WOUNDED WARRIOR PROJECT

TESTIMONY

OF

RALPH IBSON, NATIONAL POLICY DIRECTOR

WOUNDED WARRIOR PROJECT

BEFORE THE

SUBCOMMITTEE ON THE EFFICIENCY AND EFFECTIVENESS OF FEDERAL PROGRAMS AND THE FEDERAL WORKFORCE

COMMITTEE ON HOMELAND SECURITY AND GOVERNMENT AFFAIRS

U.S. SENATE

MAY 23, 2013

Chairman Tester, Ranking Member Portman, and Members of the Subcommittee:

Thank you for inviting Wounded Warrior Project (WWP) to testify this morning.

With WWP's mission of honoring and empowering those wounded in Afghanistan and Iraq, our vision is to foster the most successful, well-adjusted generation of veterans in our nation's history. The mental health of our returning warriors is among our very highest priorities.

Gaps in VA Mental Health Care

Given that priority, we continue to be concerned that after more than a decade of combat operations marked by multiple deployments, the systems dedicated to providing mental health care to service members and veterans are still struggling to accomplish their missions. In our experience, wide gaps remain between well-intentioned policies and on-the-ground practices. Perhaps nowhere are those gaps wider than in rural America.

Wounded warriors as a population continue to experience remarkably high rates of post-traumatic stress disorder (PTSD), depression, and other combat-related mental health conditions.

Last year WWP surveyed more than 13,000 service members and veterans wounded after 9/11 to learn more about their physical and mental well-being and progress toward achieving economic self-sufficiency. Among its findings, the survey provides a compelling snapshot of the widespread co-occurrence of combat injury and psychological wounds. With nearly 70% of responding warriors having been hospitalized because of wounds or other injuries,[1] some 69 percent of respondents also screened positive for PTSD.[2] More than 62 percent indicated they were currently experiencing symptoms of major depression.[3] Only 8.5 percent of respondents reported that they did not experience mental health concerns since deployment.[4] Of those surveyed, PTSD was their most commonly identified health condition.[5] Asked to comment on the most challenging aspect of their transition, two in five of those surveyed cited mental health issues. Some acknowledged finding help from VA therapists and clinics. But more than one in three reported difficulties in accessing effective care for mental health services.[6]

Others report that the VA was quick to provide medications,[7] but that it was difficult to get therapy. Still others have been resistant to seeking professional help, particularly at military medical facilities. Overall, warriors' battles with mental health issues – coinciding with alarming rates of suicide among service members -- underscore the urgency and importance of taking action.

The rising suicide rate alone argues for more attention to evidence that a majority of soldiers deployed to Afghanistan or Iraq are not seeking the help they need.[8] While stigma and organizational barriers to care are cited as explanations for why only a small proportion of soldiers with psychological problems seek professional help, soldiers' negative perceptions about the utility of mental health care may be even stronger deterrents.[9] To reach these warriors, we see merit in a strategy of expanding the reach of treatment, to include greater engagement, understanding the reasons for negative perceptions of mental health care, and "meeting veterans where they are."[10] VA's vet centers have proven valuable assets in fostering such engagement.

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[1] Franklin, et al, 2012 Wounded Warrior Project Survey Report, ii (June 2012). WWP surveyed more than 13,300 warriors, and received responses from more than 5,600. (Hereinafter "WWP Survey").
[2] Id. at 104. The data reflect measurements of responses to a Primary Care PTSD scale included in the survey.
[3] Id. at 45.
[4] Id.at 57.
[5] Id.at ii. Questioned about their experience in theater, 82 percent had a friend who was seriously wounded or killed; 78 percent witnessed an accident that resulted in serious injury or death; 76 percent saw dead or seriously injured non-combatants; more than one in five engaged in hand to hand combat; and 61 percent experienced six or more of these types of traumatic incidents. Id. at 15-16.
[6] Id.at 105.

[7] Id.at 105. Studies document widespread off-label VA use of antipsychotic drugs to treat symptoms of PTSD, and the finding that one such medication is no more effective than a placebo in reducing PTSD symptoms. D. Leslie,;S. Mohamed,; and R. Rosenheck, "Off-Label Use of Antipsychotic Medications in the Department of Veterans Affairs Health Care System" *60* (9) *Psychiatric Services,* 1175-1181 (2009); John Krystal, et al. "Adjunctive Risperidone Treatment for Antidepressant-Resistant Symptoms of Chronic Military Service–Related PTSD: A Randomized Trial," 306(5) *JAMA* 493-502 (August 3, 2011).
[8] Paul Kim, et al. "Stigma, Negative Attitudes about Treatment, and Utilization of Mental Health Care Among Soldiers," 23 *Military Psychology*,66 (2011).
[9] Id. at 78.
[10] Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," 306(5) *JAMA* 548 (August 3, 2011).

Importantly, current law requires VA medical facilities to employ and train warriors to conduct outreach to engage peers in behavioral health care,[11] and it is encouraging that VA has begun hiring and training 800 peer to peer counselors this year, pursuant to a Presidential executive order on mental health promulgated last year.[12] (Underscoring the benefit of warriors reaching out to other warriors, our recent survey found that nearly 30 percent identified talking with another OEF/OIF veteran as the most effective resource in coping with stress.[13]) Unfortunately, VA has yet to implement a requirement under current law (or acknowledge its obligation) to provide needed, but time-limited, mental health services to members of the immediate family of OEF/OIF veterans.[14] With access to such services available to family members for only a three-year period beginning with return from deployment on Operation Enduring Freedom or Operation Iraqi Freedom, some are already beginning to lose eligibility for that assistance as a result of VA's inaction.

Against the backdrop of a series of congressional hearings highlighting long delays in scheduling veterans for mental health treatment, the VA last April released plans to hire an additional 1900 mental health staff.[15] While appreciative of VA's course-reversal,[16] WWP has urged that other related critical problems also be remedied. Access remains a problem, particularly for those living at a distance from VA facilities and for those whose work or school requirements make it difficult to meet less-flexible clinic schedules. Mental health care must also be effective, of course. As one provider explained, "*Getting someone in quickly for an initial appointment is worthless if there is no treatment available following that appointment.*"[17] Providing effective care requires building a relationship of trust between provider and patient – a bond that is not necessarily instantly established.[18] Accordingly, congressional testimony that many VA medical centers routinely place patients in group-therapy settings rather than provide needed individual therapy merits further scrutiny.[19] We have also urged more focus on the soundness and effectiveness of the VA's mental health performance measures; these track adherence to process requirements, but fail to assess whether veterans are actually improving.[20]

Unfortunately, the imperative of meeting performance requirements can create perverse incentives, at odds with good clinical care. As one provider explained, *"Veterans face many obstacles to care that are designed to meet 'measures' rather than good clinical care, i.e. having*

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[11] Public Law 111-163, sec. 304(a); National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239, sec. 730, (January 2, 2013).

[12] Exec. Order No. 13625," Improving Access to Mental Health Services for Veterans, Service Members, and Military Families" (August 31, 2012), accessed at http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service

[13] WWP Survey, at 54.

[14] Public Law 111-163, sec. 304(a).

[15] Department of Veterans' Affairs Press Release, "VA to Increase Mental Health Staff by 1,900," April 19, 2012, available at: http://www.va.gov/opa/pressrel/pressrelease.cfm?id=2302

[16] During a budget hearing earlier that year, Department leaders had assured the Chairman of the Senate Veterans Affairs Committee that – despite strong evidence to the contrary -- VHA has all the mental health staff it needed

[17] Id.

[18] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Nicole Sawyer).

[19] *VA Mental Health Care: Evaluating Access and Assessing Care: Hearing Before the S. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Nicholas Tolentino).

[20] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Ralph Ibson), supra note 21.

to wait hours to be seen in walk-in clinic as the only point of access, , etc."[21] Prior hearings also documented instances of such measures being "gamed."[22]

WWP has welcomed both VA's acknowledgment of a "need [for] improvement" in its mental health system,[23]and its report of success in its effort over the last year to hire additional mental health staff. But the impact of that hiring in terms of improving the timeliness of treatment appears to vary markedly from facility to facility. In conferring earlier this month with WWP field staff who work daily with our wounded warriors across the country, we have heard "mixed reviews." Waiting times have been reduced substantially at some locations, while at others they remain a problem. In one location, for example, warriors are waiting three months to be seen after an initial appointment, and complain that once able to be seen are being afforded group therapy rather than one-on-one assistance, and of being rushed through therapy.

One cannot assume that simply filling mental health positions in the VA necessarily translates into effective mental health care. Consider, for example, the following comments from our field staff regarding warriors' experience with VA mental health care:

> *"The biggest [warrior] complaint seems to be... [that providers have] no military background and they don't 'get it' or understand what I am going through and struggling with....[It's] hard to connect with someone when they haven't been in your shoes."*

> *"I ask warriors how they are coming along in their recovery; in more cases than not, warriors do not want to talk about their war time experiences with non-vets."*[24]

Even as VA is bringing on new providers, several staff reported that facilities are still confronting turnover issues. As one reported --

> *"Many of the good counselors and psychologists have left [a major VA medical center] because the appointment schedulers continued to disrupt their best efforts to see their patients on a routine basis....At the Vet Centers and CBOCs the scheduling is better but still only reaches a small number of veterans who have access to those facilities...."*[25]

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[21] WWP Survey of VA Mental Health Staff (2011).

[22] As one WWP-survey respondent explained in describing practices at a *VA facility, "Unreasonable barriers have been created to limit access into Mental Health treatment, especially therapy. Vets must go to walk-in clinic so they are never given a scheduled initial appointment. Walk-in only provided medication management, but Vets who just want therapy must still go to walk-in. After initial intake, Vets are required to attend a group session, typically a month out. After completing the group session, Vets can be scheduled for individual therapy, typically another month out. Performance measures are gamed. When a consult is received, the Veteran is called and told to go to walk-in. The telephone call is not documented directly (that would activate a performance measure)...Then the consult is completed without any services being provided to the Veteran. Vets often slip through the cracks since there is no follow-up to see if they actually went to walk-in. Focus of the Mental Health [sic] is to make it appear as if access is meeting measures. There is no measure for follow-up, so even if Vets get into the system in a reasonable time, the actual treatment is significantly delayed. Trauma work is almost impossible to do since appointments tend to be 6-8 weeks apart."*

[23] *VA Mental Health Care Staffing: Ensuring Quality and Quantity: Hearing Before the Subcommittee on Health of the H. Comm. on Veterans' Affairs*, 112th Cong. (2012) (Testimony of Secretary of the Dept. of Veterans' Affairs, Eric Shinseki).

[24] Conference call with WWP alumni managers; May 1, 2013.

[25] Id.

Yet even as we hear reports of problems, we hear of facilities that have substantially reduced waiting times and/or where mental health care is described as "excellent." The watchword continues to be, "you've seen one VA, you've seen one VA."

Challenges in Rural America

To the extent that warriors have problems getting needed health care from VA facilities, those problems are magnified in rural areas. Long travel distances are, of course, a formidable barrier. Importantly, VA policy sets systemwide expectations regarding the mental health services that should be available to veterans at VA facilities of varying sizes. The policy states:

> "the services that must be 'available' are those that must be made accessible when clinically needed to patients receiving health care from VHA. They may be provided by appropriate facility staff, by telemental health, by referral to other VA facilities, or by sharing agreements, contracts, or non-VA fee basis care to the extent that the veteran is eligible."[26]

Where VA itself cannot provide a particular needed service at all or cannot provide it to an eligible veteran because of "geographical inaccessibility"[27] VA policy calls for VA facilities to provide the needed service through contract arrangements. But we see evidence of significant gaps between policy and practice here, as warriors who live in remote areas often encounter VA reluctance or resistance to authorize community-based care. The following illustration from a warrior's caregiver is not unusual –

> *"We live in a smaller community [in Arizona] so our community-based outpatient clinic couldn't help because they were overloaded and "short staffed" I asked our OEF/ OIF social worker repeatedly for help! It even went as far as [the warrior] running out of his mental health medication in June 2012 and they would not refill until they saw him but the soonest they could would be Feb 2013!! To say I was angry would be an understatement! I started making various phone calls going up the chain of command!! Finally help came from a lab tech...who suggested I take him to the mental health clinic as a 'crisis patient.' We are FINALLY after almost two years getting some counseling on a fee basis."*

A Colorado caregiver of a warrior who is rated 100% service-connected disabled due to PTSD described the experience of living in an area where "we are so remote that we do not even have a traffic light in the entire county" and where "all access to care the VA offers requires travel through a treacherous mountain pass going in any direction of a CBOC… [with] solid snowfall at our high elevation for 8-9 months out of the year:"

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[26] Department of Veterans Affairs, "Uniform Mental Health Services in VA Medical Centers and Clinics," VHA Handbook 1160.01 (Sept 11, 2008), accessed http://www.mirecc.va.gov/VISN16/docs/UMHS_Handbook_1160.pdf

[27] See 38 USC sec. 1703(a)

"Getting approval for fee basis is a nightmare and most people don't know to even push for it. The only approval we've gotten for fee basis was twice: once for physical therapy, and fee basis screwed up the processing and left us with a bill for the services. I had it re-routed through Medicare just to get it paid for. The other approval was for the sleep study that took two years to process."

Exacerbating access challenges is a historical and growing crisis in the mental health workforce. According to a recent report from the Substance Abuse and Mental Health Services Administration (SAMHSA), 55% of U.S counties, all rural, have no practicing psychiatrists, psychologists, or social workers and 77% of counties have a severe shortage. The report highlighted issues impacting the dearth of available providers such as high staff turnover, inadequate compensation, stigma, and licensing and credentialing issues. The report also acknowledged deficiencies in the adoption of evidence-based practices and the use of technology, which is especially problematic with the great need for effective trauma-specific approaches for this generation of veterans.[28] With the drawdown of forces in Afghanistan, more and more service members will be transitioning to veteran status, with many returning to their homes in rural America. With additional demands from population growth and increased coverage of services, the challenge of access to effective mental health care in rural America will continue to grow.

A Role for Partnerships

VA mental health programs certainly have a role to play in early identification and treatment of mental health conditions. Yet evidence suggests that success in addressing combat-related mental health conditions is not simply a matter of a veteran's getting professional help, but of learning – with help -- to navigate the transition from combat to home.[29] In addition to coping with the often disabling symptoms, many OEF/OIF veterans with PTSD and other conditions, and wounded warriors generally, are likely also struggling to readjust to a "new normal," and to often profound uncertainties about finances, employment, education, career and their place in the community. While some find their way to VA programs, no single VA program necessarily addresses the range of issues these young veterans face, and few, if any, of those programs are embedded in the veteran's community. VA and community each has a distinct role to play. The path of a veteran's transition, and successful community-reintegration, if it is to occur, ultimately occurs in that community. For some veterans that success may take a community – perhaps the collective efforts of local not-for-profit groups, businesses, a community college, the faith community, veterans' service organizations, and agencies of local government, all playing a role. Yet there are relatively few communities dedicated, and effectively organized, to help returning veterans and their families reintegrate successfully, and other instances where VA and veterans' communities are not closely aligned. The experience of still other communities, however, suggests that linking critical VA programs with committed community engagement can make a marked difference to warriors' realizing successful reintegration.

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[28] U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration, Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues, (January 24, 2013).

[29] Charles W. Hoge, M.D.; *Once a Warrior Always a Warrior: Navigating the Transition from Combat to Home*, (Globe Pequot Press, 2010).

With limited exceptions, however, VA mental health programs are generally not focused on, or integrated with, the adjacent community. (One important exception is the support some VA facilities have provided veterans treatment courts, in efforts to divert individuals from the criminal justice system into treatment and rehabilitation.) Importantly, VA not only has broad authority to contract, or enter into partnerships, with community providers or other entities,[30] but Congress has expressly encouraged the Department to work with communities to expand veterans' access to needed mental health services, expressly inviting it to "partner" with community entities.[31]

It has long been WWP's view that VA should partner with and assist community entities or collaborative community programs in providing needed mental health services to wounded warriors, to include providing training to clinicians on military culture and the combat experience. Our own experience in that regard has been disappointing. At Wounded Warrior Project, one of the 18 programs we offer warriors is our "Project Odyssey," an outdoor rehabilitative retreat for warriors with PTSD that promotes peer-connection and healing with other combat veterans as part of a challenging outdoor experience. We run approximately 50 such retreats around the country annually, and in the past benefitted from a collaborative relationship with VA's Vet Center program, with Vet Center counselors participating in each Odyssey. This was a symbiotic relationship, consistent with the Vet Center's outreach mission, that frequently resulted in warriors becoming Vet Center clients after the Odyssey experience. Unfortunately and inexplicably, VA Central Office officials terminated this partnership in 2010 (seemingly on the basis that there were questions about its underlying statutory authority. Since then Congress has made crystal clear that VA has the authority to provide Vet Center support to recreational programs operated by veterans service organizations to foster the readjustment of warriors. But while we have reached out to Secretary Shinseki to reinstate this relationship, citing the specific authority Congress provided VA to support such programming,[32] we have to date received only a noncommittal response.

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[30] See 38 U.S.C. sec. 8153. Section 8153(a)(1) provides, "To secure health-care resources which otherwise might not be feasibly available, or to effectively utilize certain other health-care resource, the Secretary may…make arrangements, by contract or other form of agreement for the mutual use, or exchange of use, of health care resources between Department health-care facilities and any health-care provider, or other entity or individual."

[31] "…the Secretary may partner with a community entity or nonprofit organization or assist in the development of a community entity or nonprofit organization, including by entering into an agreement under section 8153 of title 38, United States Code, that provides strategic coordination of the societies, organizations, and government entities…in order to maximize the availability and efficient delivery of mental health services to veterans by such societies, organizations, and government entities." Section 729, National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239.

[32] 38 U.S.C. sec. 1712A(g), as added by section 727, National Defense Authorization Act for Fiscal Year 2013, Public Law 112-239. Under that provision,"…[T]he Secretary may provide for and facilitate the participation of personnel employed by the Secretary to provide services under this section in recreational programs that are – (1) designed to encourage the readjustment of veterans described in subsection (a)(1)(C) [of section 1712A of title 38, U.S. Code]; and operated by any organization named in or approved under section 5902 of this title."

Leveraging VA's Workforce and Programs

VA often cites the numbers of OEF/OIF veterans "seen" in VA health care facilities for mental health conditions. But what is less readily acknowledged is the significant percentages of OEF/OIF veterans who drop out of treatment, as well as those who need, but do not seek, mental health care. As a leading researcher described it, "with only 50% of veterans seeking care and a 40% recovery rate, current strategies will effectively reach no more than 20% of all veterans needing PTSD treatment."[33] The Administration has since formulated a strategy that we believe holds real promise to counter those twin challenges. Its direction to have VA hire and train peers to provide outreach and support to fellow warriors can provide a cadre of warriors who can win other warriors trust and both foster a path to treatment and provide support to sustain warriors who have embarked on treatment. As such, we applaud the White House initiative directing VA to hire and train 800 peer to peer counselors. We understand that VA has made progress, but appears still to be at a relatively early stage of implementation. What is more concerning, however, is that – as it is being implemented, the program has no specific OEF/OIF focus. Rather, as we understand it, individual VA facilities may establish and fill peer positions in any of their mental health programs, without regard to the population served. While we agree that peer-support can be widely beneficial, the most compelling need for this can of help, in our view, is among returning veterans. We recommend that VA peer to peer program either be re-oriented to target the OEF/OIF population or that VA expand substantially the number of veterans it hires and trains to serve as peer to peer counselors. Either step would have a potential multiplier effect throughout the VA system in engaging and sustaining warriors in treatment.

A second key VA program, its Vet Centers also incorporate the critical peer-to-peer component. For this and other reasons, the program has had singular success, in our experience, in reaching and connecting effectively, with wounded warriors. We recommend that VA both improve coordination between its medical facilities and Vet Centers, and that it increase both Vet Center staffing and the number of Vet Center sites, with emphasis on locating new ones near military facilities.

Finally, VA's telemental health capability has seen significant growth, and there is potential for further expansion. A 2008 journal article described the VA as having one of the largest telemental health networks in the world, with over 45,000 videoconferencing and over 5,000 home telemental health encounters annually.[34] By fiscal year 2012, the program had grown to providing 217,000 remote mental health visits to 76,000 veterans via clinical video telehealth through VA community-based clinics and 7,100 via home telehealth. 49% of veterans receiving telehealth live in rural areas.[35] While VA encourages the use of telemental health and there is emerging evidence for its expanded use to provide mental health services—including individual and group therapy and diagnostic assessment-- some facilities still do not offer these services or

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[33] Charles W. Hoge, MD, "Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are," supra, note 14.

[34] Godleski, et al. "VA Telemental Health: Suicide Assessment," *Behavioral Sciences and the Law*, 26 (3), 271-86. May/June 2008.

[35] Interview with Linda Godleski, PhD, Director National Telemental Health Center, VA Office of Telehealth, May 17, 2013

experience barriers to utilizing the modality. [36] [37] Recent studies have indicated that telemental health holds promise in increasing the availability of care, reducing the need for inpatient care, and improving patient outcomes[38] [39] and there is some evidence it might be a more cost-effective model.[40] There are certainly areas that warrant further careful evaluation.[41] But the advances in telehealth and developing knowledge in the area are encouraging and we urge greater expansion of an approach that could engage more warriors in needed mental health care.

Thank you for your consideration of our views.

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[36] Department of Veterans Affairs Office of Inspector General, "Evaluation of Mental Health Treatment Continuity at Veterans Health Administration Facilities," (April 29, 2013).

[37] Jameson et al. "VA Community Mental Health Service Providers' Utilization of and Attitudes Toward Telemental Health Care: The Gatekeeper's Perspective," *The Journal of Rural Health* 27: 425–432. 2011.

[38] Godleski, Darkins, and Peters. "Outcomes of 98,609 U.S. Department of Veterans Affairs Patients Enrolled in Telemental Health Services, 2006–2010," *Psychiatric Services* 63 (4), 2012.

[39] Koch. "The VA Maryland Health Care System's telemental health program," *Psychological Services* 9(2):203-5. 2012.

[40] Shore et al. "An economic evaluation of telehealth data collection with rural populations," *Psychiatric Services* 2007 Jun;58(6):830-5.

[41] Yuen et al. "Challenges and opportunities in internet-mediated telemental health," *Professional Psychology: Research and Practice*, Vol 43(1), Feb 2012, 1-8.