG made two recommendations which have been resolved.

OIG Recommendation 1: Ensure that Vet Center Team Leaders perform monthly provider's record reviews and provide supervision and consultation to providers in compliance with Readjustment Counseling Service (RCS) policy.

All Vet Center Team Leaders are required to comply with the supervision and consultation requirements and all Vet Centers are being monitored for compliance through annual site visits. A performance goal for the Team Leaders specifically related to supervision and consultation and is within the FY 2012 performance appraisal. In FY 2011, a performance goal regarding the remediation of all site visit deficiencies was included. RCS has increased the level of specificity for FY 2012.

OIG Recommendation 2: Ensure that corrective action is taken when supervision and consultation issues are identified through the annual clinical quality reviews.

RCS has developed an electronic template to monitor clinical site visit reports and deficiency remediation. Once the Regional Manager approves a clinical site visit, an electronic template identifying any deficiencies is completed in the Vet Center electronic recordkeeping system. Until all deficiencies are resolved, the clinical site visit report will remain in an incomplete status and highlighted on the responsible officials' menu every time they enter the Vet Center electronic recordkeeping system. This process was implemented on October 1, 2011.

Question 4. What is the suicide rate among our veterans who have been treated for mental health problems?

Response. In FY 2009 (the most recent year for which VA has data), the suicide rate among Veteran patients with mental health or substance use disorder diagnoses was 56.4 per 100,000, as compared to 23.5 per 100,000 among patients without these diagnoses. The resulting rate ratio was 2.4. This continues a steady trend of lowering rate ratios observed since FY 2001, when the rate among patients with mental health or substance use disorder diagnoses was 78.0 per 100,000, as compared to 24.7 per 100,000 among patients without these diagnoses (rate ratio of 3.2).

Question 5. What is the percentage of veterans who are receiving follow-up contact within 7 days of being discharged from a mental health ward as required?

Response. Data through November 2011 indicate that approximately 65.8 percent of VHA patients discharged from acute inpatient mental health hospitalization are contacted within 7 days of inpatient discharge. VA has targeted this measure for improvement in FY 2012, recognizing that Veteran preference and enrollment in fol-

low-up care outside of VA are factors in increasing the rates. The RAND/Altarum report indicated that private sector benchmarks for this measure were under 50 percent for follow-up.

Question 6. Is that follow-up contacting helping to identify at-risk veterans and reduce suicide rates?

Response. Yes, along with the follow-up requirements, there are more stringent requirements for those patients who have been identified as being at high risk. All of these efforts combined are making a difference. All patients who have a high risk designation should be seen a minimum of 2 times during the first 14 days after designation and 2 more times during weeks 3 and 4 after designation. Specific interventions, such as safety planning and attention to means control, are required. We believe that these interventions and follow-up strategies are effective and that the decreasing suicide rates among the Veterans with mental health diagnoses is an indication of this. The follow-up strategies and enhanced care package were started in 2008, and at this point we only have 2009 data to compare to. We will know more about effectiveness next year when the 2010 data is available from the Centers for Disease Control and Prevention.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SCOTT P. BROWN TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Should a Vietnam veteran suffering from PTSD be placed in the same peer counseling group with 21-year old Iraq and Afghanistan veterans? In other words, should the VA rely solely on evidence-based treatments without an appreciation for cultural, age and environmental concerns?

Response. OMHS is committed to transforming mental health services in VHA to the recovery model. One key part of that transformation includes individualized treatment plans that are designed to meet the Veteran's self-determined goals. The treatments that are recommended and provided to the Veteran take into account the Veteran's goals and individual characteristics and needs. Depending on the specific goals that are to be achieved, group therapy with Veterans from different service eras can be very beneficial, as can group therapy with Veterans from a single service era. The most important consideration, though, is what the individual Veteran needs in order to reach his or her recovery goals.

Given VA's Veteran-centric orientation, a decision about the type of group in which a Veteran should be involved for counseling should be based on a discussion of treatment options between the Veteran and his or her clinician. Although VA does rely heavily on evidence-based treatment, VA also has an appreciation for cultural, age, and environmental concerns. While VA policy indicates that all Veterans with PTSD must be offered and informed about evidence-based psychotherapies for PTSD, decisions about which psychotherapy a Veteran receives must be discussed with the Veteran and the Veteran's preferences must be considered. VA is extremely supportive of peer counseling programs (both formal and informal) and supports the fact that many Veterans choose to participate in peer counseling groups instead of, or in conjunction with, evidence-based psychotherapy. Although there are some Veterans who may not feel comfortable participating in peer support groups with Veterans from a different Service Era, there are other Veterans who may benefit from being in a peer counseling group with someone from a different generation who has had many similar experiences, despite the differences in service or generation. Treatment considerations should always be made on an individualized basis, as each Veteran has unique concerns and issues.

Question 2. The Committee has received anecdotal evidence from psychiatrists being ordered to reduce treatment sessions from one hour to 30 minutes in order to get more patients in each day, despite the doctor's belief that the patients need an hour of therapy. In an effort to get more veterans seen by mental health care providers, is the VA compromising on the quality of care it is providing?

Response. VA policy on delivery of psychotherapy services is designed to effect quality of care. Psychiatrists in the VA system as well as those in community private, Medicare/Medicaid, and self-pay settings typically provide medication management. VA patients are typically assigned to a psychiatrist for medication management and to a psychologist, social worker, or other licensed mental health provider for psychotherapy. However, psychiatrists can also provide psychotherapy if it is determined that it is clinically indicated. There are no national VA policies in place that restrict psychiatrists from providing any service that they determine is clinically indicated, as long as it is within their scope of practice. The appointment lengths for psychotherapy are determined by the standard of practice, typically either 20–30 minutes or 45–50 minutes, depending on what is determined to be clini-

cally indicated. For prolonged exposure, the appointment length is 90 minutes; this, however, is atypical of most psychotherapies. Local mental health leadership may direct its local resources of psychiatrists, psychologists, and other mental health providers to make services available to Veterans to meet their mental health care needs. In addition to local quality monitors, VA's Office of Mental Health Operations, assisted by the Office of Mental Health Services, is carrying out a series of sites visits designed to assess compliance with policy concerning access to care and provision of treatment services. The first wave of these visits was completed on December 30, 2011.

Question 3. Many of the panelists this morning are VA mental health care providers who are concerned with the timeliness and quality of care being provided to our veterans. They are frustrated by some of the administrative provisions that, from their prospective, are inhibiting their ability to provide meaningful, quality care. How is the VA using the knowledge and experience of its own practitioners to improve the currently challenged VA mental health care system?

Response. VA has a number of efforts underway to collect information from providers and to use this information to drive improvements in care. VA is currently sending site visitors to all VA health care systems in FY 2012. Part of the protocol is to interview frontline mental health staff about their experiences in care delivery and to ask them both for best practices that should be disseminated and for recommendations to improve care delivery at their site. Findings from the site visits will be used to develop improvement plans for facilities and, if widespread, to develop system-wide interventions.

VA has also contracted with Altarum to conduct 10 focus groups at facilities with front-line staff. The purpose of the focus groups is to understand concerns about barriers to delivery of care and to guide improvement. The report generated from the focus groups will be used to develop a survey that can be administered at every facility nationwide, and leadership will be charged with using the information to improve practice.

In addition, providers are often members of telephone communities of practice that VA has set up to allow providers with special skills to share information about best practices and opportunities for improvement. These national groups are often mirrored within VISNs to allow subject matter experts to meet regularly and improve care.

RESPONSE TO FOLLOW-UP POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BURR TO U.S. DEPARTMENT OF VETERANS AFFAIRS

Questions

1. Question 1 asked VA to provide the Committee with a breakdown of the providers that have been hired in mental health since 2006.

   a. For each discipline or professional listed please describe, in detail, what their primary responsibilities are in delivering mental health care to veterans?

      Response: All disciplines working in mental health may provide services within inpatient or outpatient settings. They may also provide either face-to-face or telemental health services. All disciplines may be assigned to any mental health program. In most instances, services are provided within mental health programs, but many clinicians are also assigned to medical or geriatric programs to provide support for Veterans in these programs. Most staff work within interdisciplinary teams that may provide cross coverage for Veterans receiving services within the program.

      Nurses: The majority of nurses provide services within inpatient or residential programs. Registered nurses provide initial screening and assessment on admission, primary nursing care as appropriate including ongoing monitoring of signs and symptoms, education about medications and medication administration, and assistance within the interdisciplinary team on discharge arrangements.

      In the outpatient setting, nurses assist in the injection clinic, screening, referral to service providers, advocacy, crisis intervention, education/health promotion and prevention, coordination of non-institutional and institutional services, supportive counseling and aftercare planning and case management services for Veterans with chronic mental illness.

      Physician Extenders (NOTE: Listed as "Physician Assistant" in VA's original response): Physician extenders may include advance practice nurses, such as clinical nurse specialists, nurse practitioners, and physician assistants. These staff provide many similar services to physicians but, depending on state law, may practice under the supervision of a physician.

      - **Clinical Nurse Specialists (CNS):** The assigned CNSs provide direct care to mental health clients. Functions of the role include providing health promotion activities, preventive interventions, health screening and evaluation, comprehensive mental health assessment, differential mental

health diagnosis, formulating outcome based treatment plans, psychotherapy interventions, psychobiological interventions, case management activities, mental health consultation/liaison activities, and clinical supervisory activities. CNSs assist others in the evaluation of patient outcomes. Other CNS duties include: providing individual and group therapy, family therapy, cognitive behavioral therapy and complete psychosocial assessment.

- **Nurse Practitioners (NPs):** NPs provide direct care to specific patient populations including comprehensive health assessment, differential diagnosis, ordering diagnostic tests and prescribing pharmacological and non pharmacological treatment to mental health clients. Other duties include provision of psychotherapy and medication evaluation.

- **Physician Assistants (PAs):** PAs provide direct care to patients often on inpatient psychiatric units including assessment, medication management and follow-up for physical conditions of Veterans housed in inpatient programs.

Physicians: The majority of physicians hired in mental health are psychiatrists who are responsible for providing psychiatric assessment, psychiatric consultation, treatment including evidence-based psychopharmacology, and medical evaluation with respect to physical disorders which effect cerebral functions and behaviors; assessment and ordering laboratory and diagnostic testing; comprehensive suicide risk assessment: crisis assessment and management and interdisciplinary treatment planning. Some psychiatrists may also be employed to provide integrated disability evaluation system and compensation and pension (IDES/C&P) examinations.

Some physicians hired within the mental health unit may be internists or other general medical providers and provide medical assessment and follow-up for Veterans primarily housed in mental health inpatient units or residential programs.

Psychologists: Psychologists hired within the mental health unit are responsible for providing psychological assessment including neuropsychological assessment, psychological consultation, psychotherapy including the evidence based psychotherapies for both mental health conditions and behavioral medicine concerns, suicide assessment, crisis assessment and management, and family and marital therapy. Some psychologists may also be employed to provide IDES/C&P exams.

Social Workers: Social work staff within the mental health unit provide case management for chronic mental health disorders, case management for high-risk conditions including suicidal risk and violence risk, psychosocial evaluation/treatment to include support of families and referrals to VA and

community resources, comprehensive suicide risk assessment, crisis assessment and management, psychotherapy including the evidenced based psychotherapies, and marital and family therapy.

Therapists: Other therapists may include licensed professional counselors, licensed marital and family therapists, or vocational counselors, who provide case management for high risk conditions including: suicidal and violence risk, psychosocial evaluation/treatment, to include support of families and referrals to VA and community resources, comprehensive suicide risk assessment, crisis assessment and management, psychotherapy including the evidence-based psychotherapies, and marital and family therapy.

2. Also in response to Question 1, VA indicated that the "[t]otal includes staff hired for the Homeless program as well as mental health."

   a. Please provide the Committee the amount of staff hired in each discipline for the homeless program since 2006.

   Response: The Full Time Employee Equivalent hired in each discipline for the Homeless program from 2006 to 2011 is as follows:
   Nurse: 32.76
   Physician Extender*: 8.37
   Physician: 25.87
   Psychologist: 33.89
   Social Work: 940.68
   Therapist: 38.38

   * NOTE: Listed as "Physician Assistant" in original VA response.

   VHA hires staff in both full-time and part-time positions and staff may also be assigned multiple responsibilities. To understand staffing needs, VHA aggregates workforce data based on the amount of time an employee is assigned to clinical work, education, research, or administrative responsibilities. For example, a physician who is assigned to provide direct clinical care 80 percent of the time and is working on a research grant 20 percent of the time is listed in the database as .8 Full Time Employee Equivalent (FTEE) for direct clinical care and .2 FTEE for research. A physician assigned to 100 percent direct clinical care is listed as 1 FTEE. At a national level, VHA aggregates staffing data based on the sum of the FTEE within and across the categories of research, education, clinical and administration. VHA does not collect the data based on the number of Full Time Employees (FTE).

   The breakdown of staff listed above was developed retrospectively, as prior to 2011 all homeless positions were included in total mental health hires.

b. Of the staff hired under the mental health program for the homeless program, what are the responsibilities of these positions?

Response: In early 2011, in VA Central Office, the VHA Homeless Program Office was reorganized under the Office of the Deputy Under Secretary for Health for Operations and Management. Prior to this reorganization, the VHA Homeless Program Office was organized under the Office of Mental Health Services, in the Office of Patient Care Services. Despite VA Central Office organizational changes, field-based homeless programs and staff are closely aligned with mental health services and provide a seamless continuum of care to Veterans who may be homeless or at risk of homelessness. The staff identified in the response to question 2a are considered mental health professionals.

The primary goal of VHA's Homeless Programs is to return homeless Veterans to self-sufficiency, improve mental and physical health, and move towards independent, stable living. Every VHA mental health professional working in a homeless program discipline or profession is expected to perform outreach and engage Veterans who are homeless, at-risk of homelessness, or may have limited use of VA services. Consequently, many clinicians in the homeless program spend a significant amount of time away from VA facilities providing direct services in the community, and thus have non-traditional schedules and clinic organization. Furthermore, a number of these mental health professionals perform administrative, management, and supervisory functions as needed or as described in their performance plans. Although the specific responsibilities of mental health professionals may vary, in general, their responsibilities are:

Nurses: The primary responsibilities of nurses as part of homeless teams may include but are not limited to, performing assessments, case management, health screenings, crisis intervention, medication administration, vaccinations, and care management. Nurses on homeless teams work both in VA facilities and in the community providing outreach, crisis intervention, and case management and home visits for Veterans participating in the Department of Housing and Urban Development (HUD) – VA Supportive Housing (HUD-VASH) program. Nurses collaborate with other health team members to facilitate positive patient care outcomes, and provide a full range of nursing care to Veterans with a wide variety of physical and behavioral health care needs. In transitional housing settings such as Health Care for Homeless Veterans (HCHV) contract sites and Grant and Per Diem (GPD) sites, nurses provide individual nursing care as well as group health education and disease prevention classes for Veterans regarding mental health and medical conditions, medications, treatment plans, coping skills, case management, and social skills training. In all homeless programs, nurses collaborate with other health care team members to facilitate continuity of care for Veterans.

Physician Extenders (NOTE: Listed as "Physician Assistant" in original VA response): For the purpose of this response, Physician Extenders are categorized as either Physician Assistants (PA) or Advanced Practice Nursing (PA/APN): PA/APNs perform screenings and comprehensive biopsychosocial examinations to determine medical and mental health needs and appropriate levels of care. They order and interpret diagnostic studies, perform full physical and mental health examinations, formulate medical diagnoses through collaboration with consulting physicians, provide preventive health and disease management education, and prescribe medication. PA/APNs also collaborate with team members to develop and facilitate a comprehensive, individualized treatment plan. As part of a homeless medical or psychiatric team, PA/APNs have additional specialty in skills specific to working with homeless populations. These skills include using motivational interviewing to engage Veterans in medical care, understanding challenges in nutrition, medication storage and medication administration for Veterans who are homeless, and developing specialties in treating medical issues with sensitivity to housing status. PA/APNs are also able to identify ways to provide treatment when a Veteran is living on the street or in a group transitional living environment (wound care and dressing, treating injuries and poisoning, treating heat and cold related trauma related to outdoor exposure, treating infectious diseases, managing medications for chronic illnesses in a street or group living environment). Homeless teams may also have PA/APNs with internal medicine or behavioral health specializations.

Physicians: Physicians as part of homeless teams can be either internal medicine specialists as part of a homeless primary care team, or psychiatrists as part of a homeless mental health clinic or an Assertive Community Treatment team. The primary responsibility of physicians is delivery of direct patient care, including diagnostic assessment, providing pharmacological treatment, and providing preventive health education to optimize patient health and functioning. Physicians on homeless teams are required to practice with a great deal of flexibility, as walk-in patients and unscheduled patient traffic is a normal occurrence. Physicians are required to develop specialty in issues common among homeless populations. Physicians also supervise and collaborate with PA/APNs.

Psychologists: The psychologists' role in homeless teams includes outreach to homeless Veterans in the community, psychiatric diagnostic assessment, psychological testing and evaluation, group and individual psychotherapy, case management, and patient education. Psychologists participate in the development of treatment plans for each Veteran contacted through outreach. Psychologists are responsible for the assessment, identification, facilitation, referral and linkage to appropriate medical and psychiatric services for Veterans identified as eligible for services. Psychologists conduct individual and family clinical interventions to facilitate the identification of substance abuse, psychiatric illness, and social needs as treatment issues. Psychologists assist Veterans in services stabilization by consulting and intervening when problems arise with

service providers and assist in priority management and pace of services of Veterans in treatment programs. Psychologists often serve as clinical supervisors for psychology interns.

Social Workers: Social workers as part of homeless teams provide a wide range of services across all homeless programs. This includes case management and direct outreach in the community to engage Veterans at street and encampment locations, shelters, soup kitchens, homeless drop-in centers, as well as work with community agencies to develop community-wide street outreach strategies. In direct interaction with Veterans, social workers perform comprehensive biopsychosocial assessments, develop integrated treatment plans, develop referral networks of VA and non-VA providers to meet Veterans' comprehensive needs, and provide ongoing case management services to ensure care coordination. Social workers assist Veterans in locating, obtaining and maintaining safe, affordable permanent housing. Social workers at the licensed independent provider level provide individual and group therapy using evidenced-based practices such as motivational interviewing and cognitive behavioral therapy. Social workers serve Veterans in difficult situations including those with chronic, severe and persistent psychiatric, medical, and substance abuse issues, in community environments including on the street, in homeless encampments, in missions and shelters, and in jails and prisons. When working with HCHV contract agencies and Grant and Per Diem (GPD) providers, social workers are responsible for facilitating grant and contract payments through oversight, by ensuring that GPD community providers and HCHV contractors are providing the requisite services, by coordinating services provided by community-based programs funded by VA, and coordinating treatment plans between community and VA providers. When working in the HUD-VASH program, social workers are responsible for coordinating with local public housing authorities and serving as the primary liaison between VA and the housing authority. The goal of all homeless social work intervention is to increase stability in Veterans' lives and assist Veterans in returning to independent, healthy, productive lifestyles.

Therapists: Therapists are responsible for conducting assessment interviews, developing treatment plans, and providing clinical treatment to Veterans. Treatment may include individual, family and group counseling, crisis intervention, and short and long-term therapy. Homeless team therapists often provide substance use disorder treatment, bringing services to the Veteran either in group settings such as HCHV contract and GPD transitional housing facilities, or directly in a Veteran's home as part of a HUD-VASH team.

3. Question 2 asked how VA planned to address the lack of appointment availability for follow up care. In response, VA indicated they had "developed national guidance on fully implementing [evidence based practices] at the local level." VA also responded they have "developed a Task Force that has issued recommendations for a national

strategy to promote the implementation of evidence based psychotherapy for PTSD telemental health services."

a. Please provide the Committee with the national guidance on implementing evidence based practices (EBP) and the recommendations of the Task Force.

   Response: Guidance on the local implementation of evidence-based psychotherapies (EBPs) has been developed. The guidance is under review in VHA Central Office. The recommendations for a national strategy to promote the implementation of EBP for PTSD telemental health services have been adopted and incorporated into the VHA's Improving Veterans Mental Health (IVMH) Initiative. This was done to coordinate with the IVMH Initiative's focus on promoting innovative models of care and the delivery of evidence-based psychotherapy services. The elements of this national strategy include: (1) expansion of Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE) clinical video teleconferencing services provided from medical centers to community-based outpatient clinics; (2) Piloting of two to three regional CPT and PE clinical video teleconferencing clinics that will augment the delivery of CPT and PE telemental health services provided by local medical centers and clinics and serve as regional sites of excellence and technical support; (3) Expansion of CPT and PE clinical video teleconferencing services provided to Veteran patients sitting in remote non-VA sites in the community (e.g., colleges and universities, community health agencies); and (4) Acceleration of testing of home-based CPT and PE clinical video teleconferencing services. Significant activity and coordination within VHA is underway to implement this strategy nationally and ensure that clinical implementation efforts are sustained.

   Approximately $12 million has been allocated to the Veterans Integrated Service Networks (VISNs) to place specialized staff at carefully selected sites to deliver CPT and PE through clinical video teleconferencing to Veterans located at remote Community Based Outpatient Clinics and at non-VA community sites, as well as to establish regional pilot EBP for PTSD telemental health clinics at three selected sites (Charleston, San Diego, and San Antonio). Each of the regional pilot clinics have been funded for three full-time mental health staff with expertise in the delivery of EBP for PTSD telemental health services. Staff at the regional clinics, and staff being placed at local medical centers and clinics as part of promoting local delivery of EBP for PTSD telemental health services under the first component of the national strategy identified above, may be new hires or reassigned existing VA mental health staff with specific expertise in providing EBP for PTSD telemental health services. A national EBP for PTSD Telemental Health Provider position description has been developed to facilitate the local hiring or reassigning of staff to this position [position description is attached]. Furthermore, reporting and tracking tools have been developed to identify and communicate key (short- and longer-term) milestones with deliverable dates to track local implementation progress and promote accountability. A performance measure is being developed to be incorporated into the VA Mental Health Initiative Operating Plan requiring each VISN to demonstrate activation of psychotherapy for PTSD telemental health services in fiscal year 2012. For this measure, each VISN will need to demonstrate telemental health capacity for delivering these services has been activated during this first year of this initiative. This measure will be reported to VHA senior leadership as part of the monthly monitoring of implementation of the VA Mental Health Initiative. The VHA Mental Health staff will work with any VISNs having difficulty with activation to help them reach success on this measure.

ATTACHMENT: DUTIES, RESPONSIBILITIES, AND QUALIFICATIONS OF EVIDENCE-BASED PSYCHOTHERAPY (EBP) FOR PTSD TELEMENTAL HEALTH (TMH) PROVIDER

Background: As part of its efforts to innovate and transform health care, the Veterans Health Administration (VHA) has nationally implemented telehealth services, including, specifically, telemental health services. Building on these efforts, VHA is in the process of a major expansion of telehealth care. One major component of VHA's expansion of telehealth services and area of significant opportunity is the delivery of evidence-based psychotherapy for PTSD through telehealth modalities, including clinical video teleconferencing (CVT).

Over the past several years, VHA has nationally disseminated and implemented Cognitive Processing Therapy (CPT) and Prolonged Exposure Therapy (PE), two evidence-based psychological treatments for PTSD that are among the most effective treatments available for PTSD (Institute of Medicine, 2007; VA/Department of Defense, 2010). Pursuant to VHA Handbook 1160.01, *Uniform Mental Health Services in VA medical centers and Clinics*, all Veterans with PTSD must have access to CPT and PE as designed and shown to be effective. Indeed, telemental mental health modalities, such as CVT, offer increased ability to provide these specialized interventions to Veterans in remote and rural areas who may otherwise have limited access to these treatments. Moreover, recent research, including research conducted within VA, has shown these therapies to be effective and well-accepted by patients when delivered utilizing telehealth technologies, with results on par with face-to-face delivery of these treatments.

The Office of Mental Health Services, in collaboration with the Office of Mental Health Operations in the Office of the Deputy Under Secretary for Health for Operations and Management (10N), is implementing a national initiative to implement CPT and PE telemental health services, pursuant to the recommendations of a national VA Evidence-Based Psychotherapy for PTSD Telemental Health Task Force. One primary component of this initiative is the expansion of CPT and PE delivery through "hub and spoke" VAMC-to-CBOC clinical video teleconferencing. As part of this expansion, full-time EBP for PTSD Telemental Health Providers will be placed at various medical centers and clinics throughout the system. Specific plans are being developed with each VISN regarding the placement of EBP for PTSD Telemental Health Providers at specific facilities.

Summary: The EBP for PTSD Telemental Health Provider is a licensed independent mental health professional, including psychologists, social workers, advance practice nurses, marriage and family therapists and licensed mental health professional counselors (hired under Hybrid Title 38) that can provide CPT and/or PE to treat Veterans with PTSD telemental health services. Funding is available through VACO to hire new staff in this role; appropriate existing staff may also be reassigned to serve in this role. Process and outcome procedures will be implemented nationally to evaluate the impact of the specialty mental health services provided by the EBP for PTSD Telemental Health Providers.

Duties:

The EBP for PTSD TMH Provider will focus on the delivery of CPT and/or PE to Veterans through telemental health modalities. This is a full-time position. Specific duties include:

1. Providing screening, assessment, diagnosis, and treatment of Post Traumatic Stress Disorder, and concomitant conditions, with a primary focus on the delivery of Cognitive Processing Therapy (CPT; either using group or individual modalities) and/or Prolonged Exposure (PE), both time-limited, evidence-based approaches to the treatment of PTSD;
2. Providing CPT and/or PE through the use of telemental health modalities; evidence-based psychotherapies for other mental health conditions may be provided on a limited basis as a secondary role;
3. Applying advanced theories and techniques to a wide range of patients with PTSD;
4. Providing professional consultation in areas related to evidence-based treatments for PTSD;
5. Coordinating treatment planning and delivery of services that best meet the needs of patients diagnosed with PTSD and are based on scientific research on optimal treatment;
6. Promoting communication/interactions between team members, patients, and their families to facilitate the treatment process;
7. Training and supervision of clinical staff/trainees, as appropriate;

8. Participation in program evaluation efforts in conjunction with Office of Mental Health Services, the medical center, and Office of Telehealth Services as appropriate;
9. Other duties as assigned.

Qualifications:

- Knowledge of clinical research literature regarding treatment of PTSD.
- Previous experience providing direct clinical care to adults with PTSD is preferred.
- Previous experience providing evidence-based interventions for mental health problems is preferred.
- Trained to competency in CPT or PE, or is willing to complete competency-based training in one or both of these therapies.
- Ability to deliver CPT or PE through telemental health modalities is preferred.
- Independently licensed to provide the required clinical services or will become independently licensed within two years of hiring and will be supervised by licensed VA staff in the interim.
- Demonstrated ability to function successfully as a member of an interprofessional team and to independently carry out clinical responsibilities is preferred; willingness to be mentored in acquiring this capacity is acceptable.

Knowledge of common medical and mental health conditions associated with PTSD is preferred.

b. When will both the guidance on implementing EBPs and the recommendations of the Task Force be fully implemented?

Response: The guidance on implementing EBPs has been drafted and and is under review in VHA Central Office. Additionally, VHA mental health staff are assessing the implementation of EBP as part of the site visits to all VISN health care systems currently being conducted as required by the Mental Health Action Plan. Barriers to implementation are being identified and assistance is being provided to help develop action plans. Once the guidance is finalized, a timeline for implementation will be developed and facilities will be required to submit action plans with timeframes for completion.

Task Force recommendations are to be implemented and clinical activity underway by the end of fiscal year 2012, with continued expansion in 2013 and 2014.

Chairman MURRAY. Thank you very much.

Dr. Schohn, I am glad that the department has recognized the inadequacy of the waiting times and how they are measured and has pledged to hold our network directors accountable for their performance on these metrics. But I wanted to ask you if you believe that facilities are gaming the system and not fully reporting wait times and wondered what you thought.

Ms. SCHOHN. VHA does not condone gaming of any sort. I am not aware of particular facilities that are doing anything of the kind; and if I were, I would act immediately on finding that out.

We are engaged in auditing to ensure, in fact, that that is not happening. It is a requirement of the directive published by VHA in terms of auditing this on a regular basis. But we are conducting a special audit of mental health practices to reinforce that it should not be happening.

Chairman MURRAY. Why do you think there is a disconnect between what the VA providers are telling us and what VA is telling Congress?

Ms. SCHOHN. I believe the disconnect is in some of what was mentioned by Dr. Washington is that patients are not having access to the evidence-based therapies in the way that we expect they should be.

What we understood from the provider survey was that providers were saying that there is access to the system but not necessarily access to those specific therapies in the times that they should occur, and we are working on ensuring that that happens.

We have recently put through a new information to the field and are working also through site visits and actually reaching out when we get evidence that that is happening to find ways to solve the issues that Dr. Washington presented here today.

Chairman MURRAY. Dr. Zeitz, I wanted to ask you when you testified at a hearing before this Committee May 25, I asked you whether the VA had enough resources to meet OEF/OIF veterans needs for mental health care and you said the researchers were not the problem.

In light of what you have learned since last May, especially from your own providers, do you stand by that statement from May?

Ms. ZEISS. I believe that we have unprecedented resources and that we have gotten them out to the field, and we have hired an enormous number of staff; and at the time, I believe that they were adequate if used in the most effective ways possible.

We continue to have an increasing number of mental health patients. We have looked at the fiscal year 2011 data and the numbers have again jumped from fiscal year 2010 and we are proactively predicting what kinds of increases there will be in fiscal year 2012, and we are working with the Office of Policy and Planning to ensure that those predictions are embedded into the actuary model that drives the budget predictions.

So, I can say that we will be aggressively following all the data that we have available to ensure that we can make effective predictions at the policy level about what the level of funding and level of staffing is that would be essential, and we will be partnering very closely with Dr. Schohn's office who are responsible for ensuring that those resources are used most effectively in the field, are used specifically to deliver the kinds of care that we have developed.

Chairman MURRAY. So, you still today do not believe it is resources that are the issue?

Ms. ZEISS. I believe that we are at a juncture where we need absolutely to be looking at resources because of the greatly increased number of mental health patients that we are serving.

And some of that is because of the very aggressive efforts we have made to outreach and to ensure that people are aware of the care that VA can provide.

The more we succeed in getting that word across and serving an increasing number of veterans the more you are absolutely right that we have to look at what is the level of resources to keep, to be able to sustain the level of care that we believe is essential.

Chairman MURRAY. You are looking at it. You are asking. We need to have this information up front now if we need more resources. I mean, you just look the story up there of the thousands

of people coming home. The people are not getting served, the people who we are reaching out to.

It just feels to me like this is something we should know now. We have been 10 years into this.

Ms. ZEISS. We believe that people are receiving an enormous amount of service from VA, and we agree as Dr. Schohn has said that we need to focus in on some specific aspects of care particularly the evidence-based therapies, and we are working with Dr. Schohn, who will be developing a very specific staffing model so that we can identify what are the levels of staffing that are available at specific sites that and how does map on to care.

Chairman MURRAY. Well, let me ask a specific question: Dr. Schohn, according to the mental health weight data provided to the Committee by the VA, veterans at Spokane VA in my home State wait an average of 21 days for an appointment with a psychiatrist with a maximum wait time for a psychiatrist being 87 days.

Now, I have been told that all of these psychiatrists at the VA in Spokane are booked solid for several months, and there are other places in the country that are far worse than that.

You mentioned that the VA is working to fill those vacancies, but the hiring process is very slow. What can the department do now to make sure that we are shortening these wait times?

Ms. SCHOHN. In fact, there are efforts already underway in Spokane to improve the hiring. There, in fact, the waiting time has decreased. There is a shortage and there is variability in our system in terms of ability, for example, to hire psychiatrists in Spokane.

One of the efforts that is being made is to use telepsychiatry, essentially to provide service from a site where there is a greater ability to recruit psychiatrists and to use their services at the site where they are at and to then be able to provide services to Spokane, for example.

The Chief Medical Officer in Spokane has worked to ensure that coverage can come from other facilities within VISN 20 to ensure that the needs of the veterans in Spokane are met.

Those are the kinds of things that we are working on as we come across evidence that, in fact, there are shortages in some areas. We know that in some other areas there are not shortages and that there may be some surplus that can be used at those sites.

Chairman MURRAY. OK. Well, let me ask you another question. There was a provision about using community providers for mental health services in the caregivers omnibus bill that was passed by Congress earlier this year.

It included peer-to-peer services, and we heard from our first panel about how important access to care and peer- to-peer services are. I am told that the department is making very little progress on implementing that.

Can you tell me what is holding up that?

Ms. SCHOHN. We have made some progress. I am going to ask Dr. Kemp to talk specifically to that.

Ms. KEMP. As you are aware, most of our peer-to-peer services or a lot of our peer-to-peer services I should say are provided by Vet Centers, which is an exceptional program that you are all very familiar with and we endorse and support.

We have grown the number of Vet Centers. By the end of this year we will have 300 Vet Centers across the country open and working in addition to the 70 mobile Vet Centers that will be up and traveling across the country.

So, I think we have made huge strides in providing those services to combat veterans and their families across the country.

We also have a contract which has been let out and is in the process of being filled to provide training to train more peer-type support counselors. We are looking forward to that being completed, and we will get those people up and going as soon as we are able to get them on board.

We agree with the intent of that legislation for lots of good reasons. We will continue to implement those services.

Chairman MURRAY. OK. Well, this Committee will be following that very closely. And before I turn it over to Senator Burr, I just want to say I am really disturbed by the disconnect between the provider data and your testimony on the wait-time issue, and I am going to be asking the Inspector General for a review of that issue.

I assume, Senator Burr, you will join me in that, and I would like all of your commitment to work with them to make sure we get the data.

Ms. KEMP. Absolutely.

Chairman MURRAY. Senator Burr.

Senator BURR. Thank you, Madam Chairman.

Dr. Schohn, how is it that that Give an Hour can identify the need for flexibility in the delivery of mental health services but the VA cannot?

Ms. SCHOHN. I think we agree with Give an Hour that we do need to have flexible mental health services. VHA in its uniform services package has had the policy that off-hours is required at all medical centers and very large CBOCs since 2008.

What we understand from the survey is that off-hours have not always been available at the smaller Community-Based Outpatient Clinics. The policy group that Dr. Petzel has just put together is addressing those issues, and I would ask Dr. Zeiss to speak specifically to that.

Ms. ZEISS. Well, and let me just check on the question because you talked about flexibility, and there are many aspects of flexibility.

Senator BURR. I will give you credit for having one. How about that? But I have yet to see one yet.

Ms. ZEISS. I believe, as Dr. Schohn has been saying, we do have flexibility in hours of service. What we have discovered is, in looking at the data, is that the initial requirement was for evening clinic, one evening clinic at least a week and others as needed.

What we are finding is that the data suggests that what works much better for veterans is early morning hours and weekend hours. So, the policy group is looking very carefully at that in terms of changing and creating even more flexibility than the original after-hours policy.

The uniform mental health services handbook that Dr. Schohn referenced also has an incredible array of flexible programs and defines a very broad range and flexible range of mental health services that can be provided.

Senator BURR. Let me stop you there, if I can. Let me just say I have a tremendous amount of respect for all of you. I mirror what you have heard from other colleagues. I thank all the VA employees for what they do.

But the fact that you have got something written in a book or you have put out a guideline and believe that you can still come in front of this Committee and say, we have got it, it is written, it is right there.

What we hear time and time again, and I heard from Mr. Roberts in his testimony, there is no evening option in areas. It does not exist.

Whether your data shows that is preferred to be in the morning or the afternoon, in his particular case your guideline says the evening, and he testified it does not exist.

So, I hope you understand our frustration and, Dr. Schohn, I am going to ask you to provide for the Committee a detailed audit of how the $5.7 billion has been spent; and I am not talking about breaking it down into 403 million categories. I am talking about for the Committee a detailed description of how we spent that $5.7 billion in additional mental health money.

RESPONSE TO REQUEST ARISING DURING THE HEARING BY HON. RICHARD BURR TO MARY SCHOHN, PH.D., DIRECTOR, MENTAL HEALTH OPERATIONS, U.S. VETERANS HEALTH ADMINISTRATION

Aspects of VHA FY11 MH Obligations

	VHA Acute Psychiatry	Psychiatric Residential Rehab Treatment	Domiciliary Residential Rehab Treatment	VA Outpatient Clinics	Total VHA
Physicians Salary & Benefits	$92,311	$13,092	$15,423	$469,635	$590,461
Nurses Salary & Benefits	$488,181	$50,407	$61,656	$300,945	$901,189
Other Staff Salary & Benefits	$404,704	$115,821	$226,376	$1,352,502	$2,099,403
Facilities	$250,230	$45,425	$94,882	$435,897	$826,434
Research Support	$4,056	$811	$577	$34,952	$40,396
Nutritional Counselling	$280	$221	$248	$1,723	$2,472
Purchased Care	$85,278			$6,613	$91,891
Purchased Homeless Care	$158,995				$158,995
Drugs	$33,993	$7,713	$14,736	$1,707	$58,149
Medical Supplies	$12,749	$2,484	$4,641	$7,889	$27,763
Provisions (Food)	$11,626	$4,058	$12,240	$245	$28,169
Operating Supply	$5,280	$1,162	$3,048	$7,460	$16,950
Other Supplies	$6,346	$1,795	$4,099	$7,913	$20,153
Non Med Contracts	$16,268	$3,583	$6,784	$40,227	$66,862
Med Care Contracts	$6,268	$2,197	$3,080	$42,711	$54,256
House Staff Contracts	$19,014	$1,719	$1,051	$26,049	$47,833
Contract Providers	$9,444	$1,055	$2,289	$27,752	$40,540
Other Contracts	$12,971	$2,926	$5,590	$30,481	$51,968
Beneficiary Travel	$272	$516	$814	$56,537	$58,139
Other Travel and Shipments	$14,660	$2,424	$4,985	$29,584	$51,653
Equipment	$16,001	$2,161	$7,064	$20,529	$45,755
National Overhead	$82,935	$13,203	$15,996	$127,002	$239,136
Totals	$1,731,862	$272,773	$485,579	$3,028,353	$5,518,567

Mental Health Obligations ($000):

Inpatient	
VA Inpatient Hospital	$1,487,430
Contract Inpatient Hospital	$244,432
Psychiatric Residential Rehabilitation Treatment	$272,773
VA Domiciliary Residential Rehabilitation Treatment	$485,579
Outpatient	
VA Outpatient Clinics	$3,021,740
Purchased Outpatient	$6,613
Total	**$5,518,567**

Now, let me just ask you. Is Dr. Washington is correct when she said a majority of the patients seen in the 14-day window are there for the purposes of information gathering, not necessarily treatment, and many are not seen by the health care professional, they are seen by staffer there to collect data.

Ms. SCHOHN. That is not how the policy is written, and if that is happening——

Senator BURR. Then let me ask it again. Is she right or is she wrong?

Ms. SCHOHN. I do not know about Wilmington I will admit. That is something I would certainly want to follow up on because that is not the expectation of how services are to be delivered.

Senator BURR. Let me read you some comments that have been made today, Dr. Schohn, and you just tell me whether these are acceptable.

Veterans have little access to follow-up care.

Ms. SCHOHN. That is not acceptable.

Senator BURR. VA focuses on medication management.

Ms. SCHOHN. That is not acceptable, and we have a huge policy and training program to ensure, in fact, that veterans have access to evidence-based psychotherapy.

Senator BURR. Cannot fill appointments for the prescribed amount of time.

Ms. SCHOHN. That I am not totally clear what that means.

Senator BURR. I would take for granted that an attending had said that somebody with PTSD needs to have a frequency of consults, a frequency of treatment and it should extend for "X" amount of time.

Would you find it unacceptable if, in fact, the system was not providing what the health care professional prescribed to have?

Ms. SCHOHN. Absolutely. We do have a system set up in place to actually monitor if, in fact, this is not happening. We are concerned by reports that it is not happening in places. We have many evidences of places where it is happening. But as we hear these reports, we are as concerned as you are and have developed a plan to go out and visit sites to ensure that these things are happening and to make corrections when they are not.

Senator BURR. Inability to get appointments.

Ms. SCHOHN. Same thing. The VA is available to veterans. We want to assure that any veteran needing mental health care has access in the timeliness standards that we think are important.

Senator BURR. Mental health treatment is trumped by new entries into the VA system.

Ms. SCHOHN. Again, not acceptable.

Senator BURR. These are all issues that exist with the current mental health plan at VA, and I would only say to you that the one difference between what I heard from Give an Hour or any group that has been in that has focused on mental health treatment for our veterans and where the VA is, and I hope you will not take this the wrong way, is they are focused on outcome and you are focused on process.

As a policymaker, our commitment to our country's veterans are we are going to get you better, and we are sticking them in a system that they are the first one that loses confidence in it. We are sort of the last ones. We are still debating.

I would tell you that maybe we need to look at how everybody else is looking at the mental health within the VA and ask ourselves, if so many people find in substandard, if so many people

have difficulty navigating it, would it suggest to us that the plan that we have got is either not working or it is the wrong one?

It is troubling to me that you can have a not-for-profit organization like Give an Hour or any other one that is out there that the VA is not aggressively reaching out to try to utilize in some fashion to leverage our ability to deliver care.

Any comment on that?

Ms. SCHOHN. I would just like to clarify. VA is recognized as the largest integrated mental health provider in the country and quite possibly the world.

The GAO and the RAND study have recently shown that it is leading the private sector and other providers of health services in terms of mental health. We are concerned about the variability, and we are concerned about the stories that we hear where we are not living up to our aspirations.

Senator BURR. So, are we just sort of plucking out of the United States just the people that fall through the cracks, and everybody else makes it?

Ms. SCHOHN. I cannot address that. I can say that we do have evidence of patients being seen in a timely fashion, of getting access to the care they require, and again, I am personally concerned when I hear these stories about that not happening.

Senator BURR. I remember last time, and I cannot remember whether it happened, Chairman, in the last hearing but we had one that dealt with suicides, and the VA highlighted the fact that their 24-hour hotline calls had increased and how successful that was.

And my comment was that that is a demonstration that our mental health treatment does not work in the fact that more people are considering suicide and calling the 24-hour hotline.

We look at things somewhat differently. And maybe as you provide for us that detailed breakdown of how we have spent this money, maybe the Committee can glean some information; and through our collective efforts, we can find how to tweak the plan or put the parameters in place that assure us that we are making progress.

But I think what, and I do not want to speak for the Chairman, but I think what she and I are saying is these hearings are not going to be 6 months apart from now on.

They are going to be much closer together. We are going to get to the granular level of understanding of exactly the execution, and I am willing to do it facility by facility by facility.

So, the Chairman may not ask you about Washington next time, and I am not going to ask you about North Carolina. It will not be Spokane, and it will not be Fayetteville. But maybe Mars Hill and I do not expect you to know where Mars Hill, is but I would expect that our confidence that we deliver care in a town of 3,000 is as confident as we deliver care in a town of 3 million.

And if we are not there yet, which I do not think we are, then we have a long way to go. I thank you.

Chairman MURRAY. Thank you very much, Senator Burr.

I am now going to turn it over to Senator Rockefeller. He has chaired the Committee before, so I am going to turn the gavel over to him as well.

I want the VA to know that I will be submitting questions for the record; and, as Senator Burr said, this is not a one-time shot hearing. This is something we both care deeply about. We are going to continue to pursue it. Again, we have many, many soldiers coming home, many who need to be accessing the system. This is a number 1 priority for all of us.

Senator Rockefeller.

Senator ROCKEFELLER. I want the gavel.

[Laughter.]

Chairman MURRAY. I knew you would.

[Laughter.]

Senator ROCKEFELLER [presiding]. Thank you, Chairman Murray.

STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

It should be easy to tell the truth. It should be easy to say that you are not satisfying the needs of veterans, that the policy says that you should be or that you are but, in fact, that you are not and you know it.

The way this should work is that you should be able to tell us that it is not working, that the policy says that, but, in fact, it is not working.

Why do I say that? For two reasons. One, as your testimony, the three of you have been vetted by OMB.

Ms. ZEISS. Yes.

Senator ROCKEFELLER. Yes. I am pretty sure the answer is yes.

But you understand what that means to us. Why should we have a gulf between us? We do not for 1 minute doubt, in fact, we rejoice in the improvements that the VA system is making, the points about it being better than the public system and the private system and all of that I think it is true.

But it does not get all the veterans taken care of which is the only thing that matters. That you are better by a factor of seven than Johns Hopkins, it still does not matter if you are not taking care of the needs.

Now, there are things to be said in your defense. I mean, the requests for mental health from 2007 to last year have gone up by a factor of, I do not know, it is 35 requests in 2006 to 139,000 among just recent veterans, and that is just the veterans of the two wars.

So, then somebody asked you are people dropping between the cracks and then you cannot because at OMB, because you represent the Obama Administration. I happen to think that Shinseki is the best VA Secretary we have ever had, and I have been on this Committee for 26 years, 27 years.

But things go wrong, things still go wrong. You cannot grow fast enough. You have got budget problems. You are out hiring mental health counselors like crazy, thousands of them, got 150 VA centers across the country, maybe more, all kinds of Vet Centers, CBOCs and all the rest of it.

And you do not make me unhappy if you say, we are not doing what we should be doing, we are failing some people. The policy says we are not. OMB says we cannot say anything to you.

And at some point, see, that makes all of the system kind of a farce. I believe in you. I trust you. What I want to do is to be able to trust your words, what you want to be able to do is believe in your words when you answer our questions.

I do not think you can at this point because VA is huge. Twelve million people were for it or whatever it is and so there is a chain of command; and if somebody gets out of the chain of command, there is all heck to pay.

Number 1, that is not the way General Shinseki looks at it. It may be the way your supervisors look at it or the way your departmental bosses look at it.

But we cannot have hearings, we cannot make progress at the rate that we should, we cannot praise you to the extent that we should, we cannot criticize you accurately to the extent that we ought to and which you want us to do because you have a proscribed statement that you give and a proscribed policy that you have to stick with.

And that is just not conversation. That is not progress. See, I trust you more when you tell me that we are not serving a whole block of, forget about detox for the moment, I am just talking about, you know, women who are uncomfortable sitting in waiting rooms with men because they are doing PTSD or whatever it is or sexual trauma problems, and they are uncomfortable sitting in a room with men.

A very logical answer that you could give me, say, you know that is true and the reason for that is that we do not have enough rooms in which to be able to split them up so that they can have their privacy.

You would say that hopefully only if it were true but my guess is it probably is true because the rush to attention under Chairman Murray and Ranking Member Burr about the general problems of veterans has exploded in this Committee in the last five, six, seven, eight, 9 years. It has exploded. We want to help.

You know, one of the reasons that I am sort of glad that the Super Committee did not succeed is because you all are protected in the sequester process, and you were not in their process.

Now, I am not saying they would have done anything to you. I just do not know. But I just want to hear the truth. Otherwise, we are not having a hearing. We are having a you-are-holding-up-your-end-of-the-bargain. We are trying to be tough questioners. You are trying to be tough answers. And nothing is substantially accomplished from it.

That is a deep, deep frustration. It is not just with you. In the Commerce Committee, in the Finance Committee and the Intelligence Committee, Senator Burr and I are on that, it is the same thing. It is the same thing.

It tends to be less on Intelligence because that is in a room where nobody can listen, including any of the bosses.

And so, people tend to tell more truth there but we need to have that, we need to have that. I want to trust you. I do trust you. But it pains me when I feel you cannot answer the way you really want to answer because you are not in the VA because of the money. You are not in the VA because it is a hobby. You are in it because you

want to do good, and therefore, anything that stands in your way about doing good, you should rebel against.

Now, that is a naive statement. Everybody in the VA turns into a whistle blower. But darn it, I mean, if you look at the coal mines in West Virginia, you cannot whistle blow. So, people died.

If you whistle blow, you get fired, not by all companies but by a lot of them. You get fired. You get paid about $61,000 a year to be a coal miner. Well, that is about five times more than you can make it anything else within 100-mile radius of where you probably live.

So, you do not take on the system; and if nobody takes on the system, then, you know, you do not see progress.

I got around that and, Senator Burr, you might be interested in this, and I will stop talking eventually. [Laughter.]

But look at what I had to do to get around it. I knew I was not going to get any legislation on mine safety. Let us just make that into women's PTSD or mental health. I knew I was not going to be able to get legislation.

So, I went to the Chairman of the Securities and Exchange Commission, Mary Schapiro, and I said what would happen if you put up on your Web site quarterly reports on the investment enticements, your profits and losses and earnings ratio and all the kind of financial information because you use that because you are trying to get people to invest in you.

And in a very easy maneuver, she said, well, from now on, as I asked her to and she said she would do it, you also have to publish all of your violations of mine safety. That is what is happening.

Coal mines do not like it. MSHA does not like it because sometimes MSHA is not doing the job themselves. So, the coal companies can say well, it is MSHA's fault, and maybe it is MSHA's fault. I do not care so long as the truth comes out; and in this case, so long as investors can make a wise decision about whether to invest in that company or not.

We are going to do the same thing on another major problem having to do with cyber security-going around the legislative process because we cannot get it done.

So, we are having a horrible time trying to be helpful to you. Do not make it harder for us to be helpful to you by not telling us how we can be. I am much more interested in what is not working than I am in what is working because I assume that you are all doing a much better job than was true before just because the whole quality of the VA has risen, you know, exponentially, impressively, amazingly, and on all fronts and with all kinds of new pressures on them because of people coming back from Iraq and Afghanistan and the rest of it and all the women's problems, mental health problems, suicide problems, everything all at once, and then there is no money.

Nothing wrong with your telling me that. We are not doing what we could because that I will believe, and then that makes me, in turn, want to help you.

But if you say our policy will not allow that, which is the same thing as saying it will not allow it but it is happening, if you tell me that the policy will not allow that but it is happening, then I

want to help you even more because you are being fair and square with me.

That is all I want to say.

PREPARED STATEMENT OF HON. JOHN D. ROCKEFELLER IV, U.S. SENATOR FROM WEST VIRGINIA

I believe we must be diligent and honest about the challenges facing VA in caring for the invisible wounds of war for our veterans, particularly our veterans returning from Iraq and Afghanistan. I believe the VA survey and this hearing are a tremendous example of the strong leadership of Chairman Murray and a commitment to find real solutions.

I also believe that VA is working hard. Thousands of new mental health professionals have been hired in recent years. New, innovative programs have been launched, and that is promising. Dedicated VA staff at Medical Centers and Vet Centers in West Virginia and across our country wants to do their best to help our veterans.

Today's hearing is an important step. It is an effort to get to the real facts of how our veterans are served and I strongly support it. This Committee must have the real facts in order to make the necessary decisions to enhance the care promised to our veterans, and the quality of care they deserve.

Senator BURR. Is the Chairman recognizing me?

Senator ROCKEFELLER. Of course, I do.

Senator BURR. I thank my good friend. Just a couple of quick follow-ups if I can.

Dr. Schohn, in oral testimony from the July 14, 2011, hearing, Deputy Undersecretary Schoenhard said he wanted to, "* * * personally follow up with Andrea Sawyer and Daniel Williams to learn more of their story and what we can learn."

Do you know if he followed up with them personally?

Ms. SCHOHN. I do not. I did follow up with them personally.

Senator BURR. Did he ask you to follow up with them?

Ms. SCHOHN. He asked me to follow up with them personally.

Senator BURR. What policy changes resulted from those conversations?

Ms. SCHOHN. I do not believe policy changes have resulted from them. Again, I think the issue, from my perspective, is not about the policy. I think the policies are fine but I think to the point I am hearing is the implementation of the policies.

So, how we are following up is to ensure that the policies are implemented as they are intended to be. And we are, in fact, working that.

Senator BURR. Are you convinced today that we still have an implementation problem?

Ms. SCHOHN. I am.

Senator BURR. OK. At that same hearing, during an exchange with the Chairman on the reorganization of VHA's mental health office, Dr. Arana said the plan was to get out into the facility, "* * * much the way the OIG does with on-the-ground visits."

Dr. Arana indicated he wanted to, "* * * deploy this effort very strongly over the next 6 to 8 months" and wanted to come back and highlight the progress.

How many sites have been visited?

Ms. SCHOHN. We have visited one formal site in terms of piloting the site-visit program. We have scheduled the additional site visits that we had intended for this year. After discussion with Dr. Petzel, we are speeding up our timeline in terms of doing the site visits to more facilities.

Senator BURR. Am I reading something into what Dr. Arana said to us that I should not have, "* * * deploy this effort very strongly over the next 6 to 8 months."

Is one site deploying strongly?

Ms. SCHOHN. My understanding about Dr. Arana's comments was not specifically around the site visits. My office was started at the end of March and the plan——

Senator BURR. Let me read you the quote again. And I quote, Dr. Arana said the plan was to get out in the facility, "* * * much the way the OIG does with on-the-ground visits."

Ms. SCHOHN. And I think that is certainly intended. The timeline for making that happen, I do not believe he intended to say 6 to 8 months——

Senator BURR. He said very, very strongly over the next 6 to 8 months.

Ms. SCHOHN. The 6 to 8 months I believe referred to the set of follow-up actions that we had intended to pursue of which the site visits was something that was——

Senator BURR. Is it not important enough to do the site visits?

Ms. SCHOHN. It is totally important to do the site visits.

Senator BURR. Why would we have only done one?

Ms. SCHOHN. It is important to do them correctly. As I mentioned, my office was started at the end the March, the beginning of April, with the intent to set up a system to ensure implementation of the uniformed services package. We have been developing the process——

Senator BURR. So, it took us 9 months to set up the plan to determine how to gauge whether we were following the guidelines or not? I mean, you have got to put things in layman's terms. I think Senator Rockefeller just, I think, covered very eloquently that. Shoot us straight.

Ms. SCHOHN. We have to set up the right process for doing it. We want to make sure that we are looking at the right things. We have set up a mental health information system so that we have data going out there that we can validate and ensure what is going on.

We have been working with other parts of VA to ensure that we are doing site visits in a way that is reliable and believable. Of concern to us is that, in fact, and to address your concerns, is that we are able to give you information that we believe is valid. We think that is an issue, and we want to make sure that we are doing it the right way.

Senator BURR. Senator Rockefeller has been on the Committee a lot longer than I. He has been around a lot longer than I have, come to think of it.

Senator ROCKEFELLER. Thank you.

[Laughter.]

Senator BURR. But since day one, the first hearing, the issue was raised—different administrations so this crosses all lines—the issue that was raised was they cannot get appointments.

I mean, we can study the hell out of this but until we put a person on the phone that the job is whatever you do get this person an appointment. It might be, be courteous first, make sure they get an appointment, accommodate their schedule, ask them how many doctors they see at the VA facility, try to schedule all appointments

on the same day, do not make transportation a reason that they could not come back and get follow-up.

We still do not do that. It still does not happen. And the only thing I am pleading with you today is do not overanalyze this. This is not rocket science.

The private-sector figures out how to schedule appointments, deliver care, help people get better every day, and in areas of the VA we do it extremely well.

But it is typically one where they are inside the facility. We are not relying on than contacting us. They are in a room. They are not having to call for appointments. There is a floor nurse and physician that is in charge of them, and we do a pretty good job. We are rated the number 1 hospital in the world.

But I would be willing to bet if we got rated on everything else we might be the largest but we are certainly not the best; and if you did one on customer satisfaction, I would be willing to bet we came in last.

One last question. The July 14th hearing, you testified that VA was in the process of, I quote, developing a comprehensive monitoring system that looks at all the issues, implementing rates, combining the data into one place for all so that VA can write flag carriers or gaps that exist quickly based upon VA's available data. This package will be finished by year's end.

We are a month away. Is it going to be finished?

Ms. SCHOHN. Absolutely. In fact, we have already started deploying it, and we have been working with all of our VISNs in terms of looking at the data and developing plans where there are problems and issues. That is part of the whole site visit process and we are fully on board, ahead of schedule.

Senator BURR. I hope you will put into your equation your answer to a lot of issues today. We have an implementation problem. I would hate 6 months from now to come back and to have your package out there identifying deficiencies, barriers, and the answer to be we have got an implementation problem.

We are able to detect it but we have got an implementation. It is the right plan. It is just we have people who are implementing it wrong. That excuse is not going to work anymore.

So, again I thank all three of you for your service to our country's veterans. I think every day the VA tries to fulfill what their core mission is.

I do question, I will be very candid, I do question whether, when we think about the 24 hours ahead of us whether we see the human face of that veteran first. If we do not, then we are misguided, whether it is you or whether it is me from a policy standpoint.

But I thank you for being here. I thank the Senator from West Virginia.

Senator ROCKEFELLER. And the thanks is very mutual.

I think we have covered things here. I guess I will end with one of my least favorite words in the English language: something called metrics. A lot of people at the VA live by metrics, and you have got to. In other words, just as the question by Senator Burr, it is meant to be done in a month. When you said it is going to be done, I take you at your word.

But metrics can also really mess things up because they can cause people to rush. They can cause people to overlook things or not think things through carefully enough. There is no way that I am going to win on the metrics issue. The VA is going to be ruled by metrics.

Obviously, you cannot have a large organization without a real sense of control and you cannot have people going around saying all kinds of different things. Or can you? If it is in front of Congress, I think you can and I think you should.

I use this OMB thing a lot. I am not picking on you. I use it a lot because I know darn well, and because I also know the people who are giving the testimony and I know they do not believe a word they are saying. But that is what they have to say because OMB changed their thing to make it, you know, comport.

So, just take away the message that we enormously care about you. We enormously believe in you, that you are doing extraordinary work. You are accelerating faster than anybody except the new .com world, I guess, and they make a lot of money doing that and you do not.

The truth will set us all free because it allows us to fight for you because we believe in everything that you are telling us and the fact that you cannot get people within the next 24 hours that the Senator was referring to.

You have 55 people and in small place that needed attention in the next 24 hours and your doctor gets sick or you brought thousands of mental health professionals in.

It is amazing to me. I do not know where you get them because I thought they were scarce everywhere, but I will believe you because I want to believe you.

But allow us to asking the questions because that is the way we work together well. It is not your job to like us. Nobody else does so why should you. But it is our job to support you in your mission. That is our job, our only job.

So, make it as easy as possible by always telling us the truth.

Thank you. This hearing is adjourned.

[Whereupon, at 12:20 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of The American Psychiatric Association

On behalf of the American Psychiatric Association (APA), a medical specialty organization which represents 36,000 psychiatric physicians nationwide, thank you for the opportunity to submit a statement to the Senate Veterans' Affairs Committee regarding veterans' access to timely, evidence-based mental health and substance use care. APA promotes the highest standards of care for our patients and their families, and to that end we strive for standards of excellence in the education and training of our psychiatrist workforce and excellence in psychiatric research.

The APA vigorously advocates for immediate and seamless access to care for psychiatric and substance use disorders for America's veterans. We remain concerned that despite the concerted efforts of the Veterans' Administration (VA) and Department of Defense (DOD), stigma still shadows those who seek psychiatric care and discourages those who need care from seeking it. The unprecedented length and number of deployments of U.S. military personnel, as well as the nature of our current military engagements, have placed an enormous strain on those serving in all facets of the military as well as their families.

We are encouraged by the significant progress which has been achieved by the VA in hiring mental health personnel, promulgating best practices and procedures to benchmark the timeliness and appropriateness of care and coordination of services. However, like many veterans advocacy organizations, the APA remains concerned about persistent reports of lengthy wait times for treatment appointments in some geographic areas, availability of psychiatric physicians and inconsistent implementation of evidence-based care. We applaud the Committee's oversight and accountability efforts which can assist the VA with policy implementation at the local level.

The VA has undertaken extraordinary measures to overhaul its mental health system over the past ten years. The daunting task of hiring a sufficient number of mental health professionals including case managers, social workers, psychologists, and psychiatric physicians has been paramount. This task is further complicated by geographic scarcity of all physicians, including psychiatrists. Simply put, it takes time to train physicians and with a projected influx of 33,000 servicemembers returning to the United States, time is of the essence.

The APA encourages the VA to vigorously pursue training partnerships, loan forgiveness and telehealth services as opportunities which must be leveraged immediately. The VA and DOD could expand their current physician training programs to smaller, more rural hospitals with the assistance of the Center for Medicare and Medicaid Services' Graduate Medical Education (GME) program. Medical school loan forgiveness programs for psychiatrists who are in the early stages of their careers could draw more physicians into the rural areas served by the VA. A similar program has worked well under the auspices of the Indian Health Service. Telehealth consultations between a patient and his or her physician on psychiatric or substance use treatment issues are typically utilized when a patient is stable and recovering. Telehealth consultations could be encouraged between a provider in a rural area who would like to consult with a colleague or coordinate care with a case manager. These consults can improve patient care and outcomes.

The American Psychiatric Association has offered extensive continuing medical education for the past nine years on PTSD, TBI and MST. A recent example, in May 2011, the APA partnered with VA staff and staff at the Tripler DOD facility to offer an entire "track" of educational courses in diagnosing PTSD, best treatment practices as well as training regarding the specific military cultures. This "track" was offered to community-based psychiatrists who are not employed by the VA or DOD but instead might encounter military or former military members who seek are "outside the system." The APA also offers web-based tools to its members to

keep them informed of advances in treatment and research which benefit their patients.

In addition, the APA is a partner of "Give an Hour." This volunteer organization provides professional mental health and substance use disorder services through a network of professionals who volunteer their services for an hour a week to active and returning military, National Guard, veterans and their families. "Give an Hour" has been utilized as a portal for care for those who fear the stigma of seeking services within the VA or DOD structure. We encourage the VA's national leadership to pursue partnerships with "Give an Hour" especially in rural and underserved areas where lengthy waits between mental health treatment visits unfortunately remain.

The APA would like to emphasize the importance of advocacy for returning military with psychiatric and substance use disorders. Families, in particular, need to be advocates for their loved ones. They need to make sure their family members has a comprehensive evaluation by a trained and qualified mental health professional and that they have access to necessary and appropriate ongoing treatment services. They should also ask lots of questions about any proposed diagnosis or treatment plan. To this end, the APA has jointly developed a Web site, www.Healthyminds.org to provide patients, families and physicians with as much information as possible about the evaluation and treatment of depression, PTSD and substance use disorders. Over a dozen major medical, family and patient advocacy organizations have already endorsed this collaborative effort.

As physicians, researchers and family members, the APA has noted with increasing concern the increase in suicide attempts and completed suicides by veterans and those currently serving, and has advocated for direct action to address this major problem. Beginning in 2002, the suicide rate among soldiers rose significantly, reaching record levels in 2007 and again in 2008 despite the Army's major prevention and intervention efforts. In response, the Army and NIMH partnered to develop and implement "STARRS" (Study To Assess Risk and Resilience in Servicemembers) the largest study of suicide and mental health among military personnel ever undertaken. Many APA members are involved in the NIMH- Army study which will identify—as rapidly as possible—modifiable risk and protective factors related to mental health and suicide. It also will support the Army's ongoing efforts to prevent suicide and improve soldiers' overall wellbeing. The length and scope of the study will provide vast amounts of data and allow investigators to focus on periods in a military career that are known to be high-risk for psychological problems. The information gathered throughout the study will help researchers identify not only potentially relevant risk factors but potential protective factors as well. Study investigators will move quickly to provide information that the Army can use immediately in its suicide prevention efforts and use to address psychological health issues.

Finally, the APA lends its voice to the many others who continue to ask that the VA and DOD develop a seamless—or at least more transparent and collaborative approach—to mental health and substance use disorders. We know that many active military do not seek treatment early—when it is the most effective—because of stigma. We believe adjustments in leadership culture and command structure can change the perception that treatment is a career-ender.

We at the APA are hopeful that the Senate Committee hearing on November 30 will help to reduce waiting times and access to appropriate care in some VISNs by shining a light on this pernicious issue. The APA encourages expanded support for research to promulgate evidence-based care, and enhance the ability of returning military and their families to advocate effectively for the treatment they need and deserve.

Thank you for the opportunity to submit a statement for the record. We welcome any opportunity to assist the Committee with their critical endeavors on behalf of the Nation's military, veterans and their families.

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