

Choice Program Expansion Jeopardizes High-Quality VHA Mental Health Services

Russell B. Lemle, PhD

Dr. Lemle is the VA-Community Care Workgroup Lead for the Association of VA Psychologist Leaders. **Correspondence:** Dr. Lemle (russell-lemle@comcast.net)

Last summer, the Department of Veteran Affairs (VA) published the most comprehensive analysis of veteran suicide in our nation's history. That study examined 55 million records from every state and revealed that in 2014, an average of 20 veterans died by suicide each day.¹ Six of the 20 were recent users of Veterans Health Administration (VHA) services; the other 14 had not used VHA services in the prior 2 years.

Policy makers are currently deliberating whether expanding the Veterans Choice Program (VCP) is a judicious way to prevent these tragic deaths, especially for veterans who do not use the VHA. One proposal, presented at a congressional committee hearing in October 2017, advocates expanding the VCP.² Its core tenet—allowing veterans to seek mental health care from VCP providers without needing VHA preauthorization—is similar to provisions in other subsequent VCP bills regarding Access to Walk-In Care for episodic physical and mental health care.³

The original Veterans Choice Act of 2014 was enacted with \$10 billion supplemental funding for the VCP as well as \$5 billion to augment VHA staffing. In contrast, these recent proposals include no supplemental allocations. Veterans could bypass VHA approval, obtain VCP services on their own; the VHA would be sent the bill and payment would be taken from the VHA facility's budgets.

The set of proposals serves as a reminder of the need for further reflection and discussion about how the nation can best address the crisis of veteran suicide and, more broadly, how to optimize access to evidence-based, integrated mental health care services.

This article critiques the myths underlying the proposals' rationale, gives factual evidence on veterans' suicide prevention and comprehensive mental health care issues, and concludes with a cautionary warning about the

risk of VCP expansion adversely impacting veterans.

PREVENTING VETERAN SUICIDES

MYTH: *Shifting funds from the VHA to mental health care providers in the community would be a more effective suicide prevention strategy.*

FACT: *The VA is better than the community in addressing veterans' suicides.* Between 2001 and 2014, age-adjusted rates of suicide for veterans not using the VHA increased by 38%; for veterans using the VHA, the age-adjusted rate increased by 5%. For the subgroup of VHA patients with either a mental health or substance use diagnosis, the rate decreased by 25%.¹ These comparative achievements occurred even though veterans who use the VHA are twice as likely to have a mental health condition when compared with veterans who do not use VHA services.⁴

FACT: *The VHA's approach to preventing suicides is far more comprehensive than that found in the community.* Each of the 170 VA medical centers has at least 1 dedicated suicide prevention coordinator (SPC) position. The SPCs provide enhanced care coordination for veterans in VHA health care who are identified as high risk for suicide. The SPCs collaborate with the VHA's integrated network of care providers and community partners to reduce suicide risk among vulnerable veterans.

For veterans in VHA care who are at risk for suicide, mental health policies include regular screening, follow-ups to missed appointments, and safety planning. For high-risk veterans, suicide prevention policies also involve a medical record flagging and monitoring system with mandatory mental health appointments.

The 2010 National Strategy for Suicide Prevention report extolled VHA's multiple levels of evidenced-based suicide prevention practices and recommended that other health care systems emulate the practices.⁵ Despite this, few

community health care providers or systems have adopted a similar approach. As the Congressional Research Service observed in 2016, “Outside the VA, the use of suicide prevention coordinators has not been widely adopted.”⁶

FACT: *The VHA’s innovative use of suicide predictive analytics to recognize at-risk individuals is more advanced than those available in the community.* VHA has implemented a predictive analytics program that identifies veterans at risk for suicide and offers enhanced care to these veterans. The model uses clinical and administrative data to identify VHA-enrolled patients who are at the very highest risk of suicide, with a 30-fold increased risk of death by suicide within a month.⁷ The system notifies each veteran’s provider of the risk assessment and enables those providers to reevaluate and enhance these veterans’ care. Some of these ultra-high-risk veterans might not have been identified as being at risk based only on clinical signs. This is a crucial distinction because many veterans who die by suicide do not have a history of suicide attempt or recently documented suicidal ideation.⁸⁻¹¹ This cutting-edge, big-data approach allows the VHA to reach out and assist vulnerable veterans, before a crisis occurs.

FACT: *The VHA can better coordinate the care of veterans who call the Veterans Crisis Line (VCL) when they are receiving care in the VHA rather than in the community.*

Since its launch a decade ago, the 24-hour VCL has answered > 3 million calls from veterans and their family/friends, with > 500,000 follow-up referrals to local VA SPCs. Because the VCL links directly to VHA facilities, care coordination is more effective when a veteran’s provider is in the VHA. When the veteran is not a VHA patient, coordinating with his/her community provider is laden with logistic impediments.

MYTH: *If offered, the 14 of 20 veterans outside the VHA who are the target of this proposal would prefer to use VCP mental health options to get help.*

FACT: *There is no evidence that those veterans are VHA-eligible, otherwise uninsured, or would seek needed help.* The VHA’s 2017 suicide report did not probe whether veteran suicide decedents who were not recent VHA patients

were eligible for VHA care.¹ It did not ascertain whether they were veterans with other-than-honorable discharges or transitioning out of service, 2 cohorts that now qualify for VHA mental health care. It is known that the respondents’ average age was 54.3 years, an older population that in general is less prone to seek the care of a mental health provider (either in or outside the VHA) when needed.^{12,13} It also is known that of all enrolled veterans, only a small portion plan to forego VHA care, and they tend to be eligible for public insurance coverage (eg, Medicare, Medicaid, or TRICARE) and/or have private insurance coverage.¹⁴ Thus, establishing unrestrained Choice options may fail to capture most of those veterans such a plan purports to help.

COMPREHENSIVE MENTAL HEALTH CARE

MYTH: *The quality of mental health care provided to veterans in the community would be comparable with the quality of care they receive at the VHA.*

FACT: *The VHA expertise in treating veterans with posttraumatic stress disorder (PTSD) and depression is lacking in the community.* More than 12,700 VHA mental health providers have received extensive training and supervision in the most effective evidence-based psychotherapies (EBPs). This includes more than 8,500 providers trained in prolonged exposure and/or cognitive processing therapy for PTSD and more than 2,200 providers in 1 of 3 EBPs for depression.¹⁵ Veterans who received EBPs in the VHA have experienced clinically meaningful and robust improvement in their PTSD and depressive symptoms.¹⁶⁻²²

By contrast, a RAND Corporation study of therapists who treat PTSD and major depressive disorder found that when compared with providers affiliated with the VHA or DoD, “a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions.”²³ Only 13% of community therapists were trained in and used an EBP and had veteran/military cultural competency. A separate 2017 study of community providers who treat veterans found

that only a minority reported prior training in, or use of, any EBP for PTSD.²⁴ Also, as the industry leader in telemental health, the VHA's delivery of EBPs to veterans in remote locations and/or having difficulty accessing clinic-based care is far beyond that of the private sector.

FACT: *VHA patients are more likely to receive care consistent with the American Psychiatric Association (APA) guidelines than are patients treated in the community.* Recent studies of pharmaceutical treatments for mental disorders have compared the VHA with the private sector. The studies found that for all 7 indicators, VHA performance was superior to that of the private sector by > 30%.^{25,26} Another study found that 1% to 12% of private sector patients treated with antidepressants received care consistent with APA guidelines (with care of racial/ethnic minorities tending to be on the lower side of this range).²⁷ The VHA achieves higher quality because, as a unified, nationwide system, it has superior ability to assure providers' adherence to assessment and treatment standards.

FACT: *For older veterans who constitute the majority of veterans and the majority of veteran suicides, the VHA has more comprehensive and integrated mental health care services than are commonly found in community-based care.*^{1,4} The VHA provides comprehensive, integrated mental health evaluation and treatment services across the continuum of geriatric care, including geriatric primary care; home-based primary care; and nursing home, hospice, and palliative care.²⁸⁻³⁰ For older adults, a population that is more prone to seek behavioral/mental health services if combined with their medical care, these integrated services optimize access to mental health care when needed and facilitate holistic, interdisciplinary care.³¹⁻³⁵ Although interest in integrated care is growing in the private sector, it is still not the norm.

VHA providers proactively screen veterans for PTSD, alcohol misuse, depression, military sexual trauma (MST), and traumatic brain injury. When problems are identified, primary care providers are able to deliver a warm hand-off to mental health team members for further evaluation and intervention as needed. Such integration of services, required by VHA policy since 2008, appears related to increased detec-

tion and treatment of mental illness among older veterans.³⁶ Referred older veterans have shown significant reduction in depressive symptoms with antidepressant medication treatment.³⁷ Veterans with chronic obstructive pulmonary disease receiving brief cognitive behavioral psychotherapy in primary care clinics had decreased symptoms of depression and anxiety maintained at 12 months.³⁸

As the Commission on Care Final Report recognized, "Veterans who receive health care exclusively through VA generally receive well-coordinated care, yet care is often highly fragmented among those combining VHA care with care secured through private health plans, Medicare, and TRICARE. This fragmentation often results in lower quality, threatens patient safety, and shifts cost among payers."³⁹

FACT: *VHA's comprehensive and integrated health care response to MST exceeds what is available in the community.* When screened by a VHA provider, 1 in 4 women veterans and 1 in 100 men report that they experienced MST.⁴⁰ Because most veterans are men, they constitute almost 40% of all MST survivors seen in VHA. Military sexual trauma is associated with a wide range of mental and physical health conditions as well as lasting impairment in occupational and life functioning.⁴¹⁻⁴³ Those who experience MST have been shown to be at increased risk of death by suicide even when data were adjusted to account for age, mental health diagnosis, and other risk factors.⁴⁴

Given that many survivors never talk about their MST experience unless asked directly, the VHA's routine screening, culturally competent sensitivity, and unflagging efforts to engage veterans are crucial ways to proactively reach survivors who might not otherwise seek care. Each VHA facility has a dedicated MST coordinator, mandatory MST training for all primary and mental health care providers, free MST-related treatment, and MST outreach efforts. All veterans enrolled in the VHA are screened for experiences of MST, and tailored treatment plans are created for survivors who need care. More than 1 million outpatient MST-related mental health visits were provided to veterans with a positive MST screen in fiscal year (FY) 2015, a 13% increase from the prior year.¹⁵ Widespread screen-

ing and treatment programs do not exist in the community-based care, where mental health care providers are less likely to have relevant experience or recognize that it is important to ask veterans about MST.

The DoD recently indicated that lesbian, gay, bisexual, transgender (LGBT) service members experience disproportionately higher rates of MST, reporting sexual assault 5 times and harassment 3 times as often as non-LGBT service members.⁴⁵ Civilian research consistently identifies LGBT individuals as being at greater risk for suicide.⁴⁶ Although exact rates of LGBT veteran suicides are unknown, one study found that 47% of lesbian, gay, and bisexual veterans reported lifetime suicidal ideation compared with that of 22% of heterosexual veterans.⁴⁷ Each VHA facility has a dedicated LGBT care coordinator who works closely with the MST coordinator and mental health treatment teams to ensure timely referrals to appropriate care. Comparable care coordination does not exist in the community, where providers also are less likely to have relevant experience and training to address veteran-specific correlates of trauma for LGBT individuals.

FACT: *Veterans with serious mental illness (SMI) who use the VHA have greater life expectancy and reduced inpatient days of care.* Veterans with SMI conditions who receive VHA care live much longer on average than their counterparts in the general U.S. population.⁴⁸ Veterans with SMI who drop out of VHA care but then return have significantly lower rates of mortality than that of veterans who do not return.⁴⁹ Building on this success, the VHA implemented the SMI Re-Engage Program, an outreach to veterans with SMI who have not been seen in any VHA for at least 1 year, and are thus at an elevated risk for premature death. Since implementation began in March 2012, 24% returned to VHA care within 4 months.¹⁵

In the VHA's Intensive Community Mental Health Recovery (ICMHR) program, mental health staff visit veterans with SMI at least weekly to provide recovery-oriented interventions, typically in the veteran's place of residence, which ensures more routine follow-up and alleviates the burden of having to go to a medical facility. In fiscal year 2016, veterans enrolled in

ICMHR services had an average of 12 to 27 fewer hospital days after admission to the program.¹⁵

FACT: *The evidence-based interdisciplinary VHA approach to pain management rarely exists in the private sector.* About 50% of veterans treated in primary care report at least 1 chronic pain complaint, disproportionately higher than that of American nonveterans.⁵⁰ Recent CDC and VA/DoD guidelines specifically recommend the use of cognitive behavioral psychotherapy, exercise therapy, and nonopioid medications as first-line treatments for chronic pain.⁵¹ Instead of routinely sending veterans with chronic pain to specialists, the VHA uses a stepped-care model in which patients receive biopsychosocial chronic pain care first within VHA primary care. These interdisciplinary clinics collocate and integrate primary care providers, psychologists, pharmacists and/or physical therapists to provide multimodal chronic pain care.

Preliminary results show decreases in pain, opioid risk, and opioid use as well as improved provider perception of pain care delivered in primary care.^{52,53} For those veterans who require a higher level of care, the VHA has mandated the creation of tertiary pain programs, based on well-established models of more intensive, comprehensive treatment shown to be effective in the treatment of chronic pain.⁵⁴

Although interdisciplinary pain management continues to grow in the VHA, it is very rare in the U.S. private sector where health care tends to be fragmented and truncated. The VHA accounts for 40% of the U.S. interdisciplinary pain programs even though it serves 8% of the adult population.⁵⁵ The importance of effective pain management, including behavioral interventions, is further highlighted by the fact that pain is the most commonly identified risk factor in VHA users whose suicides are reported to central office.⁵⁶

MYTH: *Most veterans prefer a new care system that redirects funds from the VHA to VCP.*

FACT: *Veterans overwhelmingly want the VHA to be preserved and strengthened.*⁵⁷ Veterans like the VCP when it is presented as an add-on benefit. But when veterans are surveyed about possible changes like those

in the proposals that drain money out of the VHA, they voice near unanimous opposition. The 2017 Veterans of Foreign Wars survey of 10,800 veterans found that 92% wanted the current VHA system to be improved, not dismantled. Only 5% wanted a new system of giving veterans free access to Choice care that bypasses the VHA.⁵⁷

Anecdotal instances do arise where veterans express discontent about VA mental health services. That is no surprise in a large pool of millions of patients. One example was a 2016 VA Center for Innovation report, quoted during the October 2017 Congressional hearing, which asked about 40 veterans and 5 family members for their criticisms.⁵⁸ Using an unrepresentative sampling method, the report found that some of the veterans desired more privacy and easier access to mental health care. The report also noted that the VA's 300 Vet Centers and 80 mobile Vet Centers would provide such quick, confidential access, but many veterans did not know about that resource.

CONCLUSION

As VA Secretary David J. Shulkin, MD, has underscored, preventing suicide among all our nation's veterans, is a sacred VA responsibility. The VHA must identify areas for improvement and mitigate obstacles that impede veterans receiving quality mental health care. When prompt access to VHA mental health care for enrolled veterans isn't feasible, the VHA should continue to purchase services from VCP providers. For all veterans, their families, and non-VA professionals, the VHA should continue to share its educational and clinical expertise (as it has successfully done in efforts such as the Be There Campaign, VA Community Provider Toolkit, VA Campus Toolkit, PTSD Consultation Program and Suicide Risk Management Consultation Program.)

Nevertheless, in crafting policies, it is essential to ensure that there is no collateral damage to the overall superior quality, unique advantages, and cost-effectiveness of VHA mental health care. The guiding principle for all health care systems and providers, "first, do no harm," must be heeded.

The VCP is intended to supplement not

supplant the VHA, but the recent proposals would do the opposite. Furnishing vouchers to veterans that bypass VA preauthorization will weaken veterans' mental health care and suicide prevention efforts. It sets in motion a gradual, persistent hollowing out of VHA care. In zero-sum budgets, VHA facilities will receive less money, vacant positions will not be filled, and mental health services will be cut. As the availability of VHA services diminishes, many veterans will be placed into VCP, leading to a vicious cycle of further VHA cuts. In the name of freedom of choice, veterans, especially the most vulnerable who depend on the VHA, will ultimately have fewer quality choices.

The stand-alone mental health clinic model runs completely counter to the VHA's best practice interprofessional and integrated care approach. Veterans have more complex comorbidities and need greater, not less, integration of mental health services across the continuum, including primary care, specialty care, and geriatric/extended care programs.⁵⁹

Implementing unrestrained choice, even as a pilot for newly transitioning service members or other groups of veterans, would be the initial step on a slippery slope to vouchers for the entire VHA system. Once mental health services are privatized, the remainder of VHA services, whose overall quality also has been determined to be equal or better than that delivered in the community, would follow in quick succession.¹¹ In January 2018, the National Academies of Science, Engineering and Medicine published an exhaustive evaluation of VHA mental health care and hailed it as the preeminent system that is "positioned to inform and influence how mental health care services are provided more broadly in the United States."⁶⁰ It was decisive confirmation that, first and foremost, we must guarantee that VHA mental health care is fully funded and staffed and remains the coordinator and authorizer of care.

Acknowledgments

The considerations offered in this article are those of the author. The Association of VA Psychologist Leaders provided substantial help for the manuscript as well as for a prior white paper. Special thanks for factual assistance go to Heather Kelly, PhD, and the American Psychological Association; Suzanne Gordon; Ben Emmert-Aronson, PhD; Jennifer Boyd, PhD; Kaela Joseph, PhD; Tracey Smith, PhD; Jen Manuel, PhD; Brian Borsari, PhD; Jan Bowman, PhD; Gareth Loy, PhD; Karen Seal, MD; Ron Girona, PhD;

Sarah Palyo, PhD; Victoria Lemle Beckner, PhD, Joel Schmidt, PhD, Terri Huh, PhD, and Thomas Horvath, MD.

Author disclosures

The author reports no actual or potential conflicts of interest with regard to this article.

Disclaimer

The opinions expressed herein are those of the author and do not necessarily reflect those of *Federal Practitioner*, Frontline Medical Communications Inc., the U.S. Government, or any of its agencies.

About this column

The Mental Health Care Practice column is edited and occasionally authored by COL (Ret) Elspeth Ritchie, MD, MPH. Proposals for articles are encouraged and can be sent to elspethcameronritchie@gmail.com

References

1. U.S. Department of Veterans Affairs, Office of Suicide Prevention. Suicide among veterans and other Americans, 2001-2014. <https://www.mentalhealth.va.gov/docs/2016suicidedatareport.pdf>. Updated August 2017. Accessed February 6, 2018.
2. Provision of Mental Health Care to Veterans by Certain Mental Health Providers Participating in the Veterans Choice Program, 115th Cong, 1st Sess (2017). <http://docs.house.gov/meetings/VR/VR00/20171024/106521/BILLS-1152pih-DRAFTtodirectVAtofurnishMHcareto veterans atcommunityornon-profitMHprovidersparticipatinginChoice.pdf>. Accessed February 5, 2018.
3. Caring for Our Veterans Act of 2017, S 2193, 115th Cong, 1st Sess (2017).
4. Farmer CM, Hosek SD, Adamson DM; RAND Corporation. Balancing demand and supply for veterans' health care: a summary of three RAND assessments conducted under the Veterans Choice Act. 2016. https://www.rand.org/pubs/research_reports/RR1165z4.html. Published February 2016. Accessed February 5, 2018.
5. Suicide Prevention Resource Center, SPAN USA; Litts D, ed. Charting the future of suicide prevention: a 2010 progress review of the national strategy and recommendations for the decade ahead. http://www.sprc.org/sites/default/files/migrate/library/ChartingTheFuture_Fullbook.pdf. Published August 2010. Accessed February 5, 2018.
6. Bagalman E; Congressional Research Service. Health care for veterans: suicide prevention. <https://fas.org/sgp/crs/misc/R42340.pdf>. Published February 23, 2016. Accessed January 5, 2018.
7. McCarthy JF, Bossarte RM, Katz IR, et al. Predictive modeling and concentration of the risk of suicide: implications for preventive interventions in the US Department of Veterans Affairs. *Am J Public Health*. 2015;105(9):1935-1942.
8. Kaplan MS, McFarland BH, Hugueta N, Valenstein M. Suicide risk and precipitating circumstances among young, middle-aged, and older male veterans. *Am J Public Health*. 2012;102(suppl 1):S131-S137.
9. Louzon SA, Bossarte R, McCarthy JF, Katz IR. Does suicidal ideation as measured by the PHQ-9 predict suicide among VA patients? *Psychiatr Serv*. 2016;67(5):517-522.
10. Mills PD, Watts BV, Huh TJ, Boar S, Kemp J. Helping elderly patients to avoid suicide: a review of case reports from a national veterans affairs database. *J Nerv Ment Dis*. 2013;201(1):12-16.
11. Smith EG, Kim HM, Ganoczy D, Stano C, Pfeiffer PN, Valenstein M. Suicide risk assessment received prior to suicide death by Veterans Health Administration patients with a history of depression. *J Clin Psychiatry*. 2013;74(3):226-232.
12. Blais RK, Tsai J, Southwick SM, Pietrzak RH. Barriers

- and facilitators related to mental health care use among older veterans in the United States. *Psychiatr Serv*. 2015;66(5):500-506.
13. Gonçalves DC, Coelho CM, Byrne GJ. The use of healthcare services for mental health problems by middle-aged and older adults. *Arch Gerontol Geriatr*. 2014;59(2):393-397.
14. Gasper J, Jiu H, Kim S, May L. 2015 survey of veteran enrollees' health and use of health care. https://va.gov/HEALTHPOLICYPLANNING/SoE2015/2015_VHA_SoE_Full_Findings_Report.pdf. Published December 11, 2015. Accessed February 5, 2019.
15. U.S. Department of Veterans Affairs. VA's unparalleled integrated mental health services. <https://www.scribd.com/document/356011769/U-S-Department-of-Veterans-Affairs-mental-health-fact-sheet>. Published May 2017. Accessed January 26, 2018.
16. Karlin BE, Ruzek JI, Chard KM, et al. Dissemination of evidence-based psychological treatments for posttraumatic stress disorder in the Veterans Health Administration. *J Trauma Stress*. 2010;23(6):663-673.
17. Eftekhari A, Ruzek JI, Crowley JJ, Rosen CS, Greenbaum MA, Karlin BE. Effectiveness of national implementation of prolonged exposure therapy in Veterans Affairs care. *JAMA Psychiatry*. 2013;70(9):949-955.
18. Chard KM, Ricksecker EG, Healy ET, Karlin BE, Resick PA. Dissemination and experience with cognitive processing therapy. *J Rehabil Res Dev*. 2012;49(5):667-678.
19. Karlin BE, Walser RD, Yesavage J, Zhang A, Trockel M, Taylor CB. Effectiveness of acceptance and commitment therapy for depression: comparison among older and younger veterans. *Aging Ment Health*. 2013;17(5):555-563.
20. Karlin BE, Trockel M, Brown GK, Gordienko M, Yesavage J, Taylor CB. Comparison of the effectiveness of cognitive behavioral therapy for depression among older versus younger veterans: results of a national evaluation. *J Gerontol B Psychol Sci Soc Sci*. 2015;70(1):3-12.
21. Stewart MO, Raffa SD, Steele JL, et al. National dissemination of interpersonal psychotherapy for depression in veterans: therapist and patient-level outcomes. *J Consult Clin Psychol*. 2014;82(6):1201-1206.
22. Walser RD, Karlin BE, Trockel M, Mazina B, Barr Taylor C. Training in and implementation of Acceptance and Commitment Therapy for depression in the Veterans Health Administration: therapist and patient outcomes. *Behav Res Ther*. 2013;51(9):555-563.
23. Tanielian T, Farris C, Batka C, et al; Rand Corporation. Ready to serve: community-based provider capacity to deliver culturally competent, quality mental health care to veterans and their families. https://www.rand.org/pubs/research_reports/RR806.html. Published November 2014. Accessed February 5, 2018.
24. Finley EP, Noël PH, Lee S, et al. Psychotherapy practices for veterans with PTSD among community-based providers in Texas. *Psychol Serv*. 2017. [Epub ahead of print.]
25. Watkins KE, Smith B, Akincigil A, et al. The quality of medication treatment for mental disorders in the Department of Veterans Affairs and in private-sector plans. *Psychiatr Serv*. 2015;67(4):391-396.
26. Barry CN, Bowe TR, Suneja A. An update on the quality of medication treatment for mental disorders in the VA. *Psychiatr Serv*. 2016;67(8):930.
27. Mechanic D. More people than ever before are receiving behavioral health care in the United States, but gaps and challenges remain. *Health Aff (Millwood)*. 2014;33(8):1416-1424.
28. Karlin B, Zeiss AM. Transforming mental health care for older veterans in the Veterans Health Administration. *Generations*. 2010;34(2):74-83.
29. Karlin BE, Karel MJ. National integration of mental health providers in VA home-based primary care: an innovative model for mental health care delivery with older adults. *Gerontologist*. 2014;54(5):868-879.

30. Kearney LK, Post EP, Pomerantz AS, Zeiss AM. Applying the interprofessional patient aligned care team in the Department of Veterans Affairs: transforming primary care. *Am Psychol*. 2014;69(4):399-408.
31. DiNapoli EA, Cully JA, Wayde E, Sansgiry S, Yu HJ, Kunik ME. Age as a predictive factor of mental health service use among adults with depression and/or anxiety disorder receiving care through the Veterans Health Administration. *Int J Geriatr Psychiatry*. 2016;31(6):575-582.
32. Shepardson RL, Funderburk JS. Likelihood of attending treatment for anxiety among veteran primary care patients: patient preferences for treatment attributes. *J Clin Psychol Med Settings*. 2016;23(3):225-239.
33. Johnson-Lawrence VD, Szymanski BR, Zivin K, McCarthy JF, Valenstein M, Pfeiffer PN. Primary care-mental health integration programs in the Veterans Affairs health system serve a different patient population than specialty mental health clinics. *Prim Care Companion CNS Disord*. 2012;14(3):pii.
34. Mackenzie CS, Gekoski WL, Knox VJ. Age, gender, and the underutilization of mental health services: the influence of help-seeking attitudes. *Aging Ment Health*. 2006;10(6):574-582.
35. Bartels SJ, Coakley EH, Zubritsky C, et al; PRISM-E Investigators. Improving access to geriatric mental health services: a randomized trial comparing treatment engagement with integrated versus enhanced referral care for depression, anxiety, and at-risk alcohol use. *Am J Psychiatry*. 2004;161(8):1455-1462.
36. Wiechers IR, Karel MJ, Hoff R, Karlin BE. Growing use of mental and general health care services among older veterans with mental illness. *Psychiatr Serv*. 2015;66(11):1242-1244.
37. Mavandadi S, Klaus JR, Oslin DW. Age group differences among veterans enrolled in a clinical service for behavioral health issues in primary care. *Am J Geriatr Psychiatry*. 2012;20(3):205-214.
38. Cully JA, Stanley MA, Petersen NJ, et al. Delivery of brief cognitive behavioral therapy for medically ill patients in primary care: a pragmatic randomized clinical trial. *J Gen Intern Med*. 2017;32(9):1014-1024.
39. Commission on Care. Commission on care: final report. https://s3.amazonaws.com/sitesusa/wp-content/uploads/sites/912/2016/07/Commission-on-Care_Final-Report_063016_FOR-WEB.pdf. Published June 30, 2016. Accessed February 5, 2018.
40. U.S. Department of Veterans Affairs, Military Sexual Trauma Support Team. Military sexual trauma. https://www.mentalhealth.va.gov/docs/mst_general_factsheet.pdf. Published May 2015. Accessed February 13, 2018.
41. Kimerling R, Gima K, Smith MW, Street A, Frayne S. The Veterans Health Administration and military sexual trauma. *Am J Public Health*. 2007;97(12):2160-2166.
42. Schry AR, Hibberd R, Wagner HR, et al; Veterans Affairs Mid-Atlantic Medical Research Education and Clinical Center Workgroup, Brancu M. Functional correlates of military sexual assault in male veterans. *Psychol Serv*. 2015;12(4):384-393.
43. Millegan J, Milburn EK, LeardMann CA, et al. Recent sexual trauma and adverse health and occupational outcomes among U.S. service women. *J Trauma Stress*. 2015;28(4):298-306.
44. Kimerling R, Makin-Byrd K, Louzon S, Ignacio RV, McCarthy JF. Military sexual trauma and suicide mortality. *Am J Prev Med*. 2016;50(6):684-691.
45. U.S. Department of Defense. *Department of Defense Fiscal Year 2016 Annual Report on Sexual Assault in the Military*. Washington DC: U.S. Office of the Under Secretary of Defense; 2017.
46. Haas AP, Eliason M, Mays VM, et al. Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations. *J Homosex*. 2011;58(1):10-51.
47. Blossnich JR, Mays VM, Cochran SD. Suicidality among veterans: implications of sexual minority status. *Am J Public Health*. 2014;104(suppl 4):S535-S537.
48. Kilbourne AM, Ignacio RV, Kim HM, Blow FC. Datapoints: are VA patients with serious mental illness dying younger? *Psychiatr Serv*. 2009;60(5):589.
49. Davis CL, Kilbourne AM, Blow FC, et al. Reduced mortality among Department of Veterans Affairs patients with schizophrenia or bipolar disorder lost to follow-up and engaged in active outreach to return for care. *Am J Public Health*. 2012;102(suppl 1):S74-S79.
50. Kerns RD, Otis J, Rosenberg R, Reid MC. Veterans' reports of pain and associations with ratings of health, health-risk behaviors, affective distress, and use of the healthcare system. *J Rehabil Res Dev*. 2003;40(5):371-379.
51. Dowell D, Haegerich TM, Chou R. CDC Guideline for prescribing opioids for chronic pain — United States, 2016. *MMWR Recomm Rep*. 2016;65(11):1-49.
52. Seal K, Becker W, Tighe J, Li Y, Rife T. Managing chronic pain in primary care: it really does take a village. *J Gen Intern Med*. 2017;32(8):931-934.
53. Dorflinger LM, Ruser C, Sellinger J, Edens EL, Kerns RD, Becker WC. Integrating interdisciplinary pain management into primary care: development and implementation of a novel clinical program. *Pain Med*. 2014;15(12):2046-2054.
54. Gatchel RJ, Okifuji A. Evidence-based scientific data documenting the treatment and cost-effectiveness of comprehensive pain programs for chronic nonmalignant pain. *J Pain*. 2006;7(11):779-793.
55. Schatman ME. Interdisciplinary chronic pain management: international perspectives. *Pain Clin Updates*. 2012;20(7):1-5.
56. U.S. Department of Veterans Affairs. The US Department of Veterans Affairs Behavioral Health Autopsy Program (BHAP) Report, December 1, 2012-June 30, 2015. <https://catalog.data.gov/dataset/behavioral-health-autopsy-program-bhap>. Accessed November 3, 2017.
57. Veterans of Foreign Wars. Our care 2017: a report evaluating veterans health care. March 2017. <https://vfw-cdn.azureedge.net/-/media/VFWSite/Files/Advocacy/VFW-Our-Care-2017--Executive-Summary.pdf>. Published March 2017. Accessed February 6, 2018.
58. U.S. Department of Veterans Affairs, VA Center for Innovation and the Public Policy Lab. Veteran access to mental health services. <https://www.innovation.va.gov/docs/VeteranAccessToMentalHealthServices.pdf>. Published 2016. Accessed February 6, 2017.
59. Kramarow EA, Pastor PN. The health of male veterans and nonveterans aged 25-64: United States, 2007-2010. *NCHS Data Brief*. 2012;(101):1-8.
60. National Academies of Sciences, Engineering, and Medicine. *Evaluation of the Department of Veterans Affairs Mental Health Services*. Washington D.C.: The National Academies Press; 2018.