

**STATEMENT FOR THE RECORD
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
WITH RESPECT TO HEARING ON THE
*Improve Well-Being for Veterans Act***

*by the
American Psychological Association
Association of VA Psychologist Leaders*
Association of VA Social Workers*
Nurses Organization of Veterans Affairs*
Veterans Healthcare Policy Institute*

(*An independent organization, not representing the Department of Veterans Affairs)

WASHINGTON, D.C.

November 20, 2019

Chairman Takano, Ranking Member Roe and Members of the Committee:

On behalf of our organizations, we thank you for the opportunity to submit a statement for the record on the Improve Well-Being for Veterans Act. As a collective group who has previously presented statements for the record to your Committee, we want to convey our appreciation for your leadership on this issue and the Committee's commitment to ensure the provision of life-saving services for our nations' veterans.

The Improve Well-Being for Veterans Act would provide pilot funds to non-VA entities to offer suicide prevention services to veterans who are not using VA healthcare and/or live in geographic areas where the risk of suicide is high. It emphasizes a Public Health Model to prevent suicide by attending to the full spectrum of social needs – housing, employment, relationships, transportation, finances and legal. We concur that expansively addressing social risk factors may substantively reduce suicide.

However, the same is not the case for clinical care. Establishing a mental health care delivery lane outside of the VA and Community Care Network (CCN) would have multiple deleterious impacts, as we identify below. We also provide recommendations that could enhance suicide prevention efforts.

The Consequences of Establishing An Outside Lane to Provide Clinical Care.

Under MISSION Act directives, non-VA providers may join the CCN to deliver clinical care to at-risk veterans and their families. Since CCN is already a pathway for providers, creating another outside system for the provision of clinical care would potentially have three deleterious consequences:

1. **It would duplicate and erode the mental health care offered by VA and CCN.**

Funding non-VA clinicians outside the CCN to provide direct mental health treatment, individual therapy, group therapy, family counseling, medication management and substance use reduction programming **duplicates the clinical mental health care offered by VA and CCN.**

Care is targeted in the same geographic locations as VA facilities. There is no requirement that entities focus efforts in locations beyond the geographic reach of existing VA facilities where care is scarce. On the contrary, providers can be located close to VA Medical Centers, VA Community Based Outpatient Clinics, Vet Centers and CCN providers.

For those veterans who distrust the government or are reluctant to seek mental health help at a VA facility, there are over 300 Vet Centers and 80 mobile Vet Centers available throughout the country. More can be added if there is a need.

2. **It would lower the bar for outside providers' qualifications, quality of treatment and tracking of relevant outcomes.**

There is **no requirement that entities be held to comparable (or any) standards** of mental health or suicide prevention training, provider qualifications or documented best practices to which VA holds itself.

It does not require entities to render services in a timely manner, which is mandated in the VA and is crucial for responding to at-risk populations.

Critically important is the fact that there is **no requirement that entities track and report on suicide attempts** of veterans who receive their services, as is mandated in the VA, and is the stated purpose of the legislation.

There is **no requirement that, in order to receive grants, entities have to show a previous track record for measuring successful outcomes** of their services. They only have to demonstrate throughput.

Non-VA entities are not capable of using VA's big-data predictive analytics REACH VET to prospectively identify individuals who are at the very highest risk of suicide.

3. **It would undermine VA's model of providing health care.**

Private sector clinical care would not require VA pre-authorization. That plan begins to **replace VHA as a health care provider system, transforming it into an insurance provider.**

With no parameters for co-payment responsibility, clinical care is permitted to be provided for free. While that's laudable, it competes with and **subverts the basic VA system for veterans' priority group eligibility and co-payment.**

By creating a third lane of providing clinical care outside of VA and CCN, providers in the community would be incentivized to leave the CCN or never join it in the first place. That **erodes the whole intent of the MISSION Act to create one overarching, coordinated program.**

It covers some veterans/families receiving mental health services in the community but not at a VA facility. If the goal is to ensure that mental health care is available to all veterans/family members (including Priority Category 8), the VA should be allowed to open its doors to these veterans/families as has occurred with transitioning service members (Presidential Executive Order 13822), military veterans who served in combat, and Other Than Honorable (OTH) administrative discharged veterans.

Further Recommendations to Improve Delivery of Mental Health Care and Suicide Prevention Efforts for At-Risk Veterans

1. Better understand the veterans who die by suicide.

Very little is understood about the 11 of 17 veterans who die by suicide daily who do not use VA. It is not known whether they are already receiving mental health care in the private sector, lack knowledge about VA eligibility, or would refuse care in or outside the VA even if offered. To be better able to target interventions for veterans not using VA who die by suicide, perform a Behavioral Health Autopsy of every veteran suicide, especially veterans who don't use the VA.

2. Facilitate greater access to VA.

- a. Educate and assist newly separated service members.** Veterans who do not seek VA mental health care were studied extensively last year in the National Academies of Sciences, Engineering and Medicine *Evaluation of the Department of Veterans Affairs Mental Health Services*.¹ It found that the top reasons that veterans with a mental health need do not seek VA care include that they (a) lack knowledge of how to apply for VA benefits (42% of survey respondents), (b) lack certainty whether they are eligible for or entitled to mental health care (40%), (c) lack awareness that the VA offers mental health care (33%), or (d) did not feel they deserved to receive mental health benefits (30%). We support implementing the National Academies' recommendations for facilitating greater access to VA mental health care by eliminating barriers to accessing care, expanding outreach efforts, enhancing awareness campaigns of VA eligibility criteria and mental health care services, setting up initial VA health appointments as part of the Transition Assistance Program and providing liaisons to assist throughout the transition process.
- b. Enhance capacity.** For locations where VA/CCN mental health services capacity is lacking, build more capacity.
- c. Correct myths that hinder veterans seeking VA care.** Veteran suicide would be significantly reduced by correcting the false belief among many veterans that "the VA wants to take away our guns." If that misperception were replaced with an accurate message, more at-risk veterans would seek out mental health care. Establish a workgroup that includes gun constituencies to champion such a shift.

d. Increase the number of video-reception sites where veterans could access care via VA telemental health, particularly in rural areas (e.g. VFW posts, Community Mental Health Centers).

3. Establish suicide outcome measures.

Entities should be required to track and report suicide attempts of veterans receiving their services, including for 6+ months post-treatment.

4. Measure success of referring veterans to VA care.

Entities should be evaluated for their success in referring at-risk veterans to the VA for clinical care. VA suicide prevention services remain the best in class.²

5. Ensure quality across the system.

Require that provider qualification and service delivery standards in non-VA entities be equal to those used in the VA.

Conclusion

The provision of grants that address social risk factors may substantially help prevent veteran suicide. However, clinical care for at-risk veterans is best provided by utilizing and expanding VA/CCN's existing infrastructure. Non-VA mental health care providers should be encouraged to join CCN. Creating another outside care delivery system for non-VA providers would have multiple deleterious effects.

We thank you for the opportunity to provide our perspective on this urgent matter.

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Footnotes

¹ Evaluation of the Department of Veterans Affairs Mental Health Services. The National Academies of Sciences, Engineering and Medicine. The National Academies Press, Washington, DC. 2018
<http://nationalacademies.org/hmd/Reports/2018/evaluation-of-the-va-mental-health-services.aspx>

² Veteran Suicide Prevention Annual Report, (September 2019). U.S. Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, https://www.mentalhealth.va.gov/docs/data-sheets/2019/2019_National_Veteran_Suicide_Prevention_Annual_Report_508.pdf