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Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171) and Veterans COMPACT Act of 2020 (P.L. 116-214)

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SUMMARY

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Suicide is the 10th leading cause of death in the United States and is a significant contributor to premature mortality. Although suicide rates have increased among the U.S. general population over the past two decades, veterans are disproportionately affected by suicide. According to the Department of Veterans Affairs (VA), in 2018—the most recent year for which data are available—the suicide rate for veterans was 1.5 times greater than among nonveteran adults (adjusting for age and sex), and an average of 17.6 veterans died by suicide per day.

VA has named suicide as its top clinical priority for FY2018 to FY2024. In response, the department has implemented numerous initiatives to address veteran suicide and related mental health concerns. In addition, Congress has expressed sustained interest in reducing veteran suicide and has aimed to reduce such suicides through appropriations and authorizing legislation. Despite these efforts, Congress, VA, and stakeholders continue to express interest in efforts to further reduce veteran suicide and concern over seemingly limited progress made to date to reduce veteran suicide.

In the 116th Congress, the House and Senate Committees on Veterans' Affairs (HVAC and SVAC, respectively) focused much of their efforts on veteran suicide prevention, holding several hearings and introducing and enacting legislation on the topic. The Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act; P.L. 116-171) and the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (Veterans COMPACT Act; P.L. 116-214) were enacted at the end of the 116th Congress and were developed out of SVAC and HVAC, respectively. Both bills were enacted as part of a compromise between the two committees. Although they are separate, the bills complement each other in their efforts to increase access to and quality of the Veterans Health Administration (VHA) mental health and suicide prevention services.

Summary of Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171)

The Hannon Act was enacted on October 17, 2020. The bill was named after Commander John Scott Hannon, a Navy SEALs member who served in the U.S. Navy for 23 years and died by suicide. Divided into seven titles, the bill addresses five key areas:

1. Providing more assistance for servicemembers transitioning from the military.
2. Increasing access to mental health care and suicide prevention services for all veterans, and in particular, veterans living in rural areas.
3. Strengthening VHA's mental health workforce.
4. Providing oversight of VHA's mental health and suicide prevention services.
5. Investing in and studying mental health treatment, including alternative and complementary treatment approaches.

Summary of Veterans COMPACT Act of 2020 (P.L. 116-214)

The Veterans COMPACT Act was enacted on December 5, 2020. The bill is divided into three titles and features nine provisions adapted from different committee members to help prevent veteran suicide. The three key themes, as organized by title, include

1. Improving the transition to VHA services by helping veterans build networks of support and tracking VA's outreach to transitioning servicemembers.

2. Improving VA's response to veteran suicide by providing acute crisis care for emergent suicide symptoms and outreach to certain at-risk veterans, creating new programs, and requiring annual VA police crisis intervention training.
3. Improving care and services for women veterans by conducting a gap analysis of VA programs providing assistance to homeless women veterans and requiring a report on locations where women veterans are using VHA care.

Scope of Report

This report summarizes the provisions of the Hannon Act and the Veterans COMPACT Act. The report is not intended to provide a comprehensive analysis of every provision in these acts; rather, it provides a brief background and summary of such provisions. The report is organized by each respective law, starting with the Hannon Act, with each summarized by title and subsequent provisions within the titles. The **Appendix** of the report includes tables of relevant provisions for the Hannon Act and the Veterans COMPACT Act, respectively, that include an effective date, a required report, or an explicit sunset date. The report reflects the Hannon Act and the Veterans COMPACT Act at enactment and will not track actions pursuant to required deadlines, nor will this report be updated.

SVAC and HVAC did not produce written reports or release an explanatory statement in the *Congressional Record* to accompany the Hannon Act or the Veterans COMPACT Act at the time of passage. Therefore, for some provisions in which committees' legislative background was not clear, CRS, where applicable, approximates legislative background by providing contextual information based on testimony at committee hearings, hearing transcripts, or earlier or alternative versions of the bills, with identical provisions, among other sources. This background should not be used as the official legislative intent of those provisions.

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Background

Suicide is the 10th leading cause of death in the United States and is a significant contributor to premature mortality. There is no single cause of suicide. Rather, it results from a complex interaction between risk factors (e.g., a mental health disorder) and protective factors (e.g., community engagement). The interaction of these factors can occur at the individual, interpersonal, community, and societal level. Although suicide rates have increased among the U.S. general population over the past two decades,[1] veterans are disproportionately affected by suicide. According to the Department of Veterans Affairs (VA), in the period of 2005-2018, suicide rates increased more quickly among veterans compared with nonveteran U.S. adults, adjusting for age and sex.[2] In 2018—the most recent year for which data are available—the suicide rate for veterans was 1.5 times greater than among nonveteran adults (adjusting for age and sex), and an average of 17.6 veterans died by suicide per day.[3]

VA has named suicide as its top clinical priority for FY2018 to FY2024.[4] In response, the department has implemented numerous initiatives to address veteran suicide and related mental health concerns. VA has described in its national strategy for preventing veteran suicide how these different interventions are to be implemented to reach all veterans, from the lowest risk to the highest risk for suicide. This public health approach, which aims to prevent suicide before it occurs by focusing on population-level initiatives, uses multidisciplinary strategies to help diverse veteran communities, among other things.[5] For example, the Veteran Health Administration's (VHA's) recently implemented universal annual screening initiative evaluates all veterans receiving VHA services for suicidal risk and subsequently assesses suicidal risk among those who screened positive during the initial screening.[6] In the national strategy, VA also emphasizes the need to develop public-private partnerships to advance targeted suicide prevention strategies in different geographic areas, such as health care provider training and community-specific activities.

Congress has expressed sustained interest in reducing veteran suicide and has aimed to reduce such suicides through appropriations and authorizing legislation. In FY2021 appropriations, Congress provided $1.94 billion to VHA for suicide prevention and treatment services,[7] an

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[1] Holly Hedegaard, Sally C. Curtin, and Margaret Warner, "Increase in Suicide Mortality in the United States, 1999-2018," *National Center for Health Statistics (NCHS) Data Brief*, vol. 362 (April 2020).

[2] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, Department of Veterans Affairs, November 2020, p. 17, https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf.

[3] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, Department of Veterans Affairs, November 2020, p. 5, https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf. Previous VA reports on the suicides per-day statistic included veterans, current servicemembers, and never federally activated former Guard and Reserve members. The 2018 statistic does not include current servicemembers or never federally activated former servicemembers.

[4] Department of Veterans Affairs, *FY2018 - 2024 Strategic Plan*, May 31, 2019, https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf.

[5] Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide, 2018-2028,* Department of Veterans Affairs, p. 8, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[6] U.S. Government Accountability Office, *VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664, September 2020, p. 8, https://www.gao.gov/assets/710/709243.pdf.

[7] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, And Related Agencies Appropriations Bill, 2021*, report to

increase of over $40 million from the prior fiscal year.[8] Of that amount, $312.6 million was provided for suicide prevention outreach, which includes VHA prevention-focused activities such as the Veterans Crisis Line (VCL),[9] among other things. Previous Congresses have enacted several bills to help address veteran suicide, including the Joshua Omvig Veterans Suicide Prevention Act of 2007 (P.L. 110-110) and the Clay Hunt Suicide Prevention for American Veterans Act (Clay Hunt SAV Act; P.L. 114-2). Each of these bills included provisions designed to improve VHA's offering of mental health and suicide prevention services. Despite these efforts, Congress, VA, and stakeholders continue to express interest in efforts to further reduce veteran suicide and concern over seemingly limited progress made to date to reduce veteran suicide.

Brief Legislative History

In the 116th Congress, the House and Senate Committees on Veterans' Affairs (hereinafter referred to as HVAC and SVAC, respectively) continued to focus on veteran suicide prevention, holding hearings and introducing and enacting legislation on the topic.[10] On March 13, 2019, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (S. 785) was introduced by then ranking member of SVAC Senator Jon Tester and then chairman of SVAC Senator Jerry Moran. A key feature of the bill was the authorization of a grant program that requires VA to award grants to certain community-based organizations to provide veteran suicide prevention services.[11] During a hearing on the legislation, in May 2019, SVAC heard several views on S. 785. VA testified,

> There is much in S. 785 that keys in on what we believe are the right elements, including suicide prevention coordinators at every medical center, a grant program that taps into the resources of the local community, focused research projects and deployment of promising clinical approaches to suicide prevention, the use of complementary and integrative health care, outreach efforts to reach those veterans that are not in our system of care, and the use of joint clinical practice guidelines, among other features.[12]

In June 2019, SVAC held another hearing on engaging communities in preventing veteran suicide.[13] By January 29, 2020, SVAC reported an amended version of S. 785. That version was

accompany H.R. 7609, 116th Cong., 2nd sess., July 13, 2020; H.Rept. 116-445, p. 46.

[8] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Military Construction, Veterans Affairs, And Related Agencies Appropriations Bill, 2020*, Report to accompany H.R. 2745, 116th Cong., 1st sess., May 15, 2019, H.Rept. 116-63, p. 36.

[9] In 2007, VHA established a suicide crisis hotline. It was initially called the National Veterans Suicide Prevention Hotline. In 2011, its name was changed to the Veterans Crisis Line (VCL). In addition to calling, veterans can chat and text and connect with a counselor. See https://www.veteranscrisisline.net/Default.aspx.

[10] See for example, U.S. Congress, House Committee on Veterans' Affairs, "Suicide Prevention," https://veterans.house.gov/suicide-prevention, and House Committee on Veterans Affairs, "Takano, Roe Issue Bipartisan Statement on Veteran Suicide Prevention," press release, March 7, 2019, https://veterans.house.gov/news/press-releases/takano-roe-issue-bipartisan-statement-veteran-suicide-prevention.

[11] 38 U.S.C. §1720F note, as added by section 201 of P.L. 116-171.

[12] U.S. Congress, Senate Committee on Veterans' Affairs, *Hearing on Pending Legislation*, 116th Cong., 1st sess., May 22, 2019, S. HRG. 116-179 (Washington: GPO, 2020), p. 8.

[13] U.S. Congress, Senate Committee on Veterans' Affairs, *Harnessing the Power Of Community: Leveraging Veteran Networks To Tackle Suicide*, 116th Cong., 1st sess., June 19, 2019, S. HRG. 116-209 (Washington: GPO, 2020).

then withdrawn and Senators Jerry Moran and Jon Tester proposed an amended version[14] to S. 785 , which passed the Senate on August 5, 2020.

In the House, on June 26, 2019, Representatives Jack Bergman and Chrissy Houlahan introduced the Improve Well-Being for Veterans Act (H.R. 3495), which would have required VA to award grants to eligible community-based organizations to provide suicide prevention services. This program was substantively similar to the suicide prevention grant program included in S. 785. In September 2019, HVAC held a hearing on H.R. 3495 and other bills. Regarding the grant program that would be established by H.R. 3495, VA stated that "VA's efforts to reduce the incidence of suicidal ideations and behavior (and suicide completions) among all Veterans could be complemented by partnering with community-based providers who are able to replicate VA's suicide prevention programs in the community and to connect with Veterans that are currently beyond VA's reach."[15]

In November 2019, HVAC held another hearing on both H.R. 3495 and a discussion draft bill to establish a pilot program for the issuance of grants to eligible entities for suicide prevention activities, for which the department stated it would provide its views in a separate letter to the committee.[16] While some HVAC Members supported the grant program as outlined in H.R. 3495 and the discussion draft bill,[17] in his opening remarks, Chairman Mark Takano of HVAC, addressed several concerns he had regarding the grant program as outlined in H.R. 3495:

> While I agree with the underlying intent of H.R. 3495, I do have significant concerns. First, this bill would allow VA grants to fund community-based clinical care and would clearly circumvent the MISSION Act that streamlined clinical care under one program. Instead this legislation creates a separate lane for care in the community without critical safeguards and accountability measures in place…. Second, H.R. 3495, as introduced would provide direct temporary cash assistance to veterans, their families, and anyone else who may live with them. My understanding is that cash assistance to veterans needs further, careful consideration and should be taken up in separate legislation.... H.R. 3495 as introduced authorizes the VA Secretary to award grants to organizations unbound to any performance criteria and irrespective of whether there is demonstrated local need for the services provided by these organizations. Funding decisions should be driven by local coordinating organizations who have the pulse on their communities and regions. The coordination should be as local as possible.... Without local need and metrics tied to the award of grant funding, this is not consistent with the policy goal of reaching the 60 percent of veterans at risk for suicide who are not connected with VA.[18]

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[14] SA 25940.

[15] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Statement of Teresa Boyd, Assistant Deputy Under Secretary For Health For Clinical Operations, Veterans Health Administration (VHA) Department Of Veterans Affairs (VA)*, legislative hearing on H.R. 3636; H.R. 2972; H.R. 3036; H.R. 2798; H.R. 2645; H.R. 2681; H.R. 3224; H.R. 2982; H.R. 2752; H.R. 2628; H.R. 2816; H.R. 1527; H.R. 1163; H.R. 3798; H.R. 3867; H.R. 4096; and a draft bill, to establish in the Department of Veterans Affairs the Office of Women's Health, and for other purposes, 116th Cong., 1st sess., September 11, 2019.

[16] U.S. Congress, House Committee on Veterans' Affairs, *Statement of Robert L. Wilkie Secretary Department Of Veterans Affairs (VA)*, legislative hearing on H.R. 3495, and a draft bill, to establish a pilot program for the issuance of grants to eligible entities, 116th Cong., 1st sess., November 20, 2019.

[17] See for example, U.S. Congress, House Committee on Veterans' Affairs, *Opening Statement of Ranking Member Roe*, legislative hearing on H.R. 3495, and a draft bill, to establish a pilot program for the issuance of grants to eligible entities, 116th Cong., 1st sess., November 20, 2019. See House Committee on Veterans' Affairs Republicans, "Press Releases," November 20, 2019, https://republicans-veterans.house.gov/news/documentsingle.aspx?DocumentID=5550.

[18] U.S. Congress, House Committee on Veterans' Affairs, *Opening Statement of Chairman Takano*, legislative hearing on H.R. 3495, and a draft bill, to establish a pilot program for the issuance of grants to eligible entities, 116th Cong., 1st

On September 10, 2020, HVAC held a legislative hearing on numerous measures related to suicide prevention and veterans' behavioral health, not including H.R. 3495.[19] At the hearing, VA submitted written testimony and strongly opposed the bills under consideration by HVAC, stating that many of the bills and their provisions were very similar to provisions in S. 785:

> We note that twelve of the bills on the agenda have provisions with elements that appear very similar to (or have significant commonality with) those in S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019, which passed the Senate unanimously by voice vote on August 5, 2020…. VA testified on the introduced version of S. 785 on May 22, 2019. Through a substantial, wide-ranging effort involving technical assistance exchanges and discussions over more than a year and a half, VA has brought clinical, programmatic, and legal expertise to bear with SVAC staff to effect improvements to the Senate-passed version of S. 785. Many of the bills ... do not reflect that technical assistance. We ... instead urge the House of Representatives to pass S. 785, the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019.[20]

During the 116th Congress, HVAC Chairman Takano adopted a strategy of suicide prevention generally consistent with the Centers for Disease Control and Prevention's (CDC's) Seven Core Strategies for Suicide Prevention.[21] Legislation advanced through the committee by Chairman Takano largely followed the tenets of this public health approach. On September 14, 2020, the Veterans Comprehensive Prevention, Access to Care, and Treatment (COMPACT) Act of 2020 (H.R. 8247) was introduced by Chairman Takano. Within H.R. 8247, a significant provision was the authorization of VA to provide emergent suicide care to eligible veterans without requiring payment.[22] This new requirement expanded upon existing VHA policy that would allow for emergent mental health care, but such care was limited to certain individuals and may have required payment under some circumstances.[23] H.R. 8247 did not include any provisions

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sess., November 20, 2019. See House Committee on Veterans' Affairs, "Chairman Takano: 'In order to mitigate veteran suicide, we need new solutions,'" press release, November 20, 2019, https://veterans.house.gov/news/press-releases/chairman-takano-in-order-to-mitigate-veteran-suicide-we-need-new-solutions.

[19] U.S. Congress, House Committee on Veterans' Affairs, *Full Committee Legislative Hearing on H.R.7541; H.R. 7504; H.R. 7784; H.R. 7879; H.R. 7747; H.R. 7888; H.R. 7964; H.R. 3450; H.R. 3788; H.R. 3826; H.R. 6092; H.R. 7469; H.R. 8005; H.R. 8033; H.R. 8084; H.R. 8068; H.R. 8149; H.R. 8148; H.R. 8108; H.R. 8144; H.R. 8145; H.R. 8130; H.R. 8107; H.R. 8147; Discussion Draft - ANS for Veterans' ACCESS Act; Discussion Draft – Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020; Discussion Draft - Ensuring Veterans' Smooth Transition Act; Discussion Draft - VA Research Technology Act; Discussion Draft - VA High Altitude and Suicide Research Act; Discussion Draft - VA Expanded Care Hours Act, and Discussion Draft - Veterans Burn Pits Exposure Recognition Act of 2020*, 116th Cong., 2nd sess., September 10, 2020.

[20] Statement for the Record Department of Veterans Affairs, U.S. Congress, House Committee on Veterans' Affairs, *Full Committee Legislative Hearing on H.R.7541; H.R. 7504; H.R. 7784; H.R. 7879; H.R. 7747; H.R. 7888; H.R. 7964; H.R. 3450; H.R. 3788; H.R. 3826; H.R. 6092; H.R. 7469; H.R. 8005; H.R. 8033; H.R. 8084; H.R. 8068; H.R. 8149; H.R. 8148; H.R. 8108; H.R. 8144; H.R. 8145; H.R. 8130; H.R. 8107; H.R. 8147; Discussion Draft - ANS for Veterans' ACCESS Act; Discussion Draft – Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020; Discussion Draft - Ensuring Veterans' Smooth Transition Act; Discussion Draft - VA Research Technology Act; Discussion Draft - VA High Altitude and Suicide Research Act; Discussion Draft - VA Expanded Care Hours Act, and Discussion Draft - Veterans Burn Pits Exposure Recognition Act of 2020*, 116th Cong., 2nd sess., September 10, 2020.

[21] Deb Stone, Kristin Holland, Brad Bartholow, et al., *Preventing Suicide: A Technical Package of Policy, Programs, and Practices*, Division of Violence Prevention, National Center for Injury Prevention and Control, Centers for Disease Control and Prevention (CDC), Atlanta, GA, 2017, https://www.cdc.gov/violenceprevention/pdf/suicideTechnicalPackage.pdf.

[22] 38 U.S.C. §1720J.

[23] For more information, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

authorizing a suicide prevention grant program or provisions related to the suicide prevention grant program included in H.R. 3495 and S. 785.

In a compromise between SVAC and HVAC,[24] the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act; P.L. 116-171) and the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (Veterans COMPACT Act; P.L. 116-214) were enacted at the end of the 116th Congress. Although the bills are separate, they complement each other in their efforts to increase access to and the quality of VHA mental health and suicide prevention services.

Brief Overview of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (Hannon Act; P.L. 116-171)

The Hannon Act, enacted on October 17, 2020, was named after Commander John Scott Hannon, a Navy SEALs member who served in the U.S. Navy for 23 years and died by suicide.[25] Divided into seven titles, this legislation addresses five key areas, as stated by its co-sponsors, Senators Jon Tester and Jerry Moran.[26] These areas include the following:

1. Providing more assistance for servicemembers transitioning from the military (Title I: Improvement of Transition of Individuals to Services from Department of Veterans Affairs).
2. Increasing access to mental health care and suicide prevention services for all veterans, and in particular, veterans living in rural areas (Title II: Suicide Prevention; Title VI: Improvement of Care and Services for Women Veterans; Title VII: Other Matters).
3. Strengthening VHA's mental health workforce (Title V: Improvement of Mental Health Medical Workforce; Title VII: Other Matters).
4. Oversight of VHA's mental health and suicide prevention services (Title IV: Oversight of Mental Health Care and Related Services).
5. Investment and study into mental health treatment, including alternative and complementary treatment approaches (Title II: Suicide Prevention; Title III: Programs, Studies, and Guidelines on Mental Health; Title VII: Other Matters).

Brief Overview of the Veterans Comprehensive Prevention, Access to Care, and Treatment Act of 2020 (Veterans COMPACT Act; P.L. 116-214)

The Veterans COMPACT Act was enacted on December 5, 2020. The bill is divided into three titles and features nine provisions adapted from bills originally introduced by different committee

[24] U.S. Congress, Senate Committee on Veterans' Affairs, "Senator Moran Applauds Deal to Pass Landmark Veteran Mental Health & Suicide Prevention Legislation," September 22, 2020, https://www.veterans.senate.gov/newsroom/news/senator-moran-applauds-deal-to-pass-landmark-veteran-mental-health-and-suicide-prevention-legislation.

[25] U.S. Senator Jon Tester, "Tester's Groundbreaking Commander John Scott Hannon Veterans Mental Health and Suicide Prevention Bill Signed into Law," October 17, 2020, https://www.tester.senate.gov/?p=press_release&id=7817.

[26] U.S. Senator Jon Tester, "Tester, Moran Introduce Landmark Veterans Mental Health and Suicide Prevention Bill," March 13, 2019, https://www.veterans.senate.gov/newsroom/minority-news/tester-moran-introduce-landmark-veterans-mental-health-and-suicide-prevention-bill.

members to help prevent veteran suicide. The three key themes, as organized by title, include the following:

1. Improving the transition to VHA services by helping veterans build networks of support and tracking VA's outreach to transitioning servicemembers (Title I: Improvement of Transition of Individuals to Services from the Department of Veterans Affairs).
2. Improving VA's response to veteran suicide by providing acute crisis care for emergent suicide symptoms and outreach to certain at-risk veterans, creating new programs, and requiring annual VA police crisis intervention training (Title II: Suicide Prevention).
3. Improving care and services for women veterans by conducting a gap analysis of VA programs providing assistance to homeless women veterans and requiring a report on locations where women veterans are using VHA care (Title III: Improvement of Care and Services for Women Veterans).

Scope of Report

This CRS report summarizes the provisions of the Hannon Act and the Veterans COMPACT Act. The report does not provide a comprehensive analysis of every provision in these acts; rather, it provides a brief background and summary of such provisions. The report is organized by each respective law, starting with the Hannon Act. Each bill is summarized by title and subsequent provisions within the titles. The report reflects the Hannon Act and the Veterans COMPACT Act at enactment and will not track actions pursuant to required deadlines, nor will this report be updated.

SVAC and HVAC did not produce written reports or release an explanatory statement in the *Congressional Record* to accompany the Hannon Act or the Veterans COMPACT Act at the time of passage. Therefore, for some provisions in which either committees' legislative background was not clear, CRS, where applicable, approximates legislative background by providing contextual information based on testimony at committee hearings, hearing transcripts, or earlier or alternative versions of the bills with identical provisions, among other sources. The background provided for provisions described in this report should not be used as the official legislative intent of those provisions.

Throughout this report, unless otherwise stated, "the Secretary" refers to the Secretary of Veterans Affairs, and "department" or "VA" means the U.S. Department of Veterans Affairs. Other commonly used acronyms in this report are listed in **Table 1**. In addition, "this section" refers to matters addressed under that specific action of the act, unless otherwise noted.

Table 1. Acronyms Used in This Report

CBO	Congressional Budget Office
CBOC	Community-Based Outpatient Clinic
CCI	Center for Compassionate Innovation
CDC	Centers for Disease Control and Prevention
C.F.R.	*Code of Federal Regulations*
CIH	Complementary and Integrative Health
COVER	Creating Options for Veterans' Expedited Recovery Commission
CPG	Clinical Practice Guideline
DOD	Department of Defense

DHS	Department of Homeland Security
FDA	Food and Drug Administration
GAO	Government Accountability Office
HBOT	Hyperbaric Oxygen Therapy
HHS	Department of Health and Human Services
HIPAA	Health Insurance Portability and Accountability Act of 1996
HVAC	House Committee on Veterans' Affairs
LGBTQ	Lesbian, Gay, Bisexual, Transgender, or Queer
LPMHC	Licensed Professional Mental Health Counselor
MILCON-VA	Senate and House Committees on Appropriations, Subcommittees on Military Construction, Veterans Affairs, and Related Agencies
MFT	Marriage and Family Therapist
NAMI	National Alliance on Mental Illness
NAL	Nurse Advice Line
NASEM	National Academies of Sciences, Engineering, and Medicine
NCA	National Cemetery Administration
NIMH	National Institute of Mental Health
NIST	National Institute of Science and Technology
OMHSP	Office of Mental Health and Suicide Prevention
OPM	U.S. Office of Personnel Management
OTH	Other Than Honorable
PACT	Patient-Aligned Care Team
PREVENTS	President's Roadmap to Empower Veterans and End a National Tragedy of Suicide
PTSD	Posttraumatic Stress Disorder
REACH VET	Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment
RCS	Readjustment Counseling Service
SAFE VET	Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment
SAMHSA	Substance Abuse and Mental Health Services Administration
SMI	Serious Mental Illness
SPC	Suicide Prevention Coordinator
SPED	Safety Planning in Emergency Departments
SVAC	Senate Committee on Veterans' Affairs
TBI	Traumatic Brain Injury
U.S.C.	*United States Code*
VA	Department of Veterans Affairs
VAMC	Veterans Affairs Medical Center
VBA	Veterans Benefits Administration
VCCP	Veterans Community Care Program
VCL	Veterans Crisis Line
VHA	Veterans Health Administration
VISN	Veterans Integrated Service Network
VSO	Veterans Service Organization

Budgetary Impact

This report does not discuss cost estimates for all provisions; however, the Congressional Budget Office (CBO) provided a cost estimate of the Hannon Act.[27] Overall, the Hannon Act is expected to increase federal deficits by $277 million over the 2020-2025 year period. The estimate breaks down outlays into the following categories:

- mental health research,
- suicide prevention,
- hearing aid specialists,
- telehealth,
- treatment guidelines,
- scholarships for readjustment counselors,
- mental health programs,
- pilot program on nontraditional therapy, and
- reports and studies.

The most significant spending would result from the mental health research and suicide prevention categories. Regarding mental health research, Section 305 of the Hannon Act requires VA to collect medical information from veterans receiving VHA care and to make anonymized data available to VA and non-VA researchers. CBO estimates that this effort would cost $94 million from 2020 to 2025. Regarding suicide prevention, Section 201 of the Hannon Act requires VA to award grants to certain community-based organizations that will provide suicide prevention services for veterans and their families. CBO estimates that implementing this effort, including program expenses beyond awarding of the grants, would cost $80 million from 2020 to 2025.

At the time of this report's publication, CBO has not yet provided a cost estimate for the Veterans COMPACT Act. However, CBO has provided cost estimates for legislation with similar intent. For example, the Sergeant Daniel Somers Veterans Network Support Act of 2019 was introduced and passed by the Senate in the 116th Congress.[28] The bill is identical to Section 101 of the Veterans COMPACT Act, which requires the Secretary to establish a pilot program that would allow veterans, before separating from service, to select up to 10 people, to whom VA would provide information regarding VA services and benefits. CBO estimates that implementing this pilot program would cost $2 million over the 2020 to 2025 period.[29]

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[27] Congressional Budget Office (CBO), "At a Glance: S. 785, Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019," March 23, 2020, https://www.cbo.gov/system/files/2020-03/s0785.pdf.

[28] S. 2864 (116th Congress).

[29] Congressional Budget Office, "S. 2864, Sergeant Daniel Somers Veterans Network Support Act of 2019," February 19, 2020, https://www.cbo.gov/system/files/2020-02/s2864.pdf.

Provisions in the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019

Title I: Improvement of Transition of Individuals to Services from Department of Veterans Affairs

The period of transition from active duty military service to veteran status is a time of heightened risk for suicide.[30] Studies have shown that "most suicide attempts by those who are or will become veterans occur following separation from military service."[31] This title includes provisions to address the risk associated with this period. Such provisions include requiring VA to (1) develop and make public a strategic plan on the provision of VA health care to *any* veteran during a one-year period following the discharge or release of the veteran from active duty; (2) review records of former servicemembers who have died by suicide within the year following separation; and (3) submit and develop reports on relevant VHA suicide prevention programs.

Section 101: Strategic Plan on Expansion of Health Care Coverage for Veterans Transitioning from Service in the Armed Forces

Background

VA reports that "veterans are most vulnerable in the first three months following separation from military service, although suicide risk remains elevated for years after the transition."[32] Furthermore, VA has stated that the first 12 months after separation from service is a period marked by a high risk for suicide.[33] On January 9, 2018, President Trump signed Executive Order (EO) 13822, "Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life," which mandated the creation of a Joint Action Plan by VA, DOD, and the Department of Homeland Security (DHS) to provide transitioning servicemembers with seamless access to mental health treatment and suicide prevention resources for at least one year following their discharge, separation, or retirement. Based on this mandate, VA began to implement programs to assist newly discharged veterans to enroll in the VA health care system.[34] However,

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[30] Department of Veterans Affairs, *2019 Annual Report: VA Mental Health Program and Suicide Prevention Services Independent Evaluation*, October 2019, p. 188.

[31] Department of Veterans Affairs, *Help with Readjustment and Social Support Needed for Veterans Transitioning from Military Service*, From Science to Practice, Using Research to Promote Safety and Prevent Suicide, 2019, https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature_Review_Military_Separation_508_FINAL_05-24-2019.pdf.

[32] Department of Veterans Affairs, *Help with Readjustment and Social Support Needed for Veterans Transitioning from Military Service*, From Science to Practice, Using Research to Promote Safety and Prevent Suicide, 2019, https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature_Review_Military_Separation_508_FINAL_05-24-2019.pdf.

[33] U.S. Congress, House Committee on Veterans' Affairs, *Caring for Veterans in Crisis: Ensuring a Comprehensive Health System Approach*, Statement of Ms. Renee Oshinski, Deputy Under Secretary for Health for Operations and Management, Department of Veterans Affairs, Veterans Health Administration, 116th Cong., 2nd sess., January 29, 2020.

[34] U.S. Congress, House Committee on Veterans;' Affairs, *Caring for Veterans in Crisis: Ensuring a Comprehensive*

veterans would still need to meet the basic eligibility criteria for enrollment, such as (1) meeting the statutory definition of a "veteran," meaning an "individual who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable";[35] (2) meeting the statutory definition of "active duty," meaning full-time duty in the Armed Forces, other than active duty for training;[36] and (3) having served a minimum period of 24 months of continuous active duty, among other factors.[37] There are several exceptions and special rules to these basic eligibility criteria.[38]

Provision

Section 101(a) requires the Secretary, no later than one year after the date of the enactment (i.e., October 17, 2021), to submit a strategic plan to SVAC and HVAC on the provision of VA health care to *any* veteran during a one-year period following the discharge or release of the veteran from active duty. The strategic plan must also be published on the VA website. In developing this strategic plan, the Secretary is required to consult with the Secretary of Defense. The strategic plan must include the following elements:

- an identification of general goals and objectives for the provision of health care to recently discharged or released veterans;
- a description of how such goals and objectives could be achieved, including, among other things, a description of the use of existing personnel, information, technology, facilities, public and private partnerships; a description of the anticipated need for additional resources; and associated costs;
- an analysis of the anticipated health care needs, including mental health care, for such veterans, separated by geographic area;
- an analysis of whether recently discharged or released veterans are eligible to enroll in the VA health care system;
- a description of activities designed to promote the availability VA health care, including outreach to members of the Armed Forces though the Transition Assistance Program (TAP);[39]
- a description of legislative or administrative action required to implement the strategic plan; and
- a description of how the strategic plan would further the ongoing initiatives of EO 13822, "Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life," signed by President Trump on January 9, 2018.

Health System Approach, Statement of Ms. Renee Oshinski, 116th Cong., 2nd sess., January 29, 2020.

[35] 38 U.S.C. §101(2). Section 926 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (P.L. 116-283) amended the term "veteran" to include "space service." The Office of the Law Revision Counsel of the U.S. House of Representatives has not codified this change as of the date of this report.

[36] 38 U.S.C. §101(21).

[37] 38 U.S.C. §5303A or exceptions at 38 U.S.C. §5303A(b)(3).

[38] For more information on current eligibility and enrollment in the VA health care system, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[39] For more information about the Transition Assistance Program, see CRS In Focus IF10347, *Military Transition Assistance Program (TAP): An Overview*.

Section 102: Review of Records of Former Members of the Armed Forces Who Die by Suicide Within One Year of Separation from the Armed Forces

Background

Since at least 2005, suicide rates among military and veteran populations have consistently been higher than those among U.S. general population. During calendar year 2018, the Department of Defense (DOD) recorded the following suicide rates among different military populations: 24.9 per 100,000 for active duty servicemembers, 22.9 per 100,000 for reservists,[40] and 30.8 per 100,000 for members of the National Guard.[41] During calendar year 2018, VA recorded a suicide rate of 27.5 per 100,000 among veterans.[42] In comparison, the suicide rate for the (nonveteran) U.S. general population was 18.2 per 100,000 during the same time period.[43] Suicide and suicidal ideation has remained a top issue of concern for both DOD and VA.[44] In recent years, Congress has authorized numerous provisions to enhance DOD and VA suicide prevention efforts, improve data collection and reporting, and expand access to mental health care.

Provision

Section 102 directs the Secretary and Secretary of Defense to review certain military records of former servicemembers. Section 102(a) defines these servicemembers as those who separated from the military between October 2015 and October 2020 (i.e., the "five-year period preceding the date of enactment") and who died by suicide within one year after separating. The Secretaries are required to review DOD service treatment records, military training records, and personnel records to identify and consider certain demographic information and potential or known risk factors for suicide or suicidal ideation. Risk factors include exposure to violence or suicide, housing or financial instability, legal or vocational problems, and limited access to health care. In addition, the review is to identify whether such individuals were referred to the VA's transition assistance program (i.e., Solid Start).[45] DOD and VA are to submit a report to the House and Senate Committees on Armed Services, SVAC, and HVAC, no later than three years after enactment (i.e., October 17, 2023), providing aggregated results of their review of former servicemember records.

[40] Excludes members of the National Guard.

[41] Department of Defense, *Annual Suicide Report, Calendar Year 2019*, August 20, 2020, p. 10, https://www.dspo.mil/Portals/113/Documents/CY2019%20Suicide%20Report/DoD%20Calendar%20Year%20CY%202019%20Annual%20Suicide%20Report.pdf.

[42] Department of Veterans Affairs, *National Veteran Suicide Prevention Annual Report*, 2020, p. 5, https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf.

[43] Department of Veterans Affairs, *National Veteran Suicide Prevention Annual Report*, 2020, p. 5.

[44] VA and DOD define *suicidal ideation* as "thoughts of engaging in suicide-related behavior." Department of Veterans Affairs, "VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide," May 2019, p. 63, https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf. For more on DOD suicide prevention and response, see CRS In Focus IF10876, *Military Suicide Prevention and Response*.

[45] Solid Start is a VA-administered transition assistance program that conducts outreach to newly separated servicemembers. The program offers new veterans education and assistance with accessing certain VA benefits. For more on Solid Start, see https://benefits.va.gov/transition/solid-start.asp.

Section 103: Report on REACH VET Program of Department of Veterans Affairs

Background

The Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment (REACH VET) program was launched across VA Medical Centers (VAMCs) in April 2017 and is run by the Office of Mental Health and Suicide Prevention (OMHSP).[46] The program is intended to help VHA predict which veterans may be at the highest risk for suicide or other related adverse outcomes. Using a statistical algorithm, REACH VET analyzes existing data such as demographics, use of VA services, and medications to identify veterans at the highest risk of suicide in the next month.[47] If a veteran is identified, a REACH VET coordinator subsequently identifies the clinician closest to the veteran who will then check on the veteran and review the treatment plan to determine if additional care is needed.

Preliminary VA analyses regarding the impact of REACH VET suggest that the program is associated with fewer inpatient mental health admissions and lower all-cause mortality, among other outcomes.[48] According to VA, REACH VET has identified more than 65,000 veterans since it began in 2017.[49] However, many of these data are preliminary, as evaluation studies are still underway.[50] In addition, the methods used to generate such data are not always made publicly available.

Provision

Section 103 requires the Secretary, no later than 180 days after enactment (i.e., April 15, 2021), to submit to SVAC and HVAC a report on the REACH VET program. The report is required to include an assessment of the impact of the REACH VET program on rates of suicide among veterans and a detailed explanation, with evidence, for why conditions included in the REACH VET were chosen, among other information.

Section 104: Report on Care for Former Members of the Armed Forces with Other than Honorable Discharge

Background

Section 258 of the Military Construction, Veterans Affairs, and Related Agencies Appropriations Act, 2018 (P.L. 115-141, as amended by P.L. 115-182 and P.L. 115-251; 38 U.S.C. §1720I),

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[46] Department of Veterans Affairs, "Study evaluates VA program that identifies Vets at highest risk for suicide," https://www.research.va.gov/currents/0918-Study-evaluates-VA-program-that-identifies-Vets-at-highest-risk-for-suicide.cfm.

[47] Department of Veterans Affairs, *FY2021 Congressional Budget Submission, Volume II: Medical Programs and Information Technology Programs*, p. VHA-68, https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[48] Department of Veterans Affairs, "Study evaluates VA program that identifies Vets at highest risk for suicide," https://www.research.va.gov/currents/0918-Study-evaluates-VA-program-that-identifies-Vets-at-highest-risk-for-suicide.cfm.

[49] Department of Veterans Affairs, *FY2021 Congressional Budget Submission, Volume II: Medical Programs and Information Technology Programs*, p. VHA-68, https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[50] U.S. National Library of Medicine, "REACH VET Program Evaluation (REACH VET)," https://clinicaltrials.gov/ct2/show/NCT03280225.

authorized VA to provide an initial mental health care assessment and subsequent mental or behavioral health care services to certain former servicemembers, including those who served in the Reserve components and who meet each of the following criteria:

- **Conditions of discharge:** the veteran served on active duty and was discharged or released under a condition that is not honorable (but not a dishonorable discharge), or was discharged by court-martial (i.e., those with a dishonorable discharge or a discharge by court-martial would not be eligible for mental health care services from VA).
- **Duration of service:** the veteran served for a period of more than 100 cumulative days.
- **Conditions of service:** the veteran (1) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities occurred, including by controlling an unmanned aerial vehicle (UAV) from a location other than such theater or area; or (2) was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment.
- **Not currently enrolled** in VA's health care system.[51]

Those veterans with an other than honorable (OTH) administrative discharge and who meet the above criteria are not required to enroll in VA's health care system, to meet the minimum active duty service requirements, or to pay any copayments for mental and behavioral health care services included under VA's standard medical benefits package.[52]

The Secretary is required to submit a report at least once annually to SVAC and HVAC on the services provided under this authority.[53]

Provision

Section 104 amends the reporting requirements under 38 U.S.C. §1720I to specify that the annual report be submitted no later than February 15. In addition, the section prescribes three additional requirements for the annual report, which must specify (1) the types of mental or behavioral health care needs treated; (2) the demographics of individuals treated including age, era of service in the Armed Forces, branch of service in the Armed Forces, and geographic location; and (3) the average number of visits of individuals who were provided mental or behavioral health care.

Title II: Suicide Prevention

In 2018, the suicide rate for veterans was 1.5 times greater than among nonveteran adults (adjusting for age and sex), and an average of 17.6 veterans died by suicide per day.[54] VA has

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[51] 38 U.S.C. §1720I.

[52] Department of Veterans Affairs, Veterans Health Administration, "Eligibility Determination," VHA Directive 1601A.02, amended October 15, 2020.

[53] 38 U.S.C. §1720I(f).

[54] Office of Mental Health and Suicide Prevention, *2020 National Veteran Suicide Prevention Annual Report*, Department of Veterans Affairs, November 2020, p. 5, https://www.mentalhealth.va.gov/docs/data-sheets/2020/2020-National-Veteran-Suicide-Prevention-Annual-Report-11-2020-508.pdf. Previous VA reports on the suicides per-day statistic included veterans, current servicemembers, and never federally activated former Guard and Reserve members. The 2018 statistic does not include current servicemembers or never federally activated former servicemembers.

named suicide as its top clinical priority for FY2018 to FY2024,[55] while recognizing that coordinated efforts from different stakeholders and across settings can increase the reach of veteran suicide prevention activities.[56] This title includes provisions to address veteran suicide through a multifactorial approach. Such provisions include requiring VA to (1) award grants to certain community-based organizations to provide veteran suicide prevention services to eligible veterans; (2) examine the feasibility of and increase access to complementary and integrative health programs; and (3) examine factors potentially related to veteran suicide. In addition, GAO is required to conduct oversight of VA's management of veterans at high risk for suicide.

Section 201: Financial Assistance to Certain Entities to Provide or Coordinate the Provision of Suicide Prevention Services for Eligible Individuals and Their Families[57]

Background

As stated elsewhere in this report, the need for community-based engagement to prevent veteran suicide led to a grant program to address this issue. In its FY2021 budget request to Congress, the Trump Administration proposed legislation that would allow VA to provide grants to community-based organizations to "replicate and/or expand VA suicide prevention services."[58] In addition, the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)[59] found that

> funding initiatives that support a public health approach are vital to empowering Veterans and preventing suicide at the local level. As existing community-based grants to do this are limited, additional funding in the short and long term would expand opportunities to identify new effective strategies and ensure that all communities are provided with opportunities to create environments where Veterans will thrive. An expanded, Federal grant program can also assist in meeting the needs of the community by ensuring that critical data, training, and technical assistance are available and accessible at the program level.[60]

PREVENTS recommended developing "a coordinated, interagency Federal funding mechanism to support, provide resources for, and facilitate the implementation of successful evidence-informed mental health and suicide prevention programs focused on Veterans and their communities at the State and local levels."[61]

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[55] Department of Veterans Affairs, *FY2018 - 2024 Strategic Plan*, May 31, 2019, https://www.va.gov/oei/docs/va2018-2024strategicplan.pdf.

[56] Department of Veterans Affairs, "National Strategy for Preventing Veteran Suicide, 2018-2028," p. 13, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[57] 38 U.S.C. §1720F note.

[58] Department of Veterans Affairs, *FY2021 Congressional Budget Submission, Volume I: Supplemental Information and Appendices*, Legislative Summary, p. 10.

[59] On March 5, 2019, President Trump signed Executive Order (EO) 13861 "The President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)" to address veteran suicide in the United States. For more information, see https://www.va.gov/PREVENTS/EO-13861.asp.

[60] Department of Veterans Affairs, *President's Roadmap to Empower Veterans and End a National Tragedy of Suicide (PREVENTS)*, June 17, 2020, p. 46.

[61] Department of Veterans Affairs, *PREVENTS*, p. 46.

Provision

Section 201(a) establishes a new grant program, the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program. The purpose of the grant program is "to reduce veteran suicide through a community-based grant program to award grants to eligible entities to provide or coordinate suicide prevention services to eligible individuals and their families."

Financial Assistance and Coordination

Section 201(b) requires the Secretary to award grants to eligible entities to provide or coordinate the provision of services to eligible individuals and their families to reduce the risk of suicide. The Secretary is required to implement this grant program, to the extent practicable, in coordination with PREVENTS and in consultation with VA's OMHSP.

Award of Grants, Grant Amounts, Intervals of Payment, and Matching Funds

Section 201(c) stipulates that based on the suicide prevention services to be provided by an eligible entity, and the duration of such services, the Secretary must establish a maximum amount to be awarded under the grant program and intervals of payment for the administration of the grant. The maximum amount awarded is limited to no more than $750,000 per grantee per fiscal year.

Distribution of Grants and Preference

Section 201(d) stipulates criteria the Secretary is required to consider and follow when distributing grants. The Secretary may prioritize grants to (1) rural communities; (2) tribal lands; (3) territories of the United States; (4) medically underserved areas; (5) areas with a high number or percentage of minority veterans or women veterans; and (6) areas with a high number or percentage of calls to the Veterans Crisis Line (VCL). The Secretary is required to ensure that, to the extent practicable, grants are distributed to (1) areas of the United States that have experienced high rates of suicide and suicide attempts by eligible individuals, and (2) eligible entities that can assist eligible individuals at risk of suicide who are not currently receiving health care furnished by VA. The Secretary may provide grants to eligible entities that furnish services to eligible individuals and their families in geographically dispersed areas. Lastly, the Secretary is required to give preference to eligible entities that have demonstrated the ability to provide or coordinate suicide prevention services.

Requirements for Receipt of Grants

Section 201(e) requires that each grantee for the provision of suicide prevention services must notify eligible recipients that such services are being paid for, in whole or in part, by VA. The section also requires that any suicide prevention plan be developed in consultation with the eligible recipients and their families. Section 201(e)(3) requires that any grantee coordinate with the Secretary regarding the provision of clinical services, and inform every veteran who receives assistance through the grant of the ability to apply for enrollment in the VA health care system. If a veteran wishes to enroll, the grantee must inform the veteran of a VA point of contact who can assist with enrollment.[62] Section 201(e)(4) stipulates that a grantee must submit to the Secretary a description of such tools and assessments the entity uses or will use to determine the effectiveness of the suicide prevention services furnished. The description must also include measures and metrics on the effectiveness of the programming being provided, and may include the effect of the services furnished on the financial stability of the individual; the mental health status,

[62] For more information on current eligibility and enrollment in the VA health care system, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

wellbeing, and suicide risk of the individual; and the social support of the individuals receiving those services. Under Section 201(e)(5), the Secretary shall require each grantee to submit an annual report to the Secretary that describes the grant projects carried out during the year covered by the report. The report must include evaluation criteria and data, as specified by the Secretary, and the Secretary may require additional reports, as appropriate.

Application for Grants

Section 201(f) stipulates that an entity seeking a grant is required to submit to the Secretary an application in such form and manner as prescribed by Secretary. Each application submitted by an eligible applicant must include the following:

- a description of proposed suicide prevention services, and the need for those services;
- a detailed plan describing how the applicant proposes to coordinate or deliver suicide prevention services, including
    - identification of the community partners, if any, with which the applicant proposes to work in delivering suicide prevention services;
    - a description of the arrangements currently in place between the applicant and community partners with regard to the provision or coordination of suicide prevention services;
    - identification of the duration of those partnerships, and a description of the suicide prevention services provided by community partners, if any; and
    - identification of local VA suicide prevention coordinators (SPCs) and a description of how the applicant will communicate with VA SPCs;
- a description of the number of eligible individuals and their families that would be provided suicide prevention services;
- an estimate of the number of eligible individuals at risk of suicide and their families that will be provided suicide prevention services, including the percentage of those eligible individuals who are not currently receiving care provided by VA;
- evidence of measurable outcomes related to reductions in suicide risk and mood-related symptoms using validated instruments by the applicant (the applicant's community partners, if any);
- a description of the managerial and technological capacity of the applicant, including the following:
    - to coordinate the provision of suicide prevention services;
    - to assess on an ongoing basis the needs of eligible individuals and their families for suicide prevention services;
    - to coordinate the provision of suicide prevention services with the services provided by VA;
    - to adapt suicide prevention services to the needs of eligible individuals and their families;
    - to seek continuously new sources of assistance to ensure the continuity of suicide prevention services for eligible individuals and their families as long as they are determined to be at risk of suicide; and

    - to measure the effects of suicide prevention services provided by the applicant or partner organization, on the lives of eligible individuals and their families who receive such services provided by the organization using pre- and post-evaluations on validated measures of suicide risk and mood-related symptoms;
- clearly defined objectives for the provision of suicide prevention services;
- a description and physical address of the primary location of the applicant;
- a description of the geographic area the applicant plans to serve during the grant award period for which the application applies;
- if the applicant is a state or local government or an Indian tribe, the amount of grant funds proposed to be made available to community partners, if any, through agreements;
- a description of how the applicant will assess the effectiveness of the provision of grant funds;
- an agreement that the applicant would use the measures and metrics provided by VA; and
- any additional application criteria as prescribed the Secretary.

Training and Technical Assistance

Section 201(g) requires the Secretary to provide technical assistance and training in coordination with the Centers for Disease Control and Prevention (CDC) to grantees (or eligible entities in receipt of a grant). The technical assistance and training is to involve suicide risk identification and management, required data collection and sharing, familiarization with appropriate data collection tools, and assistance with data collections for annual reporting requirements, among other things. The Secretary may provide this technical assistance and training directly or by entering into contracts with public or nonprofit entities.

Administration of Grant Program

Section 201(h) requires the Secretary to establish criteria for the selection of grantees, in consultation with numerous entities such as veteran service organizations (VSOs), tribal alliances, state departments of veterans affairs, the National Alliance on Mental Illness (NAMI), certain federal agencies, and institutions of higher education that have expertise in creating measurement criteria, among other entities and organizations. The section also requires the Secretary to develop, in consultation with those same entities, a framework for collecting and sharing information about grantees to improve the services available for eligible individuals and their families based on service type, locality, and eligibility criteria, as well as measures and metrics to be used by the grantees to determine the effectiveness of the services they are providing. Section 201(h)(4) requires the Secretary, no later than 30 days before the notification of the availability of grant funding, to provide a report to SVAC, HVAC, and MILCON-VA on the criteria for the award of a grants.

Information on Potential Eligible Individuals

Section 201(i) allows the Secretary to provide eligible grantees information about potential eligible individuals. This information may include veteran status and enrollment status in the VA health care system, including whether they are currently receiving care through VA. The Secretary must allow veterans to opt out of having their information shared with eligible grantees.

Duration of the Grant Program

Section 201(j) stipulates that the Secretary is not authorized to award grants on the date that is three years after the date on which the first grant is awarded.

Reporting

Section 201(k) requires the Secretary to submit an interim report to SVAC, HVAC, and MILCON-VA no later than 18 months after the date on which the first grant is awarded. This report must include the following information:

- an assessment of the effectiveness of the grant program;
- a list of grantees, and the amount of each grant awarded;
- the number of eligible individuals supported by each grantee, including services provided to family members;
- the number of eligible individuals not receiving VA care;
- the number of eligible individuals who received a baseline assessment about their mental health status, well-being, and suicide risk, and who will be measured for any improvements over time;
- the types of data VA was able to collect;
- the number and percentage of eligible individuals referred for enrollment in the VA health care system;
- the number of eligible individuals newly enrolled in the VA health care system based on such referral;
- a detailed account of grant expenditures, including executive compensation, overhead costs, and other indirect costs;
- a description of any outreach activities conducted by the grantees; and
- the number of ineligible individuals who seek services under the grant program.

Furthermore, Section 201(k)(2) stipulates that the Secretary is required to submit a final report to SVAC, HVAC, and MILCON-VA no later than three years after the award of the first grant and then annually for the duration of the grant program. The final report would be a follow-up to the interim report submitted previously, and would include additional information regarding the effectiveness of the grant program, an assessment of VA's capacity to provide services to eligible individuals, feasibility and advisability of extending or expanding the grant program, and any other relevant information.

Third-Party Assessment

Section 201(l) requires the Secretary, no later than 180 days after the start of the grant program, to enter into a contract with a nongovernment entity with experience in evaluating organizations that deliver suicide prevention programs. The contracted entity must evaluate the effectiveness of the grant program and compare the results of the grant program to other national programs. The contracted entity must provide this assessment to the Secretary no later than 24 months after the start of the grant program. Upon receipt of the assessment the Secretary is required to provide a copy to SVAC, HVAC, and MILCON-VA.

Referral for Care

Section 201(m) stipulates that if a grantee determines that an eligible individual is at risk of suicide or another mental or behavioral health condition, that individual must be referred to VA for additional care. The section also stipulates that if a grantee determines that an eligible individual is provided emergency care and that individual needs further care and services, that

individual must also be referred to VA for further treatment. If the individual declines the referral to VA, any ongoing clinical care provided will be at the expense of the grantee.

Provision of Care to Eligible Individuals

Section 201(n) requires the Secretary, if clinically appropriate, to provide an initial mental health assessment and mental health or behavioral health care services through the VA health care system for individuals who are receiving services through the grant program and are referred for care.

Agreements with Community Partners

Section 201(o) allows state or local government or Indian tribe grantees to use grant funds to enter into contracts with community partners for the provision of suicide prevention services.

Authorization of Appropriations

Section 201(p) authorizes a total of $174 million to be appropriated for FY2021 through FY2025.

Definitions

Section 201(q) defines the following terms applicable to the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.

Appropriate committees of Congress. SVAC, HVAC, MILCON-VA.

Eligible Entity. (1) "an incorporated private institution or foundation in which no part of the net earnings of which incurs to the benefit of any member, founder, contributor, or individual; and that has a governing board that would be responsible for the operation of the suicide prevention services", (2) a corporation wholly owned and controlled by an organization in which no part of the net earnings incurs to the benefit of any member, founder, contributor, or individual, and that has a governing board that would be responsible for the operation of the suicide prevention services, (3) an "Indian tribe", (4) "a community-based organization that can effectively network with local civic organizations, regional health systems, and other settings where eligible individuals and their families are likely to have contact", or (5) a "State or local government."

Eligible Individual. A person at risk of suicide "who served in the active military, naval, or air service, and who was discharged or released therefrom under conditions other than dishonorable";[63] or former servicemembers, including those who served in the Reserve components and who meet each of the following criteria:[64]

- *Conditions of discharge*: the veteran served on active duty and was discharged or released under a condition that is not honorable (but not a dishonorable discharge), or was discharged by court-martial (i.e., those with a dishonorable discharge or a discharge by court-martial would not be eligible for mental health care services from VA).
- *Duration of service*: the veteran served for a period of more than 100 cumulative days.
- *Conditions of service*: the veteran (1) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities occurred, including by controlling an unmanned aerial vehicle

[63] 38 U.S.C. §101(2). Section 926 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (P.L. 116-283) amended the term "veteran" to include "space service." The Office of the Law Revision Counsel of the U.S. House of Representatives has not codified this change as of the date of this report.

[64] 38 U.S.C. §1720I(b).

(UAV) from a location other than such theater or area, or (2) was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment.

- Not currently enrolled in VA's health care system.

Additional criteria include the following:

> Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who served on active duty in a theater of combat operations or an area at a time during which hostilities occurred in that area.[65]
>
> Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who provided direct emergency medical or mental health care, or mortuary services to the causalities of combat operations or hostilities, but who at the time was located outside the theater of combat operations or area of hostilities.[66]
>
> Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who engaged in combat with an enemy of the United States or against an opposing military force in a theater of combat operations or an area at a time during which hostilities occurred in that area by remotely controlling an unmanned aerial vehicle, notwithstanding whether the physical location of such veteran or member during such combat was within such theater of combat operations or area.[67]
>
> Any individual who is a veteran or member of the Armed Forces, including a member of a reserve component of the Armed Forces, who served
>
> - on active service in response to a national emergency or major disaster declared by the President; or
> - in the National Guard of a State under orders of the chief executive of that State in response to a disaster or civil disorder in such State."[68]

Emergency Treatment. Medical services, professional services, ambulance services, ancillary care and medication rendered in a medical emergency in which it could be reasonably expected that absence of immediate medical attention would result in serious health consequences.

Family. Family includes a parent, a spouse, a child, a sibling, a step-family member, an extended family member, or any other individual who lives with the eligible individual.

Indian Tribe. "Any Indian tribe, band, nation, or other organized group or community of Indians, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act, that is recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians pursuant to the Indian Self-Determination and Education Assistance Act of 1975."[69]

Risk of Suicide. Exposure to, or the existence of, any of the following risk factors: mental health challenges; substance abuse; serious or chronic health conditions or pain; traumatic brain injury; prolonged stress; stressful life events; unemployment; homelessness; recent loss; legal or financial challenges; previous suicide attempts; family history of suicide; history of abuse,

[65] 38 U.S.C. §1712A(a)(1)(C)(i).

[66] 38 U.S.C. §1712A(a)(1)(C)(ii).

[67] 38 U.S.C. §1712A(a)(1)(C)(iii).

[68] 38 U.S.C. §1712A(a)(1)(C)(iv).

[69] Section 4 of the Native American Housing Assistance and Self-Determination Act (NAHASDA, P.L. 104-330); 25 U.S.C. §4103.

neglect, or trauma. The Secretary may establish a process for determining degrees of suicide risk through regulation.

Rural. Rurality as defined by the Rural-Urban Commuting Areas (RUCA) system.[70]

Suicide Prevention Services. Suicide prevention services are those that address the needs of eligible individuals and their families and include, among other things, outreach to identify those at risk, a baseline mental health screening for risk, peer support services, and other services necessary for improving mental health status and well-being of eligible individuals and their families, including adaptive sports and family counseling.

Veterans Crisis Line (VCL). The VCL is "a toll-free hotline for veterans to be staffed by appropriately trained mental health personnel and available at all times."[71]

Veterans Service Organization (VSO). Organizations recognized by VA to prepare, present, and prosecute claims.[72]

Sections 202 and 203: Analysis on Feasibility and Advisability of the Department of Veterans Affairs Providing Certain Complementary and Integrative Health Services; Pilot Program to Provide Veterans Access to Complementary and Integrative Health Programs through Animal Therapy, Agritherapy, Sports and Recreation Therapy, Art Therapy, and Posttraumatic Growth Programs

Background

VA has broad authority to offer health services through the standard medical benefits package if it is determined by appropriate health care professionals that the care is needed to promote, preserve, or restore the health of the individual and is in accord with generally accepted standards of medical practice.[73] Under this authority, VA has established a vetting process for including complementary and integrative health (CIH) services in the standard medical benefits process.[74] The vetting process considers the following criteria:

- licensing and credentialing;
- clinical practice guidelines, current evidence, community standards, and potential for harm;
- veteran demand; and
- supports transformation of health care delivery.

[70] For more information, see https://www.ers.usda.gov/data-products/rural-urban-commuting-area-codes/.

[71] 38 U.S.C. §1720F(h).

[72] For more information on VSOs, see CRS Report R46412, *Veterans Service Organizations (VSOs): Frequently Asked Questions*; and CRS Report R46428, *Veterans Accredited Representatives: Frequently Asked Questions*.

[73] 38 C.F.R. §17.38(b).

[74] Department of Veterans Affairs, Veterans Health Administration, "Provision of Complementary and Integrative Health (CIH)," VHA Directive 1137, p. B-1, May 18, 2017.

Under these criteria, VA has approved a number of CIH approaches for coverage under the VHA standard medical benefits package (38 C.F.R. §17.38). These include acupuncture, biofeedback, clinical hypnosis, guided imagery, massage therapy, meditation, Tai Chi/Qi Gong, and yoga.[75]

Section 931 of the Jason Simcakoski Memorial and Promise Act (Title IX of P.L. 114-198) established the Creating Options for Veterans' Expedited Recovery (COVER) Commission, which was required to examine the evidence-based therapy treatment model used by the Secretary for treating mental health conditions of veterans and the potential benefits of incorporating CIH treatments available in nondepartment facilities.[76] The COVER Commission published a final report on February 6, 2020.[77]

The final report of the COVER Commission made a recommendation to "establish an ongoing research program focused on testing and implementation of promising adjunctive CIH modalities associated with positive mental health, functional outcomes, and wellness that support whole health and the VA Health Care Transformation Model."[78] This model is the overarching recommendation of the COVER Commission, and it is intended to transform VA health care delivery from a reductionist to a whole health person-centered approach.[79]

Provisions

Section 202 requires the Secretary to complete an analysis on the feasibility and advisability of providing specified CIH treatments. The Secretary is required to complete the analysis no later than 180 days from enactment of this act (i.e., April 15, 2021). In addition, this section requires the Secretary to include an assessment of the COVER Commission final report in the aforementioned analysis. The Secretary is required to submit a report to SVAC and HVAC on the analysis that includes recommendations regarding the furnishing of CIH treatments.

Section 203 requires the Secretary to create a pilot program to provide access to specified CIH programs no later than 180 days after the date on which the COVER Commission submitted its final report (i.e., July 24, 2020).[80] This section specifies that the pilot program provide equine therapy, other animal therapy, agritherapy, sports and recreation therapy, art therapy, and posttraumatic growth programs. The pilot program must be conducted at no fewer than five VA facilities that meet specified criteria. To be eligible for services, veterans must be enrolled in the VA health care system and have received services within the two-year period preceding the initiation of the pilot program.[81] The Secretary is required to carry out the pilot program for at least three years and must submit an interim report on program progress to SVAC and HVAC no later than one year after commencement of the pilot program. The Secretary may extend the duration of the pilot program beyond three years based on the results of the interim report indicating that it is appropriate to do so. The interim report is required to include, among other

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[75] Department of Veterans Affairs, Veterans Health Administration, Office of Patient Centered Care and Cultural Transformation, *Integrative Health Coordinating Center (IHCC) Fact Sheet*, https://www.va.gov/WHOLEHEALTH/docs/IHCC_FactSheet_508.pdf.

[76] 38 U.S.C. §1701 note.

[77] Creating Options for Veterans Expedited Recovery (COVER) Commission, *Final Report*, January 24, 2020, https://www.va.gov/COVER/docs/COVER-Commission-Final-Report-2020-01-24.PDF. (Hereinafter referred to as "The COVER Commission Final Report."

[78] The COVER Commission Final Report, p. 42.

[79] *COVER Commission Final Report*, p. 71.

[80] The implementation deadline took place prior to enactment of the Hannon Act (October 17, 2020).

[81] For information on eligibility and enrollment in VA health care, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

things, the number of participants, the types of therapy offered, an assessment of effectiveness, and the determination of whether the program will be extended beyond three years. The Secretary is required to submit a final report to SVAC and HVAC no later than 90 days after termination of the pilot program.

Section 204: Department of Veterans Affairs Study of All-Cause Mortality of Veterans, Including by Suicide, and Review of Staffing Levels of Mental Health Professionals

Background

Due to combat-related injuries, among other factors, veterans have higher rates of chronic pain, traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), and other mental health conditions compared with the civilian population. Opioids are primarily prescribed for acute and chronic pain treatment. Coupled with the addictive properties of opioids and potential subsequent transition to other types of harmful opioids (e.g., heroin), increases in prescribing and use from the late 1990s until approximately 2012—prompted by a desire to improve pain management—have resulted in high levels of morbidity and mortality among both veteran and civilian populations. Benzodiazepines are typically prescribed for anxiety or insomnia, but severe adverse effects have been associated with chronic use of this medication. Similar to opioids, benzodiazepine prescribing increased from the late 1990s to approximately 2012, but, unlike for opioids, prescribing still remains at high levels. Further, concomitant opioid and benzodiazepine use is associated with increased rates of unintentional overdose and death, as well as suicide.[82]

In a 2013 HVAC hearing on narcotic overprescribing within VHA, Dr. Claudia Bahorik—at the time, a VHA provider—in her testimony recommended ways to address this issue. Among other things, she suggested addressing insufficient staffing to more closely monitor veterans receiving narcotic prescriptions.[83] To help monitor narcotic prescriptions, VHA implemented the Opioid Safety Initiative (OSI) and the Psychotropic Drug Safety Initiative (PDSI) in 2013.[84] However, even with these initiatives, it is not clear to what extent opioid and benzodiazepine co-prescribing in VHA may have contributed to adverse outcomes among veterans. In response to concerns regarding overprescribing of these medications within VHA, Congress provided funds to NASEM in FY2018 "to conduct an assessment of the potential overmedication of veterans during fiscal years 2010 to 2017 that led to suicides, deaths, mental disorders, and combat-related traumas."[85] NASEM subsequently published a 2019 assessment that, among other things, included examples of observational study protocols to estimate the causal effects of opioid and

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[82] National Academies of Sciences, Engineering, and Medicine, *An Approach to Evaluate the Effects of Concomitant Prescribing of Opioids and Benzodiazepines on Veteran Deaths and Suicides*, Washington, DC, 2019, p. 1, https://www.nap.edu/read/25532/chapter/2.

[83] U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Health, *Between Peril and Promise: Facing the Dangers of VA's Skyrocketing Use of Prescription Painkillers to Treat Veterans*, 113th Cong., 1st sess., October 10, 2013 (Washington: GPO, 2014).

[84] National Academies of Sciences, Engineering, and Medicine, *An Approach to Evaluate the Effects of Concomitant Prescribing of Opioids and Benzodiazepines on Veteran Deaths and Suicides*, 2019, p. 2, and VA Office of Inspector General (OIG), *Healthcare Inspection Patient Mental Health Care Issues at a Veterans Integrated Service Network 16 Facility*, Department of Veterans Affairs, Washington, DC, January 4, 2018, p. 4, https://www.va.gov/oig/pubs/VAOIG-16-03576-53.pdf.

[85] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, *Book 2 of 2; Divisions G-L*, committee print, 115th Cong., 2nd sess., 2018, p. 1575.

benzodiazepine co-prescribing on veteran suicides.[86] In FY2020 appropriations report language, Congress directed VA to work with NASEM to implement the study design specified in the 2019 assessment.[87]

Prior to enactment of the Hannon Act, Congress introduced other legislation in the 116th Congress to address this issue.[88] Among other things, the proposed legislation would have required VA to review the number of veterans who died by suicide and were prescribed multiple medications in a five-year period, and provide a description of the efforts of VHA to maintain appropriate mental health staffing levels.

Provision

Section 204(a) requires the Secretary to enter into an agreement with NASEM under which the Secretary shall collaborate with the National Academies on a revised study design to fulfill the goals of the 2019 study design, evaluating the effects of opioids and benzodiazepines on all-cause mortality of veterans, including suicide, among other things. As required by Section 204(d), the Secretary shall brief SVAC and HVAC on the interim results no later than two years after entering into the agreement with NASEM. Section 204(e)(1) requires the Secretary, in coordination with NASEM, to submit a report on the results of the study to SVAC and HVAC no later than 90 days after completion of the study.

Section 204(b) requires GAO, no later than 90 days after enactment (i.e., January 15, 2021), to conduct a review of staffing levels for mental health professionals within VA, including mental health counselors, marriage and family therapists, and other appropriate counselors. The review is required to include

- a description of barriers to carry out education, training, and hiring of mental health professionals, as required by 38 U.S.C. §7302(a), and strategies to address those barriers;
- a description of the objective, goals, and timing to increase representation of counselors and therapists in the VA behavioral health workforce;
- an assessment of VA's development of hiring guidelines for mental health professionals;
- a description of how VA identifies gaps in mental health professional staffing and determines successful staffing ratios for mental health professionals;
- a description of actions taken by the Secretary, in coordination with the Office of Personnel Management (OPM), to create an occupational series for mental health professionals; and
- a description of actions taken by the Secretary to ensure that the national, regional, and local professional standards boards for mental health professionals are composed of only mental health professionals, and that the VA liaison to such boards is a mental health professional.

As required by Section 204(d), the Secretary shall brief SVAC and HVAC on the interim results of the review no later than 18 months after enactment (i.e., April 17, 2022). Section 204(e)(2)

[86] National Academies of Sciences, Engineering, and Medicine, *An Approach to Evaluate the Effects of Concomitant Prescribing of Opioids and Benzodiazepines on Veteran Deaths and Suicides*, 2019.

[87] U.S. Congress, House Committee on Appropriations, Subcommittee on Military Construction, Veterans Affairs, and Related Agencies, committee print, 116th Cong., 2nd sess., 2020, p. 849.

[88] See for example, S. 2991 (116th Congress).

requires GAO to submit a report on the results of the review and make the report publicly available no later than 90 days after completion of the review.

Section 204(c) requires the data compiled under subsections (a) and (b) to be separated and disaggregated by year so that such data can be analyzed across all data fields to potentially inform and update VA clinical practice guidelines.

Section 205: Comptroller General Report on Management by Department of Veterans Affairs of Veterans at High Risk for Suicide

Background

Suicide is difficult to predict for many reasons—one reason being that there is no one cause of suicide. A 2016 meta-analysis of national and international longitudinal studies examining suicide risk among psychiatric patients concluded that "a statistically strong and reliable method to usefully distinguish patients with a high-risk of suicide remains elusive."[89] However, recent research suggests that data from health care records can be used to predict suicide risk, and such research was used in development of VHA's REACH VET program.[90]

In addition, VHA launched a new, standardized suicide screening initiative in 2018 for all veterans receiving VHA care.[91] The suicide risk screening was fully implemented in October 2019 and occurs in three phases, with the first phase comprising an annual initial screening.[92] Veterans who receive positive screenings from the first phase or who are receiving mental health care are administered the second phase, which includes six questions from the Columbia-Suicide Severity Rating Scale (C-SSRS), an evidence-based screener used by both national and international institutions.[93] The third and final phase is administered to veterans who receive a positive screening from the second phase or who have demonstrated suicidal behavior. This third phase, VA's Comprehensive Suicide Risk Evaluation, is a more in-depth evaluation that assesses warning signs and history of attempts, among other things. This final phase is intended to form a mental health treatment plan specific to the needs of the veteran.[94] Suicide prevention

[89] Matthew Large, Muthusamy Kaneson, Nicholas Myles, et al., "Meta-Analysis of Longitudinal Cohort Studies of Suicide Risk Assessment among Psychiatric Patients: Heterogeneity in Results and Lack of Improvement over Time," *PLoS ONE*, vol. 11, no. 6 (June 10, 2016), p. https://doi.org/10.1371/journal.pone.0156322.

[90] U.S. Congress, House Committee on Veterans' Affairs, *Testimony before the House Committee on Veteran's Affairs*, *Tragic Trends: Suicide Prevention Among Veterans*, prepared by Shelli Avenevoli, Ph.D., 116th Cong., 1st sess., April 29, 2019, p. 3.

[91] Department of Veterans Affairs, "VA sets standards in suicide risk assessment, offers support to community providers," January 2, 2019, https://blogs.va.gov/VAntage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers/.

[92] U.S. Government Accountability Office, *VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664, September 2020, p. 8, https://www.gao.gov/assets/710/709243.pdf.

[93] National Suicide Prevention Lifeline, "Columbia-Suicide Severity Rating Scale (C-SSRS)," https://suicidepreventionlifeline.org/wp-content/uploads/2016/09/Suicide-Risk-Assessment-C-SSRS-Lifeline-Version-2014.pdf.

[94] Department of Veterans Affairs, "VA sets standards in suicide risk assessment, offers support to community providers," January 2, 2019, https://blogs.va.gov/VAntage/55281/va-sets-standards-in-suicide-risk-assessment-offers-support-to-community-providers/.

coordinators (SPCs) coordinate the mental health care of at-risk veterans,[95] and family and friends play an important role in supporting at-risk veterans.[96]

Provision

Section 205 requires GAO to conduct a study, no later than 18 months after enactment (i.e., April 17, 2022), on VA's efforts to manage veterans at high risk for suicide. The report is required to include, among other things (1) a description of how VA identifies patients at high risk for suicide; (2) a description of how VA intervenes when a patient is identified as high risk; (3) a description of how VA monitors patients who have been identified as high risk; (4) a review of staffing levels of SPCs across VHA; (5) a review of the resources and programming offered to family members and friends of veterans with a mental health condition; and (6) any other areas GAO considers appropriate.

Title III: Programs, Studies, and Guidelines on Mental Health

An understanding of mental health disorders is strengthened through research; likewise, treatment informed by such research is evolving. This title includes provisions to require research on certain suicide risk factors among veterans; to implement an initiative to identify and validate brain and mental health biomarkers—measurable characteristics of body functions (e.g., blood pressure)—among veterans; to provide VA with additional authority to use data collected from electronic health systems to analyze mental health outcomes; and to establish and update VA and DOD mental health and suicide treatment resources.

Section 301: Study on Connection Between Living at High Altitude and Suicide Risk Factors Among Veterans

Background

Both international and domestic studies have found that individuals who live at higher altitudes are at increased risk for suicide. In one study conducted using U.S. data, this correlation held even when accounting for other factors, such as gender, poverty, access to health care, and population density.[97] Furthermore, the correlation between altitude and suicide was stronger among veterans than nonveterans. Among veterans, the correlation was not significant among veterans aged 18-34, but it was significant in all other age groups above age 35, with the greatest correlation among veterans who were older than 75.[98]

Hypoxia is a condition that causes decreased oxygenation in the body tissues. One study found that chronic hypoxic markers—living at high altitude, smoking, and chronic obstructive

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[95] Department of Veterans Affairs, Veterans Health Administration, "Uniform Mental Health Services in VA Medical Centers and Clinics," VHA Handbook 1160.01, amended November 16, 2015.

[96] Department of Veterans Affairs, "National Strategy for Preventing Veteran Suicide, 2018-2028," p. 28, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[97] Hana Sabic, Brent Kious, Danielle Boxer, et al., "Effect of Altitude on Veteran Suicide Rates," *High Altitude Medicine & Biology*, vol. 20, no. 2 (June 1, 2019), pp. 171-177.

[98] Hana Sabic, Brent Kious, and Danielle Boxer, et al., "Effect of Altitude on Veteran Suicide Rates," *High Altitude Medicine & Biology*, pp. 171-177.

pulmonary disease (COPD)—may increase suicide risk in veterans.[99] As noted by VA, although chronic hypoxia appears to play a role in the correlation between altitude and suicide, more research is needed to understand the role that demographic, social, and environmental factors may play. Understanding if and how altitude contributes to suicide could help to determine appropriate prevention and treatment options.[100]

Provision

Section 301 requires the Secretary, no later than 180 days after enactment (i.e., April 15, 2021), to conduct a study on the connection between living at high altitude and the risk of developing depression or dying by suicide among veterans on an individual level (rather than at the state or county level). The study is to be completed no later than three years after it commences, and, the Secretary shall submit a report on the findings of the study to SVAC and HVAC no later than 150 days after its completion.

Section 301(e) requires the Secretary to conduct a follow-up study if the study conducted under this section shows high altitude to be a risk factor for developing depression or dying by suicide. The follow-up study shall focus on likely biological mechanisms underlying this association, and the most effective treatment or intervention for reducing risk of adverse outcomes associated with living at high altitude. No later than 150 days after completing a follow-up study, the Secretary would be required to submit a report on the results of the study to SVAC and HVAC.

Sections 302, 303, and 304: Establishment by Department of Veterans Affairs and Department of Defense of a Clinical Provider Treatment Toolkit and Accompanying Training Materials for Comorbidities; Update of Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide; and Establishment by Department of Veteran Affairs and Department of Defense of Clinical Practice Guidelines for the Treatment of Serious Mental Illness

Background

VA and DOD often collaborate to jointly develop and publish selected clinical practice guidelines (CPGs) to help health care providers deliver evidenced-based treatment for certain health issues prevalent in military and veteran populations.[101] Although VA and DOD do not require their health care providers to use the CPGs, the documents typically provide insight on "best practices" when developing patient treatment plans.[102] Current VA/DOD CPGs include treatment pathways

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[99] Natalie B. Riblet, Daniel J. Gottlieb, Bradley V. Watts, et al., "Hypoxia-related risk factors for death by suicide in a national clinical sample," *Psychiatry Res.*, vol. 273 (March 2019), pp. 247-251.

[100] Office of Mental Health and Suicide Prevention, Veterans Health Administration, *Understanding the Relationship Between Altitude and Suicide Risk*, U.S. Department of Veterans Affairs, January 31, 2020, https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature_Review_FSTP_Altitude_CLEARED_508_1-31-20.pdf.

[101] The National Academy of Medicine (formerly the Institute of Medicine) describes *clinical practice guidelines* (CPGs) as "statements that include recommendations intended to optimize patient care. They are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options." For more on CPGs, see Institute of Medicine, *Clinical Practice Guidelines We Can Trust*, Washington, DC, 2011, pp. 25-26, https://www.nap.edu/catalog/13058/clinical-practice-guidelines-we-can-trust.

[102] Department of Veterans Affairs, "VA/DoD Clinical Practice Guidelines," accessed December 15, 2020,

for pain management, women's health, trauma rehabilitation, and certain chronic diseases or conditions (e.g., hypertension, dyslipidemia, and obstructive sleep apnea).[103] Four VA/DOD CPGs are specific to mental health:

- assessment and management of patients at risk for suicide,
- major depressive disorder,
- posttraumatic stress disorder (PTSD), and
- substance use disorder.[104]

The VA/DOD Health Executive Committee's Evidence Based Practice Work Group oversees the collaboration process used to develop, adopt, or update VA/DOD CPGs.[105]

Provisions

Section 302 directs the Secretary to develop a "clinical provider treatment toolkit and accompanying training materials" for (1) comorbid mental health conditions, (2) comorbid mental health and substance use disorders, and (3) comorbid mental health and chronic pain. The Secretary is required to consult with the Secretary of Defense in developing the toolkit, which would include elements similar to those in existing VA/DOD CPGs. The toolkit is to include additional guidance on treating patients with

- PTSD and additional mental health, substance use, or chronic pain issues;
- mental health conditions (e.g., anxiety, depression, bipolar disorder) and substance use or chronic pain issues; and
- traumatic brain injury (TBI) and mental health, substance use, or chronic pain issues.

The Secretary is required to develop this toolkit no later than two years from the date of enactment (i.e., October 17, 2022).

Section 303 requires VA and DOD to add new or enhanced guidance in the next published update of the VA/DOD CPG on Assessment and Management of Patients at Risk for Suicide. The revised CPG is to include guidance on (1) gender-specific risk factors, prevention, and treatments for suicide and suicidal ideation; (2) the efficacy of alternative therapies (e.g., yoga, meditation, art therapy, equine therapy, music therapy); and (3) the findings from the COVER Commission.[106]

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https://www.healthquality.va.gov; and Department of Defense (DOD) Psychological Health Center of Excellence, "VA/DoD Clinical Practice Guidelines and Clinical Support Tools," accessed December 18, 2020, https://www.pdhealth.mil/clinical-guidance/clinical-practice-guidelines-and-clinical-support-tools.

[103] Department of Veterans Affairs, "VA/DoD Clinical Practice Guidelines," and Department of Defense Psychological Health Center of Excellence, "VA/DoD Clinical Practice Guidelines and Clinical Support Tools."

[104] Department of Veterans Affairs, "VA/DoD Clinical Practice Guidelines," and Department of Defense Psychological Health Center of Excellence, "VA/DoD Clinical Practice Guidelines and Clinical Support Tools."

[105] The Health Executive Committee (HEC) is a joint VA/DOD entity responsible for "sharing and collaboration efforts to ensure the effective and efficient use of health services and resources." The HEC also oversees numerous work groups and "business lines," including the Evidence Based Practice Work Group (EBPWG). For more on the HEC, see https://www.health.mil/Military-Health-Topics/Access-Cost-Quality-and-Safety/Access-to-Healthcare/DoD-VA-Sharing-Initiatives/Joint-Oversight/HEC. For more on the EBPWG, see https://www.healthquality.va.gov/documents/EvidenceBasedPracticeWGCharter123020161.pdf. For more on the CPG development process, see https://www.qmo.amedd.army.mil/general_documents/GuidelinesforGuidelines.pdf.

[106] Section 931 of the Jason Simcakoski Memorial and Promise Act, as incorporated in the Comprehensive Addiction and Recovery Act of 2016 (P.L. 114-198), directed the establishment of the COVER Commission to "examine the

Section 304 directs VA, DOD, and the Department of Health and Human Services (HHS) to establish a Serious Mental Health Illness Work Group composed of representatives from federal entities, including VA's Health Services Research and Development office, the National Institute of Mental Health, and the Indian Health Service; nonfederal entities (e.g., academic institutions specializing in mental health treatments); and other organizations with relevant mental health expertise. No later than two years after enactment (i.e., October 17, 2022), the Secretary and the work group are required to develop new CPGs on the following mental health conditions:

- schizophrenia;
- schizoaffective disorder;
- persistent mood disorder, including bipolar disorders; and
- other mental health issues that result in "serious functional impairment that substantially interferes with major life activities."

In addition, the Secretary is required to consult with the Secretary of Defense and the HHS Secretary no later than two years from enactment (i.e., October 17, 2022), to assess the VA/DOD CPG on Management of Major Depressive Disorder for any necessary updates.[107]

Section 305: Precision Medicine Initiative of Department of Veterans Affairs to Identify and Validate Brain and Mental Health Biomarkers

Background

Precision medicine is defined as "an approach to disease treatment and prevention that seeks to maximize effectiveness by taking into account individual variability in genes, environment, and lifestyle."[108] In January 2015, President Obama announced the launch of the Precision Medicine Initiative (PMI); this effort was codified by the 21st Century Cures Act (P.L. 114-255) in December 2016.[109] Since 2015, the PMI has been undertaken and led by the National Institutes of Health (NIH), in collaboration with other federal agencies, primarily through the *All of Us* Research Program,[110] a million-person national research cohort program. The program has focused intensively on areas such as governance, recruitment strategies, privacy and security of data, diversity, and data access policies.

Precision medicine research efforts rely on the collection and storage of large amounts of health and other data; therefore, privacy and security of, and access to, this data may be a concern in the context of this type of research. Specifically, the *All of Us* Research Program is carried out consistent with applicable requirements in the HIPAA Privacy and Security Rules,[111] which

evidence-based therapy treatment model used by the Secretary for treating mental health conditions of veterans and the potential benefits of incorporating complementary and integrative health treatments in non-Department facilities."

[107] For more on the VA/DOD CPG on the Management of Major Depressive Disorder, see https://www.healthquality.va.gov/guidelines/MH/mdd/.

[108] Precision Medicine Initiative (PMI) Working Group Report to the Advisory Committee to the Director, NIH, "The Precision Medicine Initiative Cohort Program – Building a Research Foundation for 21st Century Medicine," September 17, 2015, p. 6, https://www.nih.gov/sites/default/files/research-training/initiatives/pmi/pmi-working-group-report-20150917-2.pdf.

[109] PHSA §498E; 42 U.S.C. §289g-5.

[110] For more information, see https://allofus.nih.gov/.

[111] 45 C.F.R. Part 164, Subparts C and E.

govern the use and disclosure of protected health information (PHI), as well as the Common Rule,[112] which governs human research subject protection in federally funded research.

Provision

Section 305 requires the Secretary, no later than 18 months after enactment (i.e., April 17, 2022), to develop and implement an initiative to identify brain and mental health biomarkers[113] among veterans for specified conditions (e.g., depression, anxiety, PTSD, among others). The initiative must be modeled on NIH's *All of Us* Precision Medicine Initiative and coordinated with the VA's Million Veterans Program. Data collected under this initiative must be standardized, as specified, and the Secretary is required to develop robust data privacy and security measures consistent with the Privacy Act of 1974,[114] as well as the HIPAA Rules,[115] with access to the data required to be similarly governed. The Secretary is required to make de-identified data, as defined, available as specified to both federal agencies and nongovernmental entities for research purposes.

Section 306: Statistical Analyses and Data Evaluation by Department of Veterans Affairs

Background

This section was derived from the VA Data Analytics and Technology Assistance Act, introduced in the 116th Congress (H.R. 8148). In a congressional hearing on this legislation, the bill's sponsor, Representative Conor Lamb, explained that the intent of the language is to provide the Secretary with authority to use artificial intelligence and other means of examining data to determine if there is a link between data collected by VA's electronic health records system or other data and mental health outcomes.[116]

Provision

This section adds a new section 119 to Chapter 1 of title 38 of U.S.C., which authorizes the Secretary to enter into a contract or other agreement with an academic institution or other qualified entity, as determined by the Secretary, to carry out statistical analyses and data evaluation as required of the Secretary under current law.

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[112] 45 C.F.R. Part 46.

[113] According to the Food and Drug Administration, a biomarker is "a defined characteristic that is measured as an indicator of normal biological processes, pathogenic processes, or responses to an exposure or intervention, including therapeutic interventions." See https://www.fda.gov/media/99221/download.

[114] 5 U.S.C. §552a.

[115] Defined in the section as "rules promulgated pursuant to the Health Insurance Portability and Accountability Act of 1996 (parts 160, 162, and 164 of title 45, Code of Federal Regulations, or successor regulations)"; 45 C.F.R. Parts 160, 162, and 164.

[116] U.S. Congress, House Committee on Veterans' Affairs, *Full Committee Legislative Hearing*, 116th Cong., 2nd sess., September 10, 2020.

Title IV: Oversight of Mental Health Care and Related Services

VA health care is considered a "high-risk area" by the GAO.[117] Recent GAO reports suggest that certain aspects of VHA's suicide prevention efforts could be improved.[118] This title includes provisions that require GAO to conduct oversight of VA's mental health and suicide prevention services, and to provide additional reporting to Congress on select suicide prevention and mental health programs within VHA and those jointly administered by VA and DOD.

Section 401: Study on Effectiveness of Suicide Prevention and Mental Health Outreach of Department of Veterans Affairs

Background

As specified by VA in its national strategy to prevent veteran suicide, public awareness and other outreach efforts are a key component of necessary prevention efforts.[119] Developing evidence-based consistent messaging requires many steps, including conducting research to ensure that the target audience understands both the problem and desired behavior to address it. Research methods can include literature reviews, surveys, and focus groups.[120] These methods can be useful for evaluating the effectiveness of public awareness campaigns once they have been disseminated.

Although VA has conducted its own evaluations of suicide prevention activities,[121] few independent evaluations have examined VHA's suicide prevention outreach materials and campaigns. Congress has previously required VA to enter into third-party contracts to evaluate VHA's mental health and suicide prevention programs, but these evaluations are not specific to mental health and suicide prevention outreach conducted by VHA.[122]

Provision

Section 401(a) requires the Secretary, no later than 180 days after enactment (i.e., April 15, 2021), to enter into an agreement with an entity outside the federal government to evaluate suicide prevention and mental health outreach materials and campaigns prepared and conducted by VA. Section 401(b) requires the Secretary to convene focus groups as part of the evaluation required under subsection (a). At minimum, the Secretary is required to convene at least eight different focus groups. Such focus groups must meet specified requirements in timing, number of

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[117] GAO, "Managing Risks and Improving VA Health Care," https://www.gao.gov/highrisk/managing-risks-and-improving-va-health-care.

[118] See, for example, U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation*, GAO-19-66, November 15, 2018, https://www.gao.gov/assets/700/695485.pdf, and U.S. Government Accountability Office, *VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664, September 2020, p. 6, https://www.gao.gov/assets/710/709243.pdf.

[119] Department of Veterans Affairs, "National Strategy for Preventing Veteran Suicide, 2018-2028," p. 9, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[120] Linda Langford, David Litts, and Jane L. Pearson, "Using Science to Improve Communications About Suicide Among Military and Veteran Populations: Looking for a Few Good Messages," *American Journal of Public Health*, vol. 103 (January 2013), p. 33.

[121] Department of Veterans Affairs, Office of Inspector General, *Evaluation of Suicide Prevention Programs in Veterans Health Administration Facilities*, May 18, 2017, https://www.va.gov/oig/pubs/VAOIG-16-03808-215.pdf.

[122] 38 U.S.C. §1709B, as added by Section 2 of the Clay Hunt SAV Act (P.L. 114-2).

participants, and representation of participants (e.g., minority veterans). Section 401(c) requires the Secretary, no later than 90 days after the last focus group meeting under subsection (b), to submit a report to SVAC and HVAC on the focus group findings. The report must include, among other things, recommendations for future suicide prevention and mental health materials and campaigns, and a description of any dissenting or opposing viewpoints raised by participants in the focus group.

Section 401(d) requires the Secretary, no later than one year after the last focus group meeting under subsection (b), to complete a survey on the effectiveness of mental health and suicide prevention materials and campaigns. The survey must be informed by the focus group findings and be representative of the veteran population, among other things. Section 401(e) requires that, for each contract regarding the development of suicide prevention and mental health materials and campaigns, the contractor must include representative veteran focus groups as part of effectiveness assessments. Per Section 401(e)(2), such contracts must include a requirement that subcontractors have experience creating influential media campaigns targeting individuals aged 18 to 34. Not more than 2% of VHA OMHSP's contractor budget for suicide prevention and mental health media outreach can be allocated to these subcontractors. Section 401(f) exempts information collection required under this section from the Paperwork Reduction Act (PRA) of 1995.[123]

Section 402: Oversight of Mental Health and Suicide Prevention Media Outreach Conducted by Department of Veterans Affairs

Background

In response to a 2018 request from then HVAC ranking member Representative Tim Walz, GAO conducted a review of VHA's suicide prevention media outreach activities and related oversight.[124] Specifically, the report examined the activities conducted by VHA for its suicide prevention media outreach campaign, and to what extent VHA evaluates the effectiveness of those activities. GAO examined VHA's contract to develop suicide prevention outreach from FY2013 to FY2016 and its contract to develop suicide prevention and mental health outreach from FY2017 to FY2018.

GAO found that VHA's suicide prevention media outreach activities declined in FY2017 and FY2018, and that, accordingly, VHA had spent significantly less than its obligated suicide prevention paid media budget. Media outreach activities include the development of social media content, public service announcements (PSAs), paid media (e.g., VHA pays a fee to more broadly disseminate social media posts), and Suicide Prevention Month activities. According to VHA, this reduction was due to leadership turnover and reorganization of the offices responsible for suicide prevention activities. GAO noted that by not assigning key leadership responsibilities and direct lines of reporting on progress, VHA was not able to effectively implement its suicide prevention media outreach activities and provide proper oversight of progress, including obligations spent and effectiveness of the campaign. To address these issues, GAO provided specific recommendations, including, among others, a delineation of roles and responsibilities, and

[123] P.L. 104-13. The PRA requires, among other things, that agencies obtain Office of Management and Budget (OMB) approval before requesting most information from the public.

[124] U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation*, GAO-19-66, November 15, 2018, https://www.gao.gov/assets/700/695485.pdf.

establishing targets for its metrics (e.g., goals for how many individuals VHA wishes to view its outreach content) to improve evaluation efforts.[125]

Provision

Section 402(a) codifies the aforementioned GAO recommendations. Namely, it requires the Secretary to establish goals for VA mental health and suicide prevention media outreach campaigns, including the establishment and tracking of targets, metrics, and action plans to describe and assess campaigns. In establishing these goals, the Secretary is required to consult with mental health and suicide prevention experts, as well as relevant stakeholders and other persons determined appropriate by the Secretary. These goals are required to be measured by metrics specific to media types (e.g., engagement rate relating to social media or response rate relating to email), and these metrics must be periodically updated as more accurate metrics become available. Section 402(a)(5) requires the Secretary, no later than 180 days after enactment (i.e., April 15, 2021), to submit an initial report to SVAC and HVAC on the goals—including metrics and targets for such metrics—established for the VA mental health suicide prevention media outreach campaigns. Section 402(a)(6) requires the Secretary, no later than one year after the report submitted under paragraph (5), to submit a report, and annually thereafter, to SVAC and HVAC on the progress of VA meeting the established goals and action to be taken by VA to modify goals and targets not being met.

Section 402(b) requires the Secretary, no later than 180 days after enactment (i.e., April 15, 2021) and semiannually thereafter, to submit a report to the MILCON-VA, SVAC, and HVAC on OMHSP obligations and expenditures during the period covered by the report.

Section 403: Comptroller General Management Review of Mental Health and Suicide Prevention Services of Department of Veterans Affairs

Background

Prior to 2017, VHA suicide prevention and mental health activities were organized in different offices. In May 2017, VHA's OMHSP was established.[126] This reorganization was intended to improve efficiency, as well as to encourage better communication and collaboration of related VHA operations. VHA's OMHSP issues policy and implementation guidance, and it provides oversight and management of VHA mental health and suicide prevention initiatives and services.[127] Such initiatives include coordination of suicide prevention efforts with DOD and oversight of the VCL, among other things. Some VAMCs and outpatient clinics offer a Nurse Advice Line—similar to the VCL—which allows veteran patients and their caregivers to speak at any time with a registered nurse about a health issue, including a mental health-related concern.[128]

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[125] U.S. Government Accountability Office, *VA Health Care: Improvements Needed in Suicide Prevention Media Outreach Campaign Oversight and Evaluation*, GAO-19-66, November 15, 2018, p. 21, https://www.gao.gov/assets/700/695485.pdf.

[126] U.S. Government Accountability Office, *VA Needs Accurate Data and Comprehensive Analyses to Better Understand On-Campus Suicides*, GAO-20-664, September 2020, p. 6, https://www.gao.gov/assets/710/709243.pdf.

[127] Department of Veterans Affairs, *FY2021 Congressional Budget Submission, Volume II: Medical Programs and Information Technology Programs*, p. VHA-66, https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[128] Department of Veterans Affairs, "VA VISN 12 Nurse Advice Line (Telephone Care Service)," https://www.madison.va.gov/documents/Telephone-Care.pdf.

Provision

Section 403 requires GAO to conduct a study, no later than three years after enactment (i.e., October 17, 2023), on the management of mental health and suicide prevention services provided by VA. The management review is required to include, among other things (1) an assessment of OMHSP infrastructure, as well as infrastructure of suicide prevention efforts not operated by OMHSP; (2) a description of OMHSP management, organization, staffing levels, and operations (including strategic planning); (3) an assessment of suicide prevention practices and initiatives available through VA and community partnerships; (4) an assessment of the Nurse Advice Line pilot program; (5) an assessment of VA/DOD coordination of suicide prevention efforts; and (6) any other areas GAO considers appropriate.

Section 404: Comptroller General Report on Efforts of Department of Veterans Affairs to Integrate Mental Health Care into Primary Care Clinics

Background

Integrated behavioral health occurs when a team of providers, including physicians, behavioral health providers, and other health care providers, work together to address a patient's physical and mental health/substance use needs.[129] Although different models of behavioral health integration exist, some models emphasize integrating behavioral health services into primary care. In general, patients with behavioral health concerns interact more frequently with primary care, and they may not follow through to the behavioral health specialty care sector if referred from primary care.[130]

VHA first began primary care-mental health integration (PC-MHI) in 2007, and by 2008, it required all VAMCs and very large community-based outpatient clinics (CBOCs; those serving more than 10,000 patients a year) to have integrated mental health services in primary care clinics on a full-time basis.[131] CBOCs serving 10,000 patients or less must also have varying levels of integrated mental health services. VHA's PC-MHI comprises two categories: (1) co-located, collaborative care (CCC) and (2) care management. CCC provides behavioral health services in short duration as part of routine primary care service, and is not necessarily specific to patients with behavioral health disorders. CCC providers—mental health staff, including social workers, psychiatric nurses, psychiatrists, psychologists—are embedded in Patient Aligned Care Teams (PACTs), a team of health care providers that provides comprehensive primary care in partnership with the patient.[132] Care management is provided in consultation with the PACTs, but is largely administered by telephone. Care management services are structured toward those with more severe behavioral health concerns and includes systematic monitoring of symptoms and referral to specialty behavioral health care if needed.[133] Once a patient starts receiving services in

[129] Health Resources and Services Administration (HRSA), "Integrated Behavioral Health Resource Library," https://www.hrsa.gov/behavioral-health/library.

[130] The Commonwealth Fund, "In Focus: Integrating Behavioral Health and Primary Care," August 28, 2014, https://www.commonwealthfund.org/publications/newsletter-article/2014/aug/focus-integrating-behavioral-health-and-primary-care.

[131] Department of Veterans Affairs, Veterans Health Administration, "Uniform Mental Health Services in VA Medical Centers and Clinics," VHA Handbook 1160.01, p. 34, amended November 16, 2015.

[132] Department of Veterans Affairs, Veterans Health Administration, "Patient Aligned Care Team (PACT) Handbook," VHA Handbook 1101.10(1), p. 4, amended May 26, 2017.

[133] Margaret Dundon, Katherine Dollar, Larry J. Lantinga, et al., *Primary Care-Mental Health Integration Co-Located,*

specialty behavioral health care, a behavioral health provider in primary care will no longer provide care, except under very specific circumstances.[134]

The Veterans Community Care Program (VCCP) was launched in June 2019, as established by the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L. 115-182). Under this program, eligible veterans receive care in the community (through non-VA providers) when specific eligibility criteria are met.[135] To implement VCCP, VA entered into Community Care Network (CCN) contracts with Optum Public Sector Solutions, Inc., and TriWest Healthcare Alliance Corporation.

Prior to the implementation of VCCP, researchers from the RAND Corporation evaluated the capacity of providers in New York to deliver care to veterans, finding that

> only 20 percent of New York–licensed health care professionals reported routinely screening their patients for a military or veteran affiliation, with significant differences across provider types and by region. As a result, many providers are missing an opportunity to begin a conversation about how having a military history and background might have contributed to their veteran patients' current medical condition.[136]

Furthermore, RAND researchers reported that "private providers were less prepared than VA providers to deliver high-quality mental health care to veterans."[137] Taking these concerns into consideration, the VA MISSION Act included Section 123, which requires VA to implement a program to provide continuing medical education material and training to non-VA medical providers.[138] The department established the VHA Training Finder Real-time Affiliate-Integrated Network (VHA-TRAIN) and provides courses and training programs such as Military Culture: Core Competencies for Health Care Professionals Stressors and Resources, Military Culture: Core Competencies for Health Care Professionals Self-Assessment and Introduction to Military Ethos, and Addressing Traumatic Guilt in PTSD Treatment, among others.[139]

Provision

Section 404(a) requires GAO to submit an initial report, no later than two years after enactment (i.e., October 17, 2022), on the integration of mental health care into VHA primary care clinics. The report is required to include, among other things (1) an assessment of efforts to integrate mental health care into VHA primary care clinics, including how effective these efforts have been and how health care is affected by integration; (2) a description of how care is coordinated under

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Collaborative Care: An Operations Manual, Center for Integrated Healthcare, June 2011, p. 5, https://www.mentalhealth.va.gov/coe/cih-visn2/Documents/Clinical/Operations_Policies_Procedures/MH-IPC_CCC_Operations_Manual_Version_2_1.pdf.

[134] Margaret Dundon, Katherine Dollar, Larry J. Lantinga, et al., *Primary Care-Mental Health Integration Co-Located, Collaborative Care: An Operations Manual*, Center for Integrated Healthcare, June 2011, p. 20.

[135] For more information, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*; 38 C.F.R. §17.4010, and 38 C.F.R. §17.4040.

[136] Terri Tanielian et al., *Ready or Not? Assessing the Capacity of New York State Health Care Providers to Meet the Needs of Veterans*, RAND Corporation, Santa Monica,, CA, 2018, https://www.rand.org/pubs/research_reports/RR2298.html.

[137] RAND Corporation, *Improving the Quality of Mental Health Care for Veterans: Lessons from RAND Research*, 2019, https://www.rand.org/pubs/research_briefs/RB10087.html.

[138] CRS Report R45390, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L.115-182)*.

[139] Department of Veterans Affairs, *Report on Section 123 of the VA Maintaining Internal Systems and Strengthening Integrated Outside Networks (MISSION) Act of 2018: Continuing Medical Education for Non-Department Medical Professionals*, June 2020, p. 6.

specified circumstances; (3) an assessment of how integration is implemented at different types of VHA facilities (e.g., VAMCs, CBOCs); (4) recommendations on how integration can be better implemented; and (5) any other areas GAO considers appropriate.

Section 404(b) requires GAO to submit, no later than two years after submission of the report required under section 404(a), a report on the integration of community-based mental health care into VHA. The report is required to include, among other things, (1) an assessment of VA's efforts to integrate community-based mental health care into VHA, including effectiveness of such efforts and how health care of veterans is affected by integration; (2) a description of how care is coordinated between community-based mental health care providers and VHA; (3) an assessment of any disparities in coordination of community-based mental health care integration into VHA by location and type of facility; (4) an assessment of military cultural competency of community-based mental health care providers; (5) recommendations on how community-based health care integration into VHA can be better implemented; and (6) any other areas GAO considers appropriate. Section 404(b)(3) defines "community-based mental health care" as mental health care paid for by VA but provided at a non-VHA health care site, including care provided under the VCCP.

Section 405: Joint Mental Health Programs by Department of Veterans Affairs and Department of Defense

Background

Congress has a long history of funding and authorizing numerous DOD and VA mental health programs and services that support servicemembers, veterans, and their families. DOD and VA deliver mental health services in wide ranges of clinical and nonclinical settings (e.g., military treatment facilities, military units, VA hospitals and clinics, community-based programs, and virtual modalities). Both departments administer a number of mental health programs, typically in accordance with various VA and DOD strategy documents on interagency collaboration and resource sharing (e.g., the Joint Strategic Plan or the Integrated Mental Health Strategy).[140] These programs aim to prevent, evaluate, diagnose, treat, or discover new mental health issues and expand new science on broad or condition-specific issues.

In 2010, DOD established the National Intrepid Center of Excellence (NICoE) to "advance treatment, research, and education in the areas of TBI and neurological and psychological health."[141] NICoE coordinates with the VA's Polytrauma Centers to synchronize specialized outpatient treatments and emerging rehabilitative therapies for servicemembers and veterans diagnosed with TBI and other mental health conditions.[142] To extend NICoE's reach, DOD

[140] Section 8111 of Title 38, *U.S. Code*, requires DOD and VA to coordinate and share certain health care resources. The statute also requires both departments to develop a Joint Strategic Plan (JSP) to "shape, focus, and prioritize the coordination and sharing efforts among appropriate elements of the two Departments." For more on the JSP, see https://prhome.defense.gov/Portals/52/Documents/VA-DoD%20FY%202019-2021%20JSP%20(signed%20March%2018%202019).pdf. In 2011, DOD and VA developed an *Integrated Mental Health Strategy* (IMHS) to implement a "coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services" for servicemembers, veterans, and their families. For more on the IMHS, see https://www.mentalhealth.va.gov/docs/VA-DoD_IMHS_Action_Summaries_040814.pdf.

[141] Department of Defense, *National Intrepid Center of Excellence Satellite Strategic Basing*, June 2020, p. 3, https://go.usa.gov/xAgDg. For more information on NICoE, see https://walterreed.tricare.mil/Health-Services/Specialty-Care/National-Intrepid-Center-of-Excellence-NICoE.

[142] Department of Defense, *National Intrepid Center of Excellence Satellite Strategic Basing*, June 2020, pp. 3-5. VA Polytrauma Centers are part of an "integrated network of specialized rehabilitative programs" that serves

established satellite sites, known as Intrepid Spirit Centers, offering similar TBI treatment and therapy services. DOD maintains eight Intrepid Spirit Centers in the United States, with two additional locations planned.[143] In 2019, the Senate Appropriations Committee report accompanying the DOD Appropriations Act, 2020, directed DOD and VA to describe the "value and merit of establishing a Joint NICoE Intrepid Spirit Center that serves both active duty and veteran populations for their mutual benefit and growth in treatment and care."[144] In the subsequent report to Congress, issued in June 2020, DOD and VA asserted that there was "neither value nor merit that supports establishment of a joint NICoE Intrepid Spirit Center at this time."[145]

Provision

Section 405 establishes two reporting requirements for DOD and VA. The first reporting requirement is the submission of an annual report to Congress, beginning in October 2021, on mental health programs individually and jointly administered by each department. The report is to be submitted to the House and Senate Armed Services, SVAC, and HVAC, and to include a description of various VA and DOD mental health or related programs, such as

- a transition assistance program;
- clinical and nonclinical mental health initiatives;
- certain quality-of-life programs (e.g., financial literacy, housing assistance, and employee assistance programs);
- mental health research on PTSD, depression, anxiety, bipolar disorder, TBI, suicide or suicidal ideation; and
- other issues or conditions as the Secretary or the Secretary of Defense consider necessary.

The report is to also include recommendations to "improve the effectiveness" of such programs and on "novel joint programming" to improve the mental health of servicemembers and veterans.

The second reporting requirement is an evaluation and report to Congress on DOD and VA collaboration on PTSD and TBI care, research, and education. The evaluation is to include an analysis of alternatives and recommendations on the establishment of a joint DOD and VA Intrepid Spirit Center. The report on DOD and VA's findings is to be submitted to the House and Senate Committees on Armed Services, SVAC, and HVAC no later than 270 days after enactment (i.e., July 14, 2021).

Title V: Improvement of Mental Health Medical Workforce

The Health Resources and Services Administration (HRSA) projects that national demand for physician services, including mental health services, will exceed supply by 2025. Further, HRSA has reported that these projected shortages will be exacerbated in rural areas, a situation that poses a particular challenge for VHA because at least 26% percent of its VAMCs are located in

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servicemembers and veterans with combat- or civilian-related TBI and polytrauma. For more on VA Polytrauma Centers, see https://www.polytrauma.va.gov.

[143] Department of Defense, *National Intrepid Center of Excellence Satellite Strategic Basing*, June 2020, p. 3.

[144] S.Rept. 116-103, p. 241.

[145] Department of Defense, *National Intrepid Center of Excellence Satellite Strategic Basing*, June 2020, p. 6.

rural areas.[146] This title includes provisions that address VHA mental health provider staffing; authorize a scholarship program for readjustment counselors at Vet Centers; and require additional reporting and oversight on Vet Centers and other VHA suicide prevention services.

Section 501: Staffing Improvement Plan for Mental Health Providers of Department of Veterans Affairs

Background

As of April 2020, VHA recommended that all VAMCs have an overall staffing level of at least 1.22 full time equivalent (FTE) psychiatrists and 7.72 FTE outpatient clinical mental health staff for every 1,000 mental health patients.[147] However, difficulties with recruitment, retention, and lengthy hiring procedures have contributed to vacancies throughout the department. As of May 2019, HVAC reported that the current rate of vacancies in VHA mental health provider staffing was 10%.[148] According to NASEM, these vacancies vary by profession (e.g., psychiatrist, psychologist) and by VISN.[149] In particular, psychiatry was the top-ranked clinical occupation determined to be in shortage by VHA facilities in FY2020.[150] To address these concerns, VHA has implemented a number of mechanisms to assist with recruitment and the retention of mental health providers.[151]

Section 201 of the Veteran Benefits, Health Care, and Information Act of 2006 (P.L. 109-461) first authorized licensed professional mental health counselors (LPMHCs) and marriage and family therapists (MFTs) as mental health professionals that could be hired by VHA.[152] Further, in 2012, VA began a mental health education expansion (MHEE) program to assist in recruitment and hiring of VA-trained mental health providers. Through this program, four new professions were allotted VA training opportunities, including internships for LPMHCs and MFTs.[153] However, these two occupations did not have an associated occupational series, a classification standard issued by the U.S. Office of Personnel Management (OPM) for federal hiring purposes. In FY2019 appropriations report language, Congress encouraged VA to work with OPM to develop the occupational series. In addition, Congress directed VA to develop a staffing plan for LPMHCs and MFTs to fill open positions and address any shortages.[154]

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[146] U.S. Government Accountability Office, *Veterans Health Administration: Better Data and Evaluation Could Help Improve Physician Staffing, Recruitment, and Retention Strategies*, GAO-18-124, October 2017, p. 6, https://www.gao.gov/assets/690/687853.pdf.

[147] Department of Veterans Affairs, Veterans Health Administration, "Productivity and Staffing in Clinical Encounters for Mental Health Providers," VHA Directive 1161, p. A-3, April 28, 2020.

[148] H.Rept. 116-70. This statistic defined mental health provider staffing as including psychiatrists, psychologists, and social workers.

[149] National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Department of Veterans Affairs Mental Health Services*, Washington, DC, January 31, 2018, p. 176, https://www.ncbi.nlm.nih.gov/books/NBK499503/pdf/Bookshelf_NBK499503.pdf.

[150] Department of Veterans Affairs, Office of Inspector General, *OIG Determination of Veterans Health Administration's Occupational Staffing Shortages Fiscal Year 2020*, Department of Veterans Affairs, September 23, 2020, p. 7, https://www.va.gov/oig/pubs/VAOIG-20-01249-259.pdf.

[151] For more information, see National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Department of Veterans Affairs Mental Health Services*, 2018, p. 180.

[152] 38 U.S.C. §§7401-7402.

[153] National Academies of Sciences, Engineering, and Medicine, *Evaluation of the Department of Veterans Affairs Mental Health Services*, 2018, p. 180.

[154] S.Rept. 115-269.

Provision

Section 501(a)(1) requires, no later than one year after enactment (i.e., October 17, 2021), VA to submit to SVAC and HVAC a plan to address mental health provider staffing within VA. The plan is required to include (1) an estimate of the number of mental health provider positions that need to be filled, (2) steps VA will take to address mental health staffing, (3) a description of region-specific hiring incentives, (4) a description of local retention or engagement incentives to be used by VISN directors, and (5) recommendations for legislative or administrative action to address mental health staffing. Section 501(a)(2) requires, no later than one year after submitting the plan required under section 501(a)(1), that VA submit to SVAC and HVAC a report on the number of mental health providers hired within VA during the one-year period preceding the report submission.

Section 501(b) requires VA, no later than one year after enactment (i.e., October 17, 2021), to develop an occupational series for LPMHCs and MFTs working for VA.

Section 502: Establishment of Department of Veterans Affairs Readjustment Counseling Service Scholarship Program

Background

To assist VHA with recruitment and retention of both clinical and nonclinical staff, Congress has authorized scholarships and student loan repayment programs under the umbrella of the Health Professional Educational Assistance Program (HPEAP).[155] These include, among others, the Health Professional Scholarship Program (HPSP),[156] the Department of Veterans Affairs Employee Incentive Scholarship Program (EISP),[157] and the Visual Impairment Education Assistance Program (VIOMPSP).[158] However, no specific scholarship program was authorized to recruit and retain Readjustment Counselors serving at Vet Centers in the Readjustment Counseling Service (RCS).

Provision

Section 502(a) amends current law and adds a new subchapter IX, Readjustment Counseling Service Scholarship Program. In the following paragraphs, "this section" refers to this new subchapter IX of chapter 76 of Title 38, and its subdivisions.

Requirement for program

This section requires the Secretary to implement a new Department of Veterans Affairs Readjustment Counseling Service Scholarship Program under the HPEAP.

Eligibility

This section stipulates that, to be eligible for the scholarship program, an individual must be accepted for enrollment or enrolled in a course of education leading to a terminal degree in psychology, social work, marriage and family therapy, or mental health counseling, at an accredited educational institution or training program that is approved by the Secretary. An

[155] 38 U.S.C. §§7601 et seq.

[156] 38 U.S.C. §§ 7611 et seq.

[157] 38 U.S.C. §§ 7671 et seq.

[158] 38 U.S.C. §§7501 et seq.

individual would need to meet VHA qualification standards for employment, and would need to agree to the requirements stipulated under the scholarship program.

Priority in Selecting Individuals

This section requires the Secretary to prioritize individuals who are veterans, or who agree to be employed by a Vet Center located in a medically underserved area, as designated by the Public Health Service Act, and in a state with a per capita population of veterans of more than 5%, as defined by the National Center for Veterans Analysis and Statistics and the Census Bureau.

Agreement

This section stipulates that a participant in the scholarship program must agree to enter into an agreement with the Secretary. The agreement would describe the number of school years during which the scholarship funds would be provided to the participant, and would require the participant to commit to a six-year period of obligated service at a Vet Center following the completion studies.

Obligated service

This section requires that each participant in the scholarship program provide service as a full-time employee at a Vet Center for a period of six years following the completion studies. The Secretary is required to provide 60 days advance notice regarding the service commencement date.

Breach of agreement

This section stipulates that a participant in the scholarship program who has entered into an agreement with the Secretary, and who does not accept scholarship payments, will have to pay $1,500 in damages. This penalty is in addition to any liabilities related to the obligated period of service. In addition, this section stipulates that the participant will be liable if the participant fails to complete course of study or does not obtain a required degree certificate. Penalties pertaining to the obligated period of service do not apply in a situation where VA is required to use Reduction in Force (RIF) procedures. Penalties are required to be paid within one year following the breach of the agreement.

Effective Date

Section 502(c) requires the Secretary to begin awarding Readjustment Counseling Service Scholarships no later than one year after the date of the enactment of this act (i.e., October 17, 2021).

Section 503: Comptroller General Report on Readjustment Counseling Service of Department of Veterans Affairs

Background

VA provides readjustment counseling services to veterans, servicemembers, and their families in community settings through Vet Centers.[159] Services provided at Vet Centers address bereavement, PTSD, military sexual trauma, and substance use assessment and referral, among other topics. Individuals do not have be enrolled in VA health care to qualify for readjustment counseling at Vet Centers. To qualify for readjustment services, a veteran or servicemember must have either (1) served on active duty in a combat theater of operations, (2) provided direct

[159] 38 U.S.C. §1712A.

emergency medical or mental health care or mortuary services to the causalities of combat operations or hostilities, or (3) engaged in combat in a theater of combat operations by remotely controlling an unmanned aerial vehicle.[160] Certain family members are also eligible for readjustment counseling services if they live with an eligible veteran or servicemember. This differs from qualification for enrollment in VA health care, which requires a veteran to meet specific criteria (e.g., means tests or disability status) to qualify for enrollment.[161]

Provision

Section 503 requires GAO to submit a report, no later than one year after enactment (i.e., October 17, 2021), to SVAC and HVAC on readjustment counseling services provided through VA. The report must include an assessment of (1) the adequacy of Vet Center treatment, counseling, and other services; (2) the efficacy of outreach efforts; (3) barriers to care; (4) the efficacy and frequency of the use of telehealth by the RCS to provide mental health services; (5) the feasibility and advisability of expanding eligibility for services; (6) the use of Vet Centers by members of the reserve components of the Armed Forces who were never activated; (7) the use of Vet Centers by eligible family members of former members of the Armed Forces; (8) the efficacy of group therapy and the level of training of providers; (9) the efficiency and effectiveness of the task organization structure of Vet Centers; and (10) the use of Vet Centers by Native American veterans.[162] This section requires GAO to make recommendations for most of the required assessments.

Section 504: Expansion of Reporting Requirements on Readjustment Counseling Services of Department of Veterans Affairs

Background

The National Defense Authorization Act for Fiscal Year 2013 (P.L. 112-239) established the organizational structure, authority, and funding source of Readjustment Counseling Services within VA.[163] This act included an annual reporting requirement on the activities of the Readjustment Counseling Service during the preceding calendar year.

Provision

Section 504 amends reporting requirements for Readjustment Counseling Services. First, this section requires that the annual report identify resources required to meet demand for unmet needs such as additional staff, locations, infrastructure, infrastructure improvements, and additional mobile Vet Centers. Second, this section adds additional requirements for reports submitted in even-numbered years. Such reports must additionally include a prediction of (1) trends in demand for care, (2) long-term investments required with respect to the provision of care, (3) requirements relating to maintenance of infrastructure, and (4) other capital investment requirements.

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[160] Department of Veterans Affairs, Veterans Health Administration, "Readjustment Counseling Services," VHA Directive 1500, January 26, 2021, pp. 2-3. Veterans who accessed readjustment services prior to January 2, 2013, are eligible regardless of combat experience.

[161] For more information on enrollment and eligibility for VA health care, see CRS Report R42747, *Health Care for Veterans: Answers to Frequently Asked Questions*.

[162] As defined in 38 U.S.C. §3765.

[163] 38 U.S.C. §7309.

Section 505: Briefing on Alternative Work Schedules for Employees of Veterans Health Administration

Background

This section was derived from the VA ECHO Act (H.R. 8212), introduced by Representatives Joe Cunningham and Jim Banks in the 116th Congress. Current VHA policy requires that VAMCs and CBOCs treating 10,000 or more unique primary care veteran patients in a fiscal year must provide individuals with access to appointments for a minimum of four extended hours per week in both a primary care clinic and a mental health clinic, and a minimum of one extended hour per month in a women veteran's clinic.[164]

Provision

Section 505 codifies existing policy of providing extended hours and requires the Secretary to conduct, no later than 180 days from enactment of this act (i.e., April 15, 2021), a survey of veterans on their attitudes toward offering appointments outside usual operating hours. In addition, this section requires that the Secretary brief SVAC and HVAC no later than 270 days from enactment (i.e., July 14, 2021) on the (1) feasibility and advisability of offering appointments outside of normal operating hours and (2) the effectiveness of offering these appointments. The briefing is required to include, among other things, the findings of the survey and feedback from specified employees.

Section 506: Suicide Prevention Coordinators

Background

Suicide prevention coordinators (SPCs) are VHA employees tasked with coordinating care for veterans at high risk for suicide who are receiving care within VHA. As part of this care coordination, SPCs can be assigned referrals from the VCL to ensure continuity of care with a veteran's local VHA provider. Among other responsibilities, SPCs also conduct outreach and disseminate best practices related to suicide prevention. As of April 2019, VA had employed approximately 444 SPCs—with at least one SPC at each VAMC and very large CBOC[165]—responsible for managing care for nearly 30,000 high-risk veterans, equating to the care coordination of nearly 90 veterans per SPC.[166] According to an internal 2018 analysis, VHA determined a need for 246 additional SPCs to meet demand.[167]

In response to concerns that SPCs were being overworked and were understaffed, Congress enacted legislation in the 116th Congress requiring GAO to look further into the issue.[168] Among

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[164] Department of Veterans Affairs, Veterans Health Administration, "Outpatient Clinic Practice Management," VHA Directive 1231(1) October 18, 2019, amended March 10, 2020. p.3.

[165] Department of Veterans Affairs, Veterans Health Administration, "Uniform Mental Health Services in VA Medical Centers and Clinics," VHA Handbook 1160.01, amended November 16, 2015. Very large CBOC are those that serve more than 10,000 unique veterans each year.

[166] H.Rept. 116-70.

[167] U.S. Congress, House Committee on Veterans' Affairs, *Testimony before the House Committee on Veteran's Affairs*, *Tragic Trends: Suicide Prevention Among Veterans*, prepared by Keita Franklin, Ph.D. on behalf of Dr. Richard Stone, Veterans Health Administration, 116th Cong., 1st sess., April 29, 2019.

[168] P.L. 116-96.

other things, GAO was required to examine the responsibilities and workload, training, and vacancy rates of SPCs, and the extent to which the Secretary provides oversight of SPCs. In its April 2021 report, GAO noted that SPCs are vulnerable to burnout and turnover, given the increasing number of suicide initiatives offered by VHA and the resulting increasing volume of veterans identified at high risk for suicide. Further, GAO found that VHA had not evaluated staffing needs considering effects of program growth on workload, leaving facilities susceptible to understaffing.[169]

Provision

Section 506(a) requires the Secretary, no later than one year after enactment (i.e., October 17, 2021), to ensure that each VAMC has at least one SPC. Section 506(b) requires the Secretary, in consultation with OMHSP, to conduct a study, no later than one year after enactment (i.e., October 17, 2021), on the feasibility of creating a SPC program office. Among other things, this feasibility assessment would examine whether the Director of the Suicide Prevention program could have ultimate supervision over the SPC program office. Section 506(c) requires the Secretary, no later than 90 days after completion of the study under subsection (b), to submit a report to SVAC and HVAC. This report shall include (1) an assessment of the feasibility and advisability of the SPC program office; (2) a review of current staffing ratios for SPCs and suicide prevention case managers in comparison to current staffing ratios for mental health providers within each VAMC; and (3) a description of the duties of SPCs to better define, delineate, and standardize specified qualifications and performance objectives.

Section 507: Report on Efforts by Department of Veterans Affairs to Implement Safety Planning in Emergency Departments

Background

In 2010, VA implemented a clinical demonstration project at five sites known as the Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment (SAFE VET) program. The program was designed to help suicidal veterans seen at VA emergency departments or mental health urgent care settings through administration of a veteran-focused, clinical safety plan intervention, including an outreach protocol following discharge.[170] The program was associated with positive outcomes, and based on those findings, VA launched a second, larger program in September 2018, the Safety Planning in Emergency Departments program of the Department of Veterans Affairs (SPED). SPED is a program for veterans presenting to emergency departments who are determined to be at risk for suicide and are safe to be discharged home. The program combines safety planning interventions with follow-up phone calls after discharge from emergency departments or urgent care centers to transition veterans to outpatient mental health care. SPED primary coordinators are the point of contact responsible for administering the program at a VAMC. As of FY2020, VA had implemented safety plans in over 60% of emergency departments, with a goal of 90% by FY2021.[171]

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[169] U.S. Government Accountability Office, *VA Health Care: Efforts Needed to Ensure Effective Use and Appropriate Staffing of Suicide Prevention Teams*, GAO-21-326, April 2021, https://www.gao.gov/assets/gao-21-326.pdf.

[170] Kerry L. Knox, Barbara Stanley, Glenn W. Currier, et al., "An Emergency Department-Based Brief Intervention for Veterans at Risk for Suicide (SAFE VET)," *American Journal of Public Health*, vol. 102, no. suppl. 1 (2012), pp. S33-37.

[171] Department of Veterans Affairs, *Agency Priority Goal Action Plan, Suicide Prevention, FY 2020 Q4 Update*,

Provision

Section 507 requires the Secretary to submit a report to HVAC and SVAC no later than 180 days from enactment (i.e., April 15, 2021) on the efforts to implement the SPED program for veterans presenting to a VHA emergency department or urgent care center who are assessed to be at risk for suicide but are safe to be discharged home. The report is required to include, among other things (1) an assessment of implementation of policies and procedures of the SPED program at each VA medical center; (2) a description of how SPED primary coordinators are deployed; (3) an assessment of the feasibility and advisability of expanding SPED coordinator deployment; (4) an assessment of the feasibility and advisability of providing services under the SPED program via telehealth; (5) a description of the status of current capabilities and use of tracking mechanisms to monitor compliance, quality, and patient outcomes; and (6) recommendations regarding how VA can better implement the SPED program.

Title VI: Improvement of Care and Services for Women Veterans

Women veterans are one of the fastest-growing veteran demographics, and the number of women using VHA care approximately tripled from 2000 to 2019.[172] However, women veterans can experience certain gender-specific barriers to accessing and receiving VHA care.[173] The Veterans Health Care Act of 1992 (P.L. 102-285) first authorized VA to provide gender-specific services. Subsequent legislation has expanded services available to women veterans.[174] This title includes two provisions that would (1) expand the capabilities of the Women Veterans Call Center (a hotline for women veterans) and (2) require VHA to publicly post relevant information for women veterans.

Section 601: Expansion of Capabilities of Women Veterans Call Center to Include Text Messaging

Background

VA administers a hotline for women veterans, the Women Veterans Call Center (WVCC). In addition to responding to incoming calls, the WVCC conducts outreach to women veterans through outgoing calls. The WVCC provides women veterans with information about available benefits, eligibility for VHA services, and resources. As of August 31, 2019, the WVCC had received 79,692 calls and made 1,213,639 calls, with 632,000 of those calls resulting in speaking with a veteran or leaving a voicemail.[175]

January 2021, p. 8, https://trumpadministration.archives.performance.gov/veterans_affairs/FY2021_january_Suicide_Prevention.pdf.

[172] Department of Veterans Affairs, "New text feature available through VA's Women Veterans Call Center," blog post, April 23, 2019, https://www.blogs.va.gov/VAntage/59278/new-text-feature-available-vas-women-veterans-call-center/.

[173] Department of Veterans Affairs, *Study of Barriers for Women Veterans to VA Health Care*, April 2015, https://www.womenshealth.va.gov/docs/Womens%20Health%20Services_Barriers%20to%20Care%20Final%20Report_April2015.pdf.

[174] P.L. 103-452 provided authority for counseling and treatment for military sexual trauma. Since 2017, appropriations acts have authorized the use of assisted reproductive technology, such as in-vitro fertilization for certain veterans. For more information on gender-specific services for veterans, see CRS In Focus IF11082, *Veterans Health Administration: Gender-Specific Health Care Services for Women Veterans*.

[175] Department of Veterans Affairs, *FY2021 Congressional Budget Submission, Volume II: Medical Programs and*

The WVCC connects with women veterans though a call, text message, or online chat.[176] The WVCC added the online chat feature in May 2016 and added text messaging capabilities in April 2019.[177]

Provision

Section 601 codifies existing practice by requiring the Secretary to expand the capabilities of the WVCC to include text messaging.

Section 602: Requirement for Department of Veterans Affairs Internet Website to Provide Information on Services Available to Women Veterans

Background

VHA administers a program for women veterans that includes preventive care, acute care, and reproductive health services.[178] VHA operates a website that directs women veterans to available services, provides outreach materials, and relevant news, among other things.[179]

Provision

Section 602(a) requires the Secretary to survey VA websites and information resources in effect on the date before enactment of this act (i.e., October 16, 2020) and to publish a website that serves as a centralized source of information about benefits and services available to veterans. Section 602(b) requires, among other things, that the website provide women veterans with information regarding services available in their district and a list of appropriate staff for benefits available through the Veterans Benefits Administration (VBA), the National Cemetery Administration (NCA), and other entities. The Secretary is also required to ensure that the information is updated at least once every 90 days. In addition, the Secretary must ensure that outreach conducted under the comprehensive program for suicide prevention among veterans[180] includes information regarding the website. Section 602(e) specifies that funds needed to carry out this section shall be derived from available funds used to publish VA websites.

Information Technology Programs, p. VHA-180, https://www.va.gov/budget/docs/summary/fy2021VAbudgetVolumeIImedicalProgramsAndInformationTechnology.pdf.

[176] The call center is available Monday through Friday 8:00 a.m. to 10:00 p.m. ET, and Saturday from 8:00 a.m. to 6:30 p.m. ET. For more information, see https://www.womenshealth.va.gov/WOMENSHEALTH/ProgramOverview/wvcc.asp.

[177] Department of Veterans Affairs, "New text feature available through VA's Women Veterans Call Center," blog post, April 23, 2019, https://www.blogs.va.gov/VAntage/59278/new-text-feature-available-vas-women-veterans-call-center/.

[178] Department of Veterans Affairs, Veterans Health Administration, "Healthcare Services for Women Veterans," VHA Directive 1330.01(3), June 19, 2020.

[179] The website is available at https://www.womenshealth.va.gov/WOMENSHEALTH/index.asp.

[180] 38 U.S.C. §1720F(i).

Title VII: Other Matters

Section 701: Expanded Telehealth from Department of Veterans Affairs

Background

On July 12, 2016, VA established the Office of Connected Care (OCC) within VHA. The goal of OCC is to "deliver [information technology (IT)] health solutions that increase a [v]eteran's access to care and supports a [v]eteran's participation in their health care."[181] OCC administers the following four VA telehealth programs:[182]

- **VA Telehealth Services,** according to VA, "[improve] convenience to [v]eterans by providing access to care from their homes or local communities when they need it";
- **My Health*e*Vet** is the web-based electronic health record (EHR) for veteran patients through which veterans can view and download electronic protected health information (ePHI);
- **VHA Innovation Program** is an annual competitive program that allows VA staff and key stakeholders in the private sector to submit innovative ideas on enhancing VA care; and
- **VA Mobile Health (VA Mobile)** develops mobile apps.[183]

Provision

Section 701 requires the Secretary to establish a new grant program for the expansion of telehealth capabilities and the provision of telehealth services. The Secretary is required to ensure, to the extent practicable, that the grant program gives preference to entities in rural areas. Grants may be awarded for a large variety of specified purposes. In addition, the section authorizes the Secretary to enter into agreements with entities that seek to establish telehealth access points but do not require grant funding. The Secretary is required to complete an assessment of barriers to accessing telehealth services no later than 18 months from enactment (i.e., April 17, 2022). No later than 120 days after completion of the assessment, the Secretary is required to submit a report to SVAC and HVAC on the assessment, including any recommendations for legislative or administrative action.

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[181] Department of Veterans Affairs, "Telehealth Services and Connected Care," *VHA Telehealth Quarterly*, January 2016, p. 2, winter edition.

[182] This list was adapted from VA, *Connected Care*, https://connectedcare.va.gov/terms/connected-health/single/About.

[183] For more information on VA telehealth services, see CRS Report R45834, *Department of Veterans Affairs (VA): A Primer on Telehealth*.

Section 702: Partnerships with Non-Federal Government Entitles to Provide Hyperbaric Oxygen Therapy to Veterans and Studies on the Use of Such Therapy for Treatment of Posttraumatic Stress Disorder and Traumatic Brain Injury

Background

Hyperbaric oxygen therapy (HBOT) is intended to increase the supply of oxygen to the blood for certain types of injuries that can cause a deficiency in the amount of oxygen reaching the tissues (i.e., hypoxia). HBOT works by having an individual intermittently breathe near 100% oxygen in a hyperbaric chamber where the air pressure is at least 1.4 times greater than normal.[184] This enhanced oxygen availability has been associated with healing processes that require large amounts of oxygen (e.g., reducing swelling).[185] Hyperbaric chambers are considered medical devices and require clearance from the Food and Drug Administration (FDA) to be marketed. FDA has cleared HBOT for specific uses, including burns, necrotizing infections, and carbon monoxide poisoning, among others. FDA has not yet cleared HBOT to treat traumatic brain injury (TBI) and posttraumatic stress disorder (PTSD), which are considered signature wounds experienced by servicemembers and veterans of the conflicts in Iraq and Afghanistan.

There has been interest in the use of HBOT to treat these often co-occurring conditions, given the potential effects of these conditions on the white matter of the brain. However, separate reviews conducted by GAO in 2015[186] and VA in 2018 suggest that the evidence regarding the effectiveness of these treatments for both TBI and PTSD is mixed. This led VA to conclude, "In summary, the large treatment benefits demonstrated for HBOT in uncontrolled case series have not been easily replicated in well-controlled [randomized controlled trials] RCTs. Potential explanations for this include that the potential benefits are subtle and demonstration requires larger RCTs, HBOT is in fact ineffective, and/or the sham [control group] design has indeed been problematic. We are unconvinced that the current evidence clearly points to one explanation over another. We simply still don't know."[187]

In 2017, VA, through its Center of Compassionate Innovation (CCI) within the Office of Community Engagement, started a pilot program that offers HBOT as a treatment option for certain veterans. Specifically, these veterans have persistent PTSD and tried two evidence-based treatments that provided no decrease in symptoms.[188] In a recent press release, the Eastern Oklahoma VA Health Care System and the VA Northern California Health Care System were mentioned as VAMCs that would initially provide this care. Since that time, other VAMCs have been added to the pilot program. In a 2019 update on its website, VA noted that four VAMCs were

[184] Richard E. Moon et al., *Hyperbaric Oxygen Therapy Indications*, Undersea and Hyperbaric Medical Society, 14th Edition, North Palm Beach, FL, 2019, https://www.uhms.org/images/UHMS-Reference-Material.pdf.

[185] Kim Peterson, Donald Bourne, Johanna Anderson, et al., *Evidence Brief: Hyperbaric Oxygen Therapy (HBOT) for Traumatic Brain Injury and/or Post-traumatic Stress Disorder*, Department of Veterans Affairs, Portland, OR, February 2018, https://www.ncbi.nlm.nih.gov/books/NBK499535/pdf/Bookshelf_NBK499535.pdf.

[186] U.S. Government Accountability Office, *Research on Hyperbaric Oxygen Therapy to Treat Traumatic Brain Injury and Post-Traumatic Stress Disorder*, GAO-16-154, December 2015, https://www.gao.gov/assets/680/674334.pdf.

[187] Kim Peterson, Donald Bourne, Johanna Anderson, et al., *Evidence Brief: Hyperbaric Oxygen Therapy (HBOT) for Traumatic Brain Injury and/or Post-traumatic Stress Disorder*, 2018, p. 19.

[188] Department of Veterans Affairs, "VA to Provide Hyperbaric Oxygen Therapy to Some Veterans with Chronic PTSD," November 2017, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=3978.

currently participating in the pilot program (although did not specify which sites).[189] According to the North Dakota Department of Veterans Affairs, the Fargo VAMC was the fifth site added to the pilot program.[190] Each of these VAMCs partners with local providers to provide HBOT.

Provision

Section 702(a) allows the Secretary, in consultation with CCI, to enter into partnerships with nonfederal government entities to provide HBOT to veterans as part of research into the effectiveness of this therapy. Such partnerships may include those that focus on conducting research, reviewing research, creating industry working groups to determine standards for research, or providing HBOT to veterans for the purpose of conducting research on the effectiveness of the therapy. Federal funds may be used only to coordinate and administer partnerships under subsection (a).

Section 702(b) requires the Secretary, no later than 90 days after enactment (i.e., January 15, 2021) and in consultation with CCI, to review the effectiveness of HBOT using an objective and quantifiable method (e.g., an FDA-approved or cleared device that assesses traumatic brain injury (TBI) by tracking eye movement). Section 702(c) requires the Secretary, no later than 90 days after enactment (i.e., January 15, 2021) and in consultation with CCI, to conduct a systematic review of literature on the off-label use of HBOT to treat PTSD and TBI among veteran and nonveteran populations. The review is required to include, among other things, an assessment of current parameters for research on VA use of HBOT and a comparative analysis of tests and questionnaires used to study PTSD and TBI in research conducted by VA, as well as other federal and nonfederal organizations. It is required to be completed no later than 180 days after it is started, and the Secretary is required to submit a report on the results of the review to SVAC and HVAC no later than 90 days after completion of the review.

Section 702(d) requires the Secretary, no later than 120 days after completion of the review conducted under subsection (c) and in consultation with CCI, to conduct a study on the efficacy and effectiveness of HBOT for PTSD and TBI, as is currently being offered through VA's pilot program. This study is required to be completed no later than three years after commencement. No later than 90 days after the study is completed, the Secretary is require to submit to SVAC and HVAC a report on the results of the study. The report shall include the Secretary's recommendation as to whether HBOT should be made available to all veterans with PTSD and TBI.

Section 703: Prescription of Technical Qualifications for Licensed Hearing Aid Specialists and Requirement for Appointment of Such Specialists

Background

The Veterans Mobility Safety Act of 2016 (P.L. 114-256) amended VHA's appointment authority to include licensed hearing aid specialists and those whose qualifications can be prescribed by the Secretary. This provision was derived from the Veterans Hearing Aid Access and Assistance Act

[189] Department of Veterans Affairs, "The Center for Compassionate Care Innovation supports treatments that may help Veterans with PTSD: Hyperbaric Oxygen Therapy (HBOT)," August 9, 2019, https://www.va.gov/healthpartnerships/updates/cci/08092019.asp.

[190] North Dakota Department of Veterans Affairs, "Hoeven, Cramer, Armstrong: VA Extends Fargo VA HBOT Demonstration Program, Expands Program to Include Jamestown Regional Medical Center and Increases Treatment Referrals for Veterans," October 15, 2020, https://www.nd.gov/veterans/news/va-extends-fargo-va-hbot-demonstration-program.

(S. 564; 114th Congress). However, VHA did not develop basic qualification standards and work assignments for this occupation and did not exercise this discretionary authority provided in the act to hire hearing aid specialists. In reports to Congress, VHA stated that

> there are technical barriers to establishing qualification standards for hearing aid specialists.... To be eligible for appointment to the title 38 positions in VA, a profession must have established qualifications that include standards for education and professional training that are applicable for all states. Presently, the hearing aid specialist occupation has no consistent national education requirements and no standardized professional training, resulting in highly variable skill sets from state to state. Most states (33) require only a high school education for hearing aid specialists to receive a license. Nine states have no educational requirement and eight states require an associate degree for state licensure…. When this profession establishes a functional national standard for hearing aid specialists that addresses the necessary education, training and licensure requirements, VA will use the authority to revise the standards when national standards are in place.[191]

Provision

Section 703 requires the Secretary to prescribe technical qualifications and appointment requirements for licensed hearing aid specialists.

Technical Qualifications

Section 703(a)(1) requires the Secretary to prescribe the technical qualifications that are required for appointment as licensed hearing aid specialists in VHA. These qualification standards are to be prescribed no later than 180 days after the date of the enactment of this act (i.e. April 15, 2021).

Elements for Qualifications

Section 703(a)(2) stipulates that when prescribing qualifications, the Secretary must ensure that the qualifications for hearing aid specialists are in keeping with licensure standards of a majority of states, have the competencies needed as hearing aid specialists, and include any other competencies required by the Secretary to provide care.

Authority to Set and Maintain Duties

Section 703(b) requires the Secretary to retain the authority to set and maintain the duties for licensed hearing aid specialists.

Appointment

Section 703(c) requires the Secretary to appoint at least one licensed hearing aid specialist at each VAMC no later than September 30, 2022.

Reporting Requirements

Section 703(d) requires the Secretary to submit an annual report to SVAC and HVAC on the appointment of licensed hearing aid specialists. The first such report must be submitted no later than September 30, 2022. The annual report must include, among other things, the following elements: assessing the progress of appointments of licensed hearing aid specialists in VAMCs, potential challenges facing appointments, and assessing access of patients to comprehensive VA hearing health services.

[191] Department of Veterans Affairs, *Report on Timely Access of Veterans to Hearing Health Services Through the Department of Veterans Affairs*, Report to Congress, December 2020, p. 2.

Section 704: Use by Department of Veterans Affairs of Commercial Institutional Review Boards in Sponsored Research Trials

Background

The HHS Human Subject Regulations are a core set of federal standards for protecting human subjects in HHS-sponsored research.[192] These regulations are commonly referred to as the "Common Rule" because the same requirements have been adopted by many non-HHS federal departments and agencies, including VA, which apply the regulations to the research they fund. Under the Common Rule, research protocols must be approved by an Institutional Review Board (IRB) to ensure that the rights and welfare of research subjects are protected.[193] The rule lists several criteria for IRB approval, including the requirement that researchers obtain the informed consent of their research subjects.[194] HHS has promulgated additional protections for certain vulnerable populations involved in research. Those groups include pregnant women, human fetuses, and neonates; prisoners; and children.[195]

VHA Directive 1200.05 ("Requirements for the Protection of Human Subjects in Research") "defines the procedures for implementing the Federal Policy for the Protection of Human Subjects, known as the Common Rule, and other applicable Federal requirements for the protection of human subjects in research."[196]

Provision

Section 704 requires the Secretary, no later than 90 days after enactment (i.e., January 15, 2021), to allow sponsored clinical research of VA to use accredited commercial IRBs to review research proposal protocols. This must be carried out through revision of VHA Directive 1200.05, titled ''Requirements for the Protection of Human Subjects in Research." Further, the Secretary is required to identify accredited commercial IRBs and to establish a process to modify existing approvals in the case that a commercial IRB loses its accreditation. Finally, the Secretary is required, no later than 90 days after the revisions of Directive 1200.05 are complete and annually thereafter, to submit to SVAC and HVAC a report on all IRB approvals used by VA, including central IRBs and commercial IRBs, as specified.

Section 705: Creation of Office of Research Reviews Within the Office of Information and Technology of the Department of Veterans Affairs

Background

Conducting medical research is one of VA's statutory missions.[197] As required by law, the medical and prosthetic research program (medical research) focuses on research into the special health

[192] 45 C.F.R. Part 46, Subpart A.

[193] 45 C.F.R. §46.109.

[194] 45 C.F.R. §46.111.

[195] 45 C.F.R. Part 46, Subparts B (pregnant women, fetuses, neonates), C (prisoners), and D (children).

[196] Department of Veterans Affairs, VHA Directive 1200.05 "Requirements for the Protection of Human Subjects in Research," amended March 3, 2020, p. 1.

[197] 38 U.S.C. §7303.

care needs of veterans.[198] Although VHA's medical research program is an intramural program, industry-funded research studies, as well as collaborative research studies with private and/or nonprofit entities, could be performed at VAMCs. VHA has a long history of nongovernmental-financed studies and private sector collaboration in its medical research program.[199]

Provision

Section 705 requires the Secretary to establish a new Office of Research Reviews within the Office of Information and Technology within one year of enactment of this act (i.e. October 17, 2021). The Office of Research Reviews will be responsible for conducting centralized security reviews and completing security processes for approved research projects, including multisite clinical trials, funded by non-VA sources. In addition, the office is required to develop and maintain a list of officially approved commercial software used in clinical trials, and to develop appropriate timelines for security reviews. One year after the establishment of the Office of Research Reviews, the Secretary is required to submit a report to SVAC and HVAC on activities of the office.

Provisions in Veterans COMPACT Act of 2020

Title I: Improvement of Transition of Individuals to Services from Department of Veterans Affairs

Transitioning from the military to civilian life can be a time of increased risk for suicide. One research study found that this risk may be elevated for years after the transition.[200] This title includes provisions that assist with this transition by (1) authorizing a pilot program that designates relatives and friends to receive information about assistance and benefits available to veterans, and (2) requires VA to report to specified committees of Congress on the status of Solid Start, a transition assistance program that conducts outreach to veterans at certain points during the first year of separation from the military.

Section 101: Pilot Program on Information Sharing Between Department of Veterans Affairs and Designated Relatives and Friends of Veterans Regarding Assistance and Benefits Available to the Veterans

Background

As VA notes in its national strategy for preventing veteran suicide, "family members, friends, co-workers, and others can play an important role in recognizing when a Veteran is in crisis and

[198] 38 U.S.C. §7303(a)(3).

[199] Marguerite T. Hays, *A Historical Look at the Department of Veterans Affairs Research and Development Program*, Department of Veterans Affairs, p. 98, https://www.research.va.gov/pubs/ord-history.cfm.

[200] Department of Veterans Affairs, "Help With Readjustment and Social Support Needed for Veterans Transitioning From Military Service," https://www.mentalhealth.va.gov/suicide_prevention/docs/Literature_Review_Military_Separation_508_FINAL_05-24-2019.pdf.

connecting the Veteran with sources of help. However, many of these people may not know the warning signs of suicidal behavior or where a distressed person can go for help."[201]

Senator Kyrsten Sinema introduced the Sergeant Daniel Somers Veterans Network of Support Act of 2019 in November 2019, which requires the Secretary to carry out a two-year pilot program on information sharing between VA and designated persons regarding assistance and benefits available to veterans.[202] The act was subsequently passed in the Senate in June 2020 and was included as Section 101 of the Veterans COMPACT Act. The bill was named after Sergeant Daniel Somers, who was diagnosed with PTSD and traumatic brain injuries following his return home from two tours in Iraq, and who died by suicide in 2013.[203]

Provision

Section 101(a) requires the Secretary to start a pilot program, no later than one year after enactment (i.e., December 5, 2021), for a duration of at least two years, that encourages Armed Forces members, before transitioning to civilian life, to designate up to 10 people to whom VA may disseminate specified information regarding assistance and benefits available to veterans. When making such a designation, the veteran is required to provide necessary contact information for the designees, including an email address. The pilot program would also provide the designees, within 30 days after being designated, the option to elect to receive information regarding assistance and benefits, and such information would be distributed at least quarterly to the designees. Among other things, the specified information would include VA services and benefits offered to veterans and their families, services available through community partner organizations to support veterans and their families, and a toll-free telephone number through which designees may request information. Disclosure of such information may not violate privacy requirements of the Armed Forces specified in statute or regulation.[204] Veterans may participate in the pilot program only if they voluntarily elect to do so. Designees may participate only if they elect to receive the specified information, and they may opt out of the program upon request.

Section 101(b)(1) requires the Secretary, no later than one year after the start of the pilot program and annually thereafter, to administer a survey to designees in the pilot program regarding the quality of information disseminated. Among other things, the survey would solicit feedback on satisfaction with the pilot program, recommendations for improving the pilot program, and reasons for opting in or out of the pilot program. Section 101(b)(2) requires the Secretary, no later than three years after the start of the pilot program, to submit a final report on the program to the HVAC and SVAC. The report is required to include, among other things, the number of participants enrolled in the pilot program who are veterans, the number of persons who opted in or out of the pilot program, and identification of necessary legislative or administrative action if the pilot program is made permanent.

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[201] Office of Mental Health and Suicide Prevention, *National Strategy for Preventing Veteran Suicide, 2018-2028,* Department of Veterans Affairs, p. 17, https://www.mentalhealth.va.gov/suicide_prevention/docs/Office-of-Mental-Health-and-Suicide-Prevention-National-Strategy-for-Preventing-Veterans-Suicide.pdf.

[202] S. 2864 (116th Congress).

[203] U.S. Senator Krysten Sinema, "Breaking: Sinema's Sgt. Daniel Somers Veterans Network of Support Act Signed Into Law," December 7, 2020, https://www.sinema.senate.gov/breaking-sinemas-sgt-daniel-somers-veterans-network-support-act-signed-law.

[204] As specified in Section 101(a)(5), such statutory requirements include 5 U.S.C. §552a (The Privacy Act of 1974) and P.L. 104-191 (the Health Insurance Portability and Accountability Act of 1996, HIPAA).

Section 102: Annual Report on Solid Start Program of Department of Veterans Affairs

Background

To address requirements associated with the January 2018 EO 13822 "Supporting our Veterans During Their Transition from Uniformed Service to Civilian Life," VA, in collaboration with DOD and DHS, launched Solid Start in December 2019. Solid Start is a transition assistance program that conducts outreach to newly separated servicemembers, regardless of separation type or characterization of service. Such outreach generally occurs at the 90-, 180-, and 365-day mark during the first year after separation, and the calls provide new veterans education about and assistance with accessing certain VA benefits. According to VA, VBA successfully connected with 70,000 newly separated servicemembers during the first year of the program (2020).[205]

Provision

Section 102 requires the Secretary to submit to SVAC and HVAC an annual report on VA's Solid Start program no later than 180 days after enactment (i.e., June 3, 2021) and every five years thereafter. The report is required to include specified information with respect to each veteran called or emailed under the program, including the Armed Force in which the veteran served and whether the call or email resulted in a call to the VCL, and any change to the Solid Start program implemented since the date of the previous such report, among other things. The report may not contain any of the veteran's personally identifiable information.

Title II: Suicide Prevention

As VHA continues to expand suicide prevention initiatives and create new programs, more veterans at risk for suicide are able to be identified.[206] However, as these veterans are identified, need for services also increases. Further, as suicide can arise from numerous factors, a multifactorial approach is needed to reach as many at-risk veterans as possible. This title includes provisions that address suicide prevention by (1) requiring the Secretary to provide acute crisis care for emergent suicide symptoms; (2) requiring the Secretary to create an education pilot program for family members and caregivers on matters related to coping with mental health disorders in veterans; (3) requiring the Secretary to establish a task force on outdoor recreation; (4) requiring VHA to contact all enrolled veterans who have not received care in the past two years to encourage them to receive a comprehensive medical examination, including a mental health evaluation; and (5) requiring annual VA police crisis intervention training.

Section 201: Department of Veteran Affairs Provision of Emergent Suicide Care

Background

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) provided the Secretary broad authority to furnish hospital care or medical services in

[205] Department of Veterans Affairs, "VA Solid Start program makes strides in first year," December 2, 2020, https://www.va.gov/opa/pressrel/pressrelease.cfm?id=5577.

[206] U.S. Government Accountability Office, *Efforts Needed to Ensure Effective Use and Appropriate Staffing of Suicide Prevention Teams*, GAO-21-326, April 2021, https://www.gao.gov/assets/gao-21-326.pdf.

emergency situations to any individual regardless of veteran status. This authority is generally referred to as the *humanitarian care authority*. Furthermore, the Jeff Miller and Richard Blumenthal Veterans Health Care and Benefits Improvement Act of 2016 (P.L. 114-315) requires VA emergency departments to, at a minimum, screen an individual for a medical emergency. If the facility determines that a medical emergency exists, the facility will provide care to stabilize the individual's emergency condition.[207] The individual is generally billed for any emergency services provided.[208]

A former servicemember with a bad conduct or dishonorable discharge who is in distress and in need of emergency mental health services may be provided services under humanitarian care provisions.[209] Former servicemembers can access the VA system by calling the VCL or by visiting a VA emergency room, urgent care center, or VAMC.

Descriptions of Military Character of Discharge

- **Honorable discharge** applies when the quality of a servicemember's service generally has met the standards of acceptable conduct and performance of duty for military personnel, or is otherwise so meritorious that any other characterization would be clearly inappropriate.
- **General (under honorable) discharge** applies when a servicemember's service has been honest and faithful. Characterization of service as general (under honorable conditions) is warranted when the positive aspects of a servicemember's conduct or performance of duty outweigh negative aspects of the servicemember's conduct or performance of duty as documented in their service record.
- **Other-than-honorable discharge** applies when separation is based on a pattern of behavior that constitutes a significant departure from the conduct expected of servicemembers, or when separation is based on one or more acts or omissions that constitute a significant departure from the conduct expected of servicemembers. Factors that may lead to such a discharge include the use of force or violence to produce serious bodily injury or death; abuse of a special position of trust; disregard by a superior of customary superior-subordinate relationships; acts or omissions that endanger the security of the United States or the health and welfare of other servicemembers; and deliberate acts or omissions that seriously endanger the health and safety of other persons.
- **Bad-conduct discharge** applies only to enlisted persons and may be adjudged by a general court-martial and by a special court-martial. A bad-conduct discharge is less severe than a dishonorable discharge and is designed as a punishment for bad conduct rather than as a punishment for serious offenses of either a civilian or military nature. It is also appropriate for an accused servicemember who has been repeatedly convicted of minor offenses and whose punitive separation appears to be necessary.
- **Dishonorable discharge** applies only to enlisted persons and warrant officers who are not commissioned and may be adjudged only by a general court-martial. A dishonorable discharge may be adjudged for any offense in which a warrant officer who is not commissioned has been found guilty. It is reserved for those who should be separated under conditions of dishonor, after having been convicted of offenses typically recognized in civil jurisdictions as felonies, or of offenses of a military nature requiring severe punishment.

Source: CRS, adapted from the Department of Defense, *Enlisted Administrative Separations,* DOD Instruction 1332.14, effective April 12, 2019, and the *Manual for Courts-Martial United States* (2019 edition).

In FY2017, VHA started providing emergent mental health services to former servicemembers with OTH administrative discharges. Eligible servicemembers were provided emergency stabilization if they presented at a VAMC with an emergent mental health need. Those with an OTH administrative discharge were able to receive care for their mental health emergency for an

[207] Department of Veterans Affairs, Veterans Health Administration, *Eligibility Determination*, VHA Directive 1601A.02, amended October 15, 2020, and 38 U.S.C. §1784A.

[208] 38 U.S.C. §1784.

[209] Department of Veterans Affairs, Veterans Health Administration, "Eligibility Determination," VHA Directive 1601A.02, amended October 15, 2020.

initial period of up to 90 days, which included inpatient, residential, or outpatient care.[210] These services are not provided to former servicemembers with bad-conduct or dishonorable discharges.

Provision

Section 201(a) amends current law and adds a new Section 1720J to title 38 of the *U.S. Code*. In the following paragraphs, "this section" refers to the newly added Section 1720J and its subdivisions.

Emergent Suicide Care

This section would require the Secretary to provide emergent suicide care to those with an acute suicidal crisis, in a VA facility, *or* to pay for care in a non-VA facility, *or* to reimburse for such care.

Eligibility

This section stipulates that individuals are eligible for emergent suicide care if they meet the statutory definition of a "veteran," meaning an "individual who served in the active military, naval, or air service and who was discharged or released under conditions other than dishonorable";[211] or a former servicemember, including those who served in the Reserve components and who meet each of the following criteria:[212]

- *Conditions of discharge*: the veteran served on active duty and was discharged or released under a condition that is not honorable (but not a dishonorable discharge), or was discharged by court-martial (i.e., those with a dishonorable discharge or a discharge by court-martial would not be eligible for mental health care services from VA).
- *Duration of service*: the veteran served for a period of more than 100 cumulative days.
- *Conditions of service*: the veteran (1) was deployed in a theater of combat operations, in support of a contingency operation, or in an area at a time during which hostilities occurred, including by controlling an unmanned aerial vehicle (UAV) from a location other than such theater or area; or (2) was the victim of a physical assault of a sexual nature, a battery of a sexual nature, or sexual harassment.
- Not currently enrolled in VA's health care system.

Period of Care

This section requires that care be provided for a period not to exceed 30 days as an inpatient or in a crisis residential care facility; if such care is unavailable or not clinically appropriate, then care must be provided on an outpatient basis for a period of no more than 90 days. After such time, if

[210] Department of Veterans Affairs, "VA Secretary Formalizes Expansion of Emergency Mental Health Care to Former Service Members With Other-Than-Honorable Discharges," press release, June 27, 2017. Also see Memorandum from Deputy Under Secretary for Health for Operations and Management (1ON) to Network Directors (10N1-23) and Network Mental Health Leads (10N1-23), *Eliminating Veteran Suicide: Emergency Services for Other Than Honorable,* June 26, 2017.

[211] 38 U.S.C. §101(2). Section 926 of the William M. (Mac) Thornberry National Defense Authorization Act for Fiscal Year 2021 (P.L. 116-283) amended the term "veteran" to include "space service.'' The Office of the Law Revision Counsel of the U.S. House of Representatives has not codified this change as of the date of this report.

[212] 38 U.S.C. §1720I(b).

the Secretary determines that such individual remains in an acute suicidal crisis, the Secretary could extend the period of care as appropriate.

Outreach and Notification Requirements

This section stipulates that an eligible individual, or someone else on behalf of the individual, must notify the Secretary within seven days if such an individual receives emergent suicide care at a non-VA facility. It also requires the following during the period when an eligible individual is receiving emergent suicide care:

- If emergent suicide care is recommended by the VCL at a VAMC, then the VCL must notify the SPC at the VAMC.
- If the eligible individual receives emergent suicide care at a VAMC without the VCL recommendation, then the SPC at the VAMC must be notified.
- If emergent suicide care is recommended by the VCL at a non-VA facility, then the VCL must notify the SPC and the Office of Community Care at the nearest VAMC.
- If the eligible individual receives emergent suicide care at a non-VA facility, without the VCL recommendation, then the Secretary must notify the SPC and the Office of Community Care at the nearest VAMC regarding the eligible individual, or someone else must notify the Secretary on behalf of the individual within seven days of receiving the emergent suicide care.
- After emergent suicide care is provided, as soon as practicable, the Secretary must make referrals to other VA benefits and services as appropriate and determine the eligibility for those benefits and services.

Prohibition on Charges

This section provides that the Secretary may not impose any charges for emergent suicide care (i.e., no "cost sharing" or "out-of-pocket" costs), and must pay for any costs of emergency transportation. The Secretary may not impose any charges, even if the eligible individual, or someone else on behalf of the individual, did not notify the Secretary within the seven day notification period.

Reimbursement and Other Health Insurance

This section stipulates that the Secretary could establish payment rates for care in non-VA facilities or from non-VA providers in a similar manner to the manner in which the Secretary determines reimbursement amounts for that nondepartment facility for medical care and services provided under another provision of this chapter. If the eligible individual has a health plan contract that would pay for the emergent suicide care treatment, the Secretary may recover the costs for nonservice-connected emergent suicide care from such third party.

Annual Report to Congress

This section requires the Secretary to submit and report annually to SVAC and HVAC. The report must include the number of eligible individuals who received emergent suicide care and related demographic information, the types of care provided, and the total cost of emergent suicide care.

Definitions

This section defines the following terms applicable to the new "Emergent suicide care" section.

Acute suicidal crisis. An individual who is determined by a trained crisis responder or health care provider to be at imminent risk of self-harm.

Crisis residential care. Care provided in a residential setting, and in a nonhospital facility.

Crisis stabilization care. Care provided to an individual in acute suicidal crisis, which would provide immediate safety and reduce the severity of the distress.

Emergent suicide care. Crisis stabilization care provided based on recommendations from the VCL or when presented at a medical facility with acute suicidal crisis.

Health-plan contract. A private health insurance policy or contract, Medicare, Medicaid, or workers' compensation law or plan.

Effective Date

This new section will be effective 270 days after the date of the enactment of this act (i.e., September 1, 2021).

Section 202: Education Program for Family Members and Caregivers of Veterans with Mental Health Disorders

Background

The Department of Veterans Affairs Health Care Programs Enhancement Act of 2001 (P.L. 107-135) first authorized VHA to provide services such as counseling, training, and mental health services to family members of veterans receiving treatment through VA. Eligibility for these services was later expanded to caregivers by the Caregivers and Veterans Omnibus Health Services Act of 2010 (P.L. 111-163). Under these authorities, VHA established policies for providing services to family members and caregivers as they pertain to a veteran's mental health goals.[213] Such services include, at a minimum, family education, veteran-centered brief family consultation, and marital and family counseling, including family psychoeducation.

Provision

Section 202 requires the Secretary to establish an education pilot program for family members and caregivers on matters related to coping with mental health disorders in veterans. The Secretary is required to establish the program no later than 270 days after enactment (i.e., September 1, 2021), and the program is required to continue for four years from the date of commencement. The component of the program that relates to education and training of noncaregiver family members must be carried out in at least five medical centers, at least five clinics, and at least five vet centers.

This section requires that the Secretary contract with nonprofit entities experienced in the relevant field to carry out the education program as specified. In addition, the Secretary is required to select department mental health care providers to monitor the progress of instruction under the program. The curriculum must consist of, among other things (1) general education on different mental health disorders, (2) techniques for handling crisis situations and administering mental health first aid, (3) techniques for coping with the stress of living with an individual suffering from a mental health disorder, and (4) information on additional services available.

The Secretary is required to survey participants for satisfaction, perceived effectiveness, and applicability of the program to issues faced. In addition, the Secretary is required to submit an annual report to HVAC and SVAC no later than one year after commencement of the program and

[213] Department of Veterans Affairs, Veterans Health Administration, *Family Services in Mental Health*, VHA Directive 1163.04, June 17, 2019.

no later than September 30 each year thereafter until 2024. The section specifies information to include in the annual report, which includes results of the surveys. Furthermore, the Secretary is required to submit a final report to HVAC and SVAC no later than one year after the completion of the program.

Section 203: Interagency Task Force on Outdoor Recreation for Veterans

Background

Some research suggests that outdoor recreation, such as camping or kayaking, may prove beneficial for veterans with mental health problems.[214] Further, group-based outdoor recreation programs may help veterans who are transitioning back to civilian life.[215]

In May 2019, legislation was jointly introduced in the House and Senate that would have created a federal interagency task force on outdoor recreation for veterans.[216] In July 2020, HVAC held a legislative hearing on the House-passed version of the bill.[217] VA supported the passage of the bill but had a few suggestions for technical corrections.[218] Organizations such as the Paralyzed Veterans of America and the Iraq and Afghanistan Veterans of America also supported the passage of the legislation.[219]

Provision

Section 203 requires the Secretary to establish the Task Force on Outdoor Recreation for Veterans (Task Force) no later than 18 months after the President's national emergency declaration pertaining to Coronavirus Disease 2019 (COVID-19) expires.[220] The Task Force must include representatives from the Departments of the Interior, Health and Human Services, Agriculture, Defense, and Homeland Security, as well as the Army Corps of Engineers, at least two representatives from VSOs, and any other member the Secretary deems appropriate. The Secretary and Secretary of the Interior are required to serve as co-chairpersons of the Task Force.

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[214] Department of Veterans Affairs, "Outdoor activities improve mental health in Veterans, study finds," February 19, 2014, https://www.research.va.gov/currents/winter2013-14/winter2013-14-25.cfm.

[215] Jason Duvall and Rachel Kaplan, *Exploring the Benefits of Outdoor Experiences on Veterans*, University of Michigan and Sierra Club, Washington, DC, June 2013, p. 23, https://content.sierraclub.org/outings/sites/content.sierraclub.org.outings/files/SIERRA_REPORT_6_13_Exploring%20the%20benefits%20of%20outdoor%20expereinces%20on%20veterans%20(1).pdf.

[216] S. 1263 (116th Congress) and H.R. 2435 (116th Congress).

[217] U.S. Congress, House Committee on Veterans' Affairs, *Legislative Hearing on: H.R. 6039; H.R. 6082 ;H.R. 4908;H.R. 2791; H.R. 4526; H.R. 3582 ; H.R. 96 ; H.R. 4281; H.R. 3010 ; H.R. 7163; H.R. 7111; H.R. 2435; H.R. 7287; H.R. 3228; H.R. 6141; H.R. 6493 ; H.R. 7445; Discussion Draft –Burial Equity for Guards and Reserves Act of 2020; Discussion Draft – To amend title 38, United States Code, to extend certain employment and reemployment rights to members of the National Guard who perform State active duty, and Discussion Draft – To amend title 38, United States Code, to clarify the scope of procedural rights of members of the uniformed services with respect to their employment and reemployment rights, and for other purposes,* 116th Cong., 2nd sess., July 23, 2020.

[218] U.S. Congress, House Committee on Veterans' Affairs, *Testimony for the House Committee on Veteran's Affairs*, prepared by Dr. Maria Llorente, Veterans Health Administration, 116th Cong., 2nd sess., July 23, 2020.

[219] See for example U.S. Congress, House Committee on Veterans' Affairs, *Statement for the Record for the House Committee on Veteran's Affairs*, prepared by Ryan Britch, Iraq and Afghanistan Veterans of America, 116th Cong., 2nd sess., July 23, 2020, and U.S. Congress, House Committee on Veterans' Affairs, *Statement for the Record for the House Committee on Veteran's Affairs*, prepared by Paralyzed Veterans of America, 116th Cong., 2nd sess., July 23, 2020.

[220] 50 U.S.C. §§1601 et seq.

Section 203(g) states that the Federal Advisory Committee Act (FACA; P.L. 92-463) is not applicable to the Task Force.

Section 203(d) stipulates the duties of the Task Force, which must be carried out in consultation with appropriate veteran outdoor recreation groups. Among other things, the Task Force is required to identify barriers that exist to providing veterans with health and wellness services through use of outdoor recreation on public lands and to develop recommendations to better accommodate the use of public lands for this purpose. Section 203(h) defines public lands as any recreational lands under federal, state, or local government jurisdiction.

Section 203(e) requires submission of reports to Congress on the findings of the Task Force. A preliminary report on initial findings of the Task Force is due no later than one year after the date on which the Task Force is established. The final report, which is required to include recommendations developed under subsection (d), must be submitted no later than one year after the submission of the preliminary report. Pursuant to section 203(f), the Task Force is required to end one year after the submission of the final report under subsection (e).

Section 204: Contact of Certain Veterans to Encourage Receipt of Comprehensive Medical Examinations

Background

In general, a veteran must be enrolled in the VA health care system as a condition for receiving care. Once a veteran is enrolled, the veteran remains in the system and does not have to reapply for enrollment annually. However, in a given year not all enrolled veterans receive care through the VA health care system, either because they are not sick or have other sources of health care coverage such as private health insurance or public sources such as Medicare.[221]

Provision

Section 204 requires the Under Secretary of Health to contact all enrolled veterans who have not received care from the VA health care system in the past two years and encourage them to receive a comprehensive medical examination, including mental health evaluations and specified vision and hearing tests. The veteran could receive this examination in a VAMC or in the community under the VCCP.[222] When care is provided in a VAMC, the Secretary must seek to schedule all examinations on the same day. Eligible veterans are to be contacted by mail, telephone, or email no later than 90 days after enactment of this act (i.e., March 5, 2021). This section allows the Secretary to pay for travel for rural covered veterans who avail themselves of this comprehensive medical examination, as well as to enter into contracts for shuttle services to transport veterans in rural areas to receive the examination. This section requires a report to Congress no later than 18 months after enactment (i.e., June 5, 2022) on how many eligible veterans scheduled comprehensive medical examinations.

[221] For more information, see CRS In Focus IF10418, *Do Veterans Have Choices in How They Access Health Care?*

[222] For more information on VCCP, see CRS Report R45390, *VA Maintaining Internal Systems and Strengthening Integrated Outside Networks Act of 2018 (VA MISSION Act; P.L.115-182)*.

Section 205: Police Crisis Intervention Training of Department of Veterans Affairs

Background

VA police officers are federal law enforcement officers who provide security and law enforcement services at VHA facilities, VBA offices co-located with VHA facilities, and for VA national cemeteries under certain circumstances.[223] There are approximately 4,000 police officers working at 139 of the 141 VAMCs, and VHA shares responsibility for the police program with the VA Office of Operations, Security, and Preparedness (OSP).[224] All VA police officers receive specialized training at the Law Enforcement Training Center (LETC), accredited by the Federal Law Enforcement Training Accreditation Board. This training entails

> a 10-week basic training course where they receive 30.5 hours of classroom training specific to de-escalation and conflict management techniques with a new special focus on suicide awareness and prevention. Officers also complete nearly 24 hours of practical based scenarios in which they are expected to successfully employ and utilize de-escalation skills to affect positive outcomes in real-life scenarios.[225]

In light of incidents involving veterans with mental health conditions being mistreated and injured by VA police,[226] among other reasons, the HVAC Subcommittee on Oversight and Investigations held a June 2019 hearing on current VA police policies and procedures.[227] A bill was subsequently introduced in the House that would, among other things, amend current law[228] to require VA police officers to receive annual training on preventing suicide among the population served (i.e., veterans).[229]

Provision

Section 205(a) requires the Secretary to provide department police officers with an annual training on veteran suicide prevention. Section 205(f) defines department police officers as employees of VA under 38 U.S.C. §902(a). Section 205(b) requires that the Secretary update any training already provided before enactment to include, at minimum, (1) effective behavioral procedures of suicide prevention and risk mitigation; (2) crisis intervention and de-escalation skills through the use of interactive training; (3) information about mental health and substance use disorders; and (4) information about local law enforcement teams and other resources for veterans experiencing mental health crises. Section 205(c) requires that the training occur at a

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223 38 U.S.C. §902(a), and VA OIG, *VA Police Management System Needs Improvement*, Department of Veterans Affairs, June 17, 2020, https://www.va.gov/oig/pubs/VAOIG-19-05798-107.pdf.

224 U.S. Congress, House Committee on Veterans' Affairs, *Testimony before the House Committee on Veteran's Affairs*, *Subcommittee on Oversight and Investigations, Examining the Department of Veterans Affairs Police Program,* prepared by Michael J. Missal, Department of Veterans Affairs Inspector General, 116th Cong., 1st sess., June 11, 2019, p. 2.

225 U.S. Congress, House Committee on Veterans' Affairs, *Testimony before the House Committee on Veteran's Affairs*, *Subcommittee on Oversight and Investigations, Examining the Department of Veterans Affairs Police Program,* prepared by Renee Oshinski, Deputy Under Secretary for Health for Operations and Management (Acting), Veterans Health Administration, 116th Cong., 1st sess., June 11, 2019, p. 4.

226 U.S. Representative Kathleen Rice, "Rice, Pappas Introduce VA Police Reform Legislation," July 24, 2020, https://kathleenrice.house.gov/news/documentsingle.aspx?DocumentID=1548.

227 U.S. Congress, House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, *Examining the Department of Veterans Affairs Police Program*, 116th Cong., 1st sess., June 11, 2019.

228 38 U.S.C. §902.

229 H.R. 7784 (116th Congress).

VAMC in consultation with the mental health experts at the VAMC, as well as law enforcement training accreditation organizations. Section 205(d) requires that each VA facility police force develop a plan to enter into partnerships with relevant local community organizations and local police departments.

Section 205(e) requires the Secretary to submit to HVAC and SVAC, no later than one year after enactment (i.e., December 5, 2021), a report with specified information on the annual training and partnerships required under this section.

Title III: Improvement of Care and Services for Women Veterans

Section 301: Gap Analysis of Department of Veterans Affairs Programs That Provide Assistance to Women Veterans Who Are Homeless

Background

Based on a single day count in January 2020, approximately 8.4% of veterans experiencing homelessness were women.[230] Programs to assist homeless veterans are funded through three agencies: VA, Department of Labor (DOL), and Department of Housing and Urban Development (HUD). Although not necessarily specific to women veterans, a number of VA-administered programs conduct outreach to homeless veterans, provide work experience, issue grants for housing, and provide supportive services for low-income families.[231]

Provision

Section 301 requires the Secretary to complete a gap analysis[232] of the programs available through VA that provide assistance to women veterans who are experiencing homelessness or who are precariously housed. The Secretary is required to submit a report on the analysis to HVAC and SVAC no later than 270 days after enactment (i.e., September 1, 2021).

Section 302: Report on Locations Where Women Veterans Are Using Health Care from Department of Veterans Affairs

Background

VA administers a women's health care program that, among other things, offers outreach and support to women veterans to put them in touch with available VHA health services. VHA offers enrolled veterans a standard medical benefits package, which includes a full range of health care, gender-specific medical services, prescription drugs, long-term care, and social support services.[233] Gender-specific health care services include primary health care, intimate partner

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[230] Department of Housing and Urban Development, *The 2020 Annual Homeless Assessment Report (AHAR) to Congress*, January 2021, p. 54, https://www.huduser.gov/portal/sites/default/files/pdf/2020-AHAR-Part-1.pdf.

[231] For more information on veteran homelessness programs, see CRS In Focus IF10167, *Veterans and Homelessness*.

[232] For the purposes of this section, gap analysis is intended to identify the areas in which the relevant programs are failing to meet the needs of women veterans who are experiencing homelessness or who are precariously housed.

[233] 38 C.F.R. §17.38.

violence services, military sexual trauma services, and maternity health care services, among others.[234]

Provision

Section 302 requires the Secretary to submit a report no later than 90 days after enactment (i.e., March 5, 2021), and annually thereafter, to HVAC and SVAC on the use of VHA care by women veterans. This report must include (1) the number of women veterans who reside in each state; (2) the number of women veterans enrolled in the VA health care system in each state; (3) the number of enrolled women veterans who received care at least during the one-year period; (4) the number of women veterans who were seen at each VA medical facility; (5) the number of appointments for women veterans disaggregated by facility and appointment type; (6) the number of appointments completed in person and through telehealth; (7) identification of the medical facility in each VISN with the largest rate of increase in women veteran patient population; and (8) identification of the medical facility in each VISN with the largest rate of decrease in women veteran patient population.

[234] For more information on gender-specific health care for women veterans, see CRS In Focus IF11082, *Veterans Health Administration: Gender-Specific Health Care Services for Women Veterans*.

Appendix. Implementation Dates, Reporting Requirements, and Deadlines

The tables below include relevant provisions for the Hannon Act and the Veterans COMPACT Act, respectively, which include an effective date, a required report, or an explicit sunset date. The tables include only reports that must be made public or be delivered to Congress. This CRS report reflects the Hannon Act and the Veterans COMPACT Act at enactment and will not track actions pursuant to these deadlines, nor will this report be updated.

Table A-1. Hannon Act Implementation Dates, Reporting Requirements, and Deadlines

Section Number	Brief Description	Effective Date/Reporting Deadline
Title I. Improvement of Transition of Individuals to Services from Department of Veterans Affairs		
Section 101	Requires the Secretary, in consultation with the Secretary of Defense, to develop a strategic plan for providing health care to veterans transitioning from service, to be submitted to specified congressional committees and published on the VA website.	No later than one year after enactment (i.e., by October 17, 2021).
Section 102	Requires the Secretary of Defense and the Secretary to submit a joint report, to specified congressional committees, on their review of the records of all members of the Armed Forces who died by suicide within one year of discharge/release during the five-year period preceding enactment (i.e., October 17, 2015 to October 17, 2020).	No later than three years after enactment (i.e., by October 17, 2023).
Section 103	Requires the Secretary to submit a report, to specified congressional committees, on the REACH VET program.	No later than 180 days after enactment (i.e., by April 15, 2021).
Section 104	Requires the Secretary to annually submit a report, to specified congressional committees, on the mental and behavioral health care services provided to servicemembers who were discharged or released with an OTH discharge.	No later than February 15 each year.
Title II. Suicide Prevention		

Section Number	Brief Description	Effective Date/Reporting Deadline
Section 201	Requires the Secretary to submit a report, to specified congressional committees, on the grant criteria, measures and metrics, and information sharing framework of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.	No later than 30 days before notifying eligible entities of the availability of grant funding.
	Requires the Secretary to submit an interim report, to specified congressional committees, on the provision of grants under the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.	No later than 18 months after the date on which the first grant is awarded.
	Requires the Secretary to submit a final report, to specified congressional committees, on the provision, effectiveness, and potential extension or expansion of grants under the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.	No later than three years after the date on which the first grant is awarded, and annually thereafter for each year in which the program is in effect.
	Requires the Secretary to seek to enter into a contract with a nongovernment entity to conduct a third-party assessment of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.	No later than 180 days after commencement of the grant program.
	Requires the Secretary to submit the third-party assessment to specified congressional committees.	No later than 24 months after the date on which the first grant is awarded.
	Sunset of the Staff Sergeant Parker Gordon Fox Suicide Prevention Grant Program.	Three years after the date on which the first grant is awarded.
Section 202	Requires the Secretary to complete an analysis and submit a report, to specified congressional committees, on the feasibility and advisability of providing select complementary and integrative health treatments at all VA medical facilities.	No later than 180 days after enactment (i.e., by April 15, 2021).
Section 203	Requires the Secretary to commence a pilot program to provide select complementary and integrative health programs to eligible veterans.	No later than 180 days after the COVER Commission submits its final report (i.e., by July 24, 2020).
	Requires the Secretary to submit an interim report, to specified congressional committees, on the pilot program.	No later than one year after the commencement of the pilot program.

Section Number	Brief Description	Effective Date/Reporting Deadline
	Requires the Secretary to submit a final report, to specified congressional committees, on the pilot program.	No later than 90 days after the termination of the pilot program.
	Sunset of the pilot program.	Three years after the commencement of the pilot program.[a]
Section 204	Requires the Secretary to brief specified congressional committees on the interim results of a VA and NASEM study on the effects of opioids and benzodiazepine on all-cause mortality of veterans, including suicide.	No later than 24 months after VA enters into an agreement with NASEM for the study.
	Requires GAO to conduct a review of the staffing levels for mental health professionals at VA.	No later than 90 days after enactment (i.e., January 15, 2021).
	Requires the Secretary to brief specified congressional committees on the interim results of the GAO review of the staffing levels for mental health professionals at VA.	No later than 18 months after enactment (i.e., by April 17, 2022).
	Requires the Secretary to submit a publically available report, to specified congressional committees, on the results of a VA and NASEM study on the effects of opioids and benzodiazepine on all-cause mortality of veterans, including suicide.	No later than 90 days after the completion of the study.
	Requires the Secretary to submit a publically available report, to specified congressional committees, on the results of the GAO review of the staffing levels for mental health professionals at VA.	No later than 90 days after the completion of the GAO review.
Section 205	Requires a GAO report, submitted to specified congressional committees, on the efforts of VA to manage veterans at high risk for suicide.	No later than 18 months after enactment (i.e., by April 17, 2022).
Title III. Programs, Studies, and Guidelines on Mental Health		
Section 301	Requires the Secretary, in consultation with Rural Health Resource Centers of the Office of Rural Health of VA, to commence a study on the connection between living at high altitude and the risk of depression or suicide among veterans.	No later than 180 days after enactment (i.e., by April 15, 2021).

Section Number	Brief Description	Effective Date/Reporting Deadline
	Deadline for the completion of the study.	No later than three years after the commencement of the study.
	Requires the Secretary to submit a report, to specified congressional committees, on the results of the study.	No later than 150 days after the completion of the study.
	If the Secretary determines, through the study, that living at high altitude is a risk factor for depression or suicide, the Secretary is required to conduct a follow-up study on (1) the most likely biological mechanism that makes living at high altitude a risk factor for depression or suicide and (2) the most effective treatment or intervention for reducing the risk of depression or suicide associated with high altitude. If the follow-up study is conducted, the Secretary is required to submit a report, to specified congressional committees, on the results of that study.	Report due no later than 150 days after the completion of the follow-up study.
Section 302	Requires the Secretary, in consultation with the Secretary of Defense, to develop a clinical provider treatment toolkit and accompanying training materials for comorbidities of mental health conditions, substance use disorders, and chronic pain.	No later than two years after enactment (i.e., by October 17, 2022).
Section 303	Requires the Secretary and the Secretary of Defense to update guidance in VA and Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide.	Update required in the first publication after enactment.[b]
Section 304	Requires the Secretary, in consultation with the Secretary of Defense and the Secretary of Health and Human Services, to develop clinical practice guidelines for the treatment of serious mental illness.	No later than two years after enactment (i.e., by October 17, 2022).
	Requires the Secretary, in consultation with the Secretary of Defense and the Secretary of Health and Human Services, to assess the 2016 Clinical Practice Guidelines for the Management of Major Depressive Disorders and determine if updates are necessary.	No later than two years after enactment (i.e., by October 17, 2022).

Section Number	Brief Description	Effective Date/Reporting Deadline
Section 305	Requires the Secretary to develop and implement an initiative to identify and validate brain and mental health biomarkers among veterans.	No later than 18 months after enactment (i.e., by April 17, 2022).
Title IV. Oversight of Mental Health Care and Related Services		
Section 401	Requires the Secretary to contract with a nonfederal government entity to complete a study using focus groups on the effectiveness of the mental health and suicide prevention outreach materials and campaigns conducted by VA.	No later than 180 days after enactment (i.e., by April 15, 2021).
	Requires the Secretary to submit a report, to specified congressional committees, on the findings of the study.	No later than 90 days after the last focus group meeting of the study.
	Requires the Secretary to complete a representative survey of veterans to collect information about the effectiveness of the mental health and suicide prevention outreach materials and campaigns conducted by VA.	No later than one year after the last focus group meeting of the study on effectiveness of mental health and suicide prevention outreach materials and campaigns conducted by VA.
Section 402	Requires the Secretary to submit an initial report, to specified congressional committees, on the established goals, metrics, and targets of the mental health and suicide prevention media outreach campaigns conducted by VA.	No later than 180 days after enactment (i.e., by April 15, 2021).
	Requires the Secretary to submit an annual report, to specified congressional committees, on the progress of VA in meeting the goals of its mental health and suicide prevention media outreach campaigns, as well as actions to be taken to better meet those goals.	No later than one year after the submittal of the initial report, and annually thereafter.
	Requires the Secretary to submit a report, to specified congressional committees, containing the expenditures and obligations of the Office of Mental Health and Suicide Prevention of the Veterans Health Administration during the period covered by the report.	No later than 180 days after enactment (i.e., by April 15, 2021), and semiannually thereafter.
Section 403	Requires GAO to submit a management review, to specified congressional committees, of the mental health and suicide prevention services provided by VA.	No later than three years after enactment (i.e., by October 17, 2023).

Section Number	Brief Description	Effective Date/Reporting Deadline
Section 404	Requires a GAO report, submitted to specified congressional committees, on the efforts of VA to integrate mental health care into primary clinics of the Department.	No later than two years after enactment (i.e., by October 17, 2022).
	Requires a GAO report, submitted to specified congressional committees, on the efforts of VA to integrate community-based mental health care into the Veterans Health Administration.	No later than two years after the submittal of the GAO report on integrating mental health care into primary care clinics.
Section 405	Requires the Secretary and Secretary of Defense to submit an annual report, to specified congressional committees, on the mental health programs and joint mental health programs conducted by VA and the Department of Defense.	No later than one year after enactment (i.e., by October 17, 2021), and annually thereafter.
	Requires the Secretary to submit a report, to specified congressional committees, on (1) the evaluation of collaborative efforts by VA and the Department of Defense related to PTSD and traumatic brain injuries; (2) the potential for new collaborative efforts to improve such care through a joint VA/Department of Defense Intrepid Spirit Center; and (3) an alternatives of analysis to establish the joint VA/Department of Defense Intrepid Spirit Center.	No later than 270 days after enactment (i.e., by July 14, 2021).
Title V. Improvement of Mental Health Medical Workforce		
Section 501	Requires the Secretary, in consultation with the Inspector General of VA, to submit a plan, to specified congressional committees, to address staffing of mental health providers at VA.	No later than one year after enactment (i.e., by October 17, 2021).
	Requires the Secretary to submit a report, to specified congressional committees, that contains the number of mental health providers hired by VA during the one-year period preceding the report.	No later than one year after the submittal of the plan.
	Requires the Secretary, in consultation with the Office of Personnel Management, to develop an occupational series for licensed professional mental health counselors and marriage and family therapists of VA.	No later than one year after enactment (i.e., by October 17, 2021).

Section Number	Brief Description	Effective Date/Reporting Deadline
Section 502	Effective period for the VA Readjustment Counseling Service Scholarship Program.	Scholarships are to begin being awarded no later than one year after enactment (i.e., by October 17, 2021).
Section 503	Requires a GAO report, submitted to specified congressional committees, on VA Readjustment Counseling Service.	No later than one year after enactment (i.e., by October 17, 2021).
Section 504	Requires the Secretary to submit, to specified congressional committees, a biennial supplement to the annual report on the Readjustment Counseling Service.	Each even-numbered year in which the annual report on the Readjustment Counseling Service is submitted (i.e., no later than March 15 of each even numbered year).
Section 505	Requires the Secretary to conduct a survey on the attitudes of eligible veterans toward VA offering appointments outside the usual operating hours of facilities of the department.	No later than 180 days after enactment (i.e., by April 15, 2021).
	Requires the Secretary to brief specified congressional committees on the feasibility, advisability, and effectiveness of offering appointments outside the usual operating hours of facilities of VA.	No later than 270 days after enactment (i.e., by July 14, 2021).
Section 506	Requires that every medical center of VA has at least one suicide prevention coordinator.	Beginning no later than one year after enactment (i.e., by October 17, 2021).
	Requires the Secretary, in consultation with the Office of Mental Health and Suicide Prevention, to commence a study on the feasibility and advisability of (1) the reorganization of suicide prevention coordinators within the Office of Mental Health and Suicide Prevention and (2) the creation of a suicide prevention coordinator program office.	No later than one year after enactment (i.e., by October 17, 2021).
	Requires the Secretary to submit a report, to specified congressional committees, on (1) the results of the study, (2) the staffing ratios for suicide prevention coordinators and case managers at VA, and (3) the responsibilities of suicide prevention coordinators across the department.	No later than 90 days after the completion of the study on suicide prevention coordinators.

Section Number	Brief Description	Effective Date/Reporting Deadline
Section 507	Requires the Secretary to submit a report, to specified congressional committees, on the efforts of the Secretary to implement a suicide prevention program for veterans presenting to a Veterans Health Administration emergency department/urgent care center who are assessed to be at risk for suicide but are safe to be discharged home.	No later than 180 days after enactment (i.e., by April 15, 2021).
Title VII. Other Matters		
Section 701	Requires the Secretary to complete an assessment of barriers faced by veterans in accessing telehealth services.	No later than 18 months after enactment (i.e., by April 17, 2022).
	Requires the Secretary to submit a report, to specified congressional committees, on the results of the assessment, as well as any recommendations for legislative or administrative action.	No later than 120 days after the completion of the assessment.
Section 702	Requires the Secretary, in consultation with the Center for Compassionate Innovation, to begin reviewing the effectiveness and applicability of hyperbaric oxygen therapy.	No later than 90 days after enactment (i.e., by January 15, 2021).
	Requires the Secretary, in consultation with the Center for Compassionate Innovation, to conduct a systematic review of published research literature on off-label use of hyperbaric oxygen therapy to treat PTSD and traumatic brain injury among veterans and nonveterans.	Review must commence no later than 90 days after enactment (i.e., by January 15, 2021). Review must be completed no later than 180 days after commencement.
	Requires the Secretary to submit a report, to specified congressional committees, on the results of the review.	No later than 90 days after the completion of the review.
	Requires the Secretary, in consultation with the Center for Compassionate Innovation, to conduct a follow-up study on all individuals receiving hyperbaric oxygen therapy for the treatment of PTSD and traumatic brain injury through the current VA pilot program.	Study must commence no later than 120 days after the completion of the review. Study must be completed no later than three years after commencement.

Section Number	Brief Description	Effective Date/Reporting Deadline
	Requires the Secretary to submit a report, to specified congressional committees, on the results of the follow-up study.	No later than 90 days after the completion of the follow-up study.
Section 703	Requires the Secretary to prescribe technical qualifications for the appointment of licensed hearing aid specialists in the Veterans Health Administration.	No later than 180 days after enactment (i.e., by April 15, 2021).
	Requires the Secretary to appoint at least one licensed hearing aid specialist at each VA medical center.	No later than September 30, 2022.
	Requires the Secretary to submit an annual report, to specified committees, on (1) progress and conflicts/obstacles in appointing licensed hearing aid specialists at VA, (2) patient access to comprehensive hearing health care services at VA, and (3) vacancies for audiologists or licensed hearing aid specialists at VA medical centers.	No later than September 30, 2022, and annually thereafter.
Section 704	Requires the Secretary to complete all necessary policy revisions to allow VA-sponsored clinical research to use accredited commercial institutional review boards to review VA research proposal protocols.	No later than 90 days after enactment (i.e., by January 15, 2021).
	Requires the Secretary to (1) identify accredited commercial institutional review boards for use in connection with VA-sponsored clinical research and (2) establish a process to modify existing approvals in the event that a commercial institutional review board loses its accreditation during an ongoing clinical trial.	No later than 90 days after the completion of the policy revisions.
	Requires the Secretary to submit an annual report, to specified congressional committees, on all approvals of institutional review boards used by VA.	No later than 90 days after the completion of the policy revisions, and annually thereafter.
Section 705	Requires the Secretary to establish an Office of Research Reviews within the VA Office of Information and Technology.	No later than one year after enactment (i.e., by October 17, 2021).
	Requires the Office of Research Reviews to submit a report, to specified congressional committees, on the activity of the office.	No later than one year after the establishment of the Office.

Source: CRS analysis of the Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019 (P.L. 116-171).

Notes: Effective dates are not included for reporting deadlines that are based on the date of completion of another reporting deadline.

COVER = Creating Options for Veterans' Expedited Recovery; GAO = U.S. Government Accountability Office; NASEM = National Academies of Sciences, Engineering, and Medicine; OTH = Other Than Honorable; PTSD = Posttraumatic Stress Disorder; REACH VET = Recovery Engagement and Coordination for Health – Veterans Enhanced Treatment; Secretary = Secretary of the Department of Veterans Affairs; VA = Department of Veterans Affairs.

a. The Secretary may extend the pilot program beyond three years if the Secretary, based on the results of the interim report submitted to the House and Senate Veterans Affairs Committees, determines it is appropriate to do so.

b. The most recent update to the VA and Department of Defense Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide was published in May 2019 and based on evidence reviewed through April 2018. Department of Veterans Affairs, "VA/DoD Clinical Practice Guideline for Assessment and Management of Patients at Risk for Suicide," May 2019, at https://www.healthquality.va.gov/guidelines/MH/srb/VADoDSuicideRiskFullCPGFinal5088212019.pdf.

Table A-2. Veterans COMPACT Act Implementation Dates, Reporting Requirements, and Deadlines

Section Number	Brief Description	Effective Date/Reporting Deadlines
Title I. Improvement of Transition of Individuals to Services from Department of Veterans Affairs		
Section 101	Requires the Secretary to commence a voluntary pilot program that connects veterans transitioning from service with designated individuals to help share information regarding assistance and benefits available to those veterans.	No later than one year after enactment (i.e., by December 5, 2021).
	Requires the Secretary to administer surveys in order to receive feedback from individuals who elected to receive information under the pilot program.	No later than one year after the commencement of the pilot program, and not less frequently than annually thereafter for the duration of the pilot program.
	Requires the Secretary to submit a final report, to specified congressional committees, on the pilot program.	No later than three years after the commencement of the pilot program.
	Duration of the pilot program.	The pilot program must be carried out for a period not less than two years.
Section 102	Requires the Secretary to submit an annual report, to specified congressional committees, on the VA Solid Start program.	No later than 180 days after enactment (i.e., by June 3, 2021), and annually thereafter for five years.
Title II. Suicide Prevention		
Section 201	Requires the Secretary to submit an annual report, to specified congressional committees, on emergent suicide care provided by VA.	Not less than once each year.

Section Number	Brief Description	Effective Date/Reporting Deadlines
	Effective date for the furnishing and/or payment of emergent suicide care by VA.	Begins 270 days after enactment (i.e., on September 1, 2021).
Section 202	Requires the Secretary to establish an education program for the education and training of caregivers and family members of eligible veterans with mental health disorders.	Not less than 270 days after enactment (i.e., by September 1, 2021).
	Requires the Secretary to submit an annual report, to specified congressional committees, on the education program and the feasibility and advisability of expanding the education program to include a peer support program.	No later than one year after the commencement of the education program and no later than September 30 each year thereafter until 2024.
	Requires the Secretary to submit a final report, to specified congressional committees, on the feasibility and advisability of continuing the education program.	No later than one year after the completion of the education program.
	Duration of education program.	Four-year period following the commencement of the education program.
Section 203	Requires the Secretary to establish an interagency task force on outdoor recreation for veterans.	No later than 18 months after the expiration of the national emergency pertaining to COVID-19.[a]
	Requires the chairpersons of the Task Force to submit a report to Congress on the preliminary findings of the Task Force.	No later than one year after the Task Force is established.
	Requires the chairpersons of the Task Force to submit a report to Congress on the final findings and recommendations of the Task Force.	No later than one year after the submittal of the preliminary report.
	Sunset of Task Force.	One year after the submittal of the final report.
Section 204	Requires the VA Under Secretary of Health to seek to contact all covered veterans in order to encourage them to receive comprehensive medical examinations.	No later than 90 days after enactment (i.e., by March 5, 2021).

Section Number	Brief Description	Effective Date/Reporting Deadlines
	Requires the Secretary to submit a report to Congress regarding how many covered veterans scheduled comprehensive medical examinations after receiving the communication described in this section.	No later than 18 months after enactment (i.e., by June 5, 2022).
Section 205	Requires the Secretary to submit a report, to specified congressional committees, regarding the annual training of VA police officers on the prevention of suicide among their served population.	No later than one year after enactment (i.e., by December 5, 2021).
Title III. Improvement of Care and Services for Women Veterans		
Section 301	Requires the Secretary to submit a report, to specified congressional committees, on the analysis of VA programs that provide assistance to women veterans who are homeless or precariously housed.	No later than 270 days after enactment (i.e., by September 1, 2021).
Section 302	Requires the Secretary to submit an annual report, to specified congressional committees, on women veterans' use of health care from VA.	No later than 90 days after enactment (i.e., by March 5, 2021).

Source: CRS analysis of the Veterans COMPACT Act of 2020 (P.L. 116-214).

Notes: Effective dates are not included for reporting deadlines that are based on the date of completion of another reporting deadline.

COVID-19 = Coronavirus Disease 2019; Secretary = Secretary of the Department of Veterans Affairs; VA = Department of Veterans Affairs.

a. 50 U.S.C. §§1601 et seq.

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