Creating Options for Veterans' Expedited Recovery

Executive Summary

January 24, 2020

COVER COMMISSION

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In accordance with the Comprehensive Addiction and Recovery Act (CARA), the Creating Options for Veterans Expedited Recovery (COVER) Commission is pleased to provide these recommendations to the President of the United States, the United States Congress, and the Secretary of Veterans Affairs. The COVER Commission's charge required far-reaching examination of the treatment models used by VA in treating veterans' mental health. Throughout its research and deliberation processes, the commission put the needs of veterans at the heart of its work. The commissioners agreed that a cross-cutting range of improvements are needed, but most importantly that VA must transform its delivery model to one that is person-centered, relationship-based, and focused on veterans' whole health.

Recommendation #1: Address concerns expressed by veterans related to VA mental health care. The COVER Commission conducted a total of 16 focus groups including 10 in-person focus groups and six virtual focus groups.

Overarching

VA needs to use patient experience data in a manner similar to private-sector health care facilities to improve and enhance mental health services, but to do so requires a legislative solution. Congress should grant VA limited relief from the Paperwork Reduction Act for that purpose.

Transition and Eligibility

Congress needs to make it easier for veterans to receive care. Additionally, DoD and VA need to continue to work together to ensure that those separating from military service understand the care to which they are entitled and the process for getting that care. They also need to educate separating service members about the signs and symptoms of various mental health conditions to help them recognize when they might need mental health care. A focus group participant suggested the response should be, "All right, you're instantly in the system instead of having to sit there waiting for multiple years for the care that you need and not being able to recognize the fact that you need the help or afraid to reach out and go, 'Hey.' We shouldn't have to do that. We fought. It's all well and good, but the VA should do, okay, you're done, let's see what we can do for you right now. Instantly get you in the system the moment you sign out."

Self-Advocacy Skills

Throughout the focus groups, respondents commented on the lack of familiarity with some VA services such as the availability of peer support specialists (PSSs). In addition to ensuring veterans are equipped with information on eligibility and the accessing of care from an administrative standpoint, VA needs to train veterans in the skills and knowledge needed to advocate for their own mental health care. Health coaches would be a vital asset in developing skills associated with mental health care provider engagement and would improve the efficiency and quality of veterans' access to care. Additionally, public service announcements, online education resources, and other outreach efforts can prepare veterans to be more proactive in seeking the types of care they believe would be most beneficial to their long-term health.

Family and Support Person Involvement

VA needs to conduct training for providers that focuses on the importance of family involvement in veteran care and that addresses clinically appropriate ways of involving families because, as one focus group participant said, "To help a veteran, is to help everybody who loves that veteran. You know, because if I've got [post traumatic stress disorder (PTSD)] then everybody who's attached to me is suffering from PTSD in some way."

Additionally, VA needs to provide training to family members, so they can help veterans navigate the VA mental health care system. The National Alliance for Mental Illness (NAMI) Homefront program is an evidence-based program that

"Trauma is about trust.... We have to have rapport with our provider.... And it's very damaging to our own treatment to be confronted by a new provider constantly.... This person doesn't understand the context. They don't know the stories.... Continuity of care is a huge problem, even in what I consider to be a very good region."

–Focus Group Participant

could assist VA in reaching veterans' families and providing necessary training. This program is an adaptation of NAMI's Family-to-Family program. More than 2,500 family members and friends have participated in the program, either in person or online. A recent study indicated that participants showed significant improvement after participating in the program, regardless of whether participation was in person or online (Haselden et al., 2019). Adoption of the Improve Well-Being for Veterans Act would help in providing grants to support programs such as NAMI Homefront.

Access to Mental Health Care

Improving access to mental health care starts with removing barriers to getting care. Veteran focus group participants offered suggestions for how VA could make it easier for veterans to get care. VA needs to ensure that veterans have adequate access to mental health care by expanding availability of evening and weekend care, committing to robust use of telehealth, and facilitating easy access to other federally-funded health care facilities. The requirement to provide evening and weekend appointments needs to be met in ways that are in the true spirit of the requirement, rather than the minimum way in which a facility can assert that it has met the requirement. The process for attaining same-day and walk-in appointments and the availability of such appointments needs to be consistent across VA. Additionally, VA needs to examine the variability in mental health staffing across the enterprise and work to provide consistent availability of providers in all VA mental health facilities. To complement in-person care, VA needs to create a robust telehealth system that takes mental health care to veterans.

Rural veterans should have seamless access to care provided at federal qualified health centers, critical access hospitals, rural health centers, tribal health centers, and Indian health services. Making care in these types of federally funded facilities easy for veterans to access would expand the pool of care options available to improve veteran care.

Based on feedback from veterans and VA mental health providers during COVER Commission site visits, there is a gap in coordination of care for high-risk veterans. VA has a large number of residential rehabilitation treatment programs (RRTPs) for PTSD, substance use disorders, and homelessness distributed throughout the enterprise, that are providing critical care for some of the most vulnerable veterans. Feedback from veterans and providers was that RRTPs are exceptionally difficult to access and veterans frequently get sent to community care despite RRTP beds being available in neighboring VA facilities.

The feedback from providers and veterans is concerning. In some instances, health care systems with RRTP beds, funded by Veterans Integrated Service Network (VISN) funds, were not allowing other health care systems within the same VISN to refer veterans due to reasons that were unclear. Furthermore, the feedback included stories of RRTPs applying more stringent admissions criteria for veterans from outside the system, which delayed care for veterans. VA recently released the RRTP handbook in 2019, which has increased uniformity in the admissions process; however, it does not address needs to create and staff a national bed control system that would allow providers to refer veterans to a centralized admissions process. Based on processes defined in VA Directive 1162.02, the system would place referrals in the next available bed closest to their home of record.

Community-Based Care

Veterans reported favorable experiences with VA providers that are specially trained to understand their military experiences. They value care coordination among their care providers within VA. Veterans who split their care between VA and the private sector indicated they had difficulty coordinating their care and would like their private-sector providers and VA providers to be able to communicate directly with each other. VA needs to improve coordination of care among VA and community providers by creating a secure messaging platform to allow for real-time communication.

Peer Support

VA needs to optimize the role of PSSs and maximize the effects of the PSS program on veterans' mental health. Veteran focus group participants indicated that they feel most comfortable seeking guidance about mental health issues from other veterans. To optimize the presence of peer providers VA needs to ensure adequate availability of PSSs by rectifying the turnover issues related to the role. In addressing the turnover issue, VA also needs to consider potential burnout of PSSs and afford them services to mitigate the stresses that cause burnout.

Veteran focus group participants expressed that the main appeal of working with providers who have military service experience is their understanding of the military vernacular and of military life. They did not indicate a strong preference for peers who are recovering from mental health issues. With that in mind, it

"Moral injury looks, smells, and tastes an awful lot like PTSD.…It diverges from PTSD in two areas. One is that the incidence of suicidal ideation tends to be a lot higher because you have violated your own moral code, and the other is that there is a strong need for redress." –Focus Group Participant

seems prudent that VA consider expanding its cadre of peer providers by adding a new position—behavioral health technician (BHT). This position exists within the DoD health care system and could provide a pipeline for bringing highly trained and skilled individuals into the VA mental health care system. Although these individuals may not necessarily have mental health issues themselves, they have extensive experience working with service members who do and have been service members themselves. The role of the PSS needs to be standardized enterprisewide. VA needs to use PSSs to help veterans understand the mental health services available to them. To help maximize the benefit of PSSs, VA should enhance the identification of PSSs in VA facilities and educate veterans on the role these providers play, so veterans can take full advantage of the services these individuals provide. To further enhance the program, VA should mandate use of coding that will ensure the time PSSs dedicate to the care of fellow veterans is accurately documented. Furthermore, to ensure availability of PSSs across the enterprise, they should be designated as a core component of a behavioral health interdisciplinary program. Veterans expressed that when they have an advocate who understands their experience, and when they understand the options available to them, they are better able to navigate the VA mental health care system and receive the care they need. For further discussion of this topic, see Recommendation #8.

Complimentary and Integrative Health

Currently, gym memberships of any sort are specifically excluded from the VA medical benefits package by regulation, and VA cannot provide gym memberships to veterans (38 CFR 17.38, VA Medical Benefits Package)—either individually or via contract—without a regulatory change. Although the VA regulation implements 38 U.S.C. § 1710, Eligibility for Hospital, Nursing Home, and Domiciliary Care, the statute does not restrict or prohibit provision of gym memberships, so no statutory changes would be required. VA should amend 38 CFR 17.38 to remove the restriction on providing gym memberships and create a program for providing mental health patients with vouchers to be used for gym memberships or memberships at facilities such as yoga, pilates, or tai chi studios. VA also needs to offer uniform availability to CIH modalities and educate veterans about the options available, so they can make informed decisions about their care.

Military Sexual Trauma

Because of the stigma attached to sex crimes and a history of military cover up, veterans say it can be extremely difficult to talk about their experiences. One focus group participant said she had to change providers because her first mental health provider was not sensitive to the fact that it was hard for her to talk about military sexual trauma (MST). "She was very focused on military sexual trauma and was very negative about my use of a service dog, so I quit seeing her really quickly." Providers need training to help ensure they are equipped to address MST in ways that are mindful of the unique power issues that characterize sexual crimes committed in military settings.

Continuity and Quality

Using health care coaches would ensure a comprehensive view of all the care services that a veteran is receiving. As outlined in other recommendations, there are promising treatment modalities available today, but it is difficult to determine exactly what the most effective mix of treatments is in individual situations. Health coaches will act as strong advocates for veterans, helping providers to offer a finely tuned array of services that suit individual veteran's needs.

Communication

VA should continue to engage veterans through the use of both traditional and emerging communication channels, including public announcements, social media, community engagement, and other methods deemed valuable. Communication efforts should focus on the availability of services, methods for determining eligibility for care, and developing self-advocacy skills in clinical environments.

Medication

To help ensure veterans use medication optimally, VA should create a fail-safe mechanism to ensure veterans can get emergency medication at nearby facilities when needed. Additionally, VA should work with veterans to devise treatment plans that take into account veteran concerns and preferences as appropriate as discussed in Recommendation 3 and to address concerns about treatment-resistant depression as discussed in Recommendation 5.

Recommendation #2: Establish an ongoing research program focused on testing and implementation of promising adjunctive CIH modalities associated with positive mental health, functional outcomes, and wellness that support whole health and the VA Health Care Transformation Model.

Current VA policy requires use of evidence-based practices in treating mental health issues. Interest in including complementary and integrative health (CIH) modalities in mental health treatment is

increasing, so it is important to understand what evidence base already exists for using CIH to treat key mental health issues, particularly as adjunctive treatment, and what areas require additional study.

Based on comprehensive evidence-based reviews of CIH and other modalities, further research is needed to solidify the strength of evidence of these modalities for each of the eight mental health conditions studied: PTSD, alcohol use disorder (AUD), opiod use disorder (OUD), major depressive disorder (MDD), generalized anxiety disorder (GAD), bipolar disorder (BD), suicidal behavior, and insomnia disorder. It is important to note and leverage existing evidence-based synthesis reviews conducted by VA that fall outside the scope of the COVER Commission's work but are critically related and were, therefore, used in making recommendations (e.g., reviews of pain management programs and CIH). Although the COVER Commission examined eight mental health conditions, there are many others that could be considered when examining the evidence for CIH treatments, such as schizophrenia, other serious mental illnesses, and anxiety disorders such as obsessive-compulsive disorder. Although the commission was limited in the scope of the conditions it could consider, research should continue in these areas with respect to CIH modalities. Conclusions related to each diagnostic category are reported below.

Post-Traumatic Stress Disorder

VA should fund/conduct research related to CIH treatment interventions and PTSD, particularly multisite trials. There were no randomized controlled-trial (RCT) research studies for PTSD outcomes with the following modalities: art therapy, cannabinoids (RCT conducted but never published), chiropractic care, hyperbaric oxygen therapy (HBOT) (two RCTs containing small percentage of PTSD patients but PTSD subgroups were not separately analyzed), massage therapy, music therapy, tai chi, and service dogs. The following modalities had low strength of evidence with respect to PTSD outcomes due to methodological and study design issues so further studies may be required: accelerated resolution therapy (ART), acupuncture, equine therapy, exercise, healing touch, relaxation therapy, and transcranial magnetic stimulation (TMS).

To mirror how treatment is generally provided in clinics, VA should fund/conduct research studying CIH modalities as an adjunct treatment to evidence-based PTSD psychotherapies and medications. For example, acupuncture could be studied as an adjunctive treatment to standard PTSD clinical care (i.e., PTSD psychotherapy plus acupuncture). Including structured or manualized forms of meditation as routinely available adjunctive treatment interventions for PTSD, such as mindfulness-based stress reduction or mantra meditation, could be helpful based on existing evidence.

Opioid Use Disorder

Based on the reviews, VA should fund/conduct research related to CIH treatment interventions and OUD, particularly multisite trials. There were no randomized, controlled trials research studies for OUD outcomes with the following modalities: ART, art therapy, cannabinoids, chiropractic care, equine therapy, healing touch, HBOT, massage therapy, meditation, music therapy, tai chi, relaxation therapy, service dogs, TMS, and yoga. Exercise and some acupuncture studies had low strength of evidence with respect to OUD outcomes due to methodological and study design issues so further studies may be required. Acupuncture with OUD had moderate evidence with reducing depression but not any of the OUD-specific outcomes (e.g., cravings, methadone consumption).

VA should fund/conduct more research with OUD patients to ensure prevention of overdose (e.g., naloxone and CIH modalities). VA also should leverage pain management research that exists and conduct studies with these modalities that include patients with OUD. For example, although yoga has shown to be helpful with pain management, there are no studies that focus on yoga and OUD. Finally, VA should conduct studies with medication-assisted treatment (e.g., Naltrexone and Suboxone) and CIH modalities, building on the services VA is already delivering.

Alcohol Use Disorder

VA should fund/conduct studies related to CIH treatment interventions and AUD, particularly multisite trials, as well as studies that focus on AUD prevention using CIH modalities, given the public health issue of alcohol use among veterans. VA should also build on the services it is already delivering by conducting research on medication-assisted treatment for alcohol use and CIH modalities. There were no randomized, controlled-trials research studies for AUD outcomes with the following modalities: ART, art therapy, chiropractic care, equine therapy, healing touch, HBOT, massage therapy, therapeutic touch, yoga, tai chi, and service dogs. Acupuncture, cannabinoids, exercise, meditation, music therapy, relaxation therapy, and TMS studies had low strength of evidence with respect to AUD outcomes due to methodological and study design issues, so further studies may be required. There is some limited evidence to suggest that meditation used in the context of mindfulness-based relapse prevention reduces cravings, postintervention alcohol or drug consumption, and perceived stress.

Major Depressive Disorder

VA should fund/conduct research related to CIH treatment interventions and depression, particularly multisite trials. There were no randomized, controlled trials research for depression outcomes with the following modalities: ART, cannabinoids, chiropractic care, equine therapy, healing touch, HBOT, massage therapy, relaxation therapy, training and care of service dogs, and therapeutic touch. Creative arts, exercise, meditation, music, tai chi, and yoga had some positive results, yet low strength of evidence with respect to depression outcomes due to methodological and study design issues, so further studies may be required. Acupuncture and repetitive transcranial magnetic stimulation (rTMS) used for those with depression had moderate evidence of reducing some depression-related outcomes. Further pragmatic trials with CIH modalities are needed given that those with depression are often receiving concurrent evidence-based treatments.

Generalized Anxiety Disorder

VA should fund/conduct research related to CIH treatment interventions and GAD, particularly multisite trials, as well

"The more peer support you have, the better chance you have of getting new services out there available.... Why can't there be an assigned sponsor to help walk them through the process... and just take them by the hand and just tell them... it's going to be okay, and walk them through the services, which would help reduce... the suicide rate."

–Focus Group Participant

as studies that take a transdiagnostic approach with respect to anxiety, thereby including symptoms with shared variance across CIH modality studies. There were no randomized, controlled-trials research studies for GAD outcomes with the following modalities: ART, acupuncture, art therapy, cannabinoids, chiropractic care, equine therapy, healing touch, HBOT, meditation, music therapy, tai chi, service dogs, therapeutic touch, and yoga. Exercise, massage, relaxation therapy, and rTMS studies had some promising results, yet low strength of evidence with respect to GAD outcomes due to methodological and study design issues so further studies may be required.

Bipolar Disorder

VA should fund/conduct research related to CIH treatment interventions and BD, particularly multisite trials. There was no randomized, controlled trials research for BD outcomes with the following modalities: ART, acupuncture, art therapy, cannabinoids, chiropractic care, equine therapy, exercise, healing touch, HBOT, massage, music therapy, relaxation, tai chi, service dogs, therapeutic touch, and yoga. Meditation studies had some promising results, yet low strength of evidence with respect to BD outcomes due to methodological and study design issues, so further studies may be required. Some rTMS studies used in those with BD had moderate evidence of reducing some BD-related outcomes.

Suicidal Behavior

VA should fund/conduct research related to CIH treatment interventions and suicide risk, particularly multisite trials. VA should fund/conduct research studying CIH modalities as an adjunct treatment to evidence-based psychotherapies for suicide risk and medications, because these trials would mirror how treatment is generally provided in clinics. For example, TMS could be studied as an adjunctive treatment to cognitive behavioral therapy (CBT). There was no randomized, controlled trials research for suicide risk outcomes with the following modalities: ART, acupuncture, art therapy, cannabinoids, chiropractic care, equine therapy, healing touch, HBOT, massage therapy, meditation, music therapy, tai chi, therapeutic touch, service dogs, and yoga. The following modalities had low strength of evidence with respect to suicidal ideation outcomes due to methodological and study design issues so further studies may be required: exercise (outdoor therapy), relaxation training, and TMS. Exercise was examined in conjunction with CBT vs. CBT alone, and demonstrated potentially promising results yet further research is needed. Bilateral TMS seemed most promising for suicidal ideation, but further study is needed.

Insomnia Disorder

VA should fund/conduct research related to CIH treatment interventions and insomnia, particularly multisite trials. There was no randomized, controlled trials research for insomnia outcomes with the following modalities: ART, art therapy, chiropractic care, equine therapy, healing touch, HBOT, and service dogs. Cannabinoids, exercise, massage, relaxation, rTMS, and yoga studies had some promising results, yet low strength of evidence with respect to insomnia outcomes due to methodological and study design issues, so further studies may be required. Some acupuncture, meditation, music therapy, tai chi and yoga studies used in those with insomnia had moderate evidence of reducing some insomnia-related outcomes.

Recommendation #3: Transform the current VA health care delivery model into one that is person-centered, relationship-based, and recovery-focused and support this transformation with a payment system that is value-based and incentivized for continuous innovation and quality improvement.

Research indicates that treatment produces better outcomes when patients are involved in setting priorities for their care, yet VA lacks a systematic protocol for ensuring that veterans' care focuses on what matters most to them. For treating acute disease and saving lives, VA's current disease-oriented model of care is stellar and VA should not abandon it. For the management of chronic and complex disease, however, this approach is failing and a recovery-focused model should replace it (Jonas, Chez, Smith, & Sakallaris, 2014).

VA needs to transform its health care delivery system into one that is person-centered, relationship-based, and recovery-focused and to support this transformation with a payment system that is value-based and incentivized for continuous innovation and quality improvement. VA health care (like the nation's health care in general) is dominated by reductionistic, evidence-based, and medical-centric processes. This approach has many benefits but is losing value as a method for managing chronic disease. VA needs a more wholistic, person-centered approach in which veterans are placed at the center of care and services that promote health, well-being, recovery, and resilience. The key to this transformation is to ask veterans what matters in their lives and then orient VA

The whole health initiative is kind of that integration with everybody on board and then getting everybody kind of educated and connected on that. I like that idea." –Focus Group Participant

health care services to help veterans advance toward those goals. The mechanisms to initiate this shift are already present in many VA programs, but these programs are not coordinated or aligned around this central mission. The VA Health Care Transformation Model shows how to establish that alignment.

To drive the transformation of VA health care, VA should build on its current innovation and improvement systems by creating a continuous innovation and improvement center and network that is focused solely on transforming veteran care into the VA Health Care Transformation Model focusing on the following key actions:

Transition VA's Veterans Equitable Resource Allocation (VERA) system from a fee-for-service funding model to a per-patient model of funding with financial incentives for improving population health and person-centered metrics.

Fully fund and integrate the whole health implementation plan into mental health, primary care, and specialty care throughout VA.

Incentivize VA health care leaders and providers with both fixed payment and variable bonus processes to engage in continuous improvement with incentives for improving population-based and person-centered metrics.

Create a continuous innovation and improvement center and network specifically focused on driving the VA Health Care Transformation Model.

Integrate VA's existing metrics systems (e.g., SAIL, VERA, Patient Experience Office) into a unified system that tracks quality, performance, and value based on the quadruple aim framework.

Recommendation #4: Implement a multipronged effort to improve the state of evidence regarding veterans' suicide, roll out proven interventions to those most at risk, and streamline VA's suicide-prevention message modeling for clarity and consistency with research.

Between 2005 and 2016, the suicide rate for veterans increased 25.9% (VA, 2018). In 2016, the suicide rate, adjusted for age and gender, was 1.5 times greater for veterans than nonveterans, with an average of more than 6,000 veteran suicides per year (VA, 2018). The state of mental health care for veterans demands attention. Despite efforts to improve mental health care for veterans, this population remains at risk. On average, 17 veterans take their own lives every day (VA, 2018), yet veteran suicide-prevention science is still in its infancy.

VA and the National Institute of Mental Health need to expand veteran suicide-prevention research. VA should develop telehealth resources to implement SAFE VET to emergency rooms throughout the country. VA needs to ensure that its suicide-prevention messaging carries the overall point that suicide is not a rational brain response to adverse experiences. Adopting a suicide-prevention model that explains the complex realities of suicide, suicide prevention, and treatment for suicidal behavior is essential, and the stress-diathesis model is ideal for grounding VA's suicide-prevention message.

Recommendation #5: Provide universal access to effective care for treatment-resistant depression for all veterans in the VA mental health system.

Treatment-resistant depression is a major issue throughout the mental health treatment system. VA's ability to serve veterans with depression is hampered by the current state of the science to diagnose and treat depression. Only about half of patients with depression receive adequate treatment by available interventions, and that treatment comes through trial and error, rather than the results of guidelines that pair patients with the ideal treatment (Akil et al., 2018). Treatment resistance often occurs as a result of this process. According to data collected by the COVER Commission, only approximately 1166 patients VA-wide were referred for electroconvulsive therapy in 2018 and about 772 were referred for rTMS.

VA must make all of these treatment modalities available to veterans that need them to address the problem of treatment-resistant depression. Treatment-resistant depression is a major component of the veteran patient population, which necessitates making such treatment available, whether through VA or through contracts with outside treatment providers. Although VA does appear to offer these services at some flagship facilities, the services are not available consistently from facility to facility, and obtaining them is particularly challenging at facilities in rural areas.

Recommendation #6: Expand VA's precision mental health efforts in partnership with the National Institute for Mental Health to more effectively diagnose and treat mental health conditions.

The state of the science in screening, diagnosing, and treating mental health conditions is in flux. The critical nature of this issue to VA's services is one of both issue severity (veteran suicide) and scope. According to VA's Office of Research and Development (2019), "More than 1.8 million veterans received specialized mental health care from VA in fiscal year 2015." VA serves almost 2 million veterans a year in a treatment system based on mental health diagnosis categorization that the former director of the National Institute of Mental Health has deemed not to be "predictive of treatment response" (Insel et al., 2010). That flaw in VA's mental health treatment system presents a fissure in its ability to prevent veteran suicides.

Advances in precision mental health research underscore the viability of using biosignatures associated with various mental health diagnoses to pinpoint the

ideal treatments for individual mental health patients. The Precision Mental Health Initiative in the Commander John Scott Hannon Veterans Mental Health Care Improvement Act would require the Secretary of Veterans Affairs to develop and implement an initiative to identify and validate brain and mental health biomarkers among veterans, with specific consideration for depression, anxiety, PTSD, traumatic brain injury, and other mental health conditions the Secretary of Veterans Affairs considers appropriate as a precision medicine for veterans initiative. Passing this bill would set the stage for streamlining mental health treatment among veterans by providing them with the optimal treatment based on biosignature markers.

The next stage of developing precision medicine in VA requires both research and translation into clinical practice. VA facilities outside of the flagship institutions will need to participate to ensure adequate representation of a diverse group of veterans. Precision medicine will be specific enough that groups that are not included in the research will not benefit from all of the findings.

VERA is critical to how facility administrators are measured. The VERA model must be aligned to support a broad-scale research and translational initiative. If precision medicine efforts are not properly incentivized in VERA, then that lack of local incentivization will stunt precision medicine efforts in VA.

Recommendation #7: Identify and rectify availability gaps for evidence-based psychotherapeutic interventions.

VA has moved toward the evidence-based model, yet the availability of different evidence-based therapies varies widely among facilities. It is unclear why treatment options offered in some places are not offered in others.

VA needs to conduct a gap analysis throughout the VA health care system of use and availability of psychotherapeutic interventions recommended in widely used clinical practice guidelines and report on why certain interventions are not widely implemented or are excluded from VA-wide rollout, and share the results across the enterprise. Additionally, VA should adopt a plan with measurable, time-limited steps to address gaps that limit veterans' access to care that is essential to treat their conditions.

Recommendation #8: Recognize and incentivize the roles of peer support specialists, behavioral health specialists, health coaches, and chaplains in mental health care in the Veterans Equitable Resource Allocation system.

The current model of accounting and valuing VA health care services—VERA—highlights the number of services provided by certain health care providers such as physicians, psychologists, and social workers. Certain professions that provide services to VA patients are left out of the VERA model; therefore, they are undervalued by the system regardless of the quality of care individuals in these professions provide to veterans. As a result of the VERA model, certain clinical fields are overwhelmed, while other professions are underutilized.

BHTs, health coaches, and chaplains are either underused or under incentivized in the current VERA system. Although PSSs, BHTs, health coaches, and chaplains cannot fix the long-term issues that need to be resolved in the overall VA care model, ensuring that these positions are effectively recognized as critical to veterans' care in VERA should help address some of the critical challenges in the current overburdening of licensed clinical staff and underutilization of nontraditional care team members that can help move the needle for veterans' whole health care.

Recommendation #9: Engage with other federal agencies, as appropriate, to research the potential short- and long-term risks, as well as benefits, of medical cannabis and psychedelic drugs.

Medical cannabis and psychedelic drugs may have uses in treating mental health issues among veterans; however, these substances are currently classified as Schedule 1 under the Controlled Substances Act, which precludes VA from conducting research on their efficacy.

There are significant questions about the benefits and costs of using cannabis and psychedelics in treating mental health issues. The efficacy and safety of these types of treatments are unclear, but it is essential that VA engage in research to better understand them. VA should engage with other federal agencies to conduct research into the positive and negative effects on veterans' mental health of medical cannabis and psychedelics, including methylenedioxymethamphetamine (MDMA). VA should provide providers with up-to-date information on research related to use of medical cannabis and psychedelics, including MDMA. Additionally, educate VA providers about their ability to discuss the benefits and possible negative effects of medical cannabis with veterans in their care.

Recommendation #10: Ensure that veterans can access mental health care by reviewing and updating transportation processes throughout the VA system.

VA has a complex transportation system that relies on a combination of different services and agencies (VA, 2019b). Transportation systems in general are rapidly changing. New forms of transportation, such as ride sharing and rental scooter and bike services have become common. VA has not updated its approach to transporting veterans to care to include these new transportation modes, yet these transportation models could increase the likelihood that some veterans will receive the mental health care they need.

Transportation is a critical element to a functioning mental health treatment system. Although telehealth is improving, veterans still require transportation to VA facilities for much of their care. Using mass transportation may be problematic for veterans with certain mental health conditions such as PTSD and anxiety disorders. If clinicians were able to order special modes of transportation (e.g., Uber or Lyft rides) for these veterans, it might help them receive the care they need. Additionally, VA needs to evaluate its overall transportation program to identify policies that may be out of date and in need of revision and to reflect the existence of new transportation systems.