MENTAL HEALTH, SUBSTANCE-USE DISORDERS, AND HOMELESSNESS

HEARING

BEFORE THE

SUBCOMMITTEE ON HEALTH

OF THE

COMMITTEE ON VETERANS' AFFAIRS HOUSE OF REPRESENTATIVES

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MENTAL HEALTH, SUBSTANCE-USE DISORDERS, AND HOMELESSNESS

WEDNESDAY, JUNE 20, 2001

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON HEALTH,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to notice, at 2 p.m., in room 334, Cannon House Office Building, Hon. Jerry Moran (chairman of the subcommittee) presiding.

Present: Representatives Moran, Gibbons, Simmons, Filner, Shows, Rodriguez, Snyder, and Evans.

OPENING STATEMENT OF CHAIRMAN MORAN

Mr. MORAN. The committee will come to order. Good afternoon, everyone. We welcome all of our witnesses today, and the others in attendance in our hearing room, this hearing on the subcommittee on health.

Today we'll hear testimony regarding mental health, substance-abuse disorders, and homelessness programs within the department of the Veterans' Administration.

Mental illness is an old problem for human society. Mentally ill people are often shunned, punished, ignored, or patronized. And in early days they were imprisoned because of violence or other kinds of unacceptable behavior.

Mentally ill people are difficult patients, they don't naturally want to cooperate with efforts designed to help them. Often, they just don't get well.

They refuse treatments, spurn care, and refuse prescribed medication, drink alcohol to excess, and take illegal drugs. Some lose touch with family, friends, employers, providers, reality, and ultimately, society itself, and they become homeless.

Just this week, Secretary Martinez, of Housing and Urban Development, stated, "Homelessness, I think, by and large, is an issue of addiction, mental illness, and things of that nature."

Whether or not one agrees with Secretary Martinez, I think we all can agree that it is surely a tragic sight to see a homeless person, and obviously mentally ill person, on the streets of our cities and towns, and know that there is not much that we can do to immediately that situation.

This is a continuing frustration, and it's confounding that after so many years of effort, a solution still alludes us.

Members of Congress have been fighting homelessness in America with McKinney funds, and with specific appropriations across

a number of government programs, including the VA's effort, for more than a decade, yet homelessness is still an unresolved problem.

Earlier this year, members of our committee, both minority and majority members of this committee, met to discuss issues which this subcommittee wanted to address. And perhaps the most frequently mentioned issue was the issue of homelessness, drug abuse, and mental illness.

This subcommittee is determined to play a role to help veterans suffering from mental illness, drug addiction, and homelessness.

It's the subcommittee's responsibility to consider resources and capacity at the VA, to provide specialized programs for care for veterans, in this instance, for veterans suffering from severe mental illness, including schizophrenia, bipolar disorders, and other forms of psychosis, as well as veterans who suffer from drug addiction.

We are concerned about VA programs that deal with the needs of homeless veterans, many of whom include mentally ill, who also abuse legal and illegal drugs and alcohol, while perhaps momentarily alleviating their suffering, ultimately worsen their situation and condition, to make it more difficult to get them the help that they need.

Congress provided a mandate in legislation, Public Law 104–262, that requires the VA to maintain nationwide capacity, provide for specialized treatment, rehabilitative needs for our veterans, including those with amputations, spinal cord injuries, traumatic brain injury, and severe chronic disabling mental illness.

To try to ensure VA's compliance, the legislation requires an annual report to Congress. The emphasis in the law is clearly on VA maintaining specialized capacity, including appropriate VA inpatient care and VA intensive case management, which a number of studies have shown to be more effective than simple primary care in the treatment of mental illness.

There is little question that primary care costs less. But is it effective as a substitute for traditional VA programs?

The subcommittee is well aware that there have been recurring problems with the VA observance of the capacity law, and they show up again in this year's report. According to the report text, the three largest problems center on lack of confidence in VA data, inability to identify patients receiving care and specialized programs, and lack of outcome measures to assess effectiveness.

After several years of these reports, all claiming the same kinds of continuing data difficulties, I pause to question whether or not the VA is in compliance with the law.

I hope that I may speak for the committee in urging our witnesses to provide an open and frank discussion of these issues and a depiction of the true situation of the VA's mental health, drug abuse, and homeless programs.

We are not seeking lip service, but clear and factual information to help the subcommittee to be a better steward of veterans' programs on behalf of the American people. It's the least we can do, and the veterans deserve more.

Mr. Evans, any opening statement today?

OPENING STATEMENT OF HON. LANE EVANS, RANKING DEMOCRATIC MEMBER, FULL COMMITTEE ON VETERANS' AFFAIRS

Mr. EVANS. Yes, sir. Mr. Chairman, I want to thank you for holding this important hearing today.

As you know, the passage of a bill to assist homeless veterans is one of my highest priorities in this Congress. On March 6th, I introduced H.R. 936, the Heather French Henry Homeless Veterans Assistance Act.

Almost a third of this body, Democrats and Republicans, have joined me in supporting this important piece of legislation. I know that this is not a legislative hearing, but I'll beg your indulgence as I seek to explain the provisions of this bill, and the needs it will address.

The bill, named for Miss America 2000, expands and enhances the most effective programs in the Department's spectrum of VA-provided or funded programs. It asks experts and consumers of homelessness, substance-use disorders, and mental health treatment programs to review VA's program mix, and effectiveness and offer guidance to VA program officials.

It tests new delivery models to determine their effectiveness. It promises dental care, the component VA and its CHALENG reviewers identified as the biggest gap in VA programming available to homeless veterans.

Advocates for the homeless know that dental care often ensures veterans are better able to find jobs, or maintain their independence. Case management, substitution therapy, and supportive housing are among the programs which have proven effectiveness with this bill, as it intends to bolster those changes.

These changes aim to ensure that veterans are given a hand up, but not a hand out, and I think it's a very important hearing today, Mr. Chairman.

I ask that the rest of my statement be put into the record.

Mr. MORAN. Without objection, so ordered. And Mr. Evans, thank you for joining us today. I appreciate that, and I appreciate your leadership on this issue, as well as other veterans' issues.

[The prepared statement of Congressman Evans appears on p. 46.]

Mr. MORAN. Now, to our first panel. Dr. Garthwaite, if you would come forward, and your colleagues, please be seated, and I'll introduce you.

We have Dr. Thomas Garthwaite, the VA Under Secretary for Health, Mr. Peter Dougherty, the VA's director of homeless veterans programs, Dr. Paul Errera, former director of the VA's mental health and behavioral science service, now at the VA West Haven Medical Center, Dr. Larry Lehmann, the VA's chief consultant on mental health and behavioral sciences, and Dr. Miklos Losonczy, and Dr. Richard McCormick, who co-chaired the VA's advisory committee on serious mental illness, which, coincidentally, has concluded its periodic meeting here in Washington this morning, and Dr. Bruce Rounsaville, the professor psychiatry at Yale University, who also practices in the Connecticut VA health system, welcome.

We appreciate your attendance today. For those of you provide formal statements, they will be entered into the record without objection.

Dr. Garthwaite, you have arrived at a very timely moment. The House will have three votes, I understand, at approximately 2 o'clock, but I think we'd like to proceed with your statement, and then the committee will recess, pending those three votes. Dr. Garthwaite.

STATEMENT OF THOMAS GARTHWAITE, UNDER SECRETARY FOR HEALTH, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY PETER H. DOUGHERTY, DIRECTOR, HOMELESS VETERANS PROGRAMS, OFFICE OF PUBLIC AND INTERGOVERNMENTAL AFFAIRS, DEPARTMENT OF VETERANS AFFAIRS; PAUL ERRERA, CONNECTICUT VA HEALTH SYSTEM; LAURENT S. LEHMANN, CHIEF CONSULTANT, MENTAL HEALTH AND BEHAVIORAL SCIENCES SERVICES, DEPARTMENT OF VETERANS AFFAIRS; MIKLOS LOSONCZY, NEW JERSEY VA HEALTH SYSTEM; RICHARD MCCORMICK, OHIO VA HEALTH SYSTEM; AND BRUCE ROUNSAVILLE, CONNECTICUT VA HEALTH SYSTEM, AND PROFESSOR OF PSYCHIATRY, YALE UNIVERSITY

Dr. GARTHWAITE. Thank you very much. I do have a brief oral statement. Mr. Chairman, members of the subcommittee, thank you for holding this hearing on VA mental health programs.

Our programs provide a comprehensive array of clinical, educational, and research activities to serve America's veterans.

Our clinical programs are designed to provide the highest quality, most cost-efficient care across a continuum, designed to meet the complex and changing needs of our patients.

The educational programs train a significant proportion of our nation's future mental health care providers, and ensure our employees remain on the cutting edge of knowledge about the best clinical practices, using traditional, as well as innovative educational approaches.

And our mental health research programs encompass both a basic science, as well as an essential translation of scientific findings in clinical practice. The mental health illness research education clinical centers, or MIRECCs, are an excellent example of the creative fusion of all three of these tasks. I'm personally planning to visit the West Haven MIRECC on July 25th.

Perhaps the most exciting aspect of the VA's mental health programs, as we look to the future, lies with the National Mental Health Improvement Program. Dedicated to the development of performance measures and their implementation through research, education, and monitoring, this new initiative will ensure that VA becomes a national leader in the development of evidence-based care for the mentally ill.

Our mental health care system is strong and effective, but no system is perfect. This National Mental Health Improvement Program concept symbolizes VA's ongoing commitment to continued improvement of delivery of comprehensive, high-quality clinical service to those veterans who need our care.

Mr. Chairman, while we truly believe that the VA mental health services remain strong and effective, no system is without problems. It is imperative that access to mental health services and best clinical practices be provided in a uniform manner, across the VA health care system.

To the extent that there are unacceptable levels of variance in these parameters, corrections must and will be made. Next year's performance measures will include volume and variance measures for mental health services, and will emphasize expansion of substance abuse programs.

If additional resources are required to provide needed care, whether by virtue of shifts of populations or unmet care needs, then a plan to provide these resources will be developed.

Two months ago, I asked for an analysis of the current state of the art in measuring patient need in mental health today. And today, I've asked that a specific review of the role of case mix and mental health funding be undertaken. We must assure that there is an incentive, rather than a disincentive to care for this most vulnerable population.

We have additional questions to answer, as well. These include, but are not limited to, have we gone too far in reducing inpatient care services for patients who need them, or neglected to establish sufficient residential care for patients who need that level of care? We've begun to answer these, but we need better answers.

Where do we need to place opiate substitution services? What kind of mental health capacities do even the smallest community-based outpatient clinics need? And what is the best and most effective way to provide them?

We will answer these questions, and other questions as well. In fact, that is what the National Mental Health Improvement Program will be expected to do, to close the loop between patient data and program execution.

Mr. Chairman, that concludes my oral statement. I'd be pleased to answer any of your questions or any of the other members of the subcommittee.

Mr. MORAN. Thank you, Dr. Garthwaite.

[The prepared statement of Dr. Garthwaite, with attachments, appears on p. 51.]

Mr. MORAN. I think we may have time, yet, for Dr. Errera, for his statement, and Doctor, welcome.

I understand that you've seen this room many times. And staff informs me that in your capacity as head of all VA mental health programs, you are a key player in the establishment of a number of special initiatives for mentally ill and homeless veterans.

I appreciate your dedication to this issue, and look forward to hearing from you today.

STATEMENT OF PAUL ERRERA

Dr. ERRERA. Mr. Chairman, members of the committee, I first appeared before this body 16 years ago, in my capacity as the physician who headed all VA mental health programs, a physician who was considered, by some, too outspoken in advocating for veterans with mental illness.

Over the ensuing years, you legislated into being a vast array of much-needed programs. I come today because we in mental health have suffered significant losses, losses which you anticipated, and which led you to pass a law in 1996, which required VA to maintain its capacity to care for disabled veterans with severe mental illness, with spinal cord injuries, with amputations, and veterans who were blind.

You left it to VA to define "capacity," and they came up with two measures—the number of patients treated, and the dollars spent on those patients.

What do the numbers say? An 8 percent decline in expenditures for the severely mentally ill, and a 36 percent decrease in the funding of substance abuse patients, while the VA budget increased, overall, by 10 percent.

These numbers mean fewer inpatient mental health and substance abuse beds. And in the past 2 years, just when the substance abuse beds were closing most rapidly, the number of outpatients receiving specialized substance abuse services began to drop, and the drop accelerated from 1998 to 2000.

Why didn't the capacity law provide an adequate check on this tendency? The sad fact is that VA officials have historically paid far more attention to Appropriations Committee report language than to statutory requirements initiated by your Committee.

To be entirely candid, I believe the prevailing view at VA has been that, "the Authorizing Committees can only scold us, so we can afford to pay them lip service." The Appropriations Committee on the other hand has demonstrated that it can discipline the Department by reducing its funding.

So what should we do next? I urge this committee to consider this hearing as a first step only. The needs of veterans with mental illness are too important to permit VA officials to leave the hearing table, go back to their desks, and put this issue on the back burner. Because I can assure you that will happen if you assume that this hearing alone will prompt real change.

I urge you to put VA officials on notice that there will be a follow-up hearing. Recognizing that there has been no effective check on the manner in which network directors or the Under Secretary for Health implemented the capacity law, I urge you to direct the VA's Inspector General to take on that role.

There is a clear need for an internal "policeman" to hold those responsible accountable for the fundamental obligations this law has imposed.

I also urge the committee to develop and move legislation to close some major loopholes in the "capacity" law. For example, the capacity law directs the Department, as a whole, to maintain programs and capacity.

However, individual network directors, who often make critical decisions on resource and program allocation within their geographic service area, have felt free to ignore that requirement. They maintain that the statute does not bar individual networks from reducing program capacity.

Mr. Chairman, with your indulgence, I've taken the liberty of offering several suggestions for amending the capacity law and provided those recommendations as an attachment to my testimony.

What about the Under Secretary for Health's Special Committee for the Severely Mentally Ill which you created in the 1996 law?

My feeling is that the office of the Under Secretary for Health is not an effective level to address this issue, because it more strongly embodies the values and priorities of the medical providers, rather than the values and needs of the veteran consumers. An effective action would be to move the committee to a higher level, the level of the Secretary.

As those of you whom I have known over the years may have noticed, my hands shake more now, my gait is less steady, and my voice is not as firm as it was. I have Parkinson's disease, a disease of brain metabolism that is probably not that different from those of the patients to whom I've devoted my professional life.

Yet, while I do not have hard data on this, my hunch is that funding for treatment of Parkinson's disease does not face the problems that I have described for the treatment of mental illness. Thank you.

[The prepared statement of Dr. Errera appears on p. 72.]

Mr. MORAN. Doctor, thank you very much for your testimony. We look forward to visiting with you and Dr. Garthwaite when we return.

The committee will be in recess for approximately 20 minutes.

[Recess.]

Mr. MORAN. Witnesses and guests, I apologize for the intrusion of the democracy that occurred across the street just a few moments ago.

I'm glad to have Mr. Filner join us, and we're ready to resume our hearing. The committee will come back to order. And do any of your other guests, Dr. Garthwaite, have any statements they would like to make? Dr. Rounsaville?

STATEMENT OF BRUCE ROUNSAVILLE

Dr. ROUNSAVILLE. Mr. Chairman, I'm Dr. Bruce Rounsaville; I'm a professor of psychiatry at Yale University School of Medicine. I've been involved in the treatment of veterans with PTSD and other mental illness for the past 20 years or more.

Today I mostly want to give you the point of mental illness in general, and PTSD, as being brain diseases, and diseases in which visible, palpable injury to the brain has now been documented.

The new research has been evolving over the past 10 years or longer, indicating that veterans with PTSD have documented brain injury, particularly to the hippocampus, which is a part of the brain that is involved in memory processing. The damage to the hippocampus seems to create a loop of stress responses that are identical to those stress responses you get when you have the original problem.

The Vietnam veterans, when they experienced traumatic events, those events became almost sort of burned into their brains. As a result of the body's automatic release of hormones like cortisone and epinephrine actual changes in the brain have taken place, and these changes have led them to have a constellation of symptoms that, when they first returned from Vietnam, were confusing to themselves and to others.

I've been witness to the evolving view of PTSD over the past 25 years, and when the veterans first came from Vietnam, they didn't know what they were experiencing.

Many of them experienced these two kinds of symptoms. They experienced numbing, an inability to connect with others, and they experienced hyper-arousal and flashback-type experiences. Those kinds of experiences led them to feel profound pain, they felt misunderstood, many of them, as a result of this profound pain, started self-medicating themselves with drugs.

Those drugs, in turn, led to further brain damage. The damage in the brain that's related to alcohol also affects memory systems. The damage in the brain related to stimulant abuse, such as cocaine or amphetamine abuse, which many of these veterans got involved with in order to self-treat their psychiatric condition, those also have led to damage that is comparable to that seen even in patients that have Parkinson's disease.

Fortunately, the damage that's related to PTSD and to substance dependence, unlike the damage that's related to brain injuries that are more visible, is reversible with treatment.

In fact, the Veterans Administration research on mental illness has been at the forefront of the treatment of PTSD and the recognition that PTSD is a much more common condition than had been expected in the past.

New treatments are available that follow from the recognition that high levels of cortisone can lead to brain damage. Anti-depressants have been shown to actually result in the release of newly discovered compounds called neurotrophins that can help the brain recover from post-traumatic stress disorder.

There are other cortisol blocking medications that have been developed that show some promise, in terms of keeping the brain from reinjuring itself each time a person has all these traumatic flashbacks, and is re-experiencing the problems that are related to post-traumatic stress disorder.

The new understanding of PTSD as a brain disorder with palpable, noticeable damage to the brain is just the best single example of the fact that the distinction between mental illness and physical illnesses is an artificial one.

The VA's mental health research has been at the forefront of understanding mental illnesses, but yet, even though 25 percent of the veterans that are treated by the VA system have mental illness and substance-use disorders, only 12 percent of VA research funds go toward mental illness and substance abuse disorders.

I urge the committee to encourage the VA leadership to fund mental illness research and treatment as a mainstream medical condition. These veterans who don't look as obviously ill as people who have lost an arm or lost a leg. However, they have been injured by their experience, and they deserve our attention and the fullest level of treatment. Thank you.

[The prepared statement of Dr. Rounsaville appears on p. 78.]

Mr. MORAN. Dr. Rounsaville, thank you very much. I thank all of our panel.

Dr. Garthwaite, you testified that you were establishing—this was back in April—that you would establish a national mental

health improvement initiative. You mentioned it again today in your testimony.

The word "improvement" suggests that something needs to be changed. What are the items that you hope to change in this initiative?

Dr. GARTHWAITE. The goal, the initiative, as I outlined it to Dr. Lehmann—and he's added a significant degree of sophistication to the proposal that he is developing—is that we need accurate data about the ability of veterans with mental illness to access services.

We then need accurate data on our provision of those services, both the consistency across the entire VA health care system, but also the effectiveness of those services, and we need to tie that, the data as to how we're doing, all the way back to the providers of care.

The example that gave me the idea that we needed this was our surgical quality improvement program, in which we first went out and improved our data collection, so we got the right data, and we decided which of those data elements reflected quality in surgery.

And then we routinely review those data elements for consistency and for variance amongst our different surgical programs. And then a committee then looks at those that might be out of variance when they just become out of variance—when we have more observed adverse events or complications of surgery than we would expect.

And then they go in and try to improve it, to discover why it might have happened, and to make sure that appropriate actions are taken before anyone even notices that there is a difference. When it statistically becomes an outliner, we begin to be concerned, and we begin to take action.

I think that possibility exists in mental health as well, to understand when we've not met the needs in terms of access, to understand when there is variance in consistency. I've heard, certainly from the committee as recently as this morning, concerns about the variance in how mental health services are delivered in different networks.

And I think we can get better at measuring that, understanding it, and then completing the loop, moving from having the data to actually changing the process and implementation.

So, that's the vision I started with. I think Dr. Lehman could probably amplify it, and I think he's added some other research components, some other enhancements on how to understand what to measure. I don't know if you want more than that, but I'm sure he can provide it.

Mr. MORAN. Thank you. Dr. Errera, the VA provided a detailed statement today, and it's several approaches to mental illness. It seems to me the statement speaks in good faith. Do you see something here more than the lip service you describe in your testimony?

Dr. ERRERA. Not very much, sir. But let me ask Dr. McCormick to answer your question.

Mr. MORAN. Doctor, before you speak, would you identify yourself for our reporter?

Dr. MCCORMICK. I'm Richard McCormick, Ph.D. I'm the co-chair of the VA's committee on the severely chronically mentally ill. I

also, in my day job, am director of mental health systems in the VA health care system of Ohio.

Again, as the co-chair of the committee, everything I say really represents not my interest, but the 200,000 veterans with psychosis, the most severe mental illness that we treat in the VA, 126,000 of those who are service-connected. The 143,000 service connected for PTSD. The 136,000 that we treat for substance abuse. These are, in my heart, the major core for VA.

Where I would differ very much with the under secretary is not on the topics that are raised, but on the pace. Many of the things that were brought up—in fact, are well-established evidence-based best practices, such as intensive case management. It's not something we need to study any more.

The problem is we have whole networks that don't have a single team, we have large metropolitan areas within networks that don't have a single team for an intervention that in the other public sector is very common, and in both VA studies and in private sectors, are evidence-based.

I don't believe we need to study any more what we do, we need to be able to take some action to get these necessary services out there while we de-institutionalize patients. We have been amazingly consistent about closing beds. We've closed over 50 percent of our beds, de-institutionalized patients.

We haven't been anywhere near consistent enough in providing a soft landing for them, to make sure that they get the community care they require, and don't become homeless. It's an embarrassment, frankly, Mr. Chairman, I believe, for the VA.

There was also mention of community-based outpatient clinics. It's wonderful that we have built so many community-based outpatient clinics, and I recognize in his statement, Dr. Garthwaite said we need to study how to get mental health services to the smallest ones.

I need to point out that among our very largest community-based outpatient clinics, only 40 percent of them provide mental health services. That means that some of the patients who have the most difficult time traveling, people with severe chronic mental illnesses, are expected to travel further than better-to-do veterans who use us often, mostly for a pharmacy.

And again, great variation. I could show you a graph, if you could see it, and you would see that in the very largest sites, by network, it goes from one network having only mental health services in 13 percent of its CBOCs to another having it in 100 percent.

For me, it's a matter of not studying more—we need to study, I agree with Dr. Garthwaite—but meanwhile, we need to take action. I applaud Dr. Garthwaite saying that one of those actions is to remove financial disincentives, I applaud and agree that there need to be performance measures.

But there also needs to be management action to hold officials accountable in the networks, accountable to the fact that we are a national system that will provide equitable access for these high-priority patients. And if those are decisions that are made nationally, and while we allow flexibility in implementation, they are not policy decisions to be made in 22 networks, or 134 facilities.

Mr. MORAN. Dr. Garthwaite, anything that Dr. McCormick said that you would like to reply or respond to?

Dr. GARTHWAITE. No, I agree with him.

Mr. MORAN. We then turn to the ranking member, Mr. Filner. Thank you for joining us, Mr. Filner, and feel free to take some time for making opening statements, and questions to the witnesses.

OPENING STATEMENT OF HON. BOB FILNER

Mr. FILNER. Thank you, Mr. Chairman, and thank you for holding a hearing on this very important matter.

Dr. Garthwaite, I'm sorry I missed your statement. I would just like to make a statement, which is my understanding of where we are and where we ought to go, and have you react to it, if you don't mind, because I think we have serious problems with the safety net.

And you may have addressed these earlier, and if you have, I apologize. Just refer me to your statement, and I'll read it later.

The problems that I am aware of are the virtual gutting of the VA inpatient mental health capacity that has taken place in less than a decade, the failure to develop a viable community mental health infrastructure, and the significant decreases in our programs to help veterans address substance-use disorders.

As VA began to make significant changes in its health care system, no program was more affected, in many people's view, than those for mentally ill veterans. You once had a huge system of long-term neuropsychiatric hospitals. Well, they were sometimes criticized for warehousing veterans. They were, at least, fulfilling some basic needs of the veterans population.

Then, as you began to right-size the mental health program, most of the acute care facilities closed their psychiatric beds, for all except the veterans that are most dangerous to themselves or to others.

A few long-term care facilities still offer care for the chronically mental ill. But even this care is for much shorter stays and focused on medication management and then discharge. There is little time to address the underlying issues that may cause or put a veteran at risk for homelessness.

While VA began to shift care into the community, it did not necessarily refocus the savings that were achieved into the development of effective community programs.

If I may refer to the draft of VA's annual capacity report, the committee on care of severely chronically mentally ill veterans noted that "A preponderance of evidence establishes that the de-institutionalized severely mentally ill patients require intensive community case management to thrive. Still, whole networks in many major metropolitan areas have no such VA service available. And in fact, network directors have reduced programs for substance abuse treatment, seriously mentally ill veterans, post-traumatic stress disorder treatment, and homeless vets around the country."

Major metropolitan areas, I think we've heard, lack settings in which they can offer supportive housing for veterans receiving substance-use disorder treatment, and also lack opiate substitution therapy clinics. I think we have to do a better job.

I'm sure you're familiar with H.R. 936, introduced by Mr. Evans, our ranking member, the Heather French Henry Homeless Veterans Assistance Act, which attempts to deal with the wrongs that I have just outlined, and attempts to re-establish the mental health infrastructure that has been lost.

These are the programs, of course, homeless veterans need to pull their lives together, and I thank Mr. Evans for introducing that bill, and Dr. Garthwaite, I'd like to hear your reaction to that bill.

That's my understanding of the VA system's problem now, and I'd just like to get your response to that, sir.

Dr. GARTHWAITE. I think I tried to point out in testimony that I, too, am concerned that we're not meeting the needs of all veterans with mental illness.

Whether or not we've gutted the program, or whether or not, as I think Dr. McCormick pointed out, that we've de-institutionalized so many veterans, would be worthy of a longer discussion. In part, because I think a lot of the decrease in substance abuse beds was taking people from a 21-day program—which I wouldn't consider institutionalization, I would consider that inpatient treatment—and moving to an outpatient treatment.

What is of concern, and I think maybe what isn't lost, but wasn't built quickly enough in some areas, was the intensive community program that was needed to substitute for that inpatient stay, and I think that's somewhat of a distinction, but I think it's an important one.

You know, in part, the move from inpatient care to outpatient care was driven by scientific studies that seemed to show that the results were similar in both settings. But I recognize that the results are similar only if you move the inpatients into an intensive outpatient setting.

I think that the understanding of what an intensive outpatient setting has probably had more variability than we realized during the early parts of transforming the VA from an inpatient to an outpatient system.

Also, I think we certainly have worked very hard at improving our programs for homelessness, and certainly have improved the number of patients seen for PTSD as there are dramatic increases in the number of veterans seen in these programs.

So, the intent was never to de-institutionalize veterans, unless that seemed to make appropriate sense for their clinical care. But what is clear to me is that the skill in building outpatient programs varies fairly dramatically.

Dr. McCormick is modest, but in VISN 10, they seem to be a leader in that, and we need to get better at exporting things they've done to every VISN.

Mr. FILNER. I'll read your earlier testimony, Dr. Garthwaite, but as I heard Dr. McCormick—and I don't want to stress differences amongst you—but you started off with the word that you often used, you're concerned.

And I agree with you. I mean, I assume you are, but I don't get a follow-up on the action.

Dr. GARTHWAITE. Well, during my oral statement, I——

Mr. FILNER. You may repeat your concern, but I don't see changes.

Dr. GARTHWAITE. During my oral statement I mentioned that we will, in this coming year, have performance measures for each network which address the variance in quality that will set goals for rebuilding substance abuse programs, and there was a third thing——

Mr. FILNER. I'm sorry, I'll conclude. I was just at a PTSD clinic in San Diego, and it is incredibly life-changing, what is happening there.

But if one of those folks that I met and spent some time with—just yesterday, actually—came and heard what you said, I mean, they need some more resources, they need some more direct action, and you're talking about performance measures—it's such a bureaucratic kind of response.

I'd like you to go into this clinic and say what you just said, and see what they say to you. They know what they need now.

I'd like to hear people tell you what is needed, and instead of saying we're going to do performance standards, and we're going to study this more, put in there the kind of professional help that they need. They'll tell you; they told me.

This program is really good, and I compliment the VA for it, but they don't even have all the expertise and resources available to do the job that they know has to be done. So I'd like you to sit down with these folks—and maybe some will testify today—and they will tell you what you need to do.

I don't think we need all this bureaucratic action. We need some *direct* addressing of the needs. Let's just do it.

Dr. GARTHWAITE. I don't mean to sound bureaucratic. With all due respect, I do believe that I could point to our performance measurement system as the most powerful non-bureaucratic method of changing how the government institution behaves of anything that I've ever seen since I've been in Washington, it's been 6 years.

We are currently being written up as a teaching case at Harvard University to show people how to actually get change to happen. So I see it as the way to make change happen, as opposed to a bureaucratic answer. But that's just from where I sit.

Mr. MORAN. Mr. Simmons? Mr. Simmons and I walked over to vote, and he was indicating this is Connecticut Day in the subcommittee, and we welcome the folks from Connecticut, and others. But Mr. Simmons, your turn.

OPENING STATEMENT OF HON. ROB SIMMONS

Mr. SIMMONS. Thank you very much, Mr. Chairman. Yes, I do welcome our distinguished panelists from Connecticut.

Let me comment very briefly on Dr. Errera's written testimony, where he says, "The bias against people with mental illness is insidious, subtle, and pervasive." And he goes on to say, "Fundamental changes in attitudes towards severe mental illness have changed less than they need to."

I'm a Vietnam veteran, everybody knows that. I spent almost 4 years in that country, in various capacities. And I observed at that time, and I observed when the war was over, that if you came back with a Purple Heart, you were a hero. If you came back missing

an arm or a leg, you were a hero. But if you came back with mental illness, you were somebody to be avoided. And yet, the research that's being done by Dr. Rounsaville at Yale demonstrates beyond a reasonable doubt that mental illness is a consequence of the stress of combat, is a physical manifestation, just as much as if you had your arm or your leg blown off.

And in his testimony, he says that "The body's programmed response to trauma exposure is to release large amounts of stress-related hormones, such as cortisol and epinephrine" and that this goes on to cause the brain damage that manifests itself in post-traumatic stress syndrome, and that actually he has the measurement standards now to measure the brain of somebody who has suffered from this stress and somebody who has not, and the critical brain area is significantly smaller.

So he goes on to say—and I think this is important, as well—"The reversibility of the brain damage from post-traumatic stress disorder is more hopeful than for those who are, say, suffering from Parkinson's disease."

This is critically important to me, because I think this committee and this Congress and the people around the table can play an important role.

Number one, mental illness is an injury of war; let's treat it like that, and let's treat the people that have these injuries with respect, and let's fund their problem.

Two, the research that's been done has brought us much closer, not only to understanding the phenomenon, but to understanding a potential cure. And let's fund that.

And three—and I think this point has already been made—while on the one hand we are still proceeding with the research, on the other hand we've developed systems that actually work for these veterans. Some need outpatient treatment, some need inpatient treatment.

But we damn well have to start treating them across the board, and effectively, and with respect. And if we ever think we're going to solve the problem of homeless veterans without solving the problem of what's going on in their head, we're wrong.

There's plenty of housing out there, but that's not the issue. The issue is that in their mind, they can't adapt to our society, to our systems of living, to their families, and to their homes.

So I am, on the one hand, very encouraged by what I'm hearing, and I invite the chairman and members of the committee to come up to New Haven and see what we are doing up there as successful across the board. And I welcome Dr. Garthwaite, I wish he'd come on a Monday or a Friday, and I'd join him in his visit. But I invite you to come see it.

But I also feel that we've got to get going, we've really got to get going on this. It's critically important. And who is to say that by coming up with the solution to post-traumatic stress syndrome we don't also come up with the solution to Parkinson's disease? Who is to say? Thank you, Mr. Chairman.

Mr. MORAN. Thank you, Mr. Simmons. Mr. Evans.

Mr. EVANS. Thank you, Mr. Chairman. I just want to take a moment and salute Dr. Errera. His candor, his ingenuity in finding solutions to homeless problems and mentally ill veterans' problems,

and the courage he has in taking on us from time to time has been in the interest of veterans and has been a highlight of his career.

We will truly miss you and your guidance in all matters affecting mentally ill veterans. I want to thank you.

I had a serious back injury in New Haven, CT, and you're the only one person that came to visit me. At the time I was to be admitted, they didn't have an extra room at that time. You went through the bureaucracy. So, you're very good at constituent service. So thank you. (Applause.)

Mr. MORAN. Thank you, Mr. Evans. Mr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman. Just a couple of questions. Dr. Garthwaite, where are we at, do you think, with regard to the VA in terms of research on substance abuse? I mean, do we put a fair amount of money into research on substance abuse?

Dr. GARTHWAITE. I don't know if I can provide that for you today, the exact amount, or even a——

Dr. SNYDER. And of course, I mean not the creation of it, but the treatment of it.

Dr. GARTHWAITE. Dick McCormick has some information.

Dr. MCCORMICK. Yes, this is an area that, as in many areas, the research VA people can be proud.

Some of the evidence—much of the evidence establishing some of the best practices in treatment, including opiate substitution treatment, some of the evidence establishing the importance of short-term treatment actually come out of VA studies, or NIAAA studies that are done, in part, by VA investigators.

And I clearly believe that we have made significant contributions to the advance in the technology, and I think it needs, therefore, to be underscored that there is a technology to treat these disorders, which is why, again, the committee is especially concerned with the decline and the availability of substance abuse treatment.

It went down more than 8 percent last year, in the very year that the Congress mandated in the Millennium Bill that we increase funding. The reality is the effect of the extra funding that you gentlemen mandated would happen in Fiscal Year 2000 was erased by the erosion of a comparable amount of resources in the same year.

So, yes, there is progress being made in research.

Dr. SNYDER. But as we're looking ahead, I mean, do we have ongoing research now that's looking at new pharmacology, you know, the days when someone can—that we will hopefully all live to see, that somebody who has a real addiction problem can come in and get an injection and they can go back to work the next—I mean, I'm talking about science fiction-kind of stuff now, but I mean, that's what we all hope to see, where we look on it as a treatable disease much more readily than it is now?

Are we investing a fair amount of VA research dollars in those kinds of—looking at that?

Dr. GARTHWAITE. Yes, and we can provide you some of the specifics in terms of dollars and the kinds of projects as well.

I would also note that we have three mental health QUERIs—these are quality enhancement research initiatives—where we are trying to get health service researchers and our clinicians working together to determine better ways of actually getting the care to

patients. We think that those will marry up well with our mental health improvement program.

Dr. SNYDER. Most of what you all have talked about today in your written statements deals with chronic mental illness. Dr. Garthwaite and anyone else who wants to comment, how do you think we're doing with regard to acute problems and acute care when folks first show up, either primary care or emergency room?

Dr. GARTHWAITE. You know, I don't know if I have good first-hand knowledge. I do know that we are challenged when there are court-ordered holds on people that are under court order that sometimes are keeping them in restraints, and so forth, and the legalities of that have been somewhat challenging, when I was chief of staff, at least. I'll let Larry, or someone else in the field respond.

Dr. LEHMANN. Certainly, I'd like to hear comments from some of our folks in the field, but——

Mr. MORAN. Dr. Lehmann, would you identify yourself, for the record?

Dr. LEHMANN. I'm sorry. I'm Dr. Larry Lehmann, I'm the chief consultant for mental health, for VA, and in fact, came into central office under Dr. Errera, way back in 1986.

I think that one of the things that we are trying to do is to enhance the capabilities of the recognition of mental disorders and primary care—you mentioned primary care in part of your statement—and to enhance the ability to either provide services in the primary care setting, or appropriate referral to specialty mental health care for those individuals, particularly individuals with PTSD, schizophrenia, and substance-use disorders. We've developed our practice guidelines in that regard.

With regard to acute care services, as Dr. Garthwaite mentioned, one of the most significant issues for acute care is when an individual is acutely unable to help themselves, or may be at risk to themselves or others.

And that's one of the primary roles for acute inpatient psychiatric services, and one of the things that I think we do provide some good services for. We can perhaps track down some numbers on that for you. A number of our facilities do, in fact, take individuals who are committed for care because they do represent a danger to self or others.

In fact, our studies, though, of our use, for example, of restraint or seclusion, show that, from an early study that Dr. McCormick and I did back in 1992 to a follow-up study that we did in 1998, our use per patient had gone from 2.6 percent of patients to 1.2 or 1.3. In other words, it has been halved.

Dr. SNYDER. I would think that our most common mental illness seen, or group that we call mental illness that's seen in the outpatient setting or the acute care setting, would be mild to moderate depression, that I assume in most cases would be handled by your primary care providers. How do you think we do at treating that malady?

Dr. LEHMANN. The incidence of depressive disorders in a general medical clinic population can be anywhere from about 5 to 10 percent of the population. I think that's true in VA as well as non-VA settings.

And one of the things that we've been doing is to promote screening for depression in mental health, and in primary care. And we find that we pick up on screening about 9 percent of individuals who may have screened positive, and then we have another marker that speaks about the referral for follow-up, because screening doesn't treat anything. Screening gives you a hint there may be a problem, and then you proceed to treat.

Some of these individuals may have major depressive disorders, some of them may have a lesser degree of depression, and others may have depressive symptoms that are not at the diagnostic level, but they're still problematic. And those things can be addressed, particularly with various kinds of counseling and talking to psychotherapists.

Dr. GARTHWAITE. I'll just add that it is one of our performance measures, since we talked about those. You know, 77 percent of all patients were screened for depression, continuing to improve as we measure it, 9 percent were found to be positive, and 75 percent of those found to be positive got a follow-up assessment referral.

You know, we obviously plan to improve that, but I think we have the numbers, and there is nothing else you compare to, no one else measures this, and I think it gets to your point.

Dr. SNYDER. Thank you, Mr. Chairman. Thank you, Dr. Garthwaite. I'll just say if you stop doing your performance measures, then we'll all send you a letter saying, "Where is your accountability? Why are you not measuring your performance?"

Dr. GARTHWAITE. Right.

Dr. SNYDER. Anyway, thank you.

Mr. MORAN. Dr. Snyder, thank you. I wanted to follow up with a question somewhat related to—you raised the topic of medication, I wanted to talk about it, just more generally.

And Dr. Garthwaite, you indicate the latest—I quote —"The latest medication for mental disorders with the latest medical evidence, including virtually all the newer atypical, antitrophic, and antidepressant drugs."

I understand that you are making this statement on behalf of a national system, but I've been told, the subcommittee staff has been told, that there is a variety among VISNs on how the newest atypical drugs are being used or not used in different VA locations.

It is my understanding that at least two of the VISNs apparently do not use the latest atypical drugs in treatment of schizophrenia, unless there is a "fail first" event, and rather, require that there be more traditional and less expensive medications. Is that contrary to your understanding?

Dr. GARTHWAITE. I have two, I think, networks testing out some algorithms and clinical guidelines of how to go about the pharmacologic treatment of psychosis, and at what stage various atypicals might be appropriately used. I think it's not failed, in the sense of failure to respond and/or an adverse event.

That was a part of the spirited discussion today at the seriously and chronically mentally ill committee. And given that I was there later and talked about it, and wasn't there for the conversation, I think either of the two doctors to my right would be much better at answering more specifically.

Mr. MORAN. Dr. Losonczy, if you would identify yourself?

Dr. LOSONCZY. Yes. I'm Miklos Losonczy, I'm a psychiatrist, I'm the co-chair of the committee for the severely and chronically mentally ill, and my day job is the associate chief of staff for mental health in VA, New Jersey.

We've had a considerable interest in the issue of identifying what are the best medications for our psychotic patients, and realizing full well that there are many differences of opinion as to what this might be.

We've been reviewing the existing literature on controlled clinical trials and find that at this point in time, there is no compelling data that shows that any given anti-psychotic has clear efficacy over any other atypical anti-psychotic.

There are trials going on that are attempting to address this question. In the absence of data that speaks to it, the committee has a unanimous opinion on this, that the proper approach that the VA should take is, given that all other clinical considerations are equivalent for a specific individual, that a clinician should be aware of the side effect profiles and the cost issues, and should make a decision based on what is the most cost-effective agent for patients.

That's not to say that there should be a restriction on what an individual provider can use to treat a schizophrenic, but that the providers need to be aware of cost issues. We are dealing with a fixed pie in the VA, and every dollar that we spend on medication is one dollar less that we can spend on other legitimate needs of our patients.

There are many, many needs. And the community support programs that Dr. Garthwaite alluded to that we need further development of, those are areas that we need to be placing new money into.

We believe that the clinical practice guidelines that are being developed by the VA for the revision for the treatment of psychosis, will allow the kind of evidence-based freedom of practice that's necessary, but that will include a cost sensitivity that any large health care system needs to have.

We don't believe that a fail first policy means that providers are not being allowed clinical freedom to select what is the most appropriate agent for a specific individual. And my understanding is that the VA, in principle, agrees with that.

There are many parts of the VA right now that are experimenting with various approaches, not all of which are necessarily consistent with the national guidelines. The national guidelines, when published, we would expect that those places that are at variance with them would be expected to be consistent. Not necessarily identical, but to be consistent with them.

Mr. MORAN. Dr. Garthwaite, that is where the VA is, and is headed? Adoption of this policy and its implementation across the country?

Dr. GARTHWAITE. Well, these are draft guidelines. I'll get a chance to see the written comments and recommendations of the SCMI committee and Dr. Lehmann, and probably the pharmacy benefits management committee, and a few others.

We try to get the front-line clinicians involved in this as well, as the best minds in terms of research and understanding. I think Dr. Losonczy alluded to the study, which is really a comprehensive look

to try to determine which patients should go on which medications first.

And we think that this is not a forever policy, this is a policy that we think is logical with what's known today. But we also are very interested in knowing more tomorrow, about what the best medicines are, who should be started on atypicals versus not, and which patients will most benefit, and so forth.

Mr. MORAN. Let me see if any of our committee members have any additional questions. Mr. Evans?

Mr. EVANS. No questions, but I ask unanimous consent that any statements by members be included in the record at this point.

Mr. MORAN. Without objection, so ordered.

[The statement of Hon. Ronnie Shows appears on p. 45.]

Mr. MORAN. Mr. Simmons?

Mr. SIMMONS. No additional questions.

Mr. MORAN. Thank you. I thank this panel very much, your time and your testimony. I apologize again for the interruption.

We may have follow-up questions for our panel. If you could respond to those within 10 days, that would be useful to us, and greatly appreciated.

Ask our second panel, please, to come forward. We have with us Ms. Linda Boone, executive director of the National Coalition for Homeless Veterans, Dr. Dennis Culhane, associate professor at the University of Pennsylvania, and Dr. Fred Frese, chairman of the veterans committee of the National Alliance for the Mentally Ill, and Mr. Ralph Ibson, vice president for government affairs, the National Mental Health Association.

Thank you for appearing, let me specifically mention Mr. Ibson, who is particularly qualified for his appearance here today and testimony before this subcommittee. He's the former staff director, and has had the unusual experience—relatively unusual experience—on Capitol Hill of working both for Republicans and Democrats. And so he personifies the bipartisanship that we strive for in this committee, and especially in this subcommittee.

On behalf of the committee, I say how much we appreciate Ralph's work in the past, and welcome him success in his new position.

Without objection, written statements that you have today will be made part of the record, and you may each proceed for up to 5 minutes.

And let's start with Dr. Culhane for his opening statement. Thank you, sir.

STATEMENTS OF DENNIS CULHANE, ASSOCIATE PROFESSOR, UNIVERSITY OF PENNSYLVANIA; RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS, NATIONAL MENTAL HEALTH ASSOCIATION; LINDA BOONE, EXECUTIVE DIRECTOR, NATIONAL COALITION FOR HOMELESS VETERANS; AND FRED FRESE, CHAIR, VETERANS COMMITTEE, NATIONAL ALLIANCE FOR THE MENTALLY ILL

STATEMENT OF DENNIS CULHANE

Mr. CULHANE. Thank you, Mr. Chairman. I appreciate this opportunity, and I'm here speaking on behalf of myself and my colleague, Steve Metraux.

We have been doing research on the problem of homelessness, particularly among people with severe mental illness and substance abuse problems for the last 10 years. We have released a couple of studies in the last couple of years—one very recently—that I think are good news, represent good news on the issue of homelessness.

And despite the fact that we hear statistics all the time, showing that homelessness is growing worse, and it may well be, I think there are some pieces of information which could be very helpful to a policy audience such as yours in trying to tackle this difficult issue.

I note, Mr. Chairman, that you, in your opening remarks, said that homelessness has persisted and that there seems not to have been any effective solutions. And I think that one of the studies which I will summarize for you today shows that we do, in fact, have, I think, a very effective and, indeed, a cost-effective solution to homelessness.

Mr. MORAN. A topic, or a point, I'm happy to be corrected on.

Mr. CULHANE. No problem. I did ask if a handout could be passed out with some graphs on it, but included in my written testimony are the same graphs.

The first study which I want to summarize for you which tried to come up with some typologies of homelessness, looked at the shelter administrative records in New York and Philadelphia. And what we found is that there are essentially three groups among the homeless population.

One group, which represents about 80 percent of the population, we categorize as transitionally homeless. The good news there is that most of the people, 80 percent of the single adults who become homeless, are homeless only once, for an average of about 25 days, and they leave homelessness and they don't come back. At least that's what the evidence suggests.

Another group will be called the episodically homeless. They are in and out of the public shelter system. We also believe they're in and out of psychiatric hospitals, detoxification facilities, and jails. This, we think, is the street homeless population. They represent about 10 percent of the homeless population.

And then the last group is the other 10 percent, and they're people who are chronically in homeless shelters, people who are essentially using the public shelter system as permanent housing. They are living in the emergency shelter system. They use, by the way,

about half of the resources that are spent in the public shelter system.

So we have some good news, in that about 10 percent—a very small percent of the homeless population, is using half of the resources in the shelter system.

If those resources were diverted and committed to permanent housing, it is very likely that we could substantially reduce the size of the homeless population, and perhaps do it in a cost-effective manner, which I'll address in a minute.

In terms of who are the people in these different sub-populations, the second figure which I have provided shows you the percentages of people with mental illness, substance abuse disorders and medical conditions in those different clusters.

What this indicates is that that chronic homeless group that I mentioned, has about an 85 percent rate of either mental or physical disability. Again, this suggests that they are inappropriately staying in the public shelter system, and suggests as well that they are probably fairly heavy users of health care systems, including the VA system.

And then to that last point, I want to summarize the study which we most recently completed. The City of New York undertook a major initiative to try to deal with the homelessness problem among people with severe mental illness, back in 1990. They developed 3600 units of housing, and placed close to 5,000 people in that housing over a 5 year period.

We tracked those 5,000 people, along with a control group of another 5,000 people, and we looked at what happened to them once they were placed in housing. How did it affect their use of other services, VA services, inpatient services paid by Medicaid, prison services, jail services, and emergency shelter?

What we found was that before folks were placed in housing, the average homeless person with severe mental illness used $40,000 a year in those types of services, most of which, about 75 percent of which, were in health care institutions, inpatient units.

However, once those folks were placed in housing, as compared to the group that remained homeless, they reduced their use of inpatient services and shelter services by about $16,200 per person, per year.

The cost of the housing was $17,200, roughly, per year. So essentially, it was a near break-even situation, 95 percent of the costs of the permanent housing for the chronically mentally ill were recouped, in terms of reductions in acute care services.

And I think this goes directly to the issue which was raised by the last panel, and the concerns which have been raised by the committee about the de-institutionalization of the VA system.

I think the choice is not merely between inpatient services and outpatient services, but that many people who previously needed to be in hospitals for their care, particularly homeless people, if they are provided with permanent housing, they would reduce their need to be in acute care settings.

And those reductions, as evidenced in what we found, could well pay for nearly all of the cost of the housing and the investment that would be made.

In our view, then, we would conclude by saying that supported housing is a sound investment of public resources. Creating permanent supportive housing for people with severe mental illness, veterans or otherwise, pays back to the taxpayers 95 percent of the housing costs, and the homeless people have a better quality of life, once they're placed in such housing.

I'd be glad to answer any questions. Thank you.

[The prepared statement of Mr. Culhane appears on p. 81.]

Mr. MORAN. Mr. Ibson? Thank you very much, Doctor Culhane.

STATEMENT OF RALPH IBSON

Mr. IBSON. Thank you, sir, and thank you for your generous introduction.

I'm honored to appear before you today on behalf of the National Mental Health Association. And let me just tell you briefly about my organization. Ours is the country's oldest and largest non-profit organization dealing with all aspects of mental health and mental illness.

Through 340 state and local mental health association affiliates, NMHA works to improve policies, understanding, and services to people with mental illness and substance-use disorders.

Mr. Chairman, it's both important and timely to raise questions about the capacity and effectiveness of VA mental health programs. And let me offer three observations, repeating somewhat, the testimony that others have presented.

First, over the last 5 years, the VA health care system, by its own measures, has markedly diminished its capability to provide care to veterans with mental illness and substance-use disorders.

Secondly, that this loss of capacity has been variable, from network to network, wholly at odds with VA's obligation to operate a national health care system, and to provide equitable access to care.

And third, with this failure over the last 5 years to maintain and to reinvest mental health funding to establish community-based programs, VA can no longer claim to provide state-of-the-art mental health care.

As has been testified, more than 450,000 veterans suffer from a mental illness which VA has determined to be service-connected. Surely, such veterans should be afforded state-of-the-art care, care of the highest quality. And indeed, VA's budget submission for this year makes that very claim, that the Department provides state-of-the-art mental health care.

In our view, the facts do not bear out that claim. And I refer the committee to the recent report of the Surgeon General on mental health, a 1999 report, which states that state-of-the-art care for severe mental illness requires an array of services that include intensive case management, access to substance abuse care, peer support, psycho-social rehabilitation, which includes housing, as we've just heard, employment services, independent living, social skills training, and psycho-social support to foster recovery. Fostering recovery is really the key.

VA mental health professionals have identified these as needs that should be the target of developmental efforts in the years to

come. But VA is clearly not furnishing this comprehensive spectrum of services today.

A health care system providing state-of-the-art mental health services would certainly not have de-institutionalized patients with mental illness without first having established community-based services in all networks to assure continuity of care.

As you know, substance abuse is a major problem among veterans, and many suffer from both substance abuse and other serious mental disorders. A state-of-the-art mental health system would surely not tolerate a more than 12 percent reduction in the numbers of veterans provided substance abuse care, at the same time that the VA is markedly increasing the number of veterans receiving care for other health conditions.

A state-of-the-art mental health system would also not subject its patients to policies or practices of "failing first" on lower cost medications before permitting its physicians to prescribe a drug of choice. We've heard of some change in that policy. I would applaud a change in policy, a departure from the two networks that were mentioned that, indeed, provided physicians freedom of choice.

I question, however, whether physicians will read between the lines in being advised about the high cost of certain medications, and come to the conclusion that this mere guideline and suggestion is, in fact, really a directive.

This committee is to be applauded for making important, valuable contributions to increase funding for mental health and substance abuse services, as well as for homeless programs. NMHA would urge the committee to go further.

Increasing VA funding, for example, will not necessarily assure that those funds find their way to the very programs you're proposing receive increases.

And I refer again to the extraordinary latitude that network directors have enjoyed, to maintain specialized programs or not, to provide community-based care or not, to institute fail first policies or not. This latitude raises a concern that spending decisions will continue to be made in accordance with vastly different priorities from network to network.

And it underscores that, regardless of veterans' needs, mental health and substance abuse will not necessarily be a high priority in each region.

Mr. Chairman, the enormous disparities from region to region in access to care for mental health and substance-use disorders, for the large numbers of veterans with these conditions, must be remedied. That remedy, in my view, should find expression in legislation.

And I would echo and follow up on Dr. Errera's suggestion that this committee hold further oversight hearings. I can assure you from having worked in the VA, having worked with this committee, there is nothing more compelling than the notion that they'll be back before the microphone to answer your questions.

NMHA urges, however, that the committee not set its sights solely on the question of capacity, challenging as that has been, but work to bring VA programs for veterans with mental illness and substance-use disorders to the level that experts inside the VA and elsewhere acknowledge to be state-of-the-art.

Thank you for the opportunity to present NMHA's views on this very, very important subject. I'd be happy to attempt to answer any questions you may have.

[The prepared statement of Mr. Ibson appears on p. 87.]

Mr. MORAN. Thank you once again. Ms. Boone. Welcome.

STATEMENT OF LINDA BOONE

Ms. BOONE. Mr. Chairman, the specific sequences of events that has led to American veterans being in a state of homelessness are as varied as there are veterans who find themselves in this condition.

It is clear that the present way of organizing the delivery of vitally needed services has failed to assist the veterans who are so overwhelmed by their problems and difficulties that they find themselves homeless for at least part of the year.

The transmutation of the Veterans' Health Administration into 22 VISNs has produced significant reductions and curtailment of services in mental health and substance abuse disorder programs which concerns NCHV.

In the December 1999 report issued by the Interagency Council on the Homeless, it found that 76 percent of homeless veterans have either a substance abuse or mental health issue. An April 2000 GAO report concluded that between 1996 and 1998, VA inpatient services to serious mentally ill patients decreased by 19 percent, substance abuse disorder treatment by 41 percent.

NCHV member organizations have report that, due to the reductions of VA inpatient services, veterans referred to these community-based organizations from the VA are often sicker, and not ready for the transition stage in the continuum of care. Patients must be sent back to the VA, or other scarce resources in the community are attempted to be accessed to aid these veterans.

NCHV supports this committee's budget recommendations to restore these services. NCHV is very supportive of the intent of H.R. 936, the Heather French Henry Homeless Veterans Assistance Act, introduced by ranking member, Mr. Evans, to provide for a wide range of services to homeless veterans, and to begin to focus on the issues of prevention.

Within this bill, NCHV has several priority items that we feel will lead us closer to the elimination of homelessness among veterans. Approximately 5,000 transitional housing beds will be available, funded through the VA homeless providers grant and per diem program. The need for increased funding for beds through this program has never diminished since its inception.

There is an unaddressed need for housing that is safe, clean, sober, and that supportive services are regularly provided, as to be sufficient to help veterans fully recover as much independence as possible.

The grant and per diem program currently has assigned funding internally within the VA, at approximately $35 million. The grant piece provides funding for the bricks and mortar, for new programs, and the per diem piece provides for daily payment, up to 50 percent, for a maximum of $19 per day to provide services to veterans housed under the grant piece.

NCHV supports a new flat fee formula, based on the state home domiciliary rate, because it is a good comparison model for types of services provided.

Additionally, we recommend a permanent authorization to allow existing programs to have access to the per diem piece to allow for program expansion that does not require bricks and mortar.

NCHV believes the grant per diem program should be $120 million funding level, and a budget line item. $120 million would add approximately 9,000 beds with increased per diem, to a total of approximately 14,000 beds.

NCHV also feels there needs to be a future vision of how to turn these transitional beds into a mix of transitional and long-term, permanent supportive housing. The current grant program has employment as an expected outcome for all veterans transitioning through the program.

However, many veterans are not able to return to work, or live without continued supportive services on a daily basis. Some of these veterans need alternatives to independent living, and the CBO system has the experience and programs in place that could support the future needs of these veterans.

The homeless veterans reintegration program managed through the Department of Labor, vets, is virtually the only program that focuses on employment of veterans who are homeless. NCHV recommends an investment of $50 million per year in HVRP to assist veterans in becoming self-sustaining and responsible, tax paying citizens.

CBOs must orchestrate a complex set of funding and service delivery streams with multiple agencies in which each one plays a key critical role. The veteran CBO system faces a capacity gap around managing this complex.

In order to respond successfully to the distribution system for funds, and then if awarded funds, the resources to pay for management and financial reporting systems to properly service those funds.

We urge this committee to consider giving capacity building services into the hands of the CBO homeless veteran provider group. While NCHV has been doing this, it's been done in a limited way, without the benefit of any federal funds.

We ask you to consider authorizing an allocation of $750,000 each year, through 2007, to NCHV, to build capacity of the veteran service provider network.

NCHV looks forward to working with this committee on solutions that will really lead to the end of homelessness among veterans. Thank you.

[The prepared statement of Ms. Boone appears on p. 93.]

Mr. MORAN. Thank you very much for your advocacy. Dr. Frese.

STATEMENT OF FRED FRESE

Mr. FRESE. Thank you very much, Chairman Moran, and members of the subcommittee, particularly Mr. Filner, who was kind enough in the last year to meet twice with our NAMI veterans committee, both in San Diego and here, in Washington.

I would request that my full statement be made part of the record, please.

Mr. MORAN. So ordered.

Mr. FRESE. My name is Fred Frese, I'm from Akron, OH, and I am here representing 210,000 members and 1,200 affiliates of the National Alliance for the Mentally Ill. NAMI is the nation's largest national organization representing people with severe mental illnesses and their families.

I would like to thank you for holding this hearing on mental health, substance abuse disorders, and homeless programs within the department of veterans affairs.

In addition to serving as the first vice president on the NAMI board, I am a veteran myself. Specifically being a retired Marine Corps captain, I was medically retired in 1966, because I was, while guarding atomic weapons, diagnosed with schizophrenia, a condition for which I have subsequently been hospitalized in state, county, military, private, and veterans' hospitals numerous times. And I continue to receive treatment from the Veterans' Administration to this day.

In that regard, my mouth will move without my wanting it to, because of 33 years of taking this medication. And sometimes it may interfere with my ability to articulate. So please excuse that.

In recent years, I have served in various advisory capacities to the VA concerning care for the seriously mentally ill veteran. I also currently serve as the NAMI board of directors chair of their subcommittee on veterans affairs.

In this capacity, I am please to offer NAMI's views on programs that serve veterans with serious mental illnesses. Specifically today, I have seven items I would like to bring to your attention.

The first is that which was underscored by Dr. Garthwaite and Mr. Filner. That is the fact that the greatest unmet need of the VA is the fact that there are not sufficient beds, particularly long-term beds. During the last 5 years, the VA has shifted its focus from serving veterans with severe mental illness from inpatient treatment to community-based care.

NAMI strongly supports the treating of veterans in the community, when the proper intensive community supports and treatment are available and accessible. However, we are very concerned that those veterans who need inpatient care are increasingly unable to access new treatment because of now-limited inpatient beds and the dramatic shift to outpatient services. In some VISNs, at least one, there are no long-term beds at all, we understand.

Second, the mental health intensive case management, which are called MHICMs, as underscored by both Dr. McCormick today and Dr. Garthwaite again. As members of the subcommittee know, the VA has issued a directive for the MHICM teams. These MHICM teams are based on SAMHSAs, that is the substance abuse and mental health services administration's standards for assertive community treatment, which NAMI believes are proven evidence-based approaches to treating the most severe mental illnesses.

NAMI strongly recommends that Congress appropriate funds necessary to oversee the transfer of funds from the reduction of inpatient care to provide the resources to at least double the existing number of MHICM teams, and to fully staff existing teams so that our nation's most vulnerable veterans will receive appropriate care.

Three, the CBOCs, our community-based outpatient clinics. As stressed by Dr. McCormick today, the VA has expanded the use of the CBOCs as primary care clinics. However, the committee on care of the seriously chronically mentally ill veterans, that is the SMI committee, reports that of the 350 CBOCs that are established now, only 40 percent of these facilities offer any services for seriously mentally ill, or any other kind of mentally ill persons. This is simply not enough.

NAMI is concerned that meaningful, community-based capacity is not being developed to treat veterans with chronic mental illnesses.

Four, access to appropriate medication. NAMI urges the subcommittee to continue to monitor proposals to implement restrictive drug formularies that cover psychotropic medications in each of the networks.

Specifically, NAMI strongly objects to any treatment directive that would interfere with a clinician's choice of the best medication for each patient, based on that individual patient's clinical needs. While cost is an appropriate consideration, it should be only one factor in medication choice, and must not be allowed to be the primary consideration in choosing medication for severe mental illnesses.

There is a proposal, as we understand it, that would establish, as mentioned previously, a fail first policy among the use of atypical anti-psychotics. Not in response to published guidelines or best practices, or the needs of the veterans, but rather as a cost-cutting mandate.

In NAMI's view, this focus should be placed on clinical decision-making in the VA. NAMI veterans committee is dedicated to the concept that each individual veteran has treatment needs that must be met, and that ultimately, the doctor and the patient must make the clinical choices, based on the needs for each particular veteran.

Five, the status of the SMI committee. We strongly applaud the VA for establishing the SMI committee and allowing us to participate in it. However, we would also recommend that that begin to report directly to the secretary—the time is right for that—as opposed to the under secretary.

Five homeless veterans. Dr. Culhane is very correct, except one thing was not mentioned, and that is the number of homeless veterans that are now in jails and prisons. Our figures show the increase in seriously mentally ill in jails and prisons has increased from 25,000 in 1985 to almost 300,000 today. This is an exorbitant amount, and we must do something for the homeless veterans, as well as those who find themselves in jails and prisons. There are initiatives in that regard.

Finally, co-occurring disorders. NAMI supports the research being done in the MIRECCs to improve the health services for patients with co-occurring addictive disorders. The American Psychiatric Association has designated integrated treatment for both disorders as an evidence-based practice, and we strongly support the continuation of that with the VA.

I'm sorry, I took more than my time. Thank you very much for listening to me today.

[The prepared statement of Mr. Frese appears on p. 101.]

Mr. MORAN. Thank you very much.

Let me explore this a moment, on this national system which I heard mentioned by several. Is there a VISN out there that is a role model for treatment, either in homelessness or drug abuse or mental illness? Is there a place that we can look to where things work better than elsewhere?

Ms. BOONE. I can speak to that a little bit. There are—the West Los Angeles area has a really good continuum of care with the community-based organizations that we represent, state agencies, and the VA.

They have a really good integrated system, and a veteran presenting themselves can find home and treatment. They have built their capacity over the last 5 or 6 years so that they can address those issues, and they have one particular facility on the grounds of the VA, which is a non-profit organization, that deals specifically with the veterans with substance abuse and mental health disorders. And it's a longer term care place, and they really work with them.

So there are programs out there, and we really wish they would propagate those throughout the VA, they are very good models of things happening.

Mr. MORAN. Anyone else? Let me ask if there is a difference between rural and urban America, and the services provided to veterans.

I know in rural areas that I represent, providing mental health services for the general population is a significant accomplishment. The attraction of the professionals, meeting the need of the population in rural America has high hurdles, and perhaps it's probably true in inner cities as well.

And I'm curious, does the VA enter into contracts with private providers of mental health services in instances that you're aware of, or are we talking about VA-employed professionals?

Ms. BOONE. I think it ends up being both. It's there are providers that they contract with that provide those services they don't have, but it's not enough.

And in rural areas, a lot of the issues that we hear are transportation issues. And I think that there is a really good model in Florida where the VA financed through the VA grant per diem program a medical mobile van that goes all over the state, going to the rural areas particularly, finding the veterans, working up relationships, and they have a benefits person on board with them, a VA benefits person, they have the VA medical centers there are very cooperative in how they're working and staffing that van and getting veterans help, getting them into programs.

So, their transportation is the issue we normally hear the most feedback on.

Mr. FRESE. Also, NAMI would like to applaud the VA for this rapid establishment of the 350 CBOCs throughout the country. That does provide much closer service in rural areas and elsewhere.

However, the fact that only 40 percent of them offer mental health services is a sincere problem, as we said.

Mr. MORAN. Mr. Frese, when we say they offer mental health services, would it be a wide array of mental health services, or basic—is that 40 percent——

Mr. FRESE. The figures we have are that 60 percent of them do not offer any mental health services at all. And so the size of the CBOCs will vary.

But I've just spent 3 days with the veterans folks on the SMI committee, asking these types of questions, and it doesn't seem to be much of a lesser figure for the larger CBOCs. I think for the larger CBOCs, it's still 50 percent of them still do not offer mental health services.

Ms. BOONE. What happens is that other resources in the community, non-veteran-specific resources, have to pick those up. The PATH program, which is funded by HHS, which is to help seriously mentally ill people transition out of homelessness, over the last few years, the percentage of veterans that they treat is around 14 to 17 percent of those patients that they treat, which seems to be a high number when you have a complete VA system.

And so those—when the VA doesn't step up to it, the community has to. Somebody has to, or they end up being lodged in jails, and other, you know——

Mr. MORAN. Do we know an average age for a veteran that's treated for mental illness? Is there a characteristic?

Ms. BOONE. I don't know that.

Mr. FRESE. I heard that figure yesterday. I believe it was somewhere in the fifties, but don't quote me on that.

Mr. MORAN. I was interested if it was—and perhaps I can find out the answer to my question—but I was interested if it was a younger veteran or an older veteran, or if it's the spectrum, all veterans. Or, even the age of the homeless veteran?

Ms. BOONE. Forty-six.

Mr. MORAN. Forty-six? Let me follow up with Dr. Culhane's statement. It might be that his research suggests that the VA's move to primary care with less reliance on inpatient approaches to dealing with mental illness and drug abuse actually can contribute to homelessness among single veterans. Is that the suggestion, Dr. Culhane?

Mr. CULHANE. No. I believe that there is a sentiment that's been expressed about increasing the inpatient capacity, and I don't have an opinion on that.

My only observation is that a lot of people who are homeless are unnecessarily hospitalized and stay in hospitals unnecessarily long. And that if people were placed in housing—and I hear a debate that seems to be framed around whether people are getting services or whether they're in hospitals—what I don't hear being said as often is that people need permanent housing.

If people have housing with support services our study found that that leads to a substantial reduction in inpatient services use. So, in fact, the provision of permanent housing and services could, indeed, help replace the inpatient capacity that has been reduced.

Mr. MORAN. And the reason for the longer stays is what?

Mr. CULHANE. People don't have anywhere to be discharged to. And their condition may be subacute, but the minute they're discharged to a homeless shelter, they're going to become acutely ill

again. So people are kept in hospitals sometimes about 30 percent longer than they might otherwise be.

We found that even among the homeless who were once placed in housing, even if they were hospitalized again, they had a 25 percent reduction in the length of time they spent in the hospital, as compared to homeless people who did not get placed in housing.

So clearly, having housing provides a buffer, if you will, the support system that permits earlier discharge from a more expensive acute care setting.

Mr. MORAN. Thank you very much. Mr. Evans.

Mr. EVANS. I have a list of questions I'd ask the witnesses to answer.

Mr. MORAN. Mr. Evans will be submitting a list, and we would appreciate your response within the next 10 days, and other members as well.

Let me follow up then, just one more with Mr. Culhane. Based upon your chart, the three——

Mr. CULHANE. Yes.

Mr. MORAN. What would you tell the VA about where they emphasize their resources now, and where they ought to reorganize those resources? Is there a message there?

Mr. CULHANE. I think that the message is that with respect to people who are homeless, that there should be a continued thoughtful examination of how to provide housing for people who are veterans, providing either some subsidy that would enable people to be in housing because the housing is, in the long term, cost effective, based on our research.

Coupled with that housing is the support services that people have talked about, such as case management and other programs.

Mr. MORAN. I thank the panel very much. I thank you for your time.

Mr. CULHANE. Thank you, Mr. Chairman.

Mr. FRESE. Thank you, Mr. Chairman.

Mr. MORAN. You're welcome. Our third panel today consists of three veterans organizations.

We have Mr. Richard Fuller, National Legislative Director of the Paralyzed Veterans of America, Ms. Joy Ilem, assistant national legislative director of the Disabled American Veterans, Ms. Linda Spoonster Schwartz, associate research scientist from Yale University School of Nursing, and she is accompanied by Mr. Richard Weidman, executive director of government relations for Vietnam Veterans of America.

Welcome to you all. The subcommittee appreciates very much your presence here today.

We also have written statements from the American Legion and the Veterans of Foreign Wars, and without objection, these statements will be made a part of the record. No objections, so ordered.

[The material to be provided appears on pp. 143 and 148.]

Mr. MORAN. And each of you may proceed up to 5 minutes, and we'll start with Mr. Fuller.

Welcome, good to have you with us today.

STATEMENTS OF RICHARD FULLER, NATIONAL LEGISLATIVE DIRECTOR, PARALYZED VETERANS OF AMERICA; JOY ILEM, ASSISTANT NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS; AND LINDA SPOONSTER SCHWARTZ, ASSOCIATE RESEARCH SCIENTIST, YALE UNIVERSITY SCHOOL OF NURSING; ACCOMPANIED BY RICHARD WEIDMAN, EXECUTIVE DIRECTOR, GOVERNMENT RELATIONS, VIETNAM VETERANS OF AMERICA

STATEMENT OF RICHARD FULLER

Mr. FULLER. Thank you, Mr. Chairman. I am Richard Fuller, National Legislative Director of Paralyzed Veterans of America. On behalf of the members of PVA, we appreciate this opportunity to express our views on the status of the Department of Veterans Affairs mental health programs.

We'd like to focus our testimony today on the role mental health programs play as one of the specialized services that are unique to the VA. The VA's wide variety of mental health programs, together with other specialized services, such as blind rehabilitation, prosthetics, amputee services, and our own spinal cord injury services are the core programs of VA health care.

In many respects, these programs are found nowhere else in U.S. medicine to the extent they are made available to veterans.

PVA has recently completed a report that indicates a high incidence of dual diagnosis of veterans with spinal cord dysfunction and mental illness. PVA's Health Policy Department surveyed VA's spinal cord dysfunction programs to assess the extent and quality of coordination between those programs and VA's mental health services.

VA SCI treatment teams confirmed that mental health services were a core part of the spinal cord injury and dysfunction rehabilitation in VA inpatient and outpatient settings. I might add, Mr. Chairman, that we do not see this in private sector spinal cord injury rehabilitation centers; it is solely unique to VA, and very positively so.

These services, however, are not always available, due to the shrinking capacity of mental health services throughout the VA health care system. We are concerned about this ongoing erosion, just as we are troubled with the failure of VA to maintain the capacity to provide all of its specialized services.

I would like to review what steps PVA has taken in our own sphere of spinal cord dysfunction to attempt to stop this deterioration of services.

And I'd like to say that we have not solved the spinal cord injury capacity problem, not by a long shot, but we have developed the tools which I think would be useful for the subcommittee to hear to quantify where the problem areas are in beds and staffing, and show clearly what the VA needs to do to solve these problems.

The subcommittee acted appropriately in passing a provision in Public Law 104–262, designating these programs with protected status. However, merely passing the law did not solve the problem. Initially, no one knew how to define capacity, and no one could agree how to quantify it.

We have had many skirmishes and battles with the VA, trying to get to the bottom of this. Our first battle was over one of definitions. VHA leadership said they could measure capacity by quantifying the intangibles of outcomes, even though they had no mechanism to do so.

We countered that counting beds and staff at SCI centers was the only way to define the capacity of the system to provide a service, particularly one that was as inpatient-based as the SCI system.

Then there was the battle over numbers. What beds and staff do you count, and how do you count them? It became clear early on that VA had 25 different ideas, depending on which of the 25 SCI centers you were reporting from, on what constituted a bed, and what constituted an SCI-dedicated health professional.

We, on the other hand, had a different idea, based on our own bed counts and head counts, conducted by our own service officers on site in the field. The VA's numbers were clearly inaccurate, but were reported to Congress anyway, in the capacity reports.

Over the years, we've taken many steps in the attempt to get this sorted out. We have tangled with VA Secretaries and VA Under Secretaries, we have testified at hearing after hearing, we have filed law suits, we have requested committee oversight and site visits in the field, we have gone to the press, all to make clear that we were serious about the fact that the capacity statute passed by this subcommittee actually means what it says.

Last year, we were finally able to sit down with VA leadership and agree to agree. We designed a template designating staffing and bed levels for each SCI center that will serve as a benchmark for all future capacity reports.

On July 26, 2000, the Under Secretary for Health issued VA directive 2000-022, stipulating that all SCI centers would be in compliance with the directive restoring staffing and beds to the agreed upon levels by September 30, 2000.

We agreed to perform a monthly count in conjunction with VHA personnel of each SCI center to determine the progress made in the restoration of capacity. We now have 9 months of data with which we can measure VHA's progress towards meeting these goals and the goals of the actual directive itself. I've attached a copy of our May 31, 2001 report to be included with my testimony for the record, which shows how we conduct this count.

Many of the designated SCI facilities have made substantial progress toward providing the minimum resources specified in the directive. We are greatly appreciative of the efforts that have been made, with the support of the Under Secretary for Health.

However, the VA has still not provided the minimum SCI resource levels it is required to provide under the directive. The number of nursing staff and staff beds have remained virtually the same, at 92 percent, for the past 3 months. We are approximately still 113 nurses short of the minimum number.

Further threatening mental health service capacity, there is a 30 percent shortfall in spinal cord injury psychologists, which is effecting the capacity on both sides of the specialized services.

As of May 31, 2001, only 1 of the 25 SCI facilities was fully compliant with the requirement of the directive, only 1. And, as of May

31, 2001, only 11 of the 25 SCI facilities were providing the number of staff as specified by the directive, as well.

It is very clear, Mr. Chairman, we have not reached the Promised Land of full SCI capacity. But at least we have developed the tools to see clearly how far we have to go, and how far VA must go to get there.

This subcommittee must insist in reauthorizing the specialized services capacity reporting requirements, that the legislation provides strong language and direction to adequately define capacity and make certain those capacity levels are met, whether it be mental health, spinal cord injury, or any of the other specialized services.

Mr. Chairman, this concludes my testimony. I'll be happy to respond to questions.

[The prepared statement of Mr. Fuller appears on p. 111.]

Mr. MORAN. Mr. Fuller, thank you very much. Ms. Ilem.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Mr. Chairman and members of the subcommittee. Good afternoon, I'm Joy Ilem, with the Disabled American Veterans.

We appreciate the opportunity to discuss VA specialized programs of care for veterans suffering from severe mental illness, substance-use disorders, and homelessness. The DAV views these programs for veterans with special needs as the core of the VA health care system.

Unfortunately, over the past 5 years, there has been a continuing erosion of specialized services for these veterans. Mental health and substance abuse programs have been significantly impacted. As VA shifted from inpatient hospital-based care to outpatient and community-based care, it did not sufficiently reinvest in or re-establish these types of programs in community-based outpatient clinics.

In May, the committee on the care of severely chronically mentally ill veterans submitted a response to a draft of the Fiscal Year 2000 annual capacity report, and noted that only half of all VA community-based outpatient clinics provided meaningful mental health services, and that there is great variation among the VISNs.

Veterans who suffer from severe mental illness, substance-use disorders, and homelessness need and rely on VA specialized programs. Access to treatment and the type of treatment provided are equally important. Intensive case management is often necessary to manage these complex patients successfully.

If care is provided at an outpatient setting, these patients, they need structured support and routine monitoring by qualified mental health professionals. Acute inpatient beds must also be available when necessary.

We need a commitment from VA management to reinvest in these programs, in both inpatient and community-based settings. VISNs must identify the need for these specialized services in their local communities, and relate such needs to the under secretary. Congress must provide adequate funding to ensure these veterans have access to high quality, timely care for their specialized needs.

The committee also concluded that based on the data supplied in the draft Fiscal Year 2000 capacity report, that the VA is still not in compliance with the capacity provisions in Public Law 104–262. We agree with those findings.

The VA continues to use a legalistic defense for capacity, indicating in the 2000 draft report that nationwide capacity appears to be maintained or improved for workload measures in seven out of eight special disability specialities.

However, we do not believe the spirit of the law has been met, which requires the Department to maintain its capacity to provide specialized treatment to certain disabled veterans in a manner that affords those veterans reasonable access to care and services for specialized needs.

We also agree with the committee's comments that to be meaningful and to meet the capacity definition, the number of patients treated and the dollars expended on their care must be taken into account, as well as an adjustment for inflation.

VA cannot continue to ignore its responsibility regarding capacity of specialized programs. Therefore, we suggest a key official be appointed to ensure that capacity is being met throughout the system, and to hold local managers accountable for maintaining capacity for specialized services at their facilities.

Given the importance of this matter, and the time necessary to monitor and oversee capacity issues throughout the VISNs, this position should be a full-time responsibility.

I would also like to take this opportunity to state our position on the recent novel anti-psychotic medication guidelines proposed for the treatment of schizophrenia in two of the VISNs.

We believe these guidelines were developed as a cost saving measure, rather than a standard of best practice. Under this policy, some patients would undergo trial periods on the lower costing novel anti-psychotic medication first, for up to 10 weeks.

A fail first policy raises serious concerns for the well-being of seriously mentally ill veterans. We strongly object to any policy directives that are cost-driven rather than based solely on standards of best practice.

We believe this policy may restrict a clinician's ability to prescribe the most effective medication first line, for a patient with schizophrenia, based on that patient's medical history and individual needs, without regard to cost.

We request that VA immediately suspend any current novel medication guidelines for the treatment of schizophrenia, pending the outcome of the clinical antipsychotic trials intervention effectiveness project being conducted by the National Institute of Mental Health.

In closing, we want to thank the subcommittee for the opportunity to present our views on these important issues. I'll be happy to answer any questions that you may have. Thank you.

[The prepared statement of Ms. Ilem appears on p. 122.]

Mr. MORAN. Thank you very much.

Dr. Schwartz, Congressman Simmons left earlier, but wanted me to make certain that I recognize that not only you were a resident of Connecticut, but assuming I can pronounce your home town and his home town—they're the same—Pawcatuck?

Ms. SCHWARTZ. Pawcatuck, CT, sir.

Mr. MORAN. Pawcatuck, CT. So, on behalf of Mr. Simmons and the remaining members of our committee, thank you very much for your presence.

STATEMENT OF LINDA SPOONSTER SCHWARTZ

Ms. SCHWARTZ. Thank you very much for inviting me. And the VVA, Vietnam Veterans of America is really grateful for the opportunity to make some comments, and wants to thank you for your attention to a very vital issue of the erosion of VA mental health and behavioral sciences capacity to treat veterans in the VA system.

This decimation of an infrastructure tasked with meeting the needs of veterans with severe and complex problems is, in essence, a failure by VA to meet the spirit and intent of the capacity legislation enacted in 1996.

Not only do we believe that this diminishment is illegal, VVA believes that VA's failure and continued reduction in resource funding is morally reprehensible. Capacity legislation clearly tasked VA with maintaining specialized programs for the severely mentally ill, veterans who bore the neuropsychiatric wounds of war.

As we look back from the time of the capacity legislation, there is cause to celebrate many innovative and substantive changes. However, one cannot help but notice that the veteran population least able to speak for themselves have become the victims of a system which has no accountability.

What the new VA has essentially done is given VISN directors unprecedented power and authority with accountability measured only—but not in patient outcomes, but only in dollars and cents. The inability and/or unwillingness of the VA officials to hold these employees accountable appears to the VA to be a vehicle for top VA officials to preserve deniability of what the know to be the real deal.

As a result of vesting enormous power and latitude to VISN directors, we have seen them ignore the congressional mandate to preserve the programs for veterans least able to navigate the system or speak for themselves.

Mr. Chair, we could go on at great length to recount the litany and disregard for the capacity legislation, and I believe Dr. Errera and Dr. McCormick have very eloquently described to you what this means in real terms to the veterans in our system. But suffice it to say that there are blatant—there is clear evidence—of a blatant and negligent disregard for the law and the veterans it sought to protect.

This has happened because there are no teeth in the capacity legislation. Additionally, the SMI advisory committee tasked with the oversight of the capacity process is limited because it is required to report to the under secretary for health.

In essence, you have charged an advisory committee to be your oversight for the capacity law, and yet their determination and impressive efforts to meet that challenge have been stymied and obstructed since the committee began.

VVA has outlined actions and directions we believe must be taken to rectify the situation. These are outlined fully in our testi-

mony, and I would just like to take a few moments to highlight several of the major recommendations.

VVA urges Congress to move quickly to pass legislation that would recentralize all specialized programs for SMI, substance abuse, homeless, and hepatitis C services. The model here is in concert with the model, the bold action that Congress took earlier to remedy the problems with VA's prosthetic needs for veterans.

Secondly, we urge Congress to establish a much greater line of authority and care for veterans in need of mental health treatment and programs, and that these treatments reside in a clinical domain, the authority for treatment of these conditions resides in a clinical domain.

We also ask that you mandate that VA prepare a plan for rebuilding the organizational capacity in the specialized programs that has been lost since Fiscal Year 1996. We urge Congress to modify the legislation authorizing the advisory committee on serious and chronic mental illness to mandate full consumer participation and accountability to the Congress, not the under secretary, via the office of the Secretary of Veterans' Affairs.

Lastly, but certainly not the least, VVA calls on this committee to pass the Heather French Homeless Act of 2001. We believe this legislative act will make a significant progress towards providing real help for veterans whose problems are so difficult and complex they become homeless.

We also believe it is essential that funding sources be authorized for community-based providers who partner with VA to fill in the space in the continuum of care to provide needed and holistic care for the veterans who are homeless.

And Mr. Chairman, I used the word "decimation" several times in my presentation. And it calls to mind the real root of that word, which you probably know came from the fact that during the Roman legions, if any of the units embarrassed themselves, or did not perform adequately during battle, they were forced to line up and every tenth man was slain.

Nobody knows how many of those lives were lost needlessly, and we cannot tell how many veterans in America today have been lost because of this action of the VA. Thank you.

[The prepared statement of Ms. Schwartz appears on p. 129.]

Mr. MORAN. Mr. Weidman.

STATEMENT OF RICHARD WEIDMAN

Mr. WEIDMAN. I believe Dr. Schwartz said it all for VVA. I would correct you on one thing, Mr. Moran. I think you inadvertently referred to me as Dr. Weidman, and although I'm very proud of having been a medic in Vietnam, and therefore been called "Doc" many times in my life, I do not have a medical degree. But I thank you for the notion, sir.

Mr. MORAN. We've been surrounded by doctors most of the time in this committee room, and I would thank you for your service to our country, as "Doc."

The gentleman from Pawcatuck has arrived, and I would see if he has any questions or comments for this panel.

Mr. SIMMONS. I thank the chairman, and I thank him for his courtesy in welcoming so many Nutmeggers here this afternoon.

But I think it's testament to our concern over these very difficult issues relative to our veterans, and in particular, Vietnam veterans.

And I would also suggest that it seems to me, based on the testimony that we've received, that at least the people in the field have their arms around not only the problem, but what I call the bones of the solution.

And again, I invite the chair and any member of this committee who wishes to come up and pursue this issue a little bit further in New Haven, or in Pawcatuck, which is a village in my home town of Stonington, where we have not only veterans, but we have people who have devoted their lives to studying these issues, because they don't want to leave their comrades behind. And that's what this is all about. Thank you, Mr. Chairman.

Mr. MORAN. Mr. Simmons, thank you. Let me explore with this panel, if they could describe for me the typical veteran that we're talking about, either in regard to homelessness or drug abuse or mental illness. Is there a profile, as to who we're talking about, who is our concern?

Ms. SCHWARTZ. Well, I've had a little experience with this, because as Mr. Simmons noted, for about 5 years I, as a volunteer, partnered with the West Haven VA and provided housing for homeless veterans. We had four homes for homeless veterans, and we took care of about 28 veterans.

And most of them, I can tell you that some of them were World War II veterans, I can tell you there were Korean veterans, I can tell you there were Gulf War veterans. And they were sometimes veterans of peace time. But most of them were on their very last leg.

And I tell you that one of the things that happened at West Haven before all of this started to occur in VA was that there was a concerted effort to redefine services to the mentally ill. And so therefore, West Haven VA took the money they saved from closing their inpatient unit, and invested it in its community-based services.

And so I know it can work, because that is how I saw the work of the master clinician, Dr. Paul Errera and his colleagues, Dr. Laurie Harkness and Dr. Nancy Buck. There is a way. That safety net was in place when that occurred.

It is not consistent throughout this country. Veterans in different VISNs have no resources to be turned to or to be helped with.

Mr. MORAN. Dr. Schwartz, you then are answering, I think, my earlier question about the role model. Is there a place in the country that's a role model for these services to be provided? Is that accurate?

Ms. SCHWARTZ. I agree with my colleague, Linda Boone, that there are places, outposts, so to speak, but I wish there was consistency. And I think that's why VVA took the position that we want to reconcentrate, recentralize the authority, the responsibility, and the accountability to people in the central office to the mental health and behavioral sciences, because there is nobody watching the store.

You know, I wanted to say just one other thing. We've heard a lot today about best practices. Do you know what best practices

are? It's a book. We don't know if people read it, we don't know how many people look into it. And we don't even know how many people actually believe in the best practices or use it. And that is a commentary on—to me, it's blue smoke and mirrors.

Mr. MORAN. We heard Dr. Culhane's testimony about the importance of housing. And maybe Ms. Ilem or Mr. Fuller, this could be directed at you.

Do you agree with, I guess, a belief that the evidence shows that part of the problem we face is just lack of resources in housing, and is there any model for us to follow in meeting that need for housing, if you agree that that's a serious issue?

Mr. FULLER. Well, I totally agree with what he had to say. Any type of deinstitutionalization is both cost-effective and most humane. From Paralyzed Veterans of America's standpoint, we've been looking at—and of course, it's a major concern to our members at many different stages of their lives, some very innovative programs.

This isn't dealing with homelessness, but one that comes to mind is one a program in Boston that has been put together which deals with very high quadriplegics and end stage AIDS patients.

What they discovered through this project is if they got these people out of the hospital, and got them out of institutions, and set them up in housing with assisted living, and throw every kind of service you could possibly throw at these people, you still saved a lot of money by avoiding recidivism and the constant going back in to hospitals for long lengths of stay and very expensive health care costs.

I think that what the doctor from Philadelphia came across with is a very similar type of model. So I think it holds true.

Ms. ILEM. I would have to agree, you know, with many of the things that he indicated, but I would also add that the importance of the supportive services once housing is made available. Many of our homeless veterans suffer from severe mental illness and substance abuse disorders, so they are extremely complex patients to deal with, and they need, you know, a lot of support.

And to keep them from just, you know, recycling through the system and it happening over and over again, they really need those support systems. And so that's equally important, and I think the Heather French bill, assistance act, you know, is a pretty comprehensive bill that looks at a lot of very different issues, and I think that's real important.

Mr. MORAN. Thank you, Ms. Ilem. Doctor Schwartz.

Ms. SCHWARTZ. Oh, one of the things I just want to echo is the fact that the reason our program in West Haven worked is that we did have clinical support from the VA, and we worked hand in hand with them.

But I believe in the homeless world today, one of the difficulties is some of the providers who come under our grant and per diem program, they are, as Linda Boone mentioned before, the per diem for them is $19 a day, and I just ask you what in the world can you buy for $19 in Washington, let alone the rest of the country?

And so that's a very small amount, and very hard for the people who take on that job of finding the housing for our homeless veterans, and work with it. It's not adequate. It's not adequate.

Mr. MORAN. Any evidence that there is a relationship, working relationship, between HUD and the VA in addressing the issue of housing?

Mr. WEIDMAN. The question is, is there a working relationship between HUD and anybody in the veterans community, sir?

Mr. MORAN. I take it by you restating my question, the answer to either your question or mine is no. Is that true?

Mr. WEIDMAN. It has been problematic, and hopefully with the new secretary, will prove to be more responsive than the last secretary and the secretary before.

And the problem may be structural, and perhaps approaching the banking subcommittee for perhaps even a joint hearing at some point, Mr. Moran, would be excellent.

I would like to take just a brief exception to the professor from Pennsylvania's comment that it's mostly housing. Many of us have been dealing with "homeless vets" since the late 1970s. And at first, we really thought it was just a problem of housing.

Well, it's never been just a problem of housing. It's helping veterans regain the ability to obtain and sustain meaningful employment at a decent living wage, or something that gives meaning to their lives for those who are unable to hold down a job. If it was just a question of housing, we could have solved this a long time ago.

We would maintain that one of the problems now is that in the last few years, since 1995, the Congress has created some very fine programs for special outreach to homeless veterans.

At the same time, specialized services, and particularly serious mentally ill services, were being reduced so that we were creating more homeless veterans because of the slashing in VA services on one side, then the Congress could pass and fund programs on the other side to try and just stay even. What we need is both, in order to succeed, sir.

Mr. MORAN. I had the same reaction that you apparently did, which is we need to see about getting VA and HUD to work together, and perhaps there is a role for this subcommittee, this committee, to play in dealing with officials from the Department of Housing and Urban Development, and officials from the VA.

Let me just—I think a final question. Ms. Ilem, this topic about medication and the concern about the fail first policy, or potential policy. Is that different than other areas of the VA and the use of medication? Are we carving out something, or is the VA potentially carving out and treating this issue of psychiatric medications different than other medications within they system?

Ms. ILEM. Well, that exact topic was discussed this morning during—I was attending the seriously mentally ill conference that was—and Dr., I think, Losonczy made comments about that, and I respect their opinion on that, and that was one of the things that they indicated that was interesting, was that in other areas, similar practices for medical conditions, there are similar practices.

And I think our big fear is that when we see the seriously mentally ill patients, if they do happen to be in a VISN where they're using this policy and they have a fail first policy in action, and they have to have some documented response to it that's negative, these veterans may not recover fully from an episode or a set-back.

And, we'd like to know that the clinician has the ultimate say, first and foremost, but they're extremely concerned about costs, because apparently they have to be. I mean, it's a big issue for them, and they want to treat as many veterans as possible as they can.

However, we want it to be that, as clinicians, that's their first and primary decision, as based on that reasoning, rather than cost first, and that policy just raised a lot of red flags for us.

And we want to be ensured that veterans are getting the best possible treatment, and that if clinicians feel, first line, a certain medication is appropriate, then that should be used.

But I think that Dr. Losonczy made some interesting statements, and he certainly, I think, has veterans' best interests at heart, mentally ill veterans, and I think that we have to respect some of the comments that he made, as well.

Mr. MORAN. Let me try once more about problems in rural America. The access to professionals: any evidence that there is a significant problem across the country bearing upon whether or not the veteran lives in an urban area versus a rural area in access to mental health services?

Ms. SCHWARTZ. I served for several years as the chairman of the VA's advisory committee on women veterans. And in fact, last year I was here when I was the chairman. And in that capacity—and also as the vice chairman of the VA's advisory committee on readjustment of combat veterans—I visited many parts of this country.

And I can tell you in the new VA, there are some startling—what do I want to say—window dressing facilities.

For example, I will give you Missoula, MT. We went there to look at their substance abuse program. The substance abuse program was not allowed to be with the CBOC because the doctor didn't want to have those people near his patients. Okay? This is a VA facility.

We go into the room, it's a very small room, you go into it, there's a desk and a telephone, and then there's a social worker sitting there. You go into the treatment room, it is absolutely bare, it does not have a chair, they borrow folding chairs from across the way.

And she tells us that when veterans come to her and having DTs, the best she can do for them is to lay them on the ground and put her shawl over them, and call the hospital, which is over at Fort Harrison, which is a two-and-a-half hour drive to get there. She is not allowed to call 911. There is a disparity.

Mr. WEIDMAN. There are many other areas, if I might point out also, Mr. Moran, where rural folks are having a very difficult time, and particularly in the—even of the 40 percent of CBOCs that have some mental health, by and large they are not—they are general mental health practitioners who don't know anything about veterans mental health, particularly the neuropsychiatric wounds of war, and therefore, are not particularly useful in terms of serving the chronic acute seriously mentally ill patients.

There is one model that seems to be working, and it seems to be working well, and you may want—the committee may want—to look into it.

And that is in Vermont, where you have two vet centers who have been tremendously responsive to the needs of the community with the state participation along with the federal, along with the

veteran service organizations. And they got a grant from Mr. Dougherty to do a homeless outreach program.

They have gone in less than 14 months, from virtually no even identification of veterans in the shelter system to 90-plus percent of the shelters, not only identifying the veterans, but having special veterans programs, just by bringing private and public dollars together to assist those community-based providers.

So the model of public/private partnership and state/federal/local partnership can work if you have the right ingredients, and if it's not messed around with by the hospital director diverting the funds to something else.

And that's why, in terms of that centralized control, the key is control of the money. We have promised the chairman of the full committee that we will not—people take two things very seriously—automatic weapons and money. And we promised the chairman of the full committee that we would eschew the first. And therefore, it has to be money.

If you're going to get the attention of those hospital directors and those VISN directors, you have to control dollars. So it's mental health, SCMI, you name it, as long as it's under the—they can play games and hide those dollars, it ain't going to work.

The VISN system, from our point of view, has been a failure. And until such time as they can prove that they built the accountability along with that power so that it's not just license to impose their view on what medical care is appropriate to veterans in a geographic area, as opposed to what the Congress has mandated, until such time as they can demonstrate that they can act like professionals, and the system has accountability in it, then we need to recentralize the funding and have more line control of the specialized services residing in the central office with clear demarcations and responsibility that is answerable back to the Congress for what they do and don't do, sir.

Mr. MORAN. Thank you, Mr. Weidman. I'll think about your very forceful argument, and I'll probably want to reread your words. You point out something that, in addition to your final concluding remarks, that I had not thought about.

We struggle, in rural America and certainly in rural Kansas, to attract and retain health care professionals. And it's particularly true in psychiatry. I live in a community of 25,000—we cannot keep a psychiatrist in town. We recruit one, and they're gone—they're in demand elsewhere.

And I had not thought, until you said, about the specialty of treating war wounds, as I think you described it. And so there has got to be not only the hurdles we have in just finding those who are practicing psychiatry, but actually those who have experience, knowledge, and training related to the veteran and his or her special needs in regard to that care and treatment.

And the hurdle of the bar would be even higher in, I think, most places across the country, but especially as I relate to home.

Let me thank Mr. Fuller and the PVA for their efforts on this issue of capacity. It appears to me that you were the dog with the bone, and you would not let go, and perhaps made some progress. And I thank you and congratulate you on that success.

Mr. FULLER. Well, we're certainly not there yet, but I think as I mentioned, we've identified a mechanism which is useful for others.

I would just like to say, Mr. Chairman, that earlier this week I happened to pick up a written history of the first 25 years of Paralyzed Veterans of American. I noticed in 1948, there was a letter from the then-Administrator of the Veterans' Administration first of all denying PVA's request to put a centralized person in the VA Central Office in charge of spinal cord injury, and next denying that shortfalls in medical care staff on spinal cord injury wards were having a deleterious effect on patient care.

So I'd just like to say that we've had over 50 years of experience in dealing with this particular problem.

Mr. MORAN. Suggesting that the adage that history repeats itself is true.

Mr. FULLER. Or, the more things change, the more they stay the same.

Mr. MORAN. I think Mr. Simmons has an opportunity to have another witness at least included in the record, another witness from Connecticut.

Mr. SIMMONS. Actually, Mr. Chairman, what I have are two letters here, one from Ray Slayton of Hamden, CT, which is a town just outside of New Haven, the other from Ted Jones, who is currently a chief steward and member of a union that provides services for the Veterans Administration hospital in West Haven.

Both of these gentlemen were homeless veterans just a few years ago, one living in a car until it was towed away, the other out on the street, homeless and a drug abuser. Both of these Vietnam veterans have gone through the program at VA West Haven, and it's turned their lives around.

And so what I would like to ask the chair is if we could include their statements and a more extended statement from Mr. Jones for the record of this hearing.

Mr. MORAN. Without objection, so ordered. Thank you.

[The statements of Ray Slayton and Ted Jones appear on pp. 159 and 156.]

Mr. MORAN. This hearing has been helpful to me, and I believe members of the subcommittee. I think we have established beyond the reasonable doubt that problems and challenges exist within the VA system to deliver mental health and services, and meet the needs of homeless veterans.

Hospital beds is only a part of the dilemma, and it appears to me that the VA may even—has admitted—that the pendulum has swung too far in the direction of the reforms and the downsizing of facilities and beds available, and certainly that residential programs, rehabilitation matter to us.

I want to work closely with Mr. Evans, the ranking member, and Mr. Filner, the ranking member of this subcommittee, to see if we cannot fashion a bill, legislation, that deals with homelessness, and that we proceed in this Congress to address this issue that the current state, it seems to me, to be unacceptable.

And I thank you for providing me with information that confirms that conclusion. Thank you for your time today, thank you to our

other witnesses, and we'll leave the record open for 5 days for submission of testimony, and the hearing is adjourned.

[Whereupon, at 4:57 p.m., the subcommittee was adjourned.]

APPENDIX

PREPARED STATEMENT OF CONGRESSMAN SHOWS

I want to begin by thanking Chairman Moran and Ranking Member Filner for holding a hearing on mental health, substance-use disorders and homelessness programs within the Department of Veterans Affairs. Your outstanding commitment to improving veterans' lives has impressed us all, and this hearing will undoubtedly shed more light on this critical issue of mental health.

All of us share a tremendous respect for the veterans of our Nation. These brave men and women put their lives on the line to protect, defend and advance the ideals of democracy and our American way of life, by serving in the United States military. The valiant service provided by these fine American citizens was not done for nay personal reward, just for knowing they had done their part to keep America and democracy strong. And yet, while we honor veterans for their service, we often disgrace ourselves in our inadequate assistance for veterans who acquire mental illness. They were there when our country needed them, now it is our turn to be there when they need us.

I am proud to have joined our esteemed Ranking Member of the Full Committee, Lane Evans, in introducing H.R. 936, the Heather French Homeless Veterans Assistance Act. This meaningful legislation will enable us to meet our national goal of ending homelessness among veterans within a decade, through a variety of grants, coordination of health services, and housing programs.

Our Nation's veterans are our heroes. They have shaped and sustained our Nation with courage, sacrifice and faith. They have earned our respect and deserve our gratitude. Let us join together and do something meaningful with today's hearing by committing to pass comprehensive legislation, like H.R. 936, the Heather French Henry Homeless Veterans Assistance Act. It is the right thing to do.

STATEMENT OF LANE EVANS
RANKING DEMOCRATIC MEMBER
COMMITTEE ON VETERANS AFFAIRS

Hearing Before the Subcommittee on Health

Mental Health, Substance-Use Disorders, and Homelessness Programs within the Department of Veterans Affairs

June 20, 2001 at 2:00 PM
334 Cannon Office Building

Chairman Moran, thank you for holding this important hearing today. As you know, I have made passage of a bill to assist homeless veterans one of my highest legislative priorities in this Congress. On March 6, I introduced H.R. 936, the "Heather French Henry Homeless Veterans Assistance Act". Almost a third of this body—Democrats and Republicans—have joined me in supporting this bill. Mr. Chairman, I know that this is not a legislative hearing, but I'll beg your indulgence as I speak to the provisions of this bill and the important needs it will address.

I know that there are many witnesses that will speak to the tremendous needs for mental health care services among our Nation's veterans. VA and the private sector have made dramatic changes in their programming for mental health care—many of these changes do not appear to have worked as well as we might have hoped. VA has almost halved its psychiatric census over the last five years. It now stands a little over a quarter of the psychiatric census VA had in FY 1994—less than a decade ago. I do not believe it has made enough investments in mental health intensive case management or supportive housing arrangements to justify these huge decreases in its programs.

VA's own accounting of the resources made available to these mental health programs, in the "Capacity Report", indicates that there have been significant decreases in most mental health programs, including programs for substance use disorders, post-traumatic stress disorder, and treatment for the veterans with so-called "dual diagnoses"—serious mental illness and substance abuse.

A draft of The Capacity Report for 2000, which has been shared with my staff, indicates that these problems persisted throughout the last year. It is also my understanding that VA is no longer providing information on "constant" 1996 dollars committed to these programs. This information gave us some idea of the purchasing power of the amounts committed to these programs. However, even without that information it is clear that even the marginal increases some of these programs received would not sustain the costs of inflation. Most of the funding for these programs has decreased even when amounts are *not* adjusted for inflation.

These trends indicate serious problems in VA's mental health care delivery system. Ask VA's own internal Committee on Care of Severely Chronically Mentally Ill Veterans. Its assertions have been loud and clear. Its members have also been brave, I might add, considering they are challenging their own institution. Every year that there has been a Capacity Report they have failed to endorse VA's assertion that it is maintaining capacity in its programs for the mentally ill. Dr. McCormick, Dr. Losonczy, and Dr. Errera, I want to thank you for your continuing advocacy on behalf of this population.

Let's face it—we know effectively managing the care of some of our most seriously mentally ill veterans is expensive—inpatient or outpatient. The Under Secretary's Committee advised VHA's leadership of this. We also know, however, that the costs of not managing this care effectively are almost as expensive and lead to far lower stability and functionality for the veterans. What works? Intensive case management is extremely effective. Care in the community—supportive housing combined with mental health, substance use disorder treatment, and vocational rehabilitation—can work very well. Our community-based homeless providers play a huge and inspiring role in this effort.

Let's think about two scenarios—in the first, VA or a community provider paid by VA actively works with the veteran, on a daily basis if needed, to help manage his medication, to assist him in learning independent skills of daily living and vocational skills, and to identify appropriate housing options. The veteran is able to become stable in a community setting and perhaps even to become a taxpayer.

Unfortunately, scenario two is the reality of far more of our veterans. VA sees veterans episodically for psychiatric care—the veteran doesn't function well enough to manage his/her medication and may also have an addiction that further impairs his/her functionality. The cost of this addiction may lead the veteran into a life of crime, for which he/she is periodically jailed or imprisoned. The veteran is only hospitalized for mental health reasons when the veteran is so acutely ill that

he/she becomes a threat to themselves or others and then for so short a time that only his/her medication is stabilized. The veteran may be homeless, jobless and hopeless. The veteran in both scenarios cost our society about the same amount of money. With whom would you prefer to share our Nation's streets?

VA's certainly not the only culprit here. In fact, VA is one of the most committed public partners addressing the needs of seriously mentally ill veterans—still it must do better. States have closed psychiatric facilities without an adequate community infrastructure on which its former patients can rely. Mental health is drastically under funded by public and private payers.

And VA is not the only solution. VA's homeless grant and per diem providers do a great job of turning our veterans' lives around. Peer support groups have offered a network for supporting the needs of veterans with mental illness. A real solution to addressing the needs of homeless and mentally ill veterans will involve all of these important players. VA, in partnership with community-based providers must be the standard bearer—it must offer the model for addressing the needs of this critically ill population in a comprehensive and compassionate way.

The Heather French Henry Homeless Veterans Assistance Act, named for Miss America 2000, expands and enhances the most effective programs in the Department's spectrum of VA provided or funded programs. It asks experts and consumers of homeless, substance use disorder, and mental illness treatment programs to review VA's program mix and effectiveness and offer guidance to VA program officials. It tests new delivery models to determine their effectiveness. It promises dental care, the component VA and its CHALENG reviewers identified as the biggest gap in VA programming available to homeless veterans. Advocates of the homeless know that dental care often ensures that veterans are better able to find jobs and maintain their independence. These changes aim to ensure that veterans are given a hand up, not a hand out.

I had hoped the agency would have views on H.R. 936 available to share with us today. Unfortunately, this was not possible. I am committed to continuing my advocacy on behalf of this population. I believe this Committee must also commit to continue to speak out on the needs of seriously mentally ill veterans because they are not a population that can advocate well on behalf of themselves. As surely as we must never forget veterans whose disabilities are more visible, we must not forget our comrades who have psychic injuries, which are equally painful and difficult to address. Their sacrifices, too, are great.

I ask the Members of this Subcommittee to honor these veterans by joining me in supporting H.R. 936, the Heather French Henry Homeless Veterans Assistance Act. We need to address some of our most vulnerable veterans' needs and it can't wait until tomorrow. I hope we will be unified and committed in our devotion to addressing these veterans' needs in this Congress.

Thank you, Mr. Chairman.

HOUSE OF REPRESENTATIVES
WASHINGTON, D.C. 20515

DAVID E. BONIOR
10TH DISTRICT, MICHIGAN

DEMOCRATIC WHIP

June 18, 2001

The Honorable Lane Evans
Ranking Member
Committee on Veterans' Affairs
333 Cannon House Office Bldg.
Washington, DC 20515

Dear Lane:

It is my understanding that your Committee will hold a hearing on June 20 to discuss mental health programs within the Department of Veterans' Affairs (VA). Prior to this hearing, I would like to share with you my concerns about the mental health prescription benefit offered to veterans in region 11 of the Veterans Integrated Service Network (VISN-11). This region includes our home states of Illinois and Michigan, as well as Indiana.

It has been brought to my attention that VISN-11 may be working toward implementation of a "fail-first" policy regarding prescription medications known as "atypical antipsychotics." These drugs are new medications which are often used to treat schizophrenia. Under the proposed policy, as I understand it, patients would have to fail trials on lower-cost atypicals before they could be prescribed other, more expensive drugs such as Zyprexa.

I am very concerned about this proposed policy. After all they have done for our country, veterans with mental illness should receive the best care we can give them. Because side effects vary from drug to drug, doctors know best which medication their patients should take. The VA should not tie the hands of doctors and restrict access to potentially life-saving drugs simply because of their cost. It should instead consider the high costs associated with forcing mentally ill veterans to suffer through trial after trial of ineffective drugs.

Therefore, I urge you to do what you can to ensure that veterans in VISN-11 have access to the newest and most effective medications available to them. They deserve to get the best treatment possible -- and at the very least, they should receive the same benefits as veterans in other VISNs. Thank you very much for your consideration. Please know that I continue to value greatly our mutual efforts on behalf of our nation's veterans.

Sincerely,

David E. Bonior
Democratic Whip

STATEMENT OF
THE HONORABLE THOMAS L. GARTHWAITE, M.D.
UNDER SECRETARY FOR HEALTH
VETERANS HEALTH ADMINISTRATION
BEFORE THE
SUBCOMMITTEE ON HEALTH
COMMITTEE ON VETERANS' AFFAIRS
U. S. HOUSE OF REPRESENTATIVES

JUNE 20, 2001

Mr. Chairman and Members of the Subcommittee:

The Department of Veterans Affairs (VA) provides mental health services for veterans across a continuum of care, from intensive inpatient mental health units for acutely ill persons to residential care settings, outpatient clinics, Day Hospital and Day Treatment programs, and intensive community care management programs. VA views mental health as an essential component of overall health and offers comprehensive mental health services, including programs for substance abuse, as part of its basic benefits package.

In FY 2000, the Veterans Health Administration (VHA) treated 678,932 unique veterans in a comprehensive array of mental health programs. This represents a 1.1 percent increase from the previous year. Only 11.2 percent of these patients required an inpatient stay, demonstrating VA's emphasis on providing care in the least restrictive, most accessible way that meets patients' needs. The clinical care costs for these services was $1,659,709,000. For FY 2001, it is estimated that VA will treat 687,000 unique patients at a cost of more than $1,735,000,000.

This statement describes VA's mental health clinical services, education and research initiatives, program monitoring efforts, and special programs for homeless veterans.

Clinical Care Services

Treatment for mental disorders in VA rests essentially on two main approaches, pharmacotherapy and psychosocial rehabilitation (including psychotherapy). It is our practice to provide the latest medications for mental disorders to veterans who need these drugs and to prescribe them in accordance with the latest medical evidence. VA's formulary for psychotropic medications is one of the most open in organized health care. It includes virtually all the newer atypical antipsychotic and anti-depressant drugs.

In virtually every instance, medications alone are not enough to bring patients with serious mental disorders to their optimal level of functioning and well being. The application of psychosocial rehabilitation techniques, designed to optimize patients' strengths and correct behavioral deficits are essential. These interventions include patient and family education, cognitive and behavioral training, working and living skills training, and intensive case management. Treatment settings are both inpatient and outpatient settings and can include supervised living arrangements in the community.

VA's clinical services are increasingly being structured to accommodate mental health participation in medical and geriatric primary care teams and medical capabilities in mental health primary care teams. An informal survey has identified over 30 VA facilities with mental health primary care teams. In FY 2000, a multidisciplinary task force of mental health, primary care, and geriatric clinicians identified examples of program criteria and best practices in mental health, primary care, and geriatric integration. Twelve sites were identified as best practice models based on criteria that included patient clinical improvement, prevention, screening activities, and patient satisfaction. Innovative uses of technology such as tele-mental health are also being implemented to enhance mental health services to distant sites (e.g., CBOCs) and provide psychiatry support to Veterans Outreach Centers. By disseminating information about best practices across the system, program development will be encouraged, and higher quality, more cost-efficient care will be delivered to VA patients. Also, FY 2001 strategic plans for several Networks include plans for expansion of mental health capabilities in new or existing CBOCs.

Mental Health Special Emphasis Programs

VA has identified several particular target populations and has developed special emphasis programs designed to serve those populations. They include veterans with serious mental illness (e.g., those suffering from schizophrenia); the homeless veterans with mental illness; veterans suffering from Post-traumatic Stress Disorder (PTSD); and those with substance abuse problems. A significant percentage of all veterans receiving mental health services are seen in the following special emphasis programs.

Serious Mental Illness

Preliminary data prepared for the FY 2000 Capacity Report on seriously mentally ill (SMI) veterans identify $1.9 billion spent treating 290,819 SMI veterans at a cost of $6,551 per veteran. Since 1996, the number of SMI veterans seen has increased by eight percent while the cost has decreased by eight percent, primarily reflecting decreased hospital days of care.

Since 1996, the average length of stay for general inpatient psychiatry decreased from 29.9 to 16.7 days nationally, and the average number of days of

hospitalization within 6 months after discharge (reflecting readmissions) dropped from 12.4 to 6.8. The percent of discharged patients receiving outpatient care within 30 days of their discharge has increased from 50 percent in FY 1996 to 60 percent in FY 2000. These indicators suggest more effective hospital treatment and aftercare. A 33 percent decrease in the number of general psychiatric patients hospitalized since FY 1996 was accompanied by a 22 percent increase in general psychiatric patients receiving specialized mental health outpatient care, resulting in a net increase of 22.5 percent of individual veterans treated in specialty mental health. These data suggest an effective move from inpatient to community-based mental health treatment nationwide.

VA has committed itself to expanding state-of-the-art treatments of serious mental illness, using the Assertive Community Treatment (ACT) model. VA now operates one of the largest networks of ACT-like programs in the country, the Mental Health Intensive Care Management (MHICM) program. As of June 2001, VA has 54 active MHICM programs with another 10-12 in various stages of development. All VISNs have submitted plans for expansion of MHICM teams, which are under review.

Another aspect of VA's care for the seriously mentally ill is our commitment to using state-of-the-art medications, which result in improved clinical outcomes, decreased incidence of side effects, and increased compliance with prescribed medications. Patient functioning and patient satisfaction are increased. In the last quarter of FY 1999, two-thirds of all new prescriptions were for the new generation of atypical antipsychotic medications such as olanzapine, clozapine, and risperidone.

Homeless Veterans

VA operates the largest national network of homeless outreach programs. VA expects to spend $142.2 million on specialized programs for homeless veterans this year and is projecting a budget of $148.1 million for these programs in FY 2002. In FY 2000, VA initiated outreach contact with 43,082 veterans. VA's Health Care for Homeless Veterans (HCHV) program incorporates:

- outreach to serve severely mentally ill veterans who are not currently patients at VA health care facilities;
- linkage with services such as VA mental health and medical care programs, contracted residential treatment in community-based halfway houses, and supported housing arrangements in transitional or permanent apartments; and
- treatment and rehabilitation provided directly by program staff.

These activities serve not only to help homeless veterans; they play a role in de-stigmatizing mental illness in the homeless population. Attachment A to this statement further describes VA's homeless programs.

Secretary Principi recently announced his decision to establish a VA Advisory Council on Homelessness Among Veterans with the mission of providing advice and making recommendations on the nature and scope of programs and services within VA. This Committee will greatly assist VA in improving the effectiveness of our programs and will allow a strong voice to be heard within the Department from those who work closely with us in providing service to these veterans.

Post-Traumatic Stress Disorder

VA operates an internationally recognized network of 140 specialized programs for the treatment of PTSD through its medical centers and clinics. In addition, 11 new specialized programs were funded from the Veterans Millennium Health Care and Benefits Act and will become fully operational in FY 2001. In FY 2000, VA Specialized Outpatient PTSD Programs (SOPPs) saw 53,192 veterans, an increase of 5.4 percent over the previous year. Of these, the number of new veterans seen was 22,607. For SOPPs, the outcome of continuity of care was consistent between FY 1999 and 2000.

Specialized Inpatient and Residential PTSD Programs had 5,106 admissions in FY 2000. Overall inpatient PTSD care is declining while the alternative, residential care, is increasing. Outcomes for Specialized Outpatient PTSD programs (e.g., Continuity of care) and for Specialized Inpatient PTSD Programs (e.g., PTSD symptoms at four months post discharge) have been maintained or improved in FY 2000.

These specialized Mental Health PTSD programs act in collaboration with VA's 206 Readjustment Counseling Service Veterans Outreach Centers. These community-based operations are staffed by a corps of mental health professionals, most of whom have seen active military service, including combat.

Substance Abuse

In FY 2000, 366,429 VA patients had a substance abuse diagnosis. Of these 131,890 were seen in specialized substance abuse treatment programs. The numbers of veterans receiving care for substance abuse disorders as inpatients is decreasing, as part of the shift to outpatient care. Studies show that residential and outpatient substance abuse treatment can be as effective as inpatient services. To accommodate this shift, services are increasingly being developed on a residential and outpatient basis. From FY 1999 to 2000, VA saw a decrease of 7.8 percent in the number of veterans treated in its in-house

specialized substance abuse programs. At the same time, a number of networks instituted contracts for residential substance abuse treatment services. Consequently, VA has begun a process to determine where these veterans are now being treated and the adequacy of that treatment.

Maintaining Capacity (Public Law 104-262)

Public Law 104-262, the "Veterans Eligibility Reform Act of 1996," requires VA to maintain its capacity to meet the specialized treatment and rehabilitative needs of certain disabled veterans whose needs can be uniquely met by VA. Mental health encompasses two of the designated populations: severely, chronically mentally ill (SMI) veterans and veterans suffering from post-traumatic stress disorder (PTSD). As part of its monitoring of the capacity of SMI programs, VA tracks its capacity for treating homeless mentally ill veterans and veterans with substance abuse disorders.

From FY 1996 to FY 2000, VA has maintained or increased capacity to treat veterans in both the SMI and PTSD categories in terms of patients served. Although overall capacity has increased, there has been a decrease in the number of veterans with substance abuse served in specialized programs by the system as a whole, from 107,074 in FY 1996 to 94,603 in FY 2000. In addition to this apparent loss of treatment capacity for substance abuse, there are also system-wide variations in the capacity to provide specialized treatment services to veterans for the other categories as well as in substance abuse. VHA is currently conducting a detailed review of specialized mental health treatment programs, to determine if the apparent loss of substance abuse treatment capacity is due to counting errors or to actual loss of services. This review will also address the quality of care provided to patients with the target diagnoses (e.g., PTSD, Substance Abuse Disorders) both within specialized VHA treatment programs and outside of these programs. We expect the results of this review to be reported in April 2002.

Program Monitoring

To track its progress and enhance its performance in mental health services, VA has one of the most sophisticated mental health performance monitoring systems in the nation. To monitor the care provided to over 670,000 veterans per year, VA uses measures of performance, quality, satisfaction, cost, and outcomes. The results published annually in VA's National Mental Health Performance Monitoring System report indicate that care is improving. Lengths of inpatient stay are decreasing as are readmission rates and days hospitalized after discharge. Outpatient visits after discharge are increasing, as is continuity of outpatient care. However, development work is continuing to improve the outcome measures for mental health care.

The Seriously Mentally Ill Treatment Research and Evaluation Center (SMITREC) has created a Psychosis Registry, a listing of all veterans hospitalized for a psychotic disorder since 1988. This registry tracks the health care utilization and outcomes of these veterans over time. Over 70 percent of these veterans are still in VA care.

To support its mental health programs and to ensure acquisition of the most current knowledge and dissemination of best practices, VA has undertaken a number of activities. These include development of practice guidelines, educational programs, and partnering with other organizations involved in mental health services.

VHA has also published up-to-date, evidence-based practice guidelines for major depressive disorders, psychoses, PTSD, and substance use disorders. The International Society for Traumatic Stress Studies used VA's PTSD guidelines as a start for their guideline development. Recently, the major depression guidelines have been revised in collaboration with the Department of Defense (FY 2001). A new "stand-alone" Substance Abuse guideline created with DOD is in final stages of development, and the Psychoses Guidelines are also being updated. Automated clinical reminders are in development to assist clinicians in following the practice guidelines and document and track compliance and outcomes.

As was previously announced, VHA will soon begin a new quality improvement program - the National Mental Health Improvement Program (NMHIP). This program will be modeled after a number of VA's well-established, data-driven improvement programs, such as the Continuous Improvement in Cardiac Surgery Program (CICSP), the National Surgical Quality Improvement Program (NSQIP), the VA Diabetes Program, the Pharmacy Benefits Management Program (PBM), and the Spinal Cord Injury/Dysfunction National Program. The NMHIP will use validated data collection, expert analysis, and active intervention by an oversight team to continuously improve the access, outcomes, and function of patients in need of our mental health programs. It will draw upon existing resources in VHA's Health Services Research and Development Service, including existing initiatives in the Quality Enhancement Research Initiative (QUERI), the Northeast Program Evaluation Center (NEPEC), and the Mental Illness Research, Education and Clinical Centers (MIRECCs).

Education

VA has been a leader in the training of health care professionals since the end of World War II. More than 1,300 trainees in psychiatry, psychology, social work, and nursing receive all or part of their clinical education in VA each year. Recently, VA has developed an innovative Psychiatry Resident Primary Care Education program with involvement of over thirty facilities and their affiliates, representing approximately 11 percent of VA's more than 700 psychiatry

residents who receive training in VA facilities each year. In addition, 100 psychology and psychiatry trainees are involved in the highly successful Primary Care Education (PRIME) initiative, which provides mental health training within a primary care setting. This type of activity is changing how VA is training mental health providers and preparing them to meet the primary care needs of mentally ill patients. It serves and improves the mental health of veterans seen in medical and geriatric primary care in both VA and the nation.

VA's educational efforts involve both traditional programs and innovative distance learning techniques. Face-to-face workshops serve a useful purpose for certain kinds of demonstrations (e.g., Prevention and Management of Disturbed Behavior Training) and for networking (e.g., the 2001 "Impact of Mental Health on Medical Illness in the Primary Care Setting and the Aging Veteran" MIRECC/GRECC conference). Distance learning such as satellite broadcasts, Internet training, and teleconferencing, offer accessible, cost-effective training.

Research

VA's National Center for PTSD, established in 1989, is a leader in research on PTSD. Its work spans the neurobiological, psychological and physiological aspects of this disorder. Women's sexual trauma and mental health aspects of disaster management are also addressed by the National Center, which has become an international resource on psychological trauma issues.

VA's Mental Illness Research, Education and Clinical Centers (MIRECCs), which began in October 1997, bring together research, education, and clinical care to provide advanced scientific knowledge on evaluation and treatment of mental illness. The MIRECCs demonstrate that the coordination of research with training health care professionals in an environment that provides care and values results in improved models of clinical services for individuals suffering from mental illness. Furthermore, they generate new knowledge about the causes and treatments of mental disorders. VA currently has eight MIRECCs located across the country, from New England to Southern California.

Mental health currently has three projects in the VHA QUERI program. These include the Substance Abuse QUERI project, associated with the PERC, the Major Depression QUERI associated with the VISN 16 MIRECC, and the Schizophrenia QUERI associated with the VISN 22 MIRECC. The goal of QUERI is to promote the translation of research findings into practice and observe their impact on quality of care.

VHA has established an interagency Memorandum of Agreement (MOA) with the Substance Abuse and Mental Health Services Administration (SAMHSA) and Bureau of Primary Health Care (BPHC) of the Health Resources and Services Administration (HRSA). This MOA will support a cross-cutting initiative

to determine if there are statistically significant differences over a full range of access, clinical, functional, and cost variables between primary care clinics that refer elderly patients to specialty mental health or substance abuse services (MH/SA) outside the primary care setting and those that provide such services in a integrated fashion within the primary care setting. It will also address improving the knowledge base of primary health care providers to recognize MH/SA problems in older adults.

VA is also a partner with the National Institutes of Mental Health and the Department of Defense (DOD) in the National Collaborative Study of Early psychosis and Suicide (NCSEPs). This ongoing project is designed to better understand the clinical and administrative issues of service members who suffer from psychotic disorders during military service, their course of care, and the transition from DOD to VA care in such a manner that continuity of care is maintained.

In FY 2000, VA Research Service funded 397 mental health projects at a cost of $53,884,518. Attachment B, "Research Highlights," provides further information about selected research projects.

Conclusion

VA Mental Health programs provide a comprehensive array of clinical, educational and research activities to serve America's veterans. Our clinical programs are designed to provide the highest quality, most cost-efficient care, across a continuum of care designed to meet the complex and changing needs of our patients. Our educational programs train a significant proportion of our nation's future mental health care providers and ensure that our employees remain on the cutting edge of knowledge about the best clinical practices using traditional as well as innovative educational approaches. Our mental health research programs encompass both basic science as well as the essential translation of scientific findings into clinical practice. The Mental Illness Research Education and Clinical Centers (MIRECCs) are excellent examples of the creative fusion of all three of these tasks. Perhaps the most exciting aspect of VA's mental health programs as we look to the future lies with the National Mental Health Improvement Program (NMHIP). Dedicated to the development of performance and outcome measures and their implementation through research, education, and monitoring, NMHIP will ensure that VA becomes a national leader in the development of evidence-based care for the continuing benefit of our veteran patients. Our mental health care system is strong and effective, but no system is perfect. The NHMIP concept symbolizes VA's ongoing commitment to continuing improvement in the delivery of comprehensive, high quality clinical services to those veterans who need our care.

Mr. Chairman, while we truly believe that VA Mental Health Services remain strong and effective, no system is without problems. It is imperative that

access to mental health services and best clinical practices be provided in a uniform manner across the VA health care system. To the extent that there are unacceptable levels of variance in these parameters, corrections must and will be made. If additional resources are required to provide needed care, whether by virtue of shifts of populations or unmet care needs, then a plan to provide these resources will be developed. We have a lot of questions to answer. For example: Have we gone too far in reducing inpatient care services for these patients who need them or neglected to establish sufficient residential care for patients who need that level of care? Where do we need to place more opiate substitution services? What kind of mental health capacities do even the smallest of CBOCs need, and what is the best and most effective way to provide them? We will answer these and other questions. Although we anticipate that much of the data gathering, practice monitoring, and staff education that will be involved in making these changes will be enhanced by technology, we must assure that clinicians, at the point of service, have adequate and timely access to these technologies so they can actually use them to benefit patients. This may require allocating additional resources within VHA for this purpose. It should be noted, however, that technology issues impact not only mental health care, but all VA health care.

Mr. Chairman, I will now be happy to answer any questions that you or other members of the Subcommittee may have.

Attachment A

Homeless Veterans Treatment and Assistance Programs

VA has developed a wide range of programs and services to address homeless veterans needs. These programs operate in partnership with community-based organizations and service providers and other federally funded programs. With the additional funding made available in the FY 2000 budget we have significantly expanded our homeless programs this year and we have initiated new program evaluation efforts as required by the Millennium Act. While many special programs have been designed to address the special needs of homeless veterans, they do not function in isolation. These programs are integrated with other VA healthcare and benefits services. In addition, VA relies heavily on its federal, state and community based partners to assure a full range of services for homeless veterans.

Secretary Principi recently announced his decision to establish a VA Advisory Council on Homelessness Among Veterans with the mission of providing advice and making recommendations on the nature and scope of programs and services within VA. The advisory committee will consist of not more than 15 members, including a Chairperson. Committee member appointments will be made from knowledgeable VA- and non-VA experts, and will include representatives from community service providers with qualifications and competence to deal effectively with care and treatment services for homeless veterans. The overall makeup of the membership will ensure that perspectives on health, benefits, education and training, and housing for homeless veterans are addressed. Close attention will be given to equitable geographic distribution and to ethnic and gender representation.

The Council is expected to meet two to four times annually. This committee will greatly assist VA in improving the effectiveness of our programs and will allow a strong voice to be heard within the Department from those who work closely with us in providing service to these veterans. We hope to have the Advisory Council members selected and the Council ready to function by the end of July.

Homeless Veteran Population

In 1996 the Federal Interagency Council on the Homeless (ICH) designed and the Census Bureau conducted the "National Survey of Homeless Assistance Providers and Clients." The survey was conducted in the 28 largest metropolitan areas, 24 randomly selected small and medium sized areas and 24 randomly selected groups of rural counties. Approximately 12,000 service providers were contacted and 4,200 consumers of homeless services were interviewed. Survey findings and a technical report written by the Urban Institute were released in December 1999. Survey findings related to homeless veterans were as follows:

- 33 percent of homeless males are veterans;
- 33 percent of homeless veterans report being stationed in a war zone;
- 28 percent of homeless veterans report being exposed to combat;
- 67 percent of homeless veterans reported serving 3 or more years in the military;

- 32 percent of veterans compared to 17 percent of non-veterans reported that their last episode of homelessness lasted more than 13 months; and
- 57 percent of homeless veterans reported using VA health care services at least once.

The Urban Institute issued a press release in February 2000, estimating that between 2.3 million to 3.5 million Americans may have experienced an episode of homelessness during 1996. Extrapolation from this estimate would suggest that between 322,000 – 491,000 veterans might have experienced homelessness during that time period.

Homeless Veterans Served by VA

In FY 2000, staff in VA's Health Care for Homeless Veterans (HCHV) Program had contacts with over 43,000 homeless veterans. Approximately 32,000 homeless veterans were given formal intake assessments to determine their clinical, housing and income status. Data from these intake assessments provides VA with detailed information about the demographic and clinical characteristics of the homeless veterans served by VA. We would like to share some of these findings with you today:

- Approximately 97 percent of homeless veterans contacted by program staff are men and 3 percent are women.
- The mean age of these veterans was 47.
- Approximately 49 percent of the veterans served in the military during the Viet Nam Era while nearly 5 percent served during the Persian Gulf era.
- Approximately 47 percent of these veterans were African Americans and 6 percent were Hispanic.
- 60 percent of homeless veterans report part-time, irregular employment or no employment during the past 3 years; 72 percent of homeless veterans report not having worked at all during the 30 days prior to the intake assessment.
- 68 percent of homeless veterans reported living in emergency shelters or outdoors at the time of the intake assessment.
- 82 percent of homeless veterans were determined by HCHV clinicians to have a serious psychiatric or substance abuse problem -
  - 44 percent had a serious psychiatric problem,
  - 69 percent were dependent on alcohol and/or drugs,
  - 32 percent were dually diagnosed with psychiatric and substance abuse disorders.

Programs and Services Provided by VA

VA is the only federal agency that provides substantial hands-on assistance directly to homeless persons. Although limited to veterans, VA's major homeless programs constitute the largest integrated network of homeless assistance programs in the country, offering a wide array of services and initiatives to help veterans recover from homelessness and live as self-sufficiently and independently as possible.

VA, using its resources or in partnerships with others, has helped to secure more than 10,000 transitional and permanent beds for homeless veterans throughout the nation. These include:

- beds in VA's Domiciliary Care for Homeless Veterans (DCHV) program;
- beds in VA's Compensated Work Therapy/Transitional Residence (CWT/TR) program;
- beds supported through contracts under the Health Care for Homeless Veterans (HCHV) program;
- the VA Supported Housing (VASH) program;
- the joint HUD-VA Supported Housing (HUD-VASH) program; and
- the Homeless Providers Grant and Per Diem Program.

With the new Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans Program and additional grant awards under the Grant and Per Diem Program, VA expects to help community service providers develop approximately 6,000 more transitional beds for homeless veterans over the next 4 years.

In addition to these special initiatives, VA provides a wide range of services to homeless veterans through its mainstream health care and benefit assistance programs. To increase this assistance, VA has initiated outreach efforts to connect more homeless veterans to both mainstream and homeless-specific VA programs and benefits. These programs strive to offer a continuum of services including:

- aggressive outreach to veterans living on streets and in shelters who otherwise would not seek assistance;
- clinical assessment and referral to needed medical treatment for physical and psychiatric disorders including substance abuse;
- long-term sheltered transitional assistance, case management and rehabilitation;
- linkage and referrals for employment assistance, linkage with available income supports; and assistance in obtaining housing.

Homeless Veterans-Specific Programs

VA's FY 2000 budget increased funding for specialized services for homeless veterans by $50 million. Of this increase, $39.6 million was included in the medical care appropriation and the remainder is available to guarantee loans made under the Multifamily Transitional Housing for Homeless Veterans Program. VA expects to spend $142.2 million on specialized programs for homeless veterans this year and is projecting a budget of $148.1 million for these programs in FY 2002. The following provides an overview of the types of programs VA has developed to meet the multiple and varied needs of homeless veterans:

VA's Health Care for Homeless Veterans Program (HCHV) operates at 127 sites where extensive outreach, physical and psychiatric health exams, treatment, referrals, and ongoing case management are provided to homeless veterans with mental health problems, including substance abuse. As appropriate, the HCHV program places homeless veterans needing longer-term treatment into one of its 250 contract community-

based facilities. During the last reporting year, this program assessed more than 32,000 veterans, with 4,800 receiving residential treatment in community-based treatment facilities. The average length of stay in community-based residential care is about 60 days and the average cost per day is approximately $38.00. VA committed $18.8 million to the expansion of the HCHV program in FY 2000 and funds were distributed in mid year. This included the activation of new sites and expansion of existing programs. When all new staff and new programs are fully operational, it is expected that 12,000 additional homeless veterans will be treated. Approximately one fourth of these veterans will be provided contract residential treatment. In FY 2000, VHA also committed an additional $3 million to establish 11 programs that are dedicated to homeless women veterans. These programs are expected to serve 1,500 homeless women veterans per year, when they are fully operational.

VA's Domiciliary Care for Homeless Veterans (DCHV) Program provides medical care and rehabilitation in a residential setting on VA medical center grounds to eligible ambulatory veterans disabled by medical or psychiatric disorders, injury or age and who do not need hospitalization or nursing home care. There are 1,781 operational beds available through the program at 35 VA medical centers in 26 states. The program provided residential treatment to some 5,500 homeless veterans in FY 2000. The domiciliaries conduct outreach and referral; admission screening and assessment; medical and psychiatric evaluation; treatment, vocational counseling and rehabilitation; and post-discharge community support.

Special Outreach and Benefits Assistance is provided through funding from VA's Veterans Health Administration to support 10 veterans benefits counselors from the Veterans Benefits Administration (VBA) as members of VA's Health Care for Homeless Veterans Program and DCHV programs.

Acquired Property Sales for Homeless Providers Program makes available properties VA obtains through foreclosures on VA-insured mortgages. These properties are offered for sale to homeless provider organizations at a discount of 20 to 50 percent. To date, 173 properties have been sold, and 9 properties are currently leased to nonprofit organizations to provide housing for the homeless.

Drop-In Centers provide homeless veterans who sleep in shelters or on the streets at night with safe, daytime environments. Eleven centers offer therapeutic activities and programs to improve daily living skills, meals, and a place to shower and wash clothes. At these VA-run centers, veterans also participate in other VA programs that provide more extensive assistance, including a variety of therapeutic and rehabilitative activities. Drop-In Center staff also coordinates with other programs to provide veterans with long-term care services.

Compensated Work Therapy (CWT) and CWT/Transitional Residence Programs have had dramatic increases in activity during the past few years. Through its CWT/TR program, VA offers structured therapeutic work opportunities and supervised therapeutic housing for at risk and homeless veterans with physical, psychiatric and substance abuse

disorders. VA contracts with private industry and the public sector for work to be done by these veterans, who learn new job skills, re-learn successful work habits and regain a sense of self-esteem and self-worth. The veterans are paid for their work and, in turn, make a monthly payment toward maintenance and upkeep of the residence.

The CWT/TR program includes 53 community-based group home transitional residences with more than 400 beds. Ten program sites with 18 residences exclusively serve homeless veterans. The average length of stay is approximately six months. There currently are more than 110 individual CWT operations connected to VA medical centers nationwide. Nearly 14,000 veterans participated in the programs in FY 2000. CWT programs developed contracts with companies and agencies of government valued at a national total of $43.2 million. Increased competitive therapeutic work opportunities are occurring each year. At discharge from the CWT/TR program 42 percent of the veterans were placed in competitive employment and 20 percent were in training programs. VA has committed $2.3 million to the activation of new CWT programs and other therapeutic work initiatives for homeless veterans. When these programs are fully operational, it is expected that they will be able to serve an additional 1,600 veterans annually.

Intradepartmental programs also support the CWT programs for homeless veterans. VA's National Cemetery Administration and Veterans Health Administration have formed partnerships at 20 national cemeteries, where more than 120 formerly homeless veterans from the CWT program have received therapeutic work opportunities while providing VA cemeteries with a supplemental work force.

HUD-VA Supported Housing (HUD-VASH) Program, a joint program with the Department of Housing and Urban Development (HUD), provides permanent housing and ongoing treatment services to the harder-to-serve homeless mentally ill veterans and those suffering from substance abuse disorders. HUD's Section 8 Voucher Program continues to renew 1,780 vouchers for $44.5 million, designated over a ten year period, for homeless chronically mentally ill veterans, and VA staff at 35 sites provide outreach, clinical care and case management services. Rigorous evaluation of this program indicates that this approach significantly reduces days of homelessness for veterans who suffer from serious mental illness and substance abuse disorders.

VA's Supported Housing Program is like the HUD-VASH program in that VA staff provides therapeutic support and assistance to help homeless veterans secure low-cost, long-term transitional or permanent housing and provide ongoing clinical case management services to help them remain in housing. It differs from HUD-VASH in that dedicated Section 8 housing vouchers are not available to homeless veterans in the program. As part of VA's clinical case management services, staff work with private landlords, public housing authorities and nonprofit organizations to find therapeutically appropriate housing arrangements. Veterans service organizations have been instrumental in helping VA establish these housing alternatives nationwide. In 2000, VA staff at 26 Supported Housing Program sites helped 1,800 homeless veterans find transitional or permanent housing in the community.

Comprehensive Homeless Centers place a variety of VA's homeless programs into an integrated organizational framework to promote coordination of VA resources and non-VA homeless programs. VA currently has seven comprehensive homeless centers connected to medical centers in Brooklyn, Cleveland, Dallas, Little Rock, Pittsburgh, San Francisco, and Los Angeles.

Stand Downs are 1-3 day safe havens for homeless veterans that provide a variety of services to veterans and opportunity for VA and community-based homeless providers to reach more homeless veterans. Stand downs provide homeless veterans a temporary place of safety and security where they can obtain food, shelter, clothing and a range of community and VA-specific assistance. In many locations, VA provides health screenings, referral and access to long-term treatment, benefits counseling, ID cards and linkage with other programs to meet their immediate needs. VA participated in 179 stand downs run by local coalitions in various cities during CY 2000. Surveys showed that more than 35,000 veterans and family members attended these events. More than 20,000 volunteers contributed to this effort.

VA Excess Property for Homeless Veterans Initiative provides for the distribution of federal excess personal property, such as clothing, footwear, socks, sleeping bags, blankets and other items to homeless veterans through VA domiciliaries and other outreach activities. In less than seven years, this initiative has been responsible for the distribution of more than $90 million worth of materiel and currently has more than $6 million in inventory. A CWT program providing a therapeutic work experience for formerly homeless veterans has been established at the VA Medical Center in Lyons campus of the VA New Jersey Health Care System, to receive, warehouse and ship these goods to VA homeless programs across the country.

The Homeless Providers Grant and Per Diem Program is a dynamic component of VA's homeless-specific programs. It provides grants and per diem payments to assist public and nonprofit organizations to establish and operate new supportive housing and service centers for homeless veterans. Grant funds may also be used to assist organizations in purchasing vans to conduct outreach or provide transportation for homeless veterans. Since the first year of funding in FY 94, VA has awarded 243 grants to nonprofit organizations, units of state or local governments and Native American tribes in 44 states and the District of Columbia.

Total VA funding for grants has exceeded $53 million. When these projects are completed, approximately 5,000 new community-based beds will be available for homeless veterans. Nearly 3,500 unique homeless veterans were cared for through these programs in FY 2000 and their care was supported by VA per diem payments to service providers.

VA announced a new round of grants in April 2001, and has committed $10 million for the eighth round of funding.

Project CHALENG (Community Homelessness Assessment, Local Education and Networking Groups) for Veterans is a nationwide initiative. VA medical center and regional office directors work with other federal, state and local agencies and nonprofit organizations. They assess the needs of homeless veterans, develop action plans to meet identified needs, and develop directories that contain local community resources to be used by homeless veterans.

More than 10,000 representatives from non-VA organizations have participated in Project CHALENG initiatives, which include holding conferences at VA medical centers to raise awareness of the needs of homeless veterans, creating new partnerships in the fight against homelessness and developing new strategies for future action.

Loan Guarantee for Multifamily Transitional Housing for Homeless Veterans is currently being implemented as authorized by P. L. 105-368. This program will allow VA to guarantee loans made by lenders to help non-VA organizations develop transitional housing for homeless veterans. VA awarded a contract to Birch and Davis Associates, Inc., and their subcontractors, Century Housing Corporation, to assist with the development of this pilot program. VA plans to guarantee 5 loans in the next two years, with a total of 15 loans guaranteed over the next 4 years. It is hoped that up to 5,000 new transitional beds for homeless veterans will be created through this program.

Mainstream VA Programs Assisting Homeless Veterans

The Veterans Benefits Administration (VBA) administers a number of compensation and pension programs: disability compensation, dependency and indemnity compensation, death compensation, death pension and disability pension. Vocational rehabilitation and counseling assist veterans with service-connected disabilities to achieve independence in daily living and to the extent possible become employable and maintain employment. In the Fiduciary or Guardianship Program, the benefits of veterans who are determined to be incapable of managing their funds are managed by fiduciary.

VBA regional offices at 57 locations have designated staffs who serve as coordinators and points of contact for homeless veterans through outreach activities. In FY 2000, VBA staff assisted over 21,000 homeless veterans and had contacts with over 6,500 community organizations.

The Readjustment Counseling Service's Vet Centers have homeless coordinators who provide outreach, psychological counseling, supportive social services and referrals to other VA and community programs. Each year approximately 140,000 veterans make more than 800,000 visits to VA's 206 Vet Centers. During the winter months, approximately 10 percent of Vet Center clients report being homeless.

A substantial number of homeless veterans are served by VHA's general inpatient and outpatient mental health programs. For the past six years VA 's at its Northeast Program Evaluation Center (NEPEC), has conducted an End-of-Year Survey of hospitalized homeless veterans in VA health care facilities. On September 30, 2000, 17,023 veterans

were being treated in acute medical surgical and psychiatric beds, acute substance abuse beds, psychosocial residential rehabilitation and treatment program (PRRTP) beds and domiciliary beds. A total of 4,774 veterans (28 percent) were homeless at admission. Nearly 20 percent were living on the streets or in shelters before admission and 8 percent had no residence and were temporarily residing with family or friends.

A total of 4,148 veterans were being treated in VA mental health beds. Approximately one-third of these veterans were homeless at admission and another 6 percent, while not homeless when admitted, were at high risk for homelessness if discharged on the day of the survey. The following is a break out of the type of mental health bed section veterans occupied:

- 23.7 percent of 2,692 veterans in Acute Psychiatry beds were homeless at admission.
- 41.2 percent of 226 veterans in Acute Substance Abuse beds were homeless at admission.
- 47.3 percent of 1,230 veterans in PRRTP beds were homeless at admission.

VA has also collected information on homeless veterans seen in outpatient mental health programs. In FY 2000, approximately 104,000 veterans were identified as homeless on VA encounter forms. About 50,000 homeless veterans were treated in VA's specialized programs for homeless veterans; the remainder were treated exclusively in general mental health outpatient programs.

Homeless Veterans Program Monitoring and Evaluation

VA has the Nation's most extensive and long-standing program of monitoring and evaluating data concerning homeless individuals and the programs that serve them. In 1987, we initiated a three-fold evaluation strategy for what was then an unprecedented VA community collaborative program – the original HCMI veterans program.

Under this evaluation plan: (1) all veterans evaluated by the program were systematically assessed to assure that program resources were directed to the intended target population (now almost 30,000 under-served homeless veterans per year); (2) housing, employment, and clinical outcomes were documented for all veterans admitted to community-based residential treatment, the most expensive component of the program; and (3) a detailed outcome study documented housing and employment outcomes after program termination was initiated.

The VA study showed 30 percent to 40 percent improvement in psychiatric and substance abuse outcomes, employment rates doubled, and 64 percent exited from homelessness at the time of program completion. When these veterans were re-interviewed 7.2 months after program completion, they showed even GREATER improvement. A similar effort was mounted for the Domiciliary Care for Homeless Veterans program with similar long-term post-treatment results. These data have been published by NEPEC in leading medical journals.

After establishing the effectiveness of these standard programs with extensive follow-up studies, VA developed several enhancements to the core program in several areas. These areas include compensated work therapy (CWT), outreach to assure access to Social Security Administration (SSA) benefits, and a collaborative program with HUD that joins VA case management with HUD section 8 housing vouchers. Outcome studies demonstrated the long-term effectiveness of the CWT/TR program at reducing substance abuse and increasing employment. The Joint VA-SSA outreach effort conducted in New York City, Brooklyn, Dallas, and Los Angeles almost doubled the percentage of SSI awards made to veterans from 7.19 percent to 12.4 percent of the veterans contacted during the outreach effort.

An outcome study showed that, compared to a control group that did not receive benefits, SSA beneficiaries had improved housing and overall satisfaction with life as a result of their receipt of benefits. The outcome of the study also showed no increase in substance abuse, with the exception of tobacco use for SSA recipients. A follow-up study of the HUD-VA supported housing program shows that the benefits of this program, especially housing stability were sustained three years after program entry. This is one of the longest follow-up studies conducted on any homeless population anywhere.

All of our homeless initiatives and programs receive rigorous evaluation. VA uses a consistent set of clinical measures for the Homeless Providers Grant and Per Diem Program as with all other VA homeless veterans programs to assure that valid comparisons can be made. VA performance measures provide consistency in evaluating homeless programs.

In FY 2000, VA expanded its evaluation of homeless veterans programs to more thoroughly determine the effectiveness of these programs. Sec. 904 of the Veterans Millennium Health Care and Benefits Act (P. L. 106-117) requires VA to conduct evaluations of its homeless veterans programs. This is to include measures to show whether veterans for whom housing or employment is secured through one or more of VA's programs continue to be housed or employed after six months. The General Accounting Office (GAO) made a similar recommendation in its April 1999 Report entitled, Homeless Veterans: VA Expands Partnerships, but Homeless Program Effectiveness is Unclear. GAO's single recommendation to VA was to conduct ... "a series of program evaluation studies to clarify the effectiveness of VA's core homeless programs and provide information about how to improve those programs."

Through these ongoing and new program evaluation efforts, we expect to increase our knowledge about the effectiveness of services that are provided to assist homeless veterans. Information will be used to modify and improve our programs for homeless veterans.

Conclusion

VA health care services and other benefits programs form the core elements for the wide range of medical, work therapy, rehabilitation, transitional housing and benefits programs

that VA offers to homeless veterans. With assistance from community-based service providers and veterans service organizations, we are bringing thousands of veterans off the streets and into a continuum of care that offers them the health care and support services they need to resolve their health, housing and vocational problems.

The Department of Veterans Affairs is proud of its past contributions to homeless programs and is committed to enhancing the Nation's understanding of risk factors which contribute to this problem, to work towards reduction of homelessness among veterans and to providing high quality programs for homeless veterans.

Attachment B

Mental Health Research Highlights

Mental Health

- A study targeted to assess two interventions for women veterans with PTSD who have been exposed to a war-related or non-war related traumatic event is being initiated collaboratively between the VA and DoD in 2001. The study will compare an intensive (prolonged) type of group therapy to a standard patient-focused therapy on symptoms of PTSD.

- An ongoing CSP study is using DNA technology to search for genes that may be linked to the development of schizophrenia.

- Two types of therapy for war-related PTSD are being compared in a group treatment setting. One type of therapy (Trauma-Focused) involves a more intensive intervention in which traumatic event are recalled versus standard Group Therapy along with intensive close-monitoring through case management.

- A high-intensity ambulatory care treatment program versus standard usual care for patient with Bipolar Disorder (manic depression) is being evaluated to assess overall reduction in symptoms and treatment costs.

- Two approved treatments (haleperidol and a newer and more expensive drug olanzapine) are being compared to assess the clinical efficacy and cost-effectiveness for schizophrenia.

Substance Abuse

- VA/National Institute on Drug Abuse (NIDA) Collaboration

  The VA/NIDA clinical trials collaboration is an agreement between the two agencies to support the development and evaluation of new pharmaceuticals to treat addictive disorders and certain mental illnesses (an area of high priority by the US Congress). This represents areas of research, which are traditionally, underrepresented by the pharmaceutical industry.

- A promising FDA-approved drug (Naltrexone) is being studied to determine the effectiveness in decreasing drinking among alcoholics. All patients in the study will receive standard 12-step therapy with some receiving naltroxone as well.

- Several studies are being conducted to assess the effectiveness of novel treatments for cocaine and opiate dependency and to mediate the effects of opiate withdrawal.

- Polyunsaturated lecithin is being studied to assess the effect on reducing the progression of disease among patients with alcoholic cirrhosis of the liver.

Homelessness

- A multi-year client-level evaluation of the Access to Community Care and Effective Services (ACCESS) is being conducted at 18 sites to determine the effect of community mental health systems integration on housing stability for severely mentally ill veterans.

- The identification of more efficient and cost effective treatment interventions for homeless chronically mentally ill veterans is the focus of a multi-site study that is evaluating the effects of HUD Section 8 housing vouchers and community-based clinical case management.

Written Statement of Paul Errera, M.D. for oversight hearing, June 20, 2001, Subcommittee on Health, Committee on Veteran's Affairs, U.S. House of Representatives

Mr. Chairman, Members of the Committee, I first appeared before this body sixteen years ago in my capacity as the physician who headed all VA mental health programs – a physician who was considered, at times, by some, too outspoken in advocating for veterans with mental illness. At that time, newly arrived in Washington with big ideas, and with even bigger dreams of realizing them, I was bold enough to ask for something very special from you. I did not ask for money. I did not ask for staff. I asked for your attention and for your compassion. I explained that I came to speak to you on behalf of veterans who were not very good at speaking for themselves because of difficulties they had with their concentration, difficulties they had with overwhelming emotions, and in many cases difficulties they had with nightmarish memories of war. During the years following my first appearance you paid attention indeed. Faced with the disaster of homeless veterans on the streets of America, you spurred the development of the Homeless Chronically Mentally Ill Veterans program in 1987 and the Domiciliary Care for Homeless veterans in 1988. You stimulated our involvement with community providers with Project Challenge and the Homeless Veterans Providers Grant and Per Diem program. You were concerned about enhancing clinical care for Vietnam veterans with PTSD and you funded the PTSD clinical teams program and many others. You provided expansion funds to treat addictive disorders in association with the war on drugs.

I would especially like to acknowledge and applaud the Committee's tremendous achievement this year in successfully advocating for increased funding for VA generally, and mental health services in particular. And yet, we in mental health suffered significant losses. In the early 1970's, shortly after Congress funded its first wave of VA substance abuse treatment programs, GAO conducted an evaluation of those programs and found that in many cases the funds had been diverted to other purposes. The needs of the mentally ill, it was explained by local experts, really were not so great and there were other opportunities in medicine. These developments were not surprising. The mentally ill have long been subject to stigma and bias and remain among the lowest priorities of the medical establishment. It is easy to say their needs are not great, or even if they were great, that psychiatric treatment is ineffective. I know theses arguments well. They were wrong then and they are wrong now. In the early years, the funds you supplied were fenced – they could only be spent on their intended purpose. That fully and effectively prevented the kinds of problems uncovered by the GAO in earlier years.

But your actions in promoting these programs were not popular with some in VA. Local leaders did not like being told what programs to fund, and in the early 1990's the protection of these funds by fencing ended. In some places, but not all, they continued to be valued, but without protections some programs began to erode.

In 1995 VA began a period of major change, much, but not all of it, for the better. You may remember that after the defeat of the Clinton health plan, managed care began to transform American medicine with its focus on maximizing efficiency by limiting the use of inpatient care and emphasizing primary, general medical care rather than specialty

care. The VA in those days of tumult seemed eager to "keep up with the Joneses" and began importing many managed care slogans and techniques – utilization review, emphasis on primary care, reduction of inpatient services. VA also developed a decentralized system of local control. The advantage of this approach was that local managers were attentive to unique local needs. But it also meant that national priorities, like those you had supported, lost their major base of support.

Somewhat unfortunately, the system VA began to imitate was, in some ways, a system well designed for healthy employees of large corporations, not for people with chronic illnesses, and it appeared in those dark days of 1995 that VA might abandon its unique mission of caring for the poor and disabled among veterans – the very people whom managed care systematically, and I must acknowledge, skillfully, avoided. You may remember those ads offering free health club memberships if you signed up with health plan X. It turned out those ads were not designed to keep members of health plan x healthy, but rather to attract healthy members whose costs would be low. The message of capitated funding was "see more veterans with lower service needs." In VA our credo was 30% lower costs, 20% more patients, 10% of funds from external sources. This credo said in its unmistakable shorthand – turn you backs on those who need you most.

You came to our rescue. You wrote a law in 1996, which required VA to maintain its capacity to care for disabled veterans with severe mental illness, with spinal cord injuries, with amputations, and veterans who were blind. Your law required VA to provide specialized services to these veterans to meet their unique needs for rehabilitation.

You let there be no doubt that VA was not to imitate the ways of managed care, but to renew or at least maintain its capacity to care for those veterans with the least opportunities in other health care systems.

You left it to VA to define "capacity", and although this was a major challenge, VA came up with a definition of this population and 2 simple measures of capacity: the number of patients treated, and the dollars spent on those patients.

What do the numbers say? VA's FY 1999 report on capacity showed an 8% decline in expenditures for the severely mentally ill (without adjusting for inflation) and a 36% decrease in the funding of substance abuse patients -- while the VA budget increased overall by 10%. Other groups covered by this law, in contrast, saw funding increases: spinal cord dysfunction (10% increase), blindness (20% increase), traumatic brain injury (74% increase). In six VISNs, expenditures for the seriously mentally ill declined by 20% or more.

VHA says it has reduced its emphasis on inpatient care for the purpose of strengthening its delivery of outpatient care. Well, the first part is true. Between 1995 and 2000 VA closed 64% of its inpatient mental health beds, which included closing 90% of its substance abuse inpatient beds. But what happened on the outpatient side? From 1994 to 1997, there was an increase every year in the number of veterans who received specialized outpatient substance abuse services from VA. That was good. But then in 1998, just when the inpatient substance abuse beds were closing most rapidly, the number of outpatients receiving specialized substance abuse services began to drop and the drop is accelerating, from 2% from FY 98 to 99, to 7% from 99 to 2000. In some VISNs the changes are even more shocking than this. We have heard this before when it comes to

the mentally ill. We will reduce A but don't worry we will substitute B. And then B doesn't happen. There is one word for this behavior. Wrong. Plain wrong.

The Under Secretary of Health's oversight Special Committee repeatedly alerted VA that it was not complying with the law, but no meaningful action has been taken to correct this profoundly inequitable treatment of veterans with severe mental illness. In fact, the usual excuses have been called upon – we are being more efficient, there is less need for these services, and anyway the services are not very effective, and these veterans just want a place to stay and compensation. Left to its own devices VHA has rolled back your commitment to veterans with mental illness.

Why didn't the capacity law provide an adequate check on this tendency? The sad fact is that VA officials have historically paid far more attention to Appropriations Committee report language (which does not have the force of law) than to statutory requirements initiated by the Veterans' Affairs Committee. To be entirely candid, I believe the prevailing view at VA has been that "the Authorizing Committees can only scold us so we can afford to pay them lip service". The Appropriations Committee on the other hand has demonstrated that it can discipline the Department by reducing its funding, so VA officials do what that Committee directs, even though the direction is simply expressed in a report. VA officials have clearly looked for ways to circumvent both the language and the spirit of the statutory requirement to maintain VA's specialized capacity and programs to serve veterans with mental illness and substance abuse disorders. In hindsight, those who were disinclined to honor this statutory requirement have found "wiggle room" in the statute and wiggled their way around its clear intent.

So what should we do next? I urge this Committee to consider this hearing as a first step only. The needs of veterans with mental illness are too important to permit VA officials to leave the hearing table this morning, go back to their desks, and put this issue on the back burner for a few more years. Because I can assure you that will happen if you simply assume that this hearing alone will prompt real change. I urge you to put VA officials on notice that there will be a follow-up hearing not later than September by which time you will expect VA officials to produce real and demonstrable changes – in policy and practice – in every network to effectuate the intent of the capacity law.

Recognizing that there has been no effective check on the manner in which network directors or the Under Secretary for Health implemented (or failed to implement) the capacity law, I urge you to direct the VA's Inspector General to take on that role. To my knowledge, that office has failed to provide effective oversight – as it should have – in ensuring that the Department is meeting its obligations under the capacity law. There is a clear need for an internal "policeman" to hold those responsible for management of the VA health care system accountable for the fundamental obligations this law has imposed. Given the record of noncompliance, in my view, and I hope yours, I urge you to direct the IG to audit compliance with this law on a regular, ongoing basis.

I also urge the Committee to develop and move legislation to close what in hindsight appear to be major loopholes in the "capacity" law. For example, the capacity law directs the Department as a whole to maintain programs and capacity. However, individual network directors, who often make critical decisions on resource and program allocation within their geographic service area, have felt free to ignore that requirement. In doing so, they maintain that the statute does not bar individual networks from reducing program capacity. Mr. Chairman, with your indulgence, I have taken the liberty of

offering several suggestions for amending the capacity law and provided those recommendations as an attachment to my testimony. I ask that the document be made a part of the record and, I hope the Committee will give serious consideration to acting on these recommendations.

What about the Under Secretary for Health's Special Committee for the Severely Mentally Ill? My feeling is that the office of the Under Secretary for Health is not an effective level to address this issue because it more strongly embodies the values and priorities of the medical providers, rather than the values and needs of the veteran consumers. An effective action would be to move the committee to a higher level – the level of the Secretary – an Advisory Committee on the Care of Veterans with Severe Mental Illness that would clearly establish the importance of specialized care for these patients.

"Why?" you will say, "has all this not been mentioned loudly before?" The answer is that there are some things one can say a month before one retires; that one cannot say when one is a loyal member of a team. I love the VA and I respect its leaders. But, the bias against people with mental illness is insidious, subtle, and pervasive. Sadly it comes naturally to many people facing budget cuts to reduce mental health programs. It is an implicit standard operating procedure that I have seen active in VA quite consistently during the last 35 years – and it needs to be checked.

As those of you whom I have known over the years may have noticed, my hands shake more now, my gait is less steady, and my voice is not as firm as it was in past years. I have Parkinson's disease, a disease of brain metabolism that is probably not that different from those of the patients to whom I have devoted my professional life. Yet, while I confess I do not have hard data on this, my hunch is that funding for treatment of Parkinson's disease does not face the problems that I have described for the treatment of mental illness.

I will be retiring from VA service next month. My parting perspective is that try as we may, fundamental changes in attitudes towards severe mental illness have changed less than they need to. You have made a huge difference for these veterans. Please continue. VA is a national treasure. Preserve it well.

Attachment:

ATTACHMENT:

Recommended Changes to the VA "Capacity" Law: 38 U.S. Code Section 1706(b)

(suggested changes reflected in bold, underscored language)

(b)(1) In managing the provision of hospital care and medical services under such section, the Secretary shall ensure that the Department ***(and each geographic service area of the Veterans Health Administration)*** maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of those veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that overall capacity of the Department ***(and each geographic service area of the Veterans Health Administration)*** to provide those services, as of October 9, 1996. ***The capacity of the Department (and each geographic service area of the Veterans Health Administration) to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities shall be measured by the dollars – adjusted for inflation - expended for care of such veterans in dedicated programs which provide such specialized treatment and rehabilitative services through specialized staff.*** The Secretary shall carry out this paragraph in consultation with the Advisory Committee on Prosthetics and Special Disabilities Programs and the Committee on Care of Severely Chronically Mentally Ill Veterans.

(2)***

(3) (A) To ensure compliance with paragraph (1) –

(i) ***The Inspector General of the Department shall carry out an annual Audit to ensure that the requirements of this subsection are being carried out.***

(ii) The Under Secretary for Health shall prescribe objective standards of job performance....

(B)***

(C)***

Summary of Proposed Changes in the "Capacity" Law

The proposed changes to the "capacity" law are intended to close loopholes and help ensure compliance with the intent of that law. The suggested changes, accordingly, would:

- clarify that the obligation to maintain capacity, and thereby to provide access not simply to a clinician (whose training and experience may not have equipped him or her to diagnose and treat appropriately the unique disabilities

covered by this law) but to appropriate, specialized services, is an obligation which must be met in each of the VA's 22 networks;

- ensure that the intent of the law is not frustrated by an administrative substitution of "outcome" or other measures for objective measures to determine that VA's capacity to provide needed, specialized services is not eroded or abandoned; and
- ensure, in the face of very weak record of compliance with this law on the part of the Veterans Health Administration, that there is in place a strong, independent mechanism to audit and enforce compliance with the requirements of the law.

June 11, 2001

U.S House of Representatives
Committee on Veterans' Affairs
One Hundred Seventh Congress
335 Cannon House Office Building
Washington, DC 20515

HOUSE VETERANS' AFFAIRS COMMITTEE – JUNE 20, 2001
PROPOSED WRITTEN STATEMENT

Bruce J. Rounsaville, M.D.

Mr Chairman, Members of the Committee, I am Dr Bruce Rounsaville, a Professor of Psychiatry at Yale University and have been involved with treating veterans having post traumatic stress disorder or PTSD for over 20 years. At this hearing, I will review a small portion of extensive neurobiological work showing that veterans with post traumatic stress disorder have a profound brain disorder. Because this understanding has improved the treatment of PTSD and holds great promise for the future, it is most important to keep these mental disorders high on the agenda of biomedical research and to keep the veterans afflicted with these disorders in the mainstream of our treatment services. Less than 12% of the VA research budget has been allocated to mental and addictive disorders, yet over 25% of veterans suffer from these disorders. These types of imbalances need to be actively addressed by VA leadership.

In spite of limited research resources, over the last 25 years we have had tremendous success in understanding stress induced mental illness among our veterans. These mental illnesses are brain disorders in every sense of our biomedical vocabulary, and I will show you the evidence for altered brain structure and function due to these illnesses. However, my presentation is profoundly colored by my experience providing care to these veterans over the last 20 years and watching them be denied the care they deserve because of disproportionate budget cuts for mental illness treatment in the VA.

Veterans returning from Vietnam included a disproportionate number who continued to re-experience the traumatic events in which they had participated while in combat. These re-experienced events or flashbacks might occur several times in a month, a week or even a day and were terrifying and completely disrupted the veteran's transition back to normal civilian life. These veterans could not sleep, were easily startled and had profound memory and concentration problems. They also became socially isolated and irritable with violent outbursts in some cases. Their flashbacks were so real that they sometimes acted as if they were back in combat again.

In their attempts to cope with these disruptions and personal pain, many turned to a common form of self-medication using alcohol, sedatives prescribed by their local doctors, and sometimes illicit drugs. All of these self medication attempts were temporarily successful in attenuating their distress, but ultimately failed and worsened their distress due to withdrawal symptoms from these medications or drugs. These attempts at self-medication poisoned not only their nervous systems, but also the public attitude towards these veterans. They became viewed as drug addicts and sociopaths. This perception was and remains incorrect. These veterans suffered from significant brain damage due to their exposure to repeated trauma and the resulting stress response made by their own bodies in an attempt to respond to these traumas.

The body's programmed response to trauma exposure is to release large amounts of stress related hormones such as cortisol and epinephrine. These hormones help the body to mobilize for either fight or flight, when a crisis occurs. However, flashbacks are not real crises demanding such a dramatic response, and their continual repetition can be seriously damaging to the brain. Repeated activation of these stress response systems has been studied carefully in animals and found to damage a critical brain area for memory formation and retrieval – the hippocampus. A similar kind of brain damage is consistent with findings from our most advanced brain imaging in humans. This critical brain area is significantly smaller in veterans with post traumatic stress disorder compared to this brain area in normals. This damage compounds the damage arising from self-medication so that even when you adjust for the effects of alcoholism or drug abuse, one can still clearly see the impact attributable to PTSD. However, the self medication by these veterans was not without consequences.

We have accumulated substantial evidence that drug addiction is a brain disease associated with brain cell damage. Many of these veterans suffered this additional brain damage. While their self medication had been labeled "willful misconduct" in the past, it is not willful nor misconduct in these very ill men and women. The substance abuse was in many cases a desperate attempt to control intrusive and profoundly unpleasant thoughts that developed the same reality that hallucinations and delusions have in schizophrenic patients. These veterans did learn during their military experiences in Vietnam, Korea and World War II that alcohol, marijuana and other substances blunted their responses to the traumas that they encountered regularly. Substance abuse became a learned coping strategy that carried over into their civilian after-life; it was not a way to seek sensations and a "high", but a way to blunt overwhelming terror, anxiety, isolation and depression that followed them after their wars. Unfortunately, they had found a cure that was itself a disease and that amplified the brain destruction set in motion by the post traumatic stress disorder.

Why did these veterans not seek appropriate medical help at the VA? The answer is an unfortunate commentary on the disorder of post traumatic stress and its symptoms, as well as on the slow evolution of compassion within the bureaucracy of the VA. Post traumatic stress disorder is associated with fear that others will harm you, as you maintain a constant vigilance for "the enemy" whom you are re-experiencing. This paranoia extended to the VA healthcare system during the Vietnam conflict and the early years after Vietnam ended. This core symptom continues even now with young veterans from the Persian Gulf and the much older veterans from Korea and World War II, who now are beginning to appear at the VA with substantial symptoms of post traumatic stress disorder. The second factor contributing to abortive and ineffective self-medication was the reception veterans got from the VA system, when they presented requests for disability based on their disabling psychiatric symptoms. The VA response was discouraging and effective treatments were not yet available 25 years ago. Because this disorder was not among the diagnoses officially recognized by American Psychiatry until 1980, mis-diagnosis was a serious issue and veterans were all too often accused of "malingering" or seeking undeserved compensation. Misunderstood and scorned, they turned away from traditional providers. Veterans Outreach Centers were a positive response in the early 1980's, but they came only after many veterans with PTSD had already developed serious complications of their primary PTSD, such as substance abuse and depression. Fortunately, treatments have improved for our veterans, as we have come to understand the brain damage that these traumatic stress disorders cause.

Substance abuse can damage other brain areas that complicate the cognitive and memory problems of veterans with post traumatic stress disorder. For example, alcohol damages other brain areas critical for memory, and stimulants such as amphetamine damage the same brain pathways that lead to Parkinson's disease. Parkinson's disease is a complex disorder that prominently produces shaking and difficult, slowed movement, but it also compromises the ability to concentrate and can induce depression. Many veterans with traumatic stress disorders took stimulants to relieve the depression and social isolation that they experienced and that got worse with alcohol and the sedatives that were prescribed by their local doctors. Unfortunately, these stimulants have also taken a toll on their brain. Brain images using PET scanning of that part of the brain primarily involved in Parkinson's disease has shown that stimulant abusers' brain images are quite abnormal and very similar to those of much older patients with Parkinson's disease. This comparison is most concerning. Clearly, these stimulants have produced a brain disease that looks strikingly like the naturally occurring disease of Parkinsonism, but in much younger men. However, the situation for our veterans who have so unfortunately self-medicated themselves into an additional brain disease is perhaps more hopeful than the situation for Parkinsonian patients, because this drug induced state can be arrested, unlike the spontaneous disease. Overall, this brain disease from self-medication is quite real and sad for these veterans, but we can help them.

The reversibility of the brain damage from post traumatic stress disorder is also more hopeful than for spontaneous Parkinson's disease. For both disorders, the nerve cells appear to have degenerated, but they may not have died in PTSD and may grow back with appropriate medical interventions. Hope is on the horizon for Parkinson's disease and for PTSD with our understanding of stem cells derived from the patient's own bone marrow, and their transplantation back into that same patient's brain, as well as from nerve growth factors that can lead to sprouting of new nerve cells. A most exciting recent discovery is that anti-depressant medications, which have been a mainstay of treating veterans with traumatic stress disorder, as well as having some role in Parkinson's disease, appear to stimulate these nerve growth factors. Thus, in the younger veterans with traumatic stress disorders, long term medication treatment

with these medications and newer medications being developed may indeed provide the type of brain rehabilitation that our medical colleagues working with paralyzed veterans have been pursuing.

I want most to leave you with a message of optimism, promise and enthusiasm for treating veterans with the dual brain diseases of traumatic stress disorder and drug-induced brain damage. We have come a long way in providing rehabilitation for these veterans and helping them live with their disability. Furthermore, now that we have more clearly identified their brain disorder, we are on the research frontier of reversing it. The investment in these veterans and in research to develop definitive neurobiological treatments for them could not have a greater yield. We not only owe it to them for their sacrifice and dignity, but to our community in order to return them to the productive lives that can be salvaged from appropriate recognition and treatment of their brain disorder.

I urge you to press the VA to make appropriate levels and proportions of research funding available for these mental disorders, and to legislate the specificity of so-called "fenced funding" for these treatment programs, because without this specific and very openly accountable process, these veterans are not getting the equitable treatment that your laws have mandated.

Thank you.

US House of Representatives
Committee on Veterans' Affairs
Subcommittee on Health

Testimony of Dennis P. Culhane, Ph.D. and Stephen Metraux, MA, University of Pennsylvania
June 20, 2001

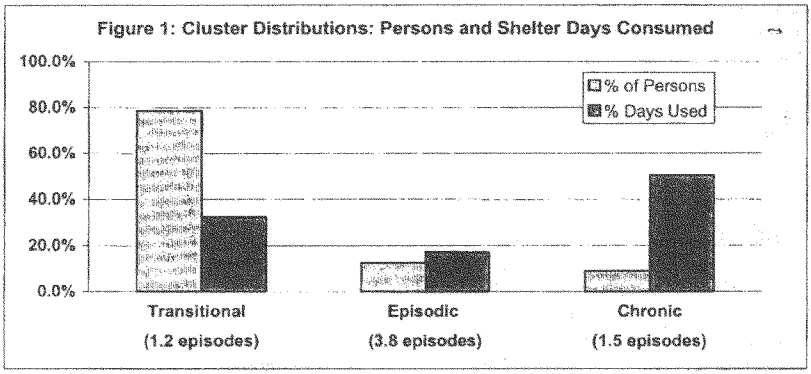
Chairman Smith and members of the committee, thank you for this opportunity to speak before you today.

Our recent research at the University of Pennsylvania has examined the dynamics of homelessness and the use of public shelters, and medical and psychiatric services in two large US cities, Philadelphia and New York. These two cities are relatively unique in the United States in that they each have over ten years of data, making it possible for us to analyze the trends and patterns in the use of these service systems over time. Today, we would like to summarize some findings from recent studies that my colleagues and we have completed and that are pertinent to homeless veterans and their use of services.

Veterans have been found primarily among the single adult homeless population – those persons experiencing homelessness while unaccompanied by family members. In 1997-98, of the 34,000 persons who responded to inquiries on veteran status in these two cities, 13% indicated that they were veterans. This percentage is higher when one looks at only the male shelter users, where the proportion is 16%.

Homeless single adults tend to be more visible than homeless families. They are therefore more consistent with the public's perception of the problem, even though homeless individuals represent only 40% of the homeless in these two cities. Among these persons, only a relatively small minority experience extended periods of homelessness. Among this minority, however, many have compelling health and social needs. It is in targeting the veterans in this minority that the VA can make the most efficient use of its homeless services and the greatest contribution towards ending homelessness.

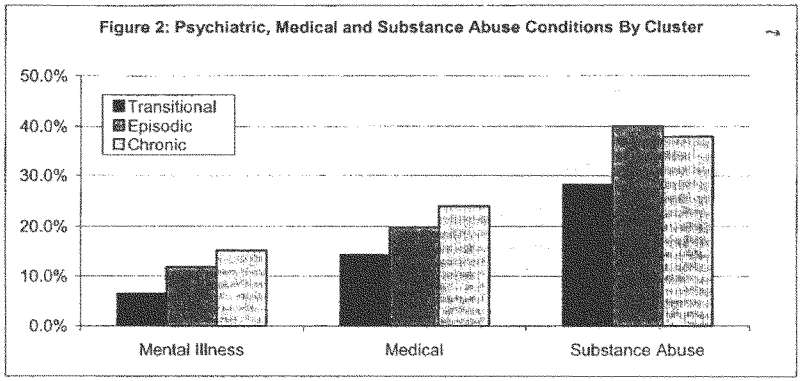
To expand on this, we would like to report the results of two studies in which we have participated. The first was authored by Culhane and Randall Kuhn (1998), on patterns of shelter use among single adults in New York City and Philadelphia. In our study, we grouped shelter users based on the number of episodes of shelter use a person had and the number of days they stayed in a shelter over a three-year period. The model produced three groups. Illustrated in Figure 1 with the Philadelphia results, the majority of homeless single adults fall into a category we called *transitionally homeless*. Persons in this group experience, on average, 1.2 episodes of shelter use that last an average of 20.4 days. About 78% of all shelter users are in this group, and they consume almost one third of all shelter days. Persons in the second group, which we called the *episodic shelter users,* have, on average, 3.8 episodes of shelter use and stay an average of 72.8



days cumulatively over a three year period. About 12% of shelter users fit this case profile, and they use about 18% of the system days. Comprising the last 10% of the shelter users is a group we called the *chronic shelter users.* Persons in this group have consumed, on average, 1.5 shelter episodes and 252.4 shelter days in a three-year time span. Interestingly, while the chronic shelter users account for only about 10% of shelter users, they consume 50% of the shelter system days. This relatively small group therefore represents about *half* of the sheltered population on a given day. The chronic and episodic shelter groups not only use a disproportionate share of shelter resources, but they also exhibit substantially higher rates of psychiatric, medical, and substance abuse conditions. Figure 2 illustrates this with the Philadelphia results.

The chronic shelter users should clearly be the target of permanent housing programs. This is a relatively older population with many special needs, with 55% having some self-reported health problem in NYC (mental health, medical or substance abuse) and 85% having some self-reported or treated health problem in Philadelphia (including 15.1% with severe mental illness, 37.9% with substance abuse, 24.0% with some physical disability). By transferring such persons to permanent housing, a very significant conservation of resources in the emergency shelter system could be achieved (as we will discuss in detail later). Based on their pattern of shelter use, the chronic shelter users are stable, and their circumstances do not constitute an "emergency." It is therefore inappropriate that half of the emergency shelter system's resources are devoted to providing what is essentially permanent housing for this relatively small part of the population. It is noteworthy that this group is also likely to be significant users of health programs; so more appropriate and stable housing could also help to reduce their over-utilization of health services (see below).

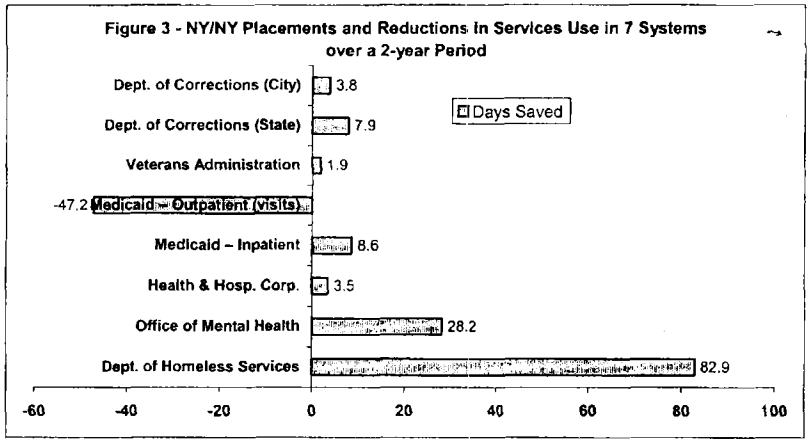
The episodic shelter users are younger than the chronic shelter users, but have fairly high rates of health conditions as well (medical, mental health and substance abuse), with approximately 52% having a self-reported condition in NYC and 66%



having a self-reported or treated condition in Philadelphia. We believe that this group is largely comprised of people who are among the street homeless, and who shuttle among various institutions (jails, hospitals, detoxification centers) in between shelter stays. Because they are likely to be much more unstable than the chronic shelter users, but not sufficiently assisted by "emergency" services alone, this group should be targeted for transitional housing programs, and/or residential treatment programs. Currently, transitional housing programs are often not targeted to this population, and it may be worth considering a requirement that transitional housing resources be targeted to this traditionally difficult to serve population. Again, this is a relatively finite population of persons, and their instability and treatment needs likely create many problems for related service systems, as well as for the public.

These two groups of homeless provide a much smaller target population from which the VA can select veterans for its housing and rehabilitation programs, and it is in targeting these veterans that the VA may be able to facilitate the greatest reductions in homelessness. The "chronic" and "episodic" shelter users comprise a relatively small percentage of persons who become homeless, yet they are the most visible and the heaviest consumers of homeless services among this population. However, in targeting this group two things must be kept in mind: first, that providing housing and material support are as important to ameliorating homelessness as clinical and rehabilitative services; and second, that these services must be available on a long-term basis, especially to those homeless with physical or psychiatric disabilities.

To illustrate this, we will briefly summarize a second study that we conducted with our colleague Trevor Hadley (Culhane, Metraux & Hadley, in press) on providing supportive housing – housing with social and psychiatric support services – to mentally ill homeless and its effect on the use of health care, correctional and shelter services. The study examined services use by formerly homeless persons with SMI before and after being placed into "New York/New York" (NY/NY) housing, a large housing program in



New York City (NYC). Administrative data from public health care, mental health, criminal justice, and shelter service providers are used to assess the aggregate level of demand for services, pre- and post-intervention, for the study group as compared to a group of matched controls, and to assess the degree to which service reductions offset the costs of the supportive housing.

In 1990 New York State (NYS) and NYC agreed to jointly fund and develop 3,600 community-based permanent housing units for homeless persons with SMI under what became known as the New York/New York Agreement to House the Homeless Mentally Ill. This initiative was in response to problems with homelessness and community mental healthcare in NYC that were perceived to have reached crisis proportions. The NY/NY Agreement, in providing housing with psychosocial services for homeless persons with SMI, was designed to target those who were among the most chronic and difficult to serve among the homeless population, and to ease demand on public shelter and psychiatric treatment services.

The placement of homeless people with severe mental illness in supportive housing is, as expected, associated with substantial reductions in homelessness. Not only do homeless people with severe mental disabilities placed in housing have marked reductions in emergency shelter use, they experience marked reductions in their use of hospital and correctional facilities as well. Results show that such persons are extensive users of publicly funded services, particularly inpatient health services, *accumulating an average of $40,449 per year in health, corrections and shelter system costs.* As shown in Figure 3, placement in NY/NY housing was associated with a subsequent reduction in services use across all systems studied except for Medicaid-reimbursed outpatient services. Translating these reductions in service use into dollar amounts, *NY/NY is associated with a combined savings $16,282 per housing unit per year.* The vast majority of these service use reductions were in health services, which accounted for 72%

of the cost reductions. Approximately 23% of the cost reductions came from a decline in shelter use; 5% came from reduced use of state and city jails.

Use of inpatient VA services by people in this study also declined significantly. People placed in housing had a 33% reduction in VA inpatient admissions once placed in that housing. Moreover, there was a 50% reduction in the total number of VA hospitals days used by people once they were placed in housing. This reduction is due not only to fewer hospitalization episodes, but among those who still required some hospitalization, they experienced a 25% reduction in the number of days they stayed in the hospital, presumably because access to permanent housing made discharge and management of the illness in a non-hospital setting more achievable.

In light of the high cost of homelessness, the importance of the effect we found – that the supportive housing intervention significantly reduces these costs – is further reinforced. For neither the public nor the people with SMI who are homeless derive a benefit from unnecessary or unnecessarily long hospital stays and incarcerations, whereas the service cost reductions associated with a housing placement represent a demonstrable benefit, both to the public and to the formerly homeless. Comparing these service reductions to the estimated annual $17,277 cost for each NY/NY supportive housing unit results in a modest cost of $995 per housing unit per year over the first two years of placement. Service reductions offset 95% of the costs of the supportive housing.

Although this study was limited to one locality, and cannot be generalized to all urban areas, the results could have important public policy implications. Research suggests that as many as 110,000 single adults with severe mental illness are homeless on a given day in the United States, and as many as 260,000 single adults are chronically homeless.[1] If such persons, or even significant proportions of them, are extensive users of acute care health services, public shelters, and criminal justice systems, then the results of this study would suggest that an aggressive investment in supportive housing is warranted. While such housing may not be appropriate or effective for every person who is homeless and mentally ill, sufficient proportions would likely benefit such that their placement in housing could significantly offset the costs of a targeted initiative, such as was demonstrated here. In effect, it is quite possible that policymakers could substantially reduce homelessness for a large and visible segment of the homeless population – often thought to be stubbornly beyond the reach of the social welfare safety net – at a modest cost to the public.

What could the VA do to improve its programs for people who are homeless? First, as these studies demonstrate, reducing homelessness, particularly among the most long-term homeless, is not only the humane thing to do, but is in the best interest of public service systems like the VA and to tax payers. The VA should do whatever it can to improve its placement of people who are homeless, particularly people with disabilities and other health problems, in permanent supportive housing. Unlike many homeless adults, many veterans have a veteran's income benefit, as well as a dedicated health system, which could establish a priority for placing people in subsidized housing with the

[1] See manuscript for derivation.

necessary supportive services provided. Second, veterans' programs could work more quickly to identify people at risk of homelessness and prevent their discharge from VA hospitals into public shelters. Again, where necessary, the VA could assist people in finding permanent housing placements, in accessing the necessary income benefits to help pay for the housing, and in providing supportive services that will make the housing work. Finally, for those veterans who are not stable enough to manage independent living, even with what supportive services provide, the VA should develop more transitional housing and residential treatment options that remove them from the general adult shelters, and better coordinate their recovery, treatment and housing needs. Such transitional programs could become an intermediate placement for people who are eventually able to stabilize in permanent housing programs. In conclusion, based on the research we have conducted, we believe that permanent solutions to homelessness for veterans, particularly veterans with mental health and substance abuse problems, can be achieved. Potential savings in VA hospital costs, reduced shelter costs, reductions in criminal justice system costs, and improvements in the quality of life for veterans provide ample support for renewed commitment to supportive housing and residential treatment solutions to homelessness.

Thank you for this opportunity to testify. We would be glad to answer any questions.

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STATEMENT

of the

NATIONAL MENTAL HEALTH ASSOCIATION
RALPH IBSON, VICE PRESIDENT FOR GOVERNMENT AFFAIRS

before the

SUBCOMMITTEE ON HEALTH
HOUSE VETERANS AFFAIRS COMMITTEE

on

VA PROGRAMS FOR VETERANS WITH MENTAL ILLNESS AND SUBSTANCE USE DISORDERS

JUNE 20, 2001

Mr. Chairman and Members of the Subcommittee:

I had the privilege of serving on the staff of this Committee for nearly 10 years, and am honored to appear before you today on behalf of the National Mental Health Association (NMHA).

The National Mental Health Association

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness. In partnership with our network of 340 state and local Mental Health Association affiliates nationwide, NMHA works to improve policies, understanding, and services for individuals with mental illness and substance use disorders. Several NMHA affiliates have developed and operate programs serving persons who are homeless and suffer from mental illness and co-occurring substance use disorders. Within the last year, NMHA has initiated a working group partnership with VA, the National Coalition for Homeless Veterans, and USVets (a Los Angeles-based non-profit that has developed transitional housing and rehabilitation programs across the country for veterans who are homeless) to foster the development of new community-based coalitions and programs to serve homeless veterans.

The Significance of VA's Specialized Treatment Programs

During my years working in the House I was often asked why there continues to be a need for a Government-operated health care system for veterans. Some questioned why,

for example, the obligation owed veterans couldn't be as effectively discharged through a voucher system or some other contractual arrangement. The response I gave to such questions was similar to a response VA Secretary Tony Principi recently gave to a C-Span interviewer. Secretary Principi identified VA's specialized treatment programs for veterans with mental illness as one of a core of specialized programs that are central to what makes VA a unique, vital national resource.

VA: A Unique "Safety Net" for Veterans with Mental Illnesses

Those explaining the importance of maintaining the VA health care system also cite its uniqueness as a "safety net" for veterans. That safety net mission is particularly important to veterans with mental illness or substance use disorders because – unlike many other veterans – these individuals often lack other health care options. Both the Medicare program and most private health insurance, for example, impose arbitrary, discriminatory barriers to mental health care. Under the Medicare program, individuals face a 50% copayment for outpatient mental health services and a lifetime cap on coverage of psychiatric hospitalization. In a report last year on the Mental Health Parity Law of 1996 (which prohibited disparate annual and lifetime dollar limits on mental health care in private group health insurance), the General Accounting Office reported that while 86% of the employers it surveyed complied with the limited parity requirement of that law, 87% of those who had complied evaded the spirit of the law by substituting other discriminatory mechanisms (such as limits on numbers of outpatient visits or days of hospital coverage, or greater cost-sharing burdens) to limit coverage of mental health services. These barriers help explain the reliance veterans with mental illness place on VA for care. For example, more than 50 percent of veterans service-connected for a psychosis, and more than 60 percent of veterans service-connected for PTSD, used VA health care services in FY 2000.

As you know, Mr. Chairman, some five years ago VA embarked on what became a remarkable transformation of its health care system. The clear danger that a zeal to achieve cost-savings would threaten the viability of often costly specialized treatment programs led Congress in 1996 to enact legislation to protect this unique program capacity. This Committee can proudly claim authorship of the statutory requirement that VA maintain its specialized capacity (within distinct programs dedicated to veterans' specialized needs) to treat veterans with mental illness and other specified conditions. As this Committee has ably documented, competing VA priorities and fiscal incentives – which were dictated by policy not law – largely thwarted that statutory protection. As a result, VA mental health programs, in particular, fell prey to sweeping contraction and cost-cutting in many networks across the country.

Capacity and Effectiveness of VA Mental Health Programs

Your inquiry today regarding the capacity and effectiveness of VA mental health programs is both timely and important. Let me offer a few observations. First, over the last five years the VA health care system has markedly diminished – by its own measures -- its capability to provide care to veterans with mental and substance use disorders.

Second, this loss of program capacity has been variable from network to network – wholly at odds with VA's obligation to operate a national health care system and provide equitable access to care. And third, with its failure over the last five years to maintain and reinvest mental health funding to establish needed community-based mental health programs, VA can no longer claim to provide state of the art mental health care. The implications of these observations are profound, in my view.

Mr. Chairman, I trust you would agree that the real issue before this Committee is not simply whether VA has maintained a specified level of program capacity – which it has not -- but whether, as a national system, it provides veterans reasonably accessible, effective, high quality care and services for mental and substance use disorders. I believe the hearing record you compile will demonstrate that it does not.

State-of-the-Art Mental Health Care

More than 450,000 veterans suffer from a mental illness which the VA has determined to be service-connected, that is, the illness was incurred or aggravated in military service. Surely such veterans should be afforded care and services of the highest quality. Indeed the Department's budget submission for FY 2002 states (at p. 2-122) that VA provides "state-of-the-art" mental health care.

Do the facts bear out that claim? As the Surgeon General documented in the landmark 1999 Report on Mental Health, state-of-the-art care for severe mental illness is recovery-oriented care which requires an array of services that include intensive case management, access to substance abuse treatment, peer support and psychosocial rehabilitation such as pharmacologic treatment, housing, employment services, independent living and social skills training, and psychological support to help persons recover from a mental illness. VA mental health professionals have recognized and identified these as needs "that should be the target of developmental efforts in the coming years" (Report of the Committee on Care of the Severely Chronically Mentally Ill Veterans [hereinafter "the SCMI Committee"], February 2000, p. 64. As an entity established pursuant to law – the product of the House Veterans Affairs Committee's initiative -- the SCMI Committee's findings and recommendations are particularly noteworthy.) But, notwithstanding the courageous advocacy of VA mental health professionals, the Department is clearly not furnishing this comprehensive spectrum of services to veterans with severe mental illness today.

While budget pressures and other constraints may in the past have posed barriers to VA's providing the spectrum of services identified by the Surgeon General, a health care system providing state of the art mental health services would certainly not have de-institutionalized patients with mental illnesses, as VA did over the last five years, without establishing accessible community based services in all networks to assure continuity of care. It is clear that in many parts of the country VA failed to meet this critical obligation. But while instituting a comprehensive, state-of-the-art mental health system for veterans remains an imperative, VA has yet to meet the more modest goal it has set of establishing a sufficient number of intensive case management programs to serve

veterans' needs. As the SCMI committee recently noted, entire networks and many major metropolitan areas have no such VA service available. And while VA opened hundreds of community-based clinics in the last five years – in part through rechanneling funds freed up from psychiatric bed closures -- only half these clinics provide mental health services.

I urge the Committee also to consider the issue of substance abuse. As many as half of people with serious mental illnesses develop alcohol or other drug abuse problems at some point. Substance abuse is a major problem among veterans, and many suffer from both substance use and other serious mental disorders, including psychoses and PTSD. A state-of-the-art mental health care system would not countenance a situation in which eight of the country's 25 largest metropolitan areas lack programs to treat drug addiction, for example, or in which the numbers of patients afforded substance use treatment has declined in the face of substantial increases in the numbers receiving care for other health conditions.

A state-of-the-art mental health care system would also not subject its patients to policies or practices of "failing first" on lower-cost medications before permitting its physicians to prescribe a drug of choice. It is our understanding, however, that such a policy -- applicable to so-called "novel" or atypical antipsychotic medications -- has, in fact, been adopted and in use in two of VA's networks. Atypical antipsychotic medications are newer medications found to be efficacious in the treatment of schizophrenia. The network policies on the use of these medications provide, in effect, that veterans are eligible for the more costly of those medications only if they have "failed" on a course of therapy with one of the less costly agents. It is our further understanding that VA clinical managers had proposed the adoption of such a policy for use systemwide.

The establishment of such a "fail-first" policy would seem to assume that the various newer antipsychotic medications can be used interchangeably in any patient with equal results. These network policies, however, ignore the reality that individual patients differ in their response to different medications and in their sensitivity to the particular side effects of the drugs. And they ignore the fact that "failing" a course of therapy can result in a psychiatric crisis that may lead to hospitalization. To our knowledge, there is no apparent scientific basis for denying veterans eligibility for particular medications. The rationale for these policies (other than cost-savings) is particularly mystifying in light of the fact that the National Institute of Mental Health has a study underway to compare the effectiveness of a wide range of antipsychotic medications in persons with schizophrenia (titled Comparative Effectiveness of Antipsychotic Medications in Patients with Schizophrenia often referred to as the "CATIE Schizophrenia Trial). If the National Institute of Mental Health is still studying the differences among these medications, it is difficult to understand the scientific basis that would warrant an individual VA network or VA itself to deny a veteran "eligibility" for a particular antipsychotic medication that his or her physician, in the exercise of clinical judgment, deems most appropriate for that individual.

Remedial Steps

Can the problems NMHA and others have identified be remedied? This Committee is to be applauded for making important, valuable recommendations to increase funding for VA mental health care, as well as for convening this hearing. NMHA would urge the Committee to go further. Increasing VA funding, for example, will not necessarily assure that additional new funds are allocated to mental health care, as proposed. The seemingly almost unfettered latitude that VA network directors have enjoyed – to maintain specialized programs or to close them, to provide substance abuse services or not, to deny veterans access to certain medications, etc. -- raises a concern that spending decisions will continue to be made in accordance with vastly divergent priorities from network to network. And it underscores that – regardless of veterans' needs -- mental health and substance abuse will not necessarily be a high priority in each region. Mr. Chairman, the enormous disparities from region to region in access to care for mental health and substance use disorders for the large numbers of veterans with these conditions must be remedied. That remedy, in my view, should find expression in legislation.

There are several avenues that might be considered. A first, though not exclusive, step might be to amend the capacity law itself to include clarifying that the requirement to maintain specialized program capacity is not simply a systemwide mandate, but one applicable to each network. NMHA would urge the Committee to go further, however. Consideration might also be given to the concept proposed in the Heather French Homeless Veterans Assistance Act, H.R. 936, (which NMHA supports) which would alter the resource allocation model for funding specialized programs serving veterans with mental illness and substance use disorders. Anomalously, fiscal incentives have often proven more powerful than statutory directives in effecting desired changes within the VA health care system. Still another approach – perhaps an intermediate step to the more far-reaching VERA proposal -- would be to direct those VA networks which have most egregiously reduced their support for these specialized mental health and/or substance abuse programs (as measured by patients served and dollars expended, as adjusted for inflation) to develop and carry out a management plan for bringing these programs to the required levels by a specified date. In any case, NMHA would recommend that any such remedial legislation provide for an independent oversight mechanism, such as auditing by the VA's Inspector General, through which the Committee could be assured that the legislation produced the intended result.

NMHA urges the Committee, however, not to set its sights solely on the issue of "capacity" – challenging as that has been – but to work to bring VA programs for veterans with mental illness and substance use disorders to the level that experts inside the VA and elsewhere acknowledge to be state-of-the-art.

Thank you for the opportunity to present NMHA's views on this very important subject.

Ralph Ibson
Vice President for Government Affairs
National Mental Health Association

Ralph Ibson is a graduate of Tufts University (B.A. 1967) and the University of Pennsylvania Law School (J.D. 1973). He is a veteran of service in the U.S. Army (1968 – 1971).

Ralph began a career of government service in 1973 working as an attorney for the Veterans Administration (VA) on its Board of Veterans Appeals. In 1976 he joined the VA's Office of General Counsel, moving in 1980 to the position of Deputy Assistant General Counsel. In that capacity, he served as counsel to the Commission on the Future Structure of the VA Health Care System.

In 1990, Ralph joined the staff of the House Veterans Affairs Committee, taking a position as Staff Director of the Subcommittee on Hospitals and Health Care (later the Subcommittee on Health). Ralph retired from the Committee in June 2000 and accepted the position of Vice President for Government Affairs with the National Mental Health Association.

The National Mental Health Association (NMHA) has not received any grant or contract from the Department of Veterans Affairs.

NMHA has received contracts or grants (which may be deemed to have some relevance to the subject matter of this testimony) during the current or previous two fiscal years from:

The Substance Abuse and Mental Health Services Administration contract for $24,000 to undertake a project on consumer involvement in public managed behavioral healthcare;

The Center for Mental Health Services of the Substance Abuse and Mental Health Services Administration contract for $300,000 to operate a resource center providing technical assistance and training to facilitate self-help approaches, recovery concepts, and empowerment for mental health consumers.

The Department of Justice, National Institute of Corrections: a grant for $150,000 to develop a manual for prison staff about effective mental health services needed in prisons, and a grant for $24,120 to address the needs of adults with mental illness in community corrections programs.

STATEMENT

of

Linda Boone
Executive Director

of the

NATIONAL COALITION *for* HOMELESS VETERANS

before the

Subcommittee on Health

of the

Committee on Veterans Affairs
United States House of Representatives

The Honorable Jerry Moran
Chairman

June 20, 2001
Washington, DC

Chairman Moran and Committee members:

The National Coalition for Homeless Veterans (NCHV) is committed to assisting the men and women who have served our Nation well to have decent shelter, adequate nutrition, and acute medical care when needed. NCHV is committed to doing all we can to help ensure that the organizations, agencies, and groups who assist veterans with these most fundamental human needs receive the resources adequate to provide these services to perform this task. Our veterans served us faithfully, often heroically. Each of us can do no less than to do our part to ensure that these men and women are treated with dignity and respect.

NCHV believes that there is no generic and separate group of people who are "homeless veterans" as a permanent characteristic. Rather, NCHV takes the position that there are veterans who have problems that have become so acute that a veteran becomes homeless for a time. In a great many cases these problems and difficulties are directly traceable to that individual's experience in military service or his or her return to civilian society.

The specific sequences of events that led to these American veterans being in the state of homelessness are as varied as there are veterans who find themselves in this condition.

It is clear that the present way of organizing the delivery of vitally needed services has failed to assist the veterans who are so overwhelmed by their problems and difficulties that they find themselves homeless for at least part of the year.

The transmutation of the Veterans Health Administration of the United States Department of Veterans Affairs (VA) from a traditional hospital facility-based system into a "services oriented" system that is organized into the 22 "Veterans Integrated Services Networks" (VISNs) has produced significant reductions in services needed by many veterans, particularly homeless veterans.

NCHV recognizes the significant effort that the VA has demonstrated in addressing the needs of homeless veterans in the past few years. We know of many extremely dedicated employees within the VA that go well beyond their normal work day to volunteer in community activities and often provide leadership to expand services to homeless veterans.

The reductions and curtailment of services are perhaps most drastic in mental health and substance abuse disorder programs which concerns NCHV. In the December 1999 report issued by the Interagency Council on the Homeless, found that ***76% of homeless veterans have a mental health and/or substance abuse issue.*** It is shocking to hear from the VA Advisory Committee on Seriously and Mental Ill Veterans an estimate that over $600 million has been diverted from mental health programs over the last few years. ***An April 2000 GAO (HEHS-00-57) report concluded that between 1996-1998 inpatient services to serious mental ill patients decreased by 19%. Substance abuse disorder inpatient treatment was reportedly decreased by 41% in the same GAO report.*** We agree we this committee's FY2002 budget recommendation report to at least partially restore lost support for these mentally ill and substance abuse disorder veterans who often experience homelessness.

NCHV member organizations have reported that due to the reductions of VA in patient services veterans referred to these community-based organizations from the VA are often sicker and not ready for the "transition" phase in the continuum of care. Patients have to be sent back to the VA or other scarce resources in the community are attempted to be accessed to aid these veterans.

That same GAO report reported that the VA generally believed that that these alternative care settings developed to move patients to an out patient treatment setting were appropriate for special disability populations, although no clear evidence exists to

support this position. ***Many communities do not have adequate resources to support this increase in demand that had once been provided by the VA.***

Additionally this GAO report concluded that VA managers are not specifically accountable for special disability programs and that responsibility for maintaining capacity is fragmented among organizational units. NCHV is concerned that the funding Congress intends to have used serving this vulnerable population has been redirected and VA accountability is lacking and veterans are suffering as a result. How many veterans are not receiving assistance? How many get turned away or virtually turned away by not having services available?

If the VA is going to continue to focus only on out patient services where will these homeless veterans live while receiving treatment? Many community based organizations (CBOs) have a strong record of performance in the delivery of services to veterans in the most vital need, and could do a great deal more inpatient care if the resources were available to meet those unmet needs of veterans. CBOs are a vital link in any continuum of care chain, particularly in an era when there is such concern toward finding the most cost effective means possible for meeting the vital needs of veterans in each community, while preserving the highest standards of quality care.

The National Coalition for Homeless Veterans (NCHV) is very supportive of the intent of H.R.936 "Heather French Henry Homeless Veterans Assistance Act" introduced by Ranking Minority Committee member Representative Lane Evans, to provide for a wide range of services to homeless veterans and to begin focus on issues of prevention.

Within this bill NCHV has several priority items that we feel will lead us closer to the elimination of homelessness among veterans.

CHALENG DATA

First start with the data. Congress recognized the need for the VA to play a leadership role within communities they serve by passing legislation (PL102-405) requiring the VA to assess and coordinate the needs of homeless veterans living within the area served by the medical center or regional office. Since that legislation passed the VA has made progress towards implementing community meetings, *Community Homelessness Assessment, Local Education and Networking Groups (CHALENG) for Veterans*, in approximately 90% of their locations. There are many local CHALENG processes that are meeting the full intent of the law passed by Congress and are providing valuable coordination of services to homeless veterans. However, not all medical centers have implemented this law or have minimally met the intent by surveying providers without a controlled assessment process.

NCHV is surprised that in the *Fifth Annual Progress Report*, published August 29, 1999 for the 1998 fiscal year, childcare came as the number two item of the unmet needs for homeless veterans. NCHV members are concerned that this conflicting data with their front line experience with homeless veterans distorts the entire validity of the CHALENG process and will misdirect the VA in their resource allocation for services to homeless veterans.

NCHV wants Congress to impress upon the VA the critical need for the VA to take a tangible leadership role to assess and coordinate services in communities for homeless veterans in a consistent and complete manner throughout the VA.

The Urban Institute produced a report for the Interagency Council On the Homeless, for the survey that was conducted in 1996 titled "Homelessness: Programs and the People They Serve" released in December 1999 that has become the report that is used as the baseline in demographic data for homelessness in America. That report found ***23% of all homeless individuals are veterans.***

In February 2001 the Urban Institute released census information on the homeless population that was done in conjunction with the 1996 survey. Their conclusion is that at

least 2.3 million people, or nearly 1% of US population are likely to experience homelessness at least once during a year. This would equate ***veterans experiencing homelessness to be 529,000 during a year.***

Further they found that there is a high seasonal variation in homelessness, with 842,000 individuals (193,660 veterans) being homeless during an average February week and in October 444,000 (102,120 veterans) individuals.

This conflicts with the CHALENG data that we find suspect based on the inconsistent process of data gathering and reporting.

HOUSING

Approximately 5000 transitional housing beds will be available funded through the Homeless Providers Grant and Per Diem program for veterans of which 2,076 are currently activated. The need for increased funding for beds through this program has never diminished since its inception. There is an un-addressed need for housing that is safe, clean, sober and has responsible staff to ensure that it stays that way, and that supportive services are regularly provided as to be sufficient to help veterans fully recover as much independence and autonomy as possible.

The Homeless Providers Grant and Per Diem Program currently is assigned funding internally within the VA at approximately $35 million. The "grant" piece provides funding for the "bricks and mortar" for new programs and the "per diem" piece provides for a daily payment of up to 50% for a maximum of $19 per day to provide services to the veterans housed under the "grant" piece. The grantees are required to obtain matching funds to the complete the 50% not funded through the VA.

NCHV supports a new flat fee formula based on the state home domiciliary rate because it is a good comparison model for types of services provided and compensation for those services. In addition we recommend removing the match requirement that would lighten the paperwork burden on the grantees and the VA. The current match requirement does not allow for in kind services to count towards the match, only hard dollars are allowed which can often create unnecessary hurdles for CBOs. Additionally we recommend a permanent authorization to allow existing programs to have access to the "per diem" piece to allow for program expansion that does not require "bricks and mortar".

NCHV believes the Homeless Providers Grant & Per Diem should be at ***$120 million funding level and a budget line item***. The current level of funded beds is 5000 for an investment of about $35 million. If funding stays at the $35 million level there would be a need to cut 1000 beds when the new per diem increase became effective.

$43 million needed to remain at same 5000 bed level with increased per diem rate

$50 million would add 813 beds with increased per diem rate to total 5813 beds

$100 million would add approximately 6600 beds with increased per diem rate to total 11,628 beds

$120 million would add approximately 9000 beds with increased per diem rate to total 13,953 beds

The demand for this grant program far exceeds its current funding level. Every year programs get turned down usually because of lack of funding.

Grant applications rejected:

2000-64
1999-42
1998-67
1997-62
1996-57
1995-67
1994-67

NCHV also feels there needs to be a future vision of how to turn these transitional beds into a mix of transitional and long term permanent supported housing. The current grant program has employment as an expected outcome for all veterans transitioning through the program. However many veteran are not able to work or live without continued supportive services on a daily basis. Some of these veterans need alternatives to independent living and the CBO system has the experience and programs in place that could support the future needs of these veterans.

NCHV is concerned that there is a tendency to provide the authority to the VA to create housing programs and other competitive services that CBOs are currently providing. We believe that the VA should provide the medical services and the CBOs can provide the other supportive services within the continuum of care for homeless veterans.

EMPLOYMENT

Work is the key to helping homeless veterans rejoin American society As important as quality clinical care, other supportive services, and transitional housing may be, the fact remains that helping veterans get and keep a job can be the most essential element in their recovery and reintegration for those that work is a realistic outcome.

The **Homeless Veteran Reintegration Program (HVRP) managed through the US Department of Labor, Veterans Employment and Training Service** is virtually the only program that focuses on employment of veterans who are homeless Since other resources that should be available to our member organizations to fund activities that result in gainful employment are not generally available, HVRP takes on an importance far beyond the very small dollar amounts involved.

The Homeless Veteran Reintegration Program is a job placement program begun in 1989 to provide grants to community-based organizations that employ flexible and innovative approaches to assist homeless, unemployed veterans reenter the workforce. Local programs offer employment and job-readiness services to place these veterans directly into paying jobs. HVRP provides the key element often missing from most homeless programming.....job placement.

Through HVRP funds veterans gain access to civilian assistance, ex-military benefits and entitlements, education and training opportunities, legal assistance, whatever is needed to begin the rebuilding process towards employment.

HVRP programs work with veterans who have special needs and are shunned by other programs and services, veterans who have hit the very bottom, including those with long histories of substance abuse, severe PTSD, serious social problems, those who have legal issues, and those who are HIV positive. These veterans require more time consuming, specialized, intensive assessment, referrals, and counseling than is possible in other programs that work with other veterans seeking employment.

This program has suffered since its inception because it is small and an easy target for elimination or reduced appropriations. Even DOL rarely asks for the full appropriation for HVRP in the budget they submit to OMB. Our coalition has spent the majority of its advocacy efforts in the past five years in keeping this program alive because it has been so vital in ending homelessness among veterans.

HVRP is an extraordinarily cost efficient program, with a cost per placement of about $1,500 per veteran entering employment. Based on years of experience of our member organizations NCHV strongly believes that helping homeless veterans to get and keep a job is the key to reducing homelessness among veterans. NCHV recommends an investment of **$50 million** per year in HVRP to assists veterans in becoming self-sustaining and responsible tax paying citizens.

$50 million is only $100 for each of the over 500,000 veterans that is estimated are homeless at some point during the year.

TECHNICAL ASSISTANCE

It is very clear that it takes a network of partnerships to be able to provide a full range of services to homeless veterans. No one entity can provide this complex set of requirements without developing relationships with others in the community.

Community-based nonprofit organizations are most often the coordinator of services because they house the veterans during their transition. These community-based organizations ***must orchestrate a complex set of funding and service delivery streams with multiple agencies*** in which each one plays a key critical role.

There are a wide variety of Federal, state and private funds that veteran service providers are eligible for in the course of serving homeless veterans. The challenge is in accessing them. Many veteran specific providers lose several years before being able to position themselves to successfully compete and receive ANY federal, state or local agency funds.

The current prevailing public policy of devolution increases likelihood that Federal dollars are ultimately allocated through a ranking process subject to local viewpoints. At the local level the ***common perception is that veterans are taken care of by the VA***. Some are, yet most are not. These perceptions can be a barrier to homeless veterans service providers' access to funds. It is a reality that must be reckoned with in order to compete successfully.

When a local group is forced into priority recommendations that choose between needy men, women, and/or their children, it is a challenge to argue for displacing the funding for women and children in favor of a man (who's a veteran the "VA is taking care of" anyway!) Sometimes a homeless veteran has his family still together, and obviously some homeless veterans are women, but these conditions are the exceptions.

Consistently at around $1 billion annually, the biggest piece of funding currently on the table is available from targeted HUD funds through the Super NOFA for Supportive Housing Programs (SHP). Historically only 3% of these grants are awarded to veteran specific programs. Three percent, when a quarter of the homeless are veterans. Any other help HUD grants give to veterans is purely by chance, and we have no information on whether the rest of the money reaches veterans.

The distribution system for these McKinney Act funds follow a devolution policy that organizes priorities for allocation of formula share dollars at a local level within a continuum of care. The Continuum of Care prescribes a planning process built on a community-by-community model. Within each community, a planning process takes place in which advocates and service providers describe the problem, access the current resources available, and decide what needs to be done using the "targeted" McKinney programs, which total $1.2 billion annually. Overall federal funding to assist the poor is about $215 billion annually and is not synchronized with targeted homeless assistance funds. So, these funds need to be accessed differently.

Until such time as a homeless veteran provider is able to convince the organizations that make up the local continuum of care that it is in THEIR best interest to juggle their dollars in a way to allow a veteran provider to the table, a veteran specific program typically gets ranked out of the money (if it even got ranked in the continuum at all). Veteran service providers report it takes several years of analysis, networking, program/funding design, and negotiations to be able to show that giving a high priority to a relatively small piece of HUD Supportive Housing Programs dollars for a veteran provider is in the community's best interest. A veteran provider can access support service money and a clinical care system (the Department of Veterans Affairs) available for veterans only. This leverages resources that can off-load the community care system of the veterans currently occupying beds and free up capacity that then becomes available for women, children and other special needs population. At one level, this is the market economy operating at its best... but it is complicated, to say the least.

The veteran community-based organization system faces a capacity gap around managing this complexity in order to respond successfully to the distribution system for accessing funds and then if awarded the resources to pay for management and financial reporting systems to properly service those funds.

The point here is to underscore the complexities involved in successfully responding to the streams of funding available and necessary to combine together adequate budgets in a sufficiently broad geographic area to put on a reasonable array of services for homeless veterans. ***Most community-based organizations throughout the country struggle to respond to this system of distribution of federal funds.***

Some Solutions

In 1990, seven homeless veteran service providers established the National Coalition for Homeless Veterans (NCHV) to educate America's people about the extraordinarily high percentage of veterans among the homeless. These seven providers are considered to be true original warriors for the cause. All former military men, they were concerned that people did not understand the unique reasons why veterans become homeless and the fact that these men and women who defended America's freedom were being dramatically under-served in a time of personal crisis. In the years since its founding, NCHV's membership has grown to 245 in 43 states and the District of Columbia.

I urge this committee to consider finding ways to get ***capacity building services*** into the hands of the community-based care provider group attempting to serve veterans. It is squarely within the mission of NCHV to help formulate this capacity. While NCHV has been doing this, it's been done in a limited way without the benefit of any federal funds. I ask you to consider authorizing an allocation $750,000 FY 2002 and each year thereafter through FY2007 to the National Coalition for Homeless Veterans to build capacity of the veteran service provider network. The goal would be to significantly increase access to the federal, state and private funding streams and to enhance the efficiency of utilization for those currently accessing these streams.

NCHV looks forward to working with this committee and the staff on solutions that will lead to the end of homelessness among veterans.

Mr. Chairman, thank you for this opportunity.

CURRICULUM VITAE

Linda Boone, Executive Director, National Coalition *for* Homeless Veterans took over the management of this national advocacy organization in April 1996. Linda's activities on veteran issues started in 1969 as a volunteer in her local community. Her advocacy for homeless veterans began in 1990 after meeting veterans living under a boardwalk near her home.

Prior to becoming executive director for NCHV Boone spent over 20 years in materials management positions at high tech manufacturing companies and as a consultant to companies and organizations for competitive management practices.

The National Coalition for Homeless Veterans was founded in 1990 by a group of veteran service providers when they became frustrated with the growing numbers of homeless veterans that were coming into their facilities and the lack of resources to adequately provide services.

The mission of NCHV is to end homeless among veterans by shaping public policy, educating the public, and building the capacity of service providers.

FEDERAL GRANT OR CONTRACT DISCLOSURE

The National Coalition for Homeless Veterans received a $60,000 grant from the US Department of Labor in FY2000 to provide incentive grants to NCHV members for employment programs serving homeless veterans.

An appropriation from Congress was provided to NCHV in the FY2001 budget for $400,000 to provide technical assistance for service providers. The actual receipt of funds has not started as of this date.

STATEMENT OF FRED FRESE

ON BEHALF OF THE NATIONAL ALLIANCE FOR THE MENTALLY ILL

BEFORE THE HOUSE OF REPRESENTATIVES COMMITTEE ON VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

JUNE 20, 2001

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Chairman Moran, Vice Chairman Stearns, Representative Filner and members of the Subcommittee, I am Fred Frese of Akron, Ohio. I am pleased today to offer the views of the National Alliance for the Mentally Ill (NAMI) on the mental health, substance-use disorders and homeless programs within the Department of Veterans Affairs.

In addition to serving on the NAMI Board, I am a veteran myself. In 1966, I had been selected for promotion to the rank of Captain in the U.S. Marine Corps. That is when I was first diagnosed as having the brain disorder schizophrenia – perhaps the most severe and disabling mental illness diagnosis. Since my original diagnosis, I have been treated within the VA medical system, both as an inpatient at the VA hospital in Chillicothe, Ohio, and as an outpatient. Over the years, I have served on numerous advisory panels to the VA on care for the seriously mentally ill; including the VA's National Psychosis Algorithm and the VA's Consumer Liaison Committee on Care of Severely Chronically Mentally Ill Veterans Committee. I also currently serve as chair of NAMI's Board of Directors Subcommittee on Veterans Affairs.

WHO IS NAMI?

NAMI is the nation's largest national organization, 210,000 members representing persons with serious brain disorders and their families. Through our 1,200 chapters and affiliates in all 50 states, we support education, outreach, advocacy and research on behalf of persons with serious brain disorders such as schizophrenia, manic depressive illness, major depression, severe anxiety disorders and major mental illnesses affecting children.

NAMI and its veterans have established a NAMI Veterans Committee to assure close attention to veterans mental health issues not only at the national level, but also within each Veterans Integrated Service Network (VISN). The NAMI Veterans Committee includes members in each of the 22 VISNs who advocate for an improved continuum of care for veterans, active military, and dependents with severe mental illness. The membership of the NAMI Veterans Committee consists of persons with mental illness, or family and friends of a person living with a severe mental illness who have an active involvement and interest in issues impacting veterans and our military. NAMI is therefore pleased to offer our views on the programs that serve veterans with severe mental illness.

Mr. Chairman, for too long severe mental illness has been shrouded in stigma and discrimination. These illnesses have been misunderstood, feared, hidden, and often ignored by science. Only in the last decade have we seen the first real hope for people with these brain disorders through pioneering research that has uncovered both biological underpinnings for these brain disorders and treatments that work. NAMI applauds the contributions of VA schizophrenia research to the understanding and treatment of these illnesses and supports the development of the VA mental illness research infrastructure through the Mental Illness Research, Education and Clinical Centers (MIRECC).

The VHA has grown from 54 hospitals in the 1930's to 173 medical centers, 650 outpatient community and outreach clinics, and over 51,000 medical center beds with the VHA treating nearly a million patients a year in VA hospitals alone. However there is ample evidence that providing consistent and quality services to the growing number of veterans presenting for care has become challenging due to a five-year budget freeze, a reorganization that decentralized authority, and substantial reductions in staff. As this Subcommittee knows,

Public Law 104-262, the Veterans' Health Care Eligibility Reform Act mandated that the Veterans Health Administration (VHA) must maintain capacity for providing treatment and services for veterans with severe mental illness. To this date, the VHA has been unable to maintain capacity in providing the necessary services and treatment for veterans with severe and chronic mental illness.

An acceptable continuum of care should include the availability and accessibility of physician services, state of the art medications, family education and involvement, inpatient and outpatient care, residential treatment, supported housing, assertive community treatment, psychosocial rehabilitation, peer support, vocational and employment services, and integrated treatment for co-occurring mental illness and substance abuse. The services a veteran requires from this continuum of care at any given time are determined by the fluctuating needs of his or her current clinical condition and should be established in conjunction with his or her treatment team. All services should be available without waiting lists or other barriers to accessing needed treatment and services. To be a comprehensive system of care—the VHA must have the capacity to provide such services.

The VHA's 22 VISNs were instituted to administer the health services (including mental illness treatment) for VA hospitals and clinics. The idea of these VISNs was to decentralize services, increase efficiency and shift treatment from inpatient care to less costly outpatient settings. The VHA is in charge of allocating annual appropriations for each of these 22 VISNs, but does not specifically direct funds to be spent for mental illness treatment and services. Once funding is received, each VISN has authority to allocate resources to hospitals and clinics within their jurisdiction with broad autonomy. NAMI's concern is that with the flat or declining budgets in each VISN, services for veterans with severe mental illness will not receive the treatment that is needed.

Mr. Chairman, in NAMI's opinion, the lack of access to treatment and community supports for veterans with severe mental illness is the greatest unmet need of the VA. The FY 2002 Independent Budget for the VA estimates that 454,598 veterans have a service connected disability due to a mental illness. Of great concern to NAMI are the 130,211 veterans who are service connected for psychosis—104,593 of them who were treated in the VHA in FY99 for schizophrenia, one of the most disabling brain disorders. Over the last five years the VHA has shifted its focus of serving veterans with severe and chronic mental illness from inpatient treatment to community based care. In FY 1999, out of the 191,606 veterans who were treated for a severe mental illness, only 33,531 veterans received treatment in an inpatient setting. NAMI strongly supports treating veterans with severe mental illness in the community when the proper intensive community supports and treatment are available and easily accessible. However, we are very concerned that those veterans who need inpatient care are increasingly unable to access needed treatment because of the limited inpatient beds, and the dramatic shift to outpatient treatment.

NAMI is extremely grateful for the leadership Congress has provided in holding the VHA accountable for its inability to ensure that savings derived from the closure of inpatient psychiatric beds is transferred into community-based treatment services. The VHA should not be allowed to make the same mistakes that so many states and communities have made over the past quarter century with respect to deinstitutionalization. Numerous studies have demonstrated that in states all across our nation dollars saved through the closing of state psychiatric hospitals were either never transferred into the community, or squandered on

community-based services that lacked focus and accountability. From NAMI's perspective, it is obvious that this significant decrease in inpatient care has not resulted in a sufficient transfer of resources to community-based treatment and supports for veterans with severe mental illnesses.

NAMI would urge this Subcommittee to specifically direct the VHA to require that all savings from cuts in inpatient psychiatric beds be reinvested in intensive case management services for veterans with severe mental illnesses.

Mental Health Intensive Case Management

As members of this Subcommittee know, the VHA has issued a directive for Mental Health Intensive Case Management (MHICM). MHICM is based on the Substance Abuse and Mental Health Services Administration's (SAMHSA) standards for assertive community treatment (ACT), which NAMI believes are proven, evidence-based approaches in treating the most severe and persistent mental illnesses. FY 1998 Compensation and Pension data show that almost 40,000 veterans with severe mental illness are in need of intensive community case management services. Further VHA data shows that assertive community treatment is cost-effective as well as effective in treating severe mental illness.

However, a 1998 survey by the Committee on Care of Severely Chronically Mentally Ill (SMI) Veterans Committee demonstrated that just over 8,000 veterans have been receiving some form of intensive case management, and that only 2,000 veterans are enrolled in treatment programs that meet the SAMHSA standards. The SMI committee also reports that intensive case management teams are operating at minimal staffing and some are facing further staff reductions. NAMI strongly recommends that Congress appropriate the funds necessary to provide the essential number of new intensive case management teams and to fully staff existing teams so that our nation's most vulnerable veterans receive appropriate and coordinated care.

Community-Based Outpatient Clinics

The VHA has expanded the use of Community Based Outpatient Clinics (CBOCs) as primary care clinics. Many of the CBOCs were instituted in areas where VA health services were not easily accessible allowing many more veterans access to needed health care. However, the SMI committee reports that out of the 350 CBOCs operated, only 40% of these facilities offer treatment services for veterans with severe mental illness. NAMI is truly concerned that meaningful community-based capacity is not being developed to treat chronically mentally ill veterans in their communities; and agrees with the recommendation of the Committee on Care of Severely Chronically Mentally Ill (SCMI) Veterans committee for a $40 million dollar enhancement to mental health capacity to give the VHA options in bettering care and treatment for veterans with acute needs.

Access to Appropriate Medications

NAMI would also urge the Subcommittee to continue to monitor proposals to implement restrictive drug formularies in VISNs that cover psychotropic medications. The NAMI Veterans' Committee continues to hear reports of veterans with mental illness not getting access to the newest and most effective atypical anti-psychotic medications. Specifically, our

members tell us about VISNs imposing limited formularies that require veterans to fail first on older medications, or in extreme cases, include only a single medication within an entire classification of drugs for major disorders such as schizophrenia and depression. The SMI committee reports that currently 17% of the VA's total pharmacy budget are being spent on psychotropic medications. At the same time there appears to be wide variance in the use of the newest and most effective medications that have been proven effective in treating schizophrenia. NAMI feels strongly that veterans with mental illness deserve full access to the newest and most effective medications.

NAMI also has deep concerns regarding deliberations taking place within the Department of Veterans Affairs concerning a proposed treatment guideline for veterans with schizophrenia. Specifically, NAMI strongly objects to any treatment directive that would interfere with the clinician's choice of the best medication for each patient, based on that individual patient's clinical needs. While cost is an appropriate consideration, it should be only one factor in medication choice and must not be allowed to be the primary consideration in choosing a medication to treat severe mental illness.

There is overwhelming peer-reviewed research establishing that atypical antipsychotic agents are the treatments of choice for schizophrenia. This evidence has informed the development of a number of guidelines for the treatment of schizophrenia, including the Texas Medication Algorithm Project and the Expert Consensus Guideline Series. Despite these guidelines, Veterans Administration pharmacy managers have occasionally proposed cost-cutting plans that would have required veterans to "fail first" on a conventional antipsychotic before being treated with an atypical antipsychotic. Such a policy would have bordered on the unethical, since for some veterans, atypicals are more effective against negative symptoms of schizophrenia and produce better outcomes, and since atypicals are far less likely to result in tardive dyskinesia, a devastating movement disorder. We were delighted that the Veterans Administration has not pursued this irresponsible cost-cutting approach.

Mr. Chairman, NAMI recently began receiving reports about an equally disturbing cost-cutting proposal at the VA. According to a presentation made by a VA Psychiatrist at a VA Schizophrenia Conference in Maryland on March 29 2001, the Department of Veterans Affairs is considering guidelines that will *reduce* treatment options for veterans struggling with devastating mental illnesses and restrict the discretion of VA staff psychiatrists. This new proposal, as NAMI understands it, would establish a "fail-first" policy among the atypical antipsychotics, not in response to published guidelines or best practices or to the needs of individual veterans, but rather in response to a cost-cutting mandate.

The fundamental issue is the role pharmacy costs should play in choosing among alternative treatments that are not equivalent. There are numerous studies demonstrating that these pharmacy costs are only a small part of the cost of schizophrenia care that can include hospitalization, residential care, supportive services, etc. Pharmacy savings that are achieved through restrictive formularies are often offset by increased clinical care costs elsewhere. Such studies do suggest the importance of looking at the costs of the entire care system for an illness rather than trying to control costs in just one area.

In NAMI's view, the focus should be placed on clinical decision-making in the Veterans Administration. The NAMI Veterans' Committee is dedicated to the idea that each

individual veteran has different treatment needs, and that ultimately the doctor and patient must make clinical choices based on the needs of that particular patient.

Because patients differ in their clinical responses to different drugs, in their sensitivity to specific side effects, and in their tolerance for these side effects when they occur – and because the atypical antipsychotic agents are different from one another in their clinical effects for a particular patient and in their side effects – the proposed "fail-first" requirement cannot represent best clinical care. None of the published guidelines establish preferred agents among the atypicals (other than clozapine) – they leave the choice to the clinician, based on the patient's needs. A "fail-first" requirement substitutes the judgment of pharmacy managers who have never seen the patient for the judgment of the patient's own doctor.

Certainly **if** a medication on average results in lower total cost of treatment, and **if** there is no clinical reason to prefer a different medication for a particular patient, that medication would be a reasonable first choice for the clinician. However, in practice, there are often reasons for preferring a different medication. It is important that the Veterans Administration leadership emphasize the decisive role of clinical judgment in the choice of medications, to guard against overzealous pharmacy management.

Congress has funded a National Institute of Mental Health (NIMH) project on Clinical Antipsychotic Trials of Intervention Effectiveness, known as the CATIE project. This study is designed to provide critical information about the relative benefits, side effects, and costs of different atypical antipsychotic medications. This study should provide the necessary data to make reasonable, informed choices based on a range of evidence – data that do not currently exist. In the absence of such data, considerable latitude should be given to each clinician to select the best medication based on the needs of a specific patient.

Veterans with schizophrenia and their families expect nothing less that the highest quality medical care. Therefore, NAMI specifically urges the Department of Veterans' Affairs to reject "fail-first" guidelines that inherently restrict the doctor's ability to choose the best medication for his or her individual patient.

A January 2001 GAO report concluded that the VA was not providing sufficient oversight in ensuring that all VISNs are in compliance with the national formulary. Further, NAMI agrees with the GAO's recommendation that in order to ensure more effective management of the national formulary, the Secretary should:

(1) direct the Under Secretary for Health to establish a mechanism to ensure that VISN directors comply with national formulary policy.
(2) require the Under Secretary for Health to establish criteria that VISNs should use to determine the appropriateness of adding drugs to supplement the national formulary and monitor the VISNs application of these criteria.
(3) direct the Under Secretary for Health to establish a non-formulary drug approval process for medical centers that ensures appropriate and timely decisions and provides that veterans for whom a non-formulary drug has been approved will have continued access to that drug, when appropriate, across VA's health care system.
(4) direct the Under Secretary for Health to enforce existing requirements that VISNs collect and analyze the data needed to determine that non-formulary drug approval processes are

implemented appropriately and effectively in their medical centers, including tracking both approved and denied requests.

Consumer Councils

The Fourth Annual Report to the Under Secretary for Health submitted by the Committee on Care of Severely Chronically Mentally Ill Veterans dated February 1, 2000 stated in recommendation 9.1: "Networks should redouble their efforts to establish mental health stakeholders councils at all VHA facilities and at the Network level. Progress in establishment of such councils should be monitored and considered in the evaluation of key officials."

NAMI fully supports the implementation of Mental Health Consumer Councils and the recommendation by the SMI committee. At the VISN level, Mental Health Consumer Council brings together consumers, family members, Veterans Service Organizations, and community agencies that can discuss services, policies, and issues which are important to veterans receiving treatment for mental illness. Approximately half of the VISNs have Mental Health Consumer Councils but full participation by all VISNs is still needed.

Staff Education

As you have heard at this hearing, the Department of Veterans Affairs has dramatically shifted its mental health service delivery from traditional, hospital-based services to outpatient and community-based rehabilitative approaches. The adoption of newer recovery-based psychiatric rehabilitation practices requires a significant paradigm shift for service providers. It requires the learning of new skills, some of which are contrary to their former professional training.

The VA has made minimal investment in the re-training of staff in conjunction with re-engineering its mental health services. For VA to successfully provide state-of-the-art services for veterans with severe mental illness, funding should be immediately targeted for this purpose. The VA should also sponsor a series of educational initiatives designed to re-train direct-care Mental Health staff in state-of-the-art psychiatric rehabilitation principles and practices, as well as to ensure these staff can actively participate in networking with other professional family and consumer advocacy organizations.

Homeless Veterans

NAMI applauds the Subcommittee's efforts to expand services for homeless veterans. NAMI would also like to thank Congressman Lane Evans for introducing HR 936, the Heather French Henry Homeless Veterans Assistance Act and recognize Vice-Chairman Stearns for his co-sponsorship. This bipartisan legislation would establish a goal of ending homelessness among veterans and encourage all federal, state and local governments, private and community agencies to work together towards the goal of eradicating homelessness among our nations veterans within the next decade.

As you know, severe mental illness and co-occurring substance abuse problems contribute significantly to homelessness among veterans. Studies have shown that nearly one-third (approximately 250,000) of homeless individuals have served in our country's armed services. Moreover, approximately 43% of homeless veterans have a diagnosis of severe and persistent mental illness, and 69% have a substance abuse disorder. NAMI strongly supports provisions in the bill that would mandate evaluation and reporting of mental illness programs in the VA and that veterans receiving care and treatment for severe mental illness be designated as "complex care" within the Veterans Equitable Resource Allocation system. Moreover, NAMI feels that language providing for two treatment trials on the effectiveness of integrated mental health service delivery models would be very beneficial in identifying best practice in serving and treating veterans with severe and persistent mental illness within the VA.

Mr. Chairman, NAMI strongly supports the Heather French Henry Homeless Veterans Assistance Act and urges you and your colleagues on the Veterans' Affairs committee to support this legislation which would help end homelessness for veterans and help meet the needs of veterans with severe mental illness. Our nations veterans with severe mental illness should be in treatment and not on the street.

Co-Occurring Disorders

National studies commissioned by the federal government estimate that 10 – 12 million Americans have co-occurring mental and addictive disorders. The prevailing research confirms that integrated treatment for co-occurring disorders is much more effective than attempting to treat these illnesses separately. Integrated treatment means mental illness and addictive disorders services and interventions are delivered simultaneously at the same treatment site, ideally with cross-trained staff. What is not considered integrated treatment is sequential treatment (treat one disorder first, then the other) or parallel treatment (in which two different treatment providers at separate locations use separate treatment plans to treat each condition separately but at the same time).

NAMI supports the research being done in the MIRECCs to improve the health services for patients who have co-occurring mental and addictive disorders. The VISN 1 MIRECC has concluded that emphasis should be placed on integrated treatment, and that attention to a veteran's multiple disorders produces better outcomes. The VA needs to continue to develop innovative programs and appropriately train staff to help veterans living with a severe mental illness and an addictive disorder.

Research

Even though the VA has made genuine progress in recent years in funding for psychiatric research at the VA, such research remains disproportionate to the utilization of mental illness treatment services by veterans. Veterans with mental illness account for approximately 25% of all veterans receiving treatment within the VA system. Despite this fact, VA resources devoted to research has lagged far behind those dedicated to other disorders. In 1998, only 11% of all research at the VA was dedicated to chronic mental illness, substance abuse and PTSD. This level has remained unchanged for the last 15 years, despite the fact the 22% of patients in the VA system receive mental illness treatment.

For FY 2002, NAMI has urged the Appropriations Subcommittee on VA, HUD, and IA to support the recommendation of the *Independent Budget* to increase the overall VA research budget by $45 million. More importantly, NAMI urges that $30 million of this increase go toward severe mental illness research. This increase would double mental illness research within the VA, an amount that has remained flat over the past 15 years. Research is one of the VA's top missions and NAMI is pleased that the VHA is taking steps to increase the number of Mental Illness Research, Education and Clinical Center (MIRECCs), centers designed to serve as infrastructure support for mental illness research. Because medical research is so important to improved treatments for severe mental illnesses and ultimately the cure of these disabling brain disorders, NAMI recommends full funding of the MIRECCs.

Our nation's dedicated veterans deserve the best care and treatment, including access to the highest quality services and state-of-the-art medications. Thank you for the opportunity to share NAMI's views on this important matter.

Fred Frese was a 25-year old Marine Corps captain when he had his first psychotic break and was diagnosed with paranoid schizophrenia. Although repeatedly hospitalized during the next decade, he completed graduate work in both management and psychology, earning a doctorate in psychology in 1978. Since then, he has continued to work in clinical and administrative positions with the Ohio Department of Mental Health. For 15 years until his retirement in 1995, he served as Director of Psychology at Western Reserve Psychiatric Hospital, a state-operated facility in the Cleveland-Akron area.

A member of the National Alliance for the Mentally Ill (NAMI) since 1989, Dr. Frese is currently the First Vice President of its National Board. He currently serves on the Board of the Summit County Alliance for the Mentally Ill.

Dr. Frese has given more than 300 presentations on topics related to serious mental illness in 30 states, Canada, Puerto Rico, and Washington, D.C. He has published extensively, and has been on the advisory reviewing boards of five professional journals, including Schizophrenia Bulletin. Along with his wife, Penny, he has also co-produced a widely distributed training video about coping with schizophrenia.

Dr. Frese has been a faculty member at Case Western Reserve University, Kent State, Ohio University, and Ashland Theological Seminary. He has also served as Chairperson of the Akron Area Mental Health Board. Dr. Frese was the founder and first president of Community and State Hospital Psychologists, the American Psychological Association's division for psychologists serving persons with serious mental illness. He also was on the Board of Trustees of the Ohio Psychological Association, where he served as Chair of the committee for the Mentally Ill Homeless. Additionally, he served as president of the National Mental Health Consumers' Association.

Dr. Frese served as a consultant to the Department of Veterans Affairs on a project to improve clinical practice. He has testified before congressional committees on priorities for public mental health services and is a part of the American Psychological Association Task Force for the Seriously Mentally Ill/Seriously Emotionally Disturbed. He and his wife and their four children live in the Cleveland-Akron area of Ohio.

NAMI—the National Alliance for the Mentally Ill is not in receipt of any federal grant or contract relevant to the subject matter of this testimony

STATEMENT OF

RICHARD B. FULLER, NATIONAL LEGISLATIVE DIRECTOR

PARALYZED VETERANS OF AMERICA

BEFORE THE

HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH

CONCERNING

THE STATUS OF VA MENTAL HEALTH PROGRAMS

JUNE 20, 2001

Chairman Moran and Ranking Democratic Member Gutierrez, members of the Subcommittee, Paralyzed Veterans of America (PVA) appreciates this opportunity to present our views on the status of the Department of Veterans Affairs (VA) mental health programs. I am Richard Fuller, PVA's National Legislative Director.

PVA would like to focus our testimony today on the role VA mental health programs play as one of the specialized services that are unique to the VA. VA's wide variety of mental health programs together with other specialized services such as blind rehabilitation, prosthetics, amputee services, and our own spinal cord dysfunction services are the core programs of VA health care. In many respects these programs are found no where else in U.S. medicine to the extent they are made available to veterans. And, rightly so, the Congress has given them special status, mandating in P.L. 104-262 that VA must maintain the capacity to provide this services.

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PVA has recently completed a report that indicates a high incidence of dual diagnosis of veterans with spinal cord dysfunction and mental illness. PVA's Health Policy Department surveyed VA's spinal cord dysfunction programs to assess the extent and quality of coordination between those programs and VA's mental health services. VA SCI treatment teams confirmed that mental health services were a core part of SCI/D rehabilitation in VA inpatient and outpatient settings.

We reviewed private sector programs of non-VHA Model System Hospitals providing SCI rehabilitation to assess the extent of the inclusion of mental health services in their programs. We also conducted a national membership survey last year to gauge the degree of self-reported concerns and incidence of mental health disorders among our members. The results showed a high incidence of mental health problems among veterans with SCI/D.

Among the findings:
Patients with SCI/D are more likely to be diagnosed with serious mental illness when compared to all veterans using VHA health care services. Patients with multiple sclerosis have the highest tendency to have serious mental illness diagnoses followed by patients with other spinal cord dysfunction disorders than veterans with spinal cord injury.

The most common serious mental illness inpatient treatments among spinal cord injury patients were for Adjustment Reaction followed by Schizophrenic Disorders

The number of SCI/D patients being treated for serious mental illness has increased by almost 5 percent since 1998. The portion of outpatient services (number of visits) has increased by a staggering 25 percent. Outpatient visits for the SCI patients alone have increased 42 percent since 1998.

Twenty-six percent of respondents to our membership survey identified "Depression and/or Anxiety" as a major health condition. Of these respondents, 55 percent were spinal cord injured, 26 percent had other spinal cord conditions, and 24 percent had MS. (some respondents indicated both spinal cord injury and spinal cord disease)

Sixty-four percent of the respondents between 40 and 64 years of age reported "depression and/or anxiety" as a major health condition, a finding that suggests that the on-set of serious mental illness increases due to the aging process and years of spinal cord dysfunction survival.

PVA surveyed four private-sector Model Spinal Cord Injury Systems. They indicated too that dual diagnosis presented a significant health care management challenge for both newly injured and annual evaluation patients. However, they reported that they had difficulty in providing adequate care and treatment under the pressures of limited lengths of stay. In addition, they reported that their rehabilitation settings are not staffed or equipped to provide suitable psychological care. Likewise, private sector psychiatric wards are unsuited to provide adequate rehabilitation care for individuals with spinal cord dysfunction.

By contrast, mental health screening and services are a stated objective of VA's SCI/D treatment plan. Demand for these services on an inpatient basis, but particularly on an outpatient basis, is high. These services, however, are not always available due to the shrinking capacity of mental health services throughout the VA health care system.

We are concerned about the on-going erosion in VA's mental health programs just as we are troubled by the failure of VA to maintain the capacity to provide all of its specialized services. I would like to review what steps PVA has taken in our own sphere of spinal cord dysfunction to attempt to stop this deterioration of services. We have not solved the SCI capacity problem. - not by a long shot.

But we have developed the tools to quantify where the problem areas are in beds and staffing and show clearly what VA needs to do to solve those problems. Hopefully our experience can assist the Subcommittee when it works to design legislation to further tighten and reauthorize the capacity reporting requirements this year. Hopefully, as well, our experience can assist advocates for other patients who need specialized services to serve as watchdogs for mental health and other endangered VA special programs.

Specialized services are labor intensive and expensive. In the mid-1990s this Subcommittee realized that changes accompanying the "re-invention" of the Veterans Health Administration, decentralization, the shift from inpatient to outpatient services, and growing budget pressures would provide the incentive for local VA managers to undermine the integrity of these programs shifting resources to other areas. The Subcommittee acted appropriately in passing a provision, now law, designating these programs with protected status, mandating VA to maintain service capacity, and requiring annual reports to Congress on VA's compliance with the capacity requirement. However, merely passing the law did not solve the problem. Initially, no one knew how to define capacity, and no one could agree how to quantify it. In the smoke and haze that blanketed the issue we continued to see local managers closing beds in SCI centers, reducing staff and curtailing services.

All of PVA's members are veterans with spinal cord injury or disease. Because of the complex nature of these disabilities and the fact that VA has developed a world-class system of 25 Spinal Cord Injury Centers, our members utilize the VA health care system at a higher percentage than any other veterans service organization. PVA's highest priority is sustaining and protecting the VA's Spinal Cord Dysfunction programs. If these programs are under threat, we are required by our board and membership to act.

Our first battle was over "definitions." VHA leadership said they could measure capacity by quantifying the intangibles of outcomes even though they had no mechanism to do so. We countered that counting beds and staff at SCI Centers was the only way to define the capacity of the system to provide a service, particularly one that was as inpatient based as the SCI system. Then there was the battle over numbers. What beds and staff do you count and how do you count them? It became clear early on that VA had 25 different ideas, depending on which of the 25 SCI Centers you were reporting from, on what constituted a bed and what constituted an SCI dedicated health professional. We, on the other hand, had a different idea based on our own bed counts and head counts conducted by our own service officers on site. The VA's numbers were clearly inaccurate, but were reported to the Congress anyway.

Over the years we have taken many steps in the attempt to get this sorted out. We have tangled with VA Secretaries and Under Secretaries. We have testified in hearing after hearing. We have filed lawsuits. We have requested Committee oversight and site visits in the field. We have gone to the press, all to point to the fact that we were serious about the fact that the capacity statute actually means what it says. We took the innovative step once of having the VA's manual on the treatment and referral of veterans with spinal cord injury hand delivered on the same day to each of the VA's 172 hospital directors by process servers. The directors didn't like it when the knock came to the door, but we got their attention.

Last year we were finally able to sit down with VA leadership and agree to agree. We designed a template designating staffing and bed levels for each SCI Center that will serve as a benchmark for all future capacity reports. On July 26, 2000, the Under Secretary for Health issued VHA Directive 2000-022 stipulating that all SCI Centers would be in compliance with the directive restoring staffing and beds to the agreed upon levels by September 30, 2000. That deadline came and went. The Under Secretary issued a memorandum extending the compliance deadline to January 1, 2001. That deadline was not met either.

We agreed to perform a monthly count in conjunction with VHA personnel of each SCI Center to determine the progress made in the restoration of capacity. We have agreed with VA on the total number of beds and staff, and we have agreed with VA how to count them. Having VA live up to that agreement is a different matter.

We now have nine months of data with which we can measure VHA's progress toward meeting the minimum resources requirements of VHA Directive 2000-022. (I am attaching a copy of the May 31, 2001 report to be included with my testimony for the hearing record.)

Many of the designated SCI facilities have made substantial progress towards providing the minimum resources specified in the directive. We are greatly appreciative of the efforts that have been made with the support of the Under Secretary for Health. However, it is clear from the data that absent something out of the ordinary occurring between now and September 30, VA will still not be providing the minimum SCI resource levels it promised PVA it would provide.

The number of nursing staff and staffed beds have remained virtually the same (92%) for the last three months, approximately 113 nurses short of the minimum number.

The SCI physician deficit has only been reduced by half.
There is a shortfall of 24 SCI therapists.
Further threatening mental health service capacity, there is a 30 percent shortfall in SCI psychologists.

As of May 31, 2001 only one of the 25 SCI facilities was fully compliant with the requirements of the directive.

As of May 31, 2001, only 11 of the 25 SCI facilities was providing the number of staffed beds specified by the directive.

It is very clear we have not reached the Promised Land of SCI full capacity. But at least we have developed the tools to see clearly how far we have to go - and how far VA must go - to get there. This Subcommittee must insist, in re-authorizing the specialized services capacity reporting requirements, that the legislation provide strong language and direction to adequately define capacity and make certain those capacity levels are met.

This concludes my testimony, Mr. Chairman. I will be happy to respond to questions.

SCI Center Beds and Staff SURVEY

May 31, 2001

	Acute & Sustaining Care Facilities	BEDS Available Reqmt	BEDS Staffed Reqmt	BEDS Staffed Actual	NURSES Reqmt	NURSES Actual	MDs Reqmt	MDs Actual	SOCIAL WKRS Reqmt	SOCIAL WKRS Actual	PSYCHOLOGISTS Reqmt	PSYCHOLOGISTS Actual	THERAPISTS Reqmt	THERAPISTS Actual
1	Albuquerque	30	26	15.6	36.9	22.2	3.1	3.0	1.5	1.5	1.5	1.0	6.0	5.4
2	Augusta	60	55	50.4	78.1	71.5	6.0	5.0	3.0	3.5	3.0	3.0	12.0	11.0
3	West Rox	40	34	17.7	48.3	25.2	3.9	3.4	2.0	2.0	2.0	2.0	8.0	8.0
4	Bronx	62	53	55.4	75.3	78.6	5.8	5.6	3.1	3.0	3.1	2.8	12.4	8.0
5	Cleveland	38	32	28.5	45.4	40.4	3.7	5.2	1.9	1.0	1.9	1.6	7.6	6.5
6	Dallas	30	26	30.6	36.9	43.4	3.1	4.0	1.5	2.0	1.5	1.0	6.0	6.5
7	East Orange	14	12	13.7	17.0	19.5	1.7	1.2	0.7	0.8	0.7	0.5	2.8	3.0
8	Hines	66	58	47.1	82.4	66.9	6.3	3.7	3.4	1.8	3.4	0.9	13.6	5.9
9	Houston	40	34	27.7	48.3	39.4	3.9	4.0	2.0	2.0	2.0	2.3	8.0	8.0
10	Long Beach	85	72	70.6	102.2	100.3	7.7	5.9	4.3	4.0	4.3	1.0	17.0	8.5
11	Memphis	70	60	60.6	85.2	86.0	6.5	6.5	3.5	3.5	3.5	3.5	14.0	11.8
12	Miami	36	31	31.3	44.0	44.5	3.6	2.5	1.8	2.0	1.8	1.0	7.2	6.0
13	Milwaukee	38	32	30.3	45.4	43.0	3.7	3.7	1.9	2.0	1.9	1.0	7.6	7.6
14	Palo Alto	43	43	42.3	61.1	60.1	4.8	6.0	2.2	3.0	2.2	1.0	8.6	9.5
15	Richmond*	100	68	58.6	96.6	83.2	7.3	5.0	5.0	5.0	5.0	2.5	20.0	19.0
16	San Antonio	30	26	29.2	36.9	41.5	3.1	3.1	1.5	1.5	1.5	1.0	6.0	7.0
17	San Diego	30	26	27.3	36.9	38.8	3.1	2.7	1.5	1.5	1.5	1.5	6.0	8.0
18	San Juan	20	17	18.3	24.1	26.0	2.2	2.0	1.0	1.0	1.0	0.3	4.0	4.0
19	Seattle	38	32	28.0	45.4	39.7	3.7	4.2	1.9	2.5	1.9	2.0	7.6	10.4
20	St. Louis	32	27	16.6	38.3	23.6	3.2	3.4	1.6	1.6	1.6	1.6	6.4	5.0
21	Tampa	70	60	60.2	85.2	85.5	6.5	5.5	3.0	2.0	3.0	2.0	12.0	10.0
	SUBTOTAL	974	824	760.0	1170.1	1079.2	92.9	85.6	48.2	47.2	48.2	33.5	192.8	169.1
	Extended Care Facilities													
1	Brockton	40	30	22.5	42.6	32.0	1.7	0.5	1.0	1.0	1.0	1.0	2.9	2.9
2	Castle Point	20	15	15.9	21.3	22.6	2.0	2.0	1.0	1.0	1.0	1.0	4.0	4.0
3	Hampton	64	50	49.3	71.0	70.0	2.5	3.0	1.6	0.0	1.6	1.5	4.6	6.0
4	Hines RCF	30	30	21.7	42.6	30.8	1.7	0.3	0.8	0.3	0.8	0.1	2.1	0.6
	SUBTOTAL	154	125	109.4	177.5	155.4	7.9	5.8	4.4	2.3	4.4	3.6	13.6	13.5
	TOTAL	1128	949	869.4	1347.6	1234.6	100.8	91.4	52.6	49.5	52.6	37.1	206.4	182.6

*Includes 20 Hoptel Beds

SYSTEM TOTALS													
Acu/Sus Care	974	824	760.02	1170.1	1079.2	92.9	85.6	48.2	47.2	48.2	33.5	192.8	169.1
Extended Care	154	125	109.4	177.5	155.4	7.9	5.8	4.4	2.3	4.4	3.6	13.6	13.5
To be Identified	180	180											
Cleveland	10	10											
Memphis	20	20											
Menlo Park	10	10											
Miami NH	10	10											
Tampa	30	30											
TOTAL	1388	1209	869.4	1347.6	1234.6	100.8	91.4	52.6	49.5	52.6	37.1	206.4	182.6

DEFICITS	Staffed Bed *Deficit*	Nurse *Deficit*	MD *Deficit*	Social Worker *Deficit*	Psych-ologist *Deficit*	Ther-apist *Deficit*
Acu/Sus Care	84.0	90.8	7.3	1.0	14.7	23.7
Extended Care	15.6	22.2	2.1	2.1	0.8	0.1
Total	79.6	113.0	9.4	3.1	15.5	23.8

Data for Bronx, East Orange, and Castle Point was provided by the VA, based on Surveys signed by the local NSO.

PARALYZED VETERANS
OF AMERICA
Chartered by the Congress
of the United States

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Richard Fuller is the National Legislative Director of Paralyzed Veterans of America (PVA) at PVA's National Office in Washington D.C. He is responsible for coordinating the organization's legislative and oversight activities on all veterans' benefits and services. PVA's primary legislative focus centers on issues supporting the VA health care system and the specialized services VA provides to PVA members, veterans with spinal cord dysfunction. As National Legislative Director, he is also responsible for oversight on all federal health systems - Medicare and Medicaid - and research activities which benefit veterans as well as all Americans with disabilities.

Paralyzed Veterans Of America is a veterans service organization chartered by the United States Congress to represent the interests of its members, veterans with spinal cord injury or dysfunction, and all Americans with disabilities.

Mr. Fuller served for eight years on the professional staff of the House Committee on Veterans' Affairs of the U.S. House of Representatives with primary responsibilities in areas of veterans' health and education legislation. Since 1987, he has worked in the field of public policy and government relations, specializing in health policy for a wide variety of health advocacy, consumer health research and provider non-profit organizations in Washington D.C.

Mr. Fuller was Director of Public Affairs of the U.S. House Committee on Veterans' Affairs from 1979 to 1981. He served on the professional staff of the House VA Committee's Subcommittee on Education, Training and Employment for the next two years and as professional staff member with the VA Committee's Hospitals and Health Care Subcommittee until 1987. In 1987 he joined the national government relations staff of Paralyzed Veterans of America, serving first as Associate Legislative Director, and then as National Legislative Director. In 1991 he joined a Washington D.C. health care consulting firm representing the public policy and legislative interests of several national medical and research societies, including: The American Federation for Clinical Research, The American Gastroenterological Association, The American Geriatrics Society and the National Association of Veterans Research and Education Foundations. He returned to PVA in 1993 to lead the organization's outreach efforts on national and state health-care reform.

Mr. Fuller graduated with a Bachelor of Arts degree from Duke University in 1968. He served in the United States Air Force from 1968 to 1972, stationed two and one-half years in Vietnam and Southeast Asia as an aircrew Vietnamese linguist with the Air Force Security Service.

Information Required by Rule XI 2(g)(4) of the House of Representatives

Pursuant to Rule XI 2(g)(4) of the House of Representatives, the following information is provided regarding federal grants and contracts.

Fiscal Year 2001

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $83,000 (estimated as of February 28, 2001).

Fiscal Year 2000

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilities Act , 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Federal Aviation Administration – Accessibility consultation -- $12,500.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $200,000.

Fiscal Year 1999

General Services Administration —Preparation and presentation of seminars regarding implementation of the Americans With Disabilties Act , 42 U.S.C. §12101, and requirements of the Uniform Federal Accessibility Standards — $30,000.

Court of Appeals for Veterans Claims, administered by the Legal Services Corporation — National Veterans Legal Services Program— $240,000.

STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
June 20, 2001

Mr. Chairman and Members of the Subcommittee:

I am pleased to present the views of the Disabled American Veterans (DAV) regarding the Department of Veterans Affairs (VA) specialized programs of care for veterans suffering from severe mental illness, substance-use disorders, and homelessness. Many severely disabled and homeless veterans need and rely on VA's specialized health care services. Therefore, this issue continues to be one of our foremost concerns and is of great importance to the DAV's more than one million members and their families.

The DAV views the Veterans Health Administration's (VHA's) programs for veterans with special needs as the core of the VA health care system. Many of these specialized programs, such as those developed to treat serious mental illness, substance-use disorders, and posttraumatic stress disorder, are unmatched in excellence. Unfortunately, over the past five years there has been a continuing erosion of specialized services for veterans suffering from these severely disabling conditions.

In 1995, VHA shifted from an inpatient model of hospital-based care to a more comprehensive outpatient-based health care delivery system. This change has yielded several positive results; however, the shift to an outpatient based primary care model has had a negative effect on many of VA's specialized programs, including mental health services. Although most veterans now have better access to community-based primary care services, mental health care services are not available at many community-based outpatient clinics (CBOCs). Since the shift to outpatient-based care, there has been insufficient development throughout the VA system of necessary outpatient-based mental health services to replace the more traditional inpatient programs. The Committee on Care of Severely Chronically Mentally Ill Veterans submitted a response to a draft of the 2000 annual Capacity Report dated May 31, 2001. In its memorandum, the Committee noted that over the past decade there has been significant deinstitutionalization of seriously mentally ill (SMI) patients and that inpatient resources for these patients had been reduced by more than 50 percent. The committee reported that in 2000 "...only half [of all CBOCs] provides meaningful mental health services, varying among networks from 100 percent to 13 percent."

Congress recognized the importance of maintaining capacity for VA's specialized programs and enacted Public Law 104-262, which mandated that

> ...the Secretary shall ensure that the Department maintains its capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including veterans with spinal cord dysfunction, blindness, amputations, and mental illness) within distinct programs or facilities of the Department that are dedicated to the specialized needs of disabled veterans in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that the overall capacity of the department to provide such services is not reduced...

It was mandated that capacity would be maintained at levels reported in fiscal year 1996. However, despite these statutory requirements to maintain its capacity to serve disabled veterans with severe mental illness, many specialized inpatient programs have been closed, cutback, or severely compromised by staff shortages or reorganization.

The Committee noted in its May 31 memorandum that capacity measures were to be determined by the number of veterans treated and the dollars expended for their care, and that capacity could only be maintained if both components were met. It also determined that the number of dollars expended was a reasonable way to monitor whether the necessary reinvestment of resources from institutional to outpatient-based care was occurring. As a final measure, the Committee noted that these figures are only meaningful if a reasonable adjustment for inflation was included.

The Committee determined that the two elements of the capacity definition were not met in the 2000 Capacity Report for PTSD, the overall SMI group, or the substance abuse population of veterans. They were met for the SMI homeless population. It noted that the 2000 report omits key information included in last year's report on inflation-adjusted dollars and uses unadjusted dollars only. Therefore, based on the data supplied in the fiscal year 2000 Capacity Report, the Committee concluded, "... that the Department is still not in compliance with the capacity provisions in Public Law 104-262." We agree with these findings.

It is essential for VHA to maintain equal access to a full continuum of mental health services across the VISNs for SMI veterans. Intensive case management is often necessary to successfully manage patients with severe mental illness on an outpatient basis. Additionally, many veterans dealing with substance abuse disorders and PTSD need a structured support system with routine monitoring by mental health care professionals. Without access to appropriate VA mental health care services, these patients may experience serious setbacks, homelessness or other related problems, and have to rely on other community resources for assistance.

Additionally, outpatient treatment programs may not always be appropriate for all veterans with specialized needs. In the past, VA was well known for its excellent programs for veterans dealing with substance-use disorders. These lengthy and intensive inpatient programs

were highly successful and helped many veterans to overcome their addictions and once again lead productive healthy lives. However, due to cutbacks, many of these programs are no longer available. Some counselors have indicated that veterans seeking treatment for substance-use disorders are at a higher risk for relapse if they do not have access to traditional long-term inpatient programs or, at the very least, intensive outpatient case management. Likewise, shifting serious chronic mentally ill veterans to primary outpatient care settings may not always relate to satisfactory care/treatment for these patients.

Resource allocation and policy decisions for specialized mental health services should be based on patient need. Unfortunately, it appears that in some cases, Network funding distribution decisions have equated to reductions in local mental health care services. Adequate funding is necessary for VHA to meet capacity mandates, to staff specialized programs with qualified individuals, and to provide quality timely care. Congressional oversight to maintain these specialized services is necessary to protect our Nation's most vulnerable veterans. Information provided in the annual Capacity Report is essential for determining the status of specialized programs within VHA. However, this is the last report mandated by Public Law 104-262. Because the information contained in the Capacity Report is necessary for tracking the status of these important programs, it is the DAV's recommendation that the Secretary should continue to submit annual reports to the House and Senate Veterans' Affairs Committees for continued oversight of capacity.

Recently, the DAV became aware of deliberations within VA concerning medication treatment guidelines for veterans with schizophrenia. We are concerned that VA clinical managers are considering the adoption of a system-wide policy that may in effect restrict the clinical discretion of VA staff psychiatrists and thereby limit the treatment options for veterans with schizophrenia.

Several medications, referred to as novel anti-psychotropics, are available to treat patients with schizophrenia and have been shown to improve cognitive functioning and reduce psychotic symptoms with fewer side effects compared to traditional medications. However, costs for the newer medications vary significantly. In an attempt to manage the increased costs for these medications, guidelines were developed in VISNs 11 and 22 that in effect may restrict a physician from prescribing first-line medication that he or she deems most appropriate based on patient need. We strongly object to any policy directives that are cost-driven rather than based solely on standards of best practice. The guidelines for the use of antipsychotic medication in VISN 11 would have a physician use, "in the absence of differential efficacy data, or any other patient specific issues for the use of one medication over another, the medication with the lowest acquisition cost first." Under this policy, patients would undergo two separate trial periods on the lowest costing novel antipsychotic medications first, for up to ten weeks each. Clinical assessment of medication failure would determine whether medication change to another novel antipsychotic was indicated.

This "fail-first" policy raises a great deal of concern for the DAV. First and foremost, we do not believe that it gives clinicians full freedom to exercise their best clinical judgment in determining the needs of his or her patient without being concerned about cost. Providers would be left to consider just how serious are the side effects reported by the veteran and can they

justify use of one of the other novel medications. Secondly, it does not take into consideration that some veterans may experience delayed access to mental health care services at local facilities. This would be especially disturbing if a SMI veteran was failing on a prescribed trial of medication and does not have immediate access to follow-up care. Patients should not be subjected to various clinical trials of medication, which could lead to a psychiatric crisis or a set back in mental health status simply because of cost saving measures. A medication trial failure may result in serious consequences for the SMI patient. He or she may cause harm to themselves or others during such an event and not recover to their previous mental health status following a full-blown psychotic episode. This policy could delay effective treatment for 20 weeks or more. Clinical managers must consider if the higher acquisition cost of one novel antipsychotic over the other will be offset by other related treatment costs such as inpatient or outpatient care if the patient experiences a serious psychotic episode on an initial medication trial, as dictated by policy.

Finally, it does not take into account that individuals react differently to different types of medication and that sensitivity to side effects from antipsychotic medications differs from individual to individual. Patients rely on clinicians to choose the best possible treatment for their specific disease and individual clinical history. It is unfair to both the patient and treating physician to have to follow specified medication treatment guidelines for the treatment of schizophrenia simply as a cost saving measure. The clinician should be able to prescribe the most effective medication for the patient based on the needs of that patient, without regard to cost.

SMI veterans deserve high quality and timely access to mental health care services. These two factors should guide all decisions concerning their care at VA facilities. Guidelines for treatment of patients with schizophrenia that restrict or limit a clinician's ability to prescribe medications based solely on clinical assessment and individual needs of the patient should be abandoned. Higher costs in medications must be weighed against offsets in other treatment costs associated with inpatient or frequent outpatient mental health services associated with a medication treatment failure. Most importantly, medications that could significantly improve an SMI patient's quality of life should be available to the patient if deemed appropriate by his or her physician, without regard to cost.

Recently, Representative Bob Filner (D-CA) wrote to Secretary of Veterans Affairs Anthony J. Principi concerning this issue. He noted that an ongoing project to determine the relative safety and efficacy of anti-psychotic medication trials has been funded by Congress. He requested that VA not promulgate new schizophrenia treatment guidelines until it has received the results from the Clinical Antipsychotic Trials Intervention Effectiveness (CATIE) Project being conducted by the National Institute of Mental Health. DAV also requests that VHA immediately suspend any current medication guidelines for the treatment of schizophrenia pending the outcome of the CATIE project.

Likewise, DAV is very concerned about VA's specialized programs for veterans who are homeless. Following his appointment to Secretary of Veterans Affairs, Jesse Brown announced, "Homelessness in America is a national tragedy. And homelessness among those men and women who so honorably served our country is an even greater tragedy. The Department of

Veterans Affairs (VA) has made the fight to end homelessness among veterans a top priority." Secretary Principi has also announced that one of his top priorities will be the issue of homeless veterans and that he will establish a task force to review this issue.

It is estimated that, on any given night, approximately 275,000 veterans are homeless. Access to VA benefits and specialized services is essential for many homeless veterans to regain and hold steady employment. A comprehensive care approach, including specialized programs for mental health care and substance abuse problems, offers homeless veterans a hand up and an opportunity to break the cycle of homelessness.

Traditionally, homeless veterans have been treated in VA inpatient and domiciliary care programs. However, as VA moved toward community-based outpatient care, we began to see a decline in the number of programs and services available to address the needs of this veteran population. Unfortunately, many homeless veterans experience serious mental illness and struggle with substance abuse disorders and posttraumatic stress disorder. Addressing the needs of homeless veterans requires more than a place to stay. Specialized programs and complex care regimes are necessary to help homeless veterans rebound and move from the streets to self-sufficiency.

We need an accurate assessment from VHA as to the staffing and funding levels dedicated to homeless services in each medical center and the types of programs currently functioning to address the complex needs of the homeless veteran population. VA must tailor its health care services to meet the unique needs of homeless veterans. The Heather French Henry Homeless Veterans Assistance Act, H.R. 936, introduced by Representative Lane Evans (D-IL), provides a vehicle to begin to address those needs.

The DAV, in concert with the other *Independent Budget* veterans service organizations, AMVETS, Paralyzed Veterans of America, and Veterans of Foreign Wars, have previously expressed serious concerns about capacity for specialized programs in VHA. The system is experiencing serious difficulties in providing quality and timely care and the specialized services veterans need consistently nationwide.

The DAV recognizes that VA has made an effort to address problems associated with capacity of its specialized programs. But clearly, more needs to be done. VHA must honestly assess and request accurate funding levels needed to fulfill its mission of providing quality and timely specialized health care services to our Nation's most vulnerable veterans.

DISABLED AMERICAN VETERANS
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FACT SHEET

BIOGRAPHICAL INFORMATION

JOY J. ILEM
Assistant National Legislative Director
Disabled American Veterans

Joy J. Ilem, a U.S. Army service-connected disabled veteran, was appointed Assistant National Legislative Director of the million-member-plus Disabled American Veterans (DAV) on August 24, 2000.

Ms. Ilem is employed at DAV National Service and Legislative Headquarters in Washington, D.C. As a member of the DAV's legislative team, she works to promote and defend reasonable and responsible legislation to assist disabled veterans and their families.

Ms. Ilem began her DAV career as a member of Class III at National Service Officer Training Academy in Denver. Following graduation from the academy in 1996, she was assigned as a NSO Trainee at the National Service Office in Phoenix, Ariz. In 1997, she was assigned as a National Appeals Officer with the DAV staff at the Board of Veterans Appeals in Washington, D.C., where she served until her appointment, as Associate National Legislative Director in April 1999.

A native of Shakopee, Minn., Ms. Ilem was raised in the greater Minneapolis area, and is a 1977 graduate of Totino Grace High School in Fridley, Minn. She earned her bachelor's degree from the University of Arizona at Tucson in 1994, where she majored in archaeology, with a minor in religious studies.

Ms. Ilem enlisted in the U.S. Army in 1982. Following basic training at Ft. Jackson, S.C., and advanced medical training at Ft. Sam Houston, Texas, she was assigned as a combat medic to the 67th Evacuation Hospital in Wurzburg, Germany, where she underwent additional certification as an emergency medical technician (EMT). Ms. Ilem's military duties included emergency room assignments and non-commissioned officer in charge (NCOIC) of recovery room operations. She was honorably discharged from the Army in 1985.

A life member of DAV Chapter 1, Washington, D.C., Ms. Ilem resides in Washington, D.C.

10/00

DISCLOSURE OF FEDERAL GRANTS OR CONTRACTS

The Disabled American Veterans (DAV) does not currently receive any money from any federal grant or contract.

During fiscal year (FY) 1995, DAV received $55,252.56 from Court of Veterans Appeals appropriated funds provided to the Legal Service Corporation for services provided by DAV to the Veterans Consortium Pro Bono Program. In FY 1996, DAV received $8,448.12 for services provided to the Consortium. Since June 1996, DAV has provided its services to the Consortium at no cost to the Consortium.

Statement of

VIETNAM VETERANS OF AMERICA

Submitted By

Dr. Linda Spoonster Schwartz, RN MSN DPH, Major USAF, NC (Ret)
Yale School of Nursing

with

Richard Weidman
Director of Government Relations

Before the
House Veterans' Affairs Committee
Subcommittee on Health

Regarding

Mental Health, Substance-Use Disorders, and Homeless Programs

June 20, 2001

Vietnam Veterans of America
Subcommittee on Veterans Health Testimony
June 20, 2001

Mr. Chairman, Vietnam Veterans of America (VVA) is grateful the opportunity to express our views on this topic of vital interest to so many veterans in great need before this distinguished panel. My name is Dr. Linda Schwartz. In addition to currently being a Researcher at the Yale School of Nursing, I serve as Chairman of the VVA Task Force on Veterans Health. I am accompanied by Rick Weidman, who serves as Director of Government Relations for Vietnam Veterans of America.

VVA is grateful to the Subcommittee for your attention to the vital issue of the continued diminishment of mental health and behavioral sciences resources and treatment available at facilities operated by the Department of Veterans Affairs (VA). This diminishment denies some of our neediest veterans, who often cannot effectively advocate for themself, access to vitally needed services. It is not only illegal of VA to allow this continued reduction in resources and funding, it is morally reprehensible.

Historical Perspective

It was not until the mass mobilization of volunteers and draftees during America's engagement in World War II that mental health and psychiatry became a significant concern of military medicine. Initially the startling numbers of men and women rejected for military service due to psychological and mental health problems heightened the Nation's awareness of a major condition not widely discussed or understood. This concern multiplied when the number of casualties sent home from the battle zones due to neuro-psychiatric wounds outnumbered casualties needing medical, surgical or trauma care. In many ways the numbers of veterans in need of psychiatric care began to define and shape the mission of the Veterans Administration in the post WW II era.

At the same time, Medical Schools eager to affiliate with VA Hospitals exerted new demands for acute care, surgical and research experiences for physicians in training. Thus, began the classic intramural struggle between Psychiatry versus the Medical-Surgical Services for patient beds, dollars, staffing and other support resources which has persisted for more than 50 years and now in a slightly different form surfaces as a major focus of today's hearing. It is important to note that amidst this tug of war, the more visible physiological needs of Korean and Vietnam War veterans positioned the care of VA patients with neuropsychiatric disorders in a "One Down Position."

Perhaps the most outrageous and unkindly cut came as a result of the Health Care Financing Administration (HCFA) use of Diagnostic Related Groupings(DRG's) as a method of quantifying patient care costs. DRG's were originally designed by Professor John D. Thompson at the Yale School of Medicine, Department of Epidemiologist and

Public Health as a tool for estimating variations in the intensity of workload in the delivery of care to patients. As a student of Professor Thompson, I learned that using DRG's to estimate the cost of health care was a misuse of the intent and utility of this methodology.

When VA adopted the HCFA criteria, the then VA Chief Medical Director Admiral Donald Custis also applied a -17% reduction or "discount" in cost estimates for the care of neuro-psychiatric patients. Whether by design or by accident this decision in essence crippled and disenfranchised veterans with psychiatric problems and severely compromised VA's capacity to care for these very needy patients. Essentially this decision solidified a preference for funding Medical-Surgical Services and Programs became the VA standard. To many observers, by the early 1980s the VA system was driven much more by the needs of Medical Schools and the VA Medical establishment's own internal vested interests as opposed to the needs of veterans. With the remodeling of VA Health Care delivery systems in the 90s, the Congress acted wisely to protect specialized care programs including the treatment of seriously mentally ill veterans, substance abuse treatment programs, post traumatic stress disorder, and care and assistance to homeless veterans. Unfortunately the protections the Congress provided have not been enough to accomplish the task thus far.

The enactment of "capacity legislation" in 1996 clearly tasked VA with maintaining these programs and the equality of the care provided, which even at that time were deliberately under funded. As we look back from that time to this there is cause to celebrate many innovative and substantive improvements for care to American's veterans, some involving Medical Schools affiliated with the Veterans Health Administration. However, one cannot help but notice that veterans least able to speak for themselves, veterans who are mentally ill, veterans who have substance abuse problems--veterans who are homeless continue to be least well treated by the VA system of care, and one of the last priorities of some of the Network Directors.

The provisions of PL 104-265 not only offered eligibility reform (broadening of that eligibility) sought by the VA, but charged the Secretary of VA with maintaining capacity to provide for specialized treatment and rehabilitation needs of veterans with spinal cord dysfunction, blindness, amputations and mental illness in a manner that affords those veterans reasonable access to care. This statute also mandates maintenance of services for those specialized needs, and "ensure the overall capacity of VA to provide such services is not reduced." The defining baseline year for determining capacity authorized was set at Fiscal Year 1996.

Congress also required the Under Secretary for Health to create the Advisory Committee on Severely Chronically Mentally Ill Veterans. This Committee is charged with assisting the Undersecretary and the Secretary with monitoring the capacity of VA under those priorities. This committee determined that the number of veterans treated and the dollars expended for their care in specialized programs were appropriate for quantifying the question of capacity. I have been privileged to witness the deliberation of this committee as a member of the Consumer Group. I have been impressed by their determination to fairly assess the progress and refine the delivery system. I have not been impressed favorably by the response of the top leadership of VA, which continues to debate "the meaning of the word is" as opposed to admitting what is apparent to all concerned: VA is not meeting the requirements of the law, and is therefore acting illegally.

Capacity Report 2000

Mr. Chairman, there has been a significant reduction in specialized capacity to treat substance abuse that has occurred between FY 1996 and FY 2000. Our organizational representatives around the country share information with us at the National level that would suggest that the decimation of alcohol and substance abuse services continues unabated. To maintain, as some have at VA, that the dramatic reductions in available services is not the cause of the reduced number of veterans in treatment for substance abuse is sophistry Newspeak thinking worthy of the now defunct Soviet system.

There is, of course, wide variation that exists among Veterans Integrated System Networks (VISNs), and even from VA Medical Center (VAMC) to VAMC within VISNs in the maintenance of specialized capacity. What the VA has done is to give the VISN directors unprecedented power and authority, with virtually no accountability except in the area of fiscal restraint (read: denial of vitally needed services to those with the least public voice!). The inability and/or unwillingness of the VA to hold these employees accountable appears to VVA to be an effort for top VA officials to preserve deniability of what they know is happening as a result of affording VISN Directors with license.

Although there were increased numbers of veterans who met the definition for seriously mentally ill, there was a reduction in funding for the specialized treatment for these veterans. That much is apparent to all who will see what they are looking at in regard to resources allocated to SCMI.

VA had a increase (8%) in the number of individual veterans that met the definition of SMI which was accompanied by a decrease (9%) in funding. (These figures do not at all

account for medical inflation that is at least 8 % to 9% per year.) Some attribute the decline in funding to a shift from patient treatment settings to outpatient and community based care. Originally, the "company line" put forth was that elimination of inpatient programs would allow these dollars to be put right into outpatient services for substance abuse treatment, seriously mentally ill patients, post traumatic stress disorder, and other neuropsychiatry problems. It simply never happened in most places. Much of the cuts in funding made at the national level were absorbed at the local level by eliminating care and services for the veterans least able to speak up.

VHA has now issued policy directives establishing centralized review of proposed "major" changes in mental health programs in the field which has dramatically improved the oversight of program of Mental Health and Behavioral Sciences, and enhanced compliance for VHA policies. However, most of the really big cuts have already been taken, and VAMCs and VISNs now continue to reduce resources just under the threshold where they would have to get permission from the Central Office of VA. If the threshold is a 10% reduction (which it is in most cases) they simply reduce by 9% per year (which is really at least a 17% cut, when inflation is taken into account), thus avoiding having to let anyone at the National level know what they are doing.

Post Traumatic Stress Disorder (PTSD)

Last Fiscal Year, VA reported a 22% increase in the number of veterans with PTSD since 1996. At the same time funding for these programs decreased by 8%. (Once again, this does not account for inflation, so the reductions were actually much greater.) A number of VISNs eliminated inpatient treatment for PTSD altogether, and are severely straining the best programs by not filling vacancies and forcing "social graduations" from relatively intensive outpatient programs.

However, even within VISNs there is inconsistency, and even greater inconsistencies between VISNs. For example, seven VISNs increased their expenditures while 15 reduced funding for these specialized services.

Veterans Who Are Homeless

Last fiscal year, VA reported an increase of 26% in the number of veterans who are homeless. This number included veterans who received care in a VA program specifically designed for specialized programs including substance abuse treatment and the Domiciliary Care Program.

The reductions in funding for treatment of SMI veterans who are homeless can be directly linked to the reduction in funding for substance abuse treatment programs. In other words, the VA has been creating homeless veterans faster than the Congress can devise, pass, and fund new programs to help reduce homelessness among veterans. It is time that all concerned recognize this fact.

Substance Abuse Treatment

The most significant reduction in specialized medical services capacity to treat substance abuse appears to have occurred between FY 1996 and FY 1999. Wide variations exist nationally among VISNs and within VISNs in the maintenance of substance abuse treatment capacity. The actual level of need is unknown, because construction of the budget of VA is never preceded by even an attempt at an honest assessment of needs at the local and regional levels. The reduction in the number of veterans in substance abuse treatment means that the law of supply and demand has come into play. Less treatment programs available mean less veterans in the program

Since the capacity legislation came into law, funding for Substance Abuse Treatment Programs overall were reduced by 37%. While some VISNs treated greater numbers of veterans, others drastically reduced the number of veterans treated, all but eliminating substance abuse treatment at some stations. While the better VISNs increase in such treatment availability of treatment reflects greater attention to the "whole veteran" concept and model of treatment, in some cases it has meant a few outpatient visits for veterans and then a referral to Alcoholics Anonymous. This has enabled some VISN Directors to pad their numbers, without really getting at the core issues of the veteran's health problems. In other VISNs there really has been a significant improvement in resources and in the treatment modalities that has resulted in many veterans becoming more healthy. So we know that at least some in the VA recognize their responsibilities in this regard and have the expertise and the competence to get the job done right the first time.

Wellness Model" of Veterans Health Care

Vietnam Veterans of America (VVA) has been committed to a holistic "wellness" model of care for veterans for almost twenty years. VVA also believes strongly that there is a significant difference between veterans' health care and general health care that happens to be for veterans. Similarly, there is a significant difference between veterans' mental health care and general mental health care that happens to be for veterans.

The "wellness" model means that all VA programs should be measured against the test of whether and how much that program helps return the individual veteran to

the highest degree of physical and psycho-social health, which would enable the veteran to achieve the highest degree of autonomy and independence possible. This cannot mean just treating the most pressing of the acute care needs that drove the veteran to seek care, and then releasing that veteran to continue to "churn" through the system. This is terribly harmful to the veteran, and wastes valuable resources. Our Nation can and must do better.

For veterans of working age, VVA believes that the litmus test of how well the VA has done its job should be measured by whether the veterans is assisted to obtain and sustain meaningful work, at a living wage. (That is why VVA continues to press for meaningful reforms in the employment programs at the Department of Labor and in VA Vocational Rehabilitation programs.)

Fifteen years ago VVA proposed to this Committee in testimony changing Dr. Paul Errera's job title to "Deputy Chief Medical Director for Veterans Mental Health" with the commensurate additional authority and clout to affect resources and methodologies for treatment at the service delivery level. VVA also proposed at the same time that VA be required to take a complete military history for every veteran who sought treatment from a VA facility, and that VA be compelled to follow through on the conditions, illnesses, and maladies to which a veteran may have potentially been exposed to during military service, including traumatic events. Both of these recommendations were brushed aside at that time. We hope that this current group of distinguished Members of Congress will take bold steps to correct what has been a chronic problem that has now reached true crisis proportions.

In regard to the taking of military history, VVA is grateful to this Committee for taking steps toward requiring such a military history at the end of the 106th Congress. VVA is also grateful to Dr. Thomas Garthwaite for conceptualizing and initiating the "Veterans Health Initiative" in September of 1999, that includes plans for such a universal use of military histories to ensure that each veteran has a complete diagnosis of everything that may be causing him or her neuro-psychiatric, physiological, or other health problems today. Taken together with bold and decisive action to restore SCMI and other specialized services to at least the resource level of FY 1996 (adjusted for inflation), the above efforts can result in major improvements in what can only be fairly described as a dire situation today.

Statement of the Problem

Mr. Chairman, we could go on for a very great length in just briefly outlining the parameters of the problem. Perhaps it will suffice to state that there has clearly

been a blatant disregard for the law in regard to maintaining the specialized services, particularly all elements of Seriously and Chronically Mentally Ill treatment and services. This has happened because there are no "teeth" or repercussions built into the law requiring maintenance of capacity. VISN and VAMC officials can ignore "best practices" and the chief consultant for mental health with total impunity. Those same officials can (and apparently do) pay little or no heed to requests and directives in regard to specialized services that are put forward by the highest levels of VA.

Possible Useful Steps for the Committee

Vietnam Veterans of America (VVA) suggest that the Committee consider the following steps to begin to meet what we regard as a chronic situation that has now become a crisis that is growing in proportion by the month.

First, VVA urges the Congress to move quickly to pass legislation that would re-centralize all of the specialized services, plus homeless programs and hepatitis C programs. The model here is the bold action the Congress took to address the problem with prosthetics needs of veterans being ignored, and we suggest that the same model be employed for all of the other services that the Congress has deemed to be at the core of the Veterans Health Administration's mission, and toward which VISN Directors have amply shown they cannot, as a group be trusted to act correctly or responsibly or lawfully.

Two, VVA urges the Congress to establish much greater line authority for results in the care in these veterans affected in the clinical domain, and away from the "bean counters" having full sway. Part of this action should include some real authority and clout for the so-called consultants who are nominally head of each of the specialized services as well as the homeless and the hepatitis C efforts.

Three, the VA must be provided the funds and full support of the Congress to mobilize needed expertise to produce proper information technology systems that can even make it possible to discover what is happening clinically or otherwise in a short amount of time, and not years later, after the damage has been done by runaway VISN Directors. Secretary Principi has announced an initiative to create a useful IT system, and he deserves full support from all Members of Congress in this effort.

It is outrageous that VA Central Office cannot even tell the Congress how much money is going where, to be used for what purpose, at any given time. Nor can the

VA collect aggregate information on the patient treatment files to judge whether outcomes overall or in a specific area are positive.

It is absurd that UPS can find any of the millions of packages it handles every day, at any location in the world, the physical condition of that package, and its status in regard to delivery, BUT the VA cannot do the same in regard to sick veterans in its system. Nor does the VA know how many staff it has, with what specialization, serving how many veterans at any given VA facility on any given day. Certainly the Congress would not put up with such lack of knowledge from any of our military commanders. Can you seriously imagine the Commandant of the Marine Corps not knowing the number of troops or status of equipment and materiel possessed by elements in his command at any given time?

Four, the system of "Best Practices" must be changed so that the VA central office officials know at any given time who has accessed the central repository to download and read the materials, who has trained all of their staff in said best practices, and whether such best practices are being adhered to in service delivery at a given facility, with what results. VA spent millions to create this electronic library and to compile the best practices as a wonderful tool, but have done virtually nothing to even check whether this tool is used, much less used to more effectively serve veterans.

Five, VVA strongly urges the Congress to mandate that the VA prepare a plan for rebuilding organizational capacity in the specialized services that has been lost since Fiscal Year 1996. VVA has estimated that it will take a bare minimum of $3 Billion over a three year period to begin to restore lost organizational capacity in the specialized services. We testified to that effect several times earlier this year, and recommended that such funding be $600 million the first year, $1 Billion the second year, and $1.4 billion the third year. These funds would be over and above additional funds to offset inflation and/or to meet other specific needs. VVA reiterates said call for restoration of capacity today.

VVA notes the simple fact that there is just not enough funding in the Veterans Health Administration system today. VVA applauds the strong efforts of Chairman Smith to secure more vitally needed funding for veterans programs, as well as those of Ranking Democrat Lane Evans. However, we note that many of the distortions in the system have been either created or certainly greatly exacerbated by the extraordinary scarcity of resources since the three year "flat-lined" era in FY 97, FY 98, and FY99.

The VA has yet to recover from the serious damage of those years. In order to recover, one needs to honestly assess the needs (and NOT start with "what did we do this year, and what is OMB's overall mark?") and then set forth a plan to restore needed capacity in an orderly manner.

Six, VVA asks that the Congress move to pass legislation that would accomplish "forward funding" of most of the VA's activities and certainly the Veterans Health Administration. Many programs at the Department of Defense and at the Department of Labor use this funding methodology, so we know that it is legally possible to accomplish this change.

What this means is that in the first year, VA would be appropriated 21 months of funding to take them from October 1, 2002 to June 30, 2004. The FY 2004 fiscal year would then begin on July 1, 2004. In this way, VHA and other VA mangers will have known for 9 months how much money they will have for the next Fiscal Year, and can therefore make more effective use of said funds toward accomplishing the mission as directed by the Congress. Obviously, this would require close cooperation and collaboration with the budget and appropriations elements of the Congress, but it would do much to begin to make our veterans health care system both more effective as well as more efficient.

Seven, VVA urges that you modify the legislation creating the Advisory Committee on Serious and Chronic Mental Illness to mandate strong consumer participation. Similarly, we urge the same legislation require that each VA Medical Center have a functioning mental health alumni group and Consumer Mental Health Advisory Committee by June of 2002.

Similarly, VVA notes that although the Management Advisory Committees (MACs) in each VISN have been somewhat effective in a few VISNs, but generally ineffective in many VISNs because of travel distances, dramatic differences in the problems and situations of VAMCs in the same VISN, and deliberate actions of some VISN Directors, there is still an abiding need for the VA to actually listen to the veterans community.

Therefore, we urge the Committee to ensure that each VAMC Director be required to meet with the veterans organizations and other leaders and advocates for veterans health care (such as homeless veteran service providers) at least once per every three months, if not at least once every other month. The purpose of these meetings would be substantive dialogue on problems affecting health care at that medical center. It should be made clear that the purpose is NOT for local VA

officials to present an over-prepared briefing that takes up all of the allotted time leaving no significant time for dialogue and questions.

Last, but certainly not least, VVA calls on the Committee to move quickly to pass the Heather French Homeless Act of 2001. VVA believes that this bill will help us make significant progress toward providing real help for veterans whose problems have become so acute that they find themselves homeless. The provisions of this

Proposed legislation will, when enacted, help solidify some of the significant improvements in homeless services provided by or through grants from the VA.

However, the Heather French Act can only have a real chance of fulfilling the real promise and potential of its provisions if the organizational capacity to provide serious and chronic mental illness treatment and services is restored to the FY 1996 level.

In addition to passage of Mr. Evans' Heather French Homeless Veterans Act with most of the provisions as drafted, VVA believes that it is essential to provide additional funding sources to community based veteran service providers and local chapters or posts of national veterans groups that are providing essential and desperately needed services in a wholistic manner to veterans who are homeless or at significant risk of being homeless. Many times these groups can be much more flexible and much more effective that the VA with some elements of the veterans population.

Vietnam Veterans of America is grateful to the Chairman, the Ranking Democrat, and all of the Members of this distinguished Subcommittee for the opportunity to present our views.

VIETNAM VETERANS OF AMERICA

Funding Statement
June 20, 2001

The national organization Vietnam Veteran of America (VVA) is a non-profit veterans membership organization registered as a 501(c)(19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

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A Not-For-Profit Veterans Service Organization Chartered by the United States Congress

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Linda Schwartz received her diploma in Nursing from Saint Thomas Hospital School of Nursing in Akron, Ohio, She is a Cum Laude graduate of the University of Maryland and received a Masters in Psychiatric Nursing from Yale University School of Nursing. She completed her Doctoral Degree in Public Health from Yale University School of Medicine, Department of Epidemiology and Public Health in April 1998. Her dissertation "Physical Health Problems of Military Women Who Served During the Vietnam War" is the first major research investigation of the health of women veterans of the Vietnam Era.

She is medically retired as a Major from the military due to injuries she sustained in an aircraft accident while on duty in the Air Force.

Dr. Schwartz has a long history of involvement in nursing and veteran organizations. She has served as President of both the Connecticut Nurses Association, and the Connecticut Nurses Foundation. In 1987 she was elected to the Board of Directors of the American Nurses Association (ANA). She also served as Member of the Board and Treasurer of the ANA PAC (1987-1989). She is currently an Associate Research Scientist at the Yale School of Nursing.

She has served as Trustee of the Connecticut Department of Veteran Affairs since 1989. She served 10 years on the VA Advisory Committee on Readjustment of Vietnam Era Veterans. She has also served as Chair of the VA Women Advisory Committee from 1997 to 2000. Dr. Schwartz was a member of the Board of Directors of Vietnam Veterans of America from 1989-1995. She was one of the founders and served (1990-1996) as the President of the Vietnam Veterans Assistance Fund (VVAF), a charitable organizations certified from the Combined Federal Campaign, which focuses on the needs of the nations 9.2 million Vietnam Era Veterans.

From 1992-1999 she served in a volunteer capacity, as the Co-Director of "Project Partnership" which is a program in which VVAF acquired and developed four homes for homeless and disabled veterans in conjunction with the West Haven VA Medical Center. Project Partnership became incorporated as s (501)© (3) non-profit organization on November 22, 1997 in West Haven, Connecticut.

Dr. Schwartz resides in Pawcatuck, Connecticut with her husband Stanley a restaurateur and her daughter Lorraine a 1998 Graduate of Syracuse University.

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RICHARD WEIDMAN

Richard Weidman serves as Director of Government Relations on the National Staff of Vietnam Veterans of America. He served as a medic with Company C, 23rd Med, Americal Division, located in I Corps of Vietnam in 1969.

Mr. Weidman was part of the staff of VVA from 1979 to 1987, serving variously as Membership Service Director, Agency Liaison, and Director of Government Relations. He left VVA to serve in the Administration of Governor Mario M. Cuomo (NY) as Director of Veterans Employment & Training for the New York State Department of Labor.

He has served as Consultant on Legislative Affairs to the National Coalition for Homeless Veterans, and served at various times on the VA Readadjustment Advisory Committee, the Secretary of Labor's Advisory Committee on Veterans Employment & Training, the President's Committee on Employment of Persons with Disabilities on Disabled Veterans, Advisory Committee on veterans' entrepreneurship on the Small Business Administration, and numerous other advocacy posts in veteran affairs.

Mr. Weidman was an instructor and administrator at Johnson State College (Vermont) in the 1970s, where he was also active in community and veteran affairs. He attended Colgate University B.A., (1967), and did graduate study at the University of Vermont.

He is married and has four children.

STATEMENT OF
JACQUELINE GARRICK, ACSW, CSW, CTS
DEPUTY DIRECTOR, HEALTH CARE
THE AMERICAN LEGION
TO THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
ON
MENTAL HEALTH, SUBSTANCE ABUSE AND HOMELESSNESS PROGRAMS WITHIN VA

JUNE 20, 2001

Mr. Chairman and Members of the Subcommittee:

The American Legion appreciates the opportunity to provide testimony on such a vital mission for the Department of Veterans Affairs (VA) healthcare system. Veterans diagnosed with mental illness are truly those who suffer the consequences of war and military service in the most subliminal ways. In our society, which attaches stigma and bias to the psychiatric realm, these veterans truly become the most vulnerable of our veterans, especially as they age. Overall, they are at greater risk for homelessness, substance abuse, incarceration and further traumatization. Serious mental illness is not easily treated. It is chronic and complex in nature. Post Traumatic Stress Disorder (PTSD), Schizophrenia, Bipolar Disorder, Personality Disorder, and Dementia, are long-term conditions that require medication maintenance, therapeutic interventions, intensive case management, socialization and economic education, and social support. These disorders and many others identified in the Diagnostic and Statistical Manual of Mental Disorders (DSM- IV) published by the American Psychiatric Association can add up to a very expensive cost per patient over the lifetime of the patient.

For these reasons, The American Legion views this population as needing our special attention and protection and feels this committee shared this position when it created the Capacity provision under the 1996 P.L. 104-262. VA was left to define capacity and they did so by looking at the number of patients treated and the dollars expended on their care. The American Legion has always been dismayed that technical quality and patient satisfaction are not part of that formula.

The American Legion, as a member of the Consumer Liaison Council of the Committee on the Care of the Severely Chronically Mentally Ill (SMI) Veteran supports their conclusion that based on FY 2000 data, VA is still not in compliance with the capacity provision. The American Legion first offered testimony on VA's non-compliance with the capacity provision on July 23, 1998. In spite of the best efforts of the SMI Committee, VA has not done what it should in order to be in compliance with the law.

Just prior to the 1996 law, VA created the 22 Veterans Integrated Service Networks (VISN) and the loci of care began shifting from the inpatient arena to outpatient and Community Based Outpatient Clinics (CBOC) as VA imported the principals of managed care. Psychiatric services were not exempt from these changes. VA closed 64 percent of its psychiatric beds, which included closing 90 percent of its substance abuse beds. The promise from VA was that these dollars would be reinvested in outpatient services, domiciliary care and mental health primary care in the community. However, history repeated itself.

Thirty years ago, the states promised to deinstitutionalize their large psychiatric facilities to open more community clinics and group homes, but never did, leaving individuals suffering from psychiatric conditions homeless, incarcerated, or dead. It would seem that the VA is on this very same course. Since 1996, VA is treating 12 percent less seriously mentally ill patients and spending 37 percent less on funding. VA has opened up several hundred new CBOCs across the country, but not nearly enough of these offer mental health services. Where are these veterans who have been lost to the VA system? It is estimated that one third of the homeless in America are veterans and that 12 percent of the incarcerated population are veterans according to a January 2000 Department of Justice study. The American Legion fears that these numbers will increase, as fewer services are available from VA. During its site visit process, The American Legion has documented mental health service inadequacies all across the country.

There is still no long-term mental health care in VISN's 8 or 18, which The American Legion brought to the attention of Congress in its September 22, 1998 testimony. In VISN 18 that problem has only gotten worse as a nursing shortage has hit that area particularly hard. Veterans who used to get some mental health care at the Albuquerque VA hospital are now being shipped to VA hospitals in Palo Alto, CA and Denver, CO or are being sent to the state hospital in Big Spring, TX (as ironic as this may be). The ability for homeless veterans suffering from substance abuse and/or other illnesses is greatly impaired when the community they will need to transition back into is hundreds or thousands of miles away. This surely cannot be anyone's idea of quality mental health services.

In its May 2000 site visit report on VISN 12, The American Legion documented the concern in the Chicago area over the lack of mental health services. Thresholds Jail Program, a Chicago community-based organization that helps individuals transition from jail, reported that as the Chicago hospitals have closed their inpatient capabilities and have offered less aftercare, more veterans are ending up in the Cook County Correctional Facility.

In VISN 19, there are Legionnaires in Colorado who are concerned that as VA has closed its substance abuse program and detoxification is being done on an outpatient basis, veterans are not going to be able to maintain their sobriety upon seeking help. According to the local members of The American Legion, veterans who can no longer get

the substance abuse services that were once available from VA are now going to the county because they feel they are getting better care there.

In VISN 11, there is a psychiatrist who feels mental health clinic patients are being denied access to proper medication because the VISN wants to adopt a "fail-first" protocol already in use in VISN 22 that basically restricts prescribing abilities of the physician to less expensive medications. The American Legion has always been opposed to a formulary process or practice guidelines that come between a physician and his/her patient. The American Legion recognizes formularies and guidelines can be useful management and training tools, but the expertise of the doctor and the needs of the patient should not be secondary.

Additionally, The American Legion, which is also a member of VA's Quality Enhancement Research Initiative (QUERI) for Mental Health, is also aware, through that committee, that VA is not prescribing Clozapine at the same rate as the private sector. Clozapine, which treats treatment resistant schizophrenia, is only being prescribed to 1,700 patients when 30,000 would benefit from it. The American Legion recognizes the complications of this drug, as does the QUERI committee, and still recommends that VA improve its use of this and all medications in this class.

The American Legion believes that if psychiatric services at the VA were handled with the same diligence as surgical programs, quality care would not be an issue. But, since VA has not made mental health the priority it should be, it is not unexpected that medications would not be properly prescribed. As noted in the opening statement, The American Legion recognizes this to be a costly patient population to treat because of its chronicity. Medication management and compliance education are key factors in the success of these patients. It takes a lot of staff time and attention to address these issues. It must be a priority. Unfortunately, it is not. The examples highlighted here are just a few from recent American Legion site visits and surveys. These problems exist throughout the VA healthcare system. The American Legion finds this a frustrating set of circumstances that has been going on way too long and respectfully asks this Subcommittee to intervene.

The American Legion recommends several steps be taken:

1. The SMI Committee reporting status should be raised to the level of the VA Secretary. This move would heighten the awareness of the work of this committee and hold VA more accountable for the care of this most vulnerable population. The Veterans Health Administration (VHA) has had almost five years to come into compliance with the Capacity provision. This has been ample time. It would seem that/more oversight is necessary.

2. In its experiences as a member of the SMI Committee Consumer Liasion Council, The American Legion has enjoyed a cooperative and respectful relationship with the committee. The council, however, does not have the same status as the committee members who are VA employees. The American Legion feels that this

should change and that the consumer council members should have the same status as the VA employees on the committee. If this is meant to be a truly cooperative effort, then the VA users should have the same voice on the committee as the providers. This could help to strengthen the findings and recommendations of the SMI Committee.

3. In addition, the Office of the Inspector General should also be assigned the task of providing evaluation of the networks for capacity compliance. The 22 networks should be audited on an annual basis to ensure that they have maintained appropriate access to mental health inpatient, outpatient, and pharmaceutical services.

4. The capacity definition created by VA should go beyond numbers of patients treated and cost per patient. This does not adequately reflect all of the issues involved in treating patients. There needs to be accountability to the quality of care and the satisfaction of the patients. VA can, and has opened CBOC's, but that does not mean that there are well-trained mental health professionals located in those facilities. The American Legion has visited CBOCs where there was no or limited access to a psychiatrist, or no one on site knew how to refer a combat veteran with PTSD to a local Vet Center.

5. Staffing patterns need to improve for there to be capacity compliance. It is not enough to open CBOCs and have programs. Clinics and programs need to be well staffed with well trained mental health providers who are specialists in case management, substance abuse, traumatic stress, rehabilitation and psychopharmacology. VA should be able to offer incentives to new hires and employees who maintain certifications or can document on-going training in these areas above and beyond hospital credentialing and privileging processes.

6. Since dollars have not been reinvested in outpatient care or the CBOCs, and in many areas there seems to be a shortage of inpatient beds, VA should reopen, at minimum, ten percent of its acute psychiatric and detoxification beds. Veterans miss this level of care and it is costing them their sobriety, their homes, their families, their freedom and their lives.

7. Psychiatrists must be able to prescribe medication that is in the best interest of their patients without the fear of poor performance evaluations and disciplinary actions. Psychiatrists, in a working relationship with their patients are the best and most cost efficient treatment asset within VA. Properly trained and well supported, physicians and other providers make decisions in the best interest of the patient and should not be second-guessed by administrators and financial officers. "Getting it right the first time" is truly the best approach to medicine. Restrictions that require patients to fail are immoral and inhumane. The American Legion recognizes that these pharmaceuticals can be expensive, but are not nearly as expensive as prolonged inpatient stays, incarceration, or rehabilitation.

The American Legion is hopeful that the members of this Subcommittee will act to protect veterans who have given so much of who they were in service to this country and will consider the recommendations it has made. Veterans deserve peace of mind.

VA is world renowned for its work in mental health. Many of its programs were designed by leading experts in the psychiatric profession. Medical journals are fraught with research studies documenting advances made by VA. However, as once noted by a Legionnaire at a town hall meeting in upstate New York, "What good is quality when you can't get an appointment?"

Mr. Chairman, that concludes my testimony. Again, I thank you for allowing The American Legion to provide testimony on these important issues. The American Legion looks forward to working with the members of this Subcommittee to improve the lives of all of America's veterans.

STATEMENT OF DENNIS CULLINAN, DIRECTOR, NATIONAL LEGISLATIVE SERVICE, VETERANS OF FOREIGN WARS OF THE UNITED STATES TO THE SUBCOMMITTEE ON HEALTH, COMMITTEE ON VETERANS' AFFAIRS, UNITED STATES HOUSE OF REPRESENTATIVES

WITH RESPECT TO MENTAL-HEALTH, SUBSTANCE-USE DISORDERS, AND HOMELESSNESS

June 20, 2001

Mr. Chairman and Members of the Subcommittee:

On behalf of the 2.7 million members of the Veterans of Foreign Wars of the United States and its Ladies Auxiliary, we are grateful for the opportunity to express our views on the Department of Veterans Affairs' (VA) ability to provide mental health, substance-use disorders and homelessness services to the veteran population.

Currently, greater than 450,000 veterans are service connected for mental health disorders including posttraumatic stress disorder (PTSD) and serious mental illnesses such as psychosis and schizophrenia. In order to develop a continuum of care for these veterans, VA decided to depart from the traditional inpatient setting to outpatient and community-based venues beginning as early as 1994. It is important to note that not all inpatient programs were abandoned.

While we viewed this shift from inpatient to primarily outpatient care as an innovative and potentially improved method of delivering services, we were skeptical of VA's ability to maintain the same level of care. This committee and Congress addressed some of our concerns by enacting P.L. 104–262 that required the (VA) Secretary to maintain "capacity to provide for the specialized treatment and rehabilitative needs of disabled veterans (including those with . . . mental illness) . . . in a manner that (A) affords those veterans reasonable access to care and services for those specialized needs, and (B) ensures that overall capacity of the Department to provide such services is not reduced below the capacity of the Department, nationwide, to provide those services. . . ."

The success—no matter the law—of VA's ability to maintain capacity, however, was and still is dependent on its ability to make a seamless transformation from inpatient to outpatient care. For example, it is the VA's responsibility to ensure that a mentally ill veteran who received counseling and medication while residing in an inpatient setting is not discharged until access to those same services are available at an outpatient clinic near the veteran's new residence. While access may have been improved for some veterans as Community-Based Outpatient Clinics (CBOC) sprung up around the country, the Committee on Care of Severely Chronically Mentally Ill reported that services for those that required specialized needs were found to be less than adequate or in some cases non-existent in these newly minted CBOCs. This lack of preparation to meet an anticipated need has impacted greatly on this unique class of veterans who demand ongoing treatment for their particular mental health disability or substance-use disorder.

As an organization whose membership is representative of the primary consumers of the VA's health care services, we are deeply troubled by the lack of accountability within the Veterans Health Care Administration (VHA) to ensure the Veterans Integrated Services Networks (VISNs) are expanding and establishing the capacity to provide these unique, specialized services. It has been our consistent position that veterans should have timely access to quality health care. It is apparent that many veterans suffering from mental illness and/or substance-use disorders do not.

Intrinsically, mental illness and substance-use disorders breed homelessness and no one single community has been more devastatedby homelessness than the veterans' community. Estimates show that more than 275,000 veterans are homeless on any given night and nearly half suffer from mental illness and/or substance abuse problems. It is truly a national tragedy, one that has only been compounded by the deinstitutionalization of inpatient programs.

The VA must recognize and address the divergent needs of the veterans' homeless population. It is not enough to open a clinic and assume homeless veterans will seek help. As demonstrated, many homeless veterans are mentally ill and feel utterly defeated and alone. These veterans need the advantage offered by VA health care (mental and physical) in order to gain employment, employment that will eventually take them off the streets and make them contributing members of society. The VA must conduct pro-active, community-based outreach in cooperation with local service providers if it is to be effective.

The testimony presented today has demonstrated that this community-based approach is needed in every VISN. VISN directors must understand that properly addressing mental health, substance-use disorders and homelessness is a priority. In VHA's Mental Health Fact Sheet (May 2000), the administration expressed its commitment to "using state-of-the-art medications" that result "in improved clinical outcomes, decreased incidence of side effects and increased compliance with prescribed medications. Patient functioning and patient satisfaction are increased." Yet it is our understanding that two VA networks, VISN's 11 and 22, have adopted "fail first" practices as a cost saving measures when it comes to prescribing atypical antipsychotic medications opting for the lower-cost medications. We are opposed to such actions that deny equal access and replace the attending physician's best judgment to prescribed the most appropriate and effective medication. It is clear that some directors do not agree with VHA's "commitment to using state-of-the-art medications."

We acknowledge the usefulness of the Mental Illness Research and Education and Clinical Care (MIRECC) Centers to develop new and better practices in treatment as well as the Homeless Veterans Reintegration Program (HVRP) in assisting homeless veterans find education and employment. These are positive steps, however, new legislation aimed at expanding the existing homeless programs in VA, the Department of Labor (DOL) and the Department of Housing and Urban Development (HUD) is needed. This legislation must ensure an adequate funding formula for specialized programs while holding individual VISNs accountable for implementation and progress through internal and congressional oversight. Such legislation would enjoy our support.

Again, thank you for the opportunity to present the views of the Veterans of Foreign Wars of the United States. I am available for any questions you or the members of this subcommittee may have for me.

American Psychiatric Association
1400 K Street, N.W.
Washington, DC 20005
Ms. Nancy Trenti
Associate Director of Government Relations
Telephone: 202.682.6046
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STATEMENT

OF THE

AMERICAN PSYCHIATRIC ASSOCIATION

TO THE

HOUSE VETERANS' AFFAIRS

HEALTH SUBCOMMITTEE

ON

VETERANS' AFFAIRS MENTAL HEALTH,

SUBSTANCE ABUSE AND

HOMELESSNESS PROGRAMS

JUNE 20, 2001

The American Psychiatric Association (APA) is a national medical specialty society, founded in 1844, whose over 40,000 psychiatric physician members specialize in the diagnosis and treatment of mental and emotional illness and substance use disorders. As a major medical association, the care and treatment of our nation's veterans is a significant concern of ours. We feel compelled to be advocates for these heroes that stood in the forefront to protect our freedoms and way of life. It is our turn to look after their needs.

An estimated 250,000 veterans, or roughly one-third of the adult homeless population, are veterans. Many of these veterans served in Vietnam. In fact, the number of homeless Vietnam era veterans is greater than the number of service persons who died during the Vietnam War. About 45% of these homeless veterans suffer from mental illness and slightly more than 70% suffer from alcohol or drug abuse problems. The VA offers an array of programs to help homeless veterans live as self-sufficiently and as independently as possible and provides the largest integrated network of homeless treatment and assistance services in the country.

Homeless Veterans Mental Illness

With the large number of homeless veterans, it follows that these veterans typically suffer the same mental illnesses as found in the general homeless populations. These illnesses include schizophrenia, schizo-affective disorder, bipolar disorder, and major depression. All these illnesses differ in their causes, course, and treatment. Frequently, those in need of protection and services the most are the chronically mentally ill individuals who suffer from the cognitive and social deficits of their illnesses. As a result of their illnesses, these individuals are left to fend for themselves in the community. As noted in a federal task force report, their symptoms may differ dramatically. Symptoms may range from exhaustion and severe depression to displaying delusional or suspicious behavior. They may be withdrawn from any human contact or become possibly hostile and dangerously aggressive. Symptoms that, by officials not trained to diagnose mental illnesses, may be interpreted to be criminal in nature.

These symptoms often occur because homeless individuals are not receiving the necessary psychotropic medications or have resisted treatment. Or, there may have been a breakdown within the familial and social network, the mental health and criminal justice systems, or societal polices ranging from housing availability to legal definitions of dangerousness to self.

Housing

Most individuals with severe mental illnesses can live in their communities with the appropriate supportive housing options. However, all too often, the suggested solution is temporary shelter residencies. Although temporary shelters may be necessary as an emergency resource, they do not offer solutions to a mentally ill person's problem. Temporary shelters even offered as solutions for the mentally ill implies that society has accepted the notion that mentally ill individuals should be permitted to refuse treatment and live on the streets.

However, based on both clinical observation and research data, the reality is quite the opposite. Life on the streets is generally characterized by dysphoria and extreme deprivation. Studies suggest that the mentally ill often reject the housing opportunities presented to them because of expectations placed upon them to enter into unrealistic or inappropriate treatments or placements.

The lack of low cost housing is one example for the high number of homeless mentally ill. Single-room-occupancy hotels have sharply declined over the years and for the most part are no longer an option for the homeless mentally ill. Without this housing option and with no other suggested options to fill the void, mentally ill individuals are left with few choices.

The APA Task Force on Homelessness advocates the following:

- The care, treatment, and rehabilitation of chronically mentally ill individuals must be made the highest priority in public mental health and receive the first priority for public funding;
- Comprehensive and coordinated community-based mental health systems to engage homeless mentally ill individuals and help them to accept treatment and suitable living arrangements, while serving this mentally ill population immediately;
- A full complement of research efforts to identify subgroups of the homeless mentally ill population, assess their service needs, study alternative clinical interventions, and evaluate those outcomes;
- Professionals serving the mentally ill must be provided to the appropriate training to assess both functional strengths and dangerous degrees of disability;
- Residential and treatment standards for homeless mentally ill individuals should measure up fully to the standards of care needed for severely disabled individuals and that they should be capable of being monitored; and
- The provision of housing opportunities, the provision of psychotropic medications, and the provision of structure, in varying amounts, are each important and interrelated matters in serving the homeless mentally ill.

President Bush's Veterans Health Care Task Force

APA commends the President for convening a Veterans Health Care Task Force composed of officials and clinicians from the Department of Veterans' Affairs (VA) and Department of Defense (DOD), leaders of veterans and military service organizations, and leaders in health care quality to make recommendations for improvements in the VA. The VA will focus its attention on treating disabled and low-income veterans. The APA hopes the task force will address the workplace shortages of psychiatrists and psychiatric nurses in looking at quality of care. The APA also believes the task force should look at quality of care issues in formularies as discussed below.

The VA is considering new treatment guidelines for veterans with schizophrenia. APA has serious concern that these new treatment directives may significantly restrict the clinical discretion of VA staff psychiatrists. As a result, the patient may not have access to highly effective atypical anti-psychotic medications by establishing a "fail-first" policy. This policy would require veterans to "fail" on certain anti-psychotic drugs before being treated with other medications that are also highly effective. APA is opposed to any administrative guidelines that appear to place the VA's pharmacy cost issues ahead of the best possible mental health care for our nation's veterans. VA staff psychiatrists should be accorded maximum clinical discretion to select among effective medications after an individualized medical assessment. Any other course of action carries the high risk of substandard mental health care.

VA Homeless Programs

Mental Illness Research, Education and Clinical Centers

An important VA program, Mental Illness Research, Education and Clinical Centers (MIRECCs), began in October 1997 with establishment of three new Centers. These Centers bring together research, education and clinical care to provide advanced scientific knowledge on evaluation and treatment of mental illness. MIRECCs demonstrate that coordinating research and training of healthcare personnel in an environment that provides care and values the synergism of bringing all three elements together results in improved models of clinical services for individuals suffering from mental illness. Further, they generate new knowledge about the causes and treatments of mental disorders.

MIRECCs were designed to deal with mental health problems that impact America's veterans. These include schizophrenia, post-traumatic stress disorders (PTSD), and dementia. In addition, MIRECCs focus on complex disorders including serious psychiatric issues complicated by homelessness, substance abuse and alcoholism. The

funding of additional MIRECCs, which would provide research for these complex medical disorders, is vital.

Alcohol and other substance use disorders continue to be a major national healthcare problem. Numerous studies show that rates of alcohol and other substance abuse are high among veterans within VA healthcare system. To its credit, VHA made significant progress during the past three years in screening all primary care patients for alcohol misuse. Which has resulted in identifying additional patients in need of specialized treatment services.

The APA recommends the VHA should increase funding for Mental Illness Research Education and Clinical Care Centers (MIRECCs). Two new MIRECCS should be funded in FY 2002. Congress should incrementally augment funding for seriously mentally ill veterans by $100 million each year from FY 2002 through FY 2004.

VHA should reinvest savings from closing inpatient mental health programs to develop an outpatient continuum of care that includes case management, psychosocial rehabilitation, housing alternatives, and other support services for severely and chronically mentally ill veterans.

Again, we thank the Subcommittee for the opportunity to deliver this statement on mental health, substance-use disorders and homelessness programs in the VA. Please do not hesitate to call on the APA as a resource, should there be any way in which we might be able to assist in working with you to provide the best health care possible to the veteran community.

AMERICAN FEDERATION OF GOVERNMENT EMPLOYEES
AFFILIATED WITH THE AFL-CIO
80 F STREET N.W., WASHINGTON, D.C. 20001

LOCAL 1674

VETERANS ADMINISTRATION HOSPITAL
WEST HAVEN, CONNECTICUT 06516

June 18, 2001

The Honorable Rob Simmons
U.S. House of Representatives
Washington, DC 20515

Dear Representative Simmons:

I understand from my union, the American Federation of Government Employees, AFL-CIO (AFGE) that the House Veterans Affairs Committee is planning to hold a hearing on mental health, substance-use disorders and homeless programs within the Department of Veterans Affairs (VA).

The VA has made a real difference for homeless veterans. But we can do so much more.

I know first-hand how VA's comprehensive support and treatment can change the life of a homeless veteran with alcohol and substance abuse problems. I was a homeless veteran. I was so homeless that I was living in an abandoned car with no windows. One night I came back to my "home" at three o'clock in the morning and someone had towed away my "home." When I was homeless I was a coke and alcohol addict. I had tried programs in the past but went back to the streets. I was unemployable and very unhopeful.

Then in 1992, I enrolled in the veterans resource program at the West Haven, CT, VAMC. I went through VA's detoxification inpatient treatment for 21 days. Then I was in VA halfway house on the West Haven campus for six months. Although this residential ward was not a domiciliary facility it was very similar. I am no longer homeless and on drugs because I had the chance to be in the six month residential program at the VA.

If had gone through detoxification and then had outpatient treatment while living in the homeless shelter instead of the VA residential ward I fear I would never have stayed sober. I can't express to you how important it is for homeless veterans to have a in-patient detoxification program combined with a stay in the sheltered, safe, drug-free residential setting. For me the VA inpatient and residential program gave me a light of hope.

I now work at the West Haven, CT, VA Medical Center. As a VA food service worker I am proud that I can help care for other veterans. I am also the Chief Steward of AFGE Local 1674. I still difficult days, but I have stayed clean for more than eight years.

Representative Simmons, more homeless veterans could benefit from the same level of intensive medical, psychological, and rehabilitative treatment in a residential setting. But it's not there. The program at the West Haven VAMC that gave me hope, no longer provides the same level of support and treatment for veterans. The 21-day inpatient substance abuse program that has been cut due to lack of funds a few years ago. The VA no longer maintains the six-month residential supportive program that I went through. VA now contracts with a halfway house that treats veterans and non-veterans. VA evaluates this contractor every six months but there are no studies to evaluate whether the use of a contractor for residential care is better for veterans than the VA program that helped me.

Representative Simmons, I ask that you help rebuild and expand the homeless programs that helped other veterans and me.

Sincerely,

Ted Jones
Chief Steward, AFGE Local 1674

cc: Representative Chris Smith
Representative Lane Evans
Representative Rosa DeLauro

STATEMENT OF DANIEL SHAGHNESSY, MSN, ADDICTION THERAPIST, HEALTH CARE FOR HOMELESS VETERANS/SUBSTANCE ABUSE TREATMENT PROGRAM, SOUTHERN ARIZONA VA HEALTH CARE SYSTEM

June 20, 2001.

Hon. JERRY MORAN,
Chairman, Committee on Veterans' Affairs Health Subcommittee,
House of Representatives, Washington, DC.

DEAR CHAIRMAN MORAN: My Name is Daniel Shaughnessy and I am a 60 percent service-connected veteran of the United States' Marine Corps. I served in Beirut in 1982–1983. I am currently employed at the Department of Veteran Affairs Hospital in Tucson, AZ, as a social worker and a proud member of AFGE Local 495.

I did not take a traditional course from the military to school to work. I had much more difficult route to follow upon discharge from the Marine Corps. I became an alcoholic and homeless living on the streets of Tucson, just one of tens of thousands of once proud men who served with honor, courage and dignity. As I found myself wandering the streets, as one of "Those People" children are taught not to look at, I began to think, "This is not how my family brought me up to be."

In 1987 I went to the local VA hospital and met a social worker named Sandy Eggleston, now the President AFGE local 495, who helped me with shelter and a referral to the VA run substance abuse treatment program. I waited in a homeless shelter for 4 weeks until there was an opening in the VA run program and completed every facet of the program requirements. I also took advantage of Vocational Rehabilitation and was awarded a bachelors and masters degree in social work.

In 1989 I founded and ran a program (Comin' Home) that serves homeless mentally ill veterans with substance abuse problems that is still in existence today even though I now work at the VA. Secretary Principi just visited the program and awarded a grant to serve more disabled homeless veterans reestablishing themselves as valuable community members.

If it were not for the comprehensive homeless veterans program and the substance abuse treatment program at the VA I would not be where I am today. Homeless people need a place to get their lives back on track, starting with detoxification services. This is the crucial starting point for any veteran. In fact, I have seen at least 10–15 veterans die in the summer head waiting for "detox" beds here in Tucson over the past 13 years. I also have stopped counting at the number 112 of homeless veterans that I have know who have died since I have started working in this field, and that just in Tucson!

We need to stop limiting and cutting inpatient services and expand them to the most needy veterans. This leaves another vet to die and nobody seems to listen or care.

As a VA social worker whose clients are homeless veterans and as a formerly homeless veteran, I support H.R. 936 and I urge your committee to pass the bill.

My struggle and comeback from homelessness is not the exception to the rule. Every year there are veterans like me that change their lives through the VA's programs. With more opportunities there can be many more like me! The passing of this bill will help the people who are the backbone of a free America. If I can be of any assistance to you in securing passage of this bill please call upon me.

June 12, 2001

U.S. House of Representatives
Committee on Veterans' Affairs
One Hundred Seventh Congress
335 Cannon House Office Building
Washington, DC 20515

HOUSE VETERANS' AFFAIRS COMMITTEE – JUNE 20, 2001
PROPOSED WRITTEN STATEMENT

Mr. Chairman, Members of the Committee, I am Ray Slayton, a proud veteran from the Vietnam era who supports and advocates for the continuation and expansion of mental health services and research. I thank you for this opportunity to address your Committee. I strongly support funding be increased in mental health and substance abuse, because new treatments come from this research, and these treatments can benefit hundreds of thousands of veterans as it did for me. In 1995, I was homeless, hopeless, and a drug abuser. I felt useless and was socially dysfunctional. I found myself not caring about anyone or anything, having no goals and not wanting to focus on reality. This was a culmination of twenty years of post Vietnam worthlessness, feeling cast aside by my own country who had no more use for me. This developed into great distrust for our government, especially the VA system. Then, one day in March of 1995, I was in a shelter when a VA representative came to see someone else. He asked if I was a veteran and that was the moment my second life began.

I found myself in various treatment programs, was diagnosed with Post-traumatic Stress Disorder and invited into the Community Rehabilitation Program at West Haven, Connecticut where I remain today, but as a volunteer. I turned my life around completely, and I expect to graduate from college next year. I have chosen a career in Psychology and Human Services to better help those who don't know help is available and here for them, and that veterans can be productive members of society like everyone else – we just sometimes need a little extra help.

Ray Slayton
Social Security #040-44-3869
364 Putnam Avenue – Apartment 9
Hamden, CT 06517

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

CHAIRMAN MORAN TO NATIONAL COALITION FOR HOMELESS VETERANS

Committee on Veterans Affairs
Subcommittee on Health
Oversight Hearing on Mental Health, Substance Use Disorders, and Homelessness
June 20, 2001

Follow up Question for Ms. Linda Boone
Executive Director
National Coalition for Homeless Veterans

1. Are NCHV members interested in providing permanent supportive housing options to veterans with mental illness who may not be able to maintain complete independence in the community? Are there effective models within your membership for the Committee to investigate?

Answer:
Currently there is no funding available to community-based providers specifically for supportive housing for homeless veterans with mental illness. The VA Homeless Providers Grant and Per Diem program has employment as an expected outcome for the veterans using this program. For veterans with serious mental illness this is not a realistic expectation and grantees cannot afford to house these veterans under this grant because the outcomes reported will be below the "successful" expectation for the grant guidelines.

HUD provides funding under the McKinney Act for supportive housing for homeless people with serious mental illnesses.

HUD homeless funding is around $1 billion annually. Historically only about 3% of these grants are awarded to veteran specific programs. Three percent, when a quarter of the homeless are veterans.

The distribution system for these McKinney Act funds follow a devolution policy that organizes priorities for allocation of formula share dollars at a local level within a continuum of care. The Continuum of Care prescribes a planning process built on a community-by-community model. Within each community, a planning process takes place in which advocates and service providers describe the problem, access the current resources available, and decide what needs to be done using the "targeted" McKinney programs.

Veteran service providers report it takes several years of analysis, networking, program/funding design, and negotiations to be able to show that giving a high priority to a relatively small piece of HUD Supportive Housing Programs and/or Shelter Plus Care program dollars for a veteran provider is in the community's best interest.

NCHV member organizations that have programs that provide longer term supportive housing for veterans with disabilities:

Veterans Benefits Clearing House
Ralph Cooper
126 Warren St.
Roxbury, MA 02119
617 541-8846

Albany Housing Coalition
David Stacey
278 Clinton Ave.
Albany, NY 12210
518 465-5251

Western NY Veterans Housing Coalition
Jim Mahoney
1125 Main St., Ste 27
Buffalo, NY 14209
716 882-5935

CHAIRMAN MORAN TO DISABLED AMERICAN VETERANS

FOLLOW-UP QUESTION TO THE
STATEMENT OF
JOY J. ILEM
ASSISTANT NATIONAL LEGISLATIVE DIRECTOR
OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON HEALTH
June 20, 2001

Question:

Are outcome measures an appropriate substitute for resource and workload measures in VA's specialized programs? Why or why not?

Answer:

Disabled American Veterans (DAV) does not believe outcome measures in VA's specialized programs are an appropriate substitute for resource and workload measures, but rather they should be an integrated part of the management of these programs.

Outcome measures are important in determining the effectiveness of a particular program or treatment plan; however, outcome measures are not always easily defined or determined. There are a variety of factors to consider depending on the program including, social functioning, employment, behavioral modification, and medical and mental health outcomes. Additionally, it is important that a patient's baseline functioning be assessed prior to entering a treatment plan/program to have a reliable outcome measure.

For example, two patients may enter a substance-use program with very different levels of functioning. Patient "A" may be homeless and unable to work due to the severity of his or her substance-use. Patient "B" may have a steady job but is depressed and isolated and having extreme difficulty relating to co-workers, family, and friends. Following completion of the treatment program determining outcome measures for both patients would be very different because of the differences in baseline functioning at the start of the program.

Patient "A" is maintaining sobriety but is still technically homeless and unemployed. However, clinicians may still consider sobriety alone as significant progress for this particular patient who now qualifies for access into a residential program to learn new job skills in order to obtain employment. Patient "B" returned to his or her former employment but is still exhibiting significant behavioral problems and having difficulty functioning at work and in the home environment. Clinicians may consider this a less favorable outcome than patient "A," although he or she is maintaining steady full-time employment. If a clinician were only monitoring employment as an indicator of success, on paper, the outcome measures for these two patients would be deceptive. In this case, social aspects of functioning, maintaining sobriety, medical and mental health status, behavioral modification, etc., are all important factors when considering outcome measures.

Currently, many of VA's specialized programs do not have a well developed system to adequately and reliably measure outcomes. VA should continue to develop a comprehensive way of measuring outcomes and determining if care was well managed. To focus solely on outcome measures as a way to manage VA's specialized programs without consideration of resource and workload measures would be inappropriate. It is important to know the number of veterans treated in VA's specialized programs and the dollars expended for their care in order to assess the capacity of these programs. Additionally, the number of dollars expended is a reasonable way to monitor whether the necessary reinvestment of resources from institutional to outpatient-based care is occurring.

It is imperative that adequate staff and resources are being expended on VA's specialized programs to meet the needs of vulnerable veterans. It is equally important that these programs are effective and helping these severally disabled veterans regain their physical and mental well being. Therefore, the DAV believes that outcome measures should be an integrated part of managing VA's specialized programs, rather than a substitute for resource and workload measures.

CONGRESSMAN EVANS TO PARALYZED VETERANS OF AMERICA

1. **Tell us in broad terms about the resources PVA committed to successfully implementing its spinal cord injury monitoring system.**

   PVA has a full-time National Service Officer (NSO) located at or near all of the 25 SCI facilities designated in VHA Directive 2000-022. The NSOs at these facilities visit inpatients on the SCI Service, keep track of SCD inpatients admitted to other services, and verify the number of medical professional staff reported in the monthly SCI Center Surveys. NSOs report problems with the quality of care being provided, denied or delayed admissions, and any other significant issues to PVA medical monitors as they occur. NSOs submit monthly situation reports and monthly staffing surveys to the PVA national office.

   PVA has 4 full-time medical monitors (all of whom are RNs with previous VA experience) who coordinate the resolution of issues arising in their assigned facilities. Additionally, they maintain records regarding staffing and medical care issues for each assigned facility.

   PVA conducts annual site visits to each of the 25 SCI facilities designated in VHA Directive 2000-022. A site visit team typically consists of a MD, the RN nurse monitor for the facility, the local NSO and, as required, other members of the national staff. A site visit lasts two days. During the course of the visit, the team attempts to ascertain the overall quality of the care provided by interviewing patients and professional staff, and VA reported staffing numbers are reviewed.

2. **Are outcome measures an appropriate substitute for resource and workload measures in VA's specialized programs? Why or why not?**

   Outcome measures are not an appropriate substitute for resource and workload measures – for several reasons.

   First, after more than five years of trying, VA has yet to develop a single outcome measure that can be shown to be related to either the quality of the care provided, or the availability of the care needed. A few examples are illustrative.

   Patient satisfaction is, in fact, not an outcome measure at all. It is simply a reflection of whether or not the patient was pleased with the care and attention he or she received. It tells us much more about the "hotel" services provided than the quality of the medical care received. In view of the abysmal scores VA has received for the last five years (less than 50% of the patients surveyed chose the top two satisfaction categories and more than 50% of the patients chose the bottom three satisfaction categories) it is hard to believe that VA would chose to use this as an outcome measure.

   Discharge to a non-institutional setting has proven to be meaningless as an outcome measure. First of all, patients who came from an institutional setting such as a nursing home are invariably returned to that setting. More importantly, many

patients are continuously recycled between their homes and an SCI facility, an indication that their medical problems were not fully resolved prior to their discharge. In view of the fact that SCI patients are getting older and sicker (as are their caregivers) and many of them will soon require institutional care, it is hard to believe that VA would chose to use this as an outcome measure.

The length of time required to gain admission to an SCI facility has proven to be meaningless as an outcome measure. First of all, the parameters set by VA for what is an acceptable delay and what is not acceptable are exceedingly low. More importantly, the "self reporting" by the facilities has been shown to be wildly inaccurate. Notwithstanding the fact that scheduled admissions are routinely cancelled or rescheduled, and that patients with acute medical conditions are routinely denied admission because of staffing shortages, virtually every SCI facility has reported 100% compliance with the specified standards.

The number of SCI patients served has proven to be meaningless as an outcome measure. This is not surprising since there is absolutely no logical nexus between how many patients are seen by a facility with the quality of the care provided to those patients. And, in fact, attempts over the last several years to provide substandard care in an outpatient setting for conditions that absolutely required inpatient care, were directly responsible for some very negative patient outcomes.

Properly devised outcome measures could provide some useful supplemental perspective to quantitative capacity measures. For instance, in the Blind Rehab Program, VA has reported that it is serving just as many patients now as it was in 1996. However, the length of the rehabilitation provided to new injuries has been drastically reduced, to the point that new injuries are discharged without having the necessary information or skills to adequately cope with their disability. A measurement of the skills/abilities of discharged newly-injured blind patients would point out the inadequacy of the rehabilitation they received. It should be noted, however, that the only reason a supplemental outcome measure (demonstrated skills) is needed in this case, is because of the misleading outcome measure (number of patients served) used in the first place. It should also be noted that the VA does not provide an accurate count of the resources devoted to the Blind Rehab Program (beds, dollars and FTEE) because no outside entity (such as PVA) is able to devote the extensive resources required to check them.

PVA does not agree that functional outcomes can ever substitute for tangible units of capacity. The methodologies of functional assessments, outcomes metrics, severity indices, and risk-adjustments are nowhere near the level of development that would allow them to support an accurate measure of VHA's ability to deliver services. While outcomes measures are appropriate means of evaluating the efficacy of medical interventions and some aspects of program effectiveness, the notion that they are related to system capacity is not realistic. We regard the suggestion that outcomes measures be used to evaluate VHA's compliance with P.L. 104-262's capacity mandate as an attempt to render the law unenforceable, and oppose it's implementation.

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