

**STATEMENT OF**  
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**PARALYZED VETERANS OF AMERICA**  
**BEFORE THE**  
**HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH**  
**CONCERNING**  
**THE STATUS OF VA MENTAL HEALTH PROGRAMS**

**JUNE 20, 2001**

Chairman Moran and Ranking Democratic Member Filner, members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views on the status of the Department of Veterans Affairs (VA) mental health programs. I am Richard Fuller, PVA's National Legislative Director.

PVA would like to focus our testimony today on the role VA mental health programs play as one of the specialized services that are unique to the VA. VA's wide variety of mental health programs together with other specialized services

such as blind rehabilitation, prosthetics, amputee services, and our own spinal cord dysfunction services are the core programs of VA health care. In many respects these programs are found no where else in U.S. medicine to the extent they are made available to veterans. And, rightly so, the Congress has given them special status, mandating in P.L. 104-262 that VA must maintain the capacity to provide this services.

PVA has recently completed a report that indicates a high incidence of dual diagnosis of veterans with spinal cord dysfunction and mental illness. PVA's Health Policy Department surveyed VA's spinal cord dysfunction programs to assess the extent and quality of coordination between those programs and VA's mental health services. VA SCI treatment teams confirmed that mental health services were a core part of SCI/D rehabilitation in VA inpatient and outpatient settings.

We reviewed private sector programs of non-VHA Model System Hospitals providing SCI rehabilitation to assess the extent of the inclusion of mental health services in their programs. We also conducted a national membership survey last year to gauge the degree of self-reported concerns and incidence of mental health disorders among our members. The results showed a high incidence of mental health problems among veterans with SCI/D.

Among the findings:

Patients with SCI/D are more likely to be diagnosed with serious mental illness when compared to all veterans using VHA health care services. Patients with multiple sclerosis have the highest tendency to have serious mental illness diagnoses followed by patients with other spinal cord dysfunction disorders than veterans with spinal cord injury.

The most common serious mental illness inpatient treatments among spinal cord injury patients were for Adjustment Reaction followed by Schizophrenic Disorders

The number of SCI/D patients being treated for serious mental illness has increased by almost 5 percent since 1998. The portion of outpatient services (number of visits) has increased by a staggering 25 percent. Outpatient visits for the SCI patients alone have increased 42 percent since 1998.

Twenty-six percent of respondents to our membership survey identified "Depression and/or Anxiety" as a major health condition. Of these respondents, 55 percent were spinal cord injured, 26 percent had other spinal cord conditions, and 24 percent had MS. (some respondents indicated both spinal cord injury and spinal cord disease)

Sixty-four percent of the respondents between 40 and 64 years of age reported "depression and/or anxiety" as a major health condition, a finding that suggests

that the on-set of serious mental illness increases due to the aging process and years of spinal cord dysfunction survival.

PVA surveyed four private-sector Model Spinal Cord Injury Systems. They indicated too that dual diagnosis presented a significant health care management challenge for both newly injured and annual evaluation patients. However, they reported that they had difficulty in providing adequate care and treatment under the pressures of limited lengths of stay. In addition, they reported that their rehabilitation settings are not staffed or equipped to provide suitable psychological care. Likewise, private sector psychiatric wards are unsuited to provide adequate rehabilitation care for individuals with spinal cord dysfunction.

By contrast, mental health screening and services are a stated objective of VA's SCI/D treatment plan. Demand for these services on an inpatient basis, but particularly on an outpatient basis, is high. These services, however, are not always available due to the shrinking capacity of mental health services throughout the VA health care system.

We are concerned about the on-going erosion in VA's mental health programs just as we are troubled by the failure of VA to maintain the capacity to provide all of its specialized services. I would like to review what steps PVA has taken in our own sphere of spinal cord dysfunction to attempt to stop this deterioration of services. We have not solved the SCI capacity problem. - not by a long shot.

But we have developed the tools to quantify where the problem areas are in beds and staffing and show clearly what VA needs to do to solve those problems. Hopefully our experience can assist the Subcommittee when it works to design legislation to further tighten and reauthorize the capacity reporting requirements this year. Hopefully, as well, our experience can assist advocates for other patients who need specialized services to serve as watchdogs for mental health and other endangered VA special programs.

Specialized services are labor intensive and expensive. In the mid-1990s this Subcommittee realized that changes accompanying the "re-invention" of the Veterans Health Administration, decentralization, the shift from inpatient to outpatient services, and growing budget pressures would provide the incentive for local VA managers to undermine the integrity of these programs shifting resources to other areas. The Subcommittee acted appropriately in passing a provision, now law, designating these programs with protected status, mandating VA to maintain service capacity, and requiring annual reports to Congress on VA's compliance with the capacity requirement. However, merely passing the law did not solve the problem. Initially, no one knew how to define capacity, and no one could agree how to quantify it. In the smoke and haze that blanketed the issue we continued to see local managers closing beds in SCI centers, reducing staff and curtailing services.

All of PVA's members are veterans with spinal cord injury or disease. Because of the complex nature of these disabilities and the fact that VA has developed a world-class system of 25 Spinal Cord Injury Centers, our members utilize the VA health care system at a higher percentage than any other veterans service organization. PVA's highest priority is sustaining and protecting the VA's Spinal Cord Dysfunction programs. If these programs are under threat, we are required by our board and membership to act.

Our first battle was over "definitions." VHA leadership said they could measure capacity by quantifying the intangibles of outcomes even though they had no mechanism to do so. We countered that counting beds and staff at SCI Centers was the only way to define the capacity of the system to provide a service, particularly one that was as inpatient based as the SCI system. Then there was the battle over numbers. What beds and staff do you count and how do you count them? It became clear early on that VA had 25 different ideas, depending on which of the 25 SCI Centers you were reporting from, on what constituted a bed and what constituted an SCI dedicated health professional. We, on the other hand, had a different idea based on our own bed counts and head counts conducted by our own service officers on site. The VA's numbers were clearly inaccurate, but were reported to the Congress anyway.

Over the years we have taken many steps in the attempt to get this sorted out. We have tangled with VA Secretaries and Under Secretaries. We have testified

in hearing after hearing. We have filed lawsuits. We have requested Committee oversight and site visits in the field. We have gone to the press, all to point to the fact that we were serious about the fact that the capacity statute actually means what it says. We took the innovative step once of having the VA's manual on the treatment and referral of veterans with spinal cord injury hand delivered on the same day to each of the VA's 172 hospital directors by process servers. The directors didn't like it when the knock came to the door, but we got their attention.

Last year we were finally able to sit down with VA leadership and agree to agree. We designed a template designating staffing and bed levels for each SCI Center that will serve as a benchmark for all future capacity reports. On July 26, 2000, the Under Secretary for Health issued VHA Directive 2000-022 stipulating that all SCI Centers would be in compliance with the directive restoring staffing and beds to the agreed upon levels by September 30, 2000. That deadline came and went. The Under Secretary issued a memorandum extending the compliance deadline to January 1, 2001. That deadline was not met either.

We agreed to perform a monthly count in conjunction with VHA personnel of each SCI Center to determine the progress made in the restoration of capacity. We have agreed with VA on the total number of beds and staff, and we have agreed with VA how to count them. Having VA live up to that agreement is a different matter.

We now have nine months of data with which we can measure VHA's progress toward meeting the minimum resources requirements of VHA Directive 2000-022. (I am attaching a copy of the May 31, 2001 report to be included with my testimony for the hearing record.)

Many of the designated SCI facilities have made substantial progress towards providing the minimum resources specified in the directive. We are greatly appreciative of the efforts that have been made with the support of the Under Secretary for Health. However, it is clear from the data that absent something out of the ordinary occurring between now and September 30, VA will still not be providing the minimum SCI resource levels it promised PVA it would provide.

The number of nursing staff and staffed beds have remained virtually the same (92%) for the last three months, approximately 113 nurses short of the minimum number.

The SCI physician deficit has only been reduced by half.

There is a shortfall of 24 SCI therapists.

Further threatening mental health service capacity, there is a 30 percent shortfall in SCI psychologists.

As of May 31, 2001 only one of the 25 SCI facilities was fully compliant with the requirements of the directive.

As of May 31, 2001, only 11 of the 25 SCI facilities was providing the number of staffed beds specified by the directive.

It is very clear we have not reached the Promised Land of SCI full capacity. But at least we have developed the tools to see clearly how far we have to go - and how far VA must go - to get there. This Subcommittee must insist, in re-authorizing the specialized services capacity reporting requirements, that the legislation provide strong language and direction to adequately define capacity and make certain those capacity levels are met.

This concludes my testimony, Mr. Chairman. I will be happy to respond to questions.