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110TH CONGRESS
2d Session

SENATE

REPORT
110–281

VETERANS MENTAL HEALTH IMPROVEMENTS ACT OF 2007

APRIL 8, 2008.—Ordered to be printed

Mr. AKAKA, from the Committee on Veterans' Affairs, submitted the following

R E P O R T

[To accompany S. 2162]

The Committee on Veterans' Affairs (hereinafter, "the Committee"), to which was referred the bill (S. 2162), to improve the treatment and services provided by the Department of Veterans Affairs to veterans with post-traumatic stress disorder and substance use disorders, and for other purposes, having considered the same, reports favorably thereon with an amendment, and recommends that the bill (as amended) do pass.

INTRODUCTION

On April 25, 2007, the Committee held an oversight hearing on mental health issues. Testimony was offered by: Tony Bailey, father of Justin Bailey, accompanied by Mary Kaye Bailey; Randall Omvig, father of Joshua Omvig, accompanied by Ellen Omvig; Patrick Campbell, Congressional Liaison, Iraq and Afghanistan Veterans of America; Connie L. Best, PhD, Senior Faculty Member, National Crime Victims Research and Treatment Center, Medical University of South Carolina; David Oslin, MD, Director, VISN 4 Mental Illness Research Education and Clinical Center, Department of Veterans Affairs; Jan Kemp, RN, PhD, Associate Director for Education, VISN 19 Mental Illness Research Education and Clinical Center, Department of Veterans Affairs; Patricia Resick, PhD, Director, Women's Division, National Center for Post Traumatic Stress Disorder, Department of Veterans Affairs, accompanied by Ira Katz, MD, PhD, Deputy Chief Patient Care Services Officer for Mental Health, Department of Veterans Affairs; and

Ralph Ibson, Vice President for Government Relations, Mental Health America.

On May 23, 2007, the Committee held a hearing on pending veterans' health legislation at which testimony was offered by: Gerald M. Cross, MD, FAAFP, Acting Principal Deputy Under Secretary for Health, Department of Veterans Affairs; Carl Blake, National Legislative Director, Paralyzed Veterans of America; Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars of the United States; Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans; Shannon Middleton, Deputy Director for Health, Veterans Affairs and Rehabilitation Commission, The American Legion; Bernard Edelman, Deputy Director for Policy and Government Affairs, Vietnam Veterans of America; Jerry Reed, Executive Director, Suicide Prevention Action Network USA (SPAN USA); John Booss, MD, American Academy of Neurology; and Meredith Beck, National Policy Director, Wounded Warrior Project.

On October 15, 2007, following these two hearings, Chairman Akaka introduced S. 2162, the proposed "Veterans Mental Health Improvements Act of 2007." S. 2162, as introduced, would establish peer outreach and peer support for veterans of Operation Enduring Freedom and Operation Iraqi Freedom, ensure adequate substance use disorder treatments in VA facilities, expand research on comorbid post-traumatic stress disorder and substance use disorders, and expand services for veterans' families. S. 2162 is cosponsored by the Committee's Ranking Member Senator Burr, and Senators Ensign, and Mikulski.

On October 24, 2007, the Committee held a hearing on pending veterans' health legislation, including S. 2162, at which testimony was offered by, among others: the Honorable Michael J. Kussman, MD, MS, MACP, Under Secretary for Health, Department of Veterans Affairs, accompanied by Walter Hall, Assistant General Counsel, Department of Veterans Affairs; Carl Blake, National Legislative Director, Paralyzed Veterans of America; Joy J. Ilem, Assistant National Legislative Director, Disabled Veterans of America; Brenda Murdough, MSN, RN-C, Military/Veterans Initiative Coordinator, American Pain Foundation; and Capt. Constance Walker, USN (Ret.), President, Southern Maryland Chapter of the National Alliance on Mental Illness.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on November 14, 2007, to consider, among other legislation, S. 2162. The Committee voted unanimously to report favorably S. 2162 with an amendment in the nature of a substitute.

SUMMARY OF S. 2162 AS REPORTED

S. 2162, as reported, (hereinafter, "the Committee bill") would make numerous enhancements and expansions to VA mental health care and services.

TITLE I—SUBSTANCE USE DISORDER AND MENTAL HEALTH CARE

Section 101 would express the sense of Congress on substance use disorders (SUD) and mental health.

Section 102 would require that a minimum set of services and treatments for SUD be available to all veterans enrolled in the VA health care system who need such services.

Section 103 would require that veterans receiving care for SUD and a comorbid mental health disorder from VA receive such care concurrently from professionals with appropriate expertise.

Section 104 would establish national centers of excellence on post-traumatic stress disorder (PTSD) and SUD.

Section 105 would require the Secretary to carry out a review of all VA residential mental health care facilities and report to Congress on the results of that review.

Section 106 provides that title I is a tribute to Justin Bailey, a veteran of the Iraq war, who died in a VA domiciliary.

TITLE II—MENTAL HEALTH ACCESSIBILITY ENHANCEMENTS

Section 201 would establish a pilot program of peer outreach and support, and on the use of community mental health centers, the Indian Health Service and other entities to provide mental health services in rural areas.

TITLE III—RESEARCH

Section 301 would establish a research program on comorbid PTSD and SUD.

Section 302 would extend the authorization for the Special Committee on Post-Traumatic Stress Disorder.

TITLE IV—ASSISTANCE FOR FAMILIES OF VETERANS

Section 401 would clarify and expand the authority of the Secretary of Veterans Affairs to provide mental health services to families of veterans.

Section 402 would establish a pilot program for the provision of readjustment and transition assistance to veterans and their families in cooperation with Readjustment Counseling Centers.

BACKGROUND AND DISCUSSION

S. 2162 would establish peer outreach and peer support for veterans of Operation Enduring Freedom and Operation Iraqi Freedom, ensure adequate substance use disorder treatments in VA facilities, expand research on comorbid post-traumatic stress disorder and substance use disorders, and expand services for veterans' families.

In testimony before the Committee on October 24, 2007, Carl Blake, National Legislative Director, Paralyzed Veterans of America (PVA), and Joy J. Ilem, Assistant National Legislative Director, Disabled Veterans of America (DAV), indicated that the organizations which they represent support the bill in its entirety. S. 2162 is also supported by the American Federation of Government Employees. In testimony before the Committee on October 24, 2007, Michael J. Kussman, Under Secretary for Health of the Department of Veterans Affairs, submitted the views of the Administra-

tion on S. 2162. VA had concerns about certain provisions of the bill as introduced, and the reported version of the bill, as amended, addresses a number of those concerns.

TITLE I—SUBSTANCE USE DISORDERS AND MENTAL HEALTH CARE

Section 101 of the Committee bill would express the sense of Congress on substance use disorders, mental health, and on VA's capability and capacity to treat these conditions.

The dangers and costs of SUD can hardly be overstated. In the words of Dr. David Oslin, Director of VISN 4 Mental Illness Research Education and Clinical Center, from testimony before the Committee on April 25, 2007, "Alcohol misuse creates more financial burden to our society than any other health behavior, including smoking and obesity. Addiction is also a deadly disease. The toll on families, friends, and coworkers is incalculable." Other witnesses at that hearing presented personal stories of struggles with SUD, PTSD, and readjustment to civilian life after deployment abroad.

While VA provides exemplary treatment for substance-related disorders at some facilities, access to quality comprehensive care is inconsistent. In general, VA's capacity to treat veterans with SUD has not kept pace with the needs of the veteran population. Testimony at the Committee hearings on April 25 and October 24, 2007, spoke to this issue.

The findings in this section of the Committee bill are derived from the 2005 Department of Defense "Survey of Health Related Behaviors Among Active Duty Personnel," the December 2006 GAO report entitled "Spending for Mental Health Strategic Plan Was Substantially Less than Planned," and consultation with VA and veterans' community experts.

The findings provide information on a number of the issues addressed by this legislation. In particular, the findings point out that while the Veterans Health Administration has significantly increased health services for veterans from 1996 through 2006, the number of veterans receiving specialized substance abuse treatment services decreased 18 percent during that time. No comparable decrease in the national rate of substance abuse has been observed during that time. Furthermore, according to the Government Accountability Office, the Department of Veterans Affairs significantly reduced its substance use disorder treatment and rehabilitation services between 1996 and 2006, and has made little progress since in restoring these services to their pre-1996 levels.

Section 102 of the Committee bill would require that a minimum level of services and treatments be available to each veteran enrolled in VA health care who is in need of treatment or services for SUD. The services required are derived from VA's Clinical Practice Guidelines for Substance Use Disorders, a 1999 NIH publication entitled "Principles of Drug Addiction Treatment," and from consultation with SUD experts.

As discussed above, under section 101, VA has the capability to offer exemplary SUD treatment, but these services are not consistently available throughout the system. Dr. Oslin testified before the Committee on April 25, 2007, that "[t]here is a clear evidence base that this type of broad-based public health initiative can identify veterans earlier in the addiction process and prevent substantial burden in the future." Some Veteran's Integrated Service Net-

works already provide comprehensive services, and this should be the norm throughout the VA system.

As set forth in section 102(b) of the Committee bill, the services and treatments set forth in section 102(a) may be provided in a VA facility, or by contract or fee-basis payments with community based organizations.

It is the Committee's view that VA has not moved quickly enough to take a comprehensive and systemic approach to SUD treatment. As previously mentioned, no consistent level of SUD services exist throughout the system. This section of the Committee bill, in addition to later sections which would expand treatment and research programs, addresses this deficiency.

Section 103 of the Committee bill would require that veterans with a mental health disorder and comorbid SUD be treated concurrently by clinicians with appropriate expertise. SUD is frequently experienced concurrently with other mental and physical disorders, and is strongly associated with PTSD. Treatments addressing these disorders concurrently are more effective, especially when administered by clinicians with experience in both disorders.

In testimony before the Committee on April 25, 2007, Dr. David Oslin stated that the concurrent treatment of PTSD and SUD has dramatically improved outcomes at the Philadelphia VA Medical Center. The Committee believes that this model should be replicated throughout the VA health care system. Studies have found that patients with psychological trauma, including PTSD, are often susceptible to alcohol and drug abuse. According to the National Institute on Drug Abuse, patients subjected to chronic stress, as experienced by those with PTSD, are prone to drug use. Research by Sinha, Fuse, Aubin and O'Malley in Psychopharmacology (2000), and by Brewer et al. in Addiction (1998) further emphasize this point.

Section 104 of the Committee bill would add a new section to title 38, 7330A, entitled "National centers of excellence on post-traumatic stress disorder and substance use disorders," which would require VA to establish six national centers of excellence on PTSD and SUD. The Committee's intent is that veterans diagnosed with both of these disorders receive comprehensive inpatient or residential care from facilities with exceptional therapeutic capabilities. In addition, under new section 7330A, VA would be required to establish a process to refer and aid the transition of veterans from these national centers to programs that provide step down rehabilitation treatment specific to these disorders.

The requirement for national centers of excellence is predicated on the need for geographically dispersed centers with exceptional capabilities to provide inpatient or residential treatment for both PTSD and SUD. It also responds to the trends described in section 101 of the Committee bill. As thousands of servicemembers return from combat with PTSD, many will be at risk for SUD. By quickly intervening, VA may be able to reduce chronic PTSD and SUD among the veteran population.

Section 105 of the Committee bill would require VA to conduct a review of all VA residential mental health care facilities, including domiciliary facilities, and to report on the results of that review. The report would be required to include, among other information, an assessment of the supervision and support provided in

the residential mental health care facilities of VA, the ratio of staff members to patients at each facility, and an assessment of the appropriateness of rules and procedures for the prescription and administration of medications to patients.

The requirements of this section respond to testimony offered at the Committee's April 25, 2007, hearing on mental health care in VA. The testimony of Tony Bailey about the care provided to his son, Justin, described inattentive staff and lax control of medications, among other issues.

Justin Bailey was receiving treatment in a VA domiciliary facility for PTSD, SUD, and a groin injury when he died of an apparent overdose of medications prescribed to him by VA clinicians. Justin's parents, Tony and Mary Kaye Bailey, believe that the lack of appropriate staff supervision and support at the domiciliary, coupled with the facility's disregard for VA rules and procedures for the management of prescription medication, contributed to his death.

The testimony of Justin Bailey's parents, excerpted below, inspired many of the provisions in the proposed legislation.

> I would like to tell you about my son, Justin Bailey, who died on January 26, 2007, at the West LA VA Hospital. He was 27 years old. Justin was seeking treatment for PTSD and drug abuse.
>
> Justin joined the Marine Corps in December 1998, approximately 6 months after graduating from high school. He was in the infantry and was due to separate from the Marines in January 2003, but was involuntarily extended due to the impending war. Justin was with the first wave of troops that arrived in Iraq when the war started in 2003. He fought in Nasarija and returned to Camp Pendleton in June, 2003.
>
> On the night of January 26th I learned that Justin was being taken to the ER at the hospital. He had just received his new prescriptions the day before. And now he had died of an apparent overdose of his prescription drugs.

According to the Baileys, the report that would be required by this section would ensure a full accounting of VA domiciliary facilities and practices, with a goal of helping to avert future tragedies.

TITLE II—MENTAL HEALTH ACCESSIBILITY ENHANCEMENTS

Section 201 of the Committee bill would require VA to carry out a pilot program to assess the feasibility and advisability of providing certain services to veterans of Operation Iraqi Freedom and Operation Enduring Freedom. The first component of the pilot program would provide peer outreach and peer support, and a second component would assess the use of community mental health centers, the Indian Health Service and other entities to provide mental health services in rural areas.

Peer outreach and support, conducted with appropriate training as discussed below, may be effective in connecting veterans with mental health services. Vet Centers and individual VISNs have been especially successful in conducting this type of outreach and support. Given the unprecedented number of National Guard and Reserve forces from rural areas deployed in current conflicts, these outreach and support services may now be more helpful.

The benefits of peer outreach and support need to be assessed. While clinicians provide essential treatments and therapies, they are not expected to provide the social support that peers can offer. The support of a strong social network of peers with similar experiences may complement and augment clinical treatment. A study by Davidson, Chinman, Sells, and Rowe, published in Schizophrenia Bulletin (July, 2006), concluded that "peer support is still early in its development as a form of mental health service provision," and recommends further exploration of this "promising, if yet unproven, practice." A number of medical facilities and VISNs are already conducting this type of outreach and support, and this pilot will build upon existing capabilities.

The training that would be required to be provided to veterans conducting outreach and support under this section is essential. In this program, peers would not be intended to act in a clinical capacity, but would receive basic training in skills necessary for working with veterans with mental health concerns. VA may have the capacity to conduct this training, or may choose to conduct training through a non-Department entity.

During the Committee's hearing on May 23, 2007, Carl Blake, of PVA, discussed successful peer outreach and support conducted by PVA to help veterans recovering from and adjusting to life after catastrophic injuries. It is the view of PVA that the model of veteran peers with common experiences and backgrounds providing non-clinical outreach and support has proven to be effective among this group of disabled veterans. The Committee believes broader use of peer outreach and support should be explored and assessed.

The second component of this pilot program would be the provision of readjustment counseling and mental health services to Operation Enduring Freedom and Operation Iraqi Freedom veterans through community mental health centers, the facilities of the Indian Health Service, and other entities. The Committee recognizes that access to VA mental health services varies significantly across the country. The second part of the pilot program would target rural veteran populations whose needs are not being met. Community mental health centers and the Indian Health Service provide services in many areas where VA does not have facilities. By permitting veterans to receive treatment from these entities, under contract or agreement in the case of community mental health centers or other community providers, or under an existing memorandum of understanding in the case of the Indian Health Service, VA will be better able to meet the needs of rural veterans.

In a number of locations, VA has already partnered with community mental health centers to reach rural populations. This part of the pilot program would build upon previous success.

Capt. Constance Walker, President of the Southern Maryland Chapter of the National Alliance on Mental Illness, testified before the Committee on October 24, 2007, that "[t]he likelihood of obtaining specialized services [for PTSD and serious mental illnesses] on a consistent basis is very small for veterans living in rural and frontier areas beyond a reasonable commute to a VA Medical Center or without access to an appropriately and consistently staffed VA Community Based Outpatient Clinic." The provisions of section 201 of the Committee bill would address this gap.

The Committee believes that this pilot effort will preserve the integrity of the VA health care system while expanding options for veterans who cannot access VA facilities. Joy Ilem, of DAV, testified that non-VA entities are, on occasion, necessary for the provision of care, but that proper training and oversight of those entities is essential. The provisions in this section of the Committee bill would ensure VA has sufficient control and oversight of quality of care and patient privacy, among other requirements. The Committee notes that the American Federation of Government Employees has expressed strong preference for this provision of the Committee bill.

TITLE III—RESEARCH

Section 301 of the Committee bill would require VA to carry out a research program on comorbid PTSD and SUD. This program would be conducted through the National Center for Post Traumatic Stress Disorder. The Committee bill would authorize $2,000,000 for the program in each fiscal year 2008 through 2011 to fund research on PTSD and comorbid SUD.

Research has demonstrated the destructive confluence of these two disorders, but research on treatments has not advanced sufficiently. According to recent research conducted by Dr. Lisa M. Najavits of Harvard Medical School, while there are studies that have directly compared various treatments, including cognitive behavioral therapy, such studies have not yet been conducted in substance abuse samples. The field is still developing its understanding of the complex issues of comorbid mental health and substance use disorders.

A recent Institute of Medicine (IOM) study, entitled "Treatment of Posttraumatic Stress Disorder: An Assessment of the Evidence," describes the current status of research on treatments of PTSD. The study indicates that insufficient high quality and focused research has been conducted to draw conclusions on the efficacy of pharmacotherapies and psychotherapies, with the exception of exposure therapies.

Among other points, IOM recommends that research on treatments for PTSD be more systematic and clearly focused with established definitions and goals. Furthermore, IOM recommends that research focus on specific veteran populations who suffer from PTSD in addition to other disorders, such as SUD. This legislation would place the National Center on PTSD in a position to effectively guide research in this area, and authorizes the necessary funding.

The emphasis in this section of the Committee bill is not without precedent. Section 122 of Public Law 102–405 calls for VA to place a high priority on treatment programs for mental health care, including for PTSD and comorbid SUD. This area of research continues to be a priority.

Section 302 of the Committee bill would modify section 110(e)(2) of the Veterans' Health Care Act of 1984, P.L. 98–528, to extend the reporting requirement for the Special Committee on Post-Traumatic Stress Disorder. Currently, the reporting requirement is set to expire in 2008; this provision would extend it through 2012.

The Special Committee has served an important role in overseeing and guiding the treatment of PTSD within VA, and has be-

come a major resource in and out of government for expertise on PTSD. The Committee believes that it is essential for the Special Committee to continue in operation beyond 2008.

TITLE IV—ASSISTANCE FOR FAMILIES OF VETERANS

Section 401 of the Committee bill would amend section 1701 (5)(B) of title 38 United States Code to clarify the authority of the Secretary of Veterans Affairs to provide mental health services to families of veterans.

The Committee recognizes that a veteran's family or legal guardian often plays a central role in his or her recovery from, or management of, mental health disorders, SUDs, and in the transition to civilian life. In this context, and given the long term trend in VA toward expanding home-based care, this section makes clear VA's authority to offer care to veterans' families, including mental health care, as well as training and other forms of assistance and support.

Through oversight activities and hearings, the Committee has identified marked irregularity in the application of existing authority to offer services to veterans' families. This section would amend existing law to explicitly require that marriage and family counseling be offered to veterans' families.

Testimony received by the Committee during hearings has repeatedly demonstrated the need for greater support for families. For example, at the October 2007 hearing, Capt. Walker testified that "it is impossible to overstate the stressors that rural and frontier family caregivers are bearing on a daily basis as they search for limited treatment and rehabilitative services."

During the Committee's April 25, 2007, hearing, a number of witnesses testified to the importance of education, training, support, and care for families in a veteran's recovery and readjustment process. Two parents, Tony Bailey and Randall Omvig, father of Spc. Joshua Omvig, who committed suicide after returning from Iraq, emphasized the need to help families. Ralph Ibson, of Mental Health America, also testified on the importance of families in helping a veteran readjust, noting that "VA health care, and particularly mental health care, would often be more effective if barriers to family involvement were eliminated." The Committee concurs with this statement.

During the Committee's hearing in May 2007, Dennis M. Cullinan of Veterans of Foreign Wars of the United States, Shannon Middleton of The American Legion, and Jerry Reed of Suicide Prevention Action Network USA testified to the importance of providing a broader range of support and clinical services to families of veterans.

Section 402 of the Committee bill would establish a pilot program to assess the feasibility and advisability of providing additional readjustment and transition assistance to veterans and their families in cooperation with Readjustment Counseling Centers. The pilot would be similar to family assistance programs previously conducted at ten Army facilities around the country. The programs have been effective in helping families prepare for deployments, and adjust to the deployment and return of servicemembers. These programs have helped families strengthen their relationships, resolve disagreements through discussion, balance professional and

family responsibilities, and make better financial decisions. Readjustment assistance geared towards military families has equipped them with tools useful in coping with deployments and the return of servicemembers, especially those who have suffered physical or mental injuries.

The Committee believes that similar programs, tailored to the needs of veterans, may prove helpful to veterans and their families. Targeted assistance in handling the stress of readjusting to civilian life, coping with physical and mental injuries, and maintaining family support may have the potential to preemptively address many of the more serious challenges facing veterans and their families.

COMMITTEE BILL COST ESTIMATE

In compliance with paragraph 11(a) of rule XXVI of the Standing Rules of the Senate, the Committee, based on information supplied by the CBO, estimates that enactment of the Committee bill would, relative to current law, increase discretionary spending by $880,000,000 over the 2008–2013 period, assuming appropriation of the necessary amounts. The Committee bill would not increase direct spending, based on information supplied by the CBO. Enactment of the Committee bill would not affect receipts, and would not affect the budget of state, local or tribal governments.

The cost estimate provided by CBO, setting forth a detailed breakdown of costs, follows:

CONGRESSIONAL BUDGET OFFICE,
Washington, DC, April 7, 2008.

Hon. DANIEL K. AKAKA,
Chairman, Committee on Veterans' Affairs,
U.S. Senate, Washington, DC.

DEAR MR. CHAIRMAN: The Congressional Budget Office has prepared the enclosed cost estimate for S. 2162, the Mental Health Improvements Act of 2007.

If you wish further details on this estimate, we will be pleased to provide them. The CBO staff contact is Sunita D'Monte.

Sincerely,

PETER R. ORSZAG,
Director.

Enclosure.

S. 2162—Mental Health Improvements Act of 2007

Summary: S. 2162 would require the Department of Veterans Affairs (VA) to expand the treatments and services available to veterans suffering from disorders related to post-traumatic stress, substance abuse, and other mental health problems. In total, CBO estimates that implementing S. 2162 would cost about $880 million over the 2008–2013 period, assuming appropriation of the specified and estimated amounts. Enacting the bill would not affect direct spending or revenues.

S. 2162 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act (UMRA); any costs to state, local, or tribal governments would be incurred voluntarily.

Estimated cost to the Federal Government: The estimated budgetary impact of S. 2162 is shown in Table 1. The costs of this legislation fall within budget function 700 (veterans benefits and services).

Basis of estimate: CBO assumes that the legislation will be enacted by the middle of calendar year 2008, that the specified and estimated amounts will be appropriated each year, and that outlays will follow historical spending patterns for the VA medical services program. (Funding for 2008 would have to be provided in a supplemental appropriations act.)

TABLE 1.—ESTIMATED BUDGETARY IMPACT OF S. 2162

	By fiscal year, in millions of dollars—					
	2008	2009	2010	2011	2012	2013
CHANGES IN SPENDING SUBJECT TO APPROPRIATION						
Estimated Authorization Level	42	168	165	170	174	182
Estimated Outlays	36	155	164	168	174	180

Clinician teams

Section 103 would require VA to ensure that veterans being treated for both substance use disorder and another mental health disorder receive treatment by a health professional trained in both disorders, a team of clinicians with the appropriate expertise, or coordinated but separate services for each disorder. According to VA, the average annual cost of its five existing teams for substance use and post-traumatic stress disorders (PTSD) is about $520,000. CBO estimates that establishing similar teams in the remaining 148 medical centers would cost $439 million over the 2008–2013 period, assuming appropriation of the necessary amounts (see Table 2).

Treatment for substance use disorders

Section 102 would require VA to provide certain services and treatments to veterans suffering from substance use disorders, either at VA medical facilities or through contracts at community-based organizations. After adjusting for anticipated inflation, CBO estimates that implementing this provision would cost $378 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

According to VA, some of the services and treatments specified under the bill are already being provided. Most of the costs of this provision stem from providing detoxification and stabilization services, residential care, and intensive outpatient care, which are discussed below. Other services, such as counseling, opiate substitution therapy, other pharmacological treatments, and relapse prevention, would result in additional costs of about $20 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

Detoxification and Stabilization Services. Based on information from VA, CBO estimates that to provide the detoxification and stabilization services specified in the bill, VA would need to hire 153 advanced practice nurses (one at each medical center) at an annual cost of $135,000 each (in 2008 dollars). CBO estimates that implementing this provision would cost $118 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

TABLE 2.—COMPONENTS OF THE ESTIMATED CHANGES IN SPENDING SUBJECT TO APPROPRIATION UNDER S. 2162

	By fiscal year, in millions of dollars—					
	2008	2009	2010	2011	2012	2013
Clinician Teams:						
Estimated Authorization Level	19	80	83	86	90	93
Estimated Outlays	17	73	82	85	89	93
Treatment for Substance Use Disorders:						
Estimated Authorization Level	19	71	70	73	76	79
Estimated Outlays	17	65	70	72	75	79
Centers of Excellence:						
Estimated Authorization Level	1	13	8	8	8	9
Estimated Outlays	1	12	8	8	8	9
Research Program on Comorbid Disorders:						
Authorization Level	2	2	2	2	0	0
Estimated Outlays	*	2	2	2	2	*
Pilot Programs:						
Estimated Authorization Level	1	2	1	*	0	0
Estimated Outlays	*	2	1	1	*	0
Report on Residential Facilities:						
Estimated Authorization Level	0	1	1	0	0	0
Estimated Outlays	0	1	1	*	*	0
Total Changes:						
Estimated Authorization Level	42	168	165	170	174	182
Estimated Outlays	36	155	164	168	174	180

Notes: Components may not sum to totals because of rounding.
* = less than $500,000.

Residential Care. Based on information from VA, CBO estimates that to provide residential care under the bill, VA would require an additional 110 beds nationwide at an annual cost of $16 million and have start-up costs of $5 million. CBO estimates that implementing this provision would cost $97 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

Intensive Outpatient Care. According to VA, the intensive outpatient care required under the bill could be provided at both community-based outpatient clinics (CBOCs) and VA medical centers. Based on information from VA, CBO estimates that VA would hire the equivalent of 185 full-time counselors to work in over 1,000 CBOCs. Each counselor would provide group treatment (therapy of three hours a week over three months to 50 patients at a time) to about 200 patients a year, and would be paid an average of $71,500 a year (in 2008 dollars).

Based on information from VA, CBO estimates that establishing similar intensive outpatient care in VA medical centers would require VA to upgrade programs in 50 medical centers by hiring three additional employees at each center, at an average annual cost of $71,500. In addition, CBO estimates that VA would require additional appropriations of $1 million a year to initiate specialty care for substance use disorders at one medical center.

In total, and after adjusting for anticipated inflation, CBO estimates that implementing this provision at CBOCs and medical centers would cost $142 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

Centers of excellence

Section 104 would require VA to establish at least six centers of excellence on PTSD and substance use disorders at its health care facilities. The centers would provide inpatient or residential treat-

ment and recovery services to veterans. Based on information from VA and after adjusting for inflation, CBO estimates that each of the six centers would have 11 employees, annual operating costs of about $1.3 million, and start-up costs of $1 million. CBO estimates that implementing this provision would cost $46 million over the 2008–2013 period, assuming appropriation of the necessary amounts.

Research program on comorbid disorders

Section 301 would authorize the appropriation of $2 million a year over the 2008–2011 period for research into comorbid (i.e., occurring concurrently) substance use disorders and PTSD in veterans. CBO estimates that implementing this provision would cost $8 million over the 2008–2013 period, assuming appropriation of the authorized amounts.

Pilot programs

Two sections of the bill would authorize new pilot programs to provide counseling, outreach, and other services to certain veterans. Based on information from VA, CBO estimates that implementing these pilot programs would cost $5 million over the 2008–2013 period, assuming appropriation of the specified and estimated amounts. Section 201 would require VA to study the feasibility of providing counseling, peer outreach, peer support, and other mental health services to veterans of Operation Iraqi Freedom and Operation Enduring Freedom, including the use of community health centers and the Indian Health Service to reach rural veterans. Section 402 would require VA to assess the feasibility of providing readjustment and transition assistance through private organizations, in collaboration with Vet Centers (community-based centers that provide counseling and outreach services to combat veterans and their families) and would authorize the appropriation of $1 million a year over the 2008–2010 period.

Report on residential facilities

Section 106 would require VA to conduct reviews of all its residential facilities for mental health care and report to the Congress. Based on information from VA, CBO estimates VA would require two employees to review 134 facilities at a cost of $2 million over the 2008–2013 period, assuming the availability of appropriated funds.

Intergovernmental and private-sector impact: S. 2162 contains no intergovernmental or private-sector mandates as defined in UMRA. State, local, and tribal governments that provide counseling and mental health services to veterans would benefit from program activities authorized in the bill. Any costs those governments incur to comply with service agreements would be incurred voluntarily.

Estimate prepared by: Federal Costs: Sunita D'Monte, Impact on State, Local, and Tribal Governments: Lisa Ramirez-Branum, Impact on the Private Sector: Victoria Liu.

Estimate approved by: Peter H. Fontaine, Assistant Director for Budget Analysis.

REGULATORY IMPACT STATEMENT

In compliance with paragraph 11(b) of rule XXVI of the Standing Rules of the Senate, the Committee on Veterans' Affairs has made an evaluation of the regulatory impact that would be incurred in carrying out the Committee bill. The Committee finds that the Committee bill would not entail any regulation of individuals or businesses or result in any impact on the personal privacy of any individuals and that the paperwork resulting from enactment would be minimal.

TABULATION OF VOTES CAST IN COMMITTEE

In compliance with paragraph 7 of rule XXVI of the Standing Rules of the Senate, the following is a tabulation of votes cast in person or by proxy by members of the Committee on Veterans' Affairs at its November 14, 2007 meeting. On that date, the Committee ordered S. 2162, as amended, reported favorably to the Senate by voice vote.

AGENCY REPORT

On October 24, 2007, the Honorable Michael J. Kussman, Under Secretary for Health, Department of Veterans Affairs, appeared before the Committee and submitted testimony on, among other things, an earlier version of S. 2162. Excerpts of this statement are reprinted below:

STATEMENT OF THE VIEWS OF THE ADMINISTRATION

Michael J. Kussman, MD, MS, MACP, Under Secretary for Health for the Department of Veterans Affairs

Good morning Mr. Chairman and Members of the Committee:

Thank you for inviting me here today to present the Administration's views on several bills that would affect Department of Veterans Affairs (VA) programs that provide veterans benefits and services. With me today is Walter A. Hall, Assistant General Counsel. I will address the five bills on today's agenda and then I would be happy to answer any questions you and the Committee members may have.

S. 2162 "MENTAL HEALTH IMPROVEMENTS ACT OF 2007"

Title I. Substance use disorders and mental health care

Mr. Chairman, title I of this bill focuses on VA treatment programs for substance use disorders and mental health disorders, particularly PTSD. Section 102 would require the Secretary to ensure the provision of the following services for substance use disorders at every VA medical center:

- Short term motivational counseling services.
- Intensive outpatient care services.
- Relapse prevention services.
- Ongoing aftercare and outpatient counseling services.
- Opiate substitution therapy services.

• Pharmacological treatments aimed at reducing cravings for drugs and alcohol.
• Detoxification and stabilization services.
• Such other services as the Secretary deems appropriate.

The Secretary could, however, exempt an individual medical center or Community-Based Outpatient Clinic (CBOC) from providing all of the mandated services. Annually the Department would have to report to Congress on the facilities receiving an exemption under this provision, including the reason for the exemption.

Section 103 would require the Secretary to ensure that VA treatment for a veteran's substance use disorder and a co-morbid mental health disorder is provided concurrently by a team of clinicians with appropriate expertise.

Section 104 would require the Secretary to carry out a program to enhance VA's treatment of veterans suffering from substance use disorders and PTSD through facilities that compete for funds for this purpose. Funding awarded to a facility would be used for the six purposes specified in the bill, in addition to the conduct of peer outreach programs through Vet Centers to re-engage OEF/OIF veterans who miss multiple appointments for PTSD or a substance use disorder. Another specified purpose for the funds would be to establish collaboration between VA's urgent care clinicians and substance use disorder and PTSD professionals to ensure expedited referral of veterans who are diagnosed with these disorders.

Not later than one year after the bill's enactment, the Secretary would need to submit a report to Congress on this program and the facilities receiving funding.

S. 2162 would provide for funding by requiring the Secretary to allocate $50 million from appropriated funds available for medical care for each of fiscal years 2008, 2009, and 2010. The bill would require the total expenditure for PTSD and substance use disorder programs to not be less than $50 million in excess of a specified baseline amount. (The bill would define the baseline as the amount of the total expenditures on VA's treatment programs for PTSD and substance use disorders for the most recent fiscal year for which final expenditure amounts are known, as adjusted to reflect any subsequent increase in applicable costs to deliver those programs.)

Section 105 would require the Secretary to establish not less than six national centers of excellence on PTSD and substance use disorders. These centers would provide comprehensive inpatient treatment and recovery services to veterans newly diagnosed with these disorders. Sites for the centers would be limited to VA medical centers that provide inpatient care; that are geographically situated in an area with a high number of veterans that have been diagnosed with both PTSD and substance use disorder; and that are capable of treating PTSD and substance use disorders. This provision would also direct the Secretary to establish a process to refer and aid the transition of vet-

erans receiving treatment in these centers to programs that provide step down rehabilitation treatment.

Section 106 would require the Secretary, acting through the Office of the Medical Inspector (MI), to review all of VA's residential mental health care facilities and to submit to Congress a detailed report on the MI's findings.

Section 107 would provide for title I of this bill to be enacted in tribute to Justin Bailey, an OIF veteran who died while under VA treatment for PTSD and a substance use disorder.

While VA respects the attention this Committee is giving these critical issues, Title I is overly prescriptive and attempts to mandate the type of treatments to be provided to covered veterans, the treatment settings, and the composition of treatment teams. Treatment decisions should be based on professional medical judgments in light of an individual patient's needs, and experienced health care managers are in the best position to decide how best to deliver needed health care services at the local level. With regard to the proposed centers of excellence, we reiterate our concerns about disease-specific treatment centers and models, although we appreciate the Committee's efforts thereby to hasten the eradication of those particular diseases. For all of the above reasons, we do not support this title.

Title II. Mental health accessibility enhancements

Section 201 would require the Secretary to establish a three-year pilot program to assess the feasibility and advisability of providing eligible OEF/OIF veterans with peer outreach services, peer support services, and readjustment counseling services, and other mental health services. This pilot would begin not later than 180 days after the bill's enactment. Eligible veterans would include those who are enrolled in VA's health care system and who, for purposes of the pilot program, receive a referral from a VHA health professional to a community mental health center or to a facility of the Indian Health Service (IHS).

In providing readjustment counseling services and other mental health services to rural veterans who do not have adequate access to VA services, section 201 would require the Secretary, acting through the Office of Rural Health, to contract for those services with community mental health centers (as defined in 42 CFR 410.2) and IHS facilities.

Sites for the pilot would need to include at least two Veterans Integrated Service Networks (selected by the Secretary), and at least two of the sites would have to be located in rural areas that lack access to comprehensive VA mental health services.

A center or IHS facility that participates in the pilot program must, to the extent practicable, provide readjustment counseling services and other mental health services to eligible veterans through the use of telehealth services. It would also need to provide the services using best prac-

tices and technologies and meet any other requirements established by the Secretary. A participating center or IHS facility would also have to comply with applicable VA protocols before incurring any liability on behalf of the Department and provide clinical information on each veteran to whom it furnishes services.

The Secretary would be required to carry out a national program of training for (1) veterans who would provide peer outreach and peer support services under the pilot program; and (2) clinicians of participating centers or IHS facilities to ensure they can furnish covered services and that such services will be provided in a manner that accounts for factors unique to OEF/OIF veterans. This provision would also establish detailed annual reporting requirements for participating centers and facilities.

As we discussed in connection with section 2 of S. 38, all of these services are already available to OEF/OIF veterans, including those who served in the National Guard or the Reserves. As such, no demonstrated need exists for the pilot program or these additional authorities, which are duplicative of currently existing authorities. And VA is already working with other entities to provide treatment to veterans at the local level if VA is not able to provide the needed care; therefore, the requirement to contract specifically with a community health center or IHS facility would limit the local VA providers' flexibility in finding the most appropriate care for our veterans.

Title III. Research

Section 301 would require the Secretary to carry out a program of research into co-morbid PTSD and substance use disorder. The purpose of this program would be to address co-morbid PTSD and substance use disorder; provide systematic integration of treatment for these two disorders; develop protocols to evaluate VA's care of veterans with these disorders; and, facilitate the cumulative clinical progress of these veterans. This provision would charge VA's National Center for PTSD with responsibility for carrying out and overseeing this program, developing the protocols and goals, and coordinating the research, data collection, and data dissemination.

Section 301 would also authorize $2 million to be appropriated for each of fiscal years 2008 through 2011 to carry out this program and specifically require these funds be allocated to the National PTSD Center. The funds made available to the Center would be in addition to any other amounts made available to it under any other provision of law.

Section 302 would continue the Special Committee on PTSD (which is established within VHA) through 2012; otherwise the Committee's mandate would terminate after 2008.

While well-intended, this title is overly prescriptive and more importantly altogether unnecessary. Therefore, with the exception of the extension of the Special Committee,

VA does not support the provisions in title III. VA is a world-recognized leader in the care of both PTSD and substance use disorders, particularly when these conditions co-exist in an individual. The activities required by title III are essentially duplicative of VHA's ongoing efforts in this area, particularly the research efforts being carried out by VA's National PTSD Center. We would welcome the opportunity to brief the Committee on VA's achievements and efforts in this area, plus the role of the Office of Mental Health in overseeing the PTSD and substance abuse programs.

Title IV. Assistance for families of veterans

In connection with the family support services authorized in chapter 17 of title 38, United States Code (i.e., mental health services, consultation, professional counseling, and training), section 401 would amend the statutory definition of "professional counseling" to expressly include marriage and family counseling. This provision would also ease eligibility requirements for these family support services by authorizing the provision of these services when considered appropriate (as opposed to essential) for the effective treatment and rehabilitation of the veteran. Section 401 would further clarify that these services are available to family members in Vet Centers, VA medical centers, CBOCs, or other VA facilities the Secretary considers necessary.

Section 402 would require the Secretary to carry out, through a non-VA entity, a three-year pilot program to assess the feasibility and advisability of providing "readjustment and transition assistance" to veterans and their families in cooperation with Vet Centers. Readjustment and transition assistance would be defined as readjustment and transition assistance that is preemptive, proactive, and principle-centered. It would also include assistance and training for veterans and their families in coping with the challenges associated with making the transition from military to civilian life.

This provision would require services furnished under the pilot program to be furnished by a for-profit or nonprofit organization(s) selected by the Secretary (pursuant to an agreement). To participate in the pilot, a participating organization(s) must have demonstrated expertise and experience in providing those types of services.

The pilot program would have to be carried out in cooperation with 10 geographically distributed Vet Centers, which would be responsible for promoting awareness of the assistance available to veterans and their families through the Vet Centers, the non-VA organization(s) conducting the pilot, and other appropriate mechanisms.

Section 403 would establish detailed reporting requirements and authorize $1 million to be appropriated for each of fiscal years 2008 through 2010 to carry out the pilot program. Such amounts would remain available until expended.

VA does not support title IV. First, it is unclear how these "readjustment and transition assistance" services are intended to differ from, or interact with, the readjustment counseling services and related mental health services already made available to veterans and their families through the Vet Centers. In our view, this provision would conflict in many respects with VA's existing authorities to provide readjustment counseling and related mental health services and lend confusion to what is otherwise a highly successful program (particularly with respect to client outreach). Indeed, client satisfaction with the Vet Centers is the highest of VA's programs (98%). The services they provide already include marriage and counseling services to family members as necessary to further the veteran's readjustment.

We also do not understand the perceived need for reliance on non-VA organizations for the provision of these services. Let me again assure you that our Vet Centers readily contract with appropriate organizations and providers to ensure veterans and their families receive covered family support services. In sum, we do not see how this provision would effectively enhance current authorities or Vet Center activities; rather, we see that it has serious potential to create confusion and disruption for both VA and our beneficiaries.

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CHANGES IN EXISTING LAW MADE BY THE COMMITTEE BILL, AS REPORTED

In compliance with rule XXVI paragraph 12 of the Standing Rules of the Senate, changes in existing law made by the Committee bill, as reported, are shown as follows (existing law proposed to be omitted is enclosed in black brackets, new matter is printed in italic, existing law in which no change is proposed is shown in roman):

TITLE 38. VETERANS' BENEFITS

PART II. GENERAL BENEFITS

CHAPTER 17. HOSPITAL, NURSING HOME, DOMICILIARY, AND MEDICAL CARE

Subchapter I. General

SEC. 1701. DEFINITIONS.

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(5) * * *

(B) such mental health services, consultation, professional counseling, *marriage and family counseling,* and training for the members of the immediate family or legal guardian of a veteran, or the individual in whose household such veteran certifies an intention to live, [as may be essential to] *as the Secretary considers appropriate for* the

effective treatment and rehabilitation of a veteran or dependent or survivor of a veteran receiving care under the last sentence of section 1781(b) of this title and

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Subchapter II. Hospital, Nursing Home, or Domiciliary Care and Medical Treatment

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SEC. 1712A. ELIGIBILITY FOR READJUSTMENT COUNSELING AND RELATED MENTAL HEALTH SERVICES.

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(e)(1) * * *

(2) Not later than May 1 of each year [through 2008] *through 2012,* the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and House of Representatives a report containing information updating the reports submitted under this subsection since the enactment of the Veterans Millennium Health Care and Benefits Act.

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Subchapter VIII. Health Care of Persons other than Veterans

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SEC. 1782. COUNSELING, TRAINING, AND MENTAL HEALTH SERVICES FOR IMMEDIATE FAMILY MEMBERS

(a) Counseling for family members of veterans receiving service-connected treatment. In the case of a veteran who is receiving treatment for a service-connected disability pursuant to paragraph (1) or (2) of section 1710(a) of this title [38 USCS § 1 A1710(a)], the Secretary shall provide to individuals described in subsection (c) such consultation, professional counseling, *marriage and family counseling,* training, and mental health services as are necessary in connection with that treatment.

(b) Counseling for family members of veterans receiving non-service-connected treatment. In the case of a veteran who is eligible to receive treatment for a non-service-connected disability under the conditions described in paragraph (1), (2), or (3) of section 1710(a) of this title [38 USCS § 1 A1710(a)], the Secretary may, in the discretion of the Secretary, provide to individuals described in subsection (c) such consultation, professional counseling, *marriage and family counseling,* training, and mental health services as are necessary in connection with that treatment if—

(1) those services were initiated during the veteran's hospitalization; and

(2) the continued provision of those services on an outpatient basis is essential to permit the discharge of the veteran from the hospital.

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PART V. BOARDS, ADMINISTRATIONS, AND SERVICES

CHAPTER 73. VETERANS HEALTH ADMINISTRATION-ORGANIZATION AND FUNCTIONS

Subchapter II. General Authority and Administration

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Sec.

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7330A. NATIONAL CENTERS OF EXCELLENCE ON POST-TRAUMATIC STRESS DISORDER AND SUBSTANCE USE DISORDERS.

(a) ESTABLISHMENT OF CENTERS.—(1) The Secretary shall establish not less than six national centers of excellence on post-traumatic stress disorder and substance use disorders.

(2) The purpose of the centers established under this section is to serve as Department facilities that provide comprehensive inpatient or residential treatment and recovery services for veterans diagnosed with both post-traumatic stress disorder and a substance use disorder.

(b) LOCATION.—Each center established in accordance with subsection (a) shall be located at a medical center of the Department that—

(1) provides specialized care for veterans with post-traumatic stress disorder and a substance use disorder; and

(2) is geographically situated in an area with a high number of veterans that have been diagnosed with both post-traumatic stress disorder and substance use disorder.

(c) PROCESS OF REFERRAL AND TRANSITION TO STEP DOWN DIAGNOSIS REHABILITATION TREATMENT PROGRAMS.—The Secretary shall establish a process to refer and aid the transition of veterans from the national centers of excellence on post-traumatic stress disorder and substance use disorders established pursuant to subsection (a) to programs that provide step down rehabilitation treatment for individuals with post-traumatic stress disorder and substance use disorders.

(d) COLLABORATION WITH THE NATIONAL CENTER FOR POST-TRAUMATIC STRESS DISORDER.—The centers established under this section shall collaborate in the research of the National Center for Post-Traumatic Stress Disorder.

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