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WILMINGTON VA MEDICAL CENTER
ON BEHALF OF
AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES, AFL-CIO
AND THE AFGE NATIONAL VA COUNCIL
BEFORE THE
SENATE COMMITTEE ON VETERANS' AFFAIRS
CONCERNING
VA MENTAL HEALTH CARE: ADDRESSING WAIT TIMES AND ACCESS TO CARE
NOVEMBER 30, 2011

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.