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JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT

JULY 23, 2007.—Ordered to be printed

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

REPORT

[To accompany S. 479]

The Committee on Veterans' Affairs, to which was referred the bill (S. 479), to reduce the incidence of suicide among veterans, having considered the same, reports favorably thereon, and recommends that the bill do pass.

INTRODUCTION

On February 1, 2007, Senator Tom Harkin introduced S. 479, the proposed "Joshua Omvig Veterans Suicide Prevention Act," which is named for an Iowa veteran who committed suicide after returning from Iraq.

On April 25, 2007, the Committee held a hearing on veterans' mental health issues at which Joshua Omvig's father, Randall, appearing with his wife Ellen, spoke in favor of S. 479.

On May 23, 2007, the Committee held a hearing on pending veterans' health legislation at which testimony on S. 479, among other bills, was offered by: Gerald M. Cross, MD, FAAFP, the Department of Veterans Affairs' Acting Principal Deputy Under Secretary for Health; Carl Blake, National Legislative Director, Paralyzed Veterans of America; Dennis M. Cullinan, Director, National Legislative Service, Veterans of Foreign Wars; 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; and Jerry Reed, Executive Director, Suicide Prevention Action Network USA (SPAN USA). All of the witnesses from the veterans' organizations and SPAN USA supported S. 479. The Department of Veterans Affairs did not support the legislation,

59–010

expressing the view that the bill's provisions are duplicative of existing programs and initiatives.

COMMITTEE MEETING

After carefully reviewing the testimony from the foregoing hearings, the Committee met in open session on June 27, 2007, to consider, among other legislation, S. 479. The Committee voted by voice vote to report favorably S. 479 to the Senate.

SUMMARY OF S. 479 AS REPORTED

S. 479, as reported (hereinafter, "the Committee bill"), would convey the sense of Congress that suicide among veterans suffering from post-traumatic stress disorder (PTSD) is a serious problem, and direct the Secretary of Veterans Affairs (hereinafter, "the Secretary") to take the measures described below.

Section 3(a) would require that the Secretary develop and implement a comprehensive program for reducing the incidence of suicide among veterans, consisting of the following elements:

Section 3(b)(1) would require that the program include a nationwide campaign to increase awareness in the veteran community that mental health is essential to overall health and that there are treatments that can promote recovery from mental illness.

Section 3(b)(2) would require that the program include mandatory suicide prevention training for all medical personnel who interact with veterans.

Section 3(b)(3) would require that the program include a mental health education and outreach effort, with special emphasis on veterans of Operations Enduring Freedom and Iraqi Freedom and their families.

Section 3(b)(4) would require that the program include a peer support program under which veterans would be permitted to serve as peer counselors on mental health matters.

Section 3(b)(5) would require that the program encourage all applicants for veterans' benefits to undergo a mental health assessment.

Section 3(b)(6) would require that the program provide for referrals for all veterans who show signs of mental health problems to appropriate counseling and treatment programs.

Section 3(b)(7) would require that the program include designation of a suicide prevention counselor at each Department of Veterans Affairs (hereinafter, "VA") medical facility.

Section 3(b)(8) would require that the program include research on best practices for suicide prevention among veterans, and establish a committee to advise on such research.

Section 3(b)(9) would require that the program provide for referrals for all veterans who show signs or symptoms of substance abuse to appropriate counseling and treatment programs.

Section 3(b)(10) would require that the program include mechanisms to ensure 24-hour mental health care services availability to veterans.

Section 3(b)(11) would provide that the program may include a 24-hour, toll-free telephone number, staffed by personnel with appropriate mental health training, through which veterans might receive information on and referral to mental health services.

Section 3(b)(12) would provide that the program may include such other activities and programs to reduce the incidence of veteran suicide as the Secretary considers appropriate.

Section 4 would require the Secretary to report within 90 days on VA programs to reduce the incidence of suicide among veterans, and to present a plan for additional programs to this effect. This plan would be required to be formulated in consultation with the National Institute of Mental Health, the Substance Abuse and Mental Health Services Administration, and the Centers for Disease Control and Prevention.

BACKGROUND AND DISCUSSION

At the Committee's April 25, 2007, hearing on veterans' mental health issues, Randall Omvig stated on behalf of his family,

> We would like to voice our strong support of the Joshua Omvig Veterans Suicide Prevention Act, S. 479, reintroduced by Senator Harkin and Senator Grassley.

Mr. Omvig addressed the need for expanded mental health outreach and education for returning servicemembers, new veterans, and their families, as well as for a more aggressive and preventative approach to mental health treatment by VA and the Department of Defense. A number of provisions of S. 479, contained in section 3 of the Committee bill, directly address these concerns and are discussed below.

De-stigmatizing Mental Health [Section 3(b)(1)]: As documented by numerous media sources, mental health issues are viewed by some members of the armed forces as a sign of weakness and an obstacle to career advancement. This stigma carries over to reservists and new veterans, some of whom choose to avoid counseling or treatment. Such was the case with Joshua Omvig, as conveyed in his father's testimony. This section would direct the Secretary to take steps to address the stigma and to convey a message of hope and recovery to the veteran community. While the section suggests a number of potential steps in this direction, it would allow the Secretary to determine the best approach.

Training of Employees and Other Personnel [Section 3(b)(2)]: Under this section, the Secretary would arrange for suicide prevention training for all mental health and social work professionals who interact with veterans. The Secretary would be left to determine the format of this training. The Committee notes that long-term employees with extensive experience in counseling veterans with PTSD, depression, or suicidal thoughts could be considered as having completed the requirements of the training.

Family Education and Outreach [Section 3(b)(3)]: Upon his return from Iraq and disposition to reserve status, Joshua Omvig did not seek help from the military or VA for his mental health problems. This section would direct the Secretary to reach out to individuals such as Joshua, and their families, in order to educate them on readjustment issues and on the symptoms of mental health problems, and to encourage them to seek assistance if needed. These programs would necessarily be geared towards individuals who have not applied for VA health care services, including those still on active duty. The Committee recognizes that certain initiatives of recent years, such as VA briefings for units returning

from Iraq or Afghanistan, as well as expanded family eligibility for counseling at Veterans' Centers, fall within the spirit of this section. The Secretary would be directed to develop additional programs in this vein, and would be given broad latitude to do so.

Peer Support Program [Section 3(b)(4)]: At the Committee's May 23, 2007, hearing on pending veterans' health legislation, two witnesses spoke in support of the peer counseling provision of S. 479. Referring to peer support received during his recovery from a spinal injury, Carl Blake of the Paralyzed Veterans of America stated:

> I know firsthand that being able to talk to someone who has experienced what you have experienced and has dealt with the same problems you are dealing with can help you overcome bouts of depression, sadness, and anger as you first come to grips with your condition. The peer counselor serves as a motivator to get you moving in the right direction.

Jerry Reed of SPAN USA testified:

> I support the provisions in S. 479 that encourage peer support programs. While there is no substitute for licensed mental health professionals with respect to diagnosis and treatment of PTSD, depression, and anxiety, it is often fellow veterans who provide the support needed to convince a veteran to visit a licensed professional.

Peer support, as envisioned under S. 479, is not a formalized, top-down, nationwide program that requires additional resources, but rather a resource in itself, whereby local managers can recruit volunteers to provide advice based on personal experience to other veterans who are willing to accept it, or to their families. The peer counselor training called for under the section is not intended as a formal, classroom process. Rather, it could be provided on a one-on-one basis whenever a clinician makes arrangements to pair a peer counselor with his or her assigned veteran.

Health Assessments of Veterans [Section 3(b)(5)]: In the interests of suicide prevention and general well-being, veterans should be fully informed of their opportunities to receive timely mental health screening. The Committee notes that under this section, veterans applying for VA health benefits in particular would be encouraged to undergo a mental health assessment.

Counseling and Treatment of Veterans [Section 3(b)(6)]: The Committee recognizes that veterans enrolled in the VA health system who report symptoms of mental illness are generally referred for appropriate counseling and treatment. This section would broadly direct the Secretary to be more aggressive in identifying at-risk veterans who exhibit symptoms of mental illness, but do not ask for help.

Suicide Prevention Counselors [Section 3(b)(7)]: Under this section, a suicide prevention counselor would be designated at each VA medical facility. The Committee notes that some VA Medical Centers have already met the requirements of this section by assigning suicide prevention counselor functions to existing staff, or else by hiring new staff for this purpose. Either of these two approaches would bring a VA medical facility into compliance with the requirements of this section.

Research on Best Practices [Section 3(b)(8)]: The research called for under this section would encompass relevant studies currently in progress in addition to any new initiatives that VA clinicians or researchers may propose. The Secretary would be encouraged to look favorably on new research proposals in the field of suicide and suicide prevention.

Substance Abuse Treatment [Section 3(b)(9)]: The Committee recognizes that veterans enrolled in the VA health system who report a substance abuse problem are generally referred for appropriate counseling and treatment. This section would broadly direct the Secretary to be more aggressive in identifying veterans who exhibit symptoms of substance abuse, but do not ask for help.

24-Hour Mental Health Care [Section 3(b)(10)]: Under this section, the program mandated under section 3(a) would be required to include mechanisms to ensure the availability of mental health care services for veterans on a 24-hour basis. The Secretary would be left to determine how best to comply with this requirement. The Committee notes that a continuously operational mental health telephone hotline for veterans, as described under section 3(b)(11), could, if established and maintained in an effective manner, fulfill a significant element of the requirements of this section.

Telephone Hotline [Section 3(b)(11)]: The Committee recognizes that the language of this section, referring to a potential mental health telephone hotline for veterans, is not obligatory. However, as noted above, the Committee believes that implementation of such a hotline could be a significant element in meeting the requirements of section 3(b)(10).

At the Committee's May 23, 2007, hearing, Mr. Reed of SPAN USA spoke of the benefits of a crisis hotline for at-risk veterans. According to Reed,

> For most individuals in a suicidal crisis, what is most important when utilizing a hotline is simply knowing that someone is listening and that they are not alone. A caller needs a competent counselor at the other end of the line who can conduct a lethality assessment and provide direction on next steps.

Should the Secretary choose to utilize a telephone hotline, the Committee notes the possibility of utilizing an existing capacity rather than building from scratch. In his testimony, Mr. Reed recommended the existing, federally funded National Suicide Prevention Lifeline (NSPL) and its 1–800–273–TALK (8255) number, for this purpose:

> I think we should build upon what Congress has already funded and let 1–800–273–TALK be the door all callers in crisis, including veterans, enter. Once a caller dials the number, an option can be provided to be transferred to a VA call center if the individual wants the services and support of the VHA.

The Committee views this as a sensible and cost-effective approach. However, it would remain up to the Secretary to determine how best to fulfill the requirements of section 3(b)(10), and whether to implement the option described in section 3(b)(11).

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, incur little, if any, cost. Enactment of the Committee bill would not affect direct spending or receipts, and would not affect the budget of State, local or tribal governments.

The cost estimate provided by CBO follows:

S. 479—Joshua Omvig Veterans Suicide Prevention Act

S. 479 would require the Secretary of Veterans Affairs (VA) to develop and implement a comprehensive program to reduce the incidence of suicide among veterans. This bill would require that the program have specific components, including training for all staff who interact with veterans, a suicide prevention counselor at each medical facility, outreach and education for veterans and their families, and a national campaign aimed at reducing the stigma of mental illness among veterans.

According to VA, most of those requirements are already in place or will be implemented before the end of the year. For example, training seminars have recently begun for all employees and peer-support groups are a regular facet of veterans' rehabilitation centers. Annual screenings for suicide risk factors such as depression and alcohol abuse are routinely performed by primary care physicians. Two medical centers are focused on research and education about suicide and its prevention. In addition, VA works with other medical providers in the community to reach veterans who may not use the VA health care system. VA also plans to hire suicide-prevention professionals at each of its hospitals. The bill would authorize VA to create a toll-free hotline staffed by mental health personnel, and the agency plans to have such a hotline in operation by the end of August 2007.

CBO estimates, therefore, that implementing this bill would have little, if any, cost because VA already has or soon will implement all the specific requirements of the bill. Enacting the bill would not affect direct spending or receipts.

S. 479 contains no intergovernmental or private-sector mandates as defined in the Unfunded Mandates Reform Act and would not affect the budgets of state, local, or tribal governments.

On March 19, 2007, CBO transmitted a cost estimate for H.R. 327, the Joshua Omvig Veterans Suicide Prevention Act, as ordered reported by the House Committee on Veterans' Affairs on March 15, 2007. The two versions of the legislation are similar, and their estimated costs are identical.

The CBO staff contact for this estimate is Michelle S. Patterson. This estimate was approved by Peter H. Fontaine, Deputy 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 June 27, 2007 meeting.

On that date, the Committee, by voice vote, ordered S. 479 reported favorably to the Senate.

AGENCY REPORT

On May 23, 2007, Gerald M. Cross, MD, FAAFP, VA's Acting Principal Deputy Under Secretary for Health, appeared before the Committee and submitted testimony on, among other things, a draft version of the Joshua Omvig Veterans Suicide Prevention Act. Excerpts from this statement are reprinted below:

STATEMENT OF THE VIEWS OF THE ADMINISTRATION

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 am pleased to provide the Department's views on 15 of the 20 bills under consideration by the Committee. I will briefly describe each bill, provide VA's comments on each measure and estimates of costs (to the extent cost information is available), and answer any questions you and the Committee members may have.

S. 479 JOSHUA OMVIG VETERANS SUICIDE PREVENTION ACT

S. 479 would require the Secretary to develop and implement a comprehensive program (comprised of 10 specific elements) for reducing the incidence of suicide among veterans. First, the program would include a national mental health campaign to increase awareness in the veteran community that mental health is essential to overall health and that effective modern treatment can promote recovery from mental illness. Second, it would call for mandatory training on suicide prevention for appropriate employees and contract personnel (including all medical personnel) who interact with veterans. This training would require the provision of information on the recognition of risk factors for suicide, protocols for responding to crisis situations involving veterans who may be at high risk for suicide, and best practices for suicide prevention. Third, the comprehensive program would include outreach programs and educational programs for veterans and their families, in particular OEF/OIF veterans and their families. The educational programs would serve to help: elimi-

nate or overcome stigmas associated with mental illness; further understanding of veterans' readjustment issues; identify signs and symptoms of mental health problems; and encourage veterans to seek assistance for these types of problems.

Fourth, the program would include a peer counseling program in which veterans are trained as peer-counselors to assist other veterans suffering from mental health issues. (Training of these veterans would have to include specific education on suicide prevention). The peer-counselors would also be responsible for conducting outreach on mental health matters to veterans and their families. The legislation would require the Secretary to make this peer-program available in addition to other mental health services already offered by VA (including those that would be established by this Act).

Fifth, the Secretary would be directed, as part of the comprehensive program, to encourage all veterans applying for VA benefits to undergo a mental health assessment at a VA medical facility or Vet Center.

Sixth, the program would include the provision of referrals, as appropriate, to veterans who show signs or symptoms of mental health problems.

Seventh, the Secretary would need to designate a suicide prevention counselor at each VA medical facility (other than a Vet Center). These counselors would work with a variety of local non-VA entities to engage in outreach to veterans about available VA mental health services. They would also be responsible for improving the coordination of mental health care furnished to veterans at the local level.

Eighth, VA's program would have to include research on best practices for suicide prevention among veterans. Moreover, the Secretary would need to establish a steering committee to advise on such research. Such committee would be comprised of representatives from the National Institute of Mental Health (NIMH), Substance Abuse and Mental Health Services Administration (SAMHSA), and the Centers for Disease Control and Prevention (CDC).

Ninth, the Secretary would have to ensure the availability of VA mental health services on a 24-hour basis.

Finally, the Secretary would be authorized to establish a continuously operational, toll-free telephone number that veterans could call for information on, and referrals to, appropriate mental health services.

This legislation would permit the Secretary to include any other activities in the comprehensive program that the Secretary deems appropriate. It would also require the Secretary to submit, not later than 90 days after the date of enactment, a detailed report to Congress on all of the Department's suicide prevention programs and activities. (Any suicide prevention programs VA establishes afterwards would have to be developed in consultation with NIMH, SAMHSA, and CDC).

We appreciate the purpose of this legislation; however, we do not support this bill. It is unnecessary because it du-

plicates many efforts already underway by the Department. Indeed, many of the bill's requirements are already being addressed and implemented through VA's current Mental Health Strategic Plan. (As you will recall, this Strategic Plan was designed to both ensure that our Department continues as a leader in the area of mental health and to implement the goals of the President's New Freedom Commission on Mental Health). We therefore ask that the Committee forbear in its consideration of S. 479. In the meantime, we will be happy to brief the Committee on the myriad initiatives we have right now and explore with you additional measures that could supplement these efforts.

Should the Committee proceed to act on this measure, we note our objection to the bill's requirement to train and use veterans as peer counselors for other veterans with mental health issues. The use of adult veterans as peer-counselors in caring for other veterans who suffer from mental health issues is simply not advisable. Data on the efficacy of these types of programs do not reflect favorable results. Although well-intended, we believe such an approach to clinical care lacks scientific support. We strongly believe that VA mental health care services, including counseling, should continue to be provided by our capable, experienced, and appropriately-trained cadre of mental health care professionals.

In addition, we do not think the bill's requirement that we encourage every veteran seeking any type of VA benefit to obtain a mental health assessment is justified, and it may cause veterans to believe they have been stigmatized.

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