

Meeting the Mental Health Needs of Returning Veterans

Frequently Asked Questions on S. 38 The Veteran's Mental Health Outreach and Access Act

Question: In calling for VA to contract for mental health services to meet the needs of veterans of service in Iraq and Afghanistan doesn't S. 38 set a dangerous precedent?

Response: No. S. 38 actually sets sharp limits on both **where** and **how** VA can contract for mental health services. If anything, it sets stronger safeguards against inappropriate contracting-out than exist in current law.

Question: WHERE would VA contract for mental health services under S. 38?

Response: The bill calls for VA to contract for mental health and readjustment counseling services only in areas where VA itself determines that its own facilities simply cannot provide the needed services.

Question: Doesn't this bill really create confusion as to whether VA is really responsible for the mental health care of veterans?

Response: To the contrary, this bill makes it much clearer that VA IS RESPONSIBLE for veterans' mental health care, whether or not the veteran lives close to VA facilities. Under current practice, the extent of VA's responsibility is much less clear, and much more closely linked to where VA facilities are located.

Question: What would prevent VA officials under this legislation from just walking away from their responsibilities to veterans and relying exclusively on the private sector for mental health care?

Response: The likelihood of VA officials ceasing to provide mental health care directly seems very unlikely, but the bill does safeguard against that kind of risk by requiring VA to submit an implementation plan to Congress within 45 days of the bill's enactment, and another report within a year of enactment. These requirements ensure close congressional scrutiny and an opportunity to require VA to "reverse course" if needed.

Question: Why is contracting needed at all? Why not have VA hire more clinicians?

Response: Large numbers of returning veterans live in areas remote from VA facilities. Many have PTSD or readjustment problems; tragically, some veterans have even taken their lives. All the experts say that it's important to intervene early and provide needed treatment to avoid having these problems become chronic. This bill does not bar VA from providing services directly where it can, or from hiring more staff IF it can. But it ALSO makes sense to partner with qualified community providers in areas where VA cannot provide that service. It isn't fair or economical to make veterans travel for hours and hours to get treatment at an already overcrowded VA facility when there are good alternatives. It also must be recognized that many veterans are reluctant to get mental health services because of perceived stigma; requiring an individual to travel a great distance to get services he or she is already hesitant to pursue is a formula for NOT providing that needed care.

Question: VA officials stated recently that they would be adding mental health staff to more primary care clinics to meet these needs; isn't that the best answer?

Response: Where VA can successfully bring mental health capacity into primary care settings that would be welcome, but the reality is that there are national shortages of mental health specialists, real difficulty in recruiting clinicians to work in rural areas, and a need to provide services to veterans NOW. So it is just not realistic to think that expanding community based clinics' capacity will solve the problem.

Question: But doesn't contracting move VA a step closer to privatization, and to taking resources away from VA facilities?

Response: Not at all. S. 38 simply provides VA a needed tool to address an immediate problem efficiently and effectively. Through the appropriations process, Congress has already laid a foundation for substantially increasing VA mental health funding for the coming fiscal year. Any funds for contracting under S. 38 would be new funds and would NOT in any way diminish funding for VA healthcare facilities.

Question: How is contracting under this approach different than giving veterans a voucher and letting them get care anyplace, because THAT approach would change VA from a provider to just a payer?

Response: S. 38 is totally different from a voucher plan, because it specifies HOW VA must contract. Instead of having VA simply to pay for services, the bill imposes major responsibilities on VA and sets important safeguards:

- VA must determine WHEN and WHERE contracting is appropriate
- VA must determine which providers with whom to contract;
- VA must be the "gatekeeper", the entity that determines that a veteran actually needs care;
- VA must get clinical summary information and demographic data from contractors so that care can be coordinated; and
- VA must provide clinical training on PTSD treatment and best practices for contractors' professional staffs;
- VA is to require contractors to employ veterans of Iraq and Afghanistan service who (under other provisions of the bill) have been trained to do peer-outreach and provide peer-support services.

Question: How will this contracting work?

Response: The legislation sets out broad safeguards but does not try to spell out operational details, which may need to vary somewhat from place to place. It is most appropriate that VA implement the bill in a way that gets people into treatment quickly and efficiently, ensures that the care they get is of high quality, and that there is appropriate coordination with VA regarding that care. It is certainly the sponsor's intention that VA consult with veterans and military service organizations on how contracting will work before it implements the legislation.

Question: But how can we be sure that clinicians working in these centers have the experience to treat PTSD or understand and can communicate effectively with veterans who have experienced combat and war trauma?

Response: First, the bill calls for community mental health centers that win a VA contract to hire a trained peer counselor, so that veterans ARE dealing with peers with whom they can relate. But the bill also puts the burden on VA to provide special training to clinicians in those clinics. This certainly is an improvement over the way VA has done business in the past, which is to authorize so-called fee-basis care for a veteran with NO oversight as to who is ultimately providing the services and whether that clinician has appropriate specialized training.

Question: How comfortable will veterans be in a community clinic that is not dedicated solely to veterans' care?

Response: S. 38 calls for participating mental health organizations to hire peer specialists to serve as a bridge to veterans entering care, so in some respects these centers may seem to veterans MORE welcoming than some VA facilities. Also, we know from extensive experience in Montana, South Dakota and Washington state where community mental health organizations have been providing mental health services to veterans for several years now that veterans have indicated high rates of satisfaction with the services provided. Like many other healthcare providers, community mental health organizations provide services in modern facilities.

Question: What kind of quality care do these community mental health organizations provide and to whom are they accountable?

Response: Like other healthcare organizations, community mental health organizations must meet state licensing and accreditation standards that address quality of care. Many community mental health organizations are private, not for profit organizations that are accountable to local boards of directors and have strong ties to their communities serving a broad range of populations. VA, of course, would be required under S. 38 to establish additional requirements for participating community mental health organizations to ensure that care is of the highest quality.