

PUBLIC WITNESS TESTIMONY FOR THE RECORD

**MAKING DEPARTMENT VETERANS AFFAIRS HEALTH FACILITIES THE WORKPLACE OF
CHOICE FOR HEALTH PROVIDERS**

SENATE VETERANS' AFFAIRS COMMITTEE

**SUBMITTED BY CHARLES INGOGLIA, VICE PRESIDENT OF PUBLIC POLICY
ON BEHALF OF THE NATIONAL COUNCIL FOR COMMUNITY BEHAVIORAL HEALTHCARE**

The National Council for Community Behavioral Healthcare appreciates the opportunity to submit testimony on behalf of its 1,400 member agencies who provide medical and rehabilitative treatment and support services to nearly six million adults, children, and families with mental and addiction disorders in every community across America.

We appreciate the Committee's interest in meeting the physical and behavioral health needs of our nation's veterans. Since the initiation of OEF and OIF, nearly 800,000 service members have been discharged and are eligible for VA care. Of those, more than one-third sought medical care within the VA. The Department has also acknowledged that mental disorders are the second most commonly reported health concern by veterans seeking care.

A June 2007 Army study found that 49% of Army National Guard members and 43% of Marine reservists reported symptoms of PTSD, anxiety and depression. At the end of their tours of duty, these citizen soldiers return to their families and communities, oftentimes miles away from a VA facility.

To meet this need, the VA has hired nearly 3,800 mental health workers, including physicians, nurses, pharmacists, social workers, and clinical psychologists, since 2005. Most of these professionals have been hired in the past 18 months. The Department has expressed interest in hiring at least an additional 500 mental health workers in the near future.

The VA's interest in hiring permanent full time staff to meet this need is based on a stated desire to assure sustainable, evidence-based programs. This approach, however, is exacerbating an existing mental health workforce shortage, and may not meet the long-term treatment and rehabilitation needs of returning veterans.

Most Americans with serious mental illnesses receive their treatment from government sponsored or not-for-profit community-based mental health organizations. From California to Maine, and in every state in between, there is currently a shortage of qualified mental health workers. While the shortage of psychiatrists and nurses is the most severe, there are shortages in all areas, including social workers, mental health counselors, and psychologists.

The VA's recent efforts to increase its mental health workforce have exacerbated this shortage. Community-based mental health organizations around the country report that staff are being recruited away by the VA, leaving them unable to serve current clients and looking once again for qualified replacements in a market with few to choose from. This situation is even more acute in rural areas of the country.

While it is clear that many returning service members are currently seeking care for mental disorders, it is less than clear what their long-term treatment needs will be. Instead of providing for a "surge capacity" to meet the current need, the VA is hiring permanent, fulltime staff in a system where the average employee remains until retirement. Such an approach would also provide the Department, and Congress, time to understand the long-term treatment needs of Veterans and to develop effective programs to meet them, as opposed to building a system that may not be relevant to what veterans need or want.

In our view, rather than competing with, or recruiting from, existing community-based mental organizations, the VA could pursue a targeted strategy of cooperation and collaboration through service partnerships. Such a course of action would provide immediate treatment capacity, as well as ameliorate the ongoing damage to the private sector inflicted by VA recruitment of mental health professionals.

Further, the establishment of service partnerships with existing community-based organizations would also extend the ability of the VA to provide needed treatment services in rural areas of the country where many returning National Guard and Reserve component veterans live. The stigma associated with mental illnesses already serves as a barrier to care, veterans do not need the further barrier of long travel times to access care.

Effective service partnership would be characterized by VA control of the referral process, as well as minimum standards for clinical training. Community organizations participating in such arrangements would be required to hire veterans as peer outreach workers, and to be competent in understanding the military culture and mindset. Additionally, all treatment records would be transmitted to the VA for inclusion in the veteran's electronic medical record to assure continuity of care.

Such models of cooperation exist, albeit in short supply. It is recognized that any such arrangements would be in existence only as long as the need existed and are not intended to replace the existing network of VA controlled care.

We would welcome the opportunity to work with the Committee to further develop these issues in support of our troops, and I would be pleased to answer any questions you might have. Please feel free to contact me by telephone at 301.984.6200, ext. 249, or via email – chucki@thenationalcouncil.org.