Creating Effective Solutions, Programs, and Policies to Improve Veterans' Mental Health Care

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Executive Summary

Since 2014, Congress and the leadership at the Department of Veterans Affairs (VA), under the administrations of Presidents Barack Obama and Donald J. Trump, have expressed growing concern over the epidemic of veteran suicide and the effectiveness of mental health treatment for veterans. The last three VA Secretaries, Robert McDonald, David Shulkin, and Robert Wilkie, all declared[1] veteran suicide to be the "#1 clinical priority" of the agency. Senate Committee on Veterans Affairs (SVAC) Chairman Jerry Moran[2], Ranking Member Jon Tester[3], as well as House Committee on Veterans Affairs (HVAC) Chairman Mark Takano and Ranking Member, Phil Roe[4] have similarly prioritized suicide prevention.

Numerous bills and other initiatives have been introduced or passed to address these concerns. These include, among others, the Clay Hunt Suicide Prevention for American Veterans (SAV) Act of 2015[5], the VA MISSION Act of 2018[6], the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2020[7] and the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)[8] stemming from President Trump's White House Executive Order 13822, as well as other introduced legislation, such as HR 2898 proposing the creation of a National Buddy Check Week[9].

While these initiatives address critical issues, the laudable desire to decrease veteran suicide and enhance the mental health of veterans is chronically undermined by serious problems that limit the effectiveness of myriad programs and initiatives and, in some cases, may cause unintended harm. This is why programs and initiatives must:

1. **BE BASED ON CORRECT ANALYSES AND INFORMATION**. Initiatives are too often grounded in false premises – untested assumptions, tropes, and even myths – about the delivery of effective mental health care, the relationships of veterans to the VA, and the (in)ability of the VA to effectively serve the nation's veterans.

2. **BUILD ON EXISTING PROGRAMS**. Initiatives often ignore and/or fail to build on current programs that Congress has already created and funded, or that the VA or the Department of Defense (DOD) has pioneered to address veterans' mental health needs and reduce suicide.

3. **ASSURE QUALITY NON-VA MENTAL HEALTH CARE.** Initiatives generally fail to adequately assess the readiness, competence, capacity, and willingness of non-VA providers, and the health care systems in which they are embedded, to effectively treat veteran-specific mental health problems[10]. They also fail to establish adequate systems

for evaluating the effectiveness of private sector programs that purport to deliver high quality mental health care to veterans and reduce veteran suicide.

4. **ASSURE ADEQUATE STAFFING AND FUNDING.** When legislation and executive initiatives require the expansion of VA mental health services, they typically fail to provide the levels of staffing and funding resources necessary to fulfill these mandates. Staffing, training, and workload issues are generally not considered when VA employees must coordinate new non-VA programs. These deficiencies then, in turn, compound existing VA staffing problems.

5. **UTILIZE SCIENCE IN IMPLEMENTING INITIATIVES.** Legislative and other health care initiatives are rarely grounded in scientific evidence that demonstrates their effectiveness. Solid evidence, in conjunction with treatment planning that takes individual patient preferences into account, is the best way to ensure that veterans won't be offered care that is ineffective or potentially harmful, and that vitally important but limited resources won't be squandered.

In this white paper, the Veterans Healthcare Policy Institute (VHPI):

- Explores manifest shortcomings in policy and legislative initiatives in the provision of veterans' mental health care and suicide prevention services; and,
- Proposes a series of recommendations to address those shortcomings that apply to programs serving veterans within the Veterans Health Administration (VA) as well as those outside VA.

Recommendations

VHPI believes the following recommendations should be considered strongly when future solutions, programs, and policies are designed to address veterans' mental health care. These evidence-based recommendations have a deep-rooted history of success in VA and the larger health care community. If properly implemented, VHPI believes these recommendations will improve veterans' mental wellbeing and help prevent veteran suicide.

Provide Funding for Sufficient VA Mental Health Staff

Any new mandates from the White House, Congress or the VA should ensure adequate VA staffing and funding. Allocations for these new initiatives should not be drawn from existing VA mental health and suicide prevention services.

- All VA facilities should be required to meet the extant agency mental health staffing ratio (currently 7.72 clinical Full Time Employees (FTE) per 1,000 mental health outpatients). Even where the ratio is met, facilities that have wait times beyond 20 days to initiate

outpatient mental health treatment due to demand outpacing capacity should fill/add VA mental health positions to fully meet demand.
- Legislation that creates new services should come with commensurate funding for additional FTE to deliver on mandates, including coordination and supervision of care delivered outside of the VA.
- Legislation and programs should augment or complement already established actions, programs and research rather than simply duplicate them.

Ensure Provider Competence and Quality of Care

Legislation should ensure that the level of training and competence of non-VA mental health providers who treat veterans matches the standard for VA providers. Legislation should ensure that the quality of non-VA care (including clinical outcomes) matches that of VA, and that both are consistently measured in the same terms and reported publicly as well as for internal quality control.

- Providers who wish to be added to, or renewed for participation in, the network of non-VA providers paid to treat veterans should be *required to be held to the same standards which are applied to VA mental health providers*, including:
    - Having a basic level of credentials and qualifications;
    - Conducting routine screening for Post-Traumatic Stress Disorder (PTSD), Military Sexual Trauma (MST), drug abuse /alcohol, depression, and Traumatic Brain Injury (TBI), including in primary care settings;
    - Having training in the assessment and treatment of common mental and physical health conditions of veterans;
    - Having training in the assessment and management of suicide risk; and
    - Measuring and reporting the outcomes of their care with veterans.

- Third party administrators should be required to assure the completion of these provider requirements in order to retain their contract.
- Training for mental health treatments should be designed to include more than a cursory introduction to the issue and should include, when feasible, training workshops that involve systematic practice of skills, and follow-on consultation.
- While the care of each veteran should be flexible and individualized, evidence-based treatments for PTSD, depression, substance abuse, chronic pain, and insomnia should be required to be available to veterans seeking non-VA treatment, as is required when veterans seek VA care.
- Non-VA providers should be required to take training in the services offered in the VA system and how to refer veterans to VA.

Ensure Access to Care

Legislation should ensure that wait times for care are continuously measured and reported. This will, among other advantages, provide eligible veterans with essential information in deciding whether to seek non-VA or VA care.

- The wait time to obtain non-VA mental health care services should be required to be measured and publicly reported using the same metrics as for VA.
- VA's access standard should make clear that the availability of telehealth within 20/28 days counts as "access to VA care" and does not require referral for non-VA telehealth. This standard should be conveyed to all facility staff and consistently applied to all sites of care. This is particularly necessary during and after COVID-19

Effectively Address Suicide Prevention

The only way to evaluate whether non-VA suicide prevention programs effectively reduce suicide is to measure suicide attempts and completed deaths of the veterans they serve. Any comprehensive veterans suicide prevention program that doesn't address access to firearms for at risk-veterans is missing an essential factor.

- Entities that receive grant funding to provide suicide prevention services should be required to conduct routine assessment and documentation of suicide risk for every veteran served in their practice for mental health services. Uniform reports should be provided on suicide ideation and attempts, safety plans and deaths of all veterans under care. Completed suicides post-treatment should also be tracked and reported.
- A uniform measure for reporting suicide attempts across VA and non-VA should be established so that it is possible to compare the performance of VA and non-VA programs.
- All Community Care Network and VA community grant entity providers should be required to take the same training in lethal means safety counseling that is mandated for VA providers.
- All VA medical, nursing and allied health trainees should be required to take the VA suicide prevention S.A.V.E. training and the lethal means safety course that is mandated for VA providers.
- To avoid duplicative and competing veterans' suicide prevention initiatives, authority needs to be given to VA's Office of Mental Health and Suicide Prevention for effective oversight, accountability and coordination of all suicide prevention grants and efforts.
- Given that mental health conditions and suicidal risk are improved by good marital and family relationships, far greater provision of couples therapy within the VA needs to be funded and incentivized.
- Semi-yearly clinical pertinence reviews should be required of each VA and non-VA mental health provider to ascertain whether a suicide assessment is recorded in the health record, and when there is elevated risk, whether the Safety Plan documents a lethal means safety assessment and plan.
- Non-VA entities should be required to adopt VA's gold standard suicide prevention assessment and safety plan template.

Require Use of Evidence in the Selection of Interventions and the Evaluation of Treatment Effectiveness

Standards for clinical programs and community public health interventions, even for pilot programs, should be grounded in demonstrated effectiveness.

- Clinicians should be required to document progress of patients. Measurements should occur at the commencement of treatment, during the course of treatment, upon completion of treatment, and at a follow-up assessment 6+ months following completion of a treatment to determine levels of sustained improvement.
- Clinically-relevant symptoms and functioning should be assessed using validated assessment instruments that are uniform across VA and non-VA treatment programs.
- The treatment outcomes of programs should be publicly reported.
- Empirical effectiveness of programs, especially those that go beyond VA/DoD Clinical Practice Guidelines, should be determined, whenever possible, with comparisons to matched or randomized control groups.

Shortcomings in Current Policy and Legislative Initiatives for Veterans' Mental Health Care and Suicide Prevention

In order to deliver high quality mental health care to veterans, one has to first have a clear definition of the term high quality healthcare. An excellent definition is the one provided in the Institute of Medicine's critical report Crossing the Quality Chasm: A New Health System for the 21st Century.

Definition of High-Quality Health Care

Patient-centered	Providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions
Timely	Reducing waits and sometimes harmful delays for both those who receive and those who give care
Effective	Providing services based on scientific knowledge to all who could benefit and refraining from providing services to those who are not likely to benefit (avoiding underuse and misuse, respectively)
Equitable	Providing care that does not vary in quality because of personal characteristics, such as gender, ethnicity, geographic location, and socioeconomic status
Safe	Avoiding harm to patients from the care that is intended to help them
Efficient	Avoiding waste, including waste of equipment, supplies, ideas, and energy

Source: Institute of Medicine, Crossing the Quality Chasm: A New Health System for the 21st Century, Washington, D.C.: National Academies Press, 2001a.[11]

To deliver this kind of high quality care that is patient-centered, timely, effective, equitable, safe, and efficient we explore some of the serious problems which compromise many programs and initiatives.

1. False Premises

Many of the proposed remedies for the problems of veterans' mental health and suicide prevention are grounded in one or more of the following false assumptions:

1. The majority of veterans who do not seek VA care avoid VA out of a strong dislike of the system and would readily seek care in the private sector if VA paid for it.

2. Private sector clinicians are qualified to deliver veteran-specific mental health care and suicide prevention interventions that are as comprehensive and effective as those provided by VA.

3. Private sector mental health providers are able to promptly add veterans to their practices, particularly in underserved and highly rural areas.

4. The static suicide rate among veterans using VA and non-VA services is an indication that the VA's Suicide Prevention Program is failing and needs to be radically overhauled.

There is little to no evidence supporting any of these assumptions. Indeed, all the current evidence points to precisely the opposite conclusions. We discuss each in turn.

Assumption 1: The majority of eligible veterans avoid VA out of a strong dislike of the system but would readily seek care in the private sector if VA paid for it.

A number of recent studies have documented that the majority of veterans prefer care in the VA over care in the private sector. The "most important takeaway" cited in the 2017 VFW survey[12] of veterans was that "the overwhelming majority of respondents said they want to fix, not dismantle the VA health care system."

In 2019, the VFW conducted another survey[13] and found that "91% of respondents recommend VA care to other veterans compared to 80% last year. Veterans who were offered community care still prefer to receive their care from the VA." In the September 10, 2020 HVAC hearing, Patrick Murray, Legislative Director of the VFW, reiterated that "veterans prefer to get their care at the VA because it offers high quality veteran-centric care." A VA survey of enrollees found overall that they were satisfied with access to and quality of VA care.

Studies also document[14] that those veterans who don't seek VA care do not bear a special animus against VA but are confused about who is and who is not an eligible veteran and don't know how to enroll for VA care.

In 2018, the National Academies of Sciences, Engineering, and Medicine studied post-9/11 veterans who had not sought VA mental health care. Their report, entitled Evaluation of the Department of Veterans Affairs Mental Health Services[15], found that the four top reasons that veterans with a mental health problems were not seeking VA care were:

- Lack of knowledge of how to apply for VA benefits (42% of survey respondents)
- Lack of certainty about whether they are eligible for or entitled to VA mental health care (40%)
- Lack of awareness that VA offers mental health care (33%)
- Not feeling that they deserve to receive VA mental health benefits (30%)

Other reports also confirm that many veterans are unsure whether they qualify as veterans or fear that, by seeking VA care, they will deprive others who are more deserving and/or are in greater need of care. Women veterans, for example, appear to be unsure whether VA is available to or appropriate for women. Still other veterans are ineligible for VA[16] care because of their discharge status[17] or because of their priority group under VA eligibility rules.

These misconceptions demonstrate the need for DoD to better educate service members and their families prior to discharge. DoD and VA should also provide outreach after transition. DoD and VA should mount a comprehensive public information campaign for veterans of all ages and their families.

Recent legislation has begun to better inform veterans of their mental health benefits. The Commander John Scott Hannon Act Section 201 sets nominal benchmarks for outreach that aim to enhance VA mental health utilization by eligible veterans. However, the only veterans who are informed of their eligibility and nearest VA facility are those who receive suicide prevention assistance under this section.

Section 101 of that law reviews (but does not change) DoD activities that promote the availability of health care from VA, including outreach to members of the Armed Forces through the Transition Assistance Program (TAP). Even so, the need for greater training and outreach to servicemembers and their families before leaving the military needs far more attention. Several bills introduced for consideration at the September 10, 2020 HVAC hearing would have improved the dissemination of health benefit information, but never made it beyond that hearing.

> Proposals at the 9/10/2020 HVAC Hearing included:
>
> REVAMP Act to make TAP mental health components mandatory and Ensuring Veterans' Smooth Transition Act (EVEST) that provides for automatic enrollment of eligible veterans in patient enrollment system of VA, with an easy alternative to "opt out."

Many recent suicide prevention/mental health bills propose grants for private sector mental health care. These bills are grounded in the assumption that there are vast numbers of veterans who do not seek VA care but would readily seek out private sector care were it available. They also assume that veterans are more likely to fully engage in such non-VA treatment, not only by attending appointments, but also by completing treatment regimens and adhering to treatment recommendations. There is no evidence to support this assumption.

Veterans will not necessarily seek care in the private sector

Similarly, when it comes to veteran suicide, it is frequently stated that, of the 20 veterans who die by suicide every day, only six have actually sought care in the VA. Policymakers assert that the other 14 would have sought care in the private sector if it were easily available. Once again, there is no evidence to support this assumption.

In fact, the average age of the veterans not using VA care was 54.3 years, an older population that, in general, is less prone to seek the care of a mental health provider[18] either in or outside the VA.

Many factors serve as barriers to seeking care for mental health problems. These include[19] a discomfort with psychological treatment[20] of any kind, logistical obstacles (difficulties taking time off from work or arranging child care, transportation difficulties), a conviction[21] among many veterans that they should be able to solve their own problems, a lack of understanding of what takes place in treatment, and a lack of recognition that they are experiencing a common, treatable mental health problem[22].

Like many other Americans, veterans fail to engage with mental health treatment because of long-standing stigma associated with seeking help for serious problems.[23] Some (incorrectly[24]) fear that the government will confiscate their firearms if they receive a diagnosis of PTSD or other mental health conditions.

Misconceptions about mental health care

These concerns reflect a deep resistance in American culture – resistance that is by no means limited to veterans – to seeking help for mental health problems. This produces a significant obstacle to the delivery of mental health treatment throughout the population. In most forms of mental health care, studies document that there are low rates of uptake, poor engagement, and high rates of dropout[25]. As studies have also documented[26], another dimension of this problem is that many of those who have mental health problems fear losing their jobs if they ask their employers for time off to attend appointments or simply if their employers discover that they are among the 20-30% of Americans suffering from a mental illness.

Such concerns are even more pronounced in the veteran population. Military training and socialization encourage service members to maintain an appearance of personal strength and characterize emotional problems as a sign of weakness.

Traditionally, servicemembers have reported that any admission of mental or behavioral problems, much less suicidal ideation, negatively impacts prospects for advancement, threatens their security clearance, and may even lead to the curtailment of their career. If Reservists or Guard members come home from a deployment and seek mental health care, they may be concerned that they may not be deployable again and may even be discharged from the military.

"In the United States, it has been widely recognized that many of the messages men receive – about self-reliance for example – can run into direct conflict with the need to reach out for help when injured or unwell. … Men may find it difficult to identify with the idea of being traumatized (which can carry the implication of being a victim) or may, when they experience uncontrollable emotion, see it as a threat to the sense of themselves as invulnerable and tough. ...How veterans and family members understand early symptoms—as illness, moral failing, or bad behavior— influences what they do about them, whether demanding behavioral change, seeking treatment, or falling into negative cycles of conflict, self-blame, or substance abuse."

– Erin P. Finley

Fields of Combat:[27] Understanding PTSD among Veterans of Iraq and Afghanistan

Assumption 2: *Private sector clinicians are qualified to deliver veteran-specific mental health care and suicide prevention interventions that are as comprehensive and effective as those provided by the VA.*

Readiness of Non-VA Healthcare Systems to Address Veteran Mental Health

There is no evidence that private sector providers have the knowledge and clinical competence to care for veterans and understand their complex problems. All current studies in fact suggest precisely the opposite. According to two separate studies conducted by the RAND Corporation, the vast majority of private sector providers know little about veteran-specific mental healthcare problems or the military culture in which veterans have served and which continues to influence their attitudes towards mental health and help-seeking.

In 2014, RAND published a report entitled Ready to Serve[28], which assessed "Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families." The results were not positive. RAND established criteria to ascertain if providers were adequately prepared to care for veterans. Only 13 % of surveyed civilian providers met all the readiness criteria, which included military cultural competency and "the capacity and inclination to deliver clinically appropriate, evidence-based care." Providers working primarily in a military or VA setting were far more likely to meet all criteria.

In March 2018, the RAND Corporation released another study titled Ready or Not?[29] which examined whether private-sector health professionals in New York had the "capacity" and "readiness" to deal with the state's eight hundred thousand veterans in need of care. It concluded that only 2% of New York providers met RAND's definition as "ready to provide timely and quality care to veterans in the community." While the majority of providers said they had room for new patients, fewer than 20% of them ever asked their patients if they were veterans. Fewer than half used appropriate clinical practice guidelines to treat their patients, and 75% didn't use the kind of screening tools commonly deployed in the VA to detect critical problems like PTSD, depression, sexual trauma, substance misuse, and risk of suicide. Most providers had no understanding of military culture. Fewer than half said they were interested in filling such knowledge gaps.

A study[30] conducted by the Medical University of South Carolina Department of Psychiatry and Behavioral Sciences and the Rural Health Program of the VA Mid-Atlantic Health Care Network (VISN 6) documented that 46% of providers disagreed with the statement that they were "confident to use best practice treatments for PTSD," 59% disagreed that they were "confident in their ability to use best practice treatments for Traumatic Brain Injury", and 40% disagreed that they were "confident in their ability to use best practice treatments for Substance Abuse/Dependence." Importantly, the study also found that 47% of private sector providers did not even screen patients to find out if they had served in the military and a vast majority did not understand military culture.

This is crucial in treating veterans, since as the study pointed out, "The military has a unique culture developed through rigorous training and maintained by a strong sense of membership in an elite group of well-trained professionals. Their experiences are difficult to understand by those who are not part of the profession."

This lack of understanding of military culture was also noted in another study[31], which found that although non-VA primary care providers had long been exhorted to "screen their patients for veteran status and become familiar with the health impacts of military service," these recommendations seem to have had little impact on their practice. Non-VA providers reported "low comfort" with "addressing common issues" among veterans.

Congress and VA fail to raise requirements of non-VA providers

In spite of these deficiencies, VA and Congress have been unwilling to require any mental health competencies in the non-VA provider network, largely because private providers object to spending time upgrading their training or monitoring the care they provide. VA and Congress have acquiesced to this objection, foregoing any assurance of quality care to veterans in order to maximize access to private sector care. In the VA Manual[32] for Community Care Network Providers which identifies the metrics needed to be designated a "high performing provider," not a single mental health measure is included.

Assumption 3. *Private sector providers are able to promptly add veterans to their practices, particularly in underserved and highly rural areas.*

There is little evidence that non-VA mental health providers have the clinical capacity to add veterans to their caseloads faster than VA, or – particularly in rural and highly rural areas – whether there is any community capacity at all.

Wait Times

At the September 30, 2020 HVAC hearing[33] on wait times, TriWest reported 90% of the veterans referred to them by VA are seen within 27 days (Optum failed to report their wait times). The MISSION Act wait time standard applied to mental health care within the VA is 20 days or less.

Many services that are available at the VA are generally not available[34] in the private sector[35] or require longer travel time[36].VA has long been a leader in the use of Telemental Health to reach these veterans who have difficulty accessing services.

As Phillip Longman and Suzanne Gordon wrote in report for the American Legion entitled A System Worth Saving[37]:

> "The entire American health-care system faces acute shortages of doctors, especially primary care physicians and mental health professionals. This means that even fully insured patients seeking care outside VA often face long wait

times[38] to see doctors. [3] In a survey by the Commonwealth Fund[39], one out of four Americans reported that they had to wait six or more days for an appointment with a primary care physician, even when they were "sick or needing care." [4] The industry consulting firm Merritt Hawkins[40], in its latest survey of 15 major metropolitan areas, found that the wait time to get a first appointment with a physician averages 24 days. In many parts of the country, the wait times are far worse, especially to see certain kinds of doctors. This is especially true in rural areas, but long wait times can also occur in cities, including ones with renowned medical schools and hospitals. People living in the Boston area, for example, require an average of 109 days to find a family physician who is still taking new patients and up to a year to get a first appointment with a cardiologist. Wait times generally have increased 30 % since 2014, according to the study. [5]

Meanwhile, the shortage of mental health professionals is even more acute throughout the American health care system. According to one government study, 77% of U.S. counties face a severe shortage of practicing psychiatrists, psychologists, or social workers; 55% of U.S. counties – all rural – have no mental health professionals at all. [6] Even when private-sector psychiatrists are available, most are unwilling to accept insurance or government payments. According to studies by the National Institute of Mental Health, 40% of people with schizophrenia and 51% of people with bipolar disorder go untreated in any given year. By contrast, the latest available data show that one in five VA patients is seen on the same day he or she initiates an appointment. Even though roughly 16% of VA primary care facilities are operating at over 100% of capacity, for the system as a whole, the average wait time to see a VA primary care doctor is five days, and nine days for appointments with VA specialists. Wait times to see a mental health professional average four days. The familiar narrative about wait times at VA being worse than in the rest of the system is just demonstrably untrue. An independent assessment commissioned by Congress found that "wait times at the VA for new patient primary and specialty care are shorter than wait times reported in focused studies of the private sector."

In a study published in Psychiatric Services[41], secret shoppers seeking mental health appointments in the private sector had wait times much longer than VA.

The VA is not allowed to count the availability of telemental health services as meeting its 20-day access standard, even during COVID-19. As a result, veterans are being channeled to private sector providers who give them telehealth rather than in-person appointments, when the VA could have provided the same telehealth services quicker, less expensively, and more effectively.

COVID-19's Impact on Non-VA Capacity

The Coronavirus pandemic has exacerbated all of these problems and created many new ones. America has long faced a crisis in the supply of primary care physicians whose care should be a cornerstone of quality healthcare delivery. According to The New Yorker[42], a survey of primary-care doctors found that nearly a fifth had temporarily closed their practices, owing to the pandemic, and two in five had laid off or furloughed staff.

Because of the coronavirus crisis, thousands of hospitals are furloughing staff, and between 20 and 40% of American hospitals face serious financial difficulties and may not survive in their current form.

The crisis has especially impacted rural hospitals. Between 2005 and the 2014, 176 rural hospitals have closed[43] and the coronavirus pandemic is, according to some reports,[44] threatening the financial stability and survival of one in four rural hospitals.

It is unclear where veterans - whether living in rural or urban areas - will be able to find care outside of the VA. These analyses must inform legislative and other initiatives to provide mental and physical healthcare to veterans. Rigorous analysis of private sector capacity must also include considerations of what would occur if veterans were pitted against private sector patients as they compete for access due to an increasing shortage of mental health, primary care, and other healthcare providers.

Assumption 4: *The steady suicide rate among veterans using VA services is an indication that the VA Suicide Prevention Program is failing and needs to be radically overhauled.*

The rate of veterans dying by suicide between 2005-2017 remained fairly steady. During this period, suicide rates among veterans not using VA care (and U.S. adults in general) continued to escalate. However, the suicide rate for veterans who use VA for their healthcare was dramatically slowed[45] and then reversed. Between 2017-2018, suicide rates for veterans who use VA for their care decreased by 2.4%, while rising 2.5% among veterans receiving their healthcare in the community. That success was in spite of the fact that the cohort of veterans who use the VA have greater risk factors for suicide.

The VA's Unmatched Suicide Prevention Efforts

Within the suicide prevention community, the VA's approach to preventing suicides is considered to be the most comprehensive. Each of the 170 VA medical centers has at least one dedicated suicide prevention coordinator (SPC) position. The SPCs provide enhanced care coordination for veterans in VA health care who are identified as high risk for suicide. The SPCs

collaborate with the VA's integrated network of care providers and community partners to reduce suicide risk among vulnerable veterans.

VA mental health policies include an extensive array of actions, including regular screening, outreach following missed appointments, training of all employees around suicide and then greater training depending on level of contact with veteran, and safety planning. For high-risk veterans, suicide prevention policies also involve a medical record flagging and monitoring system, with increased frequency of mental health care appointments.

The 2010 National Strategy for Suicide Prevention report[46] extolled VA's multiple levels of evidenced-based suicide prevention practices and recommended that other health care systems emulate the practices.[5]

Few community health care providers or systems have adopted a similar approach. As the Congressional Research Service observed in 2016, Outside the VA, the use of suicide prevention coordinators has not been widely adopted[47].

Suicide and Firearms

The VHA's comprehensive, innovative lethal means safety approach is the recognized leader in training and implementing lethal means safety concepts. Since 2012, VA's Suicide Prevention Program[48] (SPP) has distributed millions of firearm cable locks for free, and without questions asked, to veterans who request them. It created lethal means safety brochures, flyers, public service announcements, social media messages, clinician pocket cards and websites. It disseminates safe storage information in its primary care and mental health clinics.

VA developed an online lethal means safety counseling (LMSC)[49] training that 20,000 VA providers have taken to date. In November 2020, a revamped LMS training was mandated for all VA providers. VA offers free, individualized lethal means risk management consultation to VA and community clinicians who work with veterans. VA includes lethal means safety procedures in its National Strategy for Preventing Veteran Suicide, VA/DoD Clinical Practice Guideline[51], and VA Suicide Risk Evaluation and Suicide Prevention Safety Plan[52] required of clinicians.

The VA also added public health strategies to promote safe storage practices for veterans. It formed an historic partnership[53] with the National Shooting Sports Foundation (NSSF) and the American Foundation for Suicide Prevention (AFSP). Collectively, they co-branded an educational, training and resource toolkit to foster community coalitions and gun retailer projects that encourage veterans to securely store firearms. The VA partnered with NSSF to post billboards in eight states encouraging storing one's firearms responsibly to prevent suicide. VA invited the states/cities in the Governor/Mayoral Challenge[54] to Prevent Suicide (joint VA and Department of Health and Human Services' Substance Abuse and Mental Health Services Administration endeavors) to develop plans for messaging regarding enhanced lethal means safety processes.

The VA collaborated with local firearm advocates in Community Prevention Pilots and in a "Together With Veterans"[55] dissemination of material and outreach to rural veterans. Along with AFSP, VA hosted conferences for healthcare practitioners, policy makers and stakeholders on innovations related to lethal means safety.

In May 2020, VA co-sponsored a COVID-19 suicide prevention video[56] with the United States Concealed Carry Association (USCCA), NSSF and AFSP, including ways that the firearm industry, gun owners, and veterans' families can help.

Finally, because one can't frame or resolve the problem of suicide without accurate data about its incidence and prevalence, VA has led the nation in studying the epidemiology of suicide. The fact that, on average, 20 veterans die by suicide every day could not have been established without VA having pioneered new ways to obtain this data and validate it nationally with annual updates.

2. Ignoring or Failing to Build on Existing Programs

Many of the solutions proposed or enacted by Congress seem uninformed by – and, therefore, unable to capitalize upon – practices and outcomes of current programs that have been developed, funded, and implemented by DoD and VA. The VA MISSION Act of 2018, The Commander Scott Hannon Act, the new PREVENTS initiative, and the recently introduced suggestion for a National Buddy Check Week both either totally ignore or fail to build upon well-established VA programs. These include:

- VA's Primary Care and Mental Health Integration
- Lethal Means Safety Counseling and other Suicide Prevention Efforts
- The VA MISSION Act of 2018
- The Clay Hunt Suicide Prevention for American Veterans (SAV) Act[57]

Primary Care and Mental Health Integration

To address the very real challenge of engaging veterans in mental health care, VHA developed and implemented pioneering programs[58] in the integration of mental health and primary care.

We know that veterans, like other Americans, are uncomfortable going for mental health treatment. Most veterans, and most American citizens, are far more accepting of receiving medical care from their primary care doctors and nurses. Scientific literature documents that up to "70 to 80 % of all primary care visits are related to psychological distress" that remains largely[59] untreated. Although primary care providers may refer patients to mental health specialists, typically, the majority of patients who are referred either never make an initial appointment or fail to complete a course of treatment. Even a waiting time of a day or two reduces the likelihood that an individual in need of mental health care will actually receive it.

If mental health providers are located within the primary care setting as part of the patient's "medical home", mental health care can be initiated immediately as soon as a problem is identified. This eliminates the need for veteran to wait for – or follow through with – a future mental health appointment which will usually be at a different site of care and which would likely be recorded within a different system of records (thus frustrating coordination of care between primary care and mental health providers). Since 2007, VA has implemented a nationwide model of mental health and primary care integration.

This integrated system of mental health and primary care[60] integration is largely unavailable in the private sector because fragmented systems of care, shortages of mental health clinicians, and disparities between insurance coverage for physical and mental health care found in non-VA care make such systems extremely difficult to replicate.

Unfortunately, VA's system of Primary Care and Mental Health Integration is totally ignored in all of the legislation that has been proposed to deal with mental health and suicide prevention.

Addressing Lethal Means Safety as a Suicide Prevention Strategy

The June 2020 President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS) report[61] proclaims, "The science supporting lethal means safety (LMS) is robust and compelling: enhancing safety measures specific to the availability and accessibility of potential lethal means saves lives. A key component of effective suicide prevention is voluntary reduction in the ability to access lethal means with respect to time, distance, and convenience, particularly during acute suicidal crises." It further states, "Moving firearms out of the home is generally cited as the safest, most desirable option; this can include storage with another person or at a location like a firearm range, armory, pawn shop, self-storage unit, or law enforcement agency." One of its ten top recommendations is to "provide and promote comprehensive suicide prevention training across professions." Another was to "increase implementation of programs focused on lethal means safety (e.g., voluntary reduction of access to lethal means by individuals in crisis, free/inexpensive and easy/safe storage options)."

These recommendations are absolutely critical given that 70% of all veteran suicides are by firearms and lethal means safety counseling is a highly effective intervention. Community Care Network (CCN) providers have no requirement for training in lethal means safety counseling (or, troublingly, even in basic suicide risk identification and intervention). Surveys[62] have revealed that non-VA providers rarely screen or counsel their patients - even high-risk patients - about firearm safety.

Yet, in spite of PREVENTS clear directions, Congress has failed to act. Two bills were introduced in HVAC in September 2020 that would have required basic lethal means safety counseling[63] (LMSC) training for people with a high level of contact with at-risk veterans. Both bills were scuttled and never brought up for a vote.

As in VA, lethal means safety counseling training should be obligatory for CCN providers (and trainees) most likely to interface with at-risk veterans, including those working in mental health, primary care, pain and emergency departments. Training should be expanded to include geriatrics and extended care and oncology providers because the majority of older adults who die by firearm suicide have physical health problems but no known mental illness. Likewise, the training should include peer counselors, given that veterans are most receptive to fellow veterans raising the topic of safe storage. LMSC training has been shown[64] to improve medical providers' knowledge about the relationship between access to lethal means and suicide, confidence in and frequency of having LMSC conversations.

The VA MISSION Act of 2018

The VA MISSION Act of 2018 establishes an alternate lane of care for veterans who are unable to access VA care within 20 days of seeking a mental health appointment or who have to drive more than 30 minutes for an appointment. The Act sets up a Veterans Community Care Network that includes mental health professionals. One of the MISSION Act's mandates promised to amplify an Obama-era program to support peer specialists, veterans who have themselves overcome mental health or substance abuse problems and are specifically trained to work in

mental health. Section 506 of the MISSION Act mandated the hiring of 60 peer specialists to work in 30 sites in primary care centers around the country. This hiring has been hampered by lack of sufficient budget allocations.

None of the recent initiatives and legislation passed, implemented, or proposed consider how adding new lanes of care will increase fragmentation and difficulties in coordinating care, not to mention dangerous duplication of services, as occurred in Memphis when, according to the VA OIG[65], gaps in coordination with the private sector were a factor in a veteran's suicide. Nor do these initiatives attempt to address failures to fully implement and fund earlier mandates such as Section 506 of the VA MISSION Act.

The Clay Hunt Suicide Prevention for American Veterans (SAV) Act

Passed in 2015, this act mandates a variety of suicide prevention activities including annual evaluations of mental health and suicide prevention programs, publication of an internet website describing mental health programs, and pilot programs for community outreach. The Act also mandates cooperation between the VA and not-for-profit mental health organizations. Many of the legislative initiatives that have appeared since the Clay Hunt Act was passed seem to ignore its mandates or fail to discuss how they will be integrated into succeeding mandates and initiatives. This creates yet another layer of administrative and organizational confusion, increases the potential for competition rather than collaboration, and imposes burdensome and redundant efforts on already overburdened staff.

3. Failure to Assure Quality Non-VA Mental Health Care

Readiness to Treat PTSD and MST

As noted in False Assumption #2, the problem of readiness is particularly acute when it comes to treating PTSD and trauma-related mental health problems. We know that it is crucial to screen veterans for a variety of problems like PTSD, Military Sexual Trauma, Major Depressive Disorder and Substance Abuse.

The VA has built routine, annual screening for PTSD and sexual assault (for both women and men), depression, and substance use into all their primary care clinics, nationwide, so that these problems cannot be easily missed. The VA has also developed clinical pathways to assure that those who screen positive for mental health conditions receive needed care. In the integrated mental health/ primary care model, positive screens for these problems are addressed in the primary care setting.

Screening

In 2016, the U.S. Preventive Services Task Force released two recommendations[66] that primary care doctors screen[67] all adults and adolescents for depression and urged primary care doctors to perform screenings whether or not they have mental health services readily available. To date, such screenings are not a requirement but rather a suggestion to take into consideration. To the best of our knowledge, compliance is the exception rather than the rule across the private sector.

Even if screening were widely implemented, few private sector providers would be able to deal with any problems revealed in the screening process. Few have received any significant formal training in treatment of PTSD. It has been widely documented[68] that community-based providers are not practicing in ways consistent with best practices as laid out in formal Clinical Practice Guidelines for treatment of PTSD.

Failure to Expect Private Sector Providers to be Trained in or Use Evidence-Based Treatments and Evaluate Treatment Outcomes

Most mental health providers are, by necessity, generalists, seeing a wide range of clients, the majority of whom are treated for problems such as depression and anxiety or interpersonal difficulties. Most mental health professionals have not received specialized training in military related PTSD and trauma, nor are they familiar with the complex interactions between PTSD, depression, substance use and traumatic brain injury that are routinely encountered among veterans. It has been widely documented[69] that community-based providers are not practicing[70] in ways consistent with best practices[71] as laid out in formal Clinical Practice Guidelines including those focusing on treatment of PTSD.[72]

Most importantly, they have not been trained to deliver the evidence-based treatments that have received the most research[73] support for effectiveness.

By contrast, over 8,500 VHA mental health providers have received extensive training and supervision in two leading evidence-based treatments[74] for PTSD – Prolonged Exposure treatment (PE) and Cognitive Processing Therapy (CPT).

At present, grant entity programs and CCN providers are not held to any standard for training, competency or quality when treating mental health conditions common among veterans or even in suicide risk assessment and mitigation. A license is all that is required to treat veterans. MISSION Act Sec. 133 meant to fix this clinical deficit by directing competency standards to be set for CCN providers who treat veterans for PTSD, TBI, and MST. To date, no requirements have ever been developed. The Clinical TEAM Culture Act introduced in HVAC's September 10, 2020 hearing would have addressed this deficit but did not advance past the hearing. Many studies demonstrate that clinicians who work together on genuine teams achieve better outcomes in treating a wide variety of clinical problems than do clinicians who work in siloed settings where consistent communication is lacking. Clinicians working in VA's specialized

PTSD treatment programs are specialists embedded in concentric circles of expertise and teamwork. Their entire caseloads are comprised of patients with PTSD related to the specific kinds of traumatic experiences most commonly encountered by veterans (e.g., combat, traumatic bereavement, sexual assault).

Newer clinicians at the VA are supported and mentored by similar teams with special expertise in PTSD, MST, Substance Abuse, Suicide Prevention, TBI, Geriatric Psychiatry and Primary Care and Mental Health approaches specific to Women Veterans. They are also supported by more experienced colleagues across a wide range of clinical disciplines. As they treat case after case of PTSD in collaboration with other providers in mental health and primary care, they gain more experience, which they shape and refine. They are also supported by a wide range of ongoing training programs and online resource supports, such as those provided by the VA National Center for PTSD. They work within an institution that leads the world in this area because it has devoted decades to research on PTSD and other problems related to military service and culture. While many patients with milder illness can be managed in general settings, those who suffer from specific conditions such as PTSD and MST, as well as serious mental illness, homelessness, substance abuse and other service-related conditions, do not fare as well outside of the VA's highly specialized programs. Further, no other American health care system can begin to match VA's range of social support systems including access to educational benefits, mortgage benefits, caregiver support, vocational training, disability pensions, legal assistance, and housing for the homeless.

Training of Mental Health Providers in New Practices and Programs

In recent years, there has been a growing awareness of the challenges in training providers and changing practice in health care systems. A new field, "implementation science," has rapidly developed to address these challenges. VA is a national leader in implementation science and has established efforts to monitor services and ensure that best practices are actually delivered across the system. The private sector lacks programs that focus on the mental health difficulties experienced by veterans or deliver care with military cultural competence.

In most private sector settings where mental health care is practiced, clinicians have only to amass a certain number of continuing education credits to maintain their licenses. To do this, they attend conferences, workshops or presentations of their choosing, with no expectation they ever learn about veteran specific issues. Furthermore, these continuing education activities do not usually include actual practice of new skills. In the rare instances where they do, most mental health training lacks any follow-up, coaching, or post-training consultation and supervision in putting new knowledge into practice.

By contrast, VA training programs in evidence-based mental health treatments (for PTSD, depression, and several other problems common among veterans) have included not only intensive, interactive training workshops, but also the critical component of training necessary to produce competence: post-training clinical consultation during initial training cases (Karlin et al., 2010). This consultation involves a process of weekly telephone consultation and case review

that lasts for approximately six months. The VA has carefully evaluated these training programs[75] and demonstrated their impact on reduction of PTSD symptoms and painstakingly developed a core group of national trainers and expert consultants in a range of evidence-based mental health treatments. These training and implementation initiatives have been subject to extensive research[76] attention and represent achievements[77] of historic importance in the field of mental health training.

While brief, usually online, training programs in military culture have been developed in recent years, and some non-VA health care providers have been encouraged to view them, there has been no evaluation of their effectiveness in improving the ability of providers to form strong relationships with veterans and achieve positive treatment outcomes. To our knowledge, no study has evaluated the effectiveness of brief instruction in military culture or found these knowledge gaps to have been successfully addressed or remedied. VA providers, by contrast, have developed their understanding of military culture through an ongoing process of working with veterans involving experience and insights which cannot be acquired in brief presentations.

Given the emerging consensus that most conventional training approaches associated with mental health programs are unlikely to actually improve clinician skills or change their routine practices, legislative proposals that call for training of non-VA providers should include careful attention to methods of training and build in systematic, methodologically rigorous evaluation of training effectiveness. Failure to do this will likely result in wasted resources being allocated to training programs which fail to improve the performance of mental health providers.

Fragmentation of Care Secondary to The VA MISSION Act of 2018 and Commander John Scott Hannon Act

The VA MISSION Act of 2018 widened and facilitated the lane of health care outside of the VA via the Community Care Network. Ignoring the MISSION Act's provisions, the Commander John Scott Hannon Act established a third lane of care, thus creating new layers of confusion, fragmentation, and lack of coordination in veterans' care.

Studies consistently document that increasing the number of care transitions and lack of coordination between care providers is a problem in the non-VA U.S. healthcare system for all patients. It is a particularly acute issue for those with mental health and substance abuse problems and those who are at high risk for suicide. To cite only one analysis[78], the "costs of fragmentation" include "uncoordinated care, low adherence rates, and variations in sources of care". Fragmented care also has increased dangers of duplicative over-prescribing and redundant diagnostic testing.

As a September 2020 JAMA article[79] noted: "Without well-defined mechanisms for 2-way flow of information, it is unclear how easier access to private sector care, potentially at the expense of increased fragmentation, could translate into safer higher-quality care, regardless of the cost implications." A 2018 study[80] found that "Recent federal policy changes attempt to expand veterans' access to providers outside the Department of Veterans Affairs (VA). Receipt of

prescription medications across unconnected systems of care may increase the risk for unsafe prescribing, particularly in persons with dementia."

Another recent study[81] of nearly 280 000 Medicare-eligible veterans, 18.9% received 1 or more prescriptions from the VA and Medicare Part D concurrently and among these veterans, 49.7% had a potentially unsafe medication exposure. The study found that dual use of VA and Medicare Part D prescription benefits resulted in a three -fold increase in severe drug-drug interactions.

Seamless, two-way sharing of electronic health records between VA and CCN has been often promised but rarely achieved. The inability of VA and non-VA clinicians to effectively communicate further exacerbates fragmentation of care. Diagnostic information and medication lists may not be available across the divide between providers, putting veterans at greater risk. This kind of harm is generally prevented for patients seen primarily, or solely, within the VA, where all clinicians have access to the same electronic medical record at any of over a thousand points of care. The lack of interoperability between the VA and non-VA clinicians often results from the diversity of electronic health records among non-VA clinicians.

There is a critical need to evaluate the extent to which the MISSION Act has fragmented and further complicated veterans' care, jeopardized their health, and even endangered their lives. Available documentation, such as the recent OIG report[82] on the suicide of a veteran in the Memphis VA Healthcare system, has failed to identify or even consider how fragmentation of care may have contributed. It is hardly surprising, then, that there is no discussion of how new initiatives like the Commander John Scott Hannon Act will build on, coordinate with, or jeopardize the Community Care Network set up by the MISSION Act or how it will exacerbate the fragmentation of care veterans and their families receive under its new grant-making program.

Another essential point is that diversity, equity and inclusion, which are three distinct but interconnected policy issues in service delivery for veterans, cannot be monitored or assured outside the VA. Veterans who use[83] VA services are more likely to be black, unmarried, and less educated and to have lower household incomes than veterans who do not use the VA.

The Dangers of Creating Ever Expanding Layers of Uncoordinated Initiatives and New Bureaucratic Entities

After many years, of being largely ignored as a potentially preventable tragedy, death by suicide has become a core priority for VA. New programs to identify and provide interventions for suicidal individuals show promise in the short term. However, disjointed programs run the risk of creating new bureaucracies that compete with—and thus undermine – VA programs which have proven to be effective. Even more disconcertingly, when pre-funded treatment programs, such as those authorized in the Commander John Scott Hannon Act, require no VA oversight, the result can only accelerate the transformation of VA from a provider of services to a payer of services.

Recently, peer support programs that provide long-term support for veterans with PTSD and other conditions have been cut or slated for elimination to save money for new mandates such as

those in suicide prevention. These programs were introduced, in part, to capitalize on the fact that many veterans are more likely to open up to a fellow veteran than to a mental health professional. Although these peer support programs aren't described as suicide prevention programs, they are likely to help prevent veteran suicide. Indeed, many veterans who rely on peer support attest to the fact that they would have taken their own lives without the constant support of their peers and the clinicians who provide care. It is ironic (even tragic) to see such programs terminated in order to free funds and staff time for "the next new mandate."

The point is that suicide prevention aimed at the small number of veterans at high risk should not crowd out other mental and physical health programs that help alleviate the pain and suffering veterans have shouldered for decades as a result of their service and sacrifice. Dozens, perhaps hundreds, of VA programs do more than treat symptoms: they enhance veterans' personal sense of well-being and quality of life. In so doing, they also prevent veterans from becoming suicidal.

Failure of Appropriate Referral to the VA

One of the many problems of outsourcing veteran care to the private sector is that private sector providers know little about the VA, how it operates, the services it offers, and why it is the most knowledgeable provider when it comes to many of veterans' specific healthcare problems. Not only do studies document[84] that private sector providers lack basic knowledge about VA's mission and function, they also highlight the fact that they share some of the misconceptions about the VA outlined in this paper. This makes it very difficult for private sector providers to fulfill one of the most important functions of high-quality practice: knowing how to appropriately refer patients to other providers, whether individual or institutional, who can provide appropriate care to a particular patient in need.

Some clinicians may fear that VA will "take their patient" should they make a referral without realizing that VA has developed sophisticated systems for partnering with community providers in meeting a veteran's medical and social needs. The ethics of physician/provider referral prohibit self-dealing (referring to physician-owned entities or receiving kickbacks for referrals from other physicians). They also demand that practitioners appropriately refer patients[85] to other providers when they are not competent to care for the patient themselves. It is thus standard practice for medical professionals to maintain appropriate referral networks to other practitioners.

Like a specialty pediatric hospital, orthopedic hospital or oncology center, VHA is the only provider in the United States to specialize in, as its area of population expertise, veteran-specific mental health conditions. VA expertise goes way beyond so-called foundational services – PTSD, prosthetics, battlefield trauma – and integrates this knowledge into all areas of practice. If non-VA providers, as the studies cited above document, know little or nothing about veteran-specific problems and the cultural issues that influence them, these providers have an ethical and even legal obligation to refer veterans to providers in the VHA who are competent to deal with them. Because these providers do not know about VA services and resources, it will be hard for them to appropriately refer patients to the VA and thus very difficult for them to fulfill their ethical responsibilities to their patients.

4. Failure to Assure Adequate Mental Health Staffing

Resources remain[86] short of what's needed to keep up with the demand for VA mental health services. Despite large increases in the number of providers hired and visits furnished, the workforce remains markedly understaffed. The majority of facilities fail to meet the VA Directive 1161[87] (April 28, 2020) required mental health staffing ratio of 7.72 clinical FTE per 1,000 mental health patients, a ratio that when attained, has been shown to prevent suicide. As of the first quarter of fiscal year (FY) 2020, only 42% of health care systems met the minimum outpatient mental health staffing level. That's an alarming problem given the reported connection[88] between staffing shortages and suicide: "Mental health staffing enhancements have been associated with decreases in suicide rates among VA patients in regions where mental health outpatient staffing increases were greatest."

Further, in each of the last eight years, VA's OIG has identified psychiatrists and psychologists in the top seven VA occupations with critical staffing shortages[89].

New Initiatives Should Not Hurt Existing Programs

Proposed legislation and new executive orders and programs consistently impose new mandates and activities that VA staff are required to fulfill. Legislative and other initiatives require the production of new training materials and a significant time commitment from VA staff as well as non-VA providers. Proposals also mandate the coordination of care between VA and non-VA providers, and follow-up to care provided.

To cite just one example, a "Report to Congress Health Care Standards for Quality[90], Section 104" submitted in March of 2019 mandated that "The Secretary shall establish standards for quality regarding hospital care, medical services, and extended care services furnished by the Department pursuant to this title, including through non-Department Healthcare providers." The 17-page document contained a dizzying array of charts and graphs outlining the duties that VA providers and staff were expected to accomplish to implement the MISSION Act. These include helping veterans choose a provider in the new Community Care Network, monitoring complaints about the provider, tracking the timeliness of care consult requests, reviewing cases of unexpected mortality, tracking avoidable infections, conducting root cause analyses about infections, screening for suicidal ideation, educating veterans and families about care they were to receive in the community, and making sure private sector providers performed post-discharge mental health screenings for PTSD and complications of surgery – to name only a few. All of this is to be accomplished without increases in staffing or the development of new clinical and/or administrative systems at the front lines of VA health care.

Over and over again, in a variety of legislative proposals, similar duties are outlined with no discussion of how staffs are to manage the increased workload. Nor is there any assessment of

how many additional staff members would be required to implement new mandates or activities while simultaneously providing care to an increasing number of veterans. This occurs in a context where, as VHPI has written and documented[91], there are more than 50,000 vacancies in the VA, which the Secretary has only begun to address during the COVID crisis. No legislative or executive initiatives purporting to provide high quality care outside of the VA – or inside of it – should be passed or implemented without an accompanying effort to ascertain whether staff can fulfill these mandates and the new duties assigned to them, and without adequate funding to hire staff to fulfill myriad new mandates.

Funding in existing programs that help to enhance veterans' mental health should never be conceptualized as a zero-sum game, where new services are introduced at the expense of older proven programs. This is not, sadly, the current trend. To cite only two examples, The Center for the Study of Traumatic Stress (CSTS)[92] and the Center for Deployment Psychology (CDP)[93] are part of the Department of Defense based at the Uniformed Services University (USU)[94], the nation's federal health professions academy in Bethesda, Maryland. Both programs have proven to be critical in helping clinicians, policy makers, administrators, and the general public better understand and respond to the consequences of military trauma.

The CSTS' Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)[95] is the largest research project ever conducted among military personnel to understand and prevent military and veteran suicide. CSTS's neuroscience research develops effective treatments for PTSD and mild traumatic brain injury (TBI) – the signature injury of the current conflicts in Iraq and Afghanistan). CSTS built an extensive, and sought after, library of resources for military, VA, and civilian healthcare professionals, along with easy-to-understand guides for laypeople that decrease the stigma of seeking help. Since trauma can ripple through generations, CSTS' Child and Family Program brings desperately needed attention to the effects of a parent's combat injuries or death. Just as it did after September 11th, the Center's mission reaches beyond the military community to develop and share some of the best guidance available on the COVID-19 pandemic.

As one of the nation's leading developers and deliverers of clinical training on PTSD, TBI, suicide prevention, depression, chronic pain and the effects of military sexual trauma among women and men, CDP equips civilian providers to identify, understand and treat service members, veterans and their family members whose background, health risks and access to health resources differ greatly from those of the vast majority of their patients. CDP has led the training of military mental health clinicians in the evidence-based treatments for PTSD and other problems and has trained over 70,000 providers nationwide through their ever-expanding teaching network.

As proposed in the summer of 2020, the National Defense Authorization Act[96] would shutter these two critical programs by cutting the USU's budget. The budgets of both centers are being slashed in Fiscal Year 2021 and the centers will be closed by FY 2022 without urgent action. This, in spite of the fact that the combined cost of these programs is a pittance within the context of the Defense budget. At the time of this writing, these draconian cuts have been delayed only

because of continuing resolution has forestalled implementation of the FY 2021 budget. The fate of these critically important programs continues to hang in the balance.

Another example of the dangers caused by underfunding or defunding effective programs in the name of enhanced mental health and suicide prevention surfaced in 2017-2018. When President Trump announced EO 13822 to provide mental health care to 32,000 additional recently transitioned veterans yearly and VA Secretary David Shulkin announced that up to 500,000 Other Than Honorable (OTH) discharged veterans were now eligible for 90 days of VA urgent mental health care, no extra funding was added to the VA budget to meet the foreseeable need for expansion of services. On another occasion, Secretary Shulkin tried to take $1 billion[97] from other VA programs in order to enhance funding for suicide prevention. A variety of programs were thus targeted for drastic cuts or outright elimination. These included mental health programs, women's health programs, patient safety programs, and programs for the homeless. All of these programs helped with suicide prevention by addressing mental health issues before patients became suicidal, thus decreasing the number in need of more extensive care. Although the effort was prevented, this dynamic is never-ending.

> *"The real lesson is that suicide prevention must be baked into the entire VA system of care rather than isolated on its own pedestal. New knowledge and best practices should resonate from VA Central Office to the front lines of care and from the front lines back to Central Office. Only by building on elements like peer support, research, hiring, training, community outreach, etc. can the problem of veteran suicide be reliably addressed. Those who would like to get credit for ending veteran suicide need to stop gilding the most attractive lilies and support the full continuum of care."*
>
> *Harold Kudler*

In the long run, the VA budget, as defined by its Congressional allocation, is a zero-sum game. As new resources are needed in one sector, they ultimately have to come from other sector, leading to a continuous tension among clinical services and posing difficult, if not impossible, decisions for facility directors to make. Failing to fund – or to continue funding – necessary programs does two things: It produces a consistent stream of clinical mandates that are unfunded and it threatens the integrity and sustainability of programs that have proved to be effective in improving veterans' mental health and reducing veteran suicide. This infernal machine propels a perpetual cycle of unfunded and unstaffed mandates each of which is doomed to fail to fulfill its ostensible purpose.

5. Failure to Utilize Evidence in Implementing Initiatives

Failure to Expect Private Sector Providers to be Trained in or Use Evidence-Based Treatments and Evaluate Treatment Outcomes

Mental health interventions vary in their efficacy. For any specific mental health problem, some have received significant research attention and been demonstrated to be efficacious in randomized controlled trials, the gold standard for determining impact. However, not all commonly used mental health treatments have been subjected to randomized controlled studies and some do not meet standards for demonstration of efficacy. While lack of research does not equate to lack of efficacy, this produces a significant risk of some mental health treatments being less effective than what could be provided or of being entirely ineffective. The discrepancy between treatments available in routine care and the best forms of treatment is often referred to as the "research-practice gap."

The authoritative sources of information about which treatments are known to be efficacious are the clinical practice guidelines developed by major organizations in the field. For example, the joint VA-DoD Clinical Practice Guidelines for Management of Posttraumatic Stress[98] is an authoritative guidance document specifying best evidence-based treatments for PTSD. However, the psychological treatments endorsed as evidence-based in those Guidelines are generally not offered by most mental health providers outside of the VA.

Unlike most health care organizations, the VA has made great efforts to increase availability of the treatments which research indicates are most likely to benefit veterans. More than 12,700 VA mental health providers have received extensive training and supervision in the most effective evidence-based psychotherapies (EBPs). This includes over 8,500 trained in Prolonged Exposure and/or Cognitive Processing Therapy for PTSD, and more than 2,200 VA providers trained in one of three EBPs for depression. Most non-VA clinicians have not been trained in - and cannot provide - evidence-based interventions that are recognized internationally as best practices. Tri-West and Optum offer overviews of EBPs, but even those courses are optional, not required.

New treatments often appear promising, but in order to ensure that the best available assistance is provided for veterans with PTSD and other problems, scientific rigor is necessary to demonstrate their efficacy and unique advantages that are distinct from, and additive to, established Evidence-Based Psychotherapy interventions. Anecdotes by veterans of benefits, or endorsements from practitioners, are insufficient grounds for supporting new approaches (and should, for example, have given pause to Commander John Scott Hannon Act's support for equine therapy, a treatment that may make some adults feel better in the short-term but which has no proven sustained mental health or suicide prevention efficacy). This means that rigorous evaluation standards should also be applied to pilot tests of newer treatments – particularly those that are proposed as alternatives, not supplements, to evidence-based treatments. Scientific rigor is necessary to demonstrate their efficacy and any unique advantages that are distinct from and/or additive to evidence-based psychotherapy interventions.

Whenever feasible, funded program interventions should be subjected to randomized controlled outcome studies. The demonstration of simple pre- and post-program changes in outcomes are inadequate for evaluation of programs, since changes might not be due to the interventions themselves (e.g., they may represent placebo effects or changes might be caused by the passage of time or changes in the larger non-treatment environment) and it will not be possible to

compare the magnitude of any changes observed with those seen in other interventions. In the absence of rigorous scientific studies of proposed new treatments, there is a significant risk of spreading ineffective treatments that have little impact, and running the risk of displacing other, more effective efforts to improve the wellbeing of veterans.

> The VA's Center for Compassionate Care Innovation does provide access to emerging treatments that haven't yet developed the needed evidence base to be included in Clinical Practice Guidelines. See more here[99] and here[100].

That said, the individual clinical needs and preferences of a veteran require an individualized treatment plan[101] developed in collaboration with a highly skilled clinician. This is a particularly important statement with regard to PTSD because the nature of psychological trauma and its effects, while universal in many aspects, are also highly individualized. Clinical practice guidelines are designed to assist clinicians and patients rather than constrain them in their choice of treatment approach. The care of these veterans cannot be rigidly dictated by even the most rigorous treatment guidelines nor can they be legislated by Congress. As stated at the outset of most treatment guidelines, the 2017 edition[102] of the VA/DoD Clinical Practice Guideline for the Management of PTSD and Acute Stress Reaction includes the following disclaimer: "This Clinical Practice Guideline is intended for use only as a tool to assist a clinician/healthcare professional and should not be used to replace clinical judgment." This accords with the principles of the Institute of Medicine's 2011 Consensus Report, "Clinical Practice Guidelines We Can Trust.[103]" Expert care requires extensive clinical experience informed by the best available research and defined within the context of a new and unique clinician/patient relationship. It is important to allow patients and their clinicians to collaborate in making responsible choices appropriate to individual treatment needs and preferences. Such a balanced approach is rarely found outside of VA care.

Formal research should be used to establish the efficacy of treatments before they are adopted widely. But evidence of a different kind is also critical to high-quality care for veterans. As treatment occurs, it is important that clinically relevant data be collected and reported so that there is means of determining whether treatments for these veterans are effective under real world conditions. The collection of outcomes data in routine care enables clinicians and clients to collaboratively review progress during treatment and informs decisions about modifying or changing treatment as it is occurring. Whether clinician and client decide to use an EBT or an alternative, they are in a better position to evaluate progress and results if they include ongoing assessment of outcomes that can be compared with results from research trials or other similar clinical programs. VA intends to make this process, known as Measurement-Based Care, the standard across its health care system[104]. Such outcomes information also enables program managers to monitor the effectiveness of their services and remain accountable to their clients. Measurement-based care has been shown to improve outcomes and lower the cost of care. It enables ongoing improvement of services and detection of ineffective treatment efforts while increasing public accountability of treatment for veterans.

In October 2020, The RAND Corporation and the George W. Bush Institute Veteran Wellness Alliance published high-quality PTSD and TBI care[105] standards that should guide non-VA clinicians. Their key findings and recommendations, which we endorse, include:

- Veteran-centered care requires cultural competence (and understanding of veteran experiences and identity), ongoing assessment of veterans' care experiences, shared decision making between the veteran and provider, and family/caregiver involvement in care.
- Outcome monitoring involves using validated instruments to regularly assess veterans' clinical outcomes and changes to functioning, well-being, relationships, and life satisfaction.
- Evidence-based care incorporates treatments and practices that are backed by the best available research.
- The definition of high-quality care for veterans with PTSD and TBI should continue to be defined through ongoing research and by monitoring developments in the evidence base.
- Data needed to implement the definition of high-quality care — including data to monitor quality and track veteran outcomes — should be easily available and feasible to collect.
- An implementation plan should be developed for how the veteran-serving community will use and measure the proposed standard of high-quality care for PTSD and TBI.

Each of the authors of this paper have decades of experience in researching and/ or delivering high quality healthcare services to veterans. We are deeply concerned about the ability of the VA and the private sector to deliver the best and most efficacious services possible. We also appreciate the time and energy legislators, legislative staff, veterans service organizations, as well as individual veterans, veterans' caregivers, and their families have devoted to crafting legislative and practice initiatives to assure that veterans receive optimal care. In perhaps some areas, producing a thousand points of light or letting a thousand flowers bloom may be the best approach. When it comes to producing the best outcomes in veterans' mental health and suicide prevention, only an integrated and coordinated approach will work to make sure that the best practices are designed, followed, implemented, evaluated, and then refined and improved. We offer this paper to encourage policy makers and veterans advocates to ground their work in the kind of approach that can best assure the health and well-being of those millions of men and women who have made so many sacrifices to serve us all.

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Harold Hildreth Award, 2013 Association of VA Psychologist Leaders' Antonette Zeiss Distinguished Career Award and 2016 AVAPL Patrick DeLeon Advocacy Award. In 2017, the AVAPL Russell B. Lemle Leadership Award was established in his honor for those who promote leadership development to improve mental health care for veterans. He has testified at the Commission on Care and Congressional Committees on Veterans Affairs hearings, and published numerous scientific articles on veterans' mental health and on the downstream devastation to veterans that will occur if VA healthcare is expanded rapidly into the community. Lemle received the 2020 Special Recognition Award for Veterans Health Care Advocacy from the Disabled American Veterans (DAV).

Harold Kudler, M.D. received his M.D. from Downstate Medical Center, trained in Psychiatry at Yale and is Associate Consulting Professor at Duke. From 2000 through 2005, he co-chaired VA's Special Committee on PTSD which reports to Congress. He served on the International Society for Traumatic Stress Studies Board of Directors, co-led development of joint VA/Department of Defense Guidelines for the Management of Posttraumatic Stress and advised Sesame Street's *Talk Listen Connect* series for military families. From 2006 to 2014, he co-led the North Carolina Governor's Focus on Returning Military Members and their Families and, in 2012, was appointed to the North Carolina Institute of Medicine. From 2004 to 2014, Dr. Kudler co-founded and served as Associate Director of the VA Mid-Atlantic Mental Illness Research, Education, and Clinical Center (MIRECC) on Deployment Mental Health. In July 2014, he joined VA Central Office in Washington DC as Chief Consultant for Mental Health Services. Beginning in May 2017, he served as Acting Assistant Deputy Under Secretary for Patient Care Services until his retirement from VA in June 2018. Dr. Kudler remains on the Duke faculty and plays an active leadership role in a number of professional organizations and as a without compensation employee in the VA Physician Ambassador Champion Program. He also provides consultation in clinical and administrative settings and is developing an integrated set of writing projects designed to advance the mental health and wellness of Service Members, Veterans, their families and communities.

Acronyms

AFSP: American Foundation for Suicide Prevention
Army STARRS: Army Study to Assess Risk and Resilience in Servicemembers
CCN: Community Care Network
CDP: Center for Deployment Psychology
CPT: Cognitive Processing Therapy
CSTS: The Center for the Study of Traumatic Stress
DoD: Department of Defense
FTE: Full Time Employees
LMS: Lethal means safety
LMSC: Lethal means safety counseling
MISSION Act: Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018
MST: Military Sexual Trauma
MST: Military Sexual Assault
NSSF: National Shooting Sports Foundation
PE: Prolonged Exposure treatment
PREVENTS: President's Roadmap to Empower Veterans and End a National Tragedy of Suicide
PTSD: Post Traumatic Stress Disorder
SPC: Suicide prevention coordinator
SPP: Suicide Prevention Program
TAP: Transition Assistance Program
TBI: Traumatic Brain Injury
USCCA: United States Concealed Carry Association
VA: Department of Veterans Affairs
VHA: Veterans Health Administration

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