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STATEMENT OF
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OFFICE OF INSPECTOR GENERAL
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
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HEARING ON
"VA MENTAL HEALTH CARE: CLOSING THE GAPS"
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Madam Chairman and Members of the Senate, thank you for this opportunity to testify on the delivery and the quality of mental health care provided by the Department of Veterans Affairs. My statement is based on the many reports issued by the Office of Inspector General (OIG) including reports on system-wide reviews and reports on the care provided to individual veterans. Accompanying me today is Michael Shepherd, M.D., Senior Physician, in the OIG's Office of Healthcare Inspections.

BACKGROUND

The Veterans Health Administration (VHA) has been a national health care leader for many years due to the quality and dedication of VA employees, their use of the electronic medical record, their national patient safety program, and their commitment to use data to improve the quality of care. VHA's decision to provide public access to extensive data on quality and process measures is a further step forward as is the decision to limit the surgical procedures at facilities based on the facility's ability to handle follow-up care.

The delivery of mental health care to veterans is a significant challenge for VA, especially due to the growing number of Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans seeking care and their often coexisting complex medical conditions. According to VA, more than 1.2 million of the 5.2 million veterans seen in 2009 in VA had a mental health diagnosis. This represents about a 40 percent increase since 2004.

The percentage of OEF/OIF veterans enrolled in VA is historically high compared to prior service eras. Among VA-enrolled OEF/OIF veterans, 51 percent have received mental health diagnoses and rates of post-traumatic stress disorder (PTSD) and depression have steadily risen as the contemporary nature of warfare increases both the chance for injuries that affect mental health and the difficulties facing veterans upon their return home. In addition, mental health issues are often contributing factors to veterans' homelessness.

UTILIZATION OF VA CARE

One area that many perceive as a gap is in mental health services for women veterans. The OIG was asked to review VA's capacity to address combat stress in women veterans (Review of Combat Stress in Women Veterans Receiving VA Healthcare and Disability Benefits, December 16, 2010). We assessed women veterans' use of VA health care for traumatic brain injury (TBI), PTSD, and other mental health conditions. To conduct this review, we analyzed integrated data from almost 500,000 male and female veterans who separated from the military from July 1, 2005, to September 30, 2006, for their experience transitioning to VA and using VA health care and compensation benefits through March 31, 2010. Nearly half of these veterans served in OEF/OIF before their separation. Using this data, we described veterans' experience transitioning to VA and using VA health care and their compensation benefits through March 31, 2010.

We found the following:

• Female veterans generally were more likely to transition to and continue using VA health care services – As of March 31, 2010, 199,301 (40 percent) veterans in the study population and 52 percent OEF/OIF veterans used or transitioned to VA health care. Higher proportions of female veterans transitioned to VA care than their male counterparts, except for the non-OEF/OIF reserve component cohort in which proportions of females and males were the same. In addition, 23 percent used Department of Defense care (including TriCare), although they did not use VA care. Among veterans who transitioned to VA health care, female veterans generally were more likely to use VA health care and used it more frequently than male veterans. We examined individuals' numbers of VA outpatient visits by year for the 3 years after military separation to assess whether veterans continued their use of VA health care after their initial decision to use VA. Female veterans continued more frequent use of VA care than their male counterparts by years after separation. Increasing trends of utilization were observed for male and female veterans diagnosed with mental health issues, PTSD, TBI, and veterans with military sexual trauma.

• Higher proportions of female veterans generally were diagnosed with mental health conditions by VA after separation, but lower proportions were diagnosed with PTSD and TBI – VA diagnosed about 22 percent of the study population with mental health conditions, with higher proportions of female veterans generally diagnosed than their male counterparts. Overall, VA diagnosed more than 9 percent of the study population with PTSD. The proportion of OEF/OIF veterans VA diagnosed with PTSD was at least 3 times higher than those of their non-OEF/OIF counterparts. However, VA diagnosed fewer female veterans with the specific mental health condition of PTSD except for the veterans in the non-OEF/OIF active duty cohort. VA diagnosed over 2 percent of the study population with TBI. The proportion of OEF/OIF males diagnosed with TBI was twice as high as those of females across military components. The proportion of OEF/OIF veterans diagnosed with TBI was more than 3 times greater than their non-OEF/OIF counterparts.

• In keeping with the results of the VA diagnosis, higher proportions of female veterans generally were receiving disability benefits for mental health conditions, but a lower proportion for PTSD and TBI – As of March 31, 2010, nearly 126,500 (26 percent) veterans in the study population were receiving compensation for their service-connected disabilities. Among the veterans

awarded disability compensation, 30 percent of them were receiving some disability award for mental health conditions. Higher proportions of female veterans were receiving service-connected disability compensation and receiving some compensation for mental health conditions, except for the OEF/OIF reserve duty component cohort in which the corresponding proportion of females was about 1 percentage point lower than that of males. However, lower proportions of females generally were awarded disability compensation with a component for the specific mental health condition of PTSD.

For OEF/OIF veterans, PTSD was the most common disability award component for both women and men, while major depression was the most prevalent for the non-OEF/OIF veterans. Higher proportions of female veterans received some disability compensation than their male counterparts for each of the five prevailing mental disability award components, except for PTSD. Less than 1 percent of the veterans in the study population were awarded service-connected TBI disability, with lower proportions of females than their male counterparts.

PROGRESS MADE, BUT MORE WORK REMAINS

VA Mental Health Residential Rehabilitation Treatment Programs

The OIG issued a follow-up report to a comprehensive 2009 review of VHA residential health care facilities (A Follow-Up Review of VHA Mental Health Residential Rehabilitation Treatment Programs, June 22, 2011). The 2009 report contained 10 recommendations based on identified areas of concerns (Healthcare Inspection – Review of Veterans Health Administration Residential Mental Healthcare Facilities,
June 25, 2009). Our 2011 review evaluated any improvements made or problems remaining in these areas since our 2009 report.

The 2011 review found that progress was made in many areas, but in one key area, VHA made little interim progress—ensuring contact with patients during the time interval between acceptance into a mental health residential rehabilitation program and the start of the program—indicating an ongoing challenge with continuity during care transitions. Also, we found two other areas of concern: the actual staffing in place despite core mental health clinician staffing guidelines and, in light of the emphasis on a recovery based model, the 4 percent of patients referred to vocational rehabilitation services. We also remain concerned about the provision of more than a 7-day supply of narcotics to veterans in residential programs. We made 7 recommendations to the Under Secretary for Health; we will monitor VHA's implementation of those recommendations through the OIG's Follow-Up Program.

Post-Traumatic Stress Disorder Counseling Services

We conducted an inspection of the Readjustment Counseling Service (RSC) Vet Centers' PTSD counseling services to determine how Vet Centers screen for PTSD; if documentation of clients' treatment is in compliance with policy; and if providers are trained to provide PTSD counseling services according to policy (Healthcare Inspection – Post-Traumatic Stress Disorder Counseling Services at Vet Centers, May 17, 2011).

In a previous OIG review of the RCS Vet Centers' operational services provided during FY 2008, we found that documentation in client treatment records and staff PTSD counseling training was in need of improvement (Healthcare Inspection – Readjustment Counseling Service Vet Center

Report, July 20, 2009). As part of the 2011 review, we evaluated whether any improvements had occurred in these areas.

Our 2011 review found that RCS Vet Center counselors utilized appropriate tools to screen clients for PTSD. Client treatment case file documentation improved from our FY 2009 report. While staff training has improved, approximately 15 percent of Vet Center providers have not attended RCS' required training on PTSD, and 47 percent of the providers have not attended VHA-sponsored PTSD training. In addition, some Vet Center providers received supplemental training in Evidence-Based Therapy (EBT), and most Vet Centers were providing EBT to PTSD clients.

Although RCS made improvement from our previous review, we found that Vet Center Directors were not consistently providing supervision and consultation to the Vet Center providers in accordance with RCS policy. We made two recommendations which the Under Secretary for Health concurred with and provided an acceptable implementation plan. We will continue to follow up until all actions are complete.

Suicide Prevention

Veteran suicides remain an important focus of VA's mental health delivery plan. VHA estimates that there are approximately 1,600 to 1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans.

At the request of VHA, we reviewed VHA facilities' suicide prevention safety plan (SPSP) practices at 45 facilities as part of the OIG Combined Assessment Program reviews from January 1 through September 30, 2010 (Combined Assessment Program Summary Report – Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities, March 22, 2011). Our report found the VHA facilities recognized the importance of developing comprehensive and timely SPSPs for high-risk patients. Additionally, VHA issued appropriate timeframes for initiating SPSPs. However, despite VHA's efforts to comply with suicide prevention program requirements, problems with SPSP development continue to occur. We reviewed the medical records of 469 inpatients and outpatients placed on the high risk for suicide list. We found that 12 percent of these records did not have documented SPSPs. We recommended that the Under Secretary for Health, in conjunction with Veterans Integrated Service Network and facility senior managers, ensure that mental health providers develop and document timely SPSPs that meet all applicable criteria.

Additional areas that would benefit from increased VHA attention include: ensuring follow-up contact with veterans who have been discharged from a mental health ward within 7 days of discharge to check on their mental health status because this is a time of high suicide risk (in FY 2010, only 4 of 111 medical centers met VA's 85 percent goal for this indicator); and efforts to facilitate ongoing engagement and retention of OEF/OIF veterans in mental health treatment.

Coordination of Care

We reviewed the quality of a veteran's care at a VA Medical Center to determine if the events leading to the veteran's death were connected to any issues with the quality of care (Healthcare Inspection – Review of Quality of Care at a VA Medical Center, December 9, 2010). Our review identified three areas that the medical center could improve on. Specifically, the medical center

needed to ensure smooth transitions when there are changes in veterans' providers and/or care settings. The medical center also needed to improve internal communications between providers and external communications with veterans and other parts of the VA system to ensure that significant information is communicated timely and with individuals who have a need to know. Lastly, the medical center needed to review the procedures of the Disruptive Behavior Committee to ensure clear and consistent messages about patient risk and to promote patient-centered solutions when risks are identified. Whether addressing these three issues previously would have resulted in a different outcome for the veteran is unknown.

While this report focused on one veteran's care, it follows a series of reports on individual veterans' care that continue to indicate that for those veterans with a complex interplay of mental health, medical, and psychosocial issues, VHA needs to better coordinate care internally among providers and clinics, between VBA and VHA, and when possible between private sector health care providers, families, and VA.

TOPICS AFFECTED BY MENTAL HEALTH CARE

Homeless Veterans and the Relationship to Mental Health

The Secretary has committed to reducing the number of homeless veterans. In many instances, VHA has provided compassionate care to a most challenging population. We conducted a review of allegations that VHA staff discharged a homeless veteran to a shelter without the ability and appropriate supplies to care for himself, and against his will (Healthcare Inspection – Alleged Continuity of Care Issues VA Greater Los Angeles Healthcare System Los Angeles, California, March 4, 2011). We did not substantiate the allegations.

At the time of discharge, system staff determined that the patient had capacity to make decisions, was medically stable, and was able to care for himself. Discharge planners explored and offered appropriate disposition options. However, the veteran refused all available options because each required behavioral agreements and/or Social Security contributions. Throughout the discharge planning process, the veteran often told staff he intended to return to being homeless. Staff negotiated plans for him to go to a homeless shelter (which he agreed to do), and provided him with instructions on self-care, medication that did not require refrigeration, medical supplies, follow-up appointments, and transportation to a shelter. We found that staff made multiple and reasonable efforts to negotiate acceptable and safe disposition plans with the veteran while also respecting his right to make his own decision. VHA is challenged to determine which sub-population of veterans is most at risk of becoming homeless, and of placing homeless or at risk veterans into programs that are demonstrated to be effective.

Pain Management Program Impact on Mental Health Treatment

Pain management programs remain a difficult problem for VA to manage and appear to have an uneven impact upon patient care across the country. The OIG has published a number of hotline reports on this topic and is in the process of a national review of issues related to pain management (Healthcare Inspection – Prescribing Practices in the Pain Management Clinic, John D. Dingell VA Medical Center, Detroit, Michigan, June 15, 2011, and Healthcare Inspection – Alleged Inappropriate Prescription and Staffing Practices, Hampton VA Medical Center, Hampton, Virginia, October 12, 2010).

The combination of physical injury, medication dependence, and mental illness make this an extremely difficult but important aspect of VA care that requires improved outcomes to assist veterans in their re-entry into civilian society.

CONCLUSION

VA continues to make progress in their mental health programs despite increasing numbers of veterans with significant mental health disorders, particularly among women veterans. Continued attention must be given to improving staffing and access to care, providing continuity during integral care transitions, coordinating care for individual veterans with mental health issues, and linking pain management, mental health, and substance use programs.

Madam Chairman, this concludes my statement. Dr. Shepherd and I would be pleased to answer any questions that you or other members of Committee may have.