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TESTIMONY OF
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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 warrants 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 cancelled/ 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 towards 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."

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

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."

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.

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).

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

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.

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."

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 benefitting 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 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%).

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.

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. 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.