November 12, 2014

Secretary Robert A. McDonald
Veterans Administration
810 Vermont Ave. NW
Washington, DC 20420

Re: Healthcare deficiencies for returning Veterans with PTSD and other mental disorders with five recommendations for cost-effective resolutions.

Honorable Secretary McDonald,

The exposure of the deficiencies in access to healthcare of Veterans by whistleblowers from the Phoenix VA has shocked the nation. Subsequent follow-up investigations have shown system wide problems related to access, veracity of reporting, and policies that keep the system from modernizing and adapting. Their charges that the VA provides second class care to Veterans who performed first class military duties for our nation are Especially troubling. The VHA has not been able to provide access to needed healthcare for qualified Veterans due to the increased demands for authorized treatments for 200,000 returning Veterans from Iraq and Afghanistan. For several years, the VFW (Veterans of Foreign Wars) has testified before Congress that the VA's patient-load is 20% above its maximum allowed capacity! Yet, the VA continued its archaic administrative policies that concealed deficiencies its healthcare networks and falsified records regarding its delays in both mental and physical treatments. This deceit led to untimely deaths of Veterans needing prompt physical care**. Delays in the diagnosis and treatment of mental conditions have resulted in significant increases in suicide rates among Veterans suffering from PTSD and Depression.**

Delays in treatment were not caused solely by a lack of Congressional funding. Rather, VA mismanagement of conflicts of interests in the missions of the VHA and VBA resulted in shortages of trained healthcare personnel and failures to provide the necessary treatments for rehabilitating and restoring the health of Veterans. These shortages in trained health professionals have been well-known within the VA bureaucracy for a decade for some professions and up to a half-century for others. Surgeon General David Satcher delivered his epic report, *Mental Health: A Report of the Surgeon General* on June 8, 2000. In its Preface he states, "Even more than other areas of health and medicine, the mental health field is plagued by disparities in the availability access to its services."

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It is urgent that the shameful shortage qualified healthcare personnel be addressed by the VA. Any reformed VA administration will be required to hire and manage a sufficient number of physicians, psychologists, nurses, dentists and social workers to improve access to care for Veterans.

The Academy of Medical Psychology urges prompt steps be taken to meet the existing needs of returning Veterans with PTSD and mental conditions that contribute to patient overload in the VA.

The following steps to improving care for Veterans include:

1. Modifications of VA treatment protocols to accelerate access to mental care.
2. Modification of hiring practices to promptly expand qualified mental health specialists.
3. Establish specialty treatment programs for mental conditions seen in VA facilities.
4. Secure enabling legislation to expedite care by removing hidden barriers to care.
5. Public relations to distinguish VHA health care services from the VBA legal services for compensation claims.

Suggested Cost-effective Modifications in VHA Policies

1. Administrative Acceleration of Access to Mental Health Care

The VA already has the legislative authority to implement the intent of The Mental Health Parity and Addiction Equity Act (2008) and amended into the Patient Protection and Affordable Care Act (ACA) in 2010. However, the value these and other healthcare initiatives has not been reflected in improvements in VA policies for treatment of returning Veterans over the past six years. Nearly 60% of the patients seen in primary care practice settings have co-occurring mental symptoms. **The VHA uses psychotropic drugs as its first-line treatment for behavioral healthcare that are only 35% effective for these conditions.** The Institute of Medicine states that psychological treatments are equally effective as first-line treatment for mental conditions. **When psychotherapy is used concurrently with psychotropic medications the percentage of positive mental treatment outcomes increase up to as much as 70%!**

The VA hospital-based network protocols for treatment of PTSD and mental disorders is a prime example of this less effective "medication first" approach to care. Each VA hospital-based network is affiliated with a medical school which creates a system of 140 silos of health care. However, the VA silo system of health care is more aligned with the medical schools' training procedures than with treatment responsibilities of the VA central office. In essence this makes the VA more of a handmaiden to medicine rather than the Manager of Healthcare for Veterans.

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The affiliation of VA hospitals with medical school curricula requirements provides many benefits for training medical students in hospitals. However the behavioral aspects of healthcare in medical schools are minimal. Typically, medical students only have a six week clinical rotation on a psychiatric ward exposes them to a "medication only" method of mental health treatments. **The VA hospital affiliation with medical schools neglects out of hospital needs of Veterans and "medicalizes" both normal human functioning and psychological dysfunctions.** The unintended but disastrous consequence of the VA's medication first approach for behavioral problems results in lengthy delays. Clinical laboratory findings that are used to diagnosis physical conditions are not useful in diagnosing behavioral disorders.
Using "defensive medicine" to establish Veterans symptoms are not due to a biological condition before receiving appropriate behavioral care is a wasteful practice. This "diagnosis by exclusion" approach creates unnecessary delays in mental treatments by requiring additional appointments, longer wait times and increased numbers of missed appointments.

Studies of effectiveness of primary care physicians treating mental conditions reveal as much as a 50% failure to diagnose mental conditions accurately. To remedy failures to diagnose PTSD and other mental conditions, the Department of Defense (DoD) has embedded psychologists in combat and primary care panels of military hospitals as well. The DoD Behavioral Health Optimization Program (BHOP) authorizes psychologists to provide behavioral care evaluations in the initial diagnostic medical evaluation in military hospitals. This has been highly successful in treating military personnel with accurate mental diagnoses, reducing unnecessary delays in treatment and maintaining active duty status. The prompt access to care of the BHOP results in a substantial cost reductions in treating mental conditions.

The VA claims to have attempted early access to behavioral care in some VHA hospital facilities but has not made it a system-wide protocol due to the silo- effect of medical school domination of VA hospital practice. It is the VHA's responsibility to control clinical practices in local VA facilities in order to advance behavioral healthcare access for Veterans. For example, the States of New Mexico and Louisiana laws authorize licensed psychologists trained in prescribing psychotropic medications for mental disorders. Yet, psychologists with this training are not allowed to prescribe in VA facilities in those States because the unwillingness of VHA Central Office to utilize their expertise!

2. Modification of VHA Hiring Policy of Clinical Psychologists

VHA hiring practices exclude 10,000+ licensed psychologists trained to provide first-line treatments for PTSD and other mental conditions. The VHA requirements for hiring clinical psychologists a doctoral degree from a program approved by the American Psychological Association (APA) and an internship also approved by the APA. Graduate training programs in clinical and counseling psychology produce nearly 4,000 students with doctorates per year that are eligible for state licensure as psychologists. About 1,000 of these newly licensed psychologists lack a credential of training from an APA approved doctoral or internship. Yet, these newly licensed clinical psychologists practice as safely and effectively as those with an APA credential and accept each other as collegial peers.

The VHA current hiring protocol judge's competency of clinical psychologists by the rating initial training programs and internships they completed. **It our view that the qualifications for hiring of licensed psychologists must be determined by their current skills and treatment practices rather where they received their initial training.** The APA has not produced studies to attest its training accreditations result in greater competency among licensed psychologists. Yet, there is no cure for lacking an APA credential when being considered for employment to practice in a VHA facility which leaves an unfilled shortage of behavior healthcare within the VA. The VHA hiring protocol does not exclude hiring psychiatrists if they were not trained in a United States medical school. The VHA hiring requirements for licensed clinical psychologists must be modified to meet existing Veterans' needs.

We welcome the new Veterans Access to Care through Choice, Accountability and Transparency Act of 2014 and await for its immediate implementation. This law has not, as yet, resolved some of the dilemmas Veterans face when they attempt to seek care outside to the VA. However, this treatment option for Veterans outside of VA facilities does not resolve the shortage of mental health specialists within the VHA. Psychiatric Services reports recent telephone appointment survey of 360 psychiatrists' offices in 3 metropolitan areas were only able to secure appointment in 93 offices (26%), with 23% of these offices not returning calls and 16% listing wrong numbers. If a Veteran seeks behavioral care services from their family doctor using private insurance, Health Affairs reports that only 42% of the accountable health organizations include behavioral care. This survey also reported the integration of behavioral health and primary care was low and fragmented and lacking in innovation. Thus, returning Veterans are, in effect limited to VA facilities for behavioral healthcare and are dependent upon the VA to revise its policies in order to provide this needed behavioral care.

The VA could contract with over 10,000+ licensed clinical psychologists could provide immediate relief to the problem of access to behavioral care in rural and

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underserved areas. This could become the model to resolve VHA long term shortages of behavioral health care Most of these licensed psychologists are already trained and experienced in treating patients with PTSD since 25% of the patients with chronic illness and surgical procedures report such symptoms. Psychologists in private practice also have relationships with physicians in their area with whom they collaborate for patients requiring psychotropic medications.

The VHA is still advertising worldwide for more than 500 psychiatric positions which remain unfilled despite using J-1 Waivers of the Health Resources and Services Administration (HRSA). These J-1Waivers are used to recruit foreign medical graduates, including some without MD degrees. Foreign medical trainees comprise 40% of psychiatric residents whose training is paid for by US taxpayers. Lack of fluency with the English language has made it impractical to train psychiatric residents in psychotherapy and other behavior health techniques. Thus, hiring psychiatrists does not guarantee patients will have access to behavioral care. Psychiatry has not been able to fill its quota of psychiatric training slots authorized by HRSA for the last decade. **Allocated funds for psychiatric training should be re-allocated for training psychological practitioners in the VA where there is an existing critical shortage of behavioral health services for returning Veterans with mental conditions.**

3. Facilitating Cost-Effective Mental Health Services in the VHA

Establishing positions for VA psychologists experienced in psychopharmacology as mental health consultants in primary care panels and specialty clinics could promptly remedy this shortage. The VHA employs about 4,000 clinical psychologists. Many of these psychologists are already trained in psychopharmacology and can provide consultation to primary care practitioners in the VA. The immediate needs of Veterans and the VA are for early intervention to prevent long term mental disabilities. However, psychologists often assigned to long term psychiatric maintenance care units, while needed do not have an assigned preventive mission. The DoD early intervention model of embedding clinical psychologists into primary care panels mentioned previously could easily be adopted by the VA.

Establishing specialty treatment programs for mental conditions seen in VA facilities is a feasible approach to reduce the shortage of access to behavioral care for Veterans. The VHA employs about 4,000 clinical psychologists. Many of these psychologists are already trained in psychopharmacology and can provide consultation to primary care practitioners in the VA. However, psychologists often assigned to tertiary maintenance care units when the immediate needs of the VA are for early intervention to prevent long

term mental disabilities. DoD model of embedding clinical psychologists in primary care panels mentioned earlier could easily be adopted by the VA. **Establishing positions for VA psychologists experienced in psychopharmacology as mental health consultants in primary care panels and specialty clinics could promptly remedy this shortage**. Primary care doctors could prescribe necessary psychotropic medications along with any other necessary medication in the initial consultation.

A course in consultation in psychopharmacology used by the DOD could be used to introduce this program to primary care physicians to ensure VA standards of care are being followed. The VHA could assess the economic and humane value of this protocol for Veterans with PTSD and other mental conditions in their initial diagnostic evaluation. This would accelerate mental healthcare, reduce delays in treatment and improve treatment outcomes that reduce costs.

Making mental assessment is part of the routine procedure in VHA care it would reduce the stigma of psychiatric specialty care label being placed on Veterans. Making behavioral health assessment a VHA routine procedure would also reduce pervading biases in the VA against professionals with doctoral degrees other than MD or DO. This embedding of clinical or medical psychologists could be the basis of expanded treatment skills which would reduce both existing shortages of behavioral care. This would be consistent with the National Defense Authorization Act of Fiscal 2012 Title VII Sec. 703 expanded Mental Health Assessment 3(i) "medical, dental and behavioral health readiness" that includes the term "behavioral health" for the first time.

A significant number of Veterans troubled by PTSD and depression avoid VA services due their fear of being labeled a "wacko." They become self-medicating with alcohol and drugs and tend to avoid social contact by isolating themselves into rural areas. These Veterans require a strong outreach program for their care. Tele health provisions authorize both psychiatrists and clinical psychologists with hospital privileges to diagnose and treat through tele health.

4. De-stigmatizing Mental Health Services in the VHA

Modifications to VA administrative regulations modifications recognizing clinical and medical psychologists as doctors in Title 38 would be a major step in reducing the stigma of psychiatric or mental health care. Currently, Doctoral degrees of psychologists are not recognized under Title 38 of VHA regulations that lists 12 diagnosing and treating professions, such as MD or DO and some nurses, Instead mental health specialty services of clinical psychologists and clinical social workers are listed under a lesser classification of Hybrid Title 38 revealing the VHA bias against profession with "non-medical" doctoral degrees. The Hybrid Title 38 classification Clinical

Psychologists and Clinical Social Workers among a host of medical technicians. Yet, the VHA lists four mental health professions, Psychiatry, Clinical Psychology, Clinical Social Workers and Psychiatric Nurse practitioners. Psychologists with clinical and medical psychology training with "doctor degrees" can and do perform diagnostic and treatments of mental conditions as other doctors do in Title 38. Clinical and medical psychologists should be classified under Title 38 since they have fulfilled the by the same degree requirements of other healthcare professions listed in Title 38. This would expand the scope of services to Veterans and reduce the costs of mental treatments. This could also facilitate Veterans obtaining concurrent diagnosis and treatment of mental conditions in primary care panels in their initial contact with VHA services.

5. Public Relations Clarification of the Limits of the Role of the VHA for Veterans

It is public responsibility of the Veterans Administration to clearly differentiate the limits of health care functions of the VHA from the compensation awards granted through the VBA legal system. Veterans come to VHA for health care treatments as they did in seeking medical assistance when in military service. However, when Veterans seek healthcare services from the VA they also expect not only recovery of their health but also "fair and just" compensation for the injuries they received. Veterans tend to confuse the treatment role of VHA healthcare interventions with the adjudication functions of VBA legal system. This confusion in VA oversight places Veterans in a conflict of interest dilemma. If the Veteran's symptoms requiring healthcare are reduced by VHA care and the Veteran demonstrates improved functionality, this reduces the justification for compensation for disabilities. Increases in healthcare functioning may result in the Veteran losing some VA financial benefits for disablement. Thus, the Veteran has conscious or un-recognized choices of trying to return to a normal civilian life with minimized disablements or to accept a wounded Veteran status unable return to normal civilian life and embittered with the amount of benefits received from the VA. Failure of Veterans to differentiate between health care services from the VA legal system for adjudicating compensation for residual health impairments from military service has resulted in many embittered wounded Veterans. This is a major public relations problem to be addressed the VA. The VBA has a 600,000 case backlog the VBA claims. In 2012 disability claims for PTSD amounted to $13.5 Billion, or 1/3 of the total cost $41 Billion for disability claims paid.

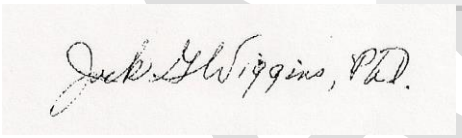
Clear distinction between VA healthcare services the VHA from the legal services of the VBA is a continuing issue for Veterans, the VA staff and the public. Simplifying the role of the VHA to focusing on health treatment has the potential to accelerate treatment times and reduce treatment costs. Questions of "fair and just" compensation may still remain an issue there in the minds of some Veterans. However, Veterans seeking "just" compensation by the frequent use of health care could be greatly reduced. Until the legal

ruling on compensation of the VBA is made clear to Veterans and accepted by Veterans, the VHA will be held responsible for their suffering in the minds of Veterans.

The foregoing five unsolicited recommendations present our concerns for the welfare of Veterans and the nation for whom they valiantly served. The present VA structure was built hodge-podge over time. The present VA system does not meet the needs of Veterans or our nation and must be thoroughly revamped. These five recommendations for improving behavioral health of Veterans with efficient cost-effective psychological treatments that can be implemented promptly and provide a path for the future of the VA. We stand ready to assist your success in their implementation and await your reply to these recommendations

In closing, we wish thank you as a citizen for your courage in accepting the challenges of the position of Secretary of Veterans Affairs to find cures for the widespread and long term deficiencies existing in the VA that have been identified in the media and in this missive. The Academy of Medical Psychology and American Board of Medical Psychology stands ready to assist you and the VA with implementation of corrective measures that will enhance the VA's ability to recruit, retain, and improve access to doctors of psychology and to identify board certified Medical Psychologists for VA psychology department and systems leadership roles.

With appreciation and best wishes on behalf of the Academy of Medical Psychology and the American Board of Medical Psychology that has approved, prepared, and submitted this communication. (www.amphome.org).



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