

STATEMENT

of the

NATIONAL MENTAL HEALTH ASSOCIATION
RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS

before the

SUBCOMMITTEE ON HEALTH
HOUSE VETERANS AFFAIRS COMMITTEE

on

VA PROGRAMS FOR VETERANS
WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

JUNE 20, 2001

Mr. Chairman and Members of the Subcommittee:

I had the privilege of serving on the staff of this Committee for nearly 10 years, and am honored to appear before you today on behalf of the National Mental Health Association (NMHA).

The National Mental Health Association

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 340 state and local Mental Health Association affiliates nationwide, NMHA works to improve policies, understanding, and services for individuals with mental illness and substance use disorders. Several NMHA affiliates have developed and operate programs serving persons who are homeless and suffer from mental illness and co-occurring substance use disorders. Within the last year, NMHA has initiated a working group partnership with VA, the National Coalition for Homeless Veterans, and USVets (a Los Angeles-based non-profit that has developed transitional housing and rehabilitation programs across the country for veterans who are homeless) to foster the development of new community-based coalitions and programs to serve homeless veterans.

The Significance of VA's Specialized Treatment Programs

During my years working in the House I was often asked why there continues to be a need for a Government-operated health care system for veterans. Some questioned why,

for example, the obligation owed veterans couldn't be as effectively discharged through a voucher system or some other contractual arrangement. The response I gave to such questions was similar to a response VA Secretary Tony Principi recently gave to a C-Span interviewer. Secretary Principi identified VA's specialized treatment programs for veterans with mental illness as one of a core of specialized programs that are central to what makes VA a unique, vital national resource.

VA: A Unique "Safety Net" for Veterans with Mental Illnesses

Those explaining the importance of maintaining the VA health care system also cite its uniqueness as a "safety net" for veterans. That safety net mission is particularly important to veterans with mental illness or substance use disorders because – unlike many other veterans – these individuals often lack other health care options. Both the Medicare program and most private health insurance, for example, impose arbitrary, discriminatory barriers to mental health care. Under the Medicare program, individuals face a 50% copayment for outpatient mental health services and a lifetime cap on coverage of psychiatric hospitalization. In a report last year on the Mental Health Parity Law of 1996 (which prohibited disparate annual and lifetime dollar limits on mental health care in private group health insurance), the General Accounting Office reported that while 86% of the employers it surveyed complied with the limited parity requirement of that law, 87% of those who had complied evaded the spirit of the law by substituting other discriminatory mechanisms (such as limits on numbers of outpatient visits or days of hospital coverage, or greater cost-sharing burdens) to limit coverage of mental health services. These barriers help explain the reliance veterans with mental illness place on VA for care. For example, more than 50 percent of veterans service-connected for a psychosis, and more than 60 percent of veterans service-connected for PTSD, used VA health care services in FY 2000.

As you know, Mr. Chairman, some five years ago VA embarked on what became a remarkable transformation of its health care system. The clear danger that a zeal to achieve cost-savings would threaten the viability of often costly specialized treatment programs led Congress in 1996 to enact legislation to protect this unique program capacity. This Committee can proudly claim authorship of the statutory requirement that VA maintain its specialized capacity (within distinct programs dedicated to veterans' specialized needs) to treat veterans with mental illness and other specified conditions. As this Committee has ably documented, competing VA priorities and fiscal incentives – which were dictated by policy not law – largely thwarted that statutory protection. As a result, VA mental health programs, in particular, fell prey to sweeping contraction and cost-cutting in many networks across the country.

Capacity and Effectiveness of VA Mental Health Programs

Your inquiry today regarding the capacity and effectiveness of VA mental health programs is both timely and important. Let me offer a few observations. First, over the last five years the VA health care system has markedly diminished – by its own measures -- its capability to provide care to veterans with mental and substance use disorders.

Second, this loss of program capacity has been variable from network to network – wholly at odds with VA’s obligation to operate a national health care system and provide equitable access to care. And third, with its failure over the last five years to maintain and reinvest mental health funding to establish needed community-based mental health programs, VA can no longer claim to provide state of the art mental health care. The implications of these observations are profound, in my view.

Mr. Chairman, I trust you would agree that the real issue before this Committee is not simply whether VA has maintained a specified level of program capacity – which it has not -- but whether, as a national system, it provides veterans reasonably accessible, effective, high quality care and services for mental and substance use disorders. I believe the hearing record you compile will demonstrate that it does not.

State-of-the-Art Mental Health Care

More than 450,000 veterans suffer from a mental illness which the VA has determined to be service-connected, that is, the illness was incurred or aggravated in military service. Surely such veterans should be afforded care and services of the highest quality. Indeed the Department’s budget submission for FY 2002 states (at p. 2-122) that VA provides “state-of-the-art” mental health care.

Do the facts bear out that claim? As the Surgeon General documented in the landmark 1999 Report on Mental Health, state-of-the-art care for severe mental illness is recovery-oriented care which requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation such as pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help persons recover from a mental illness. VA mental health professionals have recognized and identified these as needs “that should be the target of developmental efforts in the coming years” (Report of the Committee on Care of the Severely Chronically Mentally Ill Veterans [hereinafter “the SCMI Committee”], February 2000, p. 64. As an entity established pursuant to law – the product of the House Veterans Affairs Committee’s initiative – the SCMI Committee’s findings and recommendations are particularly noteworthy.) But, notwithstanding the courageous advocacy of VA mental health professionals, the Department is clearly not furnishing this comprehensive spectrum of services to veterans with severe mental illness today.

While budget pressures and other constraints may in the past have posed barriers to VA’s providing the spectrum of services identified by the Surgeon General, a health care system providing state of the art mental health services would certainly not have de-institutionalized patients with mental illnesses, as VA did over the last five years, without establishing accessible community based services in all networks to assure continuity of care. It is clear that in many parts of the country VA failed to meet this critical obligation. But while instituting a comprehensive, state-of-the-art mental health system for veterans remains an imperative, VA has yet to meet the more modest goal it has set of establishing a sufficient number of intensive case management programs to serve

veterans' needs. As the SCMI committee recently noted, entire networks and many major metropolitan areas have no such VA service available. And while VA opened hundreds of community-based clinics in the last five years – in part through rechanneling funds freed up from psychiatric bed closures -- only half these clinics provide mental health services.

I urge the Committee also to consider the issue of substance abuse. As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point. Substance abuse is a major problem among veterans, and many suffer from both substance use and other serious mental disorders, including psychoses and PTSD. A state-of-the-art mental health care system would not countenance a situation in which eight of the country's 25 largest metropolitan areas lack programs to treat drug addiction, for example, or in which the numbers of patients afforded substance use treatment has declined in the face of substantial increases in the numbers receiving care for other health conditions.

A state-of-the-art mental health care system would also not subject its patients to policies or practices of "failing first" on lower-cost medications before permitting its physicians to prescribe a drug of choice. It is our understanding, however, that such a policy -- applicable to so-called "novel" or atypical antipsychotic medications -- has, in fact, been adopted and in use in two of VA's networks. Atypical antipsychotic medications are newer medications found to be efficacious in the treatment of schizophrenia. The network policies on the use of these medications provide, in effect, that veterans are eligible for the more costly of those medications only if they have "failed" on a course of therapy with one of the less costly agents. It is our further understanding that VA clinical managers had proposed the adoption of such a policy for use systemwide.

The establishment of such a "fail-first" policy would seem to assume that the various newer antipsychotic medications can be used interchangeably in any patient with equal results. These network policies, however, ignore the reality that individual patients differ in their response to different medications and in their sensitivity to the particular side effects of the drugs. And they ignore the fact that "failing" a course of therapy can result in a psychiatric crisis that may lead to hospitalization. To our knowledge, there is no apparent scientific basis for denying veterans eligibility for particular medications. The rationale for these policies (other than cost-savings) is particularly mystifying in light of the fact that the National Institute of Mental Health has a study underway to compare the effectiveness of a wide range of antipsychotic medications in persons with schizophrenia (titled Comparative Effectiveness of Antipsychotic Medications in Patients with Schizophrenia often referred to as the "CATIE Schizophrenia Trial). If the National Institute of Mental Health is still studying the differences among these medications, it is difficult to understand the scientific basis that would warrant an individual VA network or VA itself to deny a veteran "eligibility" for a particular antipsychotic medication that his or her physician, in the exercise of clinical judgment, deems most appropriate for that individual.

Remedial Steps

Can the problems NMHA and others have identified be remedied? This Committee is to be applauded for making important, valuable recommendations to increase funding for VA mental health care, as well as for convening this hearing. NMHA would urge the Committee to go further. Increasing VA funding, for example, will not necessarily assure that additional new funds are allocated to mental health care, as proposed. The seemingly almost unfettered latitude that VA network directors have enjoyed – to maintain specialized programs or to close them, to provide substance abuse services or not, to deny veterans access to certain medications, etc. -- raises a concern that spending decisions will continue to be made in accordance with vastly divergent priorities from network to network. And it underscores that – regardless of veterans’ needs -- mental health and substance abuse will not necessarily be a high priority in each region. Mr. Chairman, the enormous disparities from region to region in access to care for mental health and substance use disorders for the large numbers of veterans with these conditions must be remedied. That remedy, in my view, should find expression in legislation.

There are several avenues that might be considered. A first, though not exclusive, step might be to amend the capacity law itself to include clarifying that the requirement to maintain specialized program capacity is not simply a systemwide mandate, but one applicable to each network. NMHA would urge the Committee to go further, however. Consideration might also be given to the concept proposed in the Heather French Homeless Veterans Assistance Act, H.R. 936, (which NMHA supports) which would alter the resource allocation model for funding specialized programs serving veterans with mental illness and substance use disorders. Anomalously, fiscal incentives have often proven more powerful than statutory directives in effecting desired changes within the VA health care system. Still another approach – perhaps an intermediate step to the more far-reaching VERA proposal -- would be to direct those VA networks which have most egregiously reduced their support for these specialized mental health and/or substance abuse programs (as measured by patients served and dollars expended, as adjusted for inflation) to develop and carry out a management plan for bringing these programs to the required levels by a specified date. In any case, NMHA would recommend that any such remedial legislation provide for an independent oversight mechanism, such as auditing by the VA’s Inspector General, through which the Committee could be assured that the legislation produced the intended result.

NMHA urges the Committee, however, not to set its sights solely on the issue of “capacity” – challenging as that has been – but to work to bring VA programs for veterans with mental illness and substance use disorders to the level that experts inside the VA and elsewhere acknowledge to be state-of-the-art.

Thank you for the opportunity to present NMHA’s views on this very important subject.

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National Mental Health Association

Ralph Ibson is a graduate of Tufts University (B.A. 1967) and the University of Pennsylvania Law School (J.D. 1973). He is a veteran of service in the U.S. Army (1968 – 1971).

Ralph began a career of government service in 1973 working as an attorney for the Veterans Administration (VA) on its Board of Veterans Appeals. In 1976 he joined the VA's Office of General Counsel, moving in 1980 to the position of Deputy Assistant General Counsel. In that capacity, he served as counsel to the Commission on the Future Structure of the VA Health Care System.

In 1990, Ralph joined the staff of the House Veterans Affairs Committee, taking a position as Staff Director of the Subcommittee on Hospitals and Health Care (later the Subcommittee on Health). Ralph retired from the Committee in June 2000 and accepted the position of Vice President for Government Affairs with the National Mental Health Association.

The National Mental Health Association (NMHA) has not received any grant or contract from the Department of Veterans Affairs.

NMHA has received contracts or grants (which may be deemed to have some relevance to the subject matter of this testimony) during the current or previous two fiscal years from:

The Substance Abuse and Mental Health Services Administration contract for \$24,000 to undertake a project on consumer involvement in public managed behavioral healthcare;

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration contract for \$300,000 to operate a resource center providing technical assistance and training to facilitate self-help approaches, recovery concepts, and empowerment for mental health consumers.

The Department of Justice, National Institute of Corrections: a grant for \$150,000 to develop a manual for prison staff about effective mental health services needed in prisons, and a grant for \$24,120 to address the needs of adults with mental illness in community corrections programs.