Analysis of the
“Commander John Scott Hannon
Veterans Mental Health Care Improvement Act of 2019”
(S. 785, §201)

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OVERVIEW:

The latest version available of S. 785 ANS “Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019” has many components that will manifestly advance life-saving mental health care for our nations’ veterans.

However, it contains language in Sec. 201 that establishes a mental health care delivery lane outside of the VA and Community Care Network (CCN). This could easily result in multiple deleterious impacts, as VHPI identifies below. VHPI also provides recommendations that could enhance suicide prevention efforts.

ADVERSE IMPACTS OF §201:

1. **It would duplicate and erode the mental health care offered by VA and CCN.**

   The bill pays for services beyond emergency evaluation and hospitalization of veterans in imminent risk of suicide. It would fund non-VA clinicians outside VA/ CCN to provide outpatient individual therapy, group therapy, family counseling, and substance use reduction programming, thus duplicating the clinical mental health care offered by VA and CCN.

   Because of Sec. 201’s emphasis on locations with high rates or suicide, VCL calls and minority/women veterans, **care is targeted in the same geographic locations as VA facilities.** There is no requirement that entities focus efforts in locations beyond the geographic reach of existing VA facilities where care is scarce. On the contrary, providers can be located close to VA Medical Centers, VA Community Based Outpatient Clinics, Vet Centers and CCN providers.
2. **Despite being a suicide prevention bill, it ignores suicide.**

There is no requirement that entities track and report on suicide attempts of veterans who receive their services (as the VHA must currently do), which is the purpose of this section. All that an entity must measure is “mental resilience and mental outlook” (whatever that means). There is one exception. Eighteen months after the grant commences and another 18 months later, the Department must report on “suicide rates” for eligible individuals seen by community partners. But the VA won’t be able to gather or report that data since the entities are not required to track suicides of the individuals they served.

Nothing in the bill mandates that grantee organizations focus on veterans who endorse being at imminent, high risk of attempting suicide. The baseline mental health assessment for risk has no requirement that veterans are evaluated for, or endorse, feeling suicidal at all in order to receive care.

3. **It would undermine VA’s model of providing health care.**

Private sector clinical care would not require VA pre-authorization. That plan begins to replace VHA as a health care provision system, transforming it into an insurance provider.

Establishing a third lane of providing clinical care to at-risk veterans outside of VA and CCN erodes the whole intent of the MISSION Act to create one overarching, coordinated program. Clinical care for at-risk veterans is best provided by utilizing and expanding VA/CCN’s existing infrastructure. Non-VA mental health care providers should be encouraged to join CCN.

These grave loopholes should be fixed.
RECOMMENDATIONS

Here are additional recommendations that would enhance suicide prevention efforts for at-risk veterans:

- **Facilitate greater access to VA.** Veterans who do not seek VA mental health care were studied extensively last year in the National Academies of Sciences, Engineering and Medicine *Evaluation of the Department of Veterans Affairs Mental Health Services*. It found that the top reasons that veterans with a mental health need do not seek VA care include that they (a) lack knowledge of how to apply for VA benefits (42% of survey respondents), (b) lack certainty whether they are eligible for or entitled to mental health care (40%), (c) lack awareness that the VA offers mental health care (33%), or (d) did not feel they deserved to receive mental health benefits (30%). That suggests what’s most needed to facilitate greater access to VA mental health care is expanding outreach efforts.

- **Enhance capacity.** For locations where VA/CCN mental health services capacity is lacking, build more capacity.

- **Establish suicide outcome measures.** Entities should be required to track and report suicide attempts of veterans receiving their services, including for 12 months post-treatment.

- **Ensure quality across the system.** Require that qualifications and service delivery standards in non-VA provider/facilities be equal to those used in the VA.

CONCLUSION:

Clinical care for at-risk veterans is best provided by utilizing and expanding VA/CCN’s existing infrastructure. Non-VA mental health care providers should be encouraged to join CCN. Creating another outside care delivery system for non-VA providers would have multiple deleterious effects.