

Critique of
S. 785
Commander John Scott Hannon
Veterans Mental Health Care Improvement Act of 2019

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by
Association of VA Psychologist Leaders

S. 785 ANS “Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019” has many laudatory ambitions. It aims to more fully understand risk factors related to suicide, improve the transition of servicemembers leaving the Armed Forces, establish new clinical practice guidelines for mental health conditions, improve the care for women veterans and much else.

Nonetheless, it has significant problems that warrant attention in order to accomplish its primary objective of enhancing the wellbeing and preventing suicides of our nations’ veterans. Below, we elaborate those problems and suggest potential modifications. Our comments are organized into four categories: (A) sections that are priorities for us; (B) sections we support but would like to see modified, (C) sections we would prefer were removed altogether; and (D) sections that are missing from the bill that we recommend adding.

A) Sections that are our top priorities

Our top priority is Sec. 201 which could deleteriously impact the delivery of VHA mental health care and suicide prevention.

Our other priorities are Sec. 501/204 (staffing) and Sec. 204 (community provider competence).

B) Sections we support but would like to see modified

Sec. 201. Grants for Providing Suicide Prevention Services

On the positive side, Sec. 201 attempts to proactively reach veterans who are at risk of suicide and provide them with emergency transportation, evaluation and hospitalization. It furnishes services to mitigate social determinants of suicide. It informs some veterans of their VHA eligibility. It recognizes access to firearms as a suicide risk factor (a rare but critical acknowledgement in suicide prevention legislation.)

However, Sec. 201 has many problems, most of which Chairman Takano identified last year when he critiqued the IMPROVE Act upon which this section is founded.

Problem:

It doesn’t address or monitor suicide per se, despite its asserted intention to prevent suicide.

Entities are not expected to track and report on suicide attempts of veterans who receive their services (as the VHA must do). All that an entity must measure are risk/protective factors for suicide and “mental resilience and mental outlook.” Entities will be selected for their description of how they will provide opportunities for “mental wellness and personal growth.” (Note that these terms omit “suicide” and are incredibly vague.) Care can be provided whether or not veterans endorse feeling suicidal on the baseline mental health assessment for risk.

There is one exception. Eighteen months after the grant commences and another 18 months later, the Department must report on suicide rates for eligible individuals seen by community partners. **But the VA won't be able to report those data if the entities are not required to track suicide attempts and deaths of the individuals to whom they provided services.**

Modifications:

- Grants should be used only for veterans who explicitly endorse feeling suicidal.
- One criterion for entity selection should be a prior record of tracking and evaluating suicide attempts of the population they have served.
- Entities should be required to report the numbers/rates of the veterans they serve under the grants for suicidal ideation, suicide attempts, safety plans and completed suicides. Completed suicides post-treatment must also be tracked and reported.
- A uniform tool for reporting of suicide attempts should be established. Otherwise, each entity will do it differently and there will be no useful way to interpret or compare entity performance.
- Entities should be expected to develop suicide prevention assessments and safety plans that meet the VHA's standards (e.g. counseling regarding access to lethal means, etc.).

Problem:

It would duplicate, and hence likely erode, VA's provision of non-emergency mental health care.

The bill allows the provision of non-VA clinical outpatient services beyond emergencies, including **individual therapy, group therapy, family counseling and substance use reduction programming. These duplicate non-emergency mental health services offered by VHA and the Veterans Community Care Program (VCCP).** Every dollar spent for a non-VA service that the VHA could provide can be presumed to eventually come out of the budget that operates VHA's facilities. That would erode VHA's provision of health care.

Further, VHA would accept financial responsibility for these non-VA mental health services for all veterans, not just enrolled veterans. Extended family members and housemates are also eligible for services. The greatly expanded population makes it even more important that there be tight control over what services are covered.

Since Congress is willing to loosen eligibility requirements for veterans and families seeking private care, it should make the identical eligibility changes for VHA. VHA should never maintain barriers for care at its own facilities that it removes in the private sector.

Modifications:

- Remove the terms “individual and group therapy,” “individual, group, or family counseling,” and “substance use reduction programming” from covered services.
- For locations where the capacity of VA/VCCP mental health services is identified as insufficient, provide funding to enhance VA/VCCP capacity.
- Make eligibility criterion for services in the private sector and the VHA identical.

Problem:

It incentivizes the provision of non-VA mental health services in the same locales as VHA facilities.

Sec. 201 targets provision of services in communities with high rates of veteran suicide, non-use of VHA, Veterans Crisis Line calls and minority/women veterans – i.e. the **same geographic locations as VA Medical Centers, VA Community Based Outpatient Clinics, Vet Centers and VCCP providers.** Funding nearby non-VA mental health facilities would supplant, not augment, VA.

Modification:

- Require that entities focus efforts in locations beyond the geographic reach of existing VA facilities where care and services are scarce.

Problem:

It undermines the intent of the MISSION Act to create one overarching, coordinated program.

VA already has a network of community providers that allows them to treat veterans under the MISSION Act, and that should remain the preferable route to care. This bill establishes a third lane of providing clinical care to at-risk veterans outside of VA and VCCP.

Modification:

- Non-VA mental health care providers/entities should be expected to join VCCP.

Problem:

It fails to set any standards for the clinical competency of providers who treat veterans in the community.

There is no minimum level of competence set for community providers who treat veterans. As with Sec. 404 below, we recommend that the qualifications and competence standards of providers in the community match those within the VHA.

Modifications:

- Require that entities’ clinical providers have suicide prevention training, as occurs with VHA providers.
- Require that clinical providers standards include graduate degree qualifications, competence and bi-annual clinical reviews equivalent to those used in the VHA.

- Authorize an evaluation of compliance of all these criteria, well beyond just that of military cultural competence.

Problem:

It falls short of outreach efforts to inform veterans about VHA care.

Veterans who do not seek VA mental health care were studied extensively in 2018 in the National Academies of Sciences, Engineering and Medicine *Evaluation of the Dept of Veterans Affairs Mental Health Services*. It found that the four top reasons that veterans with a mental health need do not seek VA care include that they (a) lack knowledge of how to apply for VA benefits (42% of survey respondents), (b) lack certainty whether they are eligible for or entitled to mental health care (40%), (c) lack awareness that the VA offers mental health care (33%), or (d) did not feel they deserved to receive mental health benefits (30%).

Sec. 201 sets nominal benchmarks for outreach that enhances VHA utilization by eligible veterans. The only veterans who are informed of their eligibility and nearest VHA facility are those who receive assistance under this section. (On the positive side, entities must report the number of eligible individuals that they newly enrolled in the VHA).

Modification:

- Facilitate greater utilization of VHA by broadly expanding outreach efforts that inform all veterans about the availability and expertise of VHA mental health services.

Problem:

It fails to identify the VA Office of Mental Health and Suicide Prevention as the administrator of the grants.

Sec. 201 is silent whether OMHSP's Suicide Prevention Program would have the authority for oversight and accountability of suicide prevention grants. That leaves open the possibility that another VA office or task force might be given the responsibility for grant administration, which could misalign with OMHSP's initiatives.

Modification:

- Explicitly name OMHSP's Suicide Prevention Program to oversee grant application review and administration of suicide prevention grants.

Sec. 501. Staffing Improvement Plan for VA Mental Health Providers

Sec. 204. Review of Staffing Levels for Mental Health Professionals

We are in basic accord with these sections. However, two changes would strengthen them.

Modifications:

- Facilities that meet the currently recommended staffing ratio of 7.72 mental health staff per 1000 patients have been shown to have better access and quality. Increases in mental

- health staffing are also associated with lower veteran suicide rates. OMHSP should be required every three years to re-evaluate the staffing ratio that would allow for the access and continuity of care for veterans, which would then be mandated at every VHA facility.
- Psychologists are repeatedly identified by OIG in the top five VHA occupations with staffing shortages. They should be included in Title 38 hiring authority, as was incorporated in the original version of this bill. The benefits for doing so are stronger now than ever. For example, last week psychologists would have received double the COVID crisis retention bonus if they were Title 38.

Sec. 404 Primary Care - Mental Health Integration

Problem:

MISSION Act failures are not adequately addressed.

This section provides an opportunity to assess the abject failure to implement MISSION Act Sec. 133, which mandated high competency standards for providers assessing and delivering mental health care to veterans in the VCCP. The MISSION Act also instructed the VHA to evaluate providers' ongoing effectiveness.

That hasn't happened. VCCP providers are not required to meet the standard of credentials, training, and service delivery that the VHA requires of its own mental health clinicians. There is no tracking what care is being delivered by a provider and no reporting of his/her patients' improvement.

If the data aren't collected, VCCP third party administrators cannot attest to the performance of its providers. Nor will veterans have relevant information to make healthcare decisions about the quality of treatment provided in the community, which was a main objective of the MISSION Act.

We endorse requiring community providers to have military cultural competency. But taking a brief on-line cultural competency course is no demonstration of or substitute for an ability to treat veterans' mental health conditions. Such a training is likely to have little to no impact on clinical outcomes. Sec. 404 of S.785 assesses providers' military cultural training, but not their mental health care proficiency.

Modifications:

- Require that standards for VCCP providers graduate degree qualifications and competence be equivalent to those used in the VA.
- Require that VCCP mental health providers have suicide prevention training, as occurs with VHA providers.
- Evaluate compliance with all these criteria, beyond just military cultural competence.
- Require that providers not be added to the VCCP network until they have demonstrated credentials, training and competence that is equivalent to VHA's own high standards.
- Require VCCP third party administrators to adhere to these requirements to retain their contract.
- Evaluate the effectiveness of community providers via measurement-based outcome instruments.

- List scores on VA/Community care comparison websites according to conditions (e.g., PTSD) so that veterans can readily search according to their disorder.

Sec. 204. Review of Deaths by Suicide of Veterans

Sec. 102. Review of Deaths by Suicide of Recently Separated Veterans

Problem:

Far more needs to be known about the risk factors and health insurance availability for veterans who do not use the VHA who die by suicide.

Two thirds of veterans who die by suicide do not use the VHA. We know very little about them. The only way that future prevention effects will be effective is if suicide deaths of non-VHA-using veterans are studied.

Sec. 204 empowers the National Academies to conduct a review of deaths by suicide of covered veterans during the prior five years. It allows collaboration with medical examiners' offices or local jurisdictions to determine veteran mortality and cause of death. Thus, the structure will be in place to inquire with medical examiners about every veteran's death by suicide. That could be the starting point to contact family members and perform a Behavioral Health Autopsy for veterans not using VHA who die by suicide.

Relatedly, Sec. 102 authorizes a review of the records of each former member of the Armed Forces who died by suicide within one year of discharge. It ascertains what risk factors were present. But it fails to inquire what non-VA health insurance services were available to veterans and whether they were utilized. That information is critical for designing future community interventions of non-VHA using veterans.

Modification:

- To refine interventions for at-risk veterans who don't use the VHA, provide federal funding for Behavioral Health Autopsies of all non-VHA using veteran suicides. That should include data on veteran's enrollment priority group, other health insurance, utilization of non-VA mental health services and method of storing the means used in their suicide.

Sec. 701. Expanded Telehealth Capabilities from the VA

Problem:

Funds could be diverted for non-VHA care.

This section aims to increase the number of non-VA locations that VHA telehealth care is available. But it appears to have unintended loopholes. Funds can be used to improve existing infrastructure to provide telehealth to any veteran by any provider. There is no stipulation as to whether telehealth providers need to be VHA, nor whether veterans need to be enrolled in VHA. Furthermore, given the rapid VA advances consequent to COVID-19, funds for hubs might be

better spent for patient in-home technology, where most telehealth (especially telemental health) is shifting.

Modifications:

- Indicate that except for rare exceptions, funds are to be used only for telehealth with enrolled veterans receiving services from VA (and associated VCCP providers).
- Train employees at the settings in how to manage a veteran who has an emergency during a telehealth session.

Sec. 202. Study of Complementary and Integrative Health (CIH) Services

Sec. 203. Pilot Program to Provide CIH Services through Animal Therapy, Agri-Therapy, Post-Traumatic Growth Therapy and Outdoor Sports and Recreation Therapy

Sec. 702. Provision and Study of the Effectiveness to Hyperbaric Oxygen Therapy

Problem:

Given the lack of scientific rigor associated with these proposals, it's unclear what information would be learned from these studies/partnerships that would be clinically valid or valuable.

We support treatment interventions that aim to produce positive life changes beyond just the reduction of symptoms. We also support continual development of novel, effective interventions for veterans who have endured trauma, as long as they are rigorously studied.

The VHA has a large randomized control study of service dogs for PTSD in progress. VHA already offers yoga, meditation, acupuncture, chiropractic care, agri-therapy, recreation therapy and outdoor sports (as the COVER Commission affirmed). Hence, it is not apparent what the bill would provide that supplements rather than duplicates VHA activities that are currently available.

It is striking that although falling under the Title II Section 200's named "Suicide Prevention," there is no requirement that CIH services be selected because they have previously been shown to impact suicide, or that these pilot programs include measures to evaluate their success in reducing suicide among veterans.

The scientific rigor necessary to demonstrate CIH's effectiveness and unique advantages over Evidence Based Psychotherapy interventions is mostly absent in these sections. Although Sec. 203 does include collaborating with academic researchers and using clinically relevant endpoints in determining the empirical effectiveness, no control groups are called for.

Funding pilot external Post-Traumatic Growth (PTG) services is premature. PTG services may have persuasive face value, but there is a lack of research that supports the benefits of PTG services that are distinct from and complementarily additive to psychotherapy. The VHA already provides robust clinical services that produce positive life changes for veterans who have experienced trauma.

There have been four randomized placebo-controlled trials of Hyperbaric Oxygen Therapy (HBOT) for TBI/PTSD. Three of the four studies showed no benefit of HBOT, and one showed some weak benefit that did not persist. One study found that both placebo HBOT and HBOT had

comparable benefits relative to usual care, which strongly suggests that its active component may be a placebo – and an expensive one. Given that private entities stand to gain significant profits, HBOT’s adoption should also be predicated on a cost/benefit analysis.

VHA’s standards for clinical programs and community public health interventions, even for pilots, must be solidly evidence-based. In the absence of rigorous scientific studies of proposed new treatments, there is a significant risk of spreading ineffective treatments that could harm, rather than improve, the well-being of veterans.

Modifications:

- Continue VHA’s existing research of these activities. If results are found to be superior to other treatments, expand implementation at that point.
- Cost/benefit analyses should be conducted and equivalent results at far higher costs should be factored. This is especially important for CIH interventions that are expensive.
- The demonstrated success in reducing suicide should be an explicit criterion for program selection, as well as a measure of pilot CIH’s success.

Sec. 401. Study on Effectiveness of VA Suicide Prevention and Mental Health Outreach Programs

Problem:

Scientific rigor is missing from the study.

Sec. 401 empanels focus groups to evaluate the effectiveness of VA’s suicide prevention and mental health media outreach. The focus groups’ findings will form recommendations for a new plan for suicide prevention and mental health outreach efforts by the VA, which is expected to be followed.

We support asking veterans about their perceptions of suicide prevention and mental health outreach. However, it is problematic to rely on focus groups to establish the effectiveness of these programs because they weight opinions more than evidence in determining what policies should be enacted. Previous studies have sometimes found programs that are popular may nonetheless be completely ineffective. Unless empaneled using randomly selected and assigned samples, focus groups do not constitute a valid approach of evaluating program effectiveness.

Modifications:

- Require that the selection and assignment of participants for focus groups use a scientifically rigorous method.
- Require that proposals that emanate from focus groups be consistent with empirical evidence of suicide prevention and mental health outreach.

Sec. 303. Update of clinical practice guidelines for assessment and management of patients at risk for suicide

Sec. 304. Establishment of VA/DoD clinical practice guidelines for the treatment of serious mental illness

Problem:

Clinical Practice Guidelines (CPGs) will lack impact unless they have accompanying dissemination guidelines and means of assisting VHA and VCCP clinicians to upgrade their behavior.

Regrettably, VA/DoD CPGs have limited impact on clinician behavior. Most clinicians don't read these guidelines and knowing what is recommended does not necessarily translate to mastering new skills.

Modifications:

- Instruct CPG Task Forces to develop effective means of disseminating guidelines and assisting clinicians in changing their behavior.
- Fund research to evaluate alternative ways of implementing the guidelines.

Sec. 602. and Sec. 604. Improvement of Care and Services for Women Veterans

These sections remedy existing deficiencies regarding homeless and other women veterans. We mention them here to emphasize AVAPL's strong support. Both sections should be preserved if there are any future changes to the bill.

C) Section we recommend removing

Sec. 705 Creation of Office of Research Reviews within the VA's Office of Information and Technology

Sec. 705 establishes an Office of Research Reviews within VACO's Office of Information and Technology. The goal of increasing data privacy and security is laudable. However, a robust network of local ethics, privacy and security officers already exists. Every research initiative launched in VA is also subject to formal reviews of university-affiliated Institutional Review Boards. Adding another layer of national review is redundant and likely to be an unnecessary impediment to research.

D) Sections missing from the bill that we recommend adding

Expand lethal means safety education and care

Any comprehensive veterans suicide prevention bill that doesn't address access to and safe storage of firearms for at risk-veterans is missing the core factor. Among possible legislative initiatives:

- Require all VCCP and VA mental healthcare providers to undertake training in lethal means safety counseling in order to have the privilege of treating veterans. Expand the training to medical providers, given that the majority of older adults who die by firearm

suicide have physical health problems but no known mental illness. Expand the training to all peer counselors, given that veterans are even more receptive to fellow veterans than clinicians raising the topic of safe storage.

- Conduct semi-yearly clinical pertinence reviews of each VA and VCCP mental health provider that ascertains whether a suicide assessment is recorded in the health record, and when there is elevated risk, the Safety Plan documents a lethal means safety assessment and plan. Evaluate frequency of changes in veterans' storage habits.
- Adopt the recent COVER Commission Final Report recommendation that "a community grant program be established to further support the development of voluntary firearm safe storage options across the country." This might include federal and state grants to gun shops and ranges to offer free lockers for voluntary, temporary safe harbor.

Improve VHA's ability to implement internet and mobile mental health interventions

The U.K. National Health Service widely uses evidence-based internet interventions for depression. VHA should invest in a review of that work and seek to enable implementation of technology-based interventions and increase research funding in the area.

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