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THE TRUTH ABOUT VETERANS' SUICIDES

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES

ONE HUNDRED TENTH CONGRESS

SECOND SESSION

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THE TRUTH ABOUT VETERANS' SUICIDES

TUESDAY, MAY 6, 2008

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:03 a.m., in Room 334, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Brown of Florida, Snyder, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Berkley, Salazar, Rodriguez, McNerney, Space, Walz, Buyer, Stearns, Moran of Kansas, Brown of South Carolina, Miller, Boozman, Brown-Waite, Turner, Lamborn, and Buchanan.

Also Present: Representatives Kennedy and Moran of Virginia.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. Good morning. This meeting of the Committee on Veterans' Affairs of the House of Representatives is now called to order.

I ask unanimous consent that two of our colleagues, Mr. Kennedy and Mr. Moran, be allowed to sit with us at the dais. They have a longstanding interest in the issues that we will be discussing today. Any objection?

Mr. BUYER. I have no objection. We should follow protocols of the Committee.

The CHAIRMAN. Thank you, Mr. Buyer.

The hearing today is entitled, "The Truth about Veterans' Suicides." I hope we can get to that truth.

A few months ago, on December 12, 2007, this Committee held a hearing that we entitled: "Stopping Suicides: Mental Health Challenges within the U.S. Department of Veterans Affairs (VA)." Nearly 5 months later, we are holding another hearing on this tragic issue and what the VA is doing. But it is brought to us because of data within the VA that seems to dispute what we were told in a hearing in December.

Much of this was occasioned because last year, in November, *CBS News* aired a story called "Suicide Epidemic Among Veterans," and recently, another story called "VA Hid Suicide Risk, Internal E-Mails Show."

I want to just make sure everybody understands what we are dealing with, and I would like to play two brief segments of those newscasts on our new video system.

[Videos played.]

The CHAIRMAN. Mr. Buyer raised an interesting point now of how we are going to refer to this in the record—a tape. We have not exactly figured it out yet. We may have a transcript or referral to a Web site. But before the transcript of this hearing is done, we will work with you to figure out a way to do this.

Mr. BUYER. Members, this is relatively new. Often we ask unanimous consent to place letters in the record. This is a first, that we actually watch a news program.

I am willing to work with the Chairman to do something new. Either we refer to a Web site, whereby individuals could pull that down from a record, actually view the video, because that was how it was viewed in the Committee; or do we transcribe what was just put in there and put that in the record?

We are going to work with the Chairman to figure out how we handle this.

The CHAIRMAN. This is a 21st century problem.

Mr. BUYER. We will work through it.

Sorry, Mr. Secretary. Housekeeping.

[A transcription of both the *November 2007* and *April 2008 CBS News* videos appear on pages 109 and 110. In addition, the videos may be viewed at http://veteransaffairs.edgeboss.net/wmedia/veteransaffairs/videos/cbs_suicide_part_1.wvx (November 2007) and http://veteransaffairs.edgeboss.net/wmedia/veteransaffairs/videos/cbs_suicide_part_2.wvx (April 2008).]

The CHAIRMAN. I think we all know that the first step in addressing a problem is to understand its full scope and extent. In the case of the VA and the epidemic of veteran suicides, either the VA has not adequately attempted to determine the scope of the problem, which I think is an indictment of the competence of the VA; or the VA knows the extent of the problem, but has attempted to obfuscate and minimize the problem to veterans, Congress, and the American people. This is an indictment, I think you would all agree, of the leadership of the entire Department.

In December, Dr. Katz' testimony before this Committee stressed a low rate of veteran suicides, stating that: "From the beginning of the war through the end of 2005, there were 144 known suicides amongst these new veterans." In responding to the figures that *CBS News* researched, Dr. Katz stated that: "Their number for veteran suicides is not, in fact, an accurate reflection of the rates of suicide."

Either Dr. Katz knew that the *CBS News* figures were indeed an accurate reflection of the rates of suicides at that hearing or he had a sudden epiphany just 3 days later.

In an internal e-mail dated December 15, 2007, Dr. Kussman, Under Secretary for Health in the Department, referred to a newspaper article and wrote that: "Eighteen veterans kill themselves every day, and this is confirmed by the VA's own statistics. Is that true? Sounds awful, but if one is considering 24 million veterans."

That same day, Dr. Katz responds, "There are about 18 suicides a day among America's 25 million veterans. This follows from CDC (Centers for Disease Control and Prevention) findings that 20 percent of suicides are among veterans, and it is supported by CBS numbers."

Just this past February, Dr. Katz sends another e-mail that starts with, "S-h-h. Our suicide prevention coordinators are identifying about 1,000 suicide attempts per month among the veterans we see in our medical facilities. Is this something we should carefully address ourselves in some sort of release before someone stumbles on it?"

There was silence from the VA.

As you saw on the viedo, the chief investigative reporter for *CBS News*, Armen Keteyian, characterized the VA's internal e-mails as a "paper trail of denial and deceit, a disservice to all veterans and their families that has rightfully been exposed."

In April of this year, a *Dallas Morning News* editorial describing a "recent spike in suicides among the psychiatric patients treated at the Dallas VA hospital," stated that "descriptions of how four veterans committed suicide in 4 months, prompting the psychiatric ward to close, suggests that patients went to conspicuous and time-consuming lengths to end their own lives. There seemed to be ample time for staffers to stop them, had they been doing their jobs better."

The RAND Corporation, in a recently published study entitled, "Invisible Wounds of War," found that since October of 2001, approximately 1.6 million U.S. troops have been deployed, and more than a quarter of them have mental health conditions.

I think it is higher than that. The study estimated that approximately 300,000 of those deployed suffer from post traumatic stress disorder (PTSD) or major depression. Among those with PTSD or major depression, only half had seen a mental health provider or physician to seek help in the past 12 months, and among those who sought help, just over half received "minimally adequate treatment."

We saw a recent *New York Times* article that said up to one-third of those diagnosed with PTSD of recent veterans had committed felonies, of which 200 had been homicides, mainly members of their own families.

Something is going on in America. The study that RAND did found minimally adequate exposure to psychotherapy as consisting of at least eight visits with a mental health professional, such as a psychiatrist, psychologist, or counselor in the past 12 months, with visits averaging at least 30 minutes.

I would like to know, how does the VA mental healthcare treatment stack up against this definition of minimally adequate care?

The RAND study also found that the VA faces challenges in providing access to Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans, many of whom have difficulty securing appointments, particularly in facilities that have been resourced primarily to meet the new demands of older veterans. Better projections of the amount and type of demand among new veterans are needed to ensure the VA has the appropriate resources to meet the potential demand. "New approaches of outreach would make facilities more acceptable to OEF/OIF veterans," so says the RAND study.

I think many of us believe that the VA healthcare system has been pushed to the edge in dealing with mental healthcare needs of our veterans. I believe we are witnessing either an inability to

address this problem or a purposeful attempt to minimize the problems faced by veterans and the VA, and sweep this epidemic of suicides under the rug.

This morning we are going to attempt to get a better idea of the scope of this epidemic and what the VA is doing to respond to it. What specific steps has the VA taken since December, steps not previously planned, to get a better idea of the scope of what problem; and what has it done to begin to address the problem?

Finally, I think we must seek real accountability from the VA.

Mr. Secretary, we are looking to you to provide that.

[The prepared statement of Chairman Filner appears on p. 77.]

The CHAIRMAN. Let me just say, for the record, that was my prepared, controlled statement. My uncontrolled statement goes something like this, Mr. Secretary:

We should all be angry at what has gone on here, at what looks like posturing before this Committee by not telling us the truth and talking about how to deal with statistics without informing this Committee. Our oversight function has to work, and can only work, with mutual respect for each other. We both, presumably, want to do the best job we can for veterans. We have to have mutual respect for each other, and the facts; and, I believe your staff exhibited neither.

If the testimony that Dr. Katz gave was wrong, being questioned 3 days after we went through a back-and-forth that was very difficult to do for both of us, why weren't we notified? Why didn't you say, "we found new statistics and we're checking them out?" You never told us anything after your chief doctor in charge of mental health testified differently.

What we see is a pattern, Mr. Secretary, a pattern that we have seen going back to the days of atomic testing, through the Agent Orange controversies of Vietnam, depleted uranium, and more recently, Persian Gulf War Illness, PTSD, traumatic brain injury (TBI), suicides, and homelessness. The same pattern that really reveals a culture of a bureaucracy.

The pattern is deny, deny, deny. Then, when facts seemingly come to disagree with a denial, you cover up, cover up, cover up. When the cover-up falls apart, you admit a little bit of a problem and underplay it: It's only a few people, only 1,000 veterans got exposed to that gas; Agent Orange didn't affect very many; atomic testing, well, nobody knew what was going on.

Then, finally, maybe you admit it's a problem and then, way after the fact, try to come to grips with it.

We have seen it again and again and again. It is not just dealing with numbers, as your whole testimony does, Mr. Secretary. You are talking about numbers as if that is all it is. It is a bureaucratic situation.

This is not a bureaucratic situation with just numbers. This is a matter of life and death for the veterans that we are responsible for.

I think there is criminal negligence in the way this was handled. If we do not admit, if we do not assume there are problems, if we do not know what the problem is, then the problem will continue, and people will die. If that is not criminal negligence, I don't know what is.

Mr. Secretary, we had a discussion right after you were confirmed. I came up to see you to congratulate you on your new role as Secretary. I asked you a question. I said, Are you going to just be a caretaker for the last year of this administration, or are you going to do something real and have a legacy? I said, I hope it is the latter, and I will help you do that.

I will tell you how you deal with this issue will determine how we see your role. There is clear evidence of a bureaucratic cover-up here.

One of the people in the e-mails is Dr. Kussman and I don't even see him here. I guess he had a previous engagement. He ought to be here. I also don't see the public relations guy that was one of the people in the other e-mail. They should be here to talk about what happened.

I want to know, since I don't see it in your testimony and I see only vague references to the e-mail, how are you going to ensure accountability? Are you going to ask for the resignations of Dr. Kussman, Dr. Katz, and anyone else who participated in the cover-up of the data?

I want to know if you are going to really take your role seriously and if there is going to be accountability for what has gone on here. This is not just an abstract discussion, this is not just a hearing to say, "We got you." This is about our veterans and whether they have a life ahead of them or not.

I will tell you I have talked to the Members of this Committee and they are pretty angry with what is going on. I think you need a better answer than your prepared statement, which just goes into bureaucratic details.

Now, we will have opening statements.

Mr. Buyer, you are recognized.

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman. I think those of us who have friends or family members that have committed suicide, number one, are haunted by that experience because we then look at that individual, and we reflect upon what could we have done to have prevented it. What did we miss? What were those risk factors?

And sometimes they are noticeable. Sometimes when they are a friend and they are closest to you, you might be providing counsel to them, you think it is a moment of just being a good friend. Then, when they commit a foolish act and take their own life, you are tortured for the rest of your life.

So this is a pretty powerful issue. Especially, it cuts across the sections of our population, when you think of suicide being the 11th leading cause of death in our society. So it is just not within the veteran population, it is within our population as a whole. When we don't have a national surveillance system, it is very difficult for us to even gain a better understanding.

But we do have defined abilities to come up with the proper cohorts not only within U.S. Department of Defense (DoD), but also in the VA, so we can better understand, and identify those risk factors.

I think, Mr. Secretary, by looking at how many Members have come here today, it sends a signal to you that the loss of a single veteran is a tragedy to us. I am sure that every Member of this Committee, in earnest, seeks to help you to identify contributing factors and to do anything we possibly can to prevent servicemembers or veterans from taking their own lives.

We recognize that many of the veterans that do take their own lives, in fact, are inpatients and in psychiatric care. So even though we can provide in a controlled environment and we do everything we can, half of them that are inpatients are committing suicide.

So it is one of those things where, even in a controlled environment, we can come up with identifying factors and still can't prevent someone from committing what we view as a very foolish act.

So the challenge that you have is real.

I want to thank the Chairman for continuing these hearings to discuss this important issue and to help those at risk. A number of questions were raised during our hearing last December regarding the validity of data on the number of veteran suicides. Such information is vital to understanding the scope of the problem, as well as identifying risk factors and providing better prevention and treatment protocols.

Chairman Filner joined me in a letter I wrote to you, Mr. Secretary—and to DoD and *CBS News*—requesting their respective data on how it was formulated. For the record, *CBS News* failed to respond to Mr. Filner's and my letter. DoD only acknowledged the letter, and we are still waiting on their reply.

Mr. Secretary, you were the only one to respond to Mr. Filner's and my letter. That letter included information and worksheets on two separate studies that the VA is conducting. So I appreciate the timeliness with which you responded to this Committee's concerns.

These studies may provide some useful information, but they are limited to data on suicide rates among veterans in the VA healthcare system. VA must have a better method for the systematic collection and tracking of veteran suicide data. It is also important to find ways to reduce the stigma associated with mental healthcare and encourage more servicemembers to seek treatment when it is needed.

During our last hearing, I asked the VA to be proactive and to reach out to soldiers and their families during premobilization, and to start with the 76th Indiana Brigade Combat Team as it prepared to deploy. Mr. Filner and I agreed that we would proceed with that.

I want to thank you, Mr. Secretary. I am very pleased that the VA came, as requested, and participated in such an outreach.

I also recognize that you are operating outside the lines of your jurisdiction. But you didn't say that. You didn't say, "That is outside my jurisdiction; I am now dancing on DoD turf." You said, "I am going to embrace the counsel of the Committee and we are going to see if we can follow this group. We will identify ourselves with the family members. They are the ones who are the closest to being able to identify individual risk factors or if there is a change in my husband, my brother, my loved one, that we could see."

I stood with 3,400 Indiana soldiers, with Joe Donnelly at the RCA Dome on January 2, for the formal send-off ceremony. Along with about 20,000 friends and family members was VA staff from the Indianapolis VA Medical Center, the regional office, and the Vet Center. The VA reported about 1,700 families received information regarding VA benefits and services, including mental health services, Mr. Chairman, and information on post traumatic stress disorder and suicide prevention.

The VA also followed up with subsequent briefings while the brigade was at Fort Stewart, Georgia, for training. As the brigade marched off to war, I believe they left with a clear impression that the VA was available to provide support and assistance to their families during their deployment, and that you will be there when they return from Iraq.

There was very positive feedback regarding the VA's presence at these events; so I want to thank you, Mr. Secretary, for working with the Committee to be proactive and to do something outside the norm.

Mr. Secretary, you have taken decisive action to meet these increased needs. This month, for example, the VA contacted nearly 570,000 recent combat veterans about VA medical care and benefits. These veterans were either injured in Iraq or Afghanistan or discharged from active duty but had yet been contacted by the VA. So I want to thank you for your outreach. It is something that Mr. Filner had also been expressing, and had expressed that to you.

So, Mr. Chairman, I think we need to acknowledge when the Secretary acts on something that you ask for, we need to compliment him for it. The Secretary has also directed the creation of an independent working group to assess VA's suicide prevention programs.

I want to thank Secretary Peake and other witnesses for their participation today, and I look forward to their testimony. In the end, I hope this hearing will drive home the message to our Nation's men and women who serve, and to their families, that if you need help, care is available and treatment works, and there is a road to recovery.

I yield back.

[The prepared statement of Congressman Buyer appears on p. 78.]

The CHAIRMAN. Before the Secretary testifies, are there opening remarks of any Members? I will call Members in the order that we have.

Mr. Hall.

OPENING STATEMENT OF HON. JOHN J. HALL

Mr. HALL. Thank you, Mr. Chairman.

Just briefly, I would say that if we can prevent any single suicide among our veterans, it is worth going to great lengths to do that. I would ask you—I know you are wearing two conflicting—and, sometimes—hats that are at cross-purposes with the "Honorable Secretary" before your name and the initials "M.D." after it, and most of my questions will be addressed toward the M.D. part of it.

It strikes me that minimally adequate treatment, as described in our documents we have before us, of at least eight visits in 1 year to a counselor, psychiatrist, or psychologist; and we understand

from testimony before this Committee that that is not necessarily the same psychiatrist, psychologist or counselor. It is hard for an individual servicemember or veteran to strike up enough of a rapport with a doctor or counselor who is treating them, if they are seeing somebody different every time they go in and they have to kind of start from scratch. We have heard that that is a problem.

Thirty minutes, anybody in this room who has been to therapy for any kind of marital counseling or depression or whatever can tell you that 30 minutes is just about enough to get started and say goodbye and book the next visit. So I would at least say that the definition of "minimally adequate treatment" is not adequate.

I would also say that with the rates of bankruptcy and divorce that we are seeing, which are records, we are told are records among our veterans, that those two things—each of them alone, not to mention bankruptcy and divorce taken together—are enough to drive people, servicemembers or regular civilians, to suicide. There are many stories during the Great Depression of people jumping off of buildings because their material wealth was gone, and they saw no hope.

So some of this is rocket science in the mental health world; some of it is really just nuts and bolts and simple common sense in taking care of our veterans.

I think that we should be as adaptable. Just as our military adapts their strategy in combat, we have had to change the course. For instance, in the war in Iraq we have had to change our strategy several times, and the insurgents have changed their strategy several times in response. They make a bigger bomb, we make a more armored vehicle, et cetera. We need to do the same thing, I think, on the VA side and constantly be ready to change our strategy.

Lastly, we had a pair of parents before, I forget whether it was the full Committee or Subcommittee on Disability Assistance and Memorial Affairs, but two parents who were courageous enough to come in, whose son had taken his own life. They asked us for universal screening for PTSD for all veterans so they don't have to self-identify.

I think that that is maybe one of the answers, because men or women who are taught to be tough and are taught to handle situations, and who also want to just get back to their families and not be held over for extra questioning and not have something on their record that might be a stigma in the future for employment or for being able to be in law enforcement or advance themselves in the Guard or Reserve or what have you.

Their son, this couple's son, had not shown a sign that they, the parents, saw that would tip them off that he was so distressed that he was going to take his own life. So if parents, people that are close to an individual, don't see the change, and can't see it, I think we need the professionals to be right on top of the case. That would probably call for universal screening at some point after separation.

With that, I look forward to your testimony. Thank you very much.

I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Miller. Mr. Brown. Ms. Brown-Waite. Mr. Turner.

Mr. Hare.

OPENING STATEMENT OF HON. PHIL HARE

Mr. HARE. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for appearing before the Committee today. It is nice to see you again.

While I appreciate the amount of time and the effort and thought the VA has put into veteran suicide prevention, which I honestly believe has saved some lives, I have to say I was shocked and very disturbed after reading the e-mails.

But this isn't about numbers or formulas or programming. This is about people; this is about families, wives, husbands, sons, daughters. This is about honoring those who serve this country.

A few weeks ago I sat and talked with Mike and Kim Bowman of Illinois, whose son, Tim, committed suicide. Tim was an incredible young man who bravely served in Iraq and came home a changed man, suffering from PTSD. His parents did their best to try to help him, but they didn't know what signs to look for and how to reach out to help him. They are rightly angry and frustrated that, from their perspective, the VA didn't do more to reach out to help their son.

I believe the first step in solving any problem is admitting that you have one. If the VA, for some reason, isn't being honest about the number of veterans committing suicide, then that is stopping us or preventing us from giving you the resources that you need to prevent them.

I have said many times at hearings, and I will continue to say as long as I serve on this Committee, the question isn't, "Can we afford to give the necessary funds out to help our veterans?" The question should be—the statement should be, "We simply can't afford not to give you the funds we need." But we have to know how severe the problem is in order to be able to help you on that.

I think, to be honest, this is more than a problem; I think it is an epidemic among veterans if these numbers are remotely close, to what is happening and I believe they are.

But we are all here today for the same reason, to find solutions to stopping veteran suicides so that no family like the Bowmans have to go through this. The RAND report found that 300,000 military servicemembers who have returned from Iraq and Afghanistan report symptoms of PTSD or major depression, but only slightly more than half have sought treatment for their conditions.

Let me just echo the sentiments of my friend from New York, Mr. Hall, when he said that screening all the veterans when they come back is something that we need to do. It is something that I think—clearly, they may not know that they have the problem, their families don't know; then we need to monitor them for some period of time down the road to make sure that if there is a problem, we can bring them in and be able to help them.

With mental health disorder being a significant precursor to suicidal thoughts, it is clear to me that the VA has to do more to proactively reach out to veterans.

As you know, Mr. Secretary, when we met—you know I come from a rural district, and I am also interested—one of my questions to you during the question period is going to be, How do we reach

out to those rural veterans that come back where there may not be a VA hospital close to them? How do we get them in quickly and timely in order to prevent what happened to Mr. Bowman?

So I thank you for coming today.

I would yield back my time. Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Mr. Rodriguez.

OPENING STATEMENT OF HON. CIRO D. RODRIGUEZ

Mr. RODRIGUEZ. Thank you, Mr. Chairman.

Let me, first of all, thank you, Mr. Secretary, for being here today. And let me just add that some of us have extremely high expectations for you—and I know that you are uniquely situated because you served not only in our military as a soldier, but also in the DoD—in terms of service there and the VA, and the difficulty that we have had as a Committee in the past to try to get both the DoD and the VA to work together.

With this situation, also I think that we are talking right now about veterans committing suicide, but we have had a lot of active-duty soldiers also committing suicide. Nothing is worse than a soldier committing suicide in terms of how badly they and their families are treated when they come home, even by other veterans. They are treated as if they were cowards and those kind of things. Those are the numbers that we also need to seek out and get the right information for us to be able to do the right thing. I think you can be helpful there.

Let me just add to what Chairman Bob Filner has said, we are coming from a perspective, when I got on this Committee some 12 years ago, I heard about Project 112, Project SHAD, where the DoD was denying that it even existed. Later on, as time went on—and 20 years have passed since the inception of those projects—we identified some 35 projects that were out there, that we did experimental things with our soldiers. Then we found it was not 30, it was 40; then it went to 50. I think the latest numbers were something like 60, where we experimented with our own soldiers.

But it took us prying and pushing and tugging to be able to get that information, when we really need to work together to see how we can help address some of these situations—and hopefully that is what we will do—to move quickly to try to meet the needs of our soldiers and our families out there.

I want to also lay down the groundwork for that in terms of how important it is, what do we do from now? We know we have a serious situation in the VA. And I know we have a serious situation in the DoD also, which I know you don't oversee, but that is also another area that we need to deal with.

We have situations where—I just did an interview in San Antonio regarding a VA patient that died; the accusations are basically that he was killed because of presumed negligence on the part of the doctors—and the importance of peer review in the military, I mean in the VA, as it deals with doctors' recommendations and those kinds of things.

So there are other areas that are very serious, and I am hoping that we can make some inroads in those areas. As we move forward on this testimony, I am hoping that we can come up with

some recommendations, and if you have recommendations for us as to what you need to get it done.

And, I know that for the longest time we didn't provide the resources that were needed, and we have a responsibility there. But we also ask that we be given the information and the data that is needed for us to be able to do that, and hopefully we can respond to some of those needs.

Thank you very much. Thank you for being here, Mr. Secretary.

[The following was subsequently received from the VA:]

1. Update on Dallas (not requested during hearing)
2. Noted patient died in San Antonio may be related to negligence—importance of peer review—provide updates.

Response: The Office of Medical Inspector (OMI) conducted a site visit to the Dallas VA Medical Center (VAMC) on April 16 through April 17, 2008. Its findings were presented to the Dallas VAMC leadership at the conclusion of the site visit and to the Veterans Health Administration (VHA) leadership on the OMI's return. The OMI identified a number of environmental issues that needed to be addressed. The Dallas VAMC reports that action to address environmental issues such as removal of metal holders for linen hampers, geriatric chairs in the showers, and replacement of unit doors that did not lock automatically were completed by April 30, 2008.

The OMI recommendations currently under assessment or in progress include increasing the amount of therapeutic patient activity, replacing the suicide risk assessment tool, and changing the current continuity of care model to an inpatient model of care. The Dallas VAMC is addressing these issues.

On April 22, 2008, a team from VA's Office of Mental Health Services visited the facility to evaluate the safety of its mental health program. It identified additional environmental, organizational, and programmatic issues that can improve the delivery of mental healthcare. Actions on many of these environmental issues, such as additional housekeeping staff, painting and repairs, installation of new doors, and moving cameras and monitors have been completed or will be in the near future. In addition to the actions noted, the Dallas VAMC is reassessing the mixing of acuities on the Mental Health unit.

The report has not been cleared by OMI and is in the pre-decisional stage. It is anticipated that it will be ready by the end of May.

San Antonio—An external Peer Review was completed in the second quarter FY 2008. South Texas is in the process of reviewing the results and developing professional practice evaluations.

The CHAIRMAN. Thank you.

Mr. Mitchell.

OPENING STATEMENT OF HON. HARRY E. MITCHELL

Mr. MITCHELL. Thank you, Mr. Chairman.

In November, *CBS News* brought some shocking and critically important information to light. Not just that those who served in the military were more than twice as likely to take their own life in 2005 than Americans who never served, or that veterans aged 20 to 24 were killing themselves when they returned home at rates between two-and-a-half to four times higher than nonveterans the same age, but that the Department of Veterans Affairs wasn't keeping track of veteran suicides nationwide.

In December we had a hearing to find out why.

Mr. Chairman, I don't know if there is anyone here who attended that hearing who will ever forget it. Mr. Hare mentioned that we heard from Mike and Kim Bowman, whose 23-year-old son, Tim, survived a year of duty in Iraq, only to come home and take his own life. Mr. Bowman warned us that our troops were coming home to an underfunded, understaffed, underequipped VA mental

health system that imposes so many challenges that many are just giving up.

So when Dr. Katz insisted at that hearing, repeatedly, that the VA had all the necessary resources to reach all veterans at risk for suicide and make special treatment available to them, I was skeptical. How could Dr. Katz be so sure that there weren't any requests for additional resources sitting somewhere within the vast VA system that have gone unfulfilled? Was he absolutely certain that there were no pending requests for an additional mental health counselor, for extra gas money to enable a VA employee to drive somewhere to contact an outreach?

As Chairman of the Subcommittee on Oversight and Investigations, I felt I had a responsibility to make sure, so I asked the VA to double-check. I asked them to take a look at their records and send us any documents relating to any request for additional resources that had gone unfulfilled or underfilled. My thought was, if we could find out what the VA needs are to address this problem, we could get to work and make sure they got it.

More than four months later, however, all I have gotten are excuses, complaints, and most recently, a suggestion that I, "Go file a Freedom of Information Act request." That is not just an insult to me, it is an insult to this Committee and to our veterans.

I have tried to be reasonable. I have tried to work with Secretary Peake's office. But, Mr. Chairman, my patience is at an end.

I have given the Department until Friday to finally produce the documents I requested. If they do not, Mr. Chairman, I want you to know that I will be asking you to pursue a subpoena.

I yield back.

[The prepared statement of Congressman Mitchell appears on p. 79.]

The CHAIRMAN. Thank you, Mr. Mitchell.

Mr. Moran, we thank you for your interest. You have been interested in this issue and have been a leader for many years, and we thank you.

OPENING STATEMENT OF HON. JIM MORAN

Mr. MORAN OF VIRGINIA. Thank you very much, Mr. Chairman and Ranking Member Buyer and my friends and colleagues.

I want to mention, incidentally, with regard to the recommendation for individual screening, in the Defense Appropriations bill, when we put $900 million in for PTSD and traumatic brain injury, we did require that everyone get an individual face-to-face screening by the Pentagon. But the problem is, that is when all they can think about is getting home to their families, and it is oftentimes only after they get home that evidence of emotional problems, whether it comes out in domestic abuse or inability to hold on to a job and so on, manifests itself.

The fact that 20 percent of our veterans from Iraq and Afghanistan show signs and symptoms of PTSD, depression, and anxiety is a compelling statistic. But even more so is the fact that that number increases to 50 percent for soldiers with multiple tours and inadequate time between deployments; and in fact, that is becoming more and more the case.

One of the measures that I would suggest that this Committee might consider is to create a stand-alone, 24-hour, national, toll-free hotline to assist our veterans in times of intense crisis. The key is that this hotline would be staffed by veterans trained to appropriately and responsibly answer calls from other veterans.

I understand that the Department of Veterans Affairs has developed a veterans option off of the National Suicide Hotline. While I applaud your effort to address this problem, I believe that there are about three deficiencies in this approach. First, oftentimes a veteran doesn't want to talk to a doctor; he or she wants to talk to someone who has got a real-life perspective on what is going on in their mind—cultural competency, if you will. That is a term that has been used to express that a fellow veteran can provide a real difference in crisis counseling because they can better relate.

Secondly, soldiers with mental illnesses face social stigma that is identified with seeking care through the VA. Research from the Air Force's Suicide Prevention efforts suggests that fear of the system, of an unfriendly mental health establishment, and of potential job-related consequences do keep many active-duty soldiers and recent veterans from seeking the care that they need.

Thirdly, the VHA is already overburdened by a great many healthcare responsibilities; and as a result, I think it is ever more difficult to provide a topnotch hotline effort. Stretched budgets, staffing shortages, they may not be able to meet the challenges of so many returning veterans when our Nation redeploys from Iraq in the future.

A nonprofit organization dedicated to suicide prevention might be better able to provide focus, stability, and commitment that the VA is particularly challenged in being able to achieve.

So to conclude, our vets deserve as much support when they return from combat as they receive while in battle, and I know that this Committee is acutely aware of that fact. But too many of our veterans are struggling to make the difficult adjustment back to society, and they desperately need someone that they can talk to, that they can relate to, someone that has walked a mile in their shoes. So that is why I have offered legislation that would do that.

I very respectfully suggest that this Committee consider that legislation. I certainly applaud this Committee for your efforts on behalf of veterans.

Mr. BUYER. Would the gentleman yield?

Mr. MORAN OF VIRGINIA. I would be happy to.

Mr. BUYER. Mr. Moran, I want to thank you for your leadership over the years. Your care and sincerity, it is real and very evident to me, having known you over the years. So I want to thank you for your leadership.

We debated your bill; and I like the idea of having veterans, but not all veterans are trained in mental health. I know that is your aspiration. But you have a good idea, and we want to work through that.

We did have a conversation, Mr. Chairman, and I want to caution my friends in the fourth branch of government who may be covering this hearing, please do not refer to suicide as an epidemic without saying that treatment is available. Because if you say or you put on the air that suicide is an epidemic in America, you are

exacerbating the problem and you could actually be moving people to suicide. So, please, if you write that, say that treatment and care are available.

Thank you for your leadership.

Mr. MORAN OF VIRGINIA. Thank you, Mr. Buyer.

If I could quickly respond, what we are suggesting is that a nonprofit organization that would be available for veterans, that would spread the word within the network of veterans and give them training simply to be able to react to people on the other side of the line. They don't need to be trained in mental health counseling, just be able to know how to listen and to talk and to calm down someone that is in a time of crisis. That is what we are talking about.

It is just that sometimes when you have very large institutions, it is difficult to accomplish what a nonprofit group that is particularly committed and understanding of the problem sometimes is able to provide with a lot less money. That is all I am suggesting.

I thank you for your comments, Mr. Buyer.

And thank you very much, Mr. Chairman, for giving me this opportunity.

[The prepared statement of Congressman Moran appears on p. 82.]

The CHAIRMAN. Thank you, Mr. Moran. We will be looking again at that legislation.

Mr. Salazar, any opening remarks?

OPENING STATEMENT OF HON. JOHN T. SALAZAR

Mr. SALAZAR. Mr. Chairman, I want to thank you for having this important hearing. I agree with my colleagues, but the one thing that I think we have to be very, very adamant about is finding out whether there was a cover-up by the VA to push these things under the carpet or was it something that they need additional tools for. We are here to help. That is what we are here for.

So with that, thank you, Mr. Chairman.

The CHAIRMAN. Ms. Berkley.

Ms. BERKLEY. I would like to submit my opening statement for the record, if I may, so we can get to the witnesses.

[The prepared statement of Ms. Berkley appears on p. 79.]

The CHAIRMAN. So ordered. I would ask unanimous consent that all Members can submit their statements for the record. Hearing no objection, so ordered.

The CHAIRMAN. Mr. McNerney, any quick opening?

OPENING STATEMENT OF HON. JERRY MCNERNEY

Mr. MCNERNEY. Thank you, Mr. Chairman. It is clear that all Members of the Committee are sincere in wanting to find the bottom of this.

There is nothing that is more tragic than suicide. As Mr. Buyer pointed out, it is a situation that haunts the family and friends for years and years, especially when young men and women who have served our country and have looked to this country to help them when they have needs and, it appears, that that may not have been followed through.

So it is our solemn responsibility to get to the bottom of this and to find ways to move forward that will prevent this in the future.

Thank you.

The CHAIRMAN. Ms. Brown.

OPENING STATEMENT OF HON. CORRINE BROWN

Ms. BROWN OF FLORIDA. Thank you, Mr. Chairman, and I want to thank you for holding this hearing today.

First of all, let me say, it is not just the veterans; it is the veterans and their families that are faced with this situation. I am looking forward to hearing from the Secretary and also from Dr. Katz on how he came up with this analysis and what can we do together to change this situation, because this is a serious problem.

I have been on this Committee for 16 years, and this is a serious situation. We have passed the largest VA budget in the history of the United States, and I want to make sure that we are properly funding that healthcare issue, and the money is going where it needs to go.

So, thank you, Mr. Chairman, for holding this hearing.

The CHAIRMAN. Thank you.

Mr. Secretary, I appreciate you being here. I was hoping that everybody who was associated with these e-mails would be with you but since they are not, I hope you can speak to those issues that we have raised.

You are recognized, sir, for your statement.

STATEMENT OF HON. JAMES B. PEAKE, M.D., SECRETARY, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY GERALD M. CROSS, M.D., FAAFP, PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND IRA KATZ, M.D., PH.D., DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

Secretary PEAKE. Mr. Chairman, with your permission, I would like to provide a written statement for the record.

The CHAIRMAN. So ordered.

Secretary PEAKE. Mr. Chairman, Congressman Buyer, Members of this Committee, thank you for the opportunity to discuss the issues of veteran suicides. I really do appreciate your holding this hearing. It is a very important subject.

We will be talking quite a bit about the numbers in this discussion. I will tell you, quite frankly, to me personally the most important thing is that each suicide number represents a soldier, a sailor, an airman, a Marine, a veteran who has served this country in uniform; and each individually is a tragedy and each deserves all that we can do to try to prevent that tragedy.

While it is appropriate—and frankly, it is necessary—to try to measure and understand variances from the norm in trending and statistical significance, I want to assure you and this Committee and, frankly, the American people that we are not waiting on these numbers to focus the VA on addressing this very important issue.

The title of today's hearing is, "The Truth about Veteran Suicides." My objective is to tell you as clearly as I can what we do

know about veteran suicides and the sources of the information. Also, I will tell you what we don't know and what I intend to do about that. I also will take this opportunity to tell you what we have been doing to address the issue of suicide directly, from a clinical perspective, and expanding our outreach even as we seek better ways to measure.

First, to compare veterans with nonveterans, the gold standard and source of the database is the National Death Index. It is a product of the National Center for Health Statistics, a U.S. Department of Health and Human Services (HHS) function. The most current complete data set is from 2005. 2006 data should be released, we are told, sometime soon.

Looking at 2005 and back to 2001, the overall rate of suicide was 14.1 per 100,000 in the general population. That is not a percent; that is per 100,000. It is important to separate the rate of men and women. Men have a higher rate of suicide than women, and that is statistically significant. We must separate by age group because there are significant differences by age groupings.

The National Death Index does not identify those who are veterans. To compare all veterans, not just those seen in the VA system, would require matching the full list of all 24 million veterans against the National Death Index to see how many of them had committed suicide. We do not have the identifying information for all veterans to do this analysis. We would love to be able to do it; we don't have that information.

The VA does have the ability to compare veteran suicide rates with the national average for groups of veterans who have used the VA health system. We have matched that group against the National Death Index by name to know the number of those veterans who have used the VA, who have committed a suicide. With that data, we can calculate a rate.

The National Death Index data that we have broken that data into—first, men and women; let me just show you this is the population, 2005. Men make up about 20 percent of the population. Men veterans make up about 20 percent of the overall population. Women veterans make up only about 1 percent of the overall population, just to give you the perspective.

What this chart is showing is for 2005. The numbers in red represent the numbers that are statistically higher than the general population. This is for women. This is for men. You can see that for 2005, in the older, but not in the younger, age groups for veterans who use the VA health system, just those veterans, the suicide rate was higher than the general population.

Looking at this for each, from 2002, will give a more complete picture. But here, just to say this is the general suicide rate, this is the veterans'—again, those who have only been seen in our system because we don't have all the veterans—you can see that it is a bit higher than the general population, and it is statistically significant.

Now, to show you the trending, this is the summary of data from 2002, 2003, 2004, 2005, and you can see that the red is the veteran population, again for age group 18 to 29, age group 30 to 64, and then the older age group. What you see, the national population figure is here in terms of rates per 100,000.

The rates for veterans who are users of the VA, again, just users of VA, have also been relatively stable over this period. You can see that it is, again, stable. This is women, the smaller group; and it is—what we are showing with these brackets here are the statistical significance. So that this is clearly statistically significant.

Looking at the veterans who have used the VA in this period, male veterans commit suicide at a somewhat higher rate, but with varying statistical significance by age over different years. You can see that in the charts.

Within the group of male veterans there are differences in age of suicide compared to what is seen in the general population with a statistically higher middle-age group. So statistically you can see this age group is generally higher for veterans—above the national average.

Male veterans commit suicide at a higher rate than female veterans. Within the group of female veterans—and that is what this slide shows—by age group, there is nearly a twofold increase over women in the general population. That is, again, variably, statistically significant over years and by age. So in this older age group in 2002, it was above the national average statistically. Here, it was about the same, and here it has bounced up again. I don't know what 2006 will show, but we need to follow that and find out.

In 2002, to better understand the nature of violent deaths, the CDC Violent National Death Reporting System was established and gradually implemented, first in six States, then expanded to 16 by 2005, to collect data on violent deaths, including suicides. It gets information from a variety of sources, including death certificates, police reports, medical examiners, coroners, crime laboratories; and unlike the National Death Index, coroner-reported veteran status is included in the database. VA can get, at least for these 16 States, information on overall suicide rates among all veterans.

This chart summarizes the 2005 data. What you see of note is that, at least in these 16 States, there is a significantly higher rate of suicide in the younger age group of veterans compared to the general population. This is similar in both veterans seen in the VA system and those who do not use the VA system. This is for veterans who are really all veterans, and these are veterans who actually use the VA system. You can see these are relatively the same, but they are higher than the national averages.

We intend to trend this information over each year of the available data, going back as far as we can go to 2002. We believe that some of these veterans' deaths in this data set represent servicemembers who were actually on active duty when they committed suicide. We will work with CDC and DoD to understand this group, particularly, obviously, wanting to know whether this represents OIF or OEF returnees.

Clearly, OIF and OEF returning servicemen and women represent a group of particular interest to us today. We have a sense of urgency to understand and intervene to prevent even a single suicide. To better understand suicide in this particular cohort, Dr. Kang, of the VA, conducted a study, which matched servicemembers who had served in OIF and OEF theater and separated between 2002 and 2005 against the National Death Index. He found—just looking only at that group, he found that 144 out of

490,346 separated OIF and OEF servicemembers committed suicide during that time, for an overall rate of 21.9 per 100,000.

Because there was some initial confusion around this study, I want to clarify that these, unlike our concerns about the last data that I presented, are deaths only of men and women who had separated from the military and do not include any deaths while a servicemember was on active duty.

To compare to other national norms, we looked at this cohort against the national averages that I discussed earlier. For OIF/OEF veterans who had deployed and separated from 2002 to 2005, the suicide rate was slightly higher than would be expected in an age-, gender-, race-matched general population, but the difference was not statistically significant except in the young non-VA user age group. So these are folks that were not seen in the VA, and again, it was only significant in the age group of 18 to 29.

We have also examined this data for differences in suicide rates between those who use the VA and those who have not used the VA. We found that 17 per 100,000 OIF/OEF veterans who used the VA for care took their own lives, compared to 24 of 100,000 OIF/OEF veterans who did not use the VA for care. Again, this apparent advantage to VA care, though encouraging, is not statistically significant. In this group, a slight but not improved rate is also true for those who visited our Vet Centers. There were only three women among the 144. So no conclusions can really be drawn from that group.

Our medical statisticians have plumbed this data in anticipation of follow-on studies when the updated National Death Index information is available. Some of the insights that we have taken from this look include that there is little variation in suicide by branch of service. We also found that a diagnosis of a mental disorder predicted a nearly 1.8 times higher suicide risk than the general population. This is consistent with what has been published regarding people in general with mental health diagnoses, but emphasizes the absolute importance of our mental health efforts.

Likewise, the use of firearms as a means of suicide in this group is consistent with the higher rate of this modality of suicide in all veterans compared to the general population.

I would reiterate that all of this data comes from national data for suicide run against those who we know from our data sources and DoD are veterans. We must use these national numbers, because our clinical records do not capture in any reliable or complete way such events as suicides or suicide attempts. This national roll-up of information from the coroners through the States offers the most complete compilation of deaths and its causes, since we may well not know of a death even if it occurs locally.

The information on deaths continues to be updated as the reports come in over time, so our confidence in the completeness of those numbers comes only after several years of data collection. We are awaiting now, again, the release of the National Death Index compilation for the year 2006 for further analysis, and we will dig into that very deeply as soon as we get it.

For this reason, and not satisfied with that data lag, Dr. Katz, who led in the institution of a VA-wide system of 153 suicide-prevention coordinators whose prime function was clinical in nature—

taking care of patients, identifying and closely following high-risk patients, educating staff on suicide issues—he directed them, beginning in October of 2007, to report specifically on suicide attempts.

This entailed getting a clear definition and reporting standards for suicide attempts. When is a suicide attempt an attempt? Does a cry for help with an overdose of a non-threatening medication ingestion or a cut on the wrist so slight as to not really risk serious injury, is that really an attempt? Those are the kind of questions that we have to get standardized across 153 different reporting entities.

On February 13, 2008, an internal e-mail from Dr. Katz discussed what was the first 3 months of this reported information. In his e-mail, he suggested that a thousand veterans a month under VA care were being reported as attempting suicide, and appropriately was concerned about releasing information that was not validated and was so very preliminary.

The data was clearly not accurate. Our suicide prevention coordinators were new to their jobs. There was a great deal of uncertainty over borderline calls, and many of them were just beginning to make the community contacts that are essential in making an accurate count of the number of suicides and suicide attempts.

A number of States had suspiciously low reporting rates. We are still not satisfied with the consistency of the reporting, its accuracy or its completeness.

Let me show you this chart. And what this is is month by month, facility by facility, and what you can just see is how erratic the reporting is even now. The VA is addressing the problem through regular review, educating coordinators with questionable data, collaborating with our coordinators on difficult calls, and encouraging them to meet the right people in their communities to obtain additional data.

To be clear, VA had not reported on suicide attempts previously, either to Congress or to the media. Though perhaps we should have been looking at it earlier, we were not. The number, 790 a year, was a *CBS News* number that they derived from a Freedom of Information data request looking at clinical records coding. I now understand, I think, the places in the spreadsheets that they got under the Freedom of Information and added together to get this number.

But for all the reasons noted earlier, this source of data should not have been considered at all reliable if the purpose of the count was to determine the total number of suicides and attempts among veterans under our care. Some people who attempt suicide, but do not die, go elsewhere for care. Others do not admit that their injuries were due to suicide attempts, and may not, even when a counselor discusses a situation with them. *CBS News*' number, while arithmetically correct, is in actuality misleading.

I can appreciate that the number of a thousand suicide attempts a month might be shocking. But in a system as large as ours, and with the numbers I have shown you nationally on suicides, and consistent with the literature, we might well expect a larger number of attempts than that because it's somewhere between 8 and 25 attempts per suicide completed in the national literature.

But what is really important is to identify them, because people who attempt suicide are more likely to commit suicide and are so, therefore, such an important target for our interventions.

There's a large body of scientific literature on suicides, and the VA has over the years, been a prime contributor to that knowledge. In fact, I can submit this binder full of peer-reviewed articles for the record.

It is where we have the basis for conclusions that target our efforts, conclusions such as: Among veterans receiving care from VA who died from suicide, almost 60 percent of those aged under 65 have a mental health or substance abuse diagnosis, but only 24 percent of those aged 65 and over have such a diagnosis.

There is significant variability in suicide rates geographically. In general, the rates are lowest in the Northeast and highest in the West. I don't know exactly why. For veterans who died from suicide, firearms are the most common means, accounting for almost two-thirds of the deaths.

Among Vietnam veterans, there appears to have been an increase in suicide rates in the first few years after veterans returned home; however, after a few years, those rates became comparable to the general population. There was no increase in suicide rates among veterans who returned from the first Gulf War. And those wounded, hospitalized and multiple wounds, have had a higher risk of suicide.

You know, I have focused a lot on the numbers and what we know and don't know. And while I am pushing our VA team to explore these numbers in greater depth and expand our understanding of them, I want to emphasize that we are not waiting for perfect numbers to appreciate the importance of extending our intervention and outreach. Whether veterans suicides are at or above or below some national average, any suicide—any suicide—in our view, is a tragic loss.

There is probably no system focusing on suicide and mental health issues in as a comprehensive and far-reaching way as your VA. And Dr. Katz here has been a key leader in that effort.

Recognition of the problem by all who serve veterans is important. So we have had two national VA Suicide Prevention Awareness Days throughout our system to focus 200,000 healthcare employees on this issue. We have trained VA staff on prevention resources, including the hotline and the roll of suicide-prevention coordinators. We are incorporating special training in suicide prevention for our case managers.

Two of our mental health education and research centers focus on technical assistance across the VA for suicide prevention. One is our Mental Health Center of Excellence in Canandaigua, New York, with expertise in testing clinical and public health intervention; the other in Denver with clinical and neurobiological sciences, emphasizing suicide risk.

In July of 2007, a suicide hotline center was established at Canandaigua. In the subsequent 10 months, the hotline has fielded more than 37,000 calls, more than 16,000 from veterans. Nearly 500 from active-duty servicemembers, and more than 2,000 from family members or friends, just as you all have pointed out. These

calls have led to more than 3,000 referrals to suicide-prevention coordinators and 885 rescues involving emergency services.

Let me introduce Dr. Jan Kemp, who is with us today, who leads this effort on the ground up there in Canandaigua.

Jan, stand up. Thanks.

VA's hotline is staffed solely by mental health professionals, 24/7/365. They are trained in crisis intervention and issues such as traumatic brain injury and post traumatic stress disorder. In emergencies, they contact local emergency resources, police or ambulances. They can use the veteran's electronic medical record during the call and link directly with the medical center if they are one of our patients. And they work with the local suicide-prevention coordinators directly.

Cards, pamphlets, refrigerator magnets—I provided samples that I believe are at your desks—are widely distributed. And our suicide-prevention coordinators ensure at-risk veterans and their family members get them.

[Samples of *cards* and *pamphlets* appear on pages 120 and 121. The refrigerator magnet will be retained in the Committee files.]

This was pulled out by one of our veterans service organizations (VSOs) who said, boy, we're using this all over the place. Posters and hotline information such as these are located throughout VA medical centers, clinics and Vet Centers. Hotline stickers are on phones and by the doors in our residential programs.

Far from hiding this issue, we are more public about it than any organization that I know. I've mentioned the suicide-prevention coordinators before. Their main function is clinical, to educate staff and the veterans and the family members and to carefully monitor those at higher risk. So they maintain everyone's higher state of awareness and alertness to suicide issues, as well as dealing with individual patients.

It was not primarily for epidemiologic purposes that they were identifying suicide attempts, but rather because we know that those who have attempted suicide are at the highest risk. Under Dr. Katz's leadership and with the help of Congress, we have grown our mental health program in a number of ways: more than 3,800 new mental health employees hired in the past 3 years; incorporating mental health into primary care in our medical centers and in our Community-Based Outpatient Clinics (CBOCs); growing the number of both CBOCs and Vet Centers; expanding our hours of operation for mental health clinics beyond normal business hours; using telemental health to reach more remote veterans; providing separate access for women veterans with mental health, primary care and gynecologic care. It recognizes their increasing proportion of the force and their special needs and special desires for privacy. We are doing this in each of our hospitals.

The standard for mental health access was tightened so that patients with mental health issues are screened within 24 hours, provide urgent care immediately when needed—and if we don't have it in our house, we will buy it—or provided a full evaluation and a treatment plan within 14 days for those non-emergent patients.

I have spoken to you before on our outreach efforts with letters and participation in transition briefings for active and reserved de-

mobilization at both deployment health reassessment sites and on bases and in military hospitals.

[A sample of an outreach letter to veterans from Hon. Michael Kussman, M.D., MS, MACP, Under Secretary for Health, U.S. Department of Veterans Affairs, appears on p. 122.]

On May 2nd, we began an outreach call center program to contact nearly 570,000 combat veterans of the war on terror to ensure that they know about our ability to provide them care. Now we can do that up to 5 years after separation and to provide them information on other benefits. The first of those calls are going to veterans who were sick or injured while serving in Iraq or Afghanistan. And if any of those 17,000 or so veterans do not have a care manager, we will offer to appoint them one.

All of these efforts support not only our general concerns for our men and women veterans but to also directly address the issue of suicide concern about which we are here today.

I am impressed by the quality of my people and the dedication to this work, but I also appreciate the value of an outside look. I have directed the creation of a blue-ribbon work group of experts in suicide and its prevention to look at all of our data, consult with our team and advise me on different looks at our own data or new lines of inquiry that they might recommend. The members will come from DoD, other government agencies, and other nationally recognized treatment research and public health experts on suicide and its prevention, all from outside the VA. They will be given all of the data that we have and access to all of our experts. I have asked for a report 15 days from the completion of their meeting to tell me how I can better approach suicide prevention and suicide research.

You know, there is nothing more tragic than the loss of even one of these great men and women who have served this Nation. The VA is committed to doing all that we can to serve the individual while we continue to try to understand a very complicated problem that is also a national problem. We owe this Committee, and the Nation, accurate information and carefully studied, thoughtful conclusions while we provide the best care anywhere to our veterans, and that's exactly what I intend us to do.

Again, Mr. Chairman, I do appreciate you holding this hearing, and I look forward to your questions.

[The prepared statement and slide presentation of Secretary Peake appear on p. 83.]

The CHAIRMAN. Thank you, Mr. Secretary.

I don't doubt your commitment, but I will tell you, if there is a book on how a bureaucratic response should be given to an emotional problem, there should be a chapter in there with your testimony. Because what you have done is make us all look at these charts, which are almost impossible to read, and all the things you're doing and, of course, the icing on the cake, a blue-ribbon commission—it's always done to avoid an issue—without us understanding what you need in terms of resources from us and what we are missing. It sounds to me, "Everything is fine, we have it under control, we are going to study our data, we dug up all this data, but it is under control." You don't ask for any additional resources,

you don't say what you could do, you don't say what mistakes you have made; everything is fine.

[The following was subsequently received from VA:]

The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population provides advice and consultation to the Secretary on various matters relating to research, education and program improvements relevant to the prevention of suicide in the veteran population. The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population will create a report, within 15 days of the completion of its meeting with recommendations for improvements in VA's programs related to suicide prevention, research, and education.

Recommendations will be directly related to the primary objective of reducing risk of suicide in the veteran population. The attached Memorandum from Hon. Michael J. Kussman, M.D., MS, MACP, Under Secretary for Health, U.S. Department of Veterans Affairs, to Hon. James B. Peake, Secretary, U.S. Department of Veterans Affairs, dated May 5, 2008, Regarding Blue Ribbon Work Group on Suicide Prevention in the Veteran Population, appears on p. 134.

The CHAIRMAN. And that is a standard answer to everything we have done for years and years in this Committee. That is why we are upset and impatient, because you are not focusing on what we can do together to make sure that all the mental illness issues that have been associated with combat: PTSD, domestic violence, homelessness and suicides—we are not doing the job. I don't care what your figures show. We have tens of thousands of young people getting out of the military or the Guard who have not been adequately diagnosed for either PTSD or brain injury.

Every one of your statistics says, "those who have come to us," which is, you know, a small fraction of who is out there. So we are not doing the job. And we can't do our job if you are not honest with us.

And as I said before in my opening statement, we only came into possession of certain e-mails—I don't know how many there are out there, but we only have a few—brought to the public by discovery in a legal case out on the West Coast.

So 3 days after the hearing in which we asked directly—and Mr. Mitchell just said this—Dr. Katz, "Do you need any help from us? What resources do you need?" And he said, "No, we have it taken care of, and here are our statistics, *CBS News* was wrong, and you guys shouldn't worry about this."

Three days after that, Dr. Kussman writes to Dr. Katz and others that—I don't know if the e-mail is from home or work, but the fact that you are all working Saturday, is good—18 veterans kill themselves every day. That is what the *CBS News* report said. "Sounds awful, but let's not worry too much if you are considering 24 million veterans."

Even in the first e-mail that we have—and I don't know what else there is—nobody is saying, "We are not doing the job here." They are saying, "Does this sound good? Does this sound bad?" And Dr. Katz says, yes, there are 18 suicides. This is supported by the *CBS News* numbers.

Now, Dr. Katz, this contradicts what you told us in the hearing 3 days earlier. Why didn't you just call us up or ask for another hearing and say, "You know, we are looking at things differently. I misspoke. I want to talk to you some more about the statistics." This looks like a cover-up, because you didn't tell us anything. And this is contradictory to what you said to our Committee in December.

Why shouldn't you go to court for perjury or resign because you didn't tell us the truth?

Dr. Katz, I am asking you. You keep looking at the Secretary, but I am asking you.

Dr. KATZ. Thank you for asking.

In response to a question from Mr. Mitchell in the December 12th hearing, I and my colleague, Dr. Fred Blow, who accompanied me to the hearing, did mention the 18-a-day for suicides among all veterans. We mentioned the four to five a day for suicides among those we cared for in VHA healthcare services.

When I asked him to, Dr. Blow mentioned the fact that, overall, veterans had a rate of suicide about 1.5 times that of age- and sex-matched individuals from the general population. And he mentioned the fact that, among women, the ratio of suicides among veterans in our system to the general population was about two.

That was mentioned in the hearing on December 12th. There was no cover-up. This was mentioned.

The CHAIRMAN. Did you not say—and we saw the clips. Did you not say that the *CBS News* data was wrong?

Dr. KATZ. I was not referring to the entire data, but the subset of data dealing with the youngest of veterans.

The CHAIRMAN. So the "Mission accomplished" should have said, "Mission accomplished only by those sailors who were aboard this ship on those 2 days." We didn't see the fine print.

We asked you several times, and you said several times that the *CBS News* data was wrong. You never made any qualification of that as far as I can remember. Your story was that they were wrong, and you didn't need any help to deal with this issue. Is that right? You were fine?

Why do you keep looking at the Secretary? I am asking you, Dr. Katz.

Dr. KATZ. Sir, I did speak about the suicide rates among veterans on December 12th, and I continue to have concerns about the *CBS News* reports about rates and standard mortality ratios or ratios among the youngest veterans. I wish they would present their data so we could review it.

The CHAIRMAN. Yes, but you are in charge. They are just reporting. They asked for all this data, and you never gave it to them, so they spent 6 months trying to find stuff that, Dr. Peake said the VA didn't have. Well, they went out and found it. So I assume somebody can go out and find it if you think it's important enough.

Secretary PEAKE. Mr. Chairman, if I may, I don't disagree with your premise that somebody should be able to go out and find it. They did not provide it to us, even though we asked. And so we have now gone out and asked for the same information. I am very anxious to see what actually came back.

As I tried to explain, we are using the data from the national sources, which is the gold standard that any responsible statistician would be able to use for this.

I will tell you, I am worried that suicide in general in this Nation is underreported, not just in the military, not just in the VA.

The CHAIRMAN. But don't start that red herring. We are talking about veterans right now. So don't tell me, "Well, the whole society is screwed up." We are going to do our job for veterans.

So on the December 12th data, you don't see any difference, Dr. Katz, between what you told us then and what you said a few days later. You say you are consistent.

Dr. KATZ. Again, the issue is the 18-a-day, the 4-to-5 a day, the ratios of 1.5 and 2.0. And those were provided at the December 12th hearing in response to a question from Mr. Mitchell.

The CHAIRMAN. Now, on one, the February 13th e-mails you said, "Shh!" what did you mean by that?

Dr. KATZ. That was very unfortunate. I think the e-mail has to be divided into the subject line and the content. I deeply regret the subject line. It was an error, and I apologize for it.

However, the content of the e-mail, the body of the e-mail reflects an appropriate and healthy dialogue among members of VA staff about when it is appropriate to disclose and make public information early in the process of developing——

The CHAIRMAN. No. An appropriate e-mail would say, "We are not sure of this data. We will study it further. Maybe we should inform the Committee." But what you said is, "This is something we should carefully address ourselves before someone stumbles on it."

I mean, that is what you are concerned about, not the suicides, but somebody stumbling on this data.

Dr. KATZ. No, sir, I am concerned about saving lives.

The CHAIRMAN. Well, but that is not what you suggest here.

Dr. KATZ. Sir, that e-mail was in poor tone, but the content was a dialogue about what we should do with new information.

The CHAIRMAN. And did you tell Secretary Peake about all this, about the new data or these thousand attempts per month?

Dr. KATZ. The purpose of that e-mail was to open extensive dialogue within VHA about this emerging data.

The CHAIRMAN. Did you tell Secretary Peake about that, that you were showing a thousand suicide attempts per month?

Dr. KATZ. I reported it to VHA's senior leadership.

The CHAIRMAN. That is not what we have in the e-mails. We just have you talking to the PR guy.

Dr. KATZ. We were opening a dialogue about what to do with the new information.

The CHAIRMAN. Yes, and the first thing you do is talk to your public relations guy instead of somebody who might know how to treat suicide. It seems to me that what you were trying to do was manage the data, not deal with the data.

Dr. KATZ. Sir, there has been extensive conversation about this with other suicide and mental health people.

The CHAIRMAN. I'm sorry? I didn't——

Dr. KATZ. There was extensive conversation about the thousand a month with other people——

The CHAIRMAN. Yes, but not in the information we have.

Dr. KATZ. Not in that e-mail, no.

The CHAIRMAN. I would think that you would tell us about it since we have a concern about the issue and we are the ones who can help get you the money to deal with the issue.

All I have is what you provided to the court by discovery motions, which I assume is as complete as you want it to be. If you have more complete information, then you probably didn't give

enough information to the original requests. It appears to me that your interest is in managing the data as opposed to helping the veteran.

Dr. KATZ. Sir, earlier at that same court, in a hearing, I testified under oath to the thousand a month and talked about how knowing about that number was so very important, because it pointed to a thousand people a month where we really could do something to dramatically decrease suicide risks.

The CHAIRMAN. Why didn't you just write us a letter, or set up a meeting, or brief us? I mean, instead of managing the data, why didn't you just talk to us about it and say, "We are on it, we are serious, we care about it, we want you to know about it, and we need this much more money or not to do something?"

Dr. KATZ. Dr. Peake spoke to the fact that this wasn't data yet. These were observations and measurements very much in the state of development.

The CHAIRMAN. When do you expect that to be real data? Another year, after your term is over?

It looks like this would never have come to our attention unless there was the court case with discovery. You never had any intention of talking to us, dealing with the data in an open way, but you were trying to manage it from the inside. And who knows when we would have heard about it.

Both the court case that got the data and the news media that has been looking at this issue have done a far better job than you have in keeping us informed.

Mr. Buyer, I took too much time. I apologize.

Mr. BUYER. I am trying to follow this. I was present at the December 12th hearing. And I know we have ongoing litigation, so I recognize, Mr. Secretary, you have to be careful if you have ongoing litigation, yet we are also asking you questions about data.

And it appears that, when this e-mail is released in discovery in litigation, *CBS News* has created an impression now in our country by their report that no one knew about this 18 per day until it was in discovery.

Now, when I look at the report on the December 12th hearing—and I want to compliment my colleague, Mr. Mitchell. You did a very good job here, when you look at the transcript. I mean, you went right in on Dr. Katz, and you asked the specific question to him.

You asked this: "One last question really quick. Do you believe that suicide is an epidemic?" Dr. Katz: "There is a suicide epidemic in America." Mr. Mitchell then says, "Among veterans?" Dr. Katz says, "The number"—then parentheses, (inaudible) end parens—"about 18 veterans kill themselves each day in America. That is too many," Dr. Katz says. And Mr. Mitchell then says, "And?" Dr. Katz's response is, "About four or five." There is cross-talk, inaudible. Mr. Mitchell then: "According to *CBS News*, it was 120 a week." Dr. Katz says, "About the same." Mr. Mitchell then says: "That is not higher than the general population?" Dr. Katz says, "It is somewhat higher than the general population among veterans because of demographics and risk factors."

Mr. Mitchell, then you asked a really good question. You said, "I think one way we can find out about that is if you have the data.

I think that is one thing that people were arguing about earlier, was the methodology of data that *CBS* had."

Now, see, when you asked that question, I homed right in on it. And that is the reason that I wrote the letter, and that is the reason Bob Filner joined me. And we sent this letter, with regard to methodology and data, not only to the Secretary but also to DoD and *CBS News*. *CBS News* has yet to share this with us. So if you can get it, Mr. Mitchell, I hope you can.

But from what I recall from the hearing, Mr. Chairman, Dr. Katz, this was in response to Mr. Mitchell's questions.

I have other questions for you, Mr. Secretary.

You have much in your toolbox. When you think about the access that you have to great intellect in your research and development and your abilities to study and define cohorts, I would like to know, is there any epidemiological resource analysis that is being done for the, quote, "at-risk," end quote, veterans from either Vietnam or the first Gulf War, specifically looking at the mortality rates for in-theater versus non-theater, veterans versus general population?

Obviously, we are trying to home in on, then, those who are most susceptible, and so obviously you want to look at—and I just mentioned this to the Chairman—those who may already show trends in mental health, depression, PTSD, wounds or disabilities, whether they occur in-theater or non-theater.

With that, I yield to you for a response.

Secretary PEAKE. Well, sir, in this gathering of documents here that have been published on the Vietnam and Gulf Wars, it addresses some of those specific issues in terms of the epidemiology of suicide in those groups.

It is very clear that those with mental health disorders, in some of our published literature just in the general veteran population, those with depression have a higher suicide attempt rate when you look at that as a group. And that gets better, that rate gets smaller if they are on medications. At least one of our studies has proved that.

So it starts to give us the opportunity to target the individual groups. Those with suicide attempts clearly have a higher rate. So, again, we are trying to target the individual specific groups based on the science behind it in terms of what we are actually finding as you really understand what groups are at risk—those with wounds; we are looking at the TBI group as a potential for specific intervention.

One of the reasons why I tried to emphasize in this call center outreach is to make sure that we are going after those who have returned who were injured, specifically to try to get them into care management, and why we are training the care managers on suicide intervention, because of just exactly that nexus. So that is exactly the direction that we are trying to go.

Mr. BUYER. Mr. Chairman, I think what would be helpful for the Committee, the Secretary keeps referring to a binder that I can see is pretty thick, and he refers to, quote, "peer-reviewed articles."

I think it would be helpful to the Committee, Mr. Secretary, if you would provide the Committee with and would submit for the record a page of references——

Secretary PEAKE. Absolutely.

Mr. BUYER [continuing]. That would list the title, the author, the publisher, dates, and/or if there are Web sites, okay?

Secretary PEAKE. Very well. We will provide that for the record.

Mr. BUYER. Thank you very much.

The CHAIRMAN. Mr. Michaud.

Mr. BUYER. Mr. Chairman, and we are doing this for the record, it is being submitted for the record, their references would be submitted for the record.

The CHAIRMAN. Yes, that is a fine idea, so ordered.

[The following was subsequently received from VA:]

In reference to the binder at the hearing, attached are research articles published in peer-reviewed medical journals that have relevance to the question of the rates and risk factors for suicide among veterans. All demonstrate VA's investment in research and epidemiology in providing scientifically evidenced understanding in mental health conditions that impact veterans.

Articles are separated by whether the population studied was population based (ie., representing the full spectrum of all veterans) or a clinical cohort (ie., representing a sample of only those veterans who sought care in VA). In cases where websites are available they are cited.

Clinical cohorts cannot be used to estimate population-based rates and risks.

Patients who seek and receive medical care differ from the general population. For instance, they may be sicker, leading to higher expected rates of death. Also, they may travel far from home to get medical care, in which case it may be hard to calculate the "denominator" (see below) of total patients at risk.

Reported suicide rates in clinical cohorts are usually higher than that of the general population. Therefore, for determining the rates and risk factors for suicides among veterans overall, population-based studies assume a higher priority. Insights from clinical cohorts, however, are valuable for suggesting more effective ways to deliver clinical care to veterans who use the VHA healthcare system.

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The attached table entitled, "*Rates and Risk of Suicide and Other Suicidal Behaviors Among U.S. Veterans*," Updated April 30, 2008, Prepared by Joseph Francis, MD, MPH, Acting Deputy Chief Quality and Performance Officer, Office of Quality and Performance, U.S. Department of Veterans Affairs, appears on p. 137.

Mr. MICHAUD. Thank you, Mr. Chairman, Mr. Ranking Member, for having this hearing today.

Mr. Secretary, just looking at some information—and, actually, one of the panelists that is coming up, Dr. Stephen Rathbun, who will be testifying later on today. *CBS News* actually asked him to run a detailed analysis on the information, the raw data that he obtained from the States.

In that raw data, it shows that, according to the doctor, that it found that veterans are more than twice as likely to commit suicide in 2005 than non-veterans. But it also goes on to say that, between the age group of 20 and 24, that veterans are two-to-four times higher likely to commit suicide than non-veterans.

I don't know if you had a chance to look at that or if Dr. Katz has. Is that analysis correct?

Secretary PEAKE. Sir, we have not seen that data.

But I would like to, if I could, and with your permission, Mr. Chairman, put up that slide again on the 16 State material, and it is on your screen now actually. This study of these States under the National Violent Death Registry does give coroners information to say if this person is or is not a veteran. We understand it may also include active-duty people. But you can see that the numbers there suggest that there is a higher rate statistically in the younger servicemember—I'm sorry, veteran or potential servicemember, both in those who have been seen in the VA and those who are not.

So at least in these 16 States, which is not necessarily representative of all of our States, it does give us that kind of inference here. And we see that both in men and in women.

And so we take that very seriously, and that is why we are pushing so hard and why I want this outreach. Because I believe if you get these people in and get them into some kind of care, if they are depressed and get on treatment, there is evidence that we can mitigate some of this tragic loss in terms of death.

So I can't speak to what was presented on data we haven't seen, but this is data that is available, and we have run it against what data we know for VA users, so we are comfortable or confident in that data.

Mr. MICHAUD. And what role has the VA found that substance abuse and the lack of treatment has played in a veteran's suicide?

Secretary PEAKE. Sir, it is one of the clearly linked conditions for suicide. Depression and the co-morbid conditions do relate to an increased suicide risk.

Mr. MICHAUD. And you had mentioned outreach. And that is one of the whole ideas behind the CARES process, is to get more access points throughout the country for our veterans. And that is probably part of the reason that we are seeing some of the problems, particularly in rural areas.

You mentioned a lot of the programs that the VA is doing to help our veterans deal with this problem that is out there. A couple of years ago, when the Congress actually provided the VA with about $300 million to take care of mental health needs, a GAO report—came back and said that only about $100 million to $150 million was used, and, out of that amount, they really couldn't tell what it was used for. It was supposed to be used specifically for mental health.

So my question to you, Mr. Secretary, is, number one, how do you know that the money and the programs you are doing are going to directly benefit our veterans?

And the second question is, have you seen a decrease in the number of suicides since these programs and outreach have been implemented?

Secretary PEAKE. Well, sir, first, I will tell you that—and as we have talked about here—for 2009, we expect to increase our expenditure on mental health to $3.9 billion. We have hired 3,800 new mental health workers—we have about 17,000 mental health folks working in mental health across our system.

Going to Mr. Moran's point, we have OEF and OIF people that we have hired specifically to do the peer review and reach into from our Vet Centers.

And so I do know that there is a history of the inability to expend the money. And that is part of the difficulty of hiring people and the slowness of it. I think we are up to speed in terms of moving forward on that. And we will monitor that very carefully to make sure that we are putting everything that we need and that we have been given to use for mental health into that process.

Mr. MICHAUD. The second question that I asked is, has there been a decrease?

Secretary PEAKE. Sir, let me ask Dr. Katz.

As I look at these numbers, you know, I can see a decrease. It is hard to say, well, that is the cause and effect. If you can put up that other slide, you can see that, at least in the one male in the slide that is up on the board now, in the younger age group, there in 2005, at least. But this is old data. And so the problem, sir, is being able to really get accurate data to be able to give you an honest answer on that. We are absolutely trying to plumb it and dig into it, but we don't have perfect knowledge about that.

So that is part of why we are very interested in getting our suicide coordinators out there, up to speed, in terms of giving us as accurate a report as we can, not because that number is exactly important, but because we want to be able to intervene for those people.

And so I don't think I can actually give you an honest answer about if we have seen a decrease in response to those specific interventions.

And I would ask Dr. Katz, if you have any more comments on that.

Dr. KATZ. 2005 is the most recent year for which information is available from the National Death Index. It is just too early to evaluate the outcomes of the Mental Health Strategic Plan (MHSP), whose implementation began in the beginning of 2005.

We are looking toward this data with incredible intensity. Just yesterday, I received data from the National Violent Death Reporting System about early data from 2006 veteran deaths. It is complex data; data like this always is.

The best way to summarize it is that, at this point, the early data does not seem to show an increase in veteran suicide rates from 2005 to 2006. This is very important, but it is very early data. The numbers may change as late reports from State medical examiners, and county coroners come in. It has to be viewed as an evolving story.

The CHAIRMAN. Mr. Hall, you are recognized.

Mr. HALL. Thank you, Mr. Chairman.

And in my short 5 minutes, I just want to ask a couple of practical questions.

Dr. Peake, if I may call you by that title, there is a problem—currently, as I understand it, when a veteran gets a prescription or has to order a refill, there is no way for a doctor to expedite the delivery of the medication, which can take 10 days sometimes. For a veteran needing an antianxiety or antidepressant medication, it seems that he or she should be able to get that refill sent quicker by allowing the doctor to request overnight delivery.

Is that something you can do by rule or that you think that is a problem that——

Secretary PEAKE. I would think that would be within my purview. That has not been up to me, but I would be delighted to look at it.

Mr. HALL. Well, it has now, and I just am asking you, if you can, to make a ruling and send it down to all of the staff. Because it is a drop—that is one of the ways in the general population, as well as the veterans population, if you are on an antianxiety/antidepressant drugs and you go off of them for a period of days, it is not a good thing; ask any doctor.

Dr. Cross, you were going to say something?

Dr. CROSS. There are some other options, as well. Many of our facilities have pharmacies, like our medical centers, and they can make an arrangement with the local commercial pharmacy, if necessary, or they can pick it up there.

And I don't think it really takes ten days for the CBOC to get the medicine out, but you raised an interesting issue. And I agree with you, that continuity of providing that medication is absolutely vital. And so I would like to look into that for you.

[The information from VA was provided in response to Mr. Hall's Post-Hearing Questions for the Record, which appears on p. 238.]

Mr. HALL. Thank you.

And also, Dr. Peake, as far as your blue-ribbon Committee, would you consider, or have you already, appointed any representatives of veterans service organizations?

Secretary PEAKE. Sir, I will tell you, what I am going after are people that have actually published and that are recognized experts. I am not looking—I am trying to get at our data. I mean, our veracity has been questioned. I think it is reasonable to be questioned. We are America's VA, and we ought to be transparent. What I want to get is some outside look at it and see from a scientific clinical research and public health perspective. And that is the kind of folks I am looking at here.

Mr. HALL. I was concerned about, on one of your slides here, the one showing—by the way, if you could provide the Committee which 16 States you were looking at in the study, that would be great.

Secretary PEAKE. Sir, this is the National Violent Death Reporting, and it is on the bottom of the slide there.

[The information from VA was subsequently received:]

Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin, Kentucky, New Mexico, Utah and 4 counties in California.

Mr. HALL. Oh, good. Okay, I'll find that. But, anyway, it seems to show that the user-veteran suicide rate is higher than the all-veteran suicide rate, which would indicate that the VA's involvement may not actually be positive in these cases. Am I reading that correctly?

Secretary PEAKE. Actually, what it shows is they are about the same, because the comparison for statistical significance is between the general population. So it is both the user and the non-user that are in that younger age group, particularly that are different from the general population. Between the two, there is not a statistical significance—it is the same whether you are in a VA or not in a VA.

Mr. HALL. So a four-point difference is not considered statistically significant?

Secretary PEAKE. In that test, in this case, it is not.

Ira.

Dr. KATZ. It really depends on the particular statistical test that one does. We are dealing with a counterbalancing of two complex effects——

Mr. HALL. Okay, thank you, Doctor. I have less than a minute left. If I may, I appreciate your explanation, but I wanted to ask two more questions.

One is, on the following slide, the non-user, 18- to 29-year-old rate of 3.4, which you have illuminated in red, is of concern. And that would seem to indicate a need for greater outreach, and refrigerator magnets and handout cards may not be doing it. I am curious, first of all, what you would propose?

Let me just ask a second question, and then you can answer them both, if you will.

There are fewer females serving than men serving, as you point out. However, the rate of suicide among female veterans is approximately twice the rate of male veterans in your testimony, if I am reading it correctly.

And I am curious if you think that is related to sexual harassment or sexual abuse, which unfortunately occurs in our bases as well as our academies, military academies, and it is a problem that we are trying to deal with, I know at West Point, in particular, where I serve on the board of visitors. And/or is it due to a difference in the way women process their experiences in battle and these things they have seen and witnessed, do they have a different emotional reaction to it?

So those are a couple of questions, if you would.

Secretary PEAKE. Sir, first, the outreach. I agree with you, we are looking for whatever way of outreach that we can do. That is why I put this call center, outreaching call center into effect, to try to get at those who haven't used us, those who may finally be at a point where they had the teachable moment to realize that we are there for them and to establish that relationship. We have talked about putting signs on buses and things like that, even, to try to do outreach.

In relation to women, sir, I would just like to correct, if I misspoke before. The women's rate is higher than the national average. Women, both veterans and non-veterans, are lower than males across the board. But our women veterans are higher than the general population.

And I think then it is fair to try to understand why. They are about 14 percent of the DoD population now; they are about 14 percent of the force. And so an increasing number are becoming veterans, and why we are pushing so hard to put women's programs into a system that, really, for years, was mostly an older men's service organization.

So we really are trying to address that and to try to understand those issues of military sexual trauma. We are seeing that. When I talk to our Vet Centers, they say that is an issue that is very important. And so we are targeting that group to try to make sure they get the counseling that they need. We train our people specifically in that.

Mr. HALL. Thank you.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Hall.

Mr. Hare.

Mr. HARE. Thank you, Mr. Chairman.

Mr. Secretary, I only have 5 minutes, so I will give you the three questions and then—and, again, thank you for being here today.

Why is there not more coordination between the DoD and the VA with soldiers separated or discharged with either TBI or PTSD? It would seem to me that more effort needs to be done to reach out to veterans to bring them into the system rather than wait for them to come to us.

The other question I have—and, again, it goes back to what I think we talked about last week, with the rural areas—and how do we, for veterans in rural areas who call the hotline—do the suicide-prevention coordinator set them up with appointments at the nearest clinic, VA clinic or hospital? Because, you know, I've talked to veterans, and then asking them to ride for a few hours in a van ride, a lot of times they are just not going to do it. They just feel very uncomfortable doing that.

And then my last question to you—it is probably and, I understand, very broad-based—but what can we do from your perspective for this Committee to be able to—is it, you know, more money, which is something I think we can look at, or what is it that we can do to help you with whatever we need to do on our end? If you were to say to us, "Listen, this is what I need from you folks, to help me move down the road with this and to be able to bring more people in," is it hiring more people? Is it a combination of a number of things?

And so, I hate to load you with three like that, but with only 5 minutes I thought I would try to get all three in.

Secretary PEAKE. Sir, let me start first at the top, with DoD coordination. There is a general roster steering Committee on the 15th of May. We have been invited to be a part of that. Dr. Katz works closely with DoD. I spoke to the DoD psych consultant this morning, who used to work for me. So I think we have good relationships going on. We have a VA deputy now for General Sutton who is going to be running that PTSD/TBI effort for DoD to make sure that we are linked.

I think the issue of outreach is important. So we do go to the Post Deployment Health Reassessments (PDHRAs), we do do the Transition Assistance Program (TAP) debriefings, to try to get that message out, as Mr. Hall was talking about, to make sure people, wherever we can get them—part of it is trying to get them when they are really ready to listen finally—the hotline.

If you have an emergency, we go to the police, we go to the fire station, we go to whoever can make the intervention. And we have had 885 rescues. We follow up a week later or 24—I guess 48 hours a week and then 2 weeks later to track them down. We work directly with the treating facility. If they are active-duty—and we have had nearly 500 active-duty people call our hotline—we have the relationships with DoD to get them back in the DoD system, if that is what they need.

So, you know, I think we are very pleased, and we continue to monitor and learn from it.

What can we do? You know, the Chairman brought up the issue of family members. I think we need to do a better job of being able to reach family members. They can be the canary in the cage, if you will, when you have a servicemember or a veteran who isn't just quite acting right and may not even recognize it.

I do appreciate the issue of stigma, and we need to continue to fight that down. I was very pleased to see what Secretary Gates did this last week about taking, you know, that question off the security questionnaires and so forth. I mean, it is those kinds of things that will help us down the road.

But it is more than stigma, I think, that keeps people from coming to us. I think some of these folks, it is a lack of realization that something is wrong, that they are not quite right. They just don't appreciate it until, sometimes, it is too late. And if we can get family members and employers to really understand that this is treatable, if you get them in, we can help them, it will make a difference.

And so for helping us to find ways and the authorities to reach out and do that would be something that would be positive.

Mr. HARE. Thank you, Mr. Secretary.

Just one last thing on the rural areas. In terms of, if somebody calls, a veteran who lives in a rural community, and they call the hotline, do you try to get them into the VA hospital?

Secretary PEAKE. Sir, we will get them wherever the care is required and where we can get it. Unfortunately, some rural areas, it is a long way, whether you are a veteran or not. And that is a different kind of issue, but it is, again, part of that national issue that we were talking about before. But it is not, well, if you can't get to the VA, we are not going to take care of you.

Mr. BUYER. Will the gentleman yield?

Mr. HARE. I certainly will be happy to.

Mr. BUYER. You just asked a very insightful question.

So say, for example, you have Montana or Kansas, and they are not close to a Vet Center or an outpatient clinic. Do you contract care, or how do you fill the gap, Mr. Secretary?

I think that is what the gentleman is trying to ask.

Secretary PEAKE. Sir, in Montana, we do contract with centers around Montana. I have had a chance to visit both Billings and Helena, because I am concerned about rural America and access to care for our veterans that live in those areas.

But the fact is we do fee-based care, as you know, sir, and we are willing to go out and we do go out and purchase the care if it is not available and it is needed.

Mr. BUYER. Mr. Secretary, I would just ask you to work with Mr. Hare. He's got a rural district in Illinois, and he has a gap in coverage. Please work with him to make sure that gets covered.

Secretary PEAKE. I absolutely will.

Mr. HARE. Thank you, sir.

The CHAIRMAN. Mr. Rodriguez.

Mr. RODRIGUEZ. Thank you, Mr. Chairman. And, once again, thank you for holding and conducting this hearing.

Good seeing you again, Mr. Secretary.

You know, I indicated earlier I think you are ideally situated, because we have been working for the longest time to try to establish a seamless transition from DoD to the VA. And I wanted to ask you, and I know there has been some questions on that, if we have made any gains in terms of where we are at on that, of trying to transition that soldier to the VA.

Because there are going to be more soldiers coming in, and there are going to be some that are really going to be hurting, and the numbers might go up you know before they go down. And I understand that. And so I wanted for you to respond to that.

Secondly, based on the Congressional Research Service (CRS) report that we have and you have also and Dr. Katz has mentioned it, that we don't have a hold on the actual suicides and attempts. We don't have a good hold on that.

[The CRS Report entitled, "Suicide Prevention Among Veterans," May 5, 2008, appears on p. 111.]

Mr. RODRIGUEZ. What else do we need to do besides possible recommendations later on where we can start getting and compiling that data in a way that makes sense where we will be able to see if we can make any inroads there?

And thirdly, what do we do now, and maybe Dr. Katz can help on this, what do we do now to provide the services that are needed that we are not doing in reaching out?

And I know that people are hurting out there. They are probably not the ones that will come out. And I know Mr. Moran had some recommendation in terms of utilizing some of those veterans organizations to reach out for those veterans that find themselves underneath the bridges throughout our country and those individuals out there.

So if you might respond to those three questions.

Secretary PEAKE. Yes, sir. First, on the issue of transition, I've been talking lately about the notion that there is "transition" with a big T and "transition" with a little T, if you will; that, you know, for these servicemembers that are coming out of our military treatment facilities and so forth that are wounded and injured, with the Federal recovery coordinators that we are starting to get into place and expanding that program, I think that will go a long way to helping them for a long-term transition.

And that really is important, because these are folks that are wounded and, therefore, you know, appropriate to our discussion today, have a higher risk for suicide. So having a care manager is important.

What we are in the process right now—and on the 15th of May, I should get my next report on it—is going back and re-reviewing every soldier that we know that has been in our system to understand, okay, what is their current status on case management, who has been in touch with them recently, and to ensure that we have the follow-up that I believe we owe them. And so we are pushing very hard on that.

Then there is the other issue of the transition. Sir, there has been a million and a half people who have deployed, a little bit more now. About 800,000 have separated from the service. About 300,000, a little more now, have come in to VHA for care. When they come into care, they do get screened for PTSD and TBI and suicidal tendencies. And so, you know, we have that relationship with them.

Is it perfect? No. In fact, the people that—the national preventive task force basically says there is no real good evidence to prove about screening. We believe in it, though. And so we are doing it every single time.

There is that other group out there, however, that 500,000 that haven't come to see us, that we will be part of this big outreach effort that we are doing now to try to help them if they need that help in transition. So we just want to make sure they have that relationship with the VA, that they know that we are there for them.

I will tell you, I know that trying to get at the data is hard. The military is looking at how to really study every single suicide. We get an in-depth review of any suicide that we know of from one of our patients, because we can try to plumb it to understand what the factors are, so that we can learn from it. So it really becomes an individual case study for each one of these, as well.

The problem is, as I say, sometimes we don't know if one of our veterans has gone out somewhere else and it has not been reported to us. And so we do want to stay in touch with the national data.

Mr. RODRIGUEZ. I would hope that we would establish and start looking at some system that would give us information, not only from the 16 States, but all of them as much as possible.

And then, finally, the last recommendation in terms of what do we do now, even if it is an initial phase to try to reach out there, and maybe even utilizing existing veterans organizations to work with some of our veterans. And I know they are not trained in this area, but they are definitely trained at reaching out and dialogueuing with them and maybe getting them to come back in.

Secretary PEAKE. You know, I, kind of, made the point that when I was talking—I meet with the veterans service organizations regularly. And when I was talking to them, they pulled it out and said, "Oh, look, this is a great tool." This is what they are using to pass out; it is a VA product.

And so we are linked with the veterans service organizations. We agree with you, sir, that they are an important ally and an important partner. And we share the same concerns with them about trying to do this kind of outreach.

Mr. RODRIGUEZ. And before I know I ran out of time, and I don't know how I can overemphasize it, let us know if we need do more—but when it comes to these issues in terms of working with a family. Because I know the VA, for a long time—you know, only in certain situations have they worked with the family. But I think when it comes to these situations, we need to really stress that and the importance of that and how we do that in different ways.

Secretary PEAKE. Thank you, sir.

The CHAIRMAN. Thank you.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman.

And thank you, Mr. Secretary, for being here. I truly appreciate what you do and appreciate your service. And as the members of the military medical community say, you are one of them, and that is a very important thing.

And you and I have talked. You know as well as I do all of us are here to serve our veterans, first and foremost. I have been your strongest supporter in whatever we can do for the VA, but because of that commitment I am also the biggest critic.

And, Dr. Katz, I will have to say, your term—using "unfortunate" for that e-mail—that is very correct. And I say this, I am not a judge of your medical professionalism, I am not a judge on the things you are doing there. What I am a judge on is oversight, and perception of our veterans, and they are losing faith in the system because of instances like this. So it is very unfortunate, because they believe the system will fail them. And that is something we are fighting hard to overcome. I believe we have made great progress. And those types of unfortunate slip-ups or whatever or these beliefs are very, very damaging to what we are going to do.

So I am deeply sorry that this incident happened. But I can tell you, today's tone is much different than when you came in December. And that troubles me, in terms of restoring that faith.

The one thing I would say, my ultimate goal—and I was just speaking with the Ranking Member—is how do we implement this plan to make sure that it is successful. I know that gathering this data is very difficult. But I know some of the new data we are seeing from the CDC, is actually—I think, Dr. Katz, when you get a chance to look at it, and we looked at it this morning, tables 5 and 6 show a fairly significant increase in 18- to 29-year-old males. And I think we are going to see somewhat of a trend.

The problem here was we didn't start looking at this until 2005. We didn't have an Inspector General (IG) report and recommendations on this until May of 2007, and here we sit in 2008. This should have been planned for, and prepared for, when we went into these conflicts. The VA knew these types of situations arose after Vietnam, and yet we weren't prepared to deal with them. That is very troubling to me.

So when those of us try and gather data or try and implement this, I can tell you, I went to the Veterans Integrated Services Network (VISN) 23, asked for data on Minnesota, they promptly replied—I was speaking with them, and they said they sent it through your office, and your office, Mr. Secretary, delivered it to me 1 hour before this hearing.

I have nothing but the best interests of the VA at heart. I wanted to have this data so I could ask the appropriate questions as it deals with my constituents. And I have to believe—why was that held up?

And I hear a Subcommittee Chairman say he has to use the Freedom of Information Act to get information from the VA? His concerns is for the veterans. He is on the Oversight and Investigation Committee. Why does he have to use the Freedom of Information Act? And why am I waiting until the hour before the hearing?

Those types of things trouble me, because the issue here—and I think all of us understand—the key is identifying and preventing suicides. That is the ultimate key. The key to doing that is making sure these people see the proper people.

Now, I had a proposal that I sent over, and I discussed it with you personally, Mr. Secretary, about this inability when a person transitions from the DoD to get his DD–214 into the hands of people who can help him.

We, in Minnesota, have County Veterans Service Officers in all of our counties. Those County Veterans Service Officers are veterans who are professionals in navigating the system. Because of the support of our Governor, the Director of Veterans Affairs in Minnesota, all of the veterans service organizations, and our nationally recognized Beyond the Yellow Ribbon campaign, our National Guard members, 99-plus percent of them are enrolled in the VA system; 36 percent are regular soldiers.

As one young veteran told me as he came back, "We come back in ones and twos and fall between the cracks," as he sat beside his father who lost his leg in Vietnam.

When we have asked, I get put off and, quite honestly, get the run around from the VA. "It can't happen because we can't trust the County Veterans Service Officers because they are not employees of the VA." That's what they tell me. They may lose data. I asked them to provide me a single case of a County Veterans Serv-

ice Officers breaching confidentiality, and they couldn't do it. I need not remind you who lost the 26 million names.

This issue of not wanting to cooperate on the State level, of not trying to get it on the front end—if we had every DD–214 assigned and put out, you would have a success rate like we have in Minnesota of 99 percent compliance, and you would have them identified. Maybe we wouldn't need bus stickers as much. Maybe we wouldn't need those types of things. We would have them identified, we would know who they are.

My County Veterans Service Officers tell me this, and I tell you today—and I am going to find out, because I am not loose with facts, as you well know, Mr. Secretary. The front page of my hometown newspaper in Mankato today says, "Standoff and Tragedy Averted; Iraqi War Veteran Takes Hostages." His complaint was he couldn't access the system.

Now, I don't know if that is true or not. I don't know if he is even an Iraqi veteran. And I don't know if he tried to access the system, because wild claims have been made in the past that were not true about that.

The VA does a wonderful job. They do a great job of caring for our veterans. We simply have improvements to be made.

So my question is, why the resistance on allowing us to register the DD–214s? Why not allow us to make the necessary changes? I understand privacy, I understand the HIPAA regulations. But why, in this case, when the least we could do is at least say, you have a veteran living here and you need to at least make contact with him.

I would like to see, and I will find out, if this young man was ever talked to, or why he slipped through the cracks.

[The following was subsequently received from VA:]

DoD controls form DD–214, Certificate of Release or Discharge from Active Duty. The military service mails Copy 3 of the DD–214 to VA. If a military member elects to do so and specifies a State, Copy 6 of the DD–2314 is sent to the State Director of Veterans Affairs. We have provided your staff with a point of contact at DoD (Lori Howes, 703–697–4491; lori.howes@osd.mil).

State Benefits Seamless Transition Program (for seriously injured): Currently forty-three states, including Minnesota, participate in the State Benefits Seamless Transition Program. To date, 350 veterans have signed the consent form authorizing VA to notify their local State Department of Veterans Affairs of their return to their home state.

The initiative involves VA staff located at the following Department of Defense medical facilities:

- Walter Reed Army Medical Center, Washington DC
- National Naval Medical Center, Bethesda
- Brooke Army Medical Center, San Antonio, TX
- Darnall Army Medical Center, Ft. Hood, TX
- Madigan Army Medical Center, Puget Sounds, WA
- Eisenhower Army Medical Center, Augusta, GA
- Evans Army Community Hospital, Ft. Carson, CO
- Naval Medical Center, San Diego, CA
- Womack Army Medical Center, Ft. Bragg, NC
- Naval Hospital, Camp Pendleton, CA
- Naval Hospital, Camp Lejeune, NC

Under the program, wounded veterans returning to their home States can elect to be contacted by their local State Department of Veterans Affairs about State benefits available to them and their families. VHA Liaisons for Healthcare identify injured military members who will be transferred to VA facilities, inform them about the program, and obtain a signed consent form from veterans electing to participate.

The State offices, in turn, contact the veterans to inform them of available State benefits.

In order to participate in the program, State Departments of Veterans Affairs must provide a point of contact and dedicate a fax machine in a private, locked office to receive the release of information forms. VA asked States to participate in the program in February 2007 when it was expanded beyond the Florida pilot program.

Transition for non-seriously injured: In order to ensure that OIF/OEF combat veterans receive high quality healthcare and coordinated VA services and benefits as they transition from the DoD system to VA, VA and the National Guard developed a creative partnership. Late in 2005, following the signing of a MOU between the National Guard and VA, the National Guard (NG) hired 54 (now 60) National Guard Transition Assistance Advisors (TAAs) to serve as VA/NG Liaisons in the field at the State level to assist NG servicemembers and their families and provide access to VA benefits and services. In February 2006, the newly hired National Guard/VA TAAs were trained by VA faculty experts about VA benefits and services at the VBA Academy in Baltimore. The purpose of the training was to enhance the outreach skills of the TAAs by learning about VA benefits and services and to connect them with VA resources and staff members in the field at the VA Medical Center (VAMC) and the Regional Office (RO). This new knowledge assisted them to help Guard members to access VA medical and benefits and address access issues in the 54 States and territories for returning Guard/Reserve members. Annual refresher training was held in January 2007 and 2008 in conjunction with the National Guard Family Program Conference. The TAAs have been the critical link in facilitating access to VA by National Guard/Reserves returning combat troops in each of the 50 States and 4 territories of Puerto Rico, Virgin Islands, Guam and District of Columbia and providing VA with critical information on numbers of returning troops, location, homecoming and reintegration events. TAAs also facilitate enrollment into VHA care for returning troops and families.

The TAA program continues to be a funded National Guard Program and is presently expanding this program with a goal of 2 TAAs per each State with large number of deployed troops. VHA OEF/OIF Outreach Office staff continues to be linked with the 60 TAAs by providing access and collaboration at monthly teleconferences, quarterly newsletters, and monthly identification of success stories and best practices in the States. Outreach staff work with VA experts at annual training events to ensure they are updated on changes in VA services/benefits. TAAs facilitate the development and maintenance of State coalitions utilizing the State Triad Leadership of the Adjutant General, State Director of Veterans Affairs (DVA) and VA leadership to integrate and coordinate the delivery of VA services and benefits to those Guard and Reservists in each State when providing needed outreach programs. Over 47 States have developed State Memorandum of Understandings (MOUs) through the Leadership Triad of the State Director VA, Adjutant General and VA Leadership from the VISN, VAMC and RO. These State partnerships are the foundation for State coalitions with participation by community and State organizations to address the coming home needs of the Guard and the Reserve members.

Outreach: On May 2, 2008, VA began contacting nearly 570,000 combat veterans of the Global War on Terror to ensure they know about VA medical services and other benefits. The Department will reach out and touch every veteran of the war to let them know it is here for them. The first of those calls are going to an estimated 17,000 veterans who were sick or injured while serving in Iraq or Afghanistan. If any of these 17,000 veterans do not now have a care manager to work with them to ensure they get appropriate healthcare, VA will offer to appoint one for them.

Mr. BUYER. Will the gentleman yield?

Mr. WALZ. Yes.

Mr. BUYER. Mr. Walz, when you referred to "the plan," "why aren't you implementing the plan," were you referring to the Mental Health Strategic Plan?

Mr. WALZ. Yes. And the Ranking Member has brought up a great point on this. In the IG's report of May 2007, we have never heard where you are at on that or what the timeline is or where you are going with that. And, as I referenced earlier, I would like to have seen that put into place before our troops landed in Iraq. But that

being the case, I am most concerned that it actually gets done now, and I am wondering where it is at.

So I thank you.

Secretary PEAKE. I think that it is absolutely the right thing to ask for both things, in terms of getting our returning servicemembers into our system is what we want to get done. And I will circle back and work with you.

I would like to apologize to you and to Mr. Mitchell for what may seem like recalcitrance. I have seen your letter, sir. I tried to call you last night, actually, because I wanted to get some clarification. I think I have some things for you. But I am interested in increasing the transparency of the VA. And, as I said, we are America's VA, and our intent is to be forthcoming. If we have something to hide, we shouldn't be hiding it, we should be doing something about it. So I will just put that on the table.

In terms of the Mental Health Strategic Plan, actually, when I looked at the IG report, it looks like we are moving ahead. I mean, it is a complicated and a big plan. And maybe I can come back, for the record, to give you the specific metrics about each one of the milestones. But I do know that we are moving forward on it. And, as I say, the complexity of it is such that I can't give you a clear summary of it right now. But I have looked at it. I have had that same discussion with Dr. Kussman and Dr. Katz. It was one of the first things that I asked him to brief me on, was the strategic plan.

It has lots of pieces. I will tell you that, like any plan, it never survives first contact with the enemy. So we don't want to be just resting on our laurels that we have a plan and that it is moving along, but that it is continuing to be relevant to the needs of our servicemen and women that are returning as veterans. And that includes finding these issues, if you have a younger group that we need to refocus some of our efforts and our resources on.

And I will just tell you that we will continue to be vigilant and look for the issues so that we become more proactive rather than just reactive.

Mr. BUYER. Will the gentleman yield?

When the Secretary answers that question—Mr. Secretary, I think you will be helpful to us if you will also take the plan and compare to it HHS, and the National Strategy for Suicide Prevention. So when you do the comparability between the two agencies, it will become helpful to us.

Mr. Walz, you asked a great question. And I yield back.

[The following was subsequently received from the VA:]

The *Comprehensive VHA Mental Health Strategic Plan*, which describes initiatives and current status, appears on p. 142. A crosswalk between the *U.S. National Strategy for Suicide Prevention, the VHA Comprehensive Mental Health Strategic Plan and VHA's Suicide Prevention Actions* comparing the three programs, also appears on p. 188.

Mr. WALZ. Well, I thank you, Mr. Secretary. And I think today, again, we can't make it any clearer that this Committee is here to serve our veterans. And I represent the Mayo Clinic area, and their mantra is: What is good for the patient is good. What is good for our veterans is good. And whatever we can do to deliver that, we are here as partners for that.

I know it is a difficult job you have taken. I know much of this has happened before you were at the helm. Many of us are very, very optimistic that you are the man to do it. Anything unfortunate needs to be swept and cleaned and put out in the public eye and let sunshine heal it and get moving forward.

So, thank you.

The CHAIRMAN. Mr. Mitchell.

Mr. MITCHELL. Thank you, Mr. Chairman.

Thank you, Mr. Secretary, for being here.

I mentioned in my opening statement about the testimony at the December hearing of Mr. and Mrs. Bowman, Mike and Kim Bowman, who lost their son to suicide. Mr. Bowman, at that hearing, warned us—and I want to quote this—that, "Our troops are coming home to an understaffed, underfunded, underequipped VA mental health system."

So, as a result of that, I asked the question to Dr. Katz, do we have the resources necessary to find these veterans and to treat these veterans, and the answer was yes. I said, do you have, again, enough resources, and the answer was yes.

As you know, I have been trying to assess what kind of additional resources your Department may need in order to make sure that we can provide these resources. We need to make sure that we conduct an outreach to veterans who are at risk of suicide, to treat veterans who are at risk of suicide, to track veterans who commit suicide. We need that information.

In light of what *CBS News* reported—in fact, it is important that in Arizona—and I don't know if Arizona is one of the 16 States list-

ed on this chart that you had, but the suicide rates among veterans in Arizona has increased 39 percent since 2003. They make up nearly a quarter of all suicides in the State. So I thought I had a responsibility to go and double-check to see if you do have all the resources necessary.

In my last letter that was sent to your office on April 24th I asked, "To review documents relating to requests for additional resources within the Department that were denied, unanswered or responded to with less than the amount of additional resources requested."

I think it is important that we know if you are being provided with enough resources to make sure that the VA is not understaffed, not underfunded, not underequipped. That is what our goal is here.

So I want to ask you three questions in response to this.

First of all, do you feel that, "Go file a Freedom of Information Act," is an appropriate response to a Member of this Committee seeking additional information about testimony offered by the VA at one of our hearings?

The next question, do you think there is something inappropriate about the Chairman of the Oversight and Investigations Subcommittee to ask to review records kept by the Department about an issue that has been the subject of one of our hearings?

And, finally, will you be producing the documents I requested by Friday?

Secretary PEAKE. First, I am saddened to hear that somebody would tell you to go file a Freedom of Information Act. I don't know where that came from. I will tell you that I don't think it is appropriate. The issue is—actually, you could file that. I mean, this is information you would be given.

If there is a concern about or a question about what you are asking for, I owe you a phone call, which is what I tried to do last night, to say I am not sure what you are really after and I want to make sure we have it. I think we ought to give you that information, because I agree with you that we share the same goal, in terms of helping veterans.

So, as I say, I will close the loop back with you before Friday to give you what I think that you are asking for.

Mr. MITCHELL. Well, and let me just repeat, Mr. Secretary. I asked for any documents relating to a request for additional resources within the Department that were denied, unanswered, or responded to with less than the amount of additional resources requested.

What we are trying to find out is, you know, we want to make sure that you are funded right, you are staffed right, you have the equipment. We can't do that unless—and there may be somebody, and I want you to be absolutely certain, that, yes, there was somebody in Montana, or wherever they may be, who asked for something and we said we didn't have the resources or we gave them less than they needed.

We just need to know what it is that we can do to make sure that our veterans are coming back and getting everything that they deserve and were promised.

Thank you.

[Congressman Mitchell received the information.]

Secretary PEAKE. Thank you, sir.

The CHAIRMAN. Dr. Snyder.

Dr. SNYDER. Thank you, Mr. Chairman.

Good to see you again, General Peake. I appreciate you being here.

Dr. Katz, I want to be a bit of an advocate for you, at least a little bit, because I want to be sure I understand. In the first—well, Mr. Chairman, I think Mr. Buyer brought this out, too—that one point of attack on you has been today that, in this exchange of e-mails in which Dr. Kussman sends you an e-mail back in December that says, the *McClatchy* newspaper article says these statistics, and you confirm those statistics. But, in fact, two or three days before, you had given those same numbers here. I mean, it is in the transcript.

So, while there are a lot of reasons to be critical, I think, of those e-mails referring to "Shh," you know, that kind of business, that was not what happened back in December. Is that correct? I mean, you gave those exact same numbers that you confirmed to Dr. Kussman. You did it here at the hearing, and then you did it—it was in response to Mr. Mitchell's question.

Dr. KATZ. Yes, sir.

Dr. SNYDER. The second thing is, with regard to the facts in the second set of e-mails, the one that you have apologized for in terms of the subject line, in fact, you instigated an e-mail going to your communications person that says, we are now identifying 1,000 suicide attempts per month, and you're asking the question, essentially, "Is this something we need to release after we sort it out?"

But what you all are saying, I think, today, if I am hearing you right, is you think that 1,000 number is a pretty loosey-goosey number. There is a lot of variation of reporting that you are trying to nail down.

Is that a fair statement, Secretary Peake.

Secretary PEAKE. Yes, sir, I do. And we are concerned that it is underreporting, probably.

Dr. SNYDER. Maybe underreporting.

So your conversation, there, Dr. Katz, is an effort to say, we have some new information but it may not be accurate yet. But you are, in fact, instigating an inquiry about, should we be releasing this. And I can understand that.

Where I would part company, I think, with you on this, Dr. Katz, is—and, Secretary Peake, you may want to address this, because, in response to somebody's question, you talked about how you want to have increased transparency. I have never trusted the press operations coming out of, I guess I have to say, this administration. And it appears to me you got bad advice. Here you, Dr. Katz, are saying, "We have new information. We think it needs to get out there." You didn't write it very artfully. "We think it needs to get out there, because this is a small town and people have a way of stumbling on stuff." And your press office comes back and says, "Oh, no, let's figure out how to spin it." I mean, that is what that response is. Is this the fact—we are stopping them. Somebody is trying to get you to spin it. In fact, what you are trying to do is, "We have new information; let's get it out there."

And my advice is you have a communications department. You ought to figure out what you want to communicate, and then communicate it. Tell them, "Here, get this information out there." But don't let people tell you how to spin information that you think is new. I don't think you are well-served.

Dr. KATZ. Sir, could I respond?

Dr. SNYDER. Go ahead and respond.

Dr. KATZ. The e-mail was only part of the communication.

Dr. SNYDER. Oh, I am sure that is right. Every one of us have bad e-mails——

Dr. KATZ. The other part of the communication from VHA's senior leadership was, make sure everything is done to address the increased risk in these thousand people a month.

The CHAIRMAN. Was that response in writing?

Dr. KATZ. No, it was in conversation.

Dr. SNYDER. A specific question I wanted to ask, Secretary Peake, is one of the folks on the second panel suggests that, because of the way some of the CBOCs are set up, that people who are coming in for treatment may be getting psychotherapy and counseling but not an appropriate level of antidepressants and pharmacological therapy.

Do you agree with that? Is that a concern that you have had?

Secretary PEAKE. I really don't have data to address that, but I would take a look at it.

[The following was subsequently received from the VA:]

No. To promote a consistent and portable prescription benefit, VA uses a single National Formulary (VANF) at all points of service, including CBOCs. The VANF provides access to a very broad array of medications used to treat mental health conditions and with few exceptions, these medications are available to CBOC mental health providers. If a CBOC mental health provider is not licensed to prescribe medications (ie., Licensed Clinical Social Worker or Psychologist), the CBOC primary care provider can prescribe them and if necessary, he or she has remote access to a VA Psychiatrist for mental health medication consultation.

At present, of CBOCs serving more than 1,500 unique patients, 452 (97%) have a meaningful mental health presence as defined by having at least 10% of the total number of visits coded as mental health visits.

For those serving less than 1500 unique veterans, mental health visits represent at least 10% of the total visits in 109 (58%) CBOCs.* In other facilities, mental health services are provided by primary care clinicians, or they are available by referral. The major difference between mental health services in medical centers or CBOCs is not the presence or absence of general mental healthcare, but difficulties in making specialty mental health services available in CBOCs, especially smaller and more rural ones. Historically, VA's approach to this has been to refer patients when necessary to specialty mental health programs in VA or non-VA sites. However, over the past few years, there has been increasing use of telemental health technologies to provide these services. Currently, telemental health is available in 196 (40%) of CBOCs serving more than 1,500 unique veterans and in 48 (21%) of smaller ones.**

Vet Centers will refer veterans to the local VAMC for medical care and follow up of prescriptions if needed. In the mental health mental status evaluation, any indicators of need for medical psychiatric or primary care are automatically referred to the medical center. If veterans are on medications and have challenges in getting prescriptions filled, they are referred to the local VAMC or CBOC.

*Data source is adapted from VSSC website, Past Performance Measures, Mental Health at CBOCs Performance Measure, FY 2008, Quarter 1.

**Telemental health data is from the Office of Care Coordination, March 08. All Telemental health visits are coded as MH visits and are not separated in the data base summary. These data include specific fee basis visits at some sites.

Dr. SNYDER. When you talk about the issue of trying to sort out veterans from active component—you may have addressed this with Mr. Walz—how are Reserve component members who come back from active duty and entitled to come to the VA for a period of time—are they counted as a veteran or an active component?

Secretary PEAKE. Sir, we count them as veterans.

Dr. SNYDER. As veterans.

Secretary PEAKE. Yes, sir. They do have DD–214s that they have then demobilized.

Dr. SNYDER. Well, I appreciate you being here.

I think a lot of this could have been avoided, Dr. Katz, by, as you pointed out, some more artfully written e-mails. Because we are all here in the spirit of trying to solve these problems. And unfortunately, you take snippets of this, and it does not provide a very good picture of what was going on at the time. It appears to be a department under siege.

And I don't think that has ever been your style professionally, Secretary Peake. I think you are one of the ones to solve problems. You may want to address that with your communications department and let them work for you rather than vice versa.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Snyder.

Mr. McNerney, any questions?

Mr. MCNERNEY. Thank you, Mr. Chairman.

Dr. Katz, last November you attacked a *CBS News* report which claimed that there were 6,200 suicides in 2005 among those who had served in the U.S. military, by saying, and I quote, "Their number is not, in fact, an accurate reflection of the rate." But then, just 3 days later, you wrote an e-mail admitting there were about 18 suicides per day among America's 25 million veterans. That is about 6,570 a year.

Did you intentionally withhold information from *CBS News*?

Dr. KATZ. From *CBS News*?

Mr. MCNERNEY. Well, you attacked the *CBS News* report, and then you admitted that their numbers were not only right but they were low. And then you didn't——

Dr. KATZ. I was concerned about their findings with respect to very young veterans, not the entire veteran population.

Mr. MCNERNEY. So was information withheld at that point?

Dr. KATZ. Sir, I was not asked for information from *CBS News*. I was merely asked to react to their information. I was given a piece of paper, and it had ratios of veteran and non-veteran suicides, and asked if I was shocked by that. I was not shocked by the overall number of veteran suicides, and I think their four-to-one ratio for the youngest of veterans may not hold up. You saw a different ratio earlier.

If you are interested in whether there is an epidemic related to the war, you would also want to see what the rates were before the war. *CBS News* never addressed that. I have concerns about the *CBS News* report. Those concerns were what I have been referring to. I have never had concern about their overall estimate for numbers of veteran suicides.

Mr. MCNERNEY. After the VA provided *CBS News* with the 790 number as the annual number of veteran suicide attempts, you

wrote an e-mail to your media advisor again, because you were concerned that there might be as high as 12,000 per year, is that correct?

Dr. KATZ. Sir, it may be even higher than that, in terms of suicide attempts. And we could speak to that.

As I recall, the number 790 came from information sent to *CBS News* when they asked for information about attempts or completed suicides from the medical records. And from that information, they extracted the number 790 as the count of attempted suicides or deaths from suicide in 2005.

The estimate of a thousand a month came from the tabulations done by the suicide-prevention coordinators, which, because it was information and methods under development, were not yet in the medical records.

Mr. MCNERNEY. Well, in the same e-mail, you question whether or not you should release the information before someone else stumbles upon it. So it seems to me that information on suicide statistics was either withheld or wrong numbers were released.

My real concern here is that that would have prevented procedures that could have saved precious lives, lives of young soldiers who served our country and depended on us to help them when they needed it.

How can you assure this Committee that that behavior doesn't constitute wanton disregard of your duties and responsibilities and that that will change and that we will see procedures put in place that will prevent this?

Secretary PEAKE. Sir, let me try to address that.

First of all, I would tell you, as I tried to comment in my opening remarks, that the numbers are important for trending and all of those kinds of things. What is important is making sure that we are doing the kinds of things that we are doing to try to intervene in this, what we know, is a high risk group, those with suicide attempts, to intervene with that younger age group that we demonstrated have a higher level of suicide risk. And, you know, that is full bore out, to try to work those issues.

Trying to get the right numbers and making sure that we give valid numbers is important, and I think that we owe appropriate, validated numbers to this Committee and to people that ask for that information.

So I can't tell you more, except to say that we are absolutely committed to trying to do the right thing by all of our servicemembers, our veterans, and not worry as much about whether this is a little above or a little below some national average, but to focus on doing the clinical right thing.

Mr. MCNERNEY. Mr. Secretary, the Joshua Omvig Suicide Prevention Act requires that you submit recommendations for further legislation and administrative action that the Secretary considers appropriate to improve suicide-prevention programs within the Department of the Veterans Affairs.

Do you have recommendations for us today, or do you have recommendations in general to meet the requirements of that act?

Secretary PEAKE. Sir, I don't have those to present to you today. But, as that may be required by the act, I will provide those.

[The following was subsequently received from the VA:]

The Comprehensive Program for Suicide Prevention Among Veterans report for P.L. 110–110 was submitted to Congress in February 2008 and is attached for your review. In the report we stated that we are able to monitor risk and needs and respond to them under existing legal authority. VA did not recommend further legislative action and remains with this position. Since the report was released, VA has the following updated information:

Requirement: Designation of Suicide Prevention Counselors—To support the identification of patients at high risk, the Suicide Prevention Coordinators have been integrating information from providers, other staff, and community contacts about veterans who have survived suicide attempts. In preliminary findings, we have identified approximately a thousand attempts per month. To address the increased needs for these vulnerable veterans, VA has implemented standardized approaches to enhancing care while, at the same time, encouraging innovation and creativity.

Further developments in process at this time include tests of the Coordinators inter-rater reliability and their sensitivity in the identification of suicide attempts. Both will be necessary before the number of attempts (or reattempts) in a facility can be used as a measure for epidemiological or quality improvement purposes.

Requirement: Hotline—From the time the veterans' Hotline was established in July, 2007 until the end of April, 2008, we received 43,294 calls. From the start of 2008 until the end of April we received 33,915 calls, with 16,414 confirmed as coming from veterans and 2,125 from family members or friends. These led to 2,725 referrals to the Suicide Prevention Coordinators at VA facilities and 746 "rescues" requiring emergency services.

The "Report to Congress for Public Law 110–110, Comprehensive Program for Suicide Prevention Among Veterans," dated February 2008, appears as an attachment to the response to Ms. Berkley's Post-Hearing Questions for the Record, which appears on p. 240.

Mr. MCNERNEY. Thank you.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Brown.

Ms. BROWN OF FLORIDA. Thank you.

Mr. Secretary, a couple of quick questions.

One, we have talked a lot today about the veterans. And I mentioned the families earlier. What are we doing to work with the families, the outreach to prevent suicide?

Secretary PEAKE. Well, first of all, within our Vet Centers, they can do family counseling, and we really encourage that. When a servicemember is within our care, providing counseling to the family member is deemed part of that care, that we can provide that kind of counseling as well.

As I was talking with Mr. Hare, one of the things I would like to find a way to do is to reach out and touch family members in a more specific way. So, as we go to the TAP briefings, you know, it is possible to have family members there, but, in all honesty, we are not seeing them available.

I think that what the Ranking Member brought up, in terms of being able to participate in those kinds of events, are things that we need to expand on. But I think it is an area that we need to come up with an action plan. And I will be happy to do that and report back to this Committee on that action plan.

[The following was subsequently received from VA:]

The Secretary has asked that assistance to families be a VA priority. Since 1979, the Vet Center program has been authorized to provide family services as it relates to the readjustment of the veteran. When an individual is reactivated, they shift from veteran status to active military status. The servicemember and dependents then revert to Department of Defense protocol. Once they complete their tour and demobilize, they are once again veterans and they and their family members are eligible for Vet Center services.

In FY 2007, Readjustment Counseling Service provided 1,055,186 visits to 164,228 total veterans. Cumulatively since the beginning of the War, Readjustment Coun-

seling Service has provided services to 288,594 OEF/OIF veterans (through 1st Quarter FY 2008). 216,172 were provided outreach services and 72,422 received readjustment counseling in the Vet Center.

Cumulatively, since 2003, (bereavement counseling authorization) Readjustment Counseling Service has provided bereavement services to the families of 1,238 fallen servicemembers, 876 of which were in theater casualties in Iraq and Afghanistan.

Ms. BROWN OF FLORIDA. The other thing is the women—I am very concerned that women veterans are one of the fastest-growing groups and one of the most underserved groups. Have you thought about having a task force just for women vets and trying to come up with how we can be more supportive and what we can do just targeting that group?

Not to take anything away from veterans in general, but I think women are unique and they have unique needs. And in a lot of our VA centers, their needs have not been addressed.

Secretary PEAKE. You know, ma'am, I have not only a Federal Advisory Committee Act (FACA) that looks at those kind of issues for women, but also an office that focuses on women's issues, with Dr. Irene Trowell-Harris as my lead.

We continue to ask this issue every time we get into it: Now, are we taking care of the women veterans? Because, in fact, we have been historically a male service organization, in a way.

Ms. BROWN OF FLORIDA. It still is, sir.

Secretary PEAKE. And I have been traveling a lot and, every time, have asked to see the women's health unit. I have been impressed with some of the things we are doing.

But it is very important to understand that they want to be able to have a single portal where they can go in and get women's healthcare, primary care, and mental healthcare without being labeled. And so we are making sure that that is in there.

But I think we must continue to monitor very closely and make sure that we have consistency across the whole VA when we do those kinds of programs.

Ms. BROWN OF FLORIDA. What can the Committee do legislatively to assist, to widen your scope?

Secretary PEAKE. As we look at being able to provide access and assistance to a family member, there may be ways that we need to work together to find a road ahead there.

If a spouse, as an example, is depressed with their servicemember or veteran spouse who may have a physical disability or mental disability or TBI or something like that, it would be nice to be able to ensure that they have the care to include medications, if that is necessary, to help them through that, even if for the short term. And so we are looking at ways to try to get that kind of an authority.

Ms. BROWN OF FLORIDA. You mentioned the Vet Centers, and I do think it is a great delivery service. But, in some cases, they have been cut or underfunded. Maybe we can think about how we can rev up those Centers. Because it is going to be comprehensive. It is going to be jobs, it is going to be healthcare, it is a whole list of things. A lot of these veterans come back, their jobs are no longer there. So it is comprehensive.

Secretary PEAKE. Yes, ma'am. To my knowledge, we have not had—I mean, I have asked specifically, and I am told that we have

not cut Vet Centers, and we are funding them as they have requested. I will go back and check on that.

I do agree with you about the jobs issue. And, frankly, you have young men and women who have gone overseas and have done something that they feel in their life is really meaningful, and they don't necessarily want to go back to that old job that they had before. We do need to increase our efforts in that regard, as well.

[The following was subsequently received from VA:]

Vet Centers are fully funded. Their funding levels:

- 2004 $87 million (206 Vet Centers)
- 2005 $94 million (207 Vet Centers)
- 2006 $100 million (209 Vet Centers)
- 2007 $113 million (215 Vet Centers)
- 2008 $153 million (232 Vet Centers)

The FY 2008 budget represents a 50% increase from 2006 through 2008.

Vet Centers provide individual and group counseling, marital and family counseling for combat service related issues, military sexual trauma counseling and referral, bereavement counseling for the families of fallen servicemembers who die while on active duty, demobilization outreach and direct service, substance abuse assessment and referral, employment services, Veterans Health Administration and Veterans Benefits Administration referral, and veteran community outreach and education.

Twenty-two new Vet Centers have been approved.

Ms. BROWN OF FLORIDA. Well, thank you.

And thank you, Mr. Chairman. I yield back the rest of my time.

The CHAIRMAN. I am trying to decide if there are additional questions. Do you want the Secretary to be back, Mr. Boozman, Mr. Lamborn, Mr. Kennedy? We have three votes. Do you want to talk to the Secretary when we return?

Mr. LAMBORN. I don't need to.

The CHAIRMAN. We will get to Mr. Kennedy when we return.

And I hope you will respond to these general questions, Secretary Peake. A half-dozen Members of Congress asked you very specifically, what do you want us to do, how can we help? You didn't ask us for one thing, one piece of legislation, one dollar of funds. Who is better at outreach than we are? That is our job. Have you ever asked a Member of Congress to help on the outreach? Nobody has ever asked me.

We know the people. We talk to the people. We are in touch with them every day. Otherwise, we wouldn't be here. Use us. But you never mentioned one thing you wanted us to do.

Second, although I guess Dr. Katz is a doctor and not a lawyer, your rhetoric still bothers me, and I am not sure you are performing your job in an effective way, given the unfortunate e-mails.

But in answer to one question, Dr. Katz, you said, "*CBS News* asked me for medical records." Why don't you say, "Here are the medical records." But if you really wanted to get that information, you should ask for the number of attempts that our coordinators are coming up with.

You are not very helpful in transparency—you are not helping. You are supposed to be the expert. If we are not asking the right questions, if the press is not asking the right questions, help us ask the right questions. You are just sitting there with all this data, "Well, he asked for this; I will give him this," or, "I am not sure that is accurate, so we won't give him that."

The data is only important to reflect—it is a symptom of a major problem with our current veterans and previous veterans. The problem is inadequate mental health treatment. Suicide is the ultimate symptom—the tragic symptom—but PTSD is a symptom, homicides are a symptom, homelessness is a symptom, marital difficulties are a symptom, domestic violence is a symptom. We have to be focused on all the symptoms and we are not doing the job.

I don't care what data you have, or what programs you are starting; if you have a thousand—and you said it could be more suicide attempts per month, we have some real difficult issues. And you never asked us for anything to help you deal with it. It is as if you have it under control. You don't have it under control.

I talked to you, as I said, in our first conversation, Secretary Peake. I said the one thing that is the most important, that is missing from the mental health problem, is a mandatory evaluation by competent medical personnel. I said I had the concept of a Heroes Homecoming Camp that I thought we could use. It was never followed up on.

We are letting tens of thousands of young men and women out of the service, out of the National Guard, without adequate diagnosis. You keep saying, well, everybody that comes to us, we screen.

Is that screen, by the way, just a questionnaire, or is that an hour interview with a psychiatrist? How do you screen? You said it several times today. How do we screen?

Secretary PEAKE. It is a reminder to the primary care physician to ask specific questions and to create the dialogue with the patient. It is not an hour-long diagnostic session with a psychiatrist.

The CHAIRMAN. So we don't adequately diagnosis anybody, unless they ask for it? Then we have to make that mandatory for every young man and woman who leaves combat so there is no stigma. I suggest that you do it in cooperation as part of their active duty service with the Army, Marines, et cetera, with their family there, and with their company of soldiers there. Let's get everybody the support system they need and get that mandatory diagnosis.

If they are coming in, psychiatrists tell me and people have testified to us, that you need competent medical personnel—and there is minimally adequate treatment here that the VA is not giving. We are not giving adequate diagnosis or treatment to these hundreds of thousands of young people who are getting out. That is the problem.

Until you tell us what you need to solve the problem, all this data is meaningless. The data is only, as you said, a way to understand the issue. But we have to get to the issue.

We have these kids in active duty. All I have to do is say, visit the psychiatrist. This is not a hard thing to do.

Mr. Kennedy.

Mr. KENNEDY. The evidence is so clear, and adherence to medical advice averts hospitalizations over and over and over again. And the same thing adheres to behavioral medicine and mental health.

If we had people who called back and stayed on top of these soldiers after they got out of the military and stayed in touch with them with care management—not just the ones that were grievously injured, as you pointed, that are at high risk for suicide, but

all the soldiers. Because we want to stay in touch with the ones that are at modest risk, because we don't know which ones may have had an exposure to trauma. Or the trauma that they were exposed to they might not have the resiliency to that that other soldiers had.

And so if we stayed in touch with all of them, and that is not a huge expense, because we don't want them to become the severe cases later on. So this is an investment in prevention for us. So if we stayed in touch with all of them, that is an investment in keeping them out of the hospital, and prevention.

We can put this in place as a preventive measure and employ these new technologies in keeping in touch and preventive medicine. And I think that is one of the recommendations in prevention you ought to put forward.

The CHAIRMAN. Mr. Kennedy, I thank you for your leadership and being a part of this.

I will make it real simple, Secretary Peake. Get us a plan with the Secretary of Defense and the VA to evaluate—not screen, not quiz, not give self-questionnaires—to diagnosis with competent medical personnel for every soldier for brain injury and for PTSD. We will make it that simple. You will bring down every single one of these figures. You will not have to start with "Shh," "Shh," "Shh." We will come to grips with this. Come back with a plan, which I already gave to you, in a week or two. I will bet you that every single issue we talked about today comes under control.

Mr. Secretary, you have been generous with your time.

We have three votes. We are going to come back in about 20 minutes. The first panel is excused, and we will go to the second and third.

[Recess.]

The CHAIRMAN. Dr. Maris, thank you for joining us. The other Members of the Committee will be following.

I know you have to catch a plane. I would like to introduce you as a Distinguished Professor Emeritus at the University of South Carolina, past director of the Suicide Center at the University of South Carolina, and you have an extensive background in research on suicidal behaviors.

I believe you will testify as to the problem of suicide among veterans, whether or not it is an epidemic, and what you think the VA is doing about it.

Let me thank you for taking the time to be here with us.

STATEMENTS OF RONALD WILLIAM MARIS, PH.D., DISTINGUISHED PROFESSOR EMERITUS, PAST DIRECTOR OF SUICIDE CENTER, ADJUNCT PROFESSOR OF PSYCHIATRY, AND ADJUNCT PROFESSOR OF FAMILY MEDICINE, UNIVERSITY OF SOUTH CAROLINA, SCHOOL OF MEDICINE, COLUMBIA, SC; STEPHEN L. RATHBUN, PH.D., INTERIM HEAD AND ASSOCIATE PROFESSOR OF BIOSTATISTICS, DEPARTMENT OF EPIDEMIOLOGY AND BIOSTATISTICS, UNIVERSITY OF GEORGIA, ATHENS, GA; AND M. DAVID RUDD, PH.D., ABPP, PROFESSOR AND CHAIR, DEPARTMENT OF PSYCHOLOGY, TEXAS TECH UNIVERSITY, LUBBOCK, TX

STATEMENT OF RONALD WILLIAM MARIS, PH.D.

Dr. MARIS. Thank you, Mr. Chairman, Committee Members, ladies and gentlemen.

Just for the record, I was a plaintiff expert in the Vets v. Peake trial in San Francisco. So I am coming at this partly with a plaintiff perspective.

In my written report, I want to highlight that suicide is more than one outcome; it is a multidimensional outcome. And for the Committee's sake, I would hope they would look not just at completed suicides, but suicide attempts and other kinds of collateral damage, partially self-destructive behaviors, depression, alcohol, domestic violence, PTSD.

Secondly, I have also identified some risk factors, and I list those in my written report, starting off, of course, with depression and affective disorders, alcohol and substance abuse. My point is that I think all these 15 risk factors that have been shown to be related to suicide outcomes ought to be asked of all vets. And I will come back to that in just a minute. What the VA does is they ask two simple questions; they don't ask all the risk factors for everybody.

I was asked whether or not we could talk about what causes veteran suicide. And I want to say that part of the problem is the Department of Veterans Affairs has not provided me or the courts with crucial data that are needed. Every time there is a military death, suicide attempt or serious incident, the VA produces something called an incident brief, which summarily decides the suicide or suicide attempt. Then, about 45 days later, each incident goes through what is called a root-cause analysis, and a three-page report is generated.

When I was an expert in San Francisco in the Vets v. Peake trial, I was given only 170 of the somewhat estimated 15,000 incident briefs and none of the root-cause analyses. My point being that such crucial documents would help clarify how many vet suicides there are and what the VA itself thinks causes them.

One of the documents in that trial was a document by William Feeley, a Deputy Under Secretary for Health Care. And he said in his deposition, I quote, "Suicide occurs like cancer." That is wrong. We all have to die, some by cancer, some by heart disease, but no one needs to suicide. It seemed to me that that comment suggested that the VA seems to think there are a certain number of vet suicide deaths that are inevitable and there is not a lot we can do about them.

The VA has a number of suicide coordinators. Interestingly, I think the Committee should remember none of these suicide coordinators are in what they call their CBOCs, their 875 outpatient clinics. They are all at the VA medical centers. So the vast majority of treatment is at these outpatient clinics, which I understand do not have suicide coordinators and do not have people who can write prescriptions for antidepressant medications.

When they measure suicide risk in the VA, they have something called the suicide template, and that just has two simple questions. Those questions have to do with whether or not the patient felt hopeless, whether or not they felt depressed, and whether or not they were thinking about suicide. If you answer "no" to either of those two questions on the so-called suicide template, you are not asked any more questions, even though there are a number of other risk factors that I have outlined in the first part of my written report and that the VA itself actually states in their suicide template the vets do not get asked those important questions.

So they are simply asking about self-reports of suicide ideation and hopelessness or depression. They don't even measure depression and hopelessness using standardized clinical scales like the Beck or the Hamilton scales. So I have some problems with how they measure these important variables and the kinds of questions that they ask.

There is surprisingly little in the VA healthcare policies about treating depressive disorders psychopharmacologically. One of the backbones of the standard of care for suicidal depression is to get somebody diagnosed appropriately and, if they need it, to put them on some sort of psychopharmacological treatment. I am not sure why this is not a major part of the documents that I have read.

There are serious questions about these suicide coordinators: Who are they? What do they do? Are they really trained as well as they claim they are trained?

And then, finally, there are some questions about delays in treatment. To even get mental health treatment for 2 years, a vet has to fill out a 23-page application, which can be hard to do if you have PTSD, and then receive a disability rating from zero to 100 percent from a compensation and pension examination. If the disability is denied or too low, found not to be related to military service, then the appeal process can be long and drawn out and sometimes——

The CHAIRMAN. Dr. Maris, I hate to interrupt you, and I apologize. There is another procedural vote that was just called and I have to run over and vote. I apologize again.

We will recess for a few minutes and hopefully return right away.

[Recess.]

Mr. HALL [presiding]. The hearing will resume and come to order. We do have a couple of Members here, so there is a quorum. And I will, at the request of Counsel, sit in as Chairman until Chairman Filner returns.

And, Dr. Maris, you were testifying. If you would be so kind as to——

Dr. MARIS. Yes, I have one sentence left.

Mr. HALL. Is that all? Well, feel free to add one or two more if you would like.

Dr. MARIS. Defense expert Alan Berman in the Peake v. Vets trial testified that it could take up to 10 years for the 2007 MHSP plan to be implemented. One wonders how many vets are going to die in the interim due to lack of assessment and intervention.

[The prepared statement of Dr. Maris appears on p. 96.]

Mr. HALL. Thank you, Dr. Maris.

Dr. Rathbun, your statement has been entered in full into the record, and you are recognized for 5 minutes.

STATEMENT OF STEPHEN L. RATHBUN, PH.D.

Dr. RATHBUN. Thank you, Mr. Substitute Chairman, I guess. The Chairman is out. I have never done this before, so you will have to excuse me if I am not quite on protocol.

I got involved in this when Pia Malbran from *CBS News* contacted me last fall. I believe it was some time in August.

The CHAIRMAN [presiding]. I apologize again for——

Dr. RATHBUN. Sure.

The CHAIRMAN. I wonder, Dr. Maris, for the people who weren't here, if you could repeat the two points you made on the 15 risk factors versus two questions and CBOCs without suicide coordinators.

Dr. MARIS. Sure. The VA suicide risk assessment has something called a suicide template. They ask two questions to vets at any particular time, either at deployment or clinic visits. Those questions are: In the last 2 weeks, have you felt hopeless or depressed? Number two, in the last 2 weeks, have you thought about harming yourself?

If the vet answers no, actually, to the second question, they are asked no more risk factors. And my point is that is way below the standard, to leave it at that. There are many reasons why somebody would not answer yes to those questions, many of which have been discussed earlier today: fear of career advancement, you know, kind of, being a tough guy. So that you need to ask all of those risk factors on their template or my 15 risk factors on my written report of all vets.

The CBOC question is that there is 154 VA medical centers; that is where the suicide coordinators are located. They also have most of their service delivered by the CBOCs, community-based outpatient clinics. None of the suicide coordinators are in those 875 outpatient clinics.

As I understand it, most of those outpatient clinics do not have licensed physicians who are capable of prescribing antidepressants. So it concerns me that the vast majority structurally of the treatment is being given at the outpatient clinics and that the suicide coordinators actually aren't even there.

The CHAIRMAN. Thank you. I think those are two very important points for us to keep in mind.

Dr. Stephen Rathbun is the Interim Head and Associate Professor of Biostatistics at the Department of Epidemiology and Biostatistics at the University of Georgia. Dr. Rathbun has performed statistical analysis of veteran suicide data for the *CBS News* and will talk about that analysis.

I, again, apologize for breaking in on you.

Dr. RATHBUN. Okay. No problem. I will just start all over.

It wasn't really made clear exactly what I should be talking about today, but I think I can go over a little bit of the history of how I came to do the data analysis and some of the results that I found.

I was approached originally back in August by Pia Malbran from *CBS News* to assist them with the analysis of veteran suicide data. After being approached, I agreed to do so, essentially as a statistical consultant. I am a biostatistician and not an expert on veteran suicides. I consulted with her on the format that the data needed to come in, and she eventually did provide the data in that format.

One of the important things when analyzing data of an observational nature, as these data are—these are not the results of experimental manipulations of study subjects—the statistical protocol should be specified in advance. So, prior to actually receiving the data, I determined what type of analysis should be carried out on the data. And in the interest of keeping things simple, which is usually a good idea, I tried to keep it the most straightforward analysis, standard data analysis as possible.

What Pia actually asked me to do was estimate rates of veteran and non-veteran suicides over the general population and broken down by gender and age, among other things. And when making these estimates, it is important to adjust for the fact that veterans are not representative of the general population. Veterans tend to be more male, and their representation in different age groups are different according to, I suppose, how many, you know—what the current state of the world affairs are. Certainly, in World War II, there were a lot higher percentage of veterans than there are currently.

So I carried out the analysis using standard statistical methods, and those analyses were reported on *CBS News* on November 13. And the general findings were that veteran suicides were about roughly double of the non-veteran suicides.

The comparisons I am making here are veterans versus non-veterans. The results that you saw earlier were veterans versus the general population. Since the general population includes veterans, that can have an impact of reducing the magnitude of the effects somewhat. So that can explain some of the differences between my results and the results that the Veterans Administration might be presenting.

But, in general, the veterans had about double, roughly double, the suicide rates as the non-veterans. If you break it down by gender, you find a similar pattern of higher rates among males than females. And within both genders, you also have higher rates of suicides among veterans than non-veterans, roughly about double the rates of non-veterans in both genders.

One of the things I was asked to look at was the breakdown by age. And in our story, we broke it down by 5-year age classes: 20 to 24, 25 to 29, and so on. And when looking at those ages, in this case gender-adjusted rates for each of the ages, the thing that stood out to me the most was the higher relative rate of veteran suicides among the 20- to 24-year-olds. Here those rates were estimated be-

tween about 24 to 36 per 100,000 veterans compared to about eight per 100,000 nonveterans.

Higher rates also can be found among the 40-year-olds, but the non-veterans in that group also have higher rates, so it is not quite as striking there.

In the interest of brevity, I guess I can leave it up for questions right now.

[The prepared statement of Dr. Rathbun appears on p. 102.]

The CHAIRMAN. Let me just make sure I understand what you said. The charts that we saw earlier included the veterans back into the general population?

Dr. RATHBUN. Yeah, the figures were general population numbers.

The CHAIRMAN. So that is a real distorting aspect?

Dr. RATHBUN. I don't know how much a distortion it is. I would have to have the actual numbers on the numbers of veterans in each of the age groups to get some idea of exactly how big an effect.

The CHAIRMAN. But it could be?

Dr. RATHBUN. Some. I think it is only just the relative magnitude that would be affected. The general story, I think, will be the same.

You might not get—if you had different ages—if you have in different age groups of our population differential veteran representation, then that can cause some pattern in the relative rates when comparing veterans to non-veterans, if you were to do that direct comparison instead.

To defend what they did, however, I think the records, the national death records were very readily obtained from the CDC, I think it is where they come from. And it is the viable thing to do, but you really have to understand what is going on with those numbers. And it can be a little bit misleading if you don't understand the numbers.

The CHAIRMAN. You know, I see Dr. Katz is still here, but I don't see the expertise in the VA that you are showing here to analyze the data. So maybe we could talk about that again of who should be questioning whom.

Dr. David Rudd is the Professor and Chairman of the Department of Psychology at Texas Tech University. He is a former Army psychologist with a background as a practicing psychologist in clinical research whose work focuses on the assessment, management and treatment of suicide. He will highlight the scope of the problem of suicide and some steps that might be taken by the VA.

Thank you again for taking the time to be here with us.

STATEMENT OF M. DAVID RUDD, PH.D.

Dr. RUDD. Thank you, Mr. Chairman. You have my testimony, and it has been entered into the record. Rather than repeat much of what has been shared this morning and some of what Dr. Maris shared, I would like to highlight a couple of points that I think are important to consider when you look at the context for this problem.

If you look at the issue of veterans being treated for depression, estimates are that the suicide rate is seven to eight times greater than the general adult population. In order to understand the context for that, it is important to look at comparable civilian data.

And I have offered some of that in the written testimony, but I will highlight a few things for you along those lines.

The suicide prevalence rate for major depression and affective disorders in general is actually lower than is oftentimes quoted, but seems to depend on the apparent severity of the illness, with the outpatient suicide prevalence rate being 2 percent in contrast to 6 percent for those previously hospitalized for suicidal symptoms and 4 percent for those hospitalized for other reasons. Basically, that is a function of severity. The more likely someone is to be hospitalized, the more severe the illness, and the higher the risk over the course of a lifetime.

If you are looking at estimates in terms of suicide attempt rates, it is estimated that 24 percent of those suffering major depression make a suicide attempt during the course of the illness. It is estimated that up to 50 percent of individuals with bipolar disorder will make a suicide attempt, and up to 80 percent will manifest suicidal symptoms of some sort during the course of the illness.

Standardized mortality ratios for major depression and bipolar disorder paint a very stark picture. Those with major depression evidence a 20-fold increase for risk of death by suicide relative to the general population; and those with bipolar disorder, a 15-fold increase. There are data available for other disorders, but the take-home message is a simple one: that suicide risk is considerable for a number of mental illnesses, and ultimately the mental illness, untreated, unrecognized or undertreated, can be fatal.

It is also important to consider the expected rates of adverse events during treatment. And this actually is something that gets very little attention in terms of the literature, particularly looking at suicide attempt rates. Data are now available from a number of randomized clinical trials. We actually have 53 randomized clinical trials that can be considered and reviewed. Estimates indicate that as many as 40 to 47 percent of those in treatment, meaning psychotherapy and/or medication, make a suicide attempt during the first year of treatment. Once they have made one suicide attempt, it is estimated that they will make an average of approximately 2.5 during the course of treatment. I think it is important to consider that in terms of providing the context.

Standardized mortality ratios for men and women recently discharged from the hospital for suicidal behavior range from 100 to 350 across several studies. These are tragically high numbers. And what those numbers indicate is that the death rate is remarkably high for people that are discharged from a hospital. And the rate varies within the first week of discharge relative to the first month of discharge as well.

I think you take those couple of points, in addition to what Dr. Maris shared, as well as what was shared this morning, and there are a number of possible conclusions.

First, as was outlined nicely in the RAND study, there are high rates of psychiatric illness following combat exposure, and that includes both direct and vicarious exposure. Multiple deployments for Operation Iraqi Freedom and Operation Enduring Freedom likely compound the situation because of repeated combat exposure, sometimes after the initial emergence of symptoms. The VA is

faced with assessing and treating very large numbers of seriously ill veterans.

Second, the overall rates of both suicide and suicide attempts are tragic but consistent with the general trends for the types and observed rates of psychiatric illness that present.

Third, an effective response requires effective resources.

And, finally, there is an element of this problem that is likely to be enduring and potentially chronic in nature. And, actually, that is one of the things that I would emphasize, is my concern that this is going to be a chronic issue, much like we saw with some of the Vietnam veterans over time.

If you look at the treatment literature in general, I would encourage you that, ultimately, the treatment literature says some very basic things about treating and addressing suicidality, that very simple things work. Making sure people have access to emergency services when they need them—that works; that will save lives. Making sure that somebody gets into the system quickly after the emergence of significant symptomatology works and can save lives. Very simple things like managing crises effectively, in terms of the removal of method or access to method, works and can save lives.

So I think, ultimately, if you take the data that is available elsewhere, it provides considerable information that helps inform a response to this problem in terms of the veteran-specific population.

Thank you, Mr. Chairman. I am happy to respond to any questions.

[The prepared statement of Dr. Rudd appears on p. 105.]

The CHAIRMAN. Thank you so much.

Mr. Hall, do you have any questions for the panel?

Mr. HALL. If the Ranking Member has none.

The CHAIRMAN. No, I am just going to call them, and then we can conclude.

Mr. HALL. Oh, okay.

I would like to ask Dr. Rudd, in your written testimony, you state that, "Delays in evaluating the escalating numbers of service-connected disability claims can be one of the barriers to effective care being provided."

And just to make a point that we voted out of this Committee a bill last week, which would help to remove some of those barriers and allow earlier decisions for service-connected disability claims.

And also to ask you—and I guess this would be to both you and Dr. Rathbun—about the standard for care of a minimum of 8 at-least-30-minute sessions per year with either a psychiatrist or psychologist or a counselor, which does not have to be the same psychiatrist, psychologist or counselor.

As a professional mental health expert, what is your opinion of that standard?

Dr. RUDD. Well, I would think that it could be potentially problematic for a number of reasons. I think one of the things that we know from the treatment outcome literature is that there is a portion of this problem that will be enduring and chronic in nature. And that amount of care may not be adequate to address the problem. There will be some chronicity. It will take more visits and probably for a longer period of time than many people expect.

Mr. HALL. And how much weight or how much credibility or belief should we put in treatment by medication versus treatment by psychotherapy?

Dr. RUDD. Well, I think both have been proven very effective. It really depends on the nature of the disorder. But both have been proven very effective. And, for many disorders, doing both simultaneously has actually been evidenced to be the most effective intervention and the most effective treatment.

Mr. HALL. I wanted to ask Dr. Rathbun about, under your statistical page here, you show what we saw earlier in the charts from the VA, that the younger veteran seems to be having a much harder time coping, and the suicide rates are higher among the 20–24-year old rate.

Obviously, we know, as was testified to earlier, that there are more males than females serving, and young men are notoriously slower to mature than young women. I am a father of a daughter, so I have witnessed, you know, the other side of it.

But I am wondering if maybe we shouldn't be trying to provide a slightly different type of treatment or screening for younger veterans who, for whatever reasons, are not either processing their experience in combat as well or are not reaching out for help as well.

Dr. RATHBUN. Well, I can only address the numbers themselves. I am not an expert on suicide and/or its treatment. I am a biostatistician, mainly trained in analysis of numerical data, numerical information. And I do have some background in other disciplines, but it is primarily ecology, the environment and environmental health, rather than the suicide issue. This is my first real exposure to suicide.

Mr. HALL. Well, maybe we should ask Dr. Rudd then.

Dr. RATHBUN. I think his comments would have a little more knowledge than mine would.

Dr. RUDD. Well, I would tell you that we do know scientifically that there are some treatments that work. We actually did a large-scale study with Army individuals on active duty a number of years ago, more than a decade ago, and had some efficacy in terms of response with those individuals that were all suicidal. That was one of the criteria to get into the study.

I think that there are issues in terms of barriers that are critical. And this is just anecdotal; I can't give you scientific evidence for it. But having served as an Army psychologist, I can tell you there is great concern among young people about issues of confidentiality, about the impact of receiving mental health, psychiatric, psychological care on their future prospects for their employment either inside the military or outside the military. Much of that is myth. I think targeting that very specifically becomes critical, helping people understand the importance of care early in the cycle of the problem.

Part of my personal concern about this is that you have young people who return from combat who have the emergence of symptoms and then are hesitant to get care because they worry about the impact on their status, the potential for promotion and success in the military, don't get care, symptoms become much more complicated, they develop comorbid disorders, in terms of substance

abuse and other problems, which makes it much more difficult to treat later on.

And so I think there is a piece of this that very much is a misunderstanding about the importance of getting care and that it is not going to impact your future, it is not going to impact your promotion and status in the military. There seems to be a considerable misunderstanding about that.

Mr. HALL. Thank you.

And I would just point out before I yield back, Mr. Chairman, that the parents of one of the veterans who took his own life who testified before us suggested that the name or the initials be changed from "PTSD" to "post traumatic stress injury" or "syndrome" or something else, because "disorder" suggested a malady, like there is something wrong with you as a person, whereas what you are really having is a reaction to an experience that is not normal.

Dr. RUDD. Absolutely.

Mr. HALL. And that the stigma should be removed somehow. Whether a name change can do that alone, I doubt. But I appreciate your comments on removing the stigma and trying to reach our veterans as early as possible.

Thank you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you.

Mr. Rodriguez, any questions?

Mr. RODRIGUEZ. Let me just follow up on the same comments. Because I know we have struggled with trying to pick them up as quickly as possible and talked about maybe providing services to them automatically and maybe not to label them at that point in time. And I don't know if you might have some comments as it relates to that, because it would be just in terms of maybe for 6 months or a year to provide services automatically. That way, every soldier that has gone into a combat would automatically go through that without the stigma of being labeled having one thing or another and getting some degree of access to some services beforehand.

I was wondering if you want to make some comments on that.

Dr. RUDD. Sure. I think it would be interesting to look at that as an option.

I think you can look at other areas of the literature, and specifically you can look at suicide-prevention programs that have been in school systems, you can look at stress debriefings that have been done for firefighters and other individuals. And what that literature seems to suggest is that universal kinds of intervention usually don't work very well, that they don't tend to reach the people that are at highest risk. And I think that what they suggest is that we need to be more creative about what we do and how we reach individuals.

When I think about that, I will tell you very simple things make a difference. Simply reminding people of the availability of a service actually has an impact on suicidality. There was a wonderful study done decades ago where they simply sent a reminder letter to people who were at suicide risk from the Los Angeles Suicide Prevention Resource Center. They sent them periodic reminders on an annual basis. And the people who got the letters actually com-

mitted suicide at markedly lower rates than those who did not get the letters. So just an expression of care and expression of concern to let someone know that you are available can go a long way.

But I am not sure that universal intervention programs would be received well and work well, I think, just from an anecdotal experience when I was in the service.

Mr. RODRIGUEZ. Doctor, you also talked about the ones who were hospitalized and their health. I guess it jumped from 2 to 4 to 6 percent in terms of actual suicide.

Are there certain programs that could be triggered automatically because there are those stressors? Any thoughts on that?

Dr. RUDD. I think speculation suggests that when somebody is hospitalized for an episode of suicidality and they are discharged, that one of the things that happens is they are returned to the environment that was stressful for them to begin with, and so risk is elevated.

I think that data suggests very simple things need to be done. When somebody is discharged from the hospital, they need to follow up very quickly with an outpatient provider. That doesn't always happen. Sometimes that takes weeks for someone to follow up.

Those sorts of interventions, I would hypothesize, would save lives. Making sure that somebody follows up within a day to 2 days after discharge from a hospital with an outpatient provider and make that something that is routine as a part of care. That is something that might well save lives.

Mr. RODRIGUEZ. And, Dr. Rathbun, your data basically, if I can summarize, let me know if I am—you indicated that veterans are twice as likely to commit suicide than the general public? Is that what it is?

Dr. RATHBUN. Yes, it is roughly about that. I can give you a little bit more precise ratios.

Mr. RODRIGUEZ. Okay. And on the data on the young soldier, that was a little higher?

Dr. RATHBUN. For the young veterans, the range that I gave in my report is on the order of about three to four times the non-veteran.

Mr. RODRIGUEZ. Okay. Thank you very much.

Thank you.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. Mr. Rathbun, I want to focus on your—I want to become clear. Your testimony is that, based upon your statistical analysis of the data, that there is approximately a 2-to-1 ratio of more veterans committing suicide than those in the general population?

Dr. RATHBUN. That is right.

Mr. BUYER. Okay. Of the non-veterans, okay. So what that *CBS News* story, then, is attempting to do is challenge the credibility of the VA, right?

Dr. RATHBUN. No, that is not the intent here.

Mr. BUYER. Pardon?

Dr. RATHBUN. My role in this was as a statistical consultant, just to provide the estimates that are given here.

Mr. BUYER. All right. I understand. You are not a health clinician. You are a statistician.

Dr. RATHBUN. Yes, I am a statistician.

Mr. BUYER. And what *CBS News* did with your analysis was their own business and how they used it and created a story with it, that is *CBS News*' business, correct?

Dr. RATHBUN. Well, I do care how they use the information.

Mr. BUYER. Well, I not only care how it is used, I care about how you came to your conclusions.

Dr. RATHBUN. I didn't——

Mr. BUYER. Wait a second.

Dr. RATHBUN. Okay, sure.

Mr. BUYER. I care because the credibility of the VA, then, has been placed at stake with the American people.

Now, I have a series of questions for you, okay?

Dr. RATHBUN. Okay.

Mr. BUYER. One, I would like to know—first of all, I would ask unanimous consent that the letter that Chairman Filner and I sent to Rick Kaplan, the Executive Producer of *CBS Evening News With Katie Couric*, dated December 21, 2007, be entered into the record.

The CHAIRMAN. Without objection.

[The letter to Rick Kaplan, Executive Director, *CBS Evening News With Katie Couric*, dated December 21, 2007, and the response from Linda Mason, Senior Vice President, Standards and Special Projects, *CBS News*, dated May 16, 2008, appears on p. 123.]

Mr. BUYER. I would also ask that the letters that you and I, Mr. Chairman, had sent to Secretary Peake, along with his responses, be entered into the record.

The CHAIRMAN. Without objection.

[The letter to Hon. James B. Peake, M.D., Secretary, U.S. Department of Veterans Affairs, letter dated December 21, 2007, and response letter dated February 5, 2008, requesting additional data on suicide rates among veterans, appears on p. 122.]

Mr. BUYER. I also ask that the responses from the Department of Defense regarding not only our letter to DoD and their response be entered into the record.

The CHAIRMAN. Without objection.

[Chairman Filner and Congressman Buyer wrote to Hon. Robert M. Gates, Secretary, U.S. Department of Defense, on December 21, 2007, requesting the number of active-duty suicides for each year from 1995 to 2006. On January 17, 2008, Secretary Gates responded designating David Chu, Under Secretary of Defense for Personnel and Readiness to provide information to the Committee. Chairman Filner again wrote to Secretary Gates on May 6 and May 21, 2008, requesting the information. On June 3, 2008, Secretary Gates again responded that he was designating David Chu, Under Secretary of Defense for Personnel and Readiness to provide information to the Committee. On June 5, 2008, Chairman Filner again wrote Secretary Gates requesting the information. As of September 25, 2008, the U.S. Department of Defense has refused to respond to the Committee's request for information regarding the number of active-duty suicides for each year from 1995 to 2006. The referenced letters appear on p. 123.]

Mr. BUYER. With letter that the Chairman and I had sent to *CBS News*, we had asked *CBS News* to share with us the data on suicide among veterans with the Committee.

Given your written statement, obviously *CBS News* is unable to do that because you destroyed the data. Is that not correct?

Dr. RATHBUN. *CBS News* retains a copy of the data, I thought. I am not certain if they do or not. But they had asked me to not keep a copy. They were concerned about the confidentiality of some of the veterans, mainly in the smaller States.

Mr. BUYER. So, is your belief that *CBS News* still has the data?

Dr. RATHBUN. I don't know one way or the other, actually.

Mr. BUYER. But they had asked for you to destroy the data?

Dr. RATHBUN. Yes.

Mr. BUYER. Okay. Did you conduct a blind analysis to improve the integrity of your tests?

Dr. RATHBUN. A blind analysis? You mean—I am not knowing what you are referring to. I am not an epidemiologist, so it is——

Mr. BUYER. A blind analysis, meaning anybody else have an opportunity to look at the data? Is it peer-reviewed?

Dr. RATHBUN. No, this is not peer-reviewed.

Mr. BUYER. It was not peer-reviewed and you destroyed the data?

Dr. RATHBUN. Yeah. That makes me feel——

Mr. BUYER. Then thereby we are to embrace with great trust that what you did in your work was correct?

Dr. RATHBUN. I have to say that, for the record, I have been very uneasy about this aspect of it, given that this is going beyond the story.

Mr. BUYER. I would think so. You are a professor?

Dr. RATHBUN. Yes, I am.

Mr. BUYER. Would you advocate that of your students?

Dr. RATHBUN. Not at all.

Mr. BUYER. As a methodology in normal business practice?

Dr. RATHBUN. That is why I have been very uneasy.

Mr. BUYER. Sir, would you advocate that to your students?

Dr. RATHBUN. No, I would not.

Mr. BUYER. No, you would not. Now, you said that you were not paid by *CBS News*; you got a baseball cap.

Dr. RATHBUN. I did get a baseball cap.

Mr. BUYER. Do you know whether or not the parent company of *CBS News* made any forms of contribution to the University of Georgia?

Dr. RATHBUN. I have no information on that.

Mr. BUYER. Viacom, is that who owns *CBS News*? You have no knowledge whether or not they made any contributions on research or anything?

Dr. RATHBUN. I am not aware of what the University receives in terms of those contributions.

Mr. BUYER. Then let me ask this. If you are uncomfortable and you would never advise your students to destroy data and not permit a peer-review process with regard to the results, why?

Dr. RATHBUN. This was not intended as a scientific investigation. I was asked as a consultant to do a data analysis.

What I am really uncomfortable with is having it gone beyond the story and being asked to testify in court about it and, actually, quite frankly, in this group, given that I no longer had the data to back up the numbers.

Mr. BUYER. Yes, I think *CBS News* put you, as a professional, in a very, very uncomfortable position. I think the best thing, Professor, coming out of this that you can always do now is use this as an example for your students here and ever after as to why you should never do something like this. Because it is being used and manipulated and it brings things into question, and it makes it challenging for us.

Dr. RATHBUN. I am comfortable with the results that I found, but I am uncomfortable in presenting them beyond their original intent, which was just that story.

Mr. BUYER. But, professionally, you would even be more comfortable if it were peer-reviewed and one of your peers objectively confirms your findings, would you not?

Dr. RATHBUN. Of course. Sure. I had never—since I do not do my work in suicide, my work is really far outside that discipline, I would have been unlikely to publish this kind of results anyway. It is just not my priority, at the moment.

Mr. BUYER. Well, I want to thank you for coming. I want to thank you for being very honest and forward with us. Because we have a new Secretary in the VA, who is a doctor himself, who spent 40 years in the Army, and he cares a lot about the men and women who wear the uniform, and I think he embraces this issue with great sincerity.

And I know the Chairman has challenged the Secretary here today and members of his staff. But when I am faced with a story that *CBS News* put out there, when, in fact, we can't gain access to the data, the data was destroyed, and a process that was not peer-reviewed, and the last thing, Mr. Chairman, I would like to conclude with is, when we look at the CRS Report for Congress, "Suicide Prevention Among Veterans," the CRS report on page five said, quote, "It is tempting to make comparisons between studies and with information about suicide in the general population. Such comparisons are often made, but they are not necessarily valid. Among other things, data about suicides in the general population includes suicides among veterans, information about suicides in groups that exclude veterans, is scant, and is information about the extent for which data for veterans may skew the data for the general population, if at all."

CRS, Mr. Chairman, did a pretty good report, they are pretty concerned, and they laid out that there is much work for us to do to build a database nationally for us to be able to track this kind of thing.

But I do appreciate you coming here today.

And I would note to the Secretary, your time is very valuable, sir, and I, with deep respect, appreciate you being here to listen to this. But I think we are going to have to place great trust and confidence in your analysis and what you are going to have to do, Mr. Secretary, if this is what has been done out in the population generally.

I yield back.

The CHAIRMAN. Thank you, Mr. Buyer.

What we heard today is that the VA data basically confirms the *CBS News* data.

Dr. Rathbun, when Dr. Katz was with us a few months ago, he said something about VA controlled for gender but in a strange way.

Do you know what he is talking about? Or how did you control for gender?

Dr. RATHBUN. I have no idea about what that would mean.

The CHAIRMAN. You don't know?

Dr. RATHBUN. I used, I think, very standard methodology adjusting for gender and age.

The CHAIRMAN. Dr. Katz, you said something about your objection to the data for younger veterans. You clarified that today. What was your problem with the way the data dealt with younger veterans? Can you just repeat that for us?

Dr. KATZ. I was much less concerned with what Dr. Rathbun did to the data than the data that was given to Dr. Rathbun.

Mr. STEARNS. Point of order, Mr. Chairman.

Dr. KATZ. When the coroner——

The CHAIRMAN. Can you just come to the microphone?

Mr. STEARNS. Point of order, Mr. Chairman. I think what you should do is bring this person up and identify who he is for the record, so we know.

The CHAIRMAN. Dr. Katz, can you come forward, please?

Dr. Katz testified earlier today.

Mr. STEARNS. Okay.

The CHAIRMAN. I was trying to clarify what I took as your general condemnation of the *CBS News* data. Today, you clarified that you were concerned with younger veterans. If you want to make that more clear, you have the opportunity.

Dr. KATZ. Well, in the spirit of attribution and review, I want to acknowledge that it was Dr. Cross who pointed out this issue to me.

When coroners and medical examiners check or don't check the veteran status box on a standardized death certificate, they don't distinguish between active duty and veterans. Someone may have died while in active duty in the community and be evaluated for cause of death by a coroner or medical examiner, and that coroner or medical examiner would check off "yes" for a veteran, because that person was, in the past, a service man or woman.

So that the States' death certificates tabulation of veteran status will include veterans as evaluated by the coroner or funeral director. It will also perhaps include some people who are active-duty personnel who took their lives while on active duty.

The CHAIRMAN. But——

Dr. KATZ. So that the number of suicides tabulated will include both active duty and veterans.

The denominator, the evaluation of the number of people at risk, given your data source, includes only veterans. An extended numerator with a focused denominator will lead to an inflated rate. That will be a greater problem in the younger veterans, for which the mathematical contribution from active-duty personnel would be

greater. And that is why I have concerns about the younger veterans.

The CHAIRMAN. I understand your concern.

Dr. KATZ. Thank you.

The CHAIRMAN. Thank you for coming back.

Dr. Rathbun, do you have any response to that?

Dr. RATHBUN. Yes, I do have some response.

CBS News, after the original taping and before they actually broadcast the story on November 13th, approached me with additional numbers which were active-duty suicide numbers, and asked me to subtract those from the data on the veteran suicides. And that is, actually, why the data on the veterans is given as a range rather than as a single number. It is really one—the lower number reflects the subtraction of those observations that were of some question. Pia Malbran expressed concern that some of the active duty may have been counted as veterans.

The CHAIRMAN. So, I mean, this was figured out before any actual——

Dr. RATHBUN. I am not really certain where she came up with those numbers. I really can't talk to the quality of those particular numbers. We didn't discuss them at any great length.

The CHAIRMAN. But the concept was understood?

Dr. RATHBUN. Yes.

The CHAIRMAN. Dr. Rudd, I missed what you were saying. When a question was asked by Mr. Hall, you said universal prevention was problematical. Did I understand you correctly?

You heard what I said earlier about universal diagnosis of everybody who is discharged or even after combat. That is a universal process that I believe can be done.

Did you say that was not a good thing to do or wasn't effective?

Dr. RUDD. No, no, that is not what I was saying. Actually, let me be a little more specific around that.

Universal prevention programs where there is a targeted intervention for everyone, where everyone gets an intervention regardless of whether or not—and those are usually psychoeducational programs that have been done in the school system.

The CHAIRMAN. But you wouldn't object to universal diagnosis?

Dr. RUDD. No, not coming out of a combat zone.

The CHAIRMAN. All right. Counsel wanted me to ask, again, it was along the same lines as Mr. Hall; the RAND report defined minimally adequate treatment, eight visits in the past 12 months, averaging at least 30 minutes.

I forget what Mr. Hall asked about that, but is that an adequate standard?

Dr. RUDD. It won't be an adequate standard for a portion of those that are diagnosed and identified as ill.

The CHAIRMAN. I remember now. Thank you. You clarified that.

In looking back at this over the years, it seems to me that, a big problem is the vast number of both National Guard and active-duty troops who do not get adequately diagnosed.

Everybody knows what they have to check on a form to get home quickly. We have had reports of commanding officers telling their troops, "Don't check that box, because that will keep you here," or lead to further security problems, which has been clarified recently,

or possible denial of law enforcement jobs. There is a self-denial. There is an ethos that says don't admit mental illness. And there may be a true lack of symptoms, which might not be seen right away.

When that soldier returns to civilian society they don't always have the support mechanisms they had while on active duty. They are often without the understanding of their family, the community and their employer. By the way, I want to invite the VA—and I appreciate you staying here.

Tomorrow at four o'clock, the *Sesame Street* people are going to roll out the DVD they just finished for young children under the age of five. There are more than a million children of those currently deployed in Iraq, those who have returned, or those who will be deployed. *Sesame Street* has done a DVD on how to deal with situations when Dad or Mom come back injured, or perhaps, with an amputation or PTSD. They rotate their puppets of Elmo and Rosita with real-life situations. For instance, they have a young child, four or five, bringing a prosthetic leg to Dad and making it look natural and that it is something not to fear.

They are doing outreach, which I think is incredible. They are going to distribute this DVD free of charge to all the families who request it. That is the kind of knowledge everybody needs to have.

If you let people out of the military without diagnosis or having that knowledge, it is going to be pretty hard to deal with, which is why we have the problem we have now.

So, my plan is for soldiers to be given treatment while on active duty within a company-size of fellow soldiers to keep that camaraderie there, along with their families who help in both diagnosis and treatment. I call it a Heroes Homecoming Camp. It is like a "de-boot camp" or a boot camp just before discharge where you can decompress and get an understanding of what went on and then get an adequate diagnosis and early treatment.

It seems to me that it would do a lot to remedying all the symptoms that we have seen in our society. You can't catch everybody, and you can't prevent every suicide. You would have to do followup at 3 months, 6 months or a year later. It seems to me we can help a lot of soliders before they are allowed out of active duty.

And I don't know if you want to comment on that as a concept.

Dr. RUDD. I think the one comment that I would offer is that the Air Force actually has had a model suicide-prevention program for a number of years and were able to significantly reduce suicide rates across several years.

And a part of that program is very much similar to what you are talking about, which is a universal change in how we think about mental illness, how we think about suicide prevention, an acceptance of the risk of mental illness from the very top and changing the community psyche about how we think about issues of illness and getting treatment when it is needed.

And that program could serve as a model and a very effective one.

The CHAIRMAN. I hope that Secretary Peake heard that.

Secretary Peake, you were the surgeon general of the Army. I just met with the current surgeon general and he was saying something about doing some education. I asked why he didn't promote

or bring out in public the generals or colonels who have had PTSD and have dealt with it to show in a public way, that they can be promoted to general. Show that they have been successful in the military, even having dealt with PTSD. That would be the way to take away the stigma and to give soldiers the confidence that it is okay. I mean, I would call it combat stress injury and get the whole "disorder" out of the name.

But that would be a real good example for soldiers, which would be faster than anything the Army or Marines are doing now to say, hey, it is okay because General X or General Petraeus says, "I have had PTSD, and it is okay."

I assume that would be a good thing for soldiers to see?

Dr. RUDD. Well, I think, actually, that is one of the things that the Air Force program did. They talked about these issues from the very top, about the importance and significance. It was emphasized from the top all the way through the system. And the focus shifted, and there is greater acceptability.

And when you have that, you have people willing to talk about their own personal issues, I think, with greater frequency. And that, sort of, demystifies and, to some degree, helps destigmatize the problem.

The CHAIRMAN. Thank you.

I appreciate you all spending the time, Dr. Rathbun and Dr. Rudd. You have helped us understand this, and we appreciate it very much. Thank you so much.

Our last panel is Dr. Michael Shepherd from the Office of Inspector General at the Department of Veterans Affairs. Dr. Shepherd is a physician with the Office of Health Care Inspections that will discuss the need for VA to continue moving forward with full implementation of the suicide-prevention initiatives from the Mental Health Strategic Plan.

Thank you, again, for taking the time.

STATEMENT OF MICHAEL SHEPHERD, M.D., SENIOR PHYSICIAN, OFFICE OF HEALTHCARE INSPECTIONS, OFFICE OF INSPECTOR GENERAL, U.S. DEPARTMENT OF VETERANS AFFAIRS

Dr. SHEPHERD. Mr. Chairman and Members of the Committee, thank you for the opportunity to testify on suicide prevention and the Office of the Inspector General report, "Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention."

My statement today is based on that report, as well as individual cases that the IG has reviewed and reported on involving veteran suicides and accompanying mental health issues.

In the process of these inspections, clinicians in our office have had the opportunity to meet with and listen to the concerns of surviving family members and to witness the devastating impact that veteran mental health issues and suicide have had on their lives.

In prior testimony, we have stressed the importance of the need for VA to continue moving forward toward full implementation of suicide-prevention initiatives from the strategic plan. In terms of some additional changes VA could make, we would offer the following observations.

Number one, community-based outreach. In our report, we noted that, while several facilities had implemented innovative, community-based suicide-prevention outreach programs, the majority of facilities did not report community linkages aimed at suicide prevention. Although facilities would need to tailor strategies to consider local demographics and resources, a system-wide effort at community outreach appears prudent.

Number two, timeliness from referral to mental health evaluation. In our report, we noted that, while most facilities reported at least three-fourths of those patients with moderate depression referred by primary care providers are seen within 2 weeks of referral, approximately 5 percent reported a 4- to 8-week wait. Because these patients are at risk of progression of symptom severity and development of suicidal ideation, VISN leadership should work with facility directors to ensure that, once referred, patients with moderate depression and those recently discharged from the hospital are seen in a timely manner at all VA medical centers.

Number three, co-occurring combat stress-related illness and substance use. Substance use may contribute to the severity of a concurrent mental health condition, such as major depression. The presence of alcohol may exacerbate impulsivity, and acute alcohol use is associated with suicide. Quality of life becomes duly impacted by anxiety and depressive symptoms and comorbid substance use issues. Augmenting services to equally address combat stress and comorbid substance use should, therefore, be given due consideration for inclusion in a comprehensive program aimed at suicide prevention.

Number four, enhanced access to mental healthcare. Treatments for mental health problems may necessitate multiple visits over time and may entail multiple modalities, including individual and group therapy, medication management and/or readjustment counseling. Therefore, efforts of enhanced patient access to appropriate treatment may help facilitate both patient engagement and the potential for treatment benefit.

For example, improved availability of mental health services at CBOCs may help mitigate vocational and logistical challenges facing some veterans residing in rural areas who otherwise may have to travel longer distances to appointments. In certain locations, availability of care during off-tour hours may increase the ability for some transitioning veterans to access mental health treatment while minimizing interference with occupational and educational obligations, and would be consistent with the recovery model for mental health treatment, which emphasizes not only symptom reduction, but also restoration of function.

Number five, facilitating early family involvement. Mental health symptoms can have a significant and disruptive impact on family and domestic relationships. Relational discord has been cited as one factor associated with suicide in active-duty military and returning veterans. The VA should consider efforts to bolster early family participation in patient treatment.

Lastly, coordination between VHA and non-VA providers. When patients receive mental health treatment from both VA and non-VHA providers, communication becomes an increasingly complex

challenge. Fragmentation of care is particularly worrisome in periods of patient destabilization or following hospital discharge.

The Office of Mental Health Services should consider development of innovative methods to facilitate flow of information for patients receiving simultaneous treatment from VA and non-VA providers within the constraints of relevant privacy statutes.

In addition, the Readjustment Counseling Service and Office of Patient Care Services should pursue further efforts to foster communication for patients receiving treatment services at Vet Centers and VAMCs or CBOCs.

Mr. Chairman, thank you again for the opportunity to testify. I would be pleased to answer any questions that you or other Members of the Committee may have.

[The prepared statement of Dr. Shepherd appears on p. 107.]

The CHAIRMAN. Thank you, Dr. Shepherd.

Mr. Rodriguez, do you have any questions?

Mr. RODRIGUEZ. On those five recommendations that you have made, do you know how the VA ranks in those areas?

Dr. SHEPHERD. Well, in terms of number one and number two——

Mr. RODRIGUEZ. Excuse me, six recommendations.

Dr. SHEPHERD. You mean from this statement?

Mr. RODRIGUEZ. Yes, from the statement. You mentioned community-based outreach, also timely referrals, between referrals. You mentioned enhancing mental healthcare. You mentioned family involvement in the last one, in terms of coordination with others.

Do you know how the VA might rank?

Dr. SHEPHERD. Sure. In terms of community-based outreach in the Mental Health Strategic Plan implementation report, we found that a minority of facilities were engaged in community linkages or use of the chaplaincy for community-based outreach.

In terms of timeliness from referral to mental health evaluation, rather than considering all waiting times, we focused on patients with moderate depression. Those with severe depression you would expect to be referred quickly. Those with minor, it would be debatable. And those with moderate depression or those who recently have been hospitalized and discharged, you would think of as a group that is an at-risk subpopulation that you would really want to hone in on. So we looked at their reporting on that, which showed that most did do a timely job in referring. But, in our view, even a small percent means there is more work to be done on that.

In terms of the other items, those reflect our observations from a series of cases involving individual patients that we have looked at.

Mr. RODRIGUEZ. Okay. Thank you.

The CHAIRMAN. Thank you.

Mr. Stearns, any questions?

Mr. STEARNS. Thank you, Mr. Chairman.

Dr. Shepherd, as mentioned, there are six recommendations here. So you say if these six recommendations were implemented, the problem would be totally solved, partially solved, would move to a better conclusion? What is your feeling?

Dr. SHEPHERD. I am not saying the problem would be solved. I am saying that it is our feeling that these recommendations would

help move the ball forward, in terms of additional considerations that may help with suicide prevention.

Mr. STEARNS. Additional considerations that would help with suicide prevention.

Dr. SHEPHERD. Right.

Mr. STEARNS. Who asked you to do the survey? I wasn't clear.

Dr. SHEPHERD. Originally, we were asked by this Committee. Specifically, we were asked by Congressman Michaud.

Mr. STEARNS. Okay. How long ago?

Dr. SHEPHERD. The report came out in May 2007. The request was in the late fall of 2006.

Mr. STEARNS. 2006, okay. So it took you, what, 2 years to do this?

Dr. SHEPHERD. No, about 6 months.

Mr. STEARNS. 6 months, okay. And were you the prime person, or were there other people?

Dr. SHEPHERD. I was the prime person, and then there were a couple other people.

Mr. STEARNS. Did it ever occur to you while you were doing this that DoD has a component of this? That is, at the point the DoD has the soldier, if they don't do anything, and then the soldier comes to the VA, perhaps it might be too late, because the soldier will not be as obligatory as he was still in the Department of Defense and still in regular duty. Had that ever occurred to you during this study?

Dr. SHEPHERD. Yes. And I would agree with that sentiment, we don't, obviously, provide oversight to the DoD, but maximizing intervention in both DoD and VA would be ideal.

Mr. STEARNS. I know you didn't look and you weren't requested to look at DoD. But if you did the study, you are saying when you came up with your six recommendations, it occurred to you that there is responsibility for the Department of Defense here?

Dr. SHEPHERD. Yes. Again, I think that it is a joint effort.

Mr. STEARNS. It is a joint effort. And would you say that is 50/50 or maybe the predominance of this initial, shall we say, solution to the problem would be at the Department of Defense?

Dr. SHEPHERD. I honestly don't know how I would partition that.

Mr. STEARNS. Dr. Shepherd, would you describe in detail the actions that the VA has taken to address the recommendations made by the May 10, 2007, IG report and perhaps what challenge exists?

Dr. SHEPHERD. Sure.

One of our recommendations in the original report was basically making arrangements for 24-hour crisis mental healthcare availability. And one of the responses to the report, VA did establish a suicide-prevention hotline based out of Canandaigua, New York. And I have visited that hotline in person and seen the folks working there in action, and have to applaud the work they are doing up there.

We suggested that they needed to develop education for non-clinical first-exposure personnel, such as clerks, on suicide prevention. VA subsequently developed a CD and training module, which they began, I believe, in December to disseminate.

We asked them to develop a similar module for clinicians. My understanding is that module and development has not occurred yet.

We had recommended that sustained sobriety should not be a barrier to treatment in specialized mental health programs for returning combat veterans. And subsequent to our report, the Deputy Under Secretary for Health Operations and Management did put out a directive basically stating—I am going to put this in my words—that substance use issues should not keep people from getting appropriate mental healthcare. Because, in the past, there were instances where people would say, well, someone needs to be completely sober before we can treat them. And so that directive did occur to address that.

Mr. STEARNS. So would you say four of the six have been implemented, it sounds like?

Dr. SHEPHERD. Yes, four of the six have been implemented.

Mr. STEARNS. Okay. And have you seen any appreciable difference since that, or has there been any feedback to say, okay, these six recommendations, we have done four of them, which is four out of six, is two-thirds, 67 percent have been done, and we have noticed a dramatic difference? Have you heard anything?

Dr. SHEPHERD. I haven't, but it is also too early a time horizon to tell. I think when you are——

Mr. STEARNS. Well, it has been a year.

Dr. SHEPHERD. It has been a year. And we have heard, again, very good feedback about the number of veterans calling the suicide hotline.

Mr. STEARNS. So when you are making these recommendations, you put in place so that you get feedback and know how it is working on your recommendations?

Dr. SHEPHERD. Yes. We have gotten feedback that a lot of the veterans are obviously calling the hotline and utilizing that as an outreach tool.

In terms of ultimate impact, because of numbers in terms of suicide, really would take a longer time horizon to fully appreciate.

Mr. STEARNS. Well, I can just tell you, in the private sector, if recommendations came that we all agreed upon, they would be put in place about a year, and everybody would move on and have a measurement, a metric to determine how well they had been implemented.

So the fact—you are saying that two of them have not been implemented, right?

Dr. SHEPHERD. Right, and that is concerning to us. And as I have stated earlier, we continue and have continued to ask them to move forward.

Mr. STEARNS. Okay. My time has expired.

Do you think it is because of lack of money, or why haven't these two been implemented?

Dr. SHEPHERD. I am not sure why they haven't been implemented.

Mr. STEARNS. Do you want to venture a guess?

Dr. SHEPHERD. It would be a pure guess.

Mr. STEARNS. No one has come back to you and said, this is a problem why haven't we done these?

Dr. SHEPHERD. No.

The CHAIRMAN. I am sorry, which two?

Mr. STEARNS. The last two.

All right. Well, I think my time has expired, Mr. Chairman. But I think the point is, it has been a year since the recommendations. Two of them have not been implemented. We can't even find out whether it is because of money or because of personnel. Dr. Shepherd can't even give us an idea——

The CHAIRMAN. What are you trying to get at? What is your conclusion?

Mr. STEARNS. Well, I am not a witness here today, Mr. Chairman, but I sure am here to try to find out. And I am just a little concerned, after a year, why these two haven't been implemented. And I would think that the IG could tell us that the feedback they get—they don't have the money, the personnel, or is it just a low priority?

The CHAIRMAN. Let me ask you the procedure on these reports. Do you have to get another request to report on the follow-up?

Dr. SHEPHERD. No. We——

The CHAIRMAN. Or do you follow it up automatically? Is the VA given a certain amount of time to respond?

Dr. SHEPHERD. The VA is given a certain amount of time to respond to the initial report. And then, subsequent to the response, I believe it is quarterly, we have an office within the IG that requests further follow-up. The next one is due mid-June. And then I look at the responses that are sent to that office, in terms of whether I think they are legitimate responses or not.

In addition, since the issuance of this report, I have had subsequent conversations with various people, for instance, I met with someone from Ann Arbor about 2 months ago, wanting to know where things are at in terms of one of the initiatives they were working on. And I have visited Canandaigua.

So, as a process, quarterly, we have an office that does do follow-up. And that is passed through me to make sure that if they say, we are going to do it and we are going to do it by blank, then I think that is reasonable, or I may say I don't think that is reasonable.

[The following was subsequently received from VHA:]

The Office of Inspector General re-opened the following recommendations:

Recommendation 2: The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all non-clinical staff who interact with veterans receive mandatory training about responding to crisis situations involving at-risk veterans; this should include suicide protocols for first contact personnel.

VHA Update 8/2007: Planning for facility based training in suicide prevention for clinical and non-clinical staff is proceeding with full rollout anticipated for no later than October 31, 2007. Suicide Prevention Coordinators have been identified at each VA Medical Center to support the implementation of these educational efforts locally. In addition to monthly conference calls, these providers attended a special training conference August 21–23, 2007. This Conference included a protocol for Guide Training to assist nonclinical personnel in appropriate identification and management of veterans who present with suicidal ideation or behavior. VA will hold a national Suicide Prevention Awareness Week (September 9–15, 2007) that will feature educational presentations for clinical and non-clinical staff from VACO and the Canandaigua Center of Excellence in Suicide Prevention.

Update 3/6/2008: The National Suicide Prevention Center of Excellence in Canandaigua has developed and distributed a standard suicide awareness training package to the field through the facility Suicide Prevention Coordinators. A memo from the Under Secretary for Health has been drafted, and is concurrent for release through the office of the Deputy Under Secretary for Health for Operations and Management, that will task each facility with developing their own ongoing train-

ing, awareness and communication plan that includes appropriate procedures/suicide protocols, and community resources for all first contact personnel in both clinical and non-clinical personnel. It is expected that all frontline staff complete the training by September 1, 2008. Facility Suicide Prevention Coordinators are required to report compliance with this training monthly to the National Suicide Prevention Coordinator.

Update 5/9/2008: Mandatory training for non-clinical staff is in place. Monitoring of the training and documentation of compliance is currently through forwarding of sign-in sheets to the National Suicide Prevention Coordinator. Processes for use of the Learning Management System for documentation are being developed.

Recommendation 3: The Acting Under Secretary for Health should ensure that VISN directors ensure that facility directors ensure that all healthcare providers receive mandatory education about suicide risks and ways to address these risks.

VHA Update 8/2007: Educational protocols for clinicians as well as non-clinicians are under development for implementation no later than October 30, 2007, and full compliance by April 30, 2008. The facility Suicide Prevention Coordinators will be critical in ensuring implementation and compliance across the system.

Update 3/6/2008: A "State of the Art" conference on Suicide Awareness and Intervention Training was held in Canandaigua on March 5 and 6, 2008 to finalize the content used in development of a mandatory "Suicide Risk and Treatment" training program for VHA clinicians. Final program content will be forwarded to the Employee Education System (EES) by April 1, 2008, who expect to complete development of the on-line standardized training program by September 30, 2008. Once the program has been fully implemented, clinicians will be given 120 days to complete. Full compliance with the training requirement is expected to be completed by January 31, 2009.

Update 5/9/08: Training activities are in place. The remaining issue is to ensure accountability of participation of all healthcare providers. A Directive to this effect is in the concurrence process; monitoring of completion will be accomplished through VA's Learning Management System (LMS).

The CHAIRMAN. Thank you.

The first thing you did mention was the National Call Center and the Secretary provided us with the pamphlet advertising this. It sounds like a lot of people are calling. I don't know if Mr. Stearns was here when Mr. Moran from Virginia was talking about the concern of many veterans dealing with the Federal Government.

I know, Mr. Stearns, that you always say, "Well, the Federal Government can't do this, and besides, people aren't worried about it." Mr. Moran made the point that many veterans may not want to interact with the Federal Government, as represented by the VA, and that this kind of advertisement may work with a certain percentage but it is probably also turning off a certain percentage.

He was arguing—and I think we need to look at his bill—for a hotline to be run by peers especially, but probably working with a nonprofit, for both privacy and the understanding that they don't want to deal with the Federal Government anymore. They don't trust them. I think there is a point there.

I don't know if there is a way to even look at that. Have you been trying to make any study about people who would call the hotline center? Of course, you can't ask anybody who committed suicide, but maybe the veterans who have attempted suicide.

Dr. SHEPHERD. No, I haven't looked at or studied who the callers are. I do think that Congressman Moran's suggestion and the existing hotline are not necessarily mutually exclusive, and maybe there could be a way to combine ideas.

The CHAIRMAN. Exactly. I think you are right. Mr. Moran stimulated me to read this, and I know Mr. Stearns would use this in another context sometime, but, "Pick up the phone if you are expe-

riencing an emotional crisis and need to talk to a trained VA professional."

I mean, there are a lot of folks where that would be the last thing they would do. You are dealing with, again, a bureaucracy or the Government, and I don't think that kind of appeal would work.

Dr. SHEPHERD. And, again, talking about combining ideas, I believe Morris Armstrong is a veteran who started the Vet-to-Vet model in New Haven, which I believe is a program that follows a Vet-to-Vet model. But he does work with VAMCs and VA facilities. And so, following that model of a joint non-VA and VA venture, perhaps is a way to think about it.

The CHAIRMAN. I think you are right; they are not mutually exclusive. I was hearing from the VA that this is their outreach; however, we need to look at it from the point of view of someone who, by their very problem, is suspicious of an organized bureaucracy.

Dr. SHEPHERD. Sure. And that is why also as I said in my statement, we would encourage all forms of aggressive outreach, including, for instance, one center invites local clergy in and gives them information about the facility and what the services are, so that if a parishioner or relative comes up to the reverend and says, "My son is having trouble," they know where to refer them or how to get them help. And I think innovative outreach ideas like that should continue to be pursued.

The CHAIRMAN. Well, again, thank you very much.

Remind me, on the quarterly reports, are they automatically sent to Congress?

Dr. SHEPHERD. No, I don't believe they are. But that is a statement out of ignorance, so I will have to check on that.

The CHAIRMAN. I hope they are. I think we have talked about this with the IG before, that the reports should come to us, we should not have to ask about what is going on.

We thank you for your contribution, and we look forward to your continuing oversight.

[The Chairman and the Ranking Member are provided quarterly updates on the status of open recommendations. The Committee receives copies of Office of Inspector General reports as they are released.]

Dr. SHEPHERD. Thank you, Mr. Chairman.

The CHAIRMAN. And unless there are further questions, this hearing is adjourned.

[Whereupon, at 2:58 p.m., the Committee was adjourned.]

APPENDIX

Prepared Statement of Honorable Bob Filner, Chairman, Full Committee on Veterans' Affairs

Good morning and welcome to the Committee on Veterans' Affairs' hearing on "The Truth about Veterans' Suicides."

On December 12, 2007, this Committee held a hearing entitled "Stopping Suicides: Mental Health Challenges within the Department of Veterans Affairs." Nearly five months later, we are again holding a hearing on the tragic issue of suicide among our veterans and what the VA is doing to address what is clearly an epidemic. In November of last year, *CBS News* aired a story entitled "Suicide Epidemic Among Veterans." On April 21, 2008, *CBS News* aired a story "VA Hid Suicide Risk, Internal E-Mails Show."

The first step in addressing a problem is to understand the scope and extent of the problem. In the case of the VA and the epidemic of veteran suicides, either the VA has not adequately attempted to determine the scope of the problem, which is an indictment of the VA's basic competence, or the VA knows the extent of the problem, but has attempted to obfuscate and minimize the problem to veterans, Congress, and the American people, which is an indictment of the leadership of the entire Department.

In December, Dr. Katz, in testimony before this Committee, stressed a low-rate of veteran suicide, stating that "from the beginning of the war through the end of 2005 there were 144 known suicides among these new veterans." In responding to the figures used by CBS, Dr. Katz stated that "their number for veteran suicides is not, in fact, an accurate reflection of the rates of suicide."

Either Dr. Katz knew that the CBS figures were indeed an accurate reflection of the rates of suicide at that hearing or had a sudden epiphany only days later.

In an internal email, Dr. Kussman, on December 15, 2007, referring to a newspaper article, writes that "18 veterans kill themselves every day and this is confirmed by the VA's own statistics. Is that true? Sounds awful but if one is considering 24 million veterans." That same day, Dr. Katz responds: "There are about 18 suicides per day among America's 25 million veterans. This follows from CDC findings that 20% of suicides are among veterans it is supported by CBS numbers."

In February of this year Dr. Katz sends an email stating "Shh!—Our suicide prevention coordinators are identifying about 1000 suicide attempts per month among the veterans we see in our medical facilities. Is this something we should (carefully) address ourselves in some sort of release before someone stumbles on it?"

There was silence from the VA.

Armen Keteyian, Chief Investigative Reporter for *CBS News*, characterized the VA's internal emails as "a paper trail of denial and deceit—a disservice to all veterans and their families—[that] has rightfully been exposed."

In an April 24, 2008, newspaper article, a VA spokeswoman stated that "there are an estimated 1,000 suicide attempts per month among the 7.8 million veterans treated by Veterans Affairs, she said."

The VA spokeswoman may have misspoke, or this could be yet another example of the VA's attempt to hide the true magnitude of the problem. In the VA's most recent budget submission, the VA claims it will treat 5.2 million veterans this year, and 5.3 million next year—2.5 million fewer veterans than the 7.8 million quoted in the newspaper article.

In April, a *Dallas Morning News* editorial, describing a "recent spike in suicides among psychiatric patients treated at the Dallas VA hospital" stated that "descriptions of how four veterans committed suicide in four months—prompting the psychiatric ward to close—suggest that patients went to conspicuous and time-consuming lengths to end their own lives. There seemed to be ample time for staffers to stop them had they been doing their jobs better."

The RAND Corporation, in a recently published study entitled the "Invisible Wounds of War," found that since October 2001, approximately 1.6 million U.S.

troops have deployed, and that "upward of 26 percent of returning troops may have mental health conditions." The study estimated that approximately 300,000 of those deployed suffer from PTSD or major depression. Among those with PTSD or major depression, only half had seen a mental health provider or physician to seek help in the past 12 months, and among those who had sought help, "just over half received minimally adequate treatment."

The study defined minimally adequate exposure to psychotherapy as consisting of at least eight visits with a mental health professional such as a psychiatrist, psychologist or counselor in the past 12 months, with visits averaging at least 30 minutes. How does VA mental health care treatment stack up against this definition of minimally adequate care?

The RAND study also found that "the VA too faces challenges in providing access to OEF/OIF veterans, many of whom have difficulty securing appointments, particularly in facilities that have been resourced primarily to meet the demands of older veterans.

"Better projections of the amount and type of demand among newer veterans are needed to ensure that the VA has the appropriate resources to meet the potential demand. New approaches of outreach could make facilities more acceptable to OEF/OIF veterans."

I think many of us believe that the VA health care system has been pushed to the edge in dealing with the mental health care needs of our veterans. And, I believe that we are witnessing either an inability to address this problem, or a purposeful attempt to minimize the problems faced by veterans and the VA and sweep the epidemic of veteran suicides, and the mental health care needs of our returning servicemembers, under the rug.

So this morning we are going to attempt to get a better idea of the scope of this epidemic, and what the VA is doing to respond to it. What specific steps has the VA taken since December, steps not previously planned before December, to get a better idea of the scope of the problem, and what has it done to begin to address the problem?

Finally, I believe we must also seek real accountability from the VA, and, Mr. Secretary, we look to you to provide that accountability.

Prepared Statement of Honorable Steve Buyer,
Ranking Repubican Member, Full Committee on Veteran's Affairs

Thank you Mr. Chairman.

The loss of a single veteran to suicide is a tragedy.

I am sure that like me, every member of this committee seeks to identify and eliminate contributing factors, and to prevent one more service-member or veteran from taking his or her own life. I want to thank Chairman Filner for continuing hearings to discuss this issue and to help those at risk.

A number of questions were raised during our hearing last December regarding the validity of data on the number of veteran suicides. Such information is vital to understanding the scope of the problem, as well as identifying risk factors and providing better prevention and treatment protocols.

Chairman Filner joined with me in a letter I wrote to VA, DoD, and CBS requesting their respective data and how it was formulated. CBS failed to respond.

DoD acknowledged the letter, yet I am still awaiting a further reply.

Secretary Peake was the only one to provide a thorough response, which was about two separate studies VA is conducting.

These studies may provide some useful information, but they are limited to data on suicide rates among veterans in the VA health care system. VA must have a better method for the systematic collection and tracking of veteran suicide data. It is also important to find ways to reduce the stigma associated with mental health care and encourage more servicemembers to seek treatment when it is needed.

During our last hearing, I asked VA to be proactive and reach out to soldiers and their families during pre-mobilization—and to start with the 76th Indiana Brigade Combat Team as it prepared to deploy to Iraq. I was very pleased that VA came as requested and participated in the outreach event.

I stood with 3,400 Indiana soldiers at the RCA dome on January 2 for the formal send-off ceremony. Along with about 20,000 friends and family members was VA staff from the Indianapolis VA Medical Center, Regional Office, and Vet Center.

VA reported that about 1,700 families received information regarding VA benefits and services, including mental health services and Information on Post Traumatic Stress Disorder (PTSD) and Suicide Prevention.

VA also followed-up with subsequent briefings while the Brigade was at Ft. Stewart, Georgia for training.

As the Brigade marched to war, I believe they left with a clear impression that VA will be available to provide support and assistance to their family during their deployment and will be there when they return from Iraq. There was very positive feedback regarding the VA presence at these events.

Secretary Peake has taken decisive actions to meet the increased needs for mental health services. For example, on May 1st, VA began contacting nearly 570,000 recent combat veterans about VA medical care and benefits.

These veterans were either injured in Iraq or Afghanistan or discharged from active duty, but have not yet contacted VA.

The Secretary has also directed the creation of an independent workgroup to assess VA's suicide prevention programs.

I want to thank Secretary Peake and the other witnesses for their participation today and I look forward to their testimony.

In the end, I hope that this hearing will drive home the message to our Nation's men and women who serve, and to their families, that if you are in need of help, care is available, treatment works and there is a road to recovery.

Prepared Statement of Honorable Harry E. Mitchell

Thank you Mr. Chairman.

In November, *CBS News* brought some shocking, and critically important information to light. Not just that those who served in the military were more than twice as likely to take their own life in 2005 than Americans who never served . . . or that Veterans aged 20–24 were killing themselves when they returned home at rates between two-and-a-half to four times higher than non-vets the same age, but that the Department of Veterans Affairs wasn't keeping track of veteran suicides nationwide.

In December, we held a hearing to find out why.

And, Mr. Chairman, I don't think there is anyone who attended that hearing who will ever forget it.

We heard from Mike and Kim Bowman, whose 23-year-old son, Tim, survived a year of duty in Iraq, only to come home and take his own life.

Mr. Bowman warned us that our troops are coming home to an, "understaffed, under-funded, under-equipped VA mental health system" that imposes so many challenges, many are just giving up.

And so, when Dr. Katz insisted at that hearing, repeatedly, that the VA had all the necessary resources to reach all veterans at risk for suicide and make treatment available to them, I was skeptical.

How could Dr. Katz be so sure that there weren't any requests for additional resources sitting somewhere, within the vast VA system, that had gone unfulfilled? Was he absolutely certain that there were no pending request for an additional mental health counselor? Or for extra gas money to enable a VA employee to drive somewhere to conduct outreach?

As Chairman of the Subcommittee on Oversight and Investigations, I felt I had a responsibility to make sure.

So I asked the VA to double-check.

I asked them take a look at their records, and send us any documents relating to any requests for additional resources that had gone unfulfilled or under-fulfilled.

My thought was, if we could find out what the VA needs to address this problem, we could get to work make sure they get it.

More than 4 months later, however, all I've gotten are excuses, complaints, and, most recently, a suggestion that I, "go file a Freedom of Information Act request."

That's not just an insult to me, it is an insult to this Committee, and to our veterans.

I've tried to be reasonable. I've tried to work with Secretary Peake's office. But, Mr. Chairman, my patience is at an end.

I've given the Department until Friday to finally produce the documents I requested. If they do not, Mr. Chairman, I want you to know that I will be asking you to pursue a subpoena.

I yield back.

Prepared Statement of Honorable Stephanie Herseth Sandlin

Thank you to everyone for being here. I congratulate Chairman Filner and Ranking Member Buyer for holding today's hearing to examine and identify mental health challenges within the Department of Veterans Affairs healthcare system and the problem of suicides among veterans.

As the wars in Iraq and Afghanistan continue to produce a new generation of veterans, it is important that Congress evaluate the impact of these conflicts on the mental well-being of returning servicemembers. We must closely evaluate the ability of the VA to meet the mental healthcare demands placed upon it.

While the VA offers a wide array of mental health programs, there continues to be room for improvement. In particular, I believe we must do more to meet the mental healthcare needs of our rural veterans—who often must travel long distances to reach VA healthcare services.

I am pleased that we have the opportunity to hear from today's panelists and am grateful to have the opportunity to hear their suggestions and answers to the critical issues involved. I look forward to hearing their testimonies.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

Prepared Statement of Hon. Shelley Berkley

Mr. Chairman,

I am extremely discouraged that we are here today holding a hearing on the VA's cover-up of veterans' suicide attempts. I find it absolutely appalling that anyone would try to conceal these numbers—preventing us from addressing the root of the issue of suicide among veterans. We must provide sufficient mental health services to our veterans in order to address the needs facing our servicemembers returning from Iraq and Afghanistan.

Nationally, one in five veterans returning from Iraq and Afghanistan suffers from PTSD. Twenty-three percent of members of the Armed Forces on active duty acknowledge a significant problem with alcohol use. It is vital that our veterans receive the help they need to deal with these conditions.

The effects of substance abuse are wide ranging, including significantly increased risk of suicide, exacerbation of mental and physical health disorders, breakdown of family support, and increased risk of unemployment and homelessness. Veterans suffering from a mental health issue are at an increased risk for developing a substance abuse disorder.

As servicemembers return from combat, it becomes increasingly important to provide them with the mental health services they need to readjust to society and deal with the invisible wounds of war.

A constituent of mine, Army Pfc. Travis Virgadamo returned home from Iraq on leave. During this trip, he told his family he had been so frightened, he had sought and received psychiatric counseling from the military in Iraq. He also received additional counseling during that trip home in late July. The Army's response was to treat him with Prozac. After returning to Iraq, Virgadamo was placed on suicide watch and the bolt from his rifle was taken away, making the weapon useless. He was also given a desk job. After Virgadamo was cleared for combat again, they gave him back the bolt to his rifle. Hours later, he killed himself.

Even though he was still on active duty (placing him under DoD jurisdiction), this incident only reinforces the fact that we need to place more emphasis on mental health of servicemembers in or returning from combat.

Prepared Statement of Honorable Jeff Miller

Thank you, Mr. Chairman.

There is no doubt that suicide under any condition is a tragedy. Suicide that could have been prevented is even more so, and we here on this Committee have a duty to provide the best services for a targeted group: our Nation's veterans. These brave men and women spend countless hours, days, and years defending liberty for us here at home, and it is imperative that we provide them the best services upon their return from combat.

As we learn more each day about mental health, it is imperative that we apply these findings toward helping those who suffer, especially when it comes to preventing suicide. To be sure, veterans have a unique set of factors that may lead to

an increased suicide rate. None of us here doubt the extreme rigors of combat and the toll it can take on a person. However, with no single factor causing suicide, it is a difficult and ongoing process to identify those most at risk and those most likely to attempt suicide.

While this Committee cannot identify and eliminate every factor that may contribute to suicide risk, especially those arising from the civilian world, we certainly can work toward addressing those arising from service, including PTSD and substance abuse. I look forward to hearing what steps have been implemented by VA, what progress has been made, and what steps they will take in the future. Our soldiers gave too much to not receive the best treatment across all fronts upon their return home. A smooth transition to civilian life and easy access to care must be ensured for them, and this can be aided with a proactive approach by the VA to see that they have everything they need before it is too late.

I yield back.

Prepared Statement of Honorable Ginny Brown-Waite

Thank you Mr. Chairman.

It is no secret that the Department of Veterans Affairs is seeing an increase in cases of Traumatic Brain Injury and Post Traumatic Stress Disorder among *OEF/OIF* veterans. While these conditions may not be as visible as an amputated leg or gun shot wound, they can be just as debilitating. Left untreated, these conditions may lead to the veteran committing suicide.

To address these growing concerns, this Committee approved and the President signed into law the Joshua Omvig Veterans Suicide Prevention Act. The act requires the VA to establish a comprehensive program for suicide prevention among veterans. Signed into law in November 2007, this act will dramatically affect the way the VA handles veterans with suicidal tendencies.

Unfortunately, a majority of veterans with conditions that lead to suicide do not seek help for these conditions. That is why the outreach section of the Joshua Omvig Veterans Suicide Prevention Act is so important. The VA must reach out to veterans, their families and the organizations that help veterans to ensure this nation's veterans receive the care they deserve.

I look forward to hearing from all of the witnesses here today about what is being done and what still needs to be done to minimize the number of veteran suicides. Specifically, I look forward to hearing from Secretary Peake as to the implementation of the programs contained in the Joshua Omvig Veterans Suicide Prevention Act and the impact they have made thus far.

Thank you, Mr. Chairman.

Prepared Statement of Honorable Timothy J. Walz

Mr. Chairman, Ranking Member Buyer, Members of the Committee, thank you for the opportunity to speak. And thank you to the witnesses who are here today.

I have been troubled by recent, credible allegations that the U.S. Department of Veterans Affairs has been withholding important information about the rates of suicides and suicide attempts among America's veterans. I wrote to Chairman Filner requesting a hearing, and I am very pleased that we are having one. We must reach out to our veterans—young and old—to make sure they know where they should go for help if they are feeling suicidal. The VA should get all of the resources and tools it needs to care for our veterans. The reason I called for an investigation is so that we can get our facts straight, and from there, we'll have a better sense of whether new legislation is needed to address this problem . . . or just new leadership on these issues. The VA must be forthcoming about what it knows about suicide attempts among veterans in the VA system and overall, as well as about suicides. Only if we have accurate information can we act decisively to address this troubling trend among veterans.

I have been very pleased to work with the fine people at the VA in Minnesota to ensure that our veterans continue to receive world-class healthcare at VA facilities. When the latest information about the VA was disclosed, I wrote to the head of VISN 23 requesting information on mental healthcare for Minnesota's veterans and statistics on suicide and suicide attempts among them. He and his staff have worked diligently to gather the facts that I had requested, and I appreciate that. I have not yet seen the information, as it came back from VA in Washington only this morning, right before this hearing began, but I look forward to reviewing it

carefully so the people of the First District and all of Minnesota can be sure that we are doing all we can to help Minnesota's veterans.

I commend CBS NEWS for bringing important facts to light, fulfilling the press' duty to the public and its right to know. Internal VA e-mails obtained by CBS show a concerted effort by Dr. Katz and others at the VA to minimize the extent to which the public would learn facts unflattering to the VA and its ability to serve veterans in need of mental health assistance. In February of this year, Dr. Katz sent an e-mail to Ev Chasen, VA's Chief Communications Officer, with the subject: "Not for the *CBS News* Interview Request." In the e-mail exchange, Dr. Katz and Ev Chasen discussed how to deal with the VA's own data showing alarming rates of suicide attempts—1000 per month—among veterans in the VA medical system itself. They were clearly trying to minimize the publicity the information might receive. The spirit of Dr. Katz's e-mail was characterized by its first line, stating, "Shhh!"

In December of 2007, the House Veterans' Affairs Committee held a hearing on the topic at which Dr. Katz testified. At that hearing, he at times sought to cast doubt on a recent CBS report about the numbers of suicides among veterans. At other times in the hearing, he appeared to confirm the numbers CBS was reporting, but did so in a way that was not clear, parsing words and numbers. In an e-mail just three days after that hearing, also published by CBS, Dr. Katz wrote an e-mail to a colleague at the VA which made clear that VA's own numbers on the rate of suicide among veterans were in line with the CBS report. Reviewing that transcript is a disturbing experience, because Dr. Katz and others seemed more interested in distracting from the issue at hand by bashing the news media, than in informing the Committee, the press and the public about this very important matter so that we can address it in as effective a way as possible.

I am pleased that we are having this follow up hearing today, so that we may gain all the facts and thereby work to prevent suicide among our veterans.

Prepared Statement of Honorable James P. Moran, a Representative in Congress from the State of Virginia

- Mr. Chairman, Members of the Committee, I thank you for holding this important hearing and I commend your work that you've already undertaken on behalf of our Nation's veterans.
- Most of us understand from the media reports and anecdotal accounts from our constituents that suicide among our veterans is one of the most pressing issues that we should address.
- We know that the new generation of returning soldiers is more vulnerable to the immediate psychological wounds of war that lead to suicide. 20 percent of our veterans from Iraq and Afghanistan show signs and symptoms of PTSD, depression and anxiety. This number increases to 50 percent for soldiers with multiple tours or inadequate time between deployments.
- One of the measures that we can take to prevent suicide is to provide a voice of understanding in their time of need. The "Veterans Suicide Prevention Hotline Act" would create a stand-alone 24-hour National toll-free hotline to assist our Nation's veterans in crisis.
- The key is that *this hotline* would be staffed by veterans, trained to appropriately and responsibly answer calls from other veterans. These volunteers would be trained in active listening and crisis de-escalation respond to a variety of crisis calls.
- I understand that the Department of Veterans' Affairs has developed a veterans' option off of the National Suicide Hotline. While I applaud their effort to finally address this problem, I believe that there are key differences in the approach.
- Sometimes a veteran doesn't want to talk to a doctor—he or she wants to talk to someone who's got a real-life perspective of what's happening. This "cultural competency" that a fellow veteran provides can make a real difference in crisis counseling.
- Moreover, soldiers with mental illnesses face societal stigma associated with seeking care through the VA. Research from the Air Force's suicide prevention efforts suggest that fear of "the system", of an unfriendly mental health establishment, and of potential job-related consequences keep many active duty soldiers and recent veterans from seeking the care they need.
- I am also concerned that the VHA is already overburdened by their many healthcare responsibilities to provide a top-notch hotline effort. Stretched budgets and staffing shortages may not be able to meet the challenges of many re-

turning veterans as our Nation redeploys from Iraq in the future. A non-profit organization dedicated to suicide prevention would be able to provide focus, stability and commitment that the VA may not.

- To conclude, our vets deserve as much support when they return from combat as they receive while in battle. Too many of our veterans are struggling to make the difficult adjustment back to society and need someone they can talk to, someone who's walked a mile in their shoes. This legislation will offer that caring voice at the end of the line.
- I applaud the Committee for their work on this effort.

Prepared Statement of Honorable James B. Peake, M.D., Secretary, U.S. Department of Veterans Affairs

1. ISSUES RELATED TO COLLECTING SUICIDE DATA

The purpose of this testimony is to provide information on the issues related to veterans suicide: what VA knows, including the sources of information we use; what we do not know, and what we intend to do about that problem; and what we have been doing to directly address the issues of suicide from a clinical perspective, and how we are expanding our outreach, even as we seek better ways to measure the problem.

The language used to talk about suicide is complex. Suicidal behavior exists along a continuum; from thinking about ending one's life, to developing a plan to do so, to non-fatal suicidal behavior, to actually ending one's own life. The Centers for Disease Control (CDC) has come up with some definitions of suicidal behavior which the Department of Veterans Affairs (VA) has adopted.

CDC has defined suicidal ideation as having thoughts of harming or killing oneself; a suicide attempt is a non-fatal, self-inflicted destructive act in which a person has either an explicit or an inferred intent to die; self-inflicted injuries are suicidal and non-suicidal behaviors such as self mutilation; and suicide itself refers to a fatal self-inflicted destructive act in which there is an explicit or an inferred intent to die.

Suicide is a relatively infrequent act. Although suicide is the 11th leading cause of death among Americans of all ages, when studying any group over short periods of time the number of actual suicides will be low. Only very large studies conducted over long periods of time allow the accumulation of enough observations to make meaningful comparisons.

Suicide risks vary by age, gender and other factors. For Americans in general, the highest rates of suicide are among older men, but middle-aged veterans appear to take their own lives in greater proportions than their elders.

Suicides often occur in close proximity, especially after media attention. This kind of behavior is called "copycat behavior," or the "Werther effect," after a wave of suicides in 18th century Europe following the publication of a book by Goethe. It can be difficult to tell when a cluster represents a temporary trend, or a sustained trend.

Official suicide rates based on death certificate data can be incomplete. There are regional differences in how suicides are defined; how ambiguous cases are classified; and how thoroughly coroners or medical examiners investigate causes of death. In some areas religious traditions, life insurance policies, or legal sanctions may lead to underreporting. The increased awareness of the relationship between mental illness and suicide may cause an apparent increase in the reported number of suicides—without the rates actually differing.

And finally, reconstructing the events leading up to a death is difficult. Death certificates provide only a limited amount of information about actual causes of death, so researchers need to contact those closest to the victim to understand the true circumstances of death, and the factors that contributed to a death. Family members and others can often provide inaccurate or incomplete information.

The way researchers determine incidences for suicide is to express the number of suicides in a population per hundred thousand people per year. Because suicide rates vary by age, with both older and younger people at higher risk, any rates that attempt to make comparisons across different populations by year must be adjusted to allow for accurate comparisons. One way to do so is to look at age specific rates of suicides and compare them to the U.S. population as distributed by age. CDC uses the U.S. population census figures for 2000 to do this.

Another method of adjustment is called the standardized mortality ratio. This ratio compares the number of observed deaths in a defined group with the number of deaths that would be expected if that group had the same age-specific rates as a standard population.

Finally, there are sophisticated statistical techniques which can be used to derive a relative risk that take into account multiple characteristics of individuals, such as gender, race and ethnicity, medical conditions and other factors.

Each of these methods of adjustment has their strengths and their weaknesses. Each is potentially misleading when comparing populations with very different age or gender distributions. A careful analysis of suicide rates that is age and gender specific is both necessary and appropriate.

Because of this, VA has long subjected its own data, that of the Department of Defense, and data from nationally accepted statistical sources to careful and painstaking analysis to obtain the truth about veterans' suicide.

A suicide rate is normally calculated by describing the number of cases occurring in a defined group over a specific period of time. These are called incidences of suicide, and to avoid expressing incidences as very small fractions, suicide rate is typically expressed in terms of the number of suicides per 100,000 persons per year.

To make accurate comparisons of suicide rates, such as trends over time or comparisons among veterans and non-veterans, three important elements are needed. First is an accurate count of events for both groups, called the numerator. Second is an accurate estimate of the total population at risk, called the denominator. And third, as already mentioned, there needs to be an adjustment for age and gender differences between populations.

2. HOW VA COLLECTS SUICIDE DATA

VA relies on multiple sources of information to identify deaths that are potentially due to suicide. This includes VA's own Beneficiary Identification and Records Locator Subsystem, called BIRLS; records from the Social Security Administration; and data compiled by the National Center for Health Statistics in its National Death Index.

This is a painstaking and difficult process for VA and for others, best illustrated by the fact that suicide data from the Centers for Disease Control and Prevention are available only through 2005. Calculating suicide rates specifically for veterans is made even more difficult by the fact that the National Death Index does not include information about whether a deceased individual is a veteran or not.

The National Death Index is simply a central computerized index of death record information on file in the vital statistics offices of every state. The Index is compiled from computer files submitted by State vital statistics offices. Death records are added to the file annually, about twelve months after the end of a calendar year. CDC uses this data to compile its statistics on American death rates.

Given that the NDI does not indicate veteran status, VA regularly submits requests for information to NDI. Because the system contains a list of all Americans who have died, and because of the capabilities of its Electronic Health Record system, VA is able to send NDI a list of all patients who have not been treated at any VA medical centers in the past twelve months and before, to see if they are still among the living.

NDI checks this list against their records, and tells VA which veterans have died, and the cause of their death as listed on the veterans' death certificates. From this information, VA is able to learn the approximate number of veterans under its care who have died of suicide, and to use that information to make comparisons on rates of suicide among those veterans and all other Americans.

This information tells VA about the suicide rates among veterans under its care, but says nothing about the rates of suicide among veterans who are not currently in the system. For those veterans, an even more complicated process has to be followed in order to estimate rates. VA obtains regular updates from the Department of Defense's Defense Manpower Data Center on soldiers separating from the military. Those new veterans immediately become part of total population and suicide calculations.

In 2002, the CDC established the National Violent Death Reporting System, or NVDRS. NVDRS today is fully implemented in 16 states, and collects data on violent deaths, including suicides. NVDRS collects data on violent deaths from a variety of sources, including death certificates, police reports, medical examiner and coroner reports, and crime laboratories. Veteran status is included in the database.

Together, these sources offer a comprehensive picture of the circumstances surrounding homicides and suicides. This, too, is a time-consuming and difficult task, and standard reports from NVDRS are available only through 2005.

Because NVDRS is a comprehensive source of data, and because it indicates whether or not a coroner has indicated that the deceased is a veteran, VA is able to obtain counts of the number of suicides among all veterans in the sixteen stats that have fully implemented this system, broken down by sex, age, race and state. To summarize, determining suicide rates among veterans is a challenging puzzle.

Multiple data sources must be used, and data must be carefully checked and rechecked. Each system helps obtain a piece of the complicated puzzle that constitutes the process of accurately estimating rates of veteran suicides.

These are time-consuming processes—but they are the best ways VA knows to obtain aggregate data on suicide. The weaknesses inherent in this method are clear.

First, the CDC's manual for completion of death certificates states that the determination of whether or not someone is a veteran should usually be done by funeral directors. The information available to directors is limited, and their willingness to investigate the question of veteran status varies. Generally, these directors allow families to self-certify their response to the question of whether their loved one was a veteran; an approach fraught with pitfalls. In addition, funeral directors may not be clear on whether a young person died on active duty, or shortly after leaving the service.

Second, the classification of a death as suicide is dependent on the work of coroner's offices throughout America. This paper has already discussed issues related to coroner determinations: regional differences in definitions; the manner in which ambiguous cases are classified; the level of investigative determination; religious traditions, and legal sanctions all create difficulties in data reliability.

And third, data takes a very long time to assemble. Neither NDI nor NVDRS has released reports of data newer than 2005—and it is midway through 2008 at present.

There are actions VA can take, and is taking, to improve the reliability and the speed of the data the Department is obtaining and providing to Congress. First, VA has begun negotiations with NVDRS staff that will provide information from all of NVDRS' sources (death certificates, police reports, medical examiner and coroner reports, and crime laboratories) on a monthly and quarterly basis, as they are received by NVDRS.

VA will not be able to determine when there is sufficient information to provide full and publishable data—only NVDRS can do that—but will be able to examine and analyze these reports in a way that will allow the Department to spot suicide trends by age, sex and even region more quickly and to take action in those areas.

The Department will also systematically assess its efforts to inform funeral directors about the importance of determining whether or not a person who has died of suicide is or is not a veteran, and what sorts of information to consider in making that determination.

VA will also investigate working directly with state vital records offices, as the NDI does, to obtain information on veteran suicides directly from them.

And finally, VA has a new way of obtaining information on both suicides and suicide attempts: the Department's suicide prevention coordinators.

Until VA committed itself last year to providing full time suicide prevention coordinators at each of its 153 hospitals, it could provide no useful number of attempted suicides among patients. Last October, a standardized definition of suicide attempts was developed and coordinators were asked to begin to count the number of such attempts of which they were aware.

VA's definition of a suicide attempt included any behaviors that might have potentially allowed veterans to injure themselves, when there was evidence that the veteran had the intent to kill himself or herself—whether or not he or she was actually injured. The definition also included events in which a veteran was rescued, an attempt thwarted, or a veteran changed his or her mind after taking an initial action.

On February 13, 2008, an internal email from VA's Deputy Chief of Patient Care Services for Mental Health discussed the existence of this information. In this email, he suggested 1,000 veterans a month under VA care were being reported as attempting suicide, and was concerned about disclosing the information.

The data was not sent to CBS because of his concerns.

The number of attempts referenced was based on only three months worth of data, too short a time period to determine if it was reliable.

The data was demonstrably not accurate. Even now, six months after collecting data began, the reports indicate that a number of states have suspiciously low reporting rates—and there is remarkable variability among individual VA facilities throughout the United States, due either to regional variability in suicide rates, differences in the manner in which individual suicide coordinators reported data, or both.

VA's suicide prevention coordinators were new to their jobs, and new to their tasks. There was a great deal of uncertainty over "borderline calls," and many of them were just beginning to make the community and in-hospital contacts that are essential in making an accurate count of the number of suicide attempts among patients.

VA is addressing the problem of the accuracy of suicide coordinators' data in a number of important ways; by regularly reviewing the data the Department receives, and educating coordinators on the proper way to collect and report this information;

And VA is regularly reviewing difficult "calls" with its suicide coordinators—and encouraging them to meet the right people in their communities to obtain additional data.

In the near future, the Department intends to ask suicide prevention coordinators for the names of all those in their facility who have attempted suicide. This will allow further refinement of this data by checking the electronic medical records of individual veterans whose names have been reported as having attempted suicide. VA will learn how this information has been entered into the health record, and how practitioners have incorporated this information into the treatment plan for the individual whose record is being reviewed—with important implications for preventing suicide throughout VA's system.

VA's suicide coordinators are providing another important service; they are providing an additional source of data on the number of completed suicides at their facilities. This data, too, has significant problems: while VA can tell with considerable accuracy how many veterans commit suicide within its facilities, suicide coordinators have both limited time and contacts among coroners and funeral directors to provide accurate counts of the numbers who have died of suicide in the community.

While coordinators will be encouraged to continue to make those contacts, and to attempt to refine the accuracy of the numbers of dead they submit, VA believes that the focus of suicide prevention coordinators must be on preventing suicide among the living. Epidemiologists and researchers, using the data sources described above, will be the ones to learn more from those who have been lost.

Before turning to the actual data, here is a brief explanation of some data which has been widely attributed to VA, but which, in fact, is not the Department's. On March 20, 2008, CBS aired a story on veterans' suicide which included a statement in which the network said it had "obtained from VA" the information that there had been 790 attempted suicides among veterans under the Department's care in all of 2007.

VA has since reviewed its records to try to understand where CBS might have gotten their information, and believes the number stemmed from a response to a Freedom of Information Act Request CBS made to the Veterans Health Administration's Freedom of Information Act Officer on December 20, 2007; a request that was subsequently modified on January 29, 2008. VA provided CBS with the information they asked for—information in the Department's National Patient Care Data base for the years 2000 through 2007, broken down by year, state, age group, gender and race.

This data provides a breakdown of why veterans were seen in VA's hospitals and clinics by International Classification of Diseases code. Once such code is "Suicide and other Self-Inflicted Injuries." CBS apparently counted the total number of veterans for whom that code was entered—and came up with 790 attempts for 2007.

That number, unfortunately, is not at all useful if the purpose of the count is to determine the total number of suicides and attempts among veterans under VA's care. Some people who attempt suicide, but do not die, do not then present directly to VA for care. Others do not admit that their injuries were due to suicide attempts until a counselor discusses their situation with them. And still others treat their own wounds without seeing a clinician; the attempt is only revealed later, during counseling. CBS's number, while arithmetically correct, is actually misleading.

3. VA'S DATA ON SUICIDES AND ATTEMPTS

To review what we do know specifically, let us compare veterans' rates of suicide to non-veterans rates. The source of the base data is the National Death Index, a product of the National Center for Health Statistics of the Department of Health and Human Services. The most current complete data in this area is from 2005; 2006 data should be released soon. The overall rates of suicide for men and women from 2001 through 2005 are shown in Tables 1 and 2. It is important to separate the rates for men and women. By doing so, we see that men have a higher rate of suicide than women; a rate that is statistically significant. It is also important to separate these figures by age groupings, because there are significant differences in that area as well. These tables provide that information as well.

Table 1: Suicide Rates Per 100,000 Male U.S. Citizens by Fiscal Year and Age

	2001	2002	2003	2004	2005
All men	23.18	23.63	23.20	23.20	23.19
18–29	20.14	20.08	19.38	20.21	19.35
30–64	22.45	23.10	23.13	23.00	23.19
65+	31.42	31.81	29.76	29.01	29.53

Table 2: Suicide Rates Per 100,000 Female U.S. Citizens by Fiscal Year and Age

	2001	2002	2003	2004	2005
All women	5.22	5.44	5.42	5.81	5.65
18–29	3.40	3.67	3.56	3.91	3.90
30–64	6.28	6.47	6.57	7.09	6.78
65+	3.88	4.09	3.79	3.79	3.99

Source: CDC's WISQARS Injury Reporting System and CDC's National Center for Health Statistics' National Death Index

Tables 3 and 4 provide overall rates of suicide for male and female Veteran VA users, broken down into three age groups: 18 to 29; 30 to 64; and 65 and older.

Table 3: Suicide Rates Per 100,000 Male Veteran VA Users by Fiscal Year and Age

	2001	2002	2003	2004	2005
All Male VA users	36.49	41.58	32.92	35.40	37.19
18–29	27.75	36.54	35.64	42.54	26.94
30–64	41.37	46.32	39.57	38.44	40.66
65+	32.03	37.03	26.77	32.09	34.27

Table 4: Suicide Rates Per 100,000 Female Veteran VA Users by Fiscal Year and Age

	2001	2002	2003	2004	2005
All Female VA users	9.87	12.49	9.00	12.28	13.59
18–29	2.12	15.75	5.93	7.41	7.81
30–64	11.99	11.17	10.76	14.88	13.96
65+	6.58	15.66	3.95	4.31	17.60

Source: CDC's National Center For Health Statistics' National Death Index

These tables show that men, whether or not they are veterans, have a higher rate of suicide than women, in numbers that can be considered statistically significant. In addition, there are significant differences by age groupings. VA is able to make these comparisons, because it is able to match the names of veterans under our care whom we have not recently seen against the National Death Index. The Death Index then provides information on which of these men and women have died, and the cause of their death, including suicide.

What cannot be learned from this table is how the rates of suicide compare among all veterans, not only those in the VA system, to the general population. Doing so would require matching the full list of 24.5 million veterans against the National Death Index to see how many of them have committed suicide. That currently is not possible. However, VA has matched up general population rates of suicide in the sixteen states reporting to NVDRS in 2005 against the rate of veteran suicide in those states.

Table 5: Suicide Rates per 100,000 in 16 States Among General Population vs. Veteran Population (Males) in 2005

	18–29	**30–64**	**65+**
All male VA users	53.18	36.85	36.00
All male veterans	44.99	25.60	31.52
All men	20.36	23.28	30.51

Table 6: Suicide Rates per 100,000 in 16 States Among General Population vs. Veteran Population (Women) in 2005

	18–29	**30–64**	**65+**
All female VA users	25.02	15.81	---
All female veterans	15.35	11.41	3.66
All women	4.35	7.04	3.63

Sources:
General Population: CDC's Web-based Injury Statistics Query and Reporting System
OEF/OIF: DoD's Defense Manpower Data Center
Suicide Data: CDC's National Center for Health Statistics National Death Index and CDC's National Violent Death Reporting System

At this time, there is no firm explanation of the reason for the disparity in rates between VA's patients and other Americans. However, the veterans VA serves—as opposed to the overall population of American veterans—are older, sicker, and poorer than the general population of the United States. VA researchers believe this may account for at least some of the apparent differences.

VA's summary of this data from 2001 through 2005 yields the following hypotheses:

- Male veterans commit suicide at a somewhat higher rate than other men, but with varying statistical significance by age and over different years.
- Within the group of male veterans there are differences in the age at which veterans die of suicide compared to what is seen in the general population—especially in the ages between 30 and 64, at which ages veterans have a statistically significant higher rate. This finding is reproducible over time.
- Male veterans commit suicide at a higher rate than female veterans.
- Within the group of female veterans, there is nearly a twofold increase over the rate of suicide for women in the general population, which is also variably statistically significant over the years and by age.

Clearly, returning service men and women represent a group of particular interest to the Nation. VA has a particular sense of urgency to understand why these men and women might be taking their own lives—and to intervene to prevent even a single suicide. To better understand suicide in this particular cohort, Dr. Han Kang of VA's Environmental Epidemiological Service conducted a study that matched those servicemembers who had served in the theater of operations, and who separated from service between 2002 and 2005 against the National Death Index.

Using this method, Dr. Kang found that 144 out of 490,346 separated OEF/OIF servicemembers committed suicide during that time, for an overall rate of 21.9 per 100,000. These are deaths only of men and women who separated from the military, and the data does not include any suicides while a servicemember was on active duty.

To compare this to other national norms, Dr. Kang looked at this cohort against the national averages discussed above. For OIF/OEF veterans who had deployed and separated from 2002–2005, the rate was slightly higher than would be expected in

an age, gender and race matched general population, but not by a statistically significant amount. (Standardized mortality Ratio of 1.15 (p >.05.)

Dr. Kang also examined this data for differences in suicide rates between those who have used VA for care and those who have not. He found that 17.0 of every 100,000 OEF/OIF veterans who use VA for care take their own lives, compared to 24.0 of every 100,000 OEF/OIF veterans who do not use VA for care. This apparent advantage of VA care, though encouraging, is not statistically significant. In this group, the same is true for vet center users.

Male veterans 18–29 who used VA care took their own lives at a rate of 21.0 per 100,000, compared to veterans of that age who did not use VA for care, a group which died of suicide at a rate of 30.4 per 100,000—a statistically significant difference. Male veterans aged 30–64 who used VA for care died of suicide at a rate of 17.5 per 100,000, compared to a rate of 22.8 per 100,000 for their fellow veterans who did not use VA for care—not a statistically significant difference. Since only 3 women OEF/OIF veterans died of suicide through 2005, accurate rates within age groups cannot be calculated.

VA statisticians have worked with this now-older data in anticipation of follow-on data when the updated National Death Index information is available. Some of the insights they have found include the knowledge that there appears to be little variation in suicide risk by branch of service. Statisticians also found that a diagnosis of a mental disorder predicted a nearly 1.8 times higher suicide risk than the general population. This is consistent with what has been published in research journals regarding the non-veteran population, and emphasizes the importance of the Department's mental health efforts.

All of this data comes from national data for suicide against those who are known, from VA's data sources or from Department of Defense records, to be veterans. These national numbers must be used because VA's clinical records do not capture, in any reliable or complete way, such events as suicides or suicide attempts.

The National Death Index, a national roll-up of information from coroners through the states, offers the most complete compilation of deaths among veterans and their causes—since VA may not know of a death even if it occurs in an area in which the Department has a facility. Because information on deaths continues to be updated as reports come in over time, confidence in the completeness of those numbers only comes after several years of data collection. VA is awaiting at this time the release of National Death Index compilations for 2006 for further analysis.

Regarding inpatient deaths: from 2000 through 2007, exactly 50 VA inpatients took their own lives while under the Department's care, based on root cause analyses of the deaths received by VA's Office of Patient Safety. That number varies from a high of 14 such suicides in 2002, to a low of 2 in 2007, when Veterans Health Administration officials demanded that all facilities pay special attention to improving their environment of care to reduce opportunities for suicide.

4. VA'S SUICIDE PREVENTION EFFORTS

The steps VA is taking to prevent suicide among veterans are important and significant. All VA employees have been given the message that even strong and resilient people can develop mental health conditions; care for those conditions is readily available and should be immediately provided; and treatment works.

VA has held two National VA Suicide Prevention Awareness Days throughout its system to focus all 200,000 health care employees on this issue. The first event focused on enhancing overall awareness of the issue. The second coincided with National Suicide Prevention Awareness Week. During that week, VA staff was trained on how to work with available prevention resources, including the hotline and the suicide prevention coordinators. VA will continue participating in Suicide Prevention Awareness Week activities every year, with a special focus on veterans and ways VA can continually improve its suicide prevention efforts.

The Department is in the process of adding 23 new vet centers throughout the Nation to provide more individual, group and family counseling to veterans of all wars who have served in combat zones, bringing the total number of vet centers to 232.

VA's suicide prevention program includes two centers that conduct research and provide technical assistance in this area to all locations of care. One is the Mental Health Center of Excellence in Canandaigua, New York, which focuses in developing and testing clinical and public health intervention related to suicide risk and prevention. The other is the VISN 19 Mental Illness Research Education and Clinical Center in Denver, which focuses on research in the clinical and neurobiological sciences with special emphasis on issues related to suicide risk.

VA's system of care also includes a suicide prevention call center, also located in Canandaigua, and the suicide prevention coordinators previously discussed, who are

located at each of VA's 153 hospitals. Altogether, VA has more than 200 mental health providers whose jobs are specifically devoted to preventing suicide among veterans.

To develop the suicide prevention call center, the Department has partnered with the Lifeline Program of the Substance Abuse and Mental Health Services Administration. Those who call 1–800–273–TALK are asked to press "1" if they are a veteran, or are calling about a veteran.

Unlike other such hotlines, VA's hotline is staffed solely by mental health professionals—24 hours a day, seven days a week. Hotline staff is trained in both crisis intervention strategies, and in issues relating specifically to veterans, such as traumatic brain injury and post traumatic stress disorder. In emergencies, the hotline contacts local emergency resources such as police or ambulance services to ensure an immediate response.

Cards, pamphlets and posters—even refrigerator magnets—bearing the number are distributed by suicide prevention coordinators to at-risk veterans and their family members.

In addition, posters with hotline information are located throughout VA medical centers and clinics, and in all residential rehabilitation programs there are stickers on phones and by doors with the hotline number. Vet Centers also make this information available.

If the caller is a veteran enrolled with VA for care, the hotline staff is able to use the veteran's electronic medical record during the call, if the veteran is a VA patient and willing to identify himself or herself. These records provide information that is invaluable during a crisis, including information on medications; the patient's treatment plan; and who to contact during this emergency.

Staff can talk directly to the facility that is treating the veteran. They can place consults in the patient's medical record, and are able to make arrangements to directly refer veterans to a Medical Center or Community-based outpatient clinic to be seen if that's appropriate.

And hotline staff follows up on these referrals. They check patient's records to see if consultations were completed; actions are taken; and followups are ongoing. If the record does not show this information, the suicide prevention coordinator is called, ensuring that no referral is lost in the process.

From its beginnings in July, 2007 through the end of April, 16, 414 calls have come to the hotline from veterans and 2125 family members or friends have called. These calls have led to 3464 referrals to suicide prevention coordinators and 885 rescues involving emergency services. 493 active duty servicemembers have also called.

Besides keeping track of veterans who have tried to take their own lives, suicide prevention coordinators receive referrals of those at risk for suicide from both the hotline and from providers in their facilities. They also ensure that care for these veterans is appropriate for their situations.

Coordinators educate their colleagues, veterans and families about risks for suicide. They provide enhanced treatment monitoring for veterans at risk and ensure that any missed appointments are followed up on. The coordinators work with the entire staff of their medical centers to maintain awareness of those who have previously attempted suicide, and ensure their care is enhanced to reduce the risk of renewed attempts.

They also work with patient safety officers to conduct quarterly safety inspections of inpatient psychiatry units, and coordinate staff education programs about suicide prevention. These coordinators are in the process of organizing a system of flags in the electronic medical record system to alert providers about those at high risk. They are also conducting training for community members who have frequent contact with veterans to help them recognize those at risk and encourage them to seek treatment.

There is a large body of scientific literature on suicide. Over the years, VA has been a prime contributor to the knowledge that has been developed in the scientific community on this issue. Our research has helped us target our efforts to reduce suicide. Some of the information our researchers have developed includes:

- Among veterans receiving care from VA who died from suicide, almost 60% of those under age 65 had a mental health or substance abuse diagnosis on their medical records—but only 24% of those 65 or over had such a diagnosis.
- There is significant variability in suicide rates among veterans by geography. In general, rates are lowest in the Northeast and highest in the West.
- Firearms are the most common means used by veterans who died of suicide, accounting for nearly two-thirds of all deaths.

- There appears to have been an increase in suicide rates among Vietnam veterans during the first two years after these veterans returned home. After a few years, however, Vietnam veterans' rates of suicide were comparable to those of the general population.
- There was no increase in suicide rates among veterans who returned from the first Gulf War.
- Those veterans who are wounded in combat are at higher risk of suicide.

5. FUTURE ACTIVITIES

In the near future, the Department will continue to educate its employees; through additional Suicide Prevention Days; through posters identifying the warning signs of suicide; and through its continuing Employee Education process to identify those at possible risk of suicide to ensure they get proper care. As new data on suicide rates, risk factors for suicide and regional variations become available, VA will use that data to refine its programs, and to better evaluate their level of success.

VA will increasingly reach out to the newest generation of veterans, by using communications outlets familiar to them. VA now has a virtual office on "Second Life;" and recently collaborated with MTV on a video on readjustment issues for returning veterans that can be found on their Web site.

VA will continue its efforts to meet the mandate of the President's New Freedom Commission to reduce the stigma that surrounds mental illness.

VA will also continue the expansion of its mental health program that has enabled the Department to hire more than 3800 new mental health employees in the past three years, and expand hours of operation for mental health clinics beyond normal business hours. These efforts to better identify and treat mental illness will help prevent contemplation of suicide and suicide attempts—and will help ensure that veterans in crisis are already involved in VA's system and have somewhere to turn when they need help.

The Department will aggressively follow up on patients in mental health and substance abuse programs who miss appointments to ensure they are not lost to follow up care. VA will also monitor the standards the Veterans Health Administration has set for itself: to provide initial evaluations of all patients with mental health issues within 24 hours, provide urgent care immediately when that evaluation indicates it is needed, and to complete a full evaluation and initiate a treatment plan within 14 days for those not needing immediate crisis care.

On May 2, VA began contacting nearly 570,000 combat veterans of the Global War on Terror to ensure they know about VA medical services and other benefits. The Department will reach out and touch every veteran of the war to let them know it is here for them. The first of those calls are going to an estimated 17,000 veterans who were sick or injured while serving in Iraq or Afghanistan. If any of these 17,000 veterans do not now have a care manager to work with them to ensure they get appropriate healthcare, VA will offer to appoint one for them.

All case managers for OEF/OIF veterans will be trained in suicide risk recognition and management for their patients, and encouraged to establish a personal relationship with those veterans to support their healthcare needs.

I have also directed the creation of a work group on suicide prevention in the veteran population. This work group will look at all matters relating to VA's ability to prevent suicide among veterans. They will be given all the data VA has, and access to the best experts VA knows.

The work group will be asked to provide a report within fifteen days of the completion of their meeting on how VA can better approach suicide prevention, suicide research, and suicide education.

All work group members will come from outside the Department of Veterans Affairs. Some will be DoD specialists; others will be from other government agencies. Nationally recognized clinical treatment, research and public health experts on suicide and suicide prevention will augment them. The work group will provide an additional level of advice and oversight to all the issues described above.

There is nothing more tragic than the loss of even one of those great men or women who have served this nation. The VA is committed to doing all that we can to serve the individual while we continue to try to understand a very complicated problem that is also a national problem. We owe this committee and the nation accurate information and carefully studied, thoughtful conclusions while we provide the "best care anywhere" to our Veterans.

US Adult Population and Veteran Demographics for 2005

Number of Adult Males
108,338,837

Number of Male Veterans
22,791,288

AGE	General Population	Veteran
18-29	25.38 M	0.77 M
30-64	67.58 M	12.85 M
65+	15.40 M	9.16 M

Number of Adult Females
114,633,984

Number of Female Veterans
1,729,959

AGE	General Population	Veteran
18-29	24.04 M	0.19 M
30-64	69.22 M	1.21 M
65+	21.38 M	0.32 M

Data Sources:
Vetpop 2007, Office of the Actuary (008A2)
General Population Rates: CDC Web-based Injury Statistics Query and Reporting System (WISQUARS)

Suicides Among General Adult Population Vs. VA Unique Users For 2005

Male Suicide General Population
25,128

Suicides of Veteran Users
1,723

AGE	General Population Suicides	Veteran Unique Users Suicides	† General Suicide Rate	† Veteran Unique Suicide Rate
18-29	4,905	36	19.35	26.94
30-64	15,673	924	23.19	40.66
65+	4,550	763	29.53	34.27

† (Rate/100,000/year)

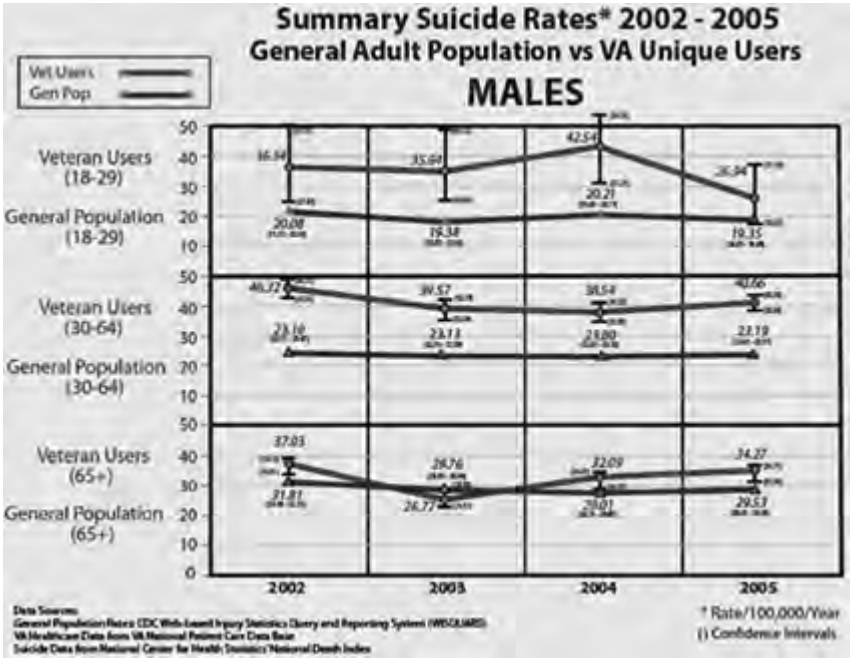
Female Suicide General Population
6,482

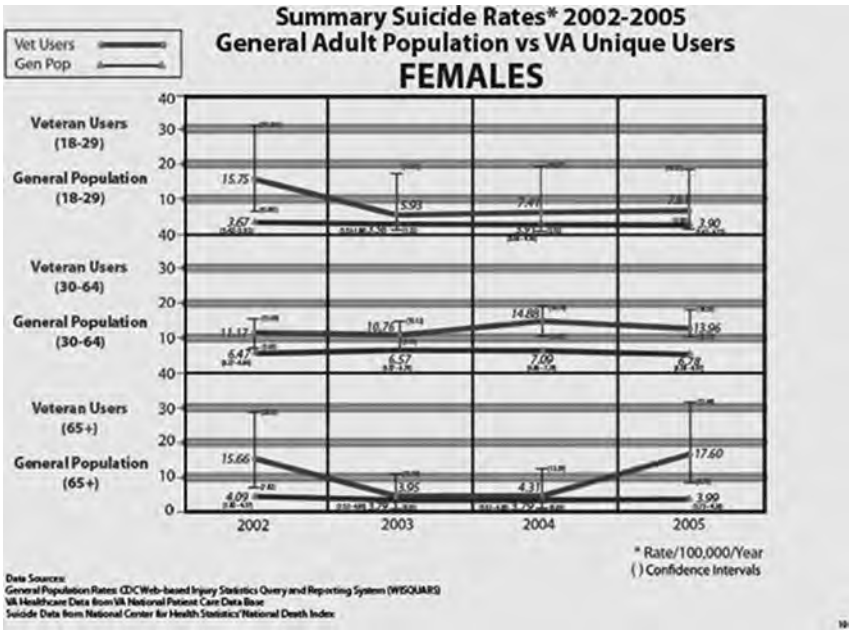
Suicides of Veteran Users
61

AGE	General Population Suicides	Veteran Unique Users Suicides	† General Suicide Rate	† Veteran Unique Suicide Rate
18-29	937	5	3.90	7.81
30-64	4,691	45	6.78	13.96
65+	854	11	3.99	17.60

† (Rate/100,000/year)

Data Sources:
General Population Rates: CDC Web-based Injury Statistics Query and Reporting System (WISQUARS)
VA Healthcare Data from VA National Patient Care Data Base
Suicide Data from National Center for Health Statistics' National Death Index


Summary Suicide Rates* 2002 - 2005
General Adult Population vs VA Unique Users
MALES
Vet Users
Gen Pop
Veteran Users (18-29)
General Population (18-29)
Veteran Users (30-64)
General Population (30-64)
Veteran Users (65+)
General Population (65+)
2002
2003
2004
2005
* Rate/100,000/Year
( ) Confidence Intervals


Summary Suicide Rates* 2002-2005
General Adult Population vs VA Unique Users
FEMALES
Vet Users
Gen Pop
Veteran Users (18-29)
General Population (18-29)
Veteran Users (30-64)
General Population (30-64)
Veteran Users (65+)
General Population (65+)
2002
2003
2004
2005
* Rate/100,000/Year
( ) Confidence Intervals

Suicides Among General Population Vs. 16-State All Veterans and Users for 2005

Male Suicide General Population 6,723

- # Separated 16-State All Veteran Suicides 1,767
- # Separated 16-State User Veteran Suicides 425

AGE	†16-State General Suicide Rate	†16-State All Veteran Suicide Rate	†16-State User Veteran Suicide Rate
18-29	20.36	44.99 (36.61-54.72)	53.18 (30.98-85.15)
30-64	23.28	25.60 (23.96-27.25)	36.85 (32.13-42.06)
65+	30.51	31.52	36.00 (31.05-41.52)

† (Rate/100,000/year)

Female Suicide General Population 1,780

- # Separated 16-State All Veteran Suicides 55
- # Separated 16-State User Veteran Suicides 18

AGE	†16-State General Suicide Rate	†16-State All Veteran Suicide Rate	†16-State User Veteran Suicide Rate
18-29	4.35	15.35 (7.02-29.15)	25.02 (6.82-64.06)
30-64	7.04	11.41 (8.26-15.37)	15.81 (8.65-26.53)
65+	3.63	3.66	**

† (Rate/100,000/year)

Data Sources:
General Population Rates: CDC Web-based Injury Statistics Query and Reporting System (WISQUARS)
OEF/OIF - DoD Defense Manpower Data Center
VA Healthcare Data from VA National Patient Care Data Base
Suicide Data from National Center for Health Statistics National Death Index

** Suicide rates and 95% confidence intervals were not calculated due to small numbers (no or one suicide). ( ) Confidence Intervals

Suicides Among General Population Vs. OEF/OIF Veteran Users for 2002 - 2005

Male Suicide General Population 122,908

- # Separated OEF/OIF Non-User Veteran Suicides 109
- # Separated OEF/OIF User Veteran Suicides 32

AGE	†General Suicide Rate	†OEF/OIF User Suicide Rate	†OEF/OIF Non-User Suicide Rate
18-29	19.8	21.0 (10.7-31.0)	30.4 (22.6-38.2)
30-64	23.0	17.5 (8.9-26.1)	22.8 (16.5-29.1)
65+	30.3	**	**

† Rate/100,000

Female Suicide General Population 30,911

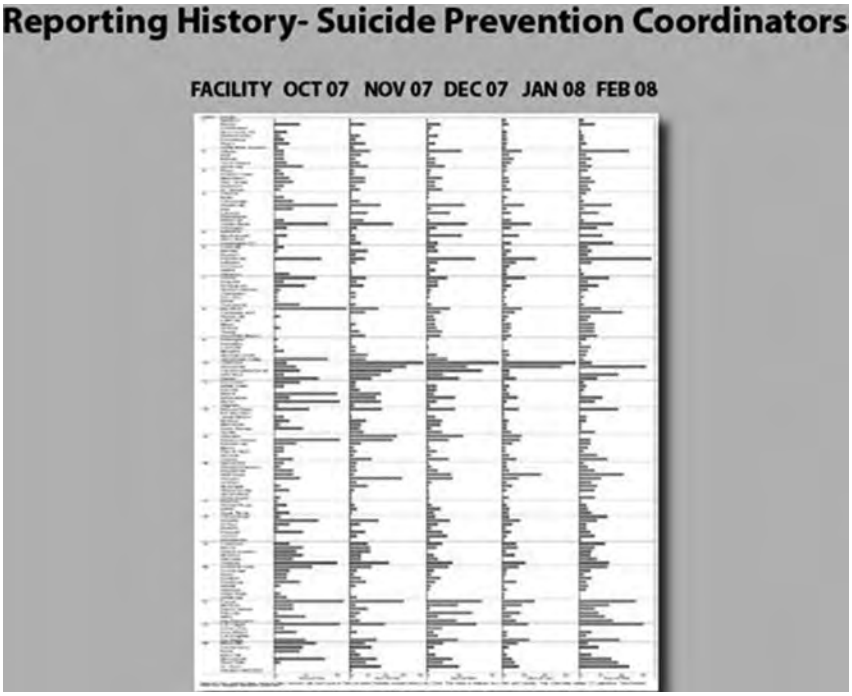
- # Separated OEF/OIF Non-User Veteran Suicides 2
- # Separated OEF/OIF User Veteran Suicides 1

AGE	†General Suicide Rate	†OEF/OIF User Suicide Rate	†OEF/OIF Non-User Suicide Rate
18-29	3.7	**	**
30-64	6.6	**	8.8 (0-21.1)
65+	3.9	**	**

† Rate/100,000

Data Sources:
General Population Rates: CDC Web-based Injury Statistics Query and Reporting System (WISQUARS)
OEF/OIF - DoD Defense Manpower Data Center
VA Healthcare Data from VA National Patient Care Data Base
Suicide Data from National Center for Health Statistics National Death Index

** Suicide rates and 95% confidence intervals were not calculated due to small numbers (no or one suicide). ( ) Confidence Intervals


Reporting History- Suicide Prevention Coordinators
FACILITY OCT 07 NOV 07 DEC 07 JAN 08 FEB 08

IT
TAKES
THE
COURAGE AND STRENGTH
OF A WARRIOR
TO ASK FOR HELP.....
If you're in an emotional crisis
call 1-800-273-TALK "Press 1 for Veterans"
www.suicidepreventionlifeline.org
SUICIDE PREVENTION
Department of Veterans Affairs

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What Causes Suicide? Suicide is not one thing, but is a multidimensional outcome (including a continuum of self-destruction from unintentional self-harm, partially self-destructive behaviors, ideas about suicide, plans to suicide, lethal and non-fatal suicide attempts, and finally, to suicide completions; which themselves can be escape, revenge, altruistic, and/or risk-taking) resulting from several risk factors interacting over time (what I call a "suicidal career," Maris, 1981). Risk factors for suicide include relatively chronic vulnerabilities (like being an aging male, owning a gun, having a history of depressive disorder, being an alcoholic, etc.) and more acute stressors (like post-traumatic stress disorder, recent losses, pharmacological crises [such as serotonergic dysfunctions], inability to get effective healthcare, etc.).

From my case-control surveys I have derived about 15 evidence-based risk factors for suicide outcomes (the following list includes statistically significant risk factors compared to controls of nonfatal suicide attempts and natural death in a random sample of 2,153 suicides (Maris, 1969 and 2002). There could be more than just fifteen risk factors for suicide (See Maris, 2000, Chapter 17) and the list below is not necessarily ranked (although factors 1 and 2 tend to be the most prevalent in suicides). The factors that cause most suicides are (See Maris et al., 2000:80; Maris, 2002; Maris, 2007):

- Depressive and affective disorders, schizophrenia
- Alcohol and substance abuse
- Suicide ideas, plans, preparations
- Prior suicide attempts (*caveat:* many white males die after one attempt)
- Available lethal methods (especially, firearms)
- Social isolation, loss of social support
- Hopelessness (Beck claims hopelessness is more predictive of a suicide outcome than depression is; See Maris et al., 1992)
- Being an older white male (generally the older, the more likely suicide is)
- History of suicide or mental disorder in one's first degree relatives
- Work problems, unemployment, lower SES, homelessness
- Marital problems & discord, separation, divorce, widowhood
- Stress, PTSD, negative life events, traumas
- Feelings of anger, aggression, impulsivity, serotonergic dysfunction
- Physical illnesses; like spinal cord, brain injury, epilepsy, arthritis, ulcers
- Repetition and co-morbidity of above risk factors; "suicidal careers"

Obviously, what causes veteran suicides has both common and unique factors compared to the general population in the United States. Murphy and Robins (1970, 1981) found in St. Louis county that about 47% of all suicides had an affective disorder and 25% had alcohol problems. Rates of depression, alcohol abuse, having a firearm, isolation, marital disruption, and trained aggression are all more prevalent in veteran populations. Zivin (12/7/07 @ 2193) estimated that veteran depression symptoms are 2 to 5 times higher than those in the general population.

Kang (12/11/07) states that as of 9/2007 among vets in healthcare at the VA, 40% had major depression diagnoses and 20% had diagnoses of PTSD (DSM IV code 309.81).

Post-traumatic stress disorder is extremely important among combat veterans (about 33% of female veterans experience sexual trauma, which can also cause PTSD) because it is common (15 to 50% of vets have PTSD; See *Vets for Common Sense et al.* v. *Peake et al.* Complaint, 7/23/07 @ 18–69) and it is interactively related to other suicide risk factors. CBS (11/13/07) reports that 28.3 percent of Iraq vets had mental health problems. Kang (12/11/07 @ 445) claims that of the approximately 1.6 million troops deployed in Afghanistan and Iraq 3,444 (now over 4,000) have been killed and 90% have been "traumatized."

PTSD was first stated as a psychiatric anxiety diagnosis in 1980 in the DSM–III (code 309.81). It involved the following symptoms or criteria:

- Being exposed to a traumatic event where death or serious injury occurs accompanied by feeling of intense fear and helplessness.
- The event is persistently re-experienced.
- The victim avoids trauma-associated stimuli.
- The victim experiences symptoms of increased arousal.
- The symptoms last one month or more (acute v. chronic) and are characterized by social and occupation dysfunction

PTSD is one of the unique suicidogenic factors among veterans and interactively raises other suicide risk factors. Note, too that the percentage of all USA general population deaths that are suicides is 2.1% (AAS, 1/24/08). But among 15 to 24 year-olds 12.3% of all death are by suicide. Kang reminds us that the median vet suicide age is 20 to 29 (12/11/07 @ 441) and 18–24 year-old soldier suicides make up 26.3 % of all suicide [about twice that of the non-soldier population]. Thus, obviously, the prompt and accurate diagnosis and treatment of vet PTSD (and related depressive and substance abuse disorders) is a major condition for veteran suicide prevention.

One reason I cannot answer definitely about what causes veteran suicides is that the Office of Veteran Affairs has not provided me or the courts crucial data that are needed. For example, each time there is a military death, suicide attempt, or other serious incident, the VA produces a short "incident brief" which summarily describes the suicide or suicide attempt (Feeley, 4/9/08 @ 158). Then about 45 days later each incident undergoes what is called a "root cause analysis" and a 3-page report is generated (Feeley @ 160). On April 22, 2008, when I was an expert for the Plaintiff in the *Veterans* . . . v. *Peake* trial in San Francisco, I was given only 170 of the estimated 15,000 incident briefs and *none* of the root cause analyses. Clearly these VA documents could go a long way in establishing what causes veteran suicides and whether or not there is an "epidemic" (Dr. Katz denies that there is an epidemic, 11/13/07). It seems that these personal, clinical documents could be redacted, with patients' names and other identifying information removed, and then supplied to independent scientific investigators, like myself. Clearly such crucial documents would help clarify how many vet suicides there are and what the VA thinks causes them (i.e., what are the root *causes*).

How High is the Veteran Suicide Rate and Is It An "Epidemic"? Virtually everyone agrees that the Iraq & Afghan vet suicide rates are higher than those of the general USA population. One problem in getting a consistent answer to our question is that there are shifting veteran populations (all vets, WWII, Korea, Viet Nam, Gulf War, Afghanistan, and Iraq), shifting times frames (e.g., yearly, 01–05, 06–08, etc.) and various samples based on different data sets (e.g., incident briefs, death certificates from the U.S. Department of Vital Statistics, Department of Defense data, etc. Consequently there is a very wide range of estimates of vet suicides.

Nevertheless, there is *consensus that the vet suicide rates* (especially in OEF/OIF veterans; viz., Afghan and Iraq vets) *are higher than those of the general population*; high enough to constitute a serious national problem that demands resolution (Katz, 11/13/07).

Some of the estimates of veteran suicides rates and how much higher they are than those of the general population are:

- Katz (VA Deputy Chief of Patient Care Services) (2/21/08) says **3.2 times higher** (suicide rate of 34.6 /11, N = 8,218, VHA patients from 2001–2005).
- OIG Mental Health Strategic Plan for Suicide Prevention (5/10/07) says **7.5 times higher** (viz., 83/100,000/11), page 8.
- Rathbun/CBS (2/28/08) says **1.8 to 2.3** times higher (6,256 vets of any war surveyed in 45 states = about 120 vet suicides per week).
- Zivin (12/7/07 @ page 2194) says 1683 of 807,694 vets suicided = 208/100,000 or about **19 times higher** than the general population.
- Katz (2/13/08 in an e-mail to Ev. Chasen) says that "VA suicide prevention coordinators are identifying about **1,000 suicide attempts per month** among vets seen in VA medical facilities (note: usually suicide attempts exceed completed suicides about ten to twenty-five times [AAS, 1/24/08]).
- Katz (e-mail to Kussman [Under Secretary for Health] on 12/15/07) reports **18 suicides per day** out of 25,000,000 total vets.
- Kang (12/11/07) simply says "the risk of death for vets from suicide and motor vehicle accidents is **higher that for the general population**" (page 444, N = 144, 01–05, OIF/OEF vets only).

How high is a high enough vet suicide rate to merit national concern? From one perspective even one suicide is too many, since suicide is one of the leading causes of unnecessary death (See Maris et al. 2000). William Feeley, Deputy Under Secretary for Health Care Operations at the VA, said in a deposition (4/9/08, p. 38): *"Suicide occurs like cancer occurs."* Wrong! We all have to die (some by cancer, some by heart disease, etc.), but no one needs to suicide. The VA seems to think that a certain number of vet suicide deaths are inevitable and that there is not much we can do about them.

When I consulted with Columbia University and the FDA to determine if 9 antidepressant medications caused child and adolescent suicide, the FDA decided that a relative risk of 2.1 or higher was sufficient to require a Black Box warning be put in the drug's package insert and in the **Physician's Desk Reference**. While

there is no arbitrary bright line for danger, note that almost all of the relative risks for vet suicide are above 2.0.

Webster says an "epidemic" means prevalent and spreading rapidly among many people in a community (like the U.S. military) at the same time." Although we often reserve the concept of epidemic for extreme cases like the plague, smallpox, influenza, polio, etc. It does seem that veteran suicides are the product of a disease process and are increasing. For example, Kang (12/11/07 @ 441) claims the following percentages for vet suicides (OIF/OEF) from 2002 to 2006:

2002 = 7%
2003 = 21%
2004 = 48%
2005 = 68%

This looks a little like an epidemic to me (although one would need to control for the numbers of vets and calculate rates).

The Office of the Inspector General's Mental Health Strategic Plan for Suicide Prevention (by John Daigh, Jr., M.D., Assistant Inspector General. 5/10/07). The purpose of this ambitious document is to assess implementation of action pertaining to suicide prevention in the VHA's mental health strategic plan (p. 1). Overall I found this plan to be a systematic, well-organized survey, but in fact it points out many of the VA's shortcomings in suicide assessment and prevention. For the record in the VA there are (1) 21 regions ("VISNs"), (2) 154 hospitals or medical centers, (3) 875 outpatient clinics or "CBOCs", and (4) 136 nursing homes (Feeley, 4/9/08 @ 45).

In the plan overview (@ iv) it indicates that "at present the MHSP initiatives for suicide prevention are only *partially implemented*." For example, on page 21 there is a chart summarizing the findings for six major objectives:

Areas:	Findings:
A. Crisis intervention	24 hour mental health services in 94.5% of facilities
B. Screening	98% screen for depression, major suicide risk factor
C. Assessment	70% do **not** have tracking system
D. Interventions	61.8% do **not** target special groups
E. Databases	See SMITREC (data not available)
F. Education	61.4% of facilities did not make information on suicide risks mandatory

The document (Cf., "Suicide Risk Assessment Guide, Reference Manual," VA 001510 in *Vets* . . . v. *Peake*, 5/21/08, p. 1, no date) argues that *suicide attempts* are a major risk factor for suicide in vets (p. 1). The problem with this finding is that about 90% of older white males only make *one* suicide attempt (usually because they shoot themselves in the head; See Maris, 1981). Thus, for most vet suicides, a prior suicide attempt cannot be used to prevent their suicides. It is too late already.

Later (p. 16) the MHSP document argues that the "VA strategy for suicide prevention should include universal screening designed to activate the system for suicide prevention." In fact (See "Suicide Template," below) universal screening for vet suicide prevention includes asking only two questions (viz., *"Have you felt depressed or hopeless in the last two weeks?"*, and *"Have you thought about hurting/harming yourself in the last two weeks?"* If the vet answers "No" to question # two, no further suicide screening is done (Cf., Marcus Nemuth deposition, 3/25/08, VA staff psychiatrist in Seattle area). Asking one or two suicide questions, which could easily be denied, misunderstood, misrepresented, etc., is not a suicide screen up to the standard of care. Probably self-destruction is under-counted by the VA with such perfunctory screens.

Importantly, when the VA measures the crucial suicide risk factors of depression and hopelessness, as far as I could determine, they just use self-reporting; not short, reliable and valid scales, like:

- The Hamilton Rating Scale for Depression (1960)
- The Beck Depression Inventory (1967; Cf., Maris et al., 2000: 84)
- Beck Hopelessness Scale (1974; Maris et al., 2000, Figure 3.5, p. 85)
- Beck Suicide Intent Scale (1990)

All of these scales are relatively short (17–20 questions), have the advantage of indirection (i.e., the vet is not sure what they measure), have known validity and reliability, and could be done in 15 to 30 minutes. Since hopelessness and depression are key suicide risk factors, they should be measured systematically, not by subjective self-reporting. Finally, some vets may not even know if they are depressed, hopeless, or suicidal.

On page 36 of the MHSP we are told "90.9% of the VA facilities do **not** have suicide case managers." Why identify vets with suicide risk, if no one follows them? Recently, I have been told that in fact there are "suicide coordinators" in all 21 VA VISNs in the 154 medical centers (but **none** at the 875 CBOCs). However, it is unclear (to me) who these people are, what their suicide prevention training is, what their exact job descriptions are, and how effective they are. There is also a question about the quality of staffing of CBOCs, most of which have LPNs, RNs, MSWs, and MA psychologists, and not psychiatrists.

We know that two psychiatric drugs have proven very effective in reducing suicidality in patient populations. One of these medications is lithium (See Baldessarini in Simon and Hales, 2006) for depressed and bipolar I patients even get lithium (@ p. 41). Likewise with suicidal schizophrenic patients, the drug Clozaril has been shown to be effective in clinical trials in reducing the suicide rate (See MHSP @ 42). In the vast majority of VA clinics (90.7%) fewer than 10% of their schizophrenic patients are on Clozaril.

Thus, most of the MHSP initiatives are only partially implemented after several years (about four years) and some of the operational definitions of key risk factors are below the standard of care.

Measuring Suicide Risk Factors and the Suicide Template. There is no reason why all veterans could not have all significant suicide risk factors measured at least at deployment, discharge, or at other crucial clinic visits (see my list of 15 suicide risk factors on page 1, above). The VA's "Suicide Risk Screening and Comprehensive Suicide Risk Assessment" form (aka "Suicide Template" or "Suicide Risk Assessment Pocket Card") is woefully inadequate to detect suicidality. As I said above, just asking if the vet felt (1) hopeless or depressed in the last two weeks or (2) thought about harming themselves in any way does not measure suicidality.

The vet could easily deny depression or suicide ideation (especially if they thought it might affect their promotions or military career, or were ashamed of their mental health issues). When I worked for the U.S. Army in Berlin, Germany, doing suicide prevention training, the staff psychiatrist there told me he had little to do, because especially male soldiers would not admit to any mental health problems for various career reasons. Many males do not seek mental health treatment. Other soldiers may not even realize they are depressed or self-destructive.

In short, *all* the questions on the suicide template need to be asked and answered and put in objective formats that do not make it obvious what is being measured. The suicide pocket assessment card has questions about (1) a suicide plan, (2) whether the plan includes firearms, (3) what psychiatric symptoms the vet is having, if any, (4) lack of social support, (5) the age, sex, race and family history of suicide of the vet, (6) whether or not there have been any prior suicide attempts, (7) levels of impulsivity, (8) past psychiatric diagnoses or treatment, (9) chronic pain, (10) protective factors like religion, (11) additional risk factors, (12) quantification of suicide risk level, and (13) immediate actions and treatment needed. Every vet should have every risk factor assessed, not just one or two of them, and asked in a manner that is effective.

Systematic Healthcare Deficiencies as Reflected in the VA Incident Briefs.

Although I was provided only 170 of the estimated 15,000 incident briefs in which VA patients' suicides and suicide attempts were described, nonetheless they provide a sample of suggested systematic healthcare and treatment deficiencies identified by the VA itself. Below are some of the highlighted treatment failures of the VA in assessing and managing suicidal veterans (all documents were provided in the *Vets v. Peake* trial in San Francisco, California and were Bates-stamped for that trial; obviously, they have been redacted to protect individual patients; in each bullet item one could add "and the vet suicided or attempted suicide," etc. Since these documents are "protected," I have removed the VA Bates-stamped numbers):

- Treatment was delayed.
- Patient with suicide ideation not evaluated for suicide risk (violates template, criterion # 2).
- No coordination of patient's care (even though there are s. coordinators).
- Vet should have been admitted but was not.
- Inadequate response to vet's expressed wish-to-die.
- VA needs a suicide hotline (Note: VA now has a hotline, but research shows that a very small percentage of suicides [perhaps < 1%] even call the hotline; Feeley @ 51; I am not persuaded that male soldiers are likely to call a hotline).
- No referral for severe antisocial behavior of vet.
- No psychiatric evaluation of vet was done in the ER.
- Suicide assessment policies and procedures were not followed.
- Hopeless vet not identified as such.

- Vet not rescheduled for appointment within one week per policy.
- Suicide risk assessment was negative, but patient suicided anyway.
- Patient denied access to VA hospital and then suicided.
- Doctor at VA fired for inadequate treatment of soldier found dead.
- Inadequate healthcare for homeless vet with suicide ideation and threat.
- VA not meeting the needs of suicidal vet.
- Feeley says of this vet's suicide: "VHA not meeting standard that we are after."
- Vet actually shoots self on the grounds of the VA outpatient clinic.

These bulleted items reflect the VA's own admissions of healthcare problems or failures in treating suicidal vets. One can only imagine how much more investigators could have learned about assessment and treatment failures of suicidal vets, had they been given all of the redacted incident briefs and root cause analyses. Since this hearing is entitled *"The Truth About Veterans' Suicides,"* it only makes sense that *all* incidents be made public, after removing references to individual vets.

William Feeley, VA Deputy Under Secretary for Health Operations and Management (He reports to Dr. Kussman and Kussman reports to Secretary Peake; the following facts are reported in Mr. Feeley's deposition of April 9, 2008 in the *Vets v. Peake* legal suit). Feeley said that although he was 3rd in the chain of command, and when it came to vet healthcare, "the buck stops here" (although later on Feeley tried to pass the buck to Dr. Katz and others at the VA).

- Feeley said (@ 19) that the 21 VISN directors all report to him at least once a week, but when asked about vet suicide rates, he said he did not talk to directors about their suicide rates (why not, if this is a "major problem"?). As Feeley put it (@ 35): "Suicide rates are not a metric we are measuring."
- When asked about implementing the MHS Plan of 7/2004, his reply was (@ 64): "I did not read the plan from cover to cover."
- When asked between 2004 and 2008 if there were a national systematic program for suicide prevention, Feeley answered "No."
- One of the policies that have been supposedly fully implemented in the MHSP of 2007 was 24-hour VA healthcare. @ 97 Feeley was asked to name that policy. His answer: "I don't know that policy."
- @ 100 Feeley was asked, (well) "where are these policies?" Answer: "I don't know where they are."
- Question @ 104: "Has the idea of screening every service person coming back from Iraq or Afghanistan for PTSD been a subject of discussion?" Answer: "I really could not give you an answer on that."
- Question @ 105: "Is there a national screening program for every returning serviceman or woman to meet with a mental health professional?" Answer: "I don't know the answer to that."
- The MHSP (7/20/04) @ A–14 says that every military person . . . will meet individually with a mental health professional as part of post-deployment and separation. Question: "Has that happened?" Answer: "I don't believe it has."
- Question @ 141–142: "Have you read the national strategy for suicide prevention and the Institute of Medicine's report **Reducing Suicide** (2002)?" Answer: "No."
- Question @ 147: "What methods are there for tracking at-risk (for suicide) veterans?" Answer: " I'm not sure, sorry." What are suicide coordinators for?
- Question @ 171: "Is there any relationship between the number of times a vet is deployed and suicide?" Answer: "Don't know."

One could easily conclude that if the "suicidal buck" stops with Mr. Feeley, then the VA is in serious trouble when it comes to assessing and preventing veteran suicides. Mr. Feeley is singularly and dramatically uninformed about suicide. But maybe that is when Feeley passes the buck to Dr. Katz?

Leftovers and Loose Ends. There are a few other important issues that at least deserve mention.

First, it is possible that soldiers become suicidal in part due to conditions *predating* their military recruitment. If so, their baseline vulnerabilities (See the concept of "stress-diathesis" in Maris et al., 1992, Chapter 27) may interact with the stressors of combat to exacerbate their suicidality. One example on this might be the DSM diagnosis of antisocial personality disorder among young males (@ least 18 years old; DSM code 301.7). There is some evidence (See *Vets v. Peake* Complaint, 7/23/07 @ 8–24) that some soldiers may have been induced to accept a discharge diagnosis of antisocial personality disorder, rather than (say) PTSD. Importantly, a diagnosis of personality disorder precludes the veteran from receiving disability benefits, since the psychopathology was presumed to be present *prior* to the recruitment. Nevertheless, even if true, the Department of Defense needs to improve its

recruitment screening procedures to keep such recruits out of the military in the first place.

Second, there is surprisingly little mention in the VA mental healthcare policies and procedures documents about treating the depressive disorders *psycho-pharmacologically*. It is axiomatic in suicide prevention that much of the treatment of suicidality requires prompt and precise diagnosis of depressive disorders, followed by appropriate specific pharmacological treatment of the patient with one or more of the SSRI antidepressants (e.g., Lexapro, Prozac, Zoloft, Paxil, Louvox, Celexa, etc.), SNRIs (e.g., Cymbalta or Effexor, etc.), anxiolytics (such as the benzodiazepines like Xanax, Klonopin, Traxene, Ativan or non BZs, like Buspar, etc.), perhaps a major tranquilizer (like Risperdal or Zyprexa, etc.), and even electroconvulsive therapy in some cases. Note that many of the VA's 875 outpatient clinics or "CBOCs" often do not even have a physician on staff, who can write critical prescriptions that suicidal vets may need. Since there are 875 CBOCs but only 154 VA hospitals or medical centers, structurally (given the VA healthcare system) a depressed vet is likely to get only psychotherapy, rather than both pharmacotherapy *and* psychotherapy.

Third, the VA takes pride that they now have *"suicide coordinators"* in their medical centers (See Feeley, 4/9/08 @ 88). However, serious questions remain about these suicide coordinators. Only the 154 medical center hospitals even have suicide coordinators; none of the 875 CBOCs do. Thus, the vast majority of VA facilities in fact do **not** have suicide coordinators. Several questions remain: (a) What do these coordinators do, exactly (job descriptions)? (b) How are they trained to do suicide assessment and prevention (Berman addressed this issue in *Vets v. Peake*)? (c) What are their professional credentials and licensing (LPN, RN, SW, MA psychologist, MH techs, etc)? (d) Who supervises these suicide coordinators? (e) Do suicide coordinators interact directly with suicidal vets in clinical care of the VA patients? (f) What exactly are they "coordinating" (data, people, policies and procedures, etc.)?

Finally, there is a whole set of issues concerning diagnosis, treatment, and benefit *delays* in VA mental healthcare, which I have not yet commented on (See *Vets v. Peake*, 4/21/08, Federal trial in San Francisco). To even get mental health treatment for up to two years the veteran must fill out a 23-page application form (which can be very hard to do, if you in fact do have PTSD) and then receive a disability rate from 0 to 100% from a "Compensation and Pension" examination (Complaint, 25–98). If the disability is denied or too low, found not to be related to military service; then the appeal process can be long and drawn-out (some vets die during the appeal process), which can encourage a suicidal resolution of the vet's problems. Note, too, that most of the VA suicide prevention initiatives (See OIG, MHSP, 5/10/07) have only been partially implemented after four years. Defense expert Alan Berman in the *Vets v. Peake* trial, testified that it could take up to 10 years for the MHSP to be implemented. One wonders how many vets are going to die in the interim due to lack of assessment and treatment?

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Summary

In the fall of 2007, I was asked to perform a statistical analysis of veterans' suicide data collected by *CBS News* for a story that was broadcast on November 13, 2007. I agreed to do so, and was not compensated for my contributions. For 2004 and 2005, CBS provided data on numbers of veteran and non-veteran suicides and veteran and non-veteran population sizes, cross-tabulated by state, gender and age class. Suicide data were obtained from state death records and population sizes from the U.S. Census. These data are the property of *CBS News* and were erased from my computer following the broadcast on November 13, 2007. To avoid investigator biases, methods of statistical analyses were specified prior to receiving the data. Standard statistical procedures were used to analyze the data; estimated suicide rates adjusted for age and gender. Veteran suicide rates were estimated to be approximately double those of non-veterans. This pattern of higher estimated veteran suicide risk was observed for both genders and all age classes. The most striking pattern was an especially high risk ratio for 20–24 year old veterans; in this age class, veteran suicide rates were estimated to be about 3 times those of non-veterans.

Introduction

This statement concerns the analyses of veterans' suicide data conducted at the request of *CBS News* during the fall of 2007, the results of which were broadcast during CBS Evening News on November 13, 2007. The following will describe my relationship with *CBS News*, the data that were analyzed, the method of statistical data analyses, and the results of those analyses.

Before proceeding, please note the following:

1. *I am an expert in biostatistics, but not an expert on veterans' suicides*. Although I have a 18-year record of teaching and research in biostatistics, I have not had any prior experience with suicide data. While I can comment on the methods of data analyses, estimated suicide rates and limits of statistical inference regarding the data analysis, I cannot make expert comments regarding what causes the observed patterns of suicide rates.
2. *The suicide data are a property of CBS News* and at the request of *CBS News*, my copy was erased following the November 13, 2007 broadcast. This was done to comply with agreements made between *CBS News* and States to ensure the confidentiality of sensitive human-subjects data.
3. *On March 4, 2008 I testified on behalf of the plaintiffs in the case of Veterans for Common Sense and Veterans United for Truth, Inc. vs. Gordon H. Mans-*

field, Acting Secretary of Veterans Affairs (U.S. District Court, Northern District of California, San Francisco Division, Case No. C–07–3758–SC). No compensation was received from the plaintiffs for this testimony. I had no prior relation with either party in this action.

Relationship with *CBS News*

I had no prior relationship with *CBS News* before Pia Malbran, producer of the veterans' suicide news story, contacted me in August 2007 asking me to analyze veterans' suicide data. Aside from the gift of a *CBS News* baseball cap (valued at less than 20), I was not paid by *CBS News* for the work that I have done. I understand from Pia Malbran, producer of the veterans' suicide news story, that I was contacted because I had no relationship with the Veterans Administration, veterans groups, or involvement with advocacy related to veterans' issues.

Data Collection

During my initial consultations, Pia Malbran discussed the sources of the data, and I advised her regarding the format in which the data should be provided for data analysis. Ms. Malbran requested that suicide rates be adjusted for age, gender, and race. She obtained population totals from the U.S. Census, and population totals for veterans from the Veterans Administration. The states provided her information on the number of veteran suicides and total number of suicides. Veteran status was to be ascertained from state death records indicating that suicide was the cause of death, and including a check box indicating whether or not the subject was a veteran. In a few cases, veteran status was not available in the death records. Data were to be provided for 2004 and 2005. Death records after 2005 were not available at the time that the news story was prepared.

In response to Pia Malbran's description of the available data, I indicated that an excel spreadsheet should be prepared including columns for state, age class, gender, race, number of veteran suicides, number of suicides with unknown veteran status, total number of suicides, number of veterans, and population total. Suicides with unknown veteran status were allocated to veterans and non-veterans in numbers proportional to the respective sizes of veteran and non-veteran populations. For example, if 10% of all 25–29 year old males in a given state were veterans, then 10% of the suicides of unknown veteran status in that group would be allocated to veterans, while the remaining 90% of suicides in that group would be allocated to non-veterans. This proportional allocation results in conservative estimates, under-estimating the differences between veteran and non-veteran suicide rates.

Preliminary data analysis indicated that states and the Veterans Administration had different definitions of race with respect to the classification of black Hispanic-Americans. So, race was dropped from the data collection efforts. Thus, the data can be cross-classified by state, age class, gender, veteran status, and population size for data analysis. A total of 45 states provided data for 2004 and 2005.

For states with small populations of veterans, the cross classification of veterans by age, gender and suicide status may suffice to identify individual subjects. For that reason, *CBS News* had to agree that data be kept confidential before data were released to *CBS News*. To ensure this confidentiality, I was asked to erase the data immediately following the November 13, 2007 broadcast of the veterans' suicides news story. This was done as requested.

Data Analysis

To avoid investigator bias, the methods of statistical data analyses were specified before data were received from *CBS News*. The specific choice of methods was based on the type of data collected, and the specific estimates that Pia Malbran requested in her memo of October 1, 2007:

1. What is the **overall rate** of suicide (per 100,000—age and gender adjusted) for veterans verses non-veterans **nationwide**?
2. What is rate (per 100,000—age and gender adjusted) of suicide for veterans verses non-veterans **state by state** ranked highest to lowest?
3. What is the overall rate of suicide (per 100,000) for veteran **males (all ages)** verses non-veteran males nationwide?
4. What is the rate of suicide (per 100,000) among **male veterans, 65 or older**? And, how does that compare with male non-veterans, 65 or older?
5 What is the rate of suicide (per 100,000) among **veterans (both genders) aged 20 to 34**?

A logistic regression model was fit to the data from each year (2004 and 2005), including main effects for age-class, gender, and veteran status, as well as two-way interactions among pairs of these explanatory variables. Logistic regression is the standard statistical method for modeling binary responses such as suicide status; a

person has either committed suicide or not committed suicide. The inclusion of interactions allows the effect of veteran status on suicide risk to depend on gender and age. As per the pre-specified protocol for data analysis, the three-way interaction among age, gender and veteran status was dropped from the model since it was not statistically significant.

All estimated suicide rates were adjusted for the impact of age and gender. This was done because suicide rates depend on age and gender. For example, suicide rates are higher among males and than among females. Moreover, males are over-represented among veterans since males are more likely to serve in the military than females. Given the higher suicide rates among males, and the over-representation of males in veteran populations, failure to adjust for gender will result in over-estimates of veteran suicide rates. Similar arguments can be made for the impact of age.

Initial data analysis was completed before my portion of the story was taped by *CBS News* on October 3, 2007. On October 16, Pia Malbran contacted me with data on the numbers of active-duty soldiers committing suicide in 2004 and 2005, cross-classified by age and gender. She expressed concern that some of these soldiers may have been mistakenly classified as veterans in the state death records, and asked me to re-analyze the data subtracting these cases from the veteran suicide counts. Thus, two estimates of veteran suicide rates will be presented. The higher estimate is based on the original analysis, while the lower estimate was obtained after these active-duty suicides were subtracted.

All analyses were carried out using SAS. Analyses using this statistical software involve written code documenting exactly how the analyses are carried out. This is as opposed to other statistical software packages that rely on point-and-click menu-driving procedures for data analysis that leave no record documenting the method of analysis. SAS code used for my data analysis was provided to Ira Katz following the November 13 *CBS News* broadcast.

Results

The estimated suicide risk is higher among veterans than non-veterans. Table 1 presents the age- and gender-adjusted estimates of suicide rates by veteran status for each of the two years. The suicide risk among veterans was estimated to be 1.86–2.32 times the risk among non-veterans in 2004, and 2.10–2.34 times the risk among non-veterans in 2005. These risk ratios were computed by dividing the suicide rates among veterans by the suicide rates among non-veterans.

Table 1. Estimates of overall suicide rates adjusted for age and gender. All rates are expressed as numbers of suicides per 100,000 people.

Veteran Status	2004	2005
Veterans	**17.5–21.8**	**18.7–20.8**.
Non-Veterans	**9.4**	**8.9**.

Table 2 presents the age-adjusted estimates of suicide rates for males and females by veteran status for each of the two years. For both veterans and non-veterans, suicide rates were higher among males than among females. Among males, the suicide risk for veterans was estimated to be 1.67–2.09 times the risk among non-veterans in 2004, and 1.79–2.01 times the risk among non-veterans in 2005. Among females, the suicide risk for veterans was estimated to be 2.08–2.60 times the risk among non-veterans, and 2.47–2.73 times the risk among non-veterans in 2005.

Table 2. Estimates of suicide rates by gender adjusted for age. All rates are expressed as numbers of suicides per 100,000 people.

Gender	Veteran Status	2004	2005
Males	**Veterans**	**30.6–38.3**	**31.5–35.3**
	Non-Veterans	**18.3**	**17.6**
Females	**Veterans**	**10.0–12.5**	**11.1–12.3**
	Non-Veterans	**14.8**	**4.5**

Table 3 presents the gender-adjusted estimates of suicide rates for the various age-classes by veteran status. The most striking result is the high relative risk of suicide among 20–24 year old veterans when compared to non-veterans. For this group of young veterans, the suicide risk is estimated to be 2.81–4.31 times the risk among non-veterans in 2004, and 2.75–3.84 times the risk among non-veterans in 2005. Veterans in their forties also had high estimated suicide rates, but the risk of suicide among non-veterans in their forties was also estimated to be high. Consequently, the risk ratio did not exceed 1.73 in this age group.

Table 3. Estimates of suicide rates by age adjusted for gender. All rates are expressed as numbers of suicides per 100,000 people.

Age Class	Veteran Status	2004	2005
20–24	Veteran	23.3–35.8	22.9–31.9
	Non-Veteran	8.3	8.3.
25–29	Veteran	12.8–15.5	13.1–16.1
	Non-Veteran	9.0	8.3
30–34	Veteran	14.1–14.7	16.1–17.7
	Non-Veteran	10.2	9.9
35–39	Veteran	16.4–17.8	16.1–16.5
	Non-Veteran	11.4	10.5
40–44	Veteran	20.4–20.6	19.4–19.7
	Non-Veteran	13.4	12.6
45–49	Veteran	22.4–22.5	23.4
	Non-Veteran	14.4	13.5
50–54	Veteran	20.3	21.0
	Non-Veteran	13.4	12.9
55–59	Veteran	15.3–15.4	16.0–16.1
	Non-Veteran	11.4	11.0
60–64	Veteran	14.3–14.4	13.6
	Non-Veteran	10.3	10.5
65+	Veteran	11.8	14.9–15.0
	Non-Veteran	9.6	9.7

Prepared Statement of M. David Rudd, Ph.D., ABPP,
Professor and Chair, Department of Psychology,
Texas Tech University, Lubbock, TX

Mr. Chairman and Members of the Committee, thank you for the invitation and opportunity to join you here today and discuss the tragic, but important problem of suicide among our Nation's veterans. I am honored to be here. My scientific and clinical opinions are influenced by a diverse background as a practicing psychologist, clinical researcher whose work focuses on the assessment, management and treatment of suicidality, along with the fact that I'm a veteran. Having served previously as an Army psychologist, I'm keenly aware of the complexity and challenge of clinical decisionmaking during wartime, the competing demands juggled by military

mental health providers, and the arduous task of managing soldiers at risk for suicide both during active duty and after discharge. As a researcher, I understand suicide is most often the end outcome of a complex web of variables, several easily identified but not so easily treated. As a veteran, I have some understanding of what it means to serve our country, the personal and professional sacrifices that are made, and the potential consequences, but only a fraction compared to those that return from war struggling with injuries both visible and invisible.

The tragic increase in both active duty and veteran suicide rates since the beginning of Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) underscore a seldom recognized but very real fact about mental illness; that it can be fatal. Data are now available from multiple sources, including the Department of Veterans Affairs (VA), the recently released RAND Corporation study, along with the existing literature indicating that anywhere from a quarter to a third of previously deployed veterans present with a mental health problem following discharge. Most prominent among the problems are major depression, post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and substance abuse. Data available prior to the most recent military conflicts (OIF/OEF) indicated heightened suicide risk among the general veteran population, with estimates indicating that veterans are twice as likely to die by suicide, regardless of whether or not they were affiliated with the VA. More recent data indicate a marked increase in suicide risk among veterans being treated for depression, with the risk being 7–8 times greater than that for the general adult population in the United States. Similarly, recent revelations about suicide and suicide attempt rates among veterans have been alarming, with estimates as high as 18 suicides a day. Recent data on TBI are also of concern, indicating suicide rates in the range of 3–4 times the general population and lifetime suicide attempt rates of 8%, along with significant rates of suicidal ideation (23%). At this point, the relationship between brain injury and suicidality is not well understood.

An accurate and meaningful interpretation of these data requires a look at and consideration of comparable civilian data. Although it is certainly difficult to accurately estimate suicide rates for those in and out of treatment, there is some data for comparison. The suicide prevalence rate for major depression and affective disorders in general (i.e. major depression, bipolar disorder I and II and affective psychosis) is actually lower than often quoted. Rates differ depending on the apparent severity of the illness, with the outpatient suicide prevalence rate being 2%, in contrast to 6% for those previously hospitalized for suicidal symptoms and 4% for those hospitalized for other reasons. Rates of suicide attempts are much higher. It is estimated that as many 24% of those suffering major depression make a suicide attempt during the course of the illness. It is estimated that up to 50% of individuals with bipolar disorder will make a suicide attempt and up to 80% will manifest suicidal symptoms of some sort. Standardized mortality ratios (ratio of observed deaths to expected deaths) for major depression and bipolar disorder paint a stark picture; those with major depression evidence a twentyfold increased risk for death by suicide relative to the general population and those with bipolar disorder a fifteenfold increase in risk. There are data available regarding other disorders, but the take home message is that the risk for suicide is considerable for a number of mental illnesses. Mental illness can be fatal, particularly if unrecognized, untreated or under-treated.

It is also important to consider the expected rates of adverse events during treatment, in particular, suicide attempt rates. Data are available from randomized clinical trials targeting suicidal behavior (irrespective of diagnosis). Estimates indicate that as many as 40–47% of those receiving treatment (psychotherapy and medications) make suicide attempts during the first year of treatment. If an attempt is made during the first year, the average is approximately 2.5 attempts. This is what routinely happens during treatment. We also know that an individual making multiple suicide attempts will likely struggle with suicidality for many years, if not a lifetime. These data, coupled with data about recent discharge from the hospital, indicate that risk for suicide (in the context of mental illness) is not only potent but enduring. Standardized mortality ratios (ratio of observed deaths to expected deaths) for men and women recently discharged from the hospital range from 100 to 350 across several studies. These are tragically high numbers. The VA experience is not markedly different than its civilian counterpart when it comes to the presentation of high-risk suicidal patients.

There are several possible conclusions. First, as outlined nicely in the RAND study, there are high rates of psychiatric illness following combat exposure, including both direct and vicarious exposure. Multiple deployments for OIF/OEF likely compound the situation because of repeated combat exposure, sometimes after the initial emergence of symptoms. The VA is faced with assessing and treating large

numbers of seriously ill veterans. Second, the overall rates of both suicide and suicide attempts are tragic but consistent with general trends for the types and observed rates of psychiatric illness. Third, an effective response requires effective resources. Finally, there is an element of this problem that is likely to be enduring and potentially chronic in nature.

The VA has already moved toward increasing recognition and treatment of suicidal veterans, implementing a telephone hotline and making available training on recognizing and responding to suicide warning signs. Treatment outcome studies targeting suicidality have confirmed that simple things work and can save lives. Limiting and removing access to the suspected method can save lives. Removing barriers to emergency care can save lives. Patient tracking and effective followup for treatment non-compliance can save lives. Evidence-based treatments for depression, bipolar disorder, PTSD are effective and can save lives. Despite the fact that treatment is effective, it's estimated that only about half of those at risk pursue care.

The military and VA system face unique barriers to providing effective care, including issues of confidentiality, delays in evaluating the escalating numbers of service-connected disability claims, and misconceptions about the nature and effectiveness of mental healthcare. The FDA warning label for antidepressants is but one example of how misunderstanding of the scientific data can lead to fewer people expressing a willingness to seek care, with potentially tragic results. Science, clinical experience, and common sense converge when it comes to suicidality. Improving our ability to both recognize and respond quickly to those at risk can save lives. Removing barriers to care, particularly emergency care, can and will save lives. Those that have served our Nation deserve no less. It is tragic and heartbreaking when a soldier that has survived the trauma of war returns home to die by his or her own hand, especially when treatment is an option.

Thank you, I appreciate the opportunity to speak with you today and welcome the chance to respond to questions.

Prepared Statement of Michael Shepherd, M.D.,
Senior Physician, Office of Healthcare Inspections,
Office of Inspector General, U.S. Department of Veterans Affairs

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on suicide prevention and the Office of Inspector General (OIG) report, *Implementing the VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*. My statement today is based on that report as well as individual cases that the OIG has reviewed and reported on involving veteran suicides and accompanying mental health issues. In the process of these inspections, clinicians in our office have had the opportunity to meet with and listen to the concerns of surviving family members, and to witness the devastating impact that veteran mental health issues and suicide have had on their lives.

The May 2007 OIG report reviewed initiatives from the Veterans Health Administration's (VHA) mental health strategic plan pertaining to suicide prevention and assessed the extent to which these initiatives had been implemented. In prior testimony, we have stressed the importance of the need for VA to continue moving forward toward full implementation of suicide prevention initiatives from the mental health strategic plan. In terms of other changes VA could make, we would offer the following observations:

Community Based Outreach—In our report, we noted that while several facilities had implemented innovative community based suicide prevention outreach programs, (e.g., facility presentations to New York City Police Department officers who are Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, participation by mental health staff in local Spanish radio and television shows) the majority of facilities did not report community based linkages and outreach aimed at suicide prevention. In addition, less than 20 percent of facilities reported utilizing the Chaplain service for liaison and outreach to faith-based organizations in the community (e.g., inviting faith-based organizations in the area to a community meeting at a VA Medical Center (VAMC) to explain VHA services available, having a VA Chaplain accompany the OIF/OEF coordinator to post-deployment events in the community). Although facilities would need to tailor strategies to consider local demographics and resources, a system-wide effort at community based outreach appears prudent.

Timeliness from Referral to Mental Health Evaluation—In our report we noted that while most facilities self-reported that three-fourths or more of those patients

with a moderate level of depression referred by primary care providers are seen within 2 weeks of referral, approximately 5 percent reported a significant 4–8 week wait. Because these patients are at risk for progression of symptom severity and possible development of suicidal ideation, Veterans Integrated Service Network leadership should work with facility directors to ensure that once referred, patients with a moderate level of depression and those recently discharged following hospitalization are seen in a timely manner at all VAMCs and Community Based Outpatient Clinics (CBOCs).

Co-Occurring Combat Stress Related Illness and Substance Use—Substance use may contribute to the severity of a concurrent or underlying mental health condition such as major depression. The presence of alcohol may cause or exacerbate impulsivity and acute alcohol use is associated with completed suicide. In a recent study published in the Journal of the American Medical Association (JAMA), *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, Milliken et al., found that soldiers frequently reported alcohol concerns on the Post Deployment Health Assessment and Reassessments "yet very few were referred to alcohol treatment."

Regardless of why a patient begins to abuse alcohol, with frequent and/or excessive use, physiologic and psychologic drives develop until alcohol misuse ultimately takes on a life of its own that is independent of patient history and circumstance. Functional ability and quality of life become dually impacted by both underlying anxiety and depressive symptoms and co-morbid substance use issues. For patients with concurrent conditions, an effective treatment paradigm may require addressing the primacy of not only anxiety/depressive conditions but also of co-morbid substance use disorders. VA should consider augmenting services that address substance use disorders co-morbid with combat stress related illness for inclusion in a comprehensive program aimed at suicide prevention.

Enhanced Access to Mental Health Care—Treatments for mental health problems may take time to show effect. For example, antidepressant medication, when indicated, may take several weeks to several months to effect symptom reduction or remission. For some patients, treatment may necessitate multiple visits that occur consistently over time and may entail multiple modalities including individual and/or group evidence based psychotherapy, medication management, and/or readjustment counseling. Therefore, efforts that enhance patient access to appropriate treatment may help facilitate both patient engagement and the potential for treatment benefit.

For example, ongoing enhancements in the availability of mental health services at CBOCs may help mitigate vocational and logistical challenges facing some veterans residing in more rural areas who otherwise may have to travel longer distances to appointments at the parent VAMC.

In certain locations, the VA may want to consider expanding care during off-tour hours to increase the ability for some transitioning OIF/OEF veterans to access mental health treatment while minimizing interference with occupational, and/or educational obligations. This would be consistent with the recovery model for mental health treatment which emphasizes not only symptom reduction but also promotion and return to functional status.

Facilitating Early Family Involvement—Mental health symptoms can have a significant and disruptive impact on family and domestic relationships. Relational discord has been cited as one factor associated with suicide in active duty military and returning veterans. In addition, some studies indicate that family involvement in a patient's treatment may enhance the ability for some patients to maintain treatment adherence. VA should consider efforts to bolster early family participation in patient treatment.

Coordination between VHA and Non-VHA Providers—When patients receive mental health treatment from both VHA and non-VHA providers, seamless communication becomes an increasingly complex challenge. This fragmentation of care is particularly worrisome in periods of patient destabilization or following discharge from a hospital or residential mental health program. VA's Office of Mental Health Services should consider development of innovative methods or procedures to facilitate flow of information for patients receiving simultaneous treatment from VA and non-VA providers while adhering to relevant privacy statutes. In addition, VA's Readjustment Counseling Service and VA's Office of Patient Care Services should pursue further efforts to heighten communication and record sharing for patients receiving both counseling at Vet Centers and treatment at VAMCs and/or affiliated CBOCs.

Mr. Chairman, thank you again for this opportunity to testify. I would be pleased to answer any questions that you or other Members of the Committee may have.

CBS News
Suicide Epidemic Among Veterans
NEW YORK, Nov. 13, 2007

(CBS) They are the casualties of wars you don't often hear about—soldiers who die of self-inflicted wounds. Little is known about the true scope of suicides among those who have served in the military.

But a 5-month *CBS News* investigation discovered data that shows a startling rate of suicide, what some call a hidden epidemic, Chief Investigative Reporter Armen Keteyian reports exclusively.

"I just felt like this silent scream inside of me," said Jessica Harrell, the sister of a soldier who took his own life.

"I opened up the door and there he was," recalled Mike Bowman, the father of an Army reservist.

"I saw the hose double looped around his neck," said Kevin Lucey, another military father.

"He was gone," said Mia Sagahon, whose soldier boyfriend committed suicide.

Keteyian spoke with the families of five former soldiers who each served in Iraq—only to die battling an enemy they could not conquer. Their loved ones are now speaking out in their names.

They survived the hell that's Iraq and then they come home only to lose their life.

Twenty-three-year-old Marine Reservist Jeff Lucey hanged himself with a garden hose in the cellar of this parents' home—where his father, Kevin, found him.

"There's a crisis going on and people are just turning the other way," Kevin Lucey said.

Kim and Mike Bowman's son Tim was an Army reservist who patrolled one of the most dangerous places in Baghdad, known as Airport Road.

"His eyes when he came back were just dead. The light wasn't there anymore," Kim Bowman said.

Eight months later, on Thanksgiving Day, Tim shot himself. He was 23.

Diana Henderson's son, Derek, served three tours of duty in Iraq. He died jumping off a bridge at 27.

"Going to that morgue and seeing my baby . . . my life will never be the same," she said.

Beyond the individual loss, it turns out little information exists about how widespread suicides are among these who have served in the military. There have been some studies, but no one has ever counted the numbers nationwide.

"Nobody wants to tally it up in the form of a government total," Bowman said.

Why do the families think that is?

"Because they don't want the true numbers of casualties to really be known," Lucey said.

Sen. Patty Murray, D-Wash., is a Member of the Veterans' Affairs Committee.

"If you're just looking at the overall number of veterans themselves who've committed suicide, we have not been able to get the numbers," Murray said.

CBS News' investigative unit wanted the numbers, so it submitted a Freedom of Information Act request to the Department of Defense asking for the numbers of suicides among all servicemembers for the past 12 years.

Four months later, they sent *CBS News* a document, showing that between 1995 and 2007, there were almost 2,200 suicides. That's 188 last year alone. But these numbers included only "active duty" soldiers.

CBS News went to the Department of Veterans Affairs, where Dr. Ira Katz is head of mental health.

"There is no epidemic in suicide in the VA, but suicide is a major problem," he said.

Why hasn't the VA done a national study seeking national data on how many veterans have committed suicide in this country?

"That research is ongoing," he said.

So *CBS News* did an investigation—asking all 50 states for their suicide data, based on death records, for veterans and non-veterans, dating back to 1995. Forty-five states sent what turned out to be a mountain of information.

And what it revealed was stunning.

In 2005, for example, in just those 45 states, there were at least 6,256 suicides among those who served in the armed forces. That's 120 each and every week, in just one year.

Dr. Steve Rathbun is the acting head of the Epidemiology and Biostatistics Department at the University of Georgia. *CBS News* asked him to run a detailed analysis of the raw numbers that we obtained from state authorities for 2004 and 2005.

It found that veterans were more than twice as likely to commit suicide in 2005 than non-vets. (Veterans committed suicide at the rate of between 18.7 to 20.8 per 100,000, compared to other Americans, who did so at the rate of 8.9 per 100,000.)

One age group stood out. Veterans aged 20 through 24, those who have served during the war on terror. They had the highest suicide rate among all veterans, estimated between two and four times higher than civilians the same age. (The suicide rate for non-veterans is 8.3 per 100,000, while the rate for veterans was found to be between 22.9 and 31.9 per 100,000.)

"Wow! Those are devastating," said Paul Sullivan, a former VA analyst who is now an advocate for veterans rights from the group Veterans For Common Sense.

"Those numbers clearly show an epidemic of mental health problems," he said.

"We are determined to decrease veteran suicides," Dr. Katz said.

"One hundred and twenty a week. Is that a problem?" Keteyian asked.

"You bet it's a problem," he said.

Is it an epidemic?

"Suicide in America is an epidemic, and that includes veterans," Katz said.

Sen. Murray said the numbers *CBS News* uncovered are significant: "These statistics tell me we've really failed people that served our country."

Do these numbers serve as a wake-up call for this country?

"If these numbers don't wake up this country, nothing will," she said. "We each have a responsibility to the men and women who serve us aren't lost when they come home."

CBS News
VA Hid Suicide Risk, Internal E-Mails Show
April 21, 2008

(CBS) The Department of Veterans Affairs came under fire again Monday, this time in California Federal court where it's facing a national lawsuit by veterans rights groups accusing the agency of not doing enough to stem a looming mental health crisis among veterans. As part of the lawsuit, internal e-mails raise questions as to whether top officials deliberately deceived the American public about the number of veterans attempting and committing suicide. *CBS News* chief investigative correspondent Armen Keteyian reports.

In San Francisco Federal court Monday, attorneys for veterans' rights groups accused the U.S. Department of Veteran's Affairs of nothing less than a cover-up—deliberately concealing the real risk of suicide among veterans.

"The system is in crisis and unfortunately the VA is in denial," said veterans rights attorney Gordon Erspamer.

The charges were backed by internal e-mails written by Dr. Ira Katz, the VA's head of Mental Health.

In the past, Katz has repeatedly insisted while the risk of suicide among veterans is serious, it's not outside the norm.

"There is no epidemic in suicide in VA," Katz told Keteyian in November.

But in this e-mail to his top media adviser, written two months ago, Katz appears to be saying something very different, stating: "Our suicide prevention coordinators are identifying about 1,000 suicide attempts per month among veterans we see in our medical facilities."

Katz's e-mail was written shortly after the VA provided *CBS News* data showing there were only 790 attempted suicides in all 2007—a fraction of Katz's estimate.

"This 12,000 attempted suicides per year shows clearly, without a doubt, that there is an epidemic of suicide among veterans," said Paul Sullivan of Veterans for Common Sense.

And it appears that Katz went out of his way to conceal these numbers.

First, he titled his e-mail: "Not for the *CBS News* Interview Request."

He opened it with "Shh!"—as in keep it quiet—before ending with "Is this something we should (carefully) address—before someone stumbles on it?"

On Monday, *CBS News* showed the e-mail to Rep. Bob Filner, D-Calif., who chairs the House Committee on Veterans Affairs.

"This is disgraceful. This is a crime against our Nation, our Nation's veterans," Filner told *CBS News*. "They do not want to come to grips with the reality, with the truth."

And that's not all.

Last November when *CBS News* exposed an epidemic of more than 6,200 suicides in 2005 among those who had served in the military, Katz attacked our report.

"Their number is not, in fact, an accurate reflection of the rate," he said last November.

But it turns out they were, as Katz admitted in this e-mail, just three days later. He wrote: there "are about 18 suicides per day among America's 25 million veterans."

That works out to about 6,570 per year, which Katz admits in the same e-mail, "is supported by the CBS numbers."

In an e-mail late Monday to *CBS News*, Katz wrote that the reason the numbers were not released was due to questions about the consistency and reliability of the findings—and that there was no public cover up involved.

CRS REPORT TO CONGRESS
Suicide Prevention Among Veterans
May 5, 2008
Order Code RL34471

By Ramya Sundararaman, Sidath Viranga Panangala, and Sarah A. Lister
Domestic Social Policy Division, Congressional Research Service

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Summary

Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF). In the United States, there are more than 30,000 suicides annually. Suicides among veterans are included in this number, but it is not known in what proportion. There is no nationwide system for surveillance of suicide specifically among veterans. Recent data show that about 20% of suicide deaths nationwide could be among veterans. It is not known what proportion of these deaths are among OIF/OEF veterans.

Veterans have a number of risk factors that increase their chance of attempting suicide. These risk factors include combat exposure, post-traumatic stress disorder (PTSD) and other mental health problems, traumatic brain injury (TBI), poor social support structures, and access to lethal means.

Several bills addressing suicide in veterans have been introduced in the 110th Congress. On November 5, 2007, the Joshua Omvig Veterans Suicide Prevention Act (P.L. 110–110) was signed into law, requiring the Department of Veterans Affairs (VA) to establish a comprehensive program for suicide prevention among veterans. More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This bill would require the VA to conduct a study, and report to Congress, regarding suicides among veterans since 1997.

The VA has carried out a number of suicide prevention initiatives, including establishing a national suicide prevention hotline for veterans, conducting awareness events at VA medical centers, and screening and assessing veterans for suicide risk.

This report discusses data sources and systems that can provide information about suicides in the general population and among veterans, and known risk and protective factors associated with suicide in each group. It also discusses suicide prevention efforts by the VA. It does not discuss Department of Defense (DoD) activities, or VA's treatment of risk factors for suicide, such as depression, PTSD, and substance abuse.

This report will be updated when legislative activity warrants.

Introduction

Considerable public attention has been drawn toward the mental healthcare needs of veterans, especially those returning from combat in Iraq and Afghanistan. Numerous news stories in the popular print and electronic media have documented suicides among servicemembers and veterans returning from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF).[1] Some veterans advocacy groups have filed a class-action lawsuit claiming that the Department of Veterans Affairs (VA) is not providing adequate and timely access to mental healthcare, and that this has led to an "epidemic of suicides."[2]

However, most often the data cited in these press reports do not differentiate between suicides among veterans and active duty servicemembers.[3] It is important to make this distinction, because two separate healthcare systems—at the VA and the Department of Defense (DoD), respectively—are responsible for providing mental healthcare to these two distinct populations. This report explains the difficulties in determining the incidence of suicide among veterans, summarizes what is known about suicides in the general population and among veterans, and discusses known risk and protective factors associated with suicide in each group. It also discusses recent congressional action to address suicide among veterans, and suicide prevention efforts by the VA. The report does not discuss DoD activities, or VA's treatment of risk factors for suicide, such as depression, post-traumatic stress disorder (PTSD), and substance abuse.

Data and Data Systems for Tracking Suicide

Suicide is the act of intentionally ending one's life, attempted suicide is an effort that does not have a fatal outcome, and suicidal ideation is thinking about or wanting to end one's life. Because completed (versus attempted) suicide results in death, national statistics on suicide come from death certificate data.[4] These data are collected by state and territorial health officials, under their authority, and are voluntarily reported to the Centers for Disease Control and Prevention's (CDC's) National Vital Statistics System. The CDC analyzes the data and publishes information on numbers and rates of death, and important trends, in the United States.[5] The CDC also publishes a U.S. standard death certificate, which states and territories can modify. Most U.S. deaths are not investigated by government officials. Possible sui-

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[1] Ken Fuson and Jennifer Jacobs, "Iowans Lauded for Anti-suicide Efforts," *The Des Moines Register*, January 26, 2008; Dana Priest, "Soldier Suicides at Record Level," *Washington Post*, January 31, 2008, Page A01; "Soldier, After Bipolar Treatment and Suicide Attempts, Sent Back to War Zone," *Editor & Publisher*, February 11, 2008; "Suicide Epidemic Among Veterans—A *CBS News* Investigation Uncovers a Suicide Rate for Veterans Twice That of Other Americans," aired November 13, 2007. OEF, which began in October 2001, conducts combat operations in Afghanistan and other locations. OIF, which began in March 2003, conducts combat operations in Iraq and other locations.

[2] *Veterans for Common Sense and Veterans United for Truth, Inc., v. James B. Peake, Secretary of Veterans Affairs, et al.*, Plaintiffs Trial Brief, Case No. C–07–3758–SC, filed April 17, 2008.

[3] Within the context of the VA, a veteran is defined as a "person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable." [38 USC § 101(2); 38 CFR § 3.1(d)]. The VA largely bases its determination of veteran status upon military department service records.

[4] In reference to fatal suicides, the public health community prefers to use the term "completed," rather than "committed" or "successful," to recognize the frequent association of suicide with mental illness, and reduce the accompanying stigma.

[5] For more information, see Centers for Disease Control and Prevention (CDC), Mortality Data from the National Vital Statistics System, at http://www.cdc.gov/nchs/deaths.htm, visited May 2, 2008.

cides may be investigated, however, pursuant to state and territorial authorities. To the extent that a death is recognized as a suicide, the standard death certificate provides the means to report suicide as the manner of death, but it has limited options for noting other information that may be relevant to the suicide.

In 2003, CDC launched the National Violent Death Reporting System (NVDRS), an active surveillance system that provides detailed information about the circumstances of violent deaths, including suicide.[6] The NVDRS augments death certificate data by linking it to death investigation reports filed by coroners, medical examiners, and law enforcement officials. These added layers of information allow the NVDRS to identify suicide risk factors, such as depression; to gather additional information, such as toxicology results; and to more reliably capture information that could have been, but was not, completed on the standard death certificate. At this time, the NVDRS is not in operation nationwide, but only in 17 states, and NVDRS data might not be generalizable to the entire U.S. population. Also, because protocols for death investigation vary from one state to the next, NVDRS data might not be comparable between those states in which it is in operation. CDC's goal is to expand the system to all 50 states, all U.S. territories, and the District of Columbia, and to continue efforts to standardize data collection and analysis across states.

At this time, there is no nationwide system for surveillance (i.e., tracking) of suicide among all veterans. As with all suicides in civilian jurisdiction, suicides among veterans may be investigated, and the death certificates completed, by state and territorial authorities. Unless a veteran's suicide occurs in a VA facility, opportunities for the VA to become aware of the incident may be limited. Three approaches are being used to track the incidence of suicide among veterans, though each of them has serious shortcomings.

First, CDC's standard death certificate allows officials to note if a decedent *has ever served*[7] in the U.S. Armed Forces. However, the fact that a decedent is a veteran is not always known when the certificate is completed. Although suicides among veterans are a part of total national suicide statistics, it is not known what proportion of that total is made up of veterans.

Second, VA data may be linked to CDC's vital statistics data through the National Death Index (NDI). This CDC data system allows authorized researchers to link national death data to other data systems, identifying the fact that an individual had died of suicide, and that a death certificate has been filed.[8] This would allow the VA to identify suicide deaths among its enrollees. (Subsequent research steps are cumbersome. For example, researchers typically must contact state officials to access the actual death certificates.) The NDI is not an ongoing data linkage that would constitute surveillance for suicide. It can be used, however, to support special studies by linking specific data sets. For example, researchers from the VA and the University of Michigan conducted a study in which they linked data from VA's National Registry for Depression (NARDEP) to the NDI, allowing VA to match its patient registry to certified suicide deaths even when the decedent's veteran status had not been noted on the death certificate.[9] However, because only about one-third of veterans receive their healthcare from the VA, using VA health systems data for linkage would not capture the complete experience of suicide among veterans.

Third, the NVDRS resolves many of the problems discussed above. Through ongoing active surveillance, NVDRS substantially improves the likelihood that a suicide victim's veteran status will be captured, and it provides additional useful information about suicide incidents. But NVDRS is in operation in only 17 states. Though CDC intends it to become a nationwide system, expansion would depend on appropriations. Congress first provided funding for NVDRS in FY 2002 and has expressed support for the program in annual appropriations report language. The program has not received a specified appropriation in recent years, but rather is funded through CDC's budget for intentional injury prevention and control.

Suicide in the U.S. General Population

There are *risk factors* that increase the likelihood that someone will attempt suicide, and *protective factors* that decrease that likelihood. This section provides some

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[6] See CDC, National Violent Death Reporting System, at http://www.cdc.gov/ncipc/profiles/nvdrs/default.htm.

[7] This definition captures current and former U.S. military servicemembers.

[8] See CDC, National Death Index, at http://www.cdc.gov/nchs/ndi.htm.

[9] Zivin et al., "Suicide Mortality among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics," *American Journal of Public Health*, Vol. 97, No. 12, pp. 2193–8, December 2007, hereafter referred to as Zivin et al., study of depression and suicide in veterans.

context for suicide among veterans by discussing the incidence, and risk and protective factors, for suicide in the U.S. general population.[10]

Incidence of Suicide

Suicide is a serious public health problem in the United States. According to CDC, there were more than 32,000 suicide deaths in the United States in 2004, making it the 11th leading cause of death that year. On average, there are four suicides among males for each one among females. Use of firearms is the most common method of suicide among males, while poisoning is the most common method among females. Suicide is the second leading cause of death among 25–34 year olds, and the third leading cause of death among 15–24 year olds. Although suicide is a leading cause of death in younger adults, the *rate* of suicide (number of suicides within the age group per 100,000 resident population in the age group) is actually highest in individuals aged 45 or older. **Table 1** presents suicide rates across age groups in the United States for 2004, as published by CDC. It is important to note that except in the youngest age group, these rates may, and probably do, include suicides among veterans, though in proportions that are not known.

Table 1. U.S. Death Rates for Suicide, by Age, 2004

Age Group	5–14 years	15–24 years	25–44 years	45–64 years	65 years and over	All age groups[a]
Suicide rate	0.7	10.3	13.9	15.4	14.3	10.9

A**Source**: CDC, death rates for suicide, according to sex, race, Hispanic origin, and age: selected years, 1950–2004, "Health, United States, 2007," Table 46, at http://www.cdc.gov/nchs/data/hus/hus07.pdf.

A**Notes**: CDC does not calculate rates based on small numbers of suicides among those younger than five years of age, as such rates are not statistically reliable. In the source above, CDC also published rates for subintervals of the age intervals presented here (e.g., for those aged 25–34 years and 35–44 years).

Aa. This rate is age-adjusted, calculated using the year 2000 standard population.

There are no official national statistics on attempted suicide (i.e., attempts that were not fatal), but it is generally estimated that there are 25 attempts for each death by suicide. Also, it is reported that there are three suicide attempts among females for every one among males.

Risk and Protective Factors

No single cause or factor leads to suicide. It is a "final common outcome with multiple potential antecedents, precipitants, and underlying causes."[11] A number of factors are known to increase or decrease the likelihood that an individual will attempt suicide. Factors that increase this likelihood are called *risk factors*. Risk factors exist at multiple levels, involving individual, family, community, and societal factors. Conversely, factors that decrease a person's inclination to attempt suicide are called *protective factors*, which also exist at multiple levels. It is important to note that none of these factors in isolation is known to cause or prevent suicide.

The single best predictor of an increased risk of suicide is a history of a prior suicide attempt. Other risk factors for suicide in the general population include certain mental illnesses such as depression, alcohol and substance abuse, history of trauma or abuse, family history of suicide, job or financial stress, the stigma associated with seeking mental healthcare, barriers to healthcare access, and easy access to lethal means. Protective factors include strong family or community connections; accessible and effective clinical care; skills in problem solving, conflict resolution, and nonviolent handling of disputes; and cultural and religious beliefs that discourage suicide.[12]

Suicide Among Veterans

In the absence of national surveillance for suicide among veterans, information is limited to the findings of special epidemiological studies and surveys. These vary

[10] Unless otherwise noted, information in this section is drawn from CDC: "Suicide, Facts at a Glance," Summer 2007, and "Understanding Suicide, Fact Sheet," 2006, at http://www.cdc.gov/ncipc/dvp/suicide/; and "Surveillance for Violent Deaths—National Violent Death Reporting System, 16 States, 2005," *MMWR*, vol. 57(SS03), April 11, 2008, hereafter referred to as NVDRS 2005 report, at http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm.

[11] Testimony of Michael Shepherd, M.D., Office of Healthcare Inspections, Office of Inspector General, Department of Veterans Affairs, in U.S. Congress, House Committee on Veterans' Affairs, hearing on *Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs*, December 12, 2007.

[12] Suicide Prevention Resource Center, "Risk and Protective Factors for Suicide," at http://www.sprc.org/library/srisk.pdf, visited April 30, 2008.

considerably in their design and in the sub-population of veterans studied, and they often yield conflicting results.

It is tempting to make comparisons between these studies, and with information about suicide in the general population. Such comparisons are often made, but they are not necessarily valid. Among other things, data about suicides in the general population includes suicides among veterans. Information about suicide in groups that exclude veterans is scant, as is information about the extent to which data for veterans may skew the data for the general population, if at all. An additional problem in interpreting the findings of these special studies is that they are often conducted on populations of veterans who are receiving treatment for suicide risk factors. On the one hand, this makes it difficult to determine whether study findings reflect the effects of risk factors, or the effects of interventions. On the other hand, it indicates that efforts to develop systematic surveillance of suicide among veterans may, with careful attention to design, also provide the means to evaluate the effectiveness of prevention and treatment programs. This section discusses the findings of some key studies of suicide among veterans.

Incidence of Suicide

The true incidence of suicide among veterans is not known. This section discusses information from two recent published studies that yield a partial picture of the burden of suicide in this group.

In 2005, the NVDRS identified 1,821 suicides among former or current military personnel, comprising 20% of all suicides, in the 16 states in which the system was operational that year.[13] CDC's published findings about these 1,821 decedents include the following:

- 1,765 (96.9%) were male.
- 1,415 (77.7%) were 45 years of age or older.
- The most common method used was firearms (67.9%), followed by poisoning (12.7%), and hanging/strangulation/suffocation (11.5%).
- 47.2% were married, 25.0% were divorced, 13.0% were widowed, and 14.0% were never married.[14]

Researchers from the VA and the University of Michigan conducted a cohort study of 807,694 veterans who were diagnosed with depression in the VA health system, and registered in the VA's National Registry for Depression (NARDEP), between 1999 and 2004.[15] During the study period, 1,683 (0.21%) of the veterans in this high-risk group committed suicide. The researchers calculated a rate of 88.25 suicides per 100,000 person-years in this group, seven to eight times higher than the rate in the general population for the same time period. They noted that this rate was similar, though, to a more relevant comparison, namely, to suicides among those in the general population who were depressed.[16] They also found the rate among the group of veterans studied to be highest among those who were younger than 45 years of age, in contrast with the age trend in the general population.

In December 2007, VA testified that it had identified 144 known suicides among OIF/OEF veterans from the time the conflicts began through the end of 2005, and that this number translated into a rate that is not statistically different from the rate for age, sex, and race matched individuals from the general population. These data have not been published.[17]

Risk and Protective Factors

While there have been a number of studies to identify risk and protective factors for suicide in the general population, few studies have looked at factors specific to

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[13] NVDRS 2005 report. The definition "current and former military personnel" is likely to include both current military personnel and veterans, but the publication does not provide information about each group separately, or about whether such separate information is available.

[14] The remaining small number of decedents were "married but separated," "single, not otherwise specified," or their marital status was not known. These findings were not cross-tabulated by age.

[15] Zivin et al., study of depression and suicide in veterans. The authors used CDC's National Death Index to link NARDEP registrants with death certificate data, in order to identify registrants who had died, and determine that they died of suicide, during the study period.

[16] The authors cited only one study on which to base this comparison, though, which likely reflects the limited availability of studies in groups that are meaningful for comparison. It is not clear whether the comparison group included or excluded veterans.

[17] Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans' Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs*, hearings, 110th Cong., 1st sess., December 12, 2007.

veterans. In the general population, suicide risk factors include male gender; older age; diminished psycho-social support (e.g., homelessness or unmarried status); availability and knowledge of firearms; and the co-existence of medical and psychiatric conditions. This profile describes a large portion of the veteran patient population, making suicide risk management particularly challenging in the VA healthcare system.[18] A study that screened 703 patients from a general medical outpatient clinic at a VA hospital found that 7.3% of the patients had suicidal ideation.[19] Younger and white patients were found to be at increased risk. The risk was higher in patients with self-described fair or poor mental health, a history of mental health treatment, and fair or poor perceived physical health. When major depression was controlled for, anxiety and substance abuse disorders continued to show an association with suicidal ideation.

CDC's NVDRS data identified the following associated circumstances among a group of 1,622 former or current military personnel who died by suicide in 2005:[20]

- Although almost half of them (47.2%) were depressed at the time of death, only about a fourth (26.7%) were receiving mental health treatment.
- 17.2% had an alcohol problem, and 7.7% had a problem with other substances.
- 24.5% had a problem with an intimate partner.
- 38.4% had a physical health problem.
- 28.0% had experienced an acute crisis during the prior two weeks.
- 33.9% had left a suicide note, 13.3% had made a previous suicide attempt, and 29.0% had disclosed their intent to commit suicide with enough time for someone to have intervened.

The VA/University of Michigan study of suicide among veterans with depression found that having a service-connected disability was associated with a lower risk of suicide in this group.[21] The authors suggest that greater access to VA health facilities and regular compensation payments may explain the protective effect.

The Effects of PTSD, TBI, and Depression on Suicide Risk

This section describes three suicide risk factors that are common among veterans: Post-traumatic Stress Disorder (PTSD), Traumatic Brain Injury (TBI), and depression. PTSD and TBI are common consequences of war, with distinct symptoms, treatment modalities, and long-term effects. PTSD has been recognized in various forms throughout military history. It is an anxiety disorder, with symptoms of varying severity, that can occur following experiences, such as military combat, in which grave physical injury occurred or was threatened. People who suffer from PTSD often relive the experience through nightmares and flashbacks, have difficulty sleeping, and feel detached or estranged. TBI occurs when a sudden physical trauma causes damage to the brain. Improvised explosive devices (IEDs), which have been used extensively in the current conflict in Iraq, can cause TBI, sometimes in the absence of obvious external signs of injury. Symptoms of TBI can be mild, moderate, or severe, depending on the extent of the brain injury. When symptoms of TBI or PTSD are mild, they may go undiagnosed, or be confused with conditions with similar symptoms, such as other mental illnesses, including depression, or substance use disorders. Either PTSD or TBI may co-occur with depression or substance abuse. Finally, some veterans have both a TBI and PTSD.

In April 2008, the RAND Corporation published a study of mental health problems in servicemembers and veterans.[22] From their review of the literature, the authors found that in the general population, depression, PTSD, and TBI are each independent risk factors for suicide. More limited information from studies of servicemembers or veterans generally shows the same effect of these three risk factors in specific groups that were studied. This information also typically shows trends comparable to those in the general population with respect to other risk factors for suicide, though the demonstrated effects of interactions of these factors with depression, PTSD and TBI may differ. For example, studies have found that while males are at greater risk of death from suicide than are females, the effects that depres-

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[18] Lambert et al., "Suicide Risk Factors among Veterans: Risk Management in the Changing Culture of the Department of Veterans Affairs," *Journal of Mental Health Administration*, Vol. 24, No. 3, pp. 350–8, Summer 1997.

[19] Lish et al., "Suicide Screening in a Primary Care Setting at a Veterans Affairs Medical Center," *Psychosomatics*, Vol. 37, No. 5, pp. 413–24, 1996.

[20] NVDRS 2005 report. This group is a subset of the 1,821 former or current military personnel whose suicides were recorded in NVDRS in 2005, for whom these additional types of information were collected.

[21] Zivin et al., study of depression and suicide in veterans.

[22] Tanelian and Jaycox, "Invisible Wounds of War," RAND, 2008, at http://RAND.org/pubs/monographs/2008/RAND_MG720.1.pdf, visited April 28, 2008.

sion, PTSD and TBI have on increasing this risk is greater in females. Among the general population, substance abuse, prior nonfatal suicide attempts, severity of PTSD symptoms, and certain types of TBI are more predictive for suicide, and may signal areas of greater suicide risk among military and veterans populations as well. Researchers also found that combat exposure increases the risk of suicide, as well as the likelihood of PTSD, which itself also increases the risk of suicide.

The VA/University of Michigan study of suicide among veterans with depression found that PTSD was associated with a lower risk of suicide in this group.[23] The authors suggest that this unexpected finding may reflect the effect of treatment for PTSD, rather than a protective effect of PTSD itself.

Congressional Action

In the 109th Congress, two measures (H.R. 5771 and S. 3808) were introduced regarding the prevention of suicide among veterans. However, these bills did not see further legislative action.

In the 110th Congress, the Joshua Omvig Veterans Suicide Prevention Act (H.R. 327) was introduced in the House, and a companion version (S. 479) was introduced in the Senate.[24] The House passed H.R. 327 on March 21, 2007, and the Senate passed the House measure with an amendment on September 27. The bill was signed into law (P.L. 110–110) on November 5, 2007.[25] The act, among other things, requires the VA to establish a comprehensive program for suicide prevention among veterans. In carrying out this comprehensive program, the VA must designate a suicide prevention counselor at each VA medical facility. Each counselor is required to work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans. The act also requires the VA to provide for research on best practices for suicide prevention among veterans, and requires the VA Secretary to provide for outreach and education for veterans and their families, with special emphasis on providing information to veterans of OIF and OEF. The act requires VA to provide for the availability of 24-hour mental healthcare for veterans and to establish a 24-hour hotline for veterans to call if needed.

Also in the 110th Congress, the National Defense Authorization Act for Fiscal Year 2008 (P.L. 110–181) requires the Secretaries of DoD and VA to develop a comprehensive care and transition policy for servicemembers who are recovering from serious injuries or illnesses related to their military service, and to specifically address the risk of suicide among these individuals in developing the required policy.[26]

More recently, the Veterans Suicide Study Act (S. 2899) was introduced. This measure would require the VA to study and report to Congress regarding suicides that have occurred among veterans since 1997. In carrying out this study, the VA Secretary would have to coordinate with the Secretary of Defense, Veterans Service Organizations, the CDC, and state public health offices and veterans agencies.

VA's Suicide Prevention Efforts[27]

In response to legislation and congressional oversight, the VA has initiated several suicide prevention activities. Following is a summary of major activities.

Mental Health Strategic Plan

In 2004, the VA developed the Mental Health Strategic Plan (MHSP), which aimed to present a new approach to mental healthcare, to focus on recovery rather than pathology, and to integrate mental healthcare into overall healthcare for veteran patients. This 5-year action plan, with more than 200 initiatives, includes timetables and responsible offices identified for each action item. A number of these action items are specifically aimed at the prevention of suicide. In 2006, following a request by the House Committee on Veterans Affairs, the VA's Inspector General (IG) undertook an assessment of VA's progress in implementing the MHSP initia-

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[23] Zivin et al., study of depression and suicide in veterans.

[24] The Joshua Omvig Veterans Suicide Prevention Act is named for a veteran who completed suicide on December 22, 2005.

[25] Codified at 38 USC § 1720F. For a detailed legislative history of PL 110–110, see H.Rept. 110–55 and S.Rept. 110–132.

[26] See CRS Report RL34371, "*Wounded Warrior" and Veterans Provisions in the FY 2008 National Defense Authorization Act*, by Sarah A. Lister, Sidath Viranga Panangala, and Christine Scott.

[27] Drawn from the Department of Veterans Affairs, Report to Congress, *P.L. 110–110, Comprehensive Program for Suicide Prevention Among Veterans*, February 2008.

tives for suicide prevention, and provided recommendations.[28] The IG's findings revealed that MHSP initiatives pertaining to 24-hour crisis availability, outreach, referral, and development of methods for tracking veterans at risk have been implemented in multiple facilities, but not yet systemwide. Initiatives focused on the development of methods for screening, assessment of veterans at risk, emerging best practice treatment interventions, education of VA health providers, and an electronic suicide prevention database have been piloted or are in the process of being piloted at selected facilities.

Mental Health Research

VA's Mental Illness Research, Education and Clinical Center (MIRECC) at Denver, Colorado, and the Center of Excellence in Mental Health and PTSD at Canandaigua, New York, have been specifically focusing on research related to suicide prevention. According to the VA, ongoing studies at these centers are studying suicide risk factors, validation of suicide ideation screening instruments, quality of mental healthcare and its relationship to suicide prevention, and risk factors for suicide as it relates to depression.

Suicide Awareness

In April 2007, VA held its first Suicide Prevention Awareness Day at all VA medical centers (VAMCs). The program included recognizing risk factors for suicide, and proper protocols for responding to crisis situations. VA held its second Suicide Prevention Awareness Day in September 2007. The program consisted of required training for all staff on general principles of suicide prevention, and the use of the national VA Suicide Prevention Hotline (see below).

VA has also appointed Suicide Prevention Coordinators who are located at each VA medical center. They were appointed in response to P.L. 110–110, which required VA to appoint suicide prevention counselors in each VA medical facility. The primary function of these coordinators is to support the identification of patients at high risk for suicide, and to ensure that their monitoring and care are intensified. Furthermore, they are involved in training and education, both within the VA and in the community. All the coordinators are licensed mental health professionals.

Screening

A screening program aims to identify individuals who have mental or emotional problems that increase their risk for suicide.[29] VA has implemented a policy to screen all OEF/OIF veterans for depression, PTSD, and alcohol abuse upon their initial visit to VA medical centers or clinics. Furthermore, screening for depression and alcohol abuse is required on an annual basis for all veterans, and screening for PTSD is required annually for the first five years after enrollment, and every five years thereafter. Veterans who screen positive for one of these conditions are required to receive a follow-up clinical evaluation that considers both the condition(s) related to the positive screen, and the risk of suicide. When this process confirms the presence of a mental disorder or suicide risk, veterans are offered mental health treatment. When there is a referral or request for mental health services, veterans must receive an initial evaluation within 24 hours. If this evaluation identifies an urgent need, treatment is to be provided immediately. Otherwise, veterans must receive a full diagnostic and treatment planning evaluation and the initiation of care within two weeks.

In addition, the DoD administers a post-deployment health reassessment (PDHRA) 90–180 days after a servicemember's return from deployment, to identify health concerns, with an emphasis placed on screening for mental health conditions that may have emerged since returning home. Information gathered during this assessment helps DoD identify servicemembers who require referrals for further evaluation.[30] The Government Accountability Office (GAO) has stated that DoD shares information gathered through the PDHRA with the VA. According to GAO, "VA officials obtain PDHRA information about servicemembers referred to VA and individual servicemembers' [PDHRA] when they access VA healthcare. Each month, VA receives a report that provides monthly and cumulative totals of servicemembers re-

[28] Department of Veterans Affairs, Office of Inspector General, "Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention," Report No. 06–03706–126, 2007.

[29] For more information on screening tools and their effectiveness, see CRS Report RS22647, *Screening for Youth Suicide Prevention*, by Ramya Sundararaman.

[30] The PDHRA (DD Form 2900) includes questions about feeling down, depressed, or hopeless, the occurrence of nightmares, relationship issues with family and friends, and increased alcohol use.

ferred, including servicemembers referred to VA facilities."[31] However, it is unclear at this time if VA uses this information to specifically screen those who may be potentially at risk of suicide.

Suicide Prevention Hotline

The VA has also partnered with the Lifeline Program, a grantee of the Substance Abuse and Mental Health Services Administration (SAMHSA), of the Department of Health and Human Services (HHS), to develop a VA suicide prevention hotline. Those who call 1–800–273–TALK are asked to press "1" if they are a veteran, or are calling about a veteran.[32] When they do so, they are connected directly to VA's hotline call center, where they speak to a VA mental health professional with real-time access to the veteran's medical records. The responders at the VA suicide prevention hotline have received American Association of Suicidology (AAS) credentialing and certification.

In emergencies, the hotline contacts local emergency resources such as police or ambulance services to ensure an immediate response. In other cases, after providing support and counseling, the hotline transfers care to the suicide prevention coordinator at the nearest VAMC for follow-up care.

From October 7 to November 10, 2007, 1,636 veterans and 311 family members or friends called the VA suicide prevention hotline. These calls led to 363 referrals to suicide prevention coordinators and 93 rescues involving emergency services.[33]

Funding for Suicide Prevention

According to VA estimates, in FY 2008, spending for the suicide prevention program will include $970,000 to establish the suicide prevention hotline; $1.97 million for the Center of Excellence in Canandaigua, New York; $2.20 million for the Mental Illness Research, Education and Clinical Center in Denver, Colorado; $90,000 for the Serious Mental Illness Research, Education and Clinical Center for monitoring of suicide rates and risk factors; and $14.32 million for Suicide Prevention Coordinators.[34]

Conclusion

There has been considerable recent interest in the burden of suicide among veterans, in particular those who have recently returned from military service in Operation Iraqi Freedom and Operation Enduring Freedom. This interest has thrown a spotlight on the fact that there is not, at this time, a system of surveillance for suicide among veterans.

Despite recent interest in comparing suicide rates between veterans and the general population, this may not be the most useful comparison. In numerous ways that affect their suicide risk, veterans are not like the general population. Also, the VA has an interest in decreasing the burden of suicide among veterans, whether this burden exceeds that of the general population or not. What may be more meaningful, and more important to achieve, is the establishment of data systems that support a more robust and reliable understanding of suicide among veterans. The ideal systems would describe a clear baseline, and provide a means to track changes going forward—with respect to such things as risk and protective factors, and the effects of treatment—in order to know which interventions work, and where to target them.

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[31] U.S. Government Accountability Office (GAO), DoD's *Post-Deployment Health Reassessment*, GAO–08–181R, January 25, 2008, p.7.

[32] VA is using the national suicide prevention hotline to provide this service to veterans.

[33] Testimony of Ira Katz, M.D., Ph.D., Deputy Chief Patient Care Services Officer, Office of Mental Health, Veterans Health Administration, Department of Veterans Affairs in U.S. Congress, House Committee on Veterans' Affairs, *Stopping Suicides: Mental Health Challenges Within the U.S. Department of Veterans Affairs*, hearings, 110th Cong., 1st sess., December 12, 2007.

[34] Department of Veterans Affairs, Report to Congress, *P.L. 110–110, Comprehensive Program for Suicide Prevention Among Veterans*, p. 7, February 2008.

We Care!

We Want To Help!

We Can Help!

1-800-273-TALK (8255)

Pick up the phone if you are experiencing an emotional crisis and need to talk to a trained VA professional.

You'll be immediately connected with a qualified caring provider who can help.

VETERANS:

Call the National Suicide toll-free hot-line number

1-800-273-TALK (8255)

Suicide Prevention

MEN & WOMEN VETERANS

KNOW THE WARNING SIGNS OF SUICIDE

Call the National Suicide toll-free hot-line number

1-800-273-TALK (8255)

IB 10 -206

P96218
SEPT 2007

Department of Veterans Affairs

Did you know... Returning veterans may be at a higher risk of suicide?

All veterans including you are our #1 priority !

VA Cares About You.

Call

1-800-273-TALK (8255)

Recognize the Suicide Warning Signs

- Thinking about hurting or killing yourself
- Looking for ways to kill yourself
- Talking about death, dying or suicide
- Self-destructive behavior such as drug abuse, weapons, etc.

The presence of these signs requires immediate attention.

Don't wait

Call

1-800-273-TALK (8255)

Immediately!

Additional warning signs may include

- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness, mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

Call us if you experience any of these warning signs.

Don't delay

Call

1-800-273-TALK (8255)

RESPONDING TO SUICIDE RISK

ASSURE THE PATIENT'S IMMEDIATE SAFETY AND DETERMINE MOST APPROPRIATE TREATMENT SETTING

- Refer for mental health treatment or assure that follow-up appointment is made
- Inform and involve someone close to the patient
- Limit access to means of suicide
- Increase contact and make a commitment to help the patient through the crisis

PROVIDE NUMBER OF ER/URGENT CARE CENTER TO PATIENT AND SIGNIFICANT OTHER

National Suicide Hotline Resource:

1 – 800 – 273 - TALK (8255)

References:
American Psychiatric Association. Practice Guidelines for the Assessment and Treatment of Patients with Suicidal Behaviors, 2nd ed. In: Practice Guidelines for the Treatment of Psychiatric Disorders Compendium. Arlington VA 2004. (835-1027).
Rudd et.al, Warning signs for suicide: theory, research and clinical applications. Suicide and Life Threatening Behavior, 2006 June36 (3)255-62.

Employee Education System

SUICIDE RISK *ASSESSMENT GUIDE*

All patients who present with positive depression screens, history of mental health diagnosis or with any of the Warning Signs listed below should be further assessed for suicide risk.

LOOK for the warning signs.
ASSESS for risk and protective factors.
ASK the questions.

LOOK FOR THE WARNING SIGNS

- **Threatening to hurt or kill self**
- **Looking for ways to kill self**
- **Seeking access to pills, weapons or other means**
- **Talking or writing about death, dying or suicide**

Presence of any of the above warning signs requires immediate attention and referral. Consider hospitalization for safety until complete assessment may be made.

Additional Warning Signs

- *Hopelessness*
- *Rage, anger, seeking revenge*
- *Acting reckless or engaging in risky activities, seemingly without thinking*
- *Feeling trapped – like there's no way out*
- *Increasing alcohol or drug abuse*
- *Withdrawing from friends, family and society*
- *Anxiety, agitation, unable to sleep or sleeping all the time*
- *Dramatic changes in mood*
- *No reason for living, no sense of purpose in life*

For any of the above, refer for mental health treatment or follow-up appointment.

Department of Veterans Affairs

ASSESS FOR SPECIFIC FACTORS THAT MAY INCREASE OR DECREASE RISK FOR SUICIDE

FACTORS THAT MAY INCREASE RISK

- Current ideation, intent, plan, access to means
- Previous suicide attempt or attempts
- Alcohol/Substance abuse
- Previous history of psychiatric diagnosis
- Impulsivity and poor self-control
- Hopelessness – presence, duration, severity
- Recent losses – physical, financial, personal
- Recent discharge from an inpatient unit
- Family history of suicide
- History of abuse (physical, sexual or emotional)
- Co-morbid health problems, especially a newly diagnosed problem or worsening symptoms
- Age, gender, race (elderly or young adult, unmarried, white, male, living alone)
- Same-sex sexual orientation

FACTORS THAT MAY DECREASE RISK

- Positive social support
- Spirituality
- Sense of responsibility to family
- Children in the home, pregnancy
- Life satisfaction
- Reality testing ability
- Positive coping skills
- Positive problem-solving skills
- Positive therapeutic relationship

ASK THE QUESTIONS

Are you feeling hopeless about the present/future?

If yes ask…

Have you had thoughts about taking your life?

If yes ask…

When did you have these thoughts and do you have a plan to take your life?

Have you ever had a suicide attempt?

? ? ?

Department of Veterans Affairs
Under Secretary for HealthAddress
Washington, DC.

In Reply Refer To:

Dear Veteran,

If you're experiencing an emotional crisis and need to talk with a trained VA professional, the **National Suicide Prevention toll-free hotline number, 1–800–273–TALK (8255)**, is now available 24 hours a day, seven days a week. You will be immediately connected with a qualified and caring provider who can help.

Here are some suicide warning signs:

1. Threatening to hurt or kill yourself
2. Looking for ways to kill yourself
3. Seeking access to pills, weapons or other self destructive behavior
4 Talking about death, dying or suicide

The presence of these signs requires immediate attention. If you or a veteran you care about has been showing any of these signs, do not hesitate to call and ask for help!

Additional warning signs may include:

1. Hopelessness
2. Rage, anger, seeking revenge
3. Acting reckless or engaging in risky activities, seemingly without thinking
4. Increasing alcohol or drug abuse
5. Feeling trapped—like there's no way out
6. Withdrawing from friends and family
7. Anxiety, agitation, inability to sleep—or, excessive sleepiness
8. Dramatic mood swings
9. Feeling there is no reason for living, no sense of purpose in life

Please call the **toll-free hotline number, 1–800–273–TALK (8255)** if you experience any of these warning signs. We'll get you the help and assistance you need right away!

Sincerely yours,

Michael J. Kussman, MD, MS, MACP

VA Suicide Crisis Hotline (1–800–273 TALK)

Who Should Call?

- Anyone, but especially those who feel sad, hopeless, or suicidal
- Family and friends who are concerned about a loved one who may be having these feelings.
- Anyone interested in suicide prevention, treatment and service

1–800–273 TALK

- The service is free and confidential
- The hotline is staffed by trained counselors
- We are available 24 hours a day, 7 days a week
- We have information about support services that can help you.

Crisis Response Plan

When thinking about suicide, I agree to do the following:

Step 1: Try to identify my thoughts and specifically what's upsetting me
Step 2: Write out and review more reasonable responses to my suicidal thoughts
Step 3: Do things that help me feel better for about 30 min (e.g., taking a bath, listening to music, going for a walk)

Step 4: If your suicidal thoughts persist, call **1–800–273–TALK**
Step 5: If the thoughts continue, get specific, and I find myself preparing to do something, call **911**
Step 6: If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room

REMEMBER: The VA Suicide Hot Line is 1–800–273–TALK
Get Mental Health Follow-Up 1–202–745–8267 for an APPOINTMENT

Committee on Veterans' Affairs
Washington, DC.
December 21, 2007

Mr. Rick Kaplan
Executive Producer
CBS Evening News With Katie Couric
524 West 57th Street
New York, NY 10019

Dear Mr. Kaplan:

On December 12, 2007, the House Committee on Veterans' Affairs held a hearing to assess the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. This hearing raised concerns regarding the discrepancy between the numbers of veteran suicides reported by VA as compared to those reported by *CBS News* on November 13, 2007.

Accurate data is crucial in identifying risk factors and providing better treatment and suicide prevention programs. For this reason, we respectfully request that *CBS News* share their data on suicide among veterans with the Committee.

Specifically, we request data on the number of veteran and non-veteran suicides for each year from 1995 through 2005 reported by State with year of death, age, race, gender and manner of suicide. Additionally, request the data that *CBS News* used to define the at-risk populations (e.g., veterans/non-veterans, men/women) by age group.

Undoubtedly, you and the entire *CBS Evening News* staff, share our desire to ensure that every possible measure is taken to prevent those who have worn the uniform from succumbing to the tragedy of suicide. As such, we would greatly appreciate your willingness to share the information you have accumulated with the Committee.

Thank you for your prompt consideration and attention to this request. Should you have any questions, please feel free to contact either Committee Staff Director, Malcom Shorter, at 202–225–9756 or Republican Staff Director, Jim Lariviere, at 202–225–3527.

Sincerely,

Bob Filner
Chairman

Steve Buyer
Ranking Member

CW/mh

CBS News
New York, NY.
May 16, 2008

Honorable Bob Filner, Chairman
Committee on Veterans' Affairs
United States House of Representatives
One Hundred Tenth Congress
335 Cannon House Office Building
Washington, DC 20515

Dear Congressmen Filner:

This is in reply to your letter of last December to Rick Kaplan, Executive Producer of the *CBS Evening News*. It appears that your letter was originally lost with-

in CBS and only came to light when a copy of it was given to Armen Keteyian, *CBS News*' Chief Investigative Correspondent, at last week's hearing of the House Committee on Veterans' Affairs. I apologize for the delay.

In your letter you request that *CBS News* provide "data on numbers the veteran and non-veteran suicides for each year from 1995 through 2005 reported by. . . . [and] data that *CBS News* used to define the at-risk populations (e.g., veterans/non-veterans, men/women) by age group."

You are quite right, Congressmen, in stating that we at *CBS News* share your desire to ensure that every possible measure is taken to prevent veteran suicide. We believe, however, that the respect in which we are best able to serve the interests of veterans and of all other segments of the American public is to preserve our ability to do effective news reporting; and that to be effective reporters, we must maintain our journalistic independence. For that reason we must respectfully decline to provide the data you request.

Insofar as the Committee's request derives from its need for the raw data on which *CBS News* based its reporting, that data is readily available to the Committee from State agencies, which are public. If the Committee's goal is to review the editorial process by which we arrived at our reports' content, we respectfully urge that it would be quite wrong of *CBS News* to submit voluntarily to such governmental oversight. Indeed, doing so would fundamentally compromise the editorial independence on which we and all news organizations depend.

I should also point out that obtaining suicide data from the various States involved more than just a basic public records request. Initially, several States refused to provide their data to *CBS News* out of a concern for the privacy of the veterans involved and their families. These States believed that the suicide numbers in some categories are small enough so that individuals could be identified and their privacy compromised. In order to obtain the data, *CBS News* had to give these States our assurance that we would keep the raw data confidential. Some States insisted upon written agreements to this effect. Accordingly, we are constrained not only by principle, but by these specific undertakings, from providing the Committee with the data you have requested.

I hope you will appreciate Congressmen, that we take the work of the House Committee on Veterans' Affairs very seriously and that we withhold our cooperation only out of deference to our own responsibilities as journalists.

Respectfully,

Linda Mason
Senior Vice President
Standards and Special Projects

cc Rick Kaplan
Armen Keteyian

Committee on Veterans' Affairs
Washington, DC.
December 21, 2007

The Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On December 12, 2007, the House Committee on Veterans' Affairs held a hearing to assess the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. This hearing raised concerns regarding the discrepancy between the numbers of veteran suicides reported by VA as compared to those reported by *CBS News* on November 13, 2007.

Accurate data is crucial in identifying risk factors and providing better treatment and suicide prevention programs. For this reason, we respectfully request that the Department of Veterans Affairs share their data on suicide among veterans with the Committee.

Specifically, we request to have the number of veteran suicides for each year from 1995 through 2006, reported by year of death, age, race, gender and manner of suicide. Additionally, we ask for the methodology the Department uses to collect data on veteran suicides.

Undoubtedly, you share our desire to ensure that every measure is taken to prevent our Nation's veterans from committing suicide. We would greatly appreciate your willingness to share any information you may have regarding this issue with the Committee.

Thank you for your prompt consideration and attention to this request. Should you have any questions, please feel free to contact either Committee Staff Director, Malcom Shorter, at 202–225–9756 or Republican Staff Director, Jim Lariviere, at 202–225–3527.

Sincerely,

Bob Filner
Chairman

Steve Buyer
Ranking Member

The Secretary of Veterans Affairs
Washington, DC.
February 5, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter requesting data on suicide rates among veterans and the methodologies used by the Department of Veterans Affairs (VA) to collect data on veteran suicides.

The enclosed information and worksheet contains data on veteran suicides from two separate projects. One is an ongoing study of mortality in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans being conducted by VA's Office of Environmental Epidemiology. Identification of veterans is based on information from the Department of Defense and includes all OEF/OIF servicemembers who were separated from active duty including National Guard and Reserve personnel. The second project is an ongoing study of suicide in veterans who have used Veterans Health Administration services from 2000 onward and who were alive at the start of 2001. The study includes veterans of all eras.

For both projects, information about the time and causes of death was derived from the National Death Index. Information contained in data files on causes of death from the National Death Index is only available through the end of 2005. I have also enclosed the methodology used for both projects.

Your interest in our Nation's veterans is appreciated. A similar letter is being sent to Congressman Steve Buyer.

Sincerely yours,

James B. Peake, M.D.

Enclosures

Study of Operation Enduring Freedom/Operation Iraqi Freedom Veterans

Methodology

Population: As part of our mortality study of veterans who served in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF), the Department of Veterans Affairs (VA) obtained the identities of 490,346 OEF/OIF veterans who served as part of either OEF or OIF and were separated or deactivated from military service between October 2001 and December 2005. This study will assess both overall mortality risk as well as cause-specific mortality risk. Among the cause specific mortality of particular interest are deaths due to motor vehicle accidents and suicides.

Data Sources: The identities of the 490,346 OEF/OIF veterans, military service characteristics, and various demographic data were provided to VA by the Department of Defense Manpower Data Center. Vital statistics data pertaining to OEF/OIF veterans was determined by using VA's database, Beneficiary Identification and Records Locator Subsystem, and deaths reported to the Social Security Administration Death Master File. The Beneficiary Identification and Records Locator Subsystem file has the identities of all veterans who have applied for VA benefits (in-

cluding death benefits), and the Social Security Administration Death Master File includes all deaths reported to that agency. All veterans were matched against the Beneficiary Identification and Records Locator Subsystem and Social Security Administration files using Social Security numbers. Cause of death data was obtained from the National Death Index. Since 1979, the Office of Vital Statistics in each State has reported deaths, including cause of death data to the National Center for Health Statistics, where the National Death Index is compiled. Causes of death were recorded using International Classification of Diseases codes 10th Revision (ICD–10). For traumatic deaths, including suicide, part of the ICD–10 codes records the method of injury. For suicides, the ICD–10 codes report the method of suicide. At the time this study began, the National Death Index had cause of death data through December 31, 2005. Using the aforementioned databases, VA identified a total of 818 deaths to include 144 suicides.

The attached table has demographic and military service characteristics as well as death certificate data and method of suicide for the 144 suicides identified in this study.

CHARACTERISTICS OF 144 SUICIDES AMONG OEF/OIF* VETERANS THROUGH 2005

Characteristic	Frequency	Percentage
Age at death		
20–29	78	54.1
30–39	39	27.1
40–49	14	9.7
50–59	13	9.1
Year of death		
2002	7	4.9
2003	21	14.6
2004	48	33.3
2005	68	47.2
Method of suicide		
Poisoning	7	4.9
Hanging	30	20.8
Firearm	105	72.9
Jumping	1	.7
Sharp Object	1	.7
Sex		
Male	141	97.9
Female	3	2.1
Race		
White	118	81.9
Non-White	26	18.1
Ever seen at VAMC		

CHARACTERISTICS OF 144 SUICIDES AMONG OEF/OIF* VETERANS THROUGH 2005—Continued

Characteristic	Frequency	Percentage
Yes	33	22.9
Branch of service		
Army	73	50.7
Marines	15	*10.4*
Air Force	33	22.9
Navy	23	16.0
Rank		
Officer	8	5.6
Warrant Officer	1	0.7
Enlisted	135	93.7
Unit component		
Active	68	47.2
Reserve	35	24.3
National Guard	41	28.5

* These suicides were identified among a cohort of 490,346 OEF/OIF veterans selected for mortality follow-up through 2005.

Study of Veterans Using Veterans Health Administration

Methodology

Population: The Veterans Health Administration defined the population of VA patients at risk for suicide in each fiscal year as those who were alive at the start of the year, and who had received VA services during either that year or the prior one. This approach to identifying VA's patient population was developed in consultation with VA mental health leadership and assumes that patients seen in VA settings in the prior year would still be considered to be in active VA care and part of the at-risk patient population in the following year.

Data Sources: This study used data from VA's National Patient Care Database to identify all veterans with inpatient or outpatient services utilization in any VA facility during the relevant years. Measures of vital status and cause of death were based on information from the National Death Index. The National Death Index is considered the "gold standard" for mortality assessment information and includes national data regarding dates and causes of death for all U.S. residents. This information is derived from death certificates filed in the Office of Vital Statistics for each State. National Death Index searches were performed for cohorts of VA patients who received any VA services during the relevant years, and who had no subsequent VA services through June 2006. This cost-efficient method for conducting National Death Index searches enables comprehensive assessment of *vital* statistics and cause of death among all veterans in the VA patient population. The National Death Index data request included Social Security number, last name, first name, middle initial, date of birth, race and ethnicity, sex, and State of residence. National Death Index search results often include multiple records that are potential matches. "True matches" were identified based on established procedures.

Veterans' age and gender were identified from VA administrative files included in the National Patient Care Database. Age at the start of Fiscal Year 2001 was categorized as being either less than 30, 30 to 39, 40 to 49, 50 to 59, 60 to 69, 70 to 79, or greater than or equal to 80 years. Information regarding race and ethnicity was not consistently available in the National Patient Care Database for all VA patients. VA identified dates and causes of death using National Death Index data.

Suicide deaths were identified using International Classification of Diseases codes X60 through X84, and Y87.0 (World Health Organization 2004).

VA is conducting a comprehensive program for preventing veteran suicides, and is conducting ongoing research to guide its prevention strategies. The VA Office of Mental Health staff is available to provide additional briefings to the Committee on rates, risks factors and strategies.

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005

Characteristic	FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
	N	%	N	%	N	%	N	%	N	%
Total*	1403	100	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over	1401	100	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Sex										
Male	1360	97.1	1682	97.0	1559	97.6	1647	96.8	1720	96.6
Female	41	2.9	52	3.0	39	2.4	54	3.2	61	3.4
Age Group										
20–29 yrs	26	1.9	44	2.5	38	2.4	50	2.9	38	2.1
30–39 yrs	108	7.7	119	6.9	111	6.9	105	6.2	105	5.9
40–49 yrs	240	17.1	283	16.3	272	17.0	256	15.0	254	14.3
50–59 yrs	359	25.6	437	25.2	407	25.5	424	24.9	470	26.4
60–69 yrs	202	14.4	261	15.1	264	16.5	272	16.0	291	16.3
70–79 yrs	320	22.8	393	22.7	345	21.6	381	22.4	380	21.3
80+ yrs	146	10.4	197	11.4	161	10.1	213	12.5	243	13.6
Race										
White Hispanic	30	2.1	25	1.4	32	2.0	24	1.4	29	1.6
Black Hispanic	2	0.1	1	0.1	1	0.1	2	0.1	2	0.1
Native American	2	0.1	6	0.3	3	0.2	2	0.1	7	0.4
African American	55	3.9	80	4.6	47	2.9	62	3.6	78	4.4
Asian/Pacific Islander	0	0.0	4	0.2	2	0.1	3	0.2	16	0.9
Caucasian	895	63.9	1078	62.2	894	55.9	814	47.9	1142	64.1
Unknown	417	29.8	540	31.1	619	38.7	794	46.7	507	28.5

*Includes age <20 years old

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005											
Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
Total*		1403	100.0	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over		1401	100.0	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Mechanism of Suicide											
X60	Intentional self-poisoning (suicide) by and exposure to non-opioid analgesics, anti-pyretics, and anti-rheumatics	5	0.4	4	0.2	8	0.5	5	0.3	12	0.7
X61	Intentional self-poisoning (suicide) by and exposure to antiepileptic, sedative-hypnotic anti-parkinsonism, and psychotropic drugs, not elsewhere classified	39	2.8	49	2.8	38	2.4	43	2.5	53	3.0
X62	Intentional self-poisoning (suicide) by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified	26	1.9	42	2.4	30	1.9	27	1.6	48	2.7
X63	Intentional self-poisoning (suicide) by and exposure to other drugs acting on the autonomic nervous system	1	0.1	3	0.2	1	0.1	0	0.0	2	0.1
X64	Intentional self-poisoning (suicide) by and exposure to other and unspecified drugs, medicaments, and biological substances	100	7.1	97	5.6	103	6.4	112	6.6	102	5.7
X65	Intentional self-poisoning (suicide) by and exposure to alcohol	2	0.1	2	0.1	5	0.3	0	0.0	1	0.1
X66	Intentional self-poisoning (suicide) by and exposure to organic solvents and halogenated hydrocarbons and their vapors	2	0.1	3	0.2	1	0.1	6	0.4	3	0.2
X67	Intentional self-poisoning (suicide) by and exposure to other gases and vapors	34	2.4	62	3.6	35	2.2	59	3.5	50	2.8

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005—Continued

Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
X68	Intentional self-poisoning (suicide) by and exposure to pesticides	1	0.1	1	0.1	1	0.1	0	0.0	0	0.0
X69	Intentional self-poisoning (suicide) by and exposure to other and unspecified chemicals and noxious substances	3	0.2	6	0.3	4	0.3	3	0.2	4	0.2
X70	Intentional self harm (suicide) by hanging, strangulation, and suffocation	163	11.6	214	12.3	189	11.8	207	12.2	189	10.6
X71	Intentional self harm (suicide) by drowning and submersion	17	1.2	19	1.1	12	0.8	10	0.6	15	0.8
X72	Intentional self harm (suicide) by handgun discharge	192	13.7	248	14.3	255	16.0	227	13.3	277	15.6
X73	Intentional self harm (suicide) by rifle, shotgun, and larger firearm discharge	145	10.3	174	10.0	150	9.4	171	10.1	170	9.5
X74	Intentional self harm (suicide) by other and unspecified firearm discharge	566	40.4	726	41.9	675	42.2	728	42.8	758	42.6
X75	Intentional self harm (suicide) by explosive material	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1
X76	Intentional self harm (suicide) by smoke, fire, and flames	6	0.4	4	0.2	6	0.4	14	0.8	12	0.7
X77	Intentional self harm (suicide) by steam, hot vapors, and hot objects	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X78	Intentional self harm (suicide) by sharp object	34	2.4	33	1.9	33	2.1	35	2.1	28	1.6
X79	Intentional self harm (suicide) by blunt object	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X80	Intentional self harm (suicide) by jumping from a high place	31	2.2	18	1.0	30	1.9	27	1.6	22	1.2

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005—Continued

Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
X81	Intentional self harm (suicide) by jumping or lying before moving object	14	1.0	10	0.6	7	0.4	12	0.7	8	0.4
X82	Intentional self harm (suicide) by crashing of motor vehicle	1	0.1	4	0.2	5	0.3	4	0.2	7	0.4
X83	Intentional self harm (suicide) by other specified means	7	0.5	6	0.3	3	0.2	4	0.2	2	0.1
X84	Intentional self harm (suicide) by unspecified means	5	0.4	6	0.3	4	0.3	4	0.2	11	0.6
V87	Sequelae of intentional self harm	7	0.5	3	0.2	3	0.2	3	0.2	5	0.3

*Includes age <20 years old

Committee on Veterans' Affairs
Washington, DC.
December 21, 2007

Honorable Robert M. Gates
Secretary
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301

Dear Secretary Gates:

On December 12, 2007, the House Committee on Veterans' Affairs held a hearing to assess the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. This hearing raised concerns regarding the discrepancy between the numbers of veteran suicides reported by VA as compared to those reported by *CBS News* on November 13, 2007.

Accurate data is crucial in identifying risk factors and providing better treatment and suicide prevention programs. For this reason, we respectfully request that the Department of Defense share their data on suicide among the active military population with the Committee.

Specifically, we request the number of active duty suicides for each year from 1995 through 2006. We ask that this information be listed by military branch, year of death, age, race, gender and manner of suicide. Additionally, we ask for the methodology the Department uses to collect data on active duty suicides.

Undoubtedly, you share our desire to ensure that every measure is taken to prevent those in the military from committing suicide. We would greatly appreciate your willingness to share any information you may have regarding this issue with the Committee.

Thank you for your prompt consideration and attention to this request. Should you have any questions, please feel free to contact either Committee Staff Director, Malcom Shorter, at 202–225–9756 or Republican Staff Director, Jim Lariviere, at 202–225–3527.

Sincerely,

Bob Filner
Chairman

Steve Buyer
Ranking Member

CW/mh

*****

The Secretary of Defense
Washington, DC
January 17, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for the letter you signed with Representative Buyer requesting data on the number of active duty suicides from 1995 through 2006. I have asked Dr. David Chu, Under Secretary of Defense for Personnel and Readiness, to address this matter. We will get back to you as soon as possible.

With best wishes,

Sincerely,

Robert M. Gates

Committee on Veterans' Affairs
Washington, DC.
May 6, 2008

Honorable Robert M. Gates
Secretary
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301–1000

Dear Secretary Gates:

I would appreciate it if you could respond to the enclosed request regarding assessing the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. Previous letters were sent to you on December 21, 2007, and the Committee received notices on January 17, 2008, indicating that your office was looking into the matter.

Because your response will be entered into the record for today's Full Committee hearing on "The Truth About Veterans' Suicides," the Committee would appreciate a reply back from your office by no later than May 20, 2008. If you have any questions in this regard, please contact Mark Heyman, Professional Staff Member, at (202) 225–9756.

Sincerely,

Bob Filner
Chairman

Enclosure
MS/jz

Committee on Veterans' Affairs
Washington, DC.
May 21, 2008

Honorable Robert M. Gates
Secretary
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301–1000

Dear Secretary Gates:

I would appreciate it if you could respond to the enclosed request regarding assessing the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. Previous letters were sent to you on December 21, 2007, and May 6, 2008, and the Committee received notices on January 17, 2008, indicating that your office was looking into the matter.

Because your response will be entered into the record for today's Full Committee hearing on "The Truth About Veterans' Suicides," the Committee would appreciate a reply back from your office by no later than June 4, 2008.

If you have any questions in this regard, please contact Mark Heyman, Professional Staff Member, at (202) 225–9756.

Sincerely,

Bob Filner
Chairman

Enclosure
MS/jz

The Secretary of Defense
Washington, DC
June 3, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Thank you for your letter regarding a Department of Defense assessment of the Department of Veterans Affairs' programs for veterans at risk for suicide. I have asked Dr. David Chu, Under Secretary of Defense for Personnel and Readiness, to address the matter. He will get back to you as soon as possible.

With best wishes,

Sincerely,

Robert M. Gates

Committee on Veterans' Affairs
Washington, DC.
June 5, 2008

Honorable Robert M. Gates
Secretary
U.S. Department of Defense
1000 Defense Pentagon
Washington, DC 20301–1000

Dear Secretary Gates:

I would appreciate it if you could respond to the enclosed request regarding assessing the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. Previous letters were sent to you on December 21, 2007; May 6, 2008; and May 21, 2008, and the Committee received notices on January 17, 2008, and June 4, 2008, indicating that your office was looking into the matter.

Because your response will be entered into the record for today's Full Committee hearing on "The Truth About Veterans' Suicides," the Committee would appreciate a completed response to the enclosed request by no later than June 19, 2008. If you have any questions in this regard, please contact Mark Heyman, Professional Staff Member, at (202) 225–9756.

Sincerely,

Bob Filner
Chairman

Enclosure
MS/jz

Department of Veterans Affairs

MEMORANDUM

Date: May 5, 2008
From: Under Secretary for Health (10)
Subj: Blue Ribbon Work Group on Suicide Prevention in the Veteran Population
To: Secretary (00)

1. At your request, VHA has developed a draft charter and draft membership list for your consideration for the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population (see attachments). We have also contacted prospective members to determine their willingness to do so and to do so without compensation.
2. With your approval, we will proceed with formally contacting the members that you have approved and setting up the one-time meeting.

Michael J. Kussman, MD, MS, MACP

APPROVE/~~DISAPPROVE~~ Date 5/5/08
James B. Peake, M.D.

Attachments:

- Draft Charter
- Draft Membership and Staff Support List (with approval/disapproval lines for each)
- CVs for Potential Members of The Work Group
- CVs for Potential Member of The Expert Panel

DEPARTMENT OF VETERANS AFFAIRS
CHARTER OF THE
BLUE RIBBON WORK GROUP ON SUICIDE PREVENTION IN THE VETERAN POPULATION

A. *OFFICIAL DESIGNATION*: Blue Ribbon Work Group on Suicide Prevention in the Veteran Population ("Work Group").

B. *OBJECTIVES AND SCOPE OF ACTIVITY*: The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population advises the Secretary on research and programs relevant to the prevention of suicide in the veteran population.

C. *PERIOD OF TIME NECESSARY FOR THE COMMITTEE TO CARRY OUT ITS PURPOSES*: Established as an Executive Branch Task Force that will meet one time for approximately 3 days with a final report to the Secretary within 15 days.

D. *OFFICIAL TO WHOM THE COMMITTEE REPORTS*: The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population reports to the Secretary of Veterans Affairs.

E. *OFFICE RESPONSIBLE FOR PROVIDING THE NECESSARY SUPPORT FOR THE COMMITTEE*: The Veterans Health Administration, Department of Veterans Affairs, is responsible for providing administrative and logistical support to the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population.

F. *DUTIES OF THE COMMITTEE*: The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population provides advice and consultation to the Secretary on various matters relating to research, education and program improvements relevant to the prevention of suicide in the veteran population. The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population will create a report within 15 days of the completion of its meeting with recommendations for improvements in VA's programs related to suicide prevention, research, and education. Recommendations will be directly related to the primary objective of reducing risk of suicide in the veteran population.

G. *MEMBERSHIP*: Blue Ribbon Work Group on Suicide Prevention in the Veteran Population membership shall include only Executive Branch employees who are experts in public health suicide programs (including suicide prevention and education programs), suicide research (especially epidemiology and suicidiology), and clinical treatment programs for patients at risk for suicide. The Work Group will be comprised of five (5) members. The Work Group process will be informed by the testimony and counsel of a panel (The Expert Panel) with nationally recognized expertise in public health suicide programs, suicide research, and clinical treatment programs for patients, and other relevant areas. Members of The Expert Panel will have no significant direct relationship with the Department of Veterans Affairs. The role of each member of the panel is to *individually* provide: expert opinion, interpretation, and conclusions on information and data presented to the Work Group; expert information and data from other (non-VA) sources; and recommendations to the Work Group on opportunities for improvement in VA's programs. The Expert Panel will be comprised of nine (9) members. Employees of the Department of Veterans Affairs and other Federal Government employees may be called upon the Work Group to provide background briefings on any relevant information to better inform the Work Group decision process and The Expert Panel.

H. *EXPENSES*: All Work Group and Expert Panel members will receive travel expenses and a per diem allowance in accordance with the Federal Travel Regulations for any travel made in connection with their duties as members of the Work Group or Expert Panel. No member of the Work Group or the Expert Panel will receive honorarium.

I. *ESTIMATED NUMBER AND FREQUENCY OF MEETING*: The Group is expected to meet once for approximately three (3) days. Administrative support to the Work Group will be provided by the Veterans Health Administration. The Veterans Health Administration, Office of Mental Health Services, will support the Chair in the development of the schedule, operation of the meeting, general logistical requirements, and production of the final report. A representative of the Secretary will be present at the meeting, and the meeting will be conducted in accordance with an agenda provided by the Secretary.

J. *COMMITTEE TERMINATION DATE*: The Work Group and The Expert Panel will be terminated upon completion and transmittal of the final report to the Secretary.

K. *DATE CHARTER IS FILES*:

Approved: James B. Peake, M.D.
Secretary of Veterans Affairs
Date 5/5/08

Membership

Work Group

- CDR (USPHS) Alex E. Crosby, MD, MPH, Medical Epidemiologists, Surveillance Team/ESB/DVP/NCIPC Centers for Disease Control and Prevent (CDC), Atlanta, GA

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- COL (USA) Charles W. Hoge, MD, Director, Division of Psychiatry And Behavior Services, Walter Reed Army Institute Of Research, Silver Spring, MD

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- COL (USAF) Robert Roy Ireland, MC, Chairman, Program Director for Mental Health Policy, Clinical and Program Policy, Office of the Assistant Secretary of Defense (Health Affairs, Falls Church, VA

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Richard McKeon, PhD, MPH, Special Advisory Suicide Prevention, CMHS, Substance Abuse and Mental Health Services Administration (SAMHSA)

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Jane Pearson, MA, PhD, Associate Director for Preventive Interventions, Division of Services and Intervention Research, National Institute of Mental Health

APPROVE/~~DISAPPROVE~~ Date 5/5/08

Expert Panel:

- Dan Blazer II, MD, MPH, PhD, Professor of Psychology, Co-Director of Clinical Training, Catholic University of America

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Greg Brown, PhD, University of Pennsylvania

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Martha Livingston Bruce, PhD, MPH, Professor, Program in Clinical Epidemiology and Health Services Research, Graduate School of Medical Sciences, and Associate Vice-Chair for Research, Weill Medical College of Cornell University

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Eric D. Caine, MD, Chair of Psychiatry, John Romano Professor Psychiatry and Chair, Department of Psychiatry, University of Rochester

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Jan Fawcett, MD Professor of Psychiatry, School of Medicine, Department of Psychiatry, University of New Mexico

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Robert D. Gibbons, Director, Center for Health Statistics, University of Illinois at Chicago

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- David Alan Jobes, PhD, ABBPP, Professor of Psychology, Department of Psychology, The Catholic University of America

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Mark S. Kaplan, PhD, Portland State University, Member, Suicide Prevention Action Network-USA National Scientific Advisory Council

APPROVE/~~DISAPPROVE~~ Date 5/5/08

- Thomas R. Ten Have, Director of the Biostatistics Analysis Center of the Center for Clinical Epidemiology and Biostatistics and Senior Scholar, Center for Clinical Epidemiology and Biostatistics, University of Pennsylvania School of Medi-

cine; Member, Biomedical Graduate Studies, University of Pennsylvania School of Medicine

APPROVE/~~DISAPPROVE~~ Date 5/5/08

Administrative Support/Planning:

- Secretary's Representative Jaewon Ryupao, JD (Secretary to specify)
- Seth Eisen, MD, Director, Health Services Research and Development (12)
- Ira Katz, MD, Deputy Chief Patient Care Services Officer for Mental Health (116)
- Antoinette Zeiss, Ph.D., Deputy Chief Mental Health Services (116)
- John O'Hara, Executive Assistant, Office of Policy and Planning (008)
- Technical Writer TBD

Rates and Risk of Suicide and other Suicidal Behaviors among U.S. Veterans

Population-based Studies of Vietnam-era Veterans				
Author Publication Year	**Institution, Sponsor**	**Study and Comparison Groups**	**Key Findings**	**Limitations and Concerns**
Cypel, 2008	WRIISC, EES, VHA	Women veterans who served in Vietnam (n=4586) or elsewhere during the Vietnam era (n=5325), compared with the U.S. population. Mortality followed through 2004 using BIRLS and SSA death files	Women Vietnam era veterans had lower all-cause mortality (SMR=0.87). SMR for *suicide* was 1.22 for women veterans who served in Vietnam, but this was not statistically significant	Only 12 suicide deaths reported in women Vietnam veterans
Herrell, 1999	VET registry, HSR&D, VHA	103 male twin pairs were identified in which one member of the pair reported male sexual partners but the other did not. *Suicidal ideation* and *suicide attempts* were assessed by a structured psychiatric interview.	Homosexual orientation was significantly associated with *suicidal ideation* and *suicide attempts* (approximately 2.5-fold increased risk after adjusting for substance abuse and depression	Analysis of discordant twin pairs is a strong scientific design because it adjusts for confounding based on genetic predisposition. Data were gathered via interview at a single point in time and do not address risk for suicide.
Bullman, 1996	EES, VHA	Vietnam veterans with nonlethal wounds (n=34,534) were assessed for risk of suicide through 1991	In comparison with the U.S. male population, veterans hospitalized because of a combat wound or wounded more than once had increased *suicide* risk (SMR=1.22 for hospitalized veterans; SMR=1.58 for multiple wounded veterans)	Death certificate data might be inaccurate; no data on psychological and behavioral characteristics that might have predisposed individuals to both injury as well as suicide.

Rates and Risks of Suicide and other Suicidal Behaviors among U.S. Veterans—Continued

Population-based Studies of Post-Vietnam Veterans				
Author Publication Year	**Institution, Sponsor**	**Study and Comparison Groups**	**Key Findings**	**Limitations and Concerns**
Bullman, 2005	EES, VHA	Gulf War Veterans potentially exposed to chemical warfare agents (n=100,487) with those not likely to have been exposed (n=224,980).	Relative risk for *suicide* not increased (RR=1.05)	Death certificates might not be accurate; exposure data might not be accurate
Kang, 2001	EES, VHA	Gulf War Veterans (n=695,516) compared with other military on active duty from 8/90 thru 4/91 (n=746,291). Deaths through 1997 obtained from BIRLS and SSA.	Relative risk for *suicide* not increased (RR=0.92 for males)	Death certificates might not be accurate; "health soldier effect"
Kang, 1996	EES, VHA	Gulf War Veterans (n=695,516) compared with other military on active duty (n= 746,291). Deaths through 9/93 obtained from BIRLS and SSA	Small increase in death rate from accidents (SMR=1.25) but no increase in *suicide* rates. There were 261 suicides among the Gulf War veterans	Death certificates might not be accurate; "health soldier effect"

Rates and Risk of Suicide and other Suicidal Behaviors among U.S. Veterans—Continued

Clinical Cohort Studies				
Author Publication Year	**Institution, Sponsor**	**Study and Comparison Groups**	**Key Findings**	**Limitations and Concerns**
Zivin, 2007	SMITREC, VHA	Veterans receiving treatment in VA for depression between 1999 and 2004 (n=807,694). Cause of death determined from state death certificates obtained from NDI	Among depressed veterans, 1683 (0.21%) committed *suicide* during followup. Rate of suicide was 90/100,000/yr among males, 29/100,000/yr among females. Risk was higher among whites, younger veterans, those without service-connected disabilities, those with prior inpatient hospitalizations, veterans with comorbid substance abuse, and those living in the southern or western United States. PTSD with comorbid depression was associated with a lower suicide rate.	Lower rate of suicide among veterans with PTSD and depression is surprising and counter-intuitive, though it may be explained by the more intensive treatment received by such veterans. Important contributors to suicide risk, such as family structure, stress, and prior suicide attempts, were not assessed
Desai, 2007	NEPEC, VHA	VA mental health outpatient users in three cohorts: 1995 (76,105), 1997 (81,512) and 2001 (102,184) followed for trends in suicide rates during the year after their mental health visit. Study occurred during a period of system-wide reorganization including bed closures	Overall, a decreasing trend in *suicide* rates over time among outpatient users (13.2/10,000/yr in 1995 versus 10.3/10,000/yr in 2001) which was not statistically significant. Greater per capita mental health expenditure was associated with lower suicide risk. Outpatients at larger programs were at greater suicide risk.	Short follow-up period (1 year). Did not control for potential confounders such as prior suicide attempts or suicidal ideation. Sicker patients may attend larger programs, accounting for some of the results. Sample likely under-represented the more chronically ill patients.
Gibbons, 2007	VA CSP, NIMH	All veterans newly diagnosed with depression in 2003 or 2004 (n=226,866), followed up for at least 6 months in VA. Inpatient and outpatient records assessed for administrative codes indicating *suicide attempt*.	Overall rate of *suicide attempts* was 364/100,000 among those receiving treatment with an SSRI, versus 1057/100,000 among the untreated. Risk of suicide was higher during the period prior to initiating an SSRI	Data apply only to suicide attempts—suicides would not necessarily show up in VA medical records. Administrative codes may not accurately reflect clinical status of veteran.

Rates and Risk of Suicide and other Suicidal Behaviors among U.S. Veterans—Continued

Clinical Cohort Studies—Continued				
Author Publication Year	**Institution, Sponsor**	**Study and Comparison Groups**	**Key Findings**	**Limitations and Concerns**
Tiet, 2006	HSR&D, VHA	Veterans aged 19 and older seeking treatment for substance use disorder or other psychiatric disorders between July and September, 1997 (n=34,245).	Veterans who had recently experienced physical or sexual abuse had a 3- to 5-fold increased risk of a *suicide attempt*.	Study examined veterans only at one point in time, so author's belief that abuse events precipitate suicide attempts is still speculative.
Desai, 2005	NEPEC, VHA	All VA mental health inpatients discharged between 1994 and 1998 (n=121,933). Death within one year of discharge was ascertained through VA records and the National Death Index. 481 suicides were identified in the study sample	*Suicide* was higher among whites, older veterans, and those with depression, as well as veterans with lengths of inpatient stay under 14 days and those with higher risk for suicide. Readmission with 6 months was associated with decreased suicide risk. No facility-level characteristics were associated with suicide risk.	Facilities could not be accurately ranked for quality based on suicide rates due to the instability of suicide estimates once adjusted for case mix.
Kausch, 2003	VHA	Reviewed charts of consecutive admissions (n=114) to a Gambling Treatment Program at the St. Louis VA.	40% of patients reported a prior *suicide attempt*. 59% of those with history of drug dependence had a history of suicide attempts	Retrospective chart review; no denominator to allow calculation of rates; did not study completed suicides
Desai, 2003	NEPEC, VHA	Homeless veterans (n=7224) participating in a national demonstration project of intensive case management.	Two-thirds of participants reported *suicidal ideation* sometime in their life, and over half had attempted suicide. Younger age, substance abuse, and psychiatric symptoms were associated with risk for *suicide attempts.*	This sample was self-selected based on willingness to enter into intensive case management. Whether homelessness causes suicidal ideation or suicidal ideation causes homelessness cannot be determined since the study examined veterans at only one point in time

Rates and Risk of Suicide and other Suicidal Behaviors among U.S. Veterans—Continued

Clinical Cohort Studies—Continued				
Author Publication Year	**Institution, Sponsor**	**Study and Comparison Groups**	**Key Findings**	**Limitations and Concerns**
Thompson, 2002	Philadelphia MIRECC, VHA	Compared cause of death among veterans receiving medical and mental healthcare at the Philadelphia VA (4123 deaths).	Confirmed and suspected *suicide* accounted for 1.1% of deaths. Suicide was much higher among mental health than general medical patients.	Total number of suicides as small (36). Lack of denominator ("at risk" group) makes calculation and comparison of rates impossible.
Kausch, 2001	Case Western, VHA	Survey of all VA medical centers in 1992 identifying suicide attempts and suicides in fiscal year 1991.	Of 248 completed *suicides*, most (63%) were committed by males with alcohol addiction; 38% had a mood disorder, and 38% a personality disorder. There were 7 suicide attempts on inpatient units and 37 *suicide attempts* in outpatient substance use disorder treatment.	Retrospective study with no control group.
Sernyak, 2001	NEPEC, VHA	All veterans who had clozapine initiated during a VA hospital stay between 1992 and 1995 (n=1415) were compared with a match group of veterans with schizophrenia not receiving clozapine. VA databases and the National Death Index were used to identify all deaths over a 3 year follow-up time.	Veterans receiving clozapine had lower overall death rates, primarily due to reduced risk of death from respiratory disease. *Suicides* and accidental deaths did not differ between the groups. Suicide rate among clozapine users was 150/100,000/yr	Only 10 deaths due to suicide among clozapine-treated veterans makes statistical comparisons difficult. Clozapine users are not likely to be representative of all veterans with serious mental illness.

Definitions:

Suicidal ideation: Thoughts of harming or killing oneself. The severity of suicidal ideation can be determined by assessing the frequency, intensity, and duration of these thoughts.

Suicide attempt: A non-fatal, self-inflicted destructive act with explicit or inferred intent to die.

Suicide: Fatal self-inflicted destructive act with explicit or inferred intent to die.

Self-inflicted injuries: Refers to suicidal and non-suicidal behaviors such as self-mutilation.

Abbreviations:

BIRLS: Beneficiary Identification and Records Locator Subsystem, maintained by VBA
CDC: Center for Disease Control and Prevention
DoD: Department of Defense
EES: VA Environmental Epidemiology Service

HSR&D: VA Health Services Research and Development Service
MIRECC: Mental Illness Research, Education, and Clinical Center
NEPEC: Department of Veterans Affairs Northeast Program Evaluation Center located in West Haven, CT
NDI: National Death Index, maintained by the National Center for Health Statistics
NIMH: National Institute of Mental Health
RR: Relative risk
SSA: Social Security Administration
SMITREC: Serious Mental Illness Treatment Research and Evaluation Center located in Ann Arbor, MI
SMR: Standardized Mortality Ratio
SSRI: Selective serotonin reuptake inhibitor (e.g. Prozac, Zoloft, Paxel)
VA CSP: VA Cooperative Studies Program
VET Registry: Vietnam Era Twin Registry, a population-based database of male-male twin pairs housed at Hines, IL
WRAMC: Walter Reed Army Medical Center
WRIISC: War-Related Illness and Injury Study Center located in Washington, DC

Summary prepared by*:*

Joseph Francis, MD, MPH
Acting Deputy Chief Quality and Performance Officer
Office of Quality and Performance (10Q)
202–266–4513
Joe.francis@va.qov
Updated April 30, 2008

The Comprehensive VHA Mental Health Strategic Plan Aligned with the Recommendations of the Action Agenda (AA)

Key

1. Completed or incorporated into ongoing operations.
2. Goal achieved by alternate mechanisms.
3. In planning.
4. Requires reevaluation or further guidance.

President's New Freedom Commission Goal 1. Americans understand that mental health is essential to overall health.

Commission Recommendation 1.1. Advance and implement a national campaign to reduce the stigma of seeking care and a national strategy for suicide prevention.

Create a VA National Mental Health Campaign to increase awareness in veteran community that mental health is essential to overall health and that very effective modern treatments can promote recovery in mental illness. Request that Secretary Principi serve as the champion for this campaign and declare 2004 Veterans Mental Health Year. A. Initiate a campaign targeted at Iraqi Freedom and Enduring Freedom veterans and their families. B. Develop monthly messages on VA's Intranet home page focused on the theme that mental health is essential to overall health. The message would change monthly. C. Develop destigmatizing messages on VA's Internet home page for veterans, their families and the general public focused on the themes that mental health is essential to overall health and on the availability of effective new treatments. The monthly message would be developed with the help of VA Mental Health Consumer/Advocate Councils to be culturally competent and acceptable to veterans and their families D. Secretary Principi and other senior officials would include this theme in public addresses, speeches, and VSO convention addresses.

AA Rec. #	Mental Health Strategies	Initiatives		
1.1.1 A, B, C, D Initiatives 1–4	Promote mental health awareness in collaboration with VA Office of Communications, EES, NAMI, SMI Committee Consumer Liaison Council, etc.	Identify a spokesperson to represent VA in this effort. This will be a cross-cutting campaign with emphasis on special groups, e.g., PTSD, women, older groups, returning service personnel. This will be accomplished by outreach to veterans & families; use of public service announcements, train VA staff in these approaches to new vets/ families. Mental Health Strategic Healthcare Group (MHSHG) will coordinate Mental Health Awareness Day, with educational activities mandated at each VAMC and kickoff of Veterans Mental Health Year in 2005.	Ongoing	1
		MHSHG will create a Mental Health Workgroup to identify existing resources and develop a communications plan, based on the Action Agenda recommendation 1.1.1 A, B, C, D, to inform the veteran community, including families, Veterans Support Organizations, VHA staff, Veterans Benefits Administration staff, and veterans themselves as well as the public of the importance of mental health care.	An enhanced communication plan is under development	3
	Promote effective outreach and reintegration of soon to be or recently deactivated military personnel.	1. Provide "State of the Art" outreach, screening and referral to military personnel transitioning from active or reserve status to civilian status. 2. Readjustment Counseling Service (RCS)/MHSHG to extend seamless care model to mental health service for combat veterans. 3. RCS/MHSHG to develop and coordinate VHA outreach to National Guard, Reserve, and soon to be or recently discharged military personnel and to the families of these groups. 4. RCS/MHSHG to develop models of care to address mental health needs of recently discharged combat veterans.	Ongoing	1
	Promote destigmatization through partnering with VBA, Department of Labor, state and local programs to provide career development services.	Design and establish Career Development Centers in VHA Medical Centers and Community-based Outpatient Clinics (CBOCs), for recently deactivated military personnel based on partnerships between Psychology Services in Mental Health, VBA, and DoL.	To be reevaluated	4

Promote a Mental Health Awareness Day, for instance in May, which is Mental Health Month.

AA Rec. #	Mental Health Strategies	Initiatives		
1.1.2	Institute an annual Mental Health Awareness Day.	Mental Health Awareness Day annually and partner with other national organizations to reach broader audience.	Ongoing	1

Identify Mental Health an Employee Education Services (EES) focus area in 2005. All health care workers should understand that mental health is essential to overall

health; reduce stigma by their interactions with veterans and their families; and understand the major suicide risk factors and the principles of suicide prevention. A. Use the Mental Illness Research, Educational and Clinical Centers (MIRECC) and National Center for PTSD (NCPTSD) Education Groups for VA staff education for Best Practices. B. A satellite broadcast program similar to the "Face Behind the File" series can be launched in which veterans; perhaps some with national stature address their mental health and physical problems and their interconnection. The profiles will illustrate veterans overcoming disability and demonstrating recovery and individual success. C. Develop a Mental Health Speakers Bureau for Continuing Medical Education (CME) credits and patient education.

AA Rec. #	Mental Health Strategies	Initiatives		
1.1.3 A, B, C Initiatives 1–2	Educate all VHA health care providers that mental health is essential to overall health and that integrating mental health care with medical health care promotes recovery in both aspects of health.	MHSHG will assign a staff person to work with EES in the development of education programs which will include issues related to all special emphasis groups, i.e., PTSD, women veterans, older adults, etc. These programs will emphasize the interrelationships between mental health and physical health and the recovery model of care.	Ongoing	1
		Task MIRECCs and NCPTSD with development of a joint education plan by 12/31/2005. This plan will include the three tenets of recovery; consumer self determination, empowering relationships and veteran consumer participation in the development and delivery of mental health care services.	Ongoing. Reassigned to OMHS PSR section	2

Endorse the National Strategy for Suicide Prevention (2001) and the Institute of Medicine's report, "Reducing Suicide: A National Imperative" (2003). Implement their recommendations. A. Develop a Suicide Prevention Program for VA patients, families, staff and the community. B. Develop electronic suicide prevention database using institutional surveillance mechanisms that support population-based screening.

AA Rec. #	Mental Health Strategies	Initiatives		
1.1.4 A, B	Reduce suicide among veterans.	Promote evidence based strategies for suicide assessment and prevention, including emphasis on special emphasis groups. MHSHG will work with HSR&D, NEPEC, and SMITREC to develop and test an electronic suicide prevention database. Develop a national systematic program for suicide prevention. MHSHG develops a plan to educate all staff that interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel.	Ongoing	1

Develop and promote support programs that: A. reinforce help seeking from marital and family counselors, etc B. establish crisis-support, and C. support programs for development of more adaptive coping skills and resilience.

AA Rec. #	Mental Health Strategies	Initiatives		
1.1.5 A, B, C Initiatives 1–11.	Promote coping skills, resiliency and community support.	1. Educate and train DoD mental health care providers about VHA and VBA programs and eligibility requirements equivalent to a TAP for staff; 2. Develop and disseminate educational material on VHA and VBA programs and eligibility requirements for mental health patients and families; 3. Outreach to active duty, especially those with life altering injuries, and recently deactivated military personnel and their families to make them aware of VHA and VBA programs and eligibility requirements for persons with mental health problems.	Ongoing through activities of multiple office	2
		In its National Mental Health Campaign, MHSHG will promote veterans' seeking help from multiple sources and points of entry (e.g., marital and family counselors, legal counselors, financial counselors, mental health specialists, clergy and other appropriate community leaders), and promote to all VHA and VBA staff a biopsychosocial/spiritual orientation to health care that includes cultural competency with relation to unique veterans, racial, ethnic, sexual orientation, and gender sensitivities.	To be reevaluated	4
		Medical Centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues at local and national levels.	Requires additional guidance	4
		MHSHG develops a plan for 24 hour mental health care availability throughout VHA.	In planning and concurrence	3
		MHSHG directs the VISNs to develop plans, including peer support programs, to assist veterans in coping with common problems.	Ongoing	1
		Peer Support: FY–05: Issue national Information Letter to promote paid Peer-led services programming, (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness. FY–06: Issue national directive with detailed procedural guidance. Peer Support: FY–06: Explore expansion of Vet Centers to include veterans with SMI.	A strategy for broad implementation of peer support is included in the Uniform MH Services package	3
	Ease Transition of victims of Military Sexual Trauma (MST) from active duty into the VA health care system.	Initiate universal MST screening at MTFs and all components of national guard and reserves for separating servicemembers (self-administered with counselors available).	Universal MST screening is ongoing at all VA facilities.	2

AA Rec. #	Mental Health Strategies	Initiatives		
		TAP literature will include material on MST.	OMHS has established a resource center for training and for monitoring MST programs	2
		Establish EPRP MST screening supporting indicator: 90% of all veterans will be screened for MST; 80% of all veterans screening positive will be referred for counseling within 30 days of screening.	Required MST screening is in place	1
		VISN 4/5 MIRECC to expand work to focus on female veteran transition issues including MST.	Ongoing, Reassigned to MST Resource Center	2
	Provide seamless transition of women veterans from outpatient care to more acute levels of mental health care and vice versa.	The outpatient and Inpatient Mental health providers will serve as team members for both treatment modalities for female veterans.	Strategies for ensuring transitional care are included in the Uniform MH Services Package	3

Commission Recommendation 1.2. Address mental health with the same urgency as physical health

Develop a modular VA-adapted mental health collaborative care model dissemination package as the basis for national rollout, in collaboration with the mental health Quality Enhancement Research Initiative (QUERI) Mental Health, VA Central Office and Veterans Integrated Service Networks (VISN) leaders.

AA Rec. #	Mental Health Strategies	Initiatives		
1.2.6 Initiatives 1–5	Develop a collaborative care model for mental health disorders that elevates mental health care to the same level of urgency/intervention as medical health care.	MHSHG will collaborate with Mental Health QUERI to develop infrastructure needed for national rollout, including an organizational structure in which the Mental Health QUERI Depression Working group connects to MHSHG, Primary and Ambulatory Care SHG, OQP, National Clinical Practice Guidelines Council and the Performance Measures Workgroup, as well as to the TIDES Leadership Group. The development will include a VA integrated care model.	Ongoing. Implementation has been based on TIDES and other models	2
		Align performance measures to promote evidence-based collaborative care for depression.	Ongoing	1
		Work with OQP to rapidly update depression guidelines to include evidence-based collaborative care for depression.	Ongoing	1
		Develop a VA integrated care model similar to the Four Quadrant Clinical Integration Model for dissemination to VA medical centers. This will be done in collaboration with the Quality Enhancement Research Initiative (QUERI) program and VISN leadership.	Completed	1

AA Rec. #	Mental Health Strategies	Initiatives		
	Assure that medical co-morbidities are identified and addressed in the mental health care population at the same rate as medical issues in the primary care population.	Develop a tool and process for assessing physical co-morbidities in mental health patients. Collect and monitor data at a national level on medical co-morbidities in the mental health population using existing electronic databases; Promote and support epidemiological research in the area of medical co-morbidities in the mental health population; Collect and monitor data at a national level regarding access to medical care for the mental health population using existing electronic databases.	Ongoing	1

Identify good working models of Mental Health/ Primary Care/ Geriatric integration (including a module on differentiating normal and abnormal aspects of aging) in terms of service delivery and workload/supervision arrangements. Promote research activities on mental health/primary care integration best practices.

AA Rec. #	Mental Health Strategies	Initiatives		
1.2.7 Initiatives 1–13	Develop an accurate mental health projection model for the full continuum of mental health care.	Continue the MH CARES Advisory Work Group to further develop the projection model with special emphasis on domiciliaries and geropsychiatry.	DOMs have been transitioned to OMHS. Projection models are run by OPP	2
		A projection model has been developed by a combined subgroup (SMI Committee and GEC). Validation of this model as an accurate projection tool will occur from now through the end of FY07. This will be monitored by the continuing subgroup which will become a subgroup of the AASC. This projection model will be further evaluated in relation to its utility in conjunction with the algorithm to guide clinical decisions for long term psychiatric and nursing home care described in 1.2.8. Expand to cover all MH.	Responsibility transferred to OMHS, who work with OPP on this projection model	2
	Develop innovative programs of integrated care involving some combination of primary care, geriatrics, and mental health.	The MHSHG will continue to work closely with geriatrics and primary care to develop clinical models of care and guidelines that better integrate mental and physical health.	Ongoing	2

AA Rec. #	Mental Health Strategies	Initiatives		
	Educate VHA providers on the normal and abnormal aspects of aging.	Develop a module on differentiating normal and abnormal aspects of aging. Address principles of information processing and memory processes for older adults, based on normal age-related changes. Provide information on sensory needs (e.g., use of large font). Differentiate normal cognitive changes with aging from changes indicating dementia or other cognitive functional problems. Cover evidence on demographics of aging and mental health, challenging common distortions (e.g., that depression is normative for older adults). Discuss evidence that older adults benefit at least as much from psychotherapy and psychotropic medication as do younger adults. Discuss adaptations of psychotherapy that enhance its effectiveness with older adults. In accord with recovery principles, articulate respect for the older veteran's choices for mental health resources.	Training for some target groups completed. Further training is being planning; was deferred to focus on returning veterans	3
	Integrate primary medical care with homeless services.	Expand two existing pilots (VA Conn HCS & West LA) to other facilities. Incorporate primary care into the women's homeless demonstration program.	In planning and development	3
	Identify outreach to homeless recently discharged military servicepersons.	Add an indicator to the intake form to assess outreach. A draft document has already been sent to the field for evaluation of feasibility and other comments.	Ongoing. Indicator completed and continues to be utilized.	1
	Ensure that mental health examinations are a part of all physical examinations in VHA.	Every returning service man/woman will meet with a mental health professional as part of the post-deployment and separation medical examinations and be provided with a brief pamphlet that reviews the information provided during the session. He/she will be encouraged to share this pamphlet with his/her family. Those found to have significant readjustment problems in the course of the examination would be triaged to care as appropriate. Those who decline intervention at time of screening, or who are not presently symptomatic, but deemed at risk for future readjustment problems based on the exam, will have their medical record flagged for repeat screening at future medical appointments.	Ongoing—PDHRA process	2
	Eliminate gender disparities and provide accessible mental health services to women veterans.	Charge a women's mental health committee to identify and design evidence based optimal women's mental health practice models.	Ongoing	1
		Expand women's HSR&D research agenda to evaluate women's mental health programs effectiveness and patient outcomes.	Assigned to Women's Mental Health Committee	2
		Appoint a women's health representative to the SMI Committee.	Completed.	1

AA Rec. #	Mental Health Strategies	Initiatives		
	Women veterans will have access to mental health services in a milieu that promotes comfort and security.	Women Veterans Program Manager will participate in the MH EOC planning process for both inpatient and residential programs.	Participation in planning is part of the WVPM duties and responsibilities as identified in the VHA Handbook.	2
	Expand dental services for homeless veterans.	NEPEC and Dental Service will jointly develop a means of monitoring services delivered.	Mental Health Enhancement funding has been used to expand dental services for SMI and homeless veterans	2
	Realign Domiciliary Program.	The domiciliary programs that primarily treat substance abuse and PTSD patients should be placed under MH in VACO and the field. A subgroup of the AASC will be formed to explore details of how this can be accomplished while maintaining domiciliary-type services for frail elderly veterans and for enhancing services for special populations such as women veterans. Subgroup to include representatives of MH, GEC and the Women's Strategic Planning Task Force, as well as others selected by the Exec Comm of the AASC. Subgroup to be formed and begin to explore implementation plans by 10/1/04.	Completed.	1

Eliminate variability in access to mental health, substance abuse, long term psychiatric care and homeless services by 2008. A. Complete expansion of specialty mental health services in all Community Based Outpatient Clinics (CBOCs). B. Use tele-mental health approaches for smaller sites including access to specialized services such as PTSD and substance abuse counseling. C. Implement the Veterans' Millennium Health Care Act requirements for long-term psychiatric care. D. Produce VHA mental health strategic plan and VISN-level tactical plans to ensure uniform implementation.

AA Rec. #	Mental Health Strategies	Initiatives		
1.2.8 A, B, C, D Initiatives 1–40	Provide a full continuum of compassionate care to veterans with mental illness.	Implement Performance Measure for FY05: 85% of CBOCs serving more than 1,500 veterans will provide on-site, contract, or tele-mental health services at or above 10% of all clinic visits by FY05. Increase to 15% of all clinic visits by FY07.	MH in CBOCs have been expanded, and initial performance measures have been met. Further enhancement will occur through Uniform MH Services package	3
		All Networks that are below the 85% standard at COB 3rd Qtr FY04 must submit an Action Plan to the Action Agenda Steering Committee Task Force for review and recommended approval, and the Task Force will monitor progress. Appendix B of the Secretary's Mental Health Task Force contains a list of over 200 CBOCs that are below the standards as of 6/30/04.	Ongoing	1

AA Rec. #	Mental Health Strategies	Initiatives		
		Establish a Point of Contact for Mental Health in CBOCs and notify VACO MHSHG who that individual is.	Directors of MH in parent VAMCs have responsibility for MH in CBOCs	2
		All CBOCs should provide access to mental health services, either on site or by contract with offsite being the option of last resort. In remote locations telemental health may be used. The level care of care and the competencies of the staff available at the CBOCs must be equivalent to the care at the parent medical center and not at the expense of the parent facility (VHA Directive 2001–060). This workgroup recommends an integrated model of 1.0 FTE behavioral health clinician per 1,500 primary care patients. Clinicians who operate at a distance from VAMCs in CBOCs manage a broader and more complex range of mental health disorders and require an adjusted case load size. Develop a national performance measure that addresses the mental health staff/patient ratios in CBOCs. All VISNs should develop a plan of how to deliver mental health services in CBOCs to patients with primary substance use disorder diagnoses.	Ongoing	1
		Develop national performance measure that addresses MH staff/patient ratios in CBOCs.	Requires additional guidance; decisions will be related to mental health productivity work group recommendations.	4
		Update CBOC application directive and form to include requirement to specifically detail MH services and staffing to be provided at all new CBOCs. Ask for a focused evaluation from the Mental Health representative on each CBOC application currently under review and secure additional information as needed.	Ongoing	1
		All medical centers and CBOCs will develop service agreements between primary care and mental health on bipolar disorder, schizophrenia, PTSD, SA defining treatment and referral guidelines.	Included in Uniform MH Services Package	3
	Reduce geographic variation and include access to specialized MH and SA service delivery to homeless veterans.	Expand homeless programs to bring all VISNs up to the current national average for provision of mental health services to homeless veterans.	Ongoing	1

AA Rec. #	Mental Health Strategies	Initiatives		
		Consistent with the recommendation that variation in service availability will be reduced, the homelessness subgroup of MHSPWG developed a model for meeting the needs of homeless vets which suggests that $11.6 M of new annual funding over the next 5 years will bring all VISNs up to the current national average of 38.4 veterans served by homeless staff in homeless programs per 1000 veterans at risk for homelessness. $33 M could bring all VISNs up to the current 85th percentile or 49.7 for 1000 at risk. It could cost $86 M to bring all VISNs up to the level of the top VISNs (73.4/1000) in FY03. NEPEC, in collaboration with Performance Measures Work Group, will develop a performance measure.	Projecting need is the responsibility of OPP. Services have been enhanced in recent years.	2
	Provide a full continuum of care to homeless veterans with mental illness.	Implement Performance Measure for FY05: 75% of homeless veterans will receive at least one mental health or substance abuse visit and one primary care visit within six months of initial outreach (The denominator against which the 75% measure is calculated will be all veterans for whom a Form X is completed).	Ongoing	1
		75% of veterans with SMI who meet clinical criteria for MHICM program will be enrolled and provided services. The denominator for this measurement is the population based need estimate developed by the SMI Subcommittee of the MHSPWG. All VISNs will submit a plan (by 9/30/04) for providing care to meet this measure.	MHICM programs have been expanded. In general, these programs do not target homeless veterans	2
		VHA Directive 2000–034 specifies the evidence based operational performance criteria for MHICM in VHA and defines the target population. This directive to be renewed and facilities held accountable for adhering to all performance criteria.	Ongoing	1
		Require that all homeless veterans who meet clinical eligibility criteria for MHICM programs be offered assignment to a MHICM team and enrollment in the MHICM program. All MHICM teams will adhere to established clinical standards and caseloads.	Homeless veterans may be entered into MHICM programs when they complete transitional housing programs	2

AA Rec. #	Mental Health Strategies	Initiatives		
	Restore VHA's ability to consistently deliver state of the art care for veterans with SA disorders.	Mandate that VAMCs restore specialized SA treatment programs. All networks will be ranked on their percentage of substance abuse treatment capacity, which is defined as follows: The numerator is the number of substance abuse patients treated in FY03 as defined in the capacity report, and the denominator is the number of enrolled veterans in the network. The lowest quartile of networks (i.e., the bottom 5) on this measure will be required to bring their networks up to the national average on this measure on the rapid schedule laid out by the Secretary.	Ongoing planning. There is a need to restore specialized SA treatment, AND to account for SA treatment in general MH care settings and primary care	3
		Develop a National Plan to meet SA capacity requirements. Capacity distributed by VISNs to meet all dimensions of access: geographic distribution, affordability, availability, acceptability, and accommodation. The plan uses VHA's clinical practice guidelines for substance abuse treatment as primary guide in reestablishing services and show how VISNs resources will be reallocated to accomplish the plan objectives.	SA capacity is being expanded through the Mental Health Enhancement Initiative	1
		Ensure that primary care at all VA facilities has physicians trained, accredited and privileged in primary care provision of buprenorphine and Naltrexone or technology to connect to services at a larger medical center. Recommend that Pharmacy and Therapeutics Committees approve these agents for the facility's formulary. Ensure that all VA facilities have the resources to provide 5 days of inpatient/residential detoxification services either on-site, at a nearby VA facility, or at a contracted facility. All facilities will have a specialized substance abuse provider to ensure linkage between the inpatient and outpatient follow-up treatment programs.	Further planning is needed. Many sites remain without OAT in spite of ongoing support for buprenorphine staffing and training.	3
		Implement HEDIS for benchmarked performance measures for substance abuse in FY06.	Ongoing	1
	Establish case management programs for homeless veterans with mental illness and/or substance abuse.	Implement a special needs grant program for homeless chronically ill veterans coupled with Critical Time Intervention (CTI) services at partnering VAMCs. Current available funding in the Homeless Provider Grant and Per Diem Program can support five collaborative projects. Based on the outcome of the pilots, a plan for national implementation will be developed. Homeless veterans with complex medical problems, serious mental illnesses and/or substance use disorders will be assigned to a targeted case management program.	Ongoing	1

AA Rec. #	Mental Health Strategies	Initiatives		
		Eligible veterans who receive services in grant and per diem programs will have the number of visits (529 stop codes) consistent with their need, but no less than one HCHV visit per month, to assure facilitated access to VA mental health and medical services. Telemental health can be used to provide these services in remote locations. NEPEC to track data and report to MHSHG.	Ongoing	1
		Establish a performance measure requiring that homeless veterans suffering from SMI and/or SA who receive residential services receive at least one MH or SA treatment visit during residential care and one follow-up visit during discharge from residential care.	Ongoing—Four performance measures have been implemented focusing on timely access for homeless veterans to VA MH/SUD and Primary Care Services.	2
	Develop a full range of supportive services for veterans in collaboration with community partners.	Provide incentives to improve homeless veterans access to VA treatment services and enhance collaboration between VA medical centers and Grant and Per Diem funded transitional housing programs.	Ongoing.	1
		Establish financial incentives for providing necessary VHA mental health services to homeless veteran in Grant and Per Diem programs. A report of options will be sent to the Secretary from the VHA National Leadership Board Finance Committee.	Ongoing.	1
		Enhance supported CWT and employment activities within VA by: 1. Establish a performance measure/monitor for assessment of occupational dysfunction, and referral to transitional and supported employment models authorized by 38 USC 1718. Such a measure/monitor will establish reasonable expectations for access to transitional and supported employment separately for veterans with homelessness and for those with psychosis. 2. Provide approx $6,000,000 in FY'04 for staffing resources to implement supported employments at 107 existing vocational programs authorized by 38 USC 1718. Provide approx $4,000,000 in FY'05 for staffing resources to operate and sustain work restoration services authorized under 38 USC 1718 for the provision of both transitional and supported employment models at facilities without existing CWT programs. These resources should be provided through recurring Specific Purpose funding with new permanent positions established.	CWT programs have been expanded through the Mental Health Enhancement Initiative	2

AA Rec. #	Mental Health Strategies	Initiatives		
		Finalize a policy directive that places a priority on making underutilized space on VAMC campuses available to nonprofit community-based organizations that wish to develop residential programs for homeless veterans. Enhance partnerships with community partners to provide transitional housing.	To be reevaluated	4
		Mandate that all VISNs address the transition needs of incarcerated veterans and develop a plan that will be implemented in FY 2005.	Ongoing for veterans being discharged from state and Federal prisons	1
		Each VISN will submit a specific plan for pre-release assessments of veterans in Federal and state correctional facilities to determine degree and type of need and methods of providing services. The assessments to include mental health, medical and social service needs.	Ongoing	1
	Meet the needs of SMI veterans for Community Residential Care.	1. Meet levels as projected by the MHSPWG for FY07. Market level plans developed for any market with a gap that exceeds 1,000 CRC stops in FY07. For meeting these gaps, a plan must be submitted by 10/1/04 to the AASC. 2. Increase staffing to meet the required minimum one case management visit per month. 3. Emphasize individualized, recovery-oriented placements versus placements that have an institutionalized atmosphere and very little rehabilitation services.	Requires guidance on organization of CRC program	4
	Each Medical Center will have a Mental Health Clinic with adequate staffing to meet the mental health needs of veterans.	Each VISN will develop a planning initiative to address service gaps in outpatient mental health care identified by the MHSP model. Analysis and Network plan to address issues (with at least a 30% gap closure by COB FY07) must be submitted to MHSHG and AASC by 10/04. Markets with positive gaps over 16,000 (actual CARES) stops in FY07 MHSP model need to be addressed. This is the same market level gap used in the original CARES model. Each VA facility that currently does not have one will have a PTSD clinical team or PTSD specialists or a plan to secure these services. The role of these clinicians is to serve the facility MHC and CBOC based OPC services and also to provide consultative or clinical support to acute inpatient units for patients with PTSD.	Ongoing, with all VAMCs have PTSD clinical teams or specialists. Adequacy of staffing is assessed through measures of access, intensity, and quality of care	2

AA Rec. #	Mental Health Strategies	Initiatives		
		Expand PTSD outpatient services in VISNs with gaps as identified in the PTSD subgroup report. Twelve VISNs, 3, 4, 5, 8, 9, 10, 11, 12, 15, 19, 22 and 23 are identified as having PTSD care gaps in the P.L. 108–170 solicitation and will be considered the first priority for new PCT development. In addition, other VISNs especially those with significant Global War on Terrorism troop returnees (2, 6, 16, 17 and 21) will also receive priority in expanding new PCTs.	Each VAMC has a PTSD clinical team or specialist	1
	Medical Centers will have adequate beds and staffing to meet the needs of the local veteran populations for acute inpatient psychiatric services.	Each VISN which has a market(s) with a MHSP projected service gap in inpatient mental health both for FY'02 and for FY'07 that exceeds 7,300 bed days of care at the market level must submit a plan to close that gap by FY'07 with phased in increments of a minimum of 10% per year. Those markets that exceed a 7,300 BDOC gap either for FY'02 or for FY'07 will assess and report if a plan is needed. Reports should be submitted to the AASC no later than 10/1/04.	Planning is in progress	3
	Expand clinical monitoring systems to include Work Restoration services.	Explore development of a Work Restoration Information Management System (WRIMS) for use in each VAMC and CBOC (using the CMIS of VISNs 1 as a model), to ensure that each veteran is offered the choice in participating in work restoration services; Increase Work Restoration services until all veterans in VAMCs and CBOCs have equal access to work skills training and development; Implement the Evidence-Based practice of Supported Employment into all Work Restoration programs; Add work restoration to Illness Mgt Training of unemployed patients who are participating in programs transferring from LT custodial care to rehabilitation in the community; Add work restoration training to MHICMs and other community support teams.	The Uniform MH Services Package includes a strategy for broader implementation of CWT and SE	3
	Meet the needs of SMI veterans for residential rehabilitation services.	General psychiatry PRRTP (residential care) services increase at the VISN level by FY'07 based on the MHSP Model projection. VISNs that have a gap of 15 or more PRRTP beds should develop a plan to reduce the gap by at least 30% by FY07, phased in annually with a minimum of 10% improvement each year. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee.	The Uniform MH Services Package includes a strategy for making residential care services available to those who need them	3

AA Rec. #	Mental Health Strategies	Initiatives		
	Meet the needs of veterans with substance abuse for residential rehabilitation services.	SARRTP (residential care) services increase at the market level by FY'07 based on the MHSP Model projection. Market areas that have a gap of 15 or more SARRTP beds, after taking into account bed section 86, DOM/SA, develop a plan to reduce the gap by at least 30% by FY07. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee.	The Uniform MH Services Package includes a strategy for making residential care services available to those who need them	3
	Meet the needs of veterans with PTSD for residential rehabilitation services.	1. PRRP (residential care) services to be increased at the VISN level by FY07 based on the MHSP Model projection. VISN areas that have a gap of 5,475 or more PRRP beds (taking into account Dom PTSD program beds as equivalents) will develop a plan to correct the gap. The plan to be developed by 10/1/04 and reviewed by the Action Agenda Steering Committee. Preliminary analyses indicates that VISNs 4, 6, 9, 16 and 22 would develop plans.	The Uniform MH Services Package includes a strategy for making residential care services available to those who need them	3
	Allocate additional resources for enhanced outpatient treatment of all Mental Illness Chemical Abuse (MICA) patients. These treatments must consist of appropriate integration of substance abuse and mental health treatment services.	Proposed that VHA adopt the standards outlined in the integrated treatment of patients contained in the MICA Task Force report (January 2004) at each facility with a substantial population of individuals who meet the definitions for MICA.	Ongoing. Standards adopted in SA operating plan, FY 2005. Resources allocated in FY 2005/06/07	1
	Expand Opiate Agonist Treatment (OAT) in urban centers with high prevalence of heroin use and large CARES-projected gaps in VA methadone treatment.	Open OAT clinics at Phoenix, AZ; Denver, CO; Tampa, FL; Orlando, FL; Salt Lake City, UT.	The Uniform MH Services Package includes a strategy for making buprenorphine prescribing available at all VAMCs	3

AA Rec. #	Mental Health Strategies	Initiatives		
	Ensure effective utilization of the continuum of long term inpatient mental health care.	1. Authorize a joint review and refinement by Mental Health, Geriatrics and Extended Care, and the SMI Committee, of the 1996 VHA Program Guide 1103.22 "Integrated Psychogeriatric Patient Care"; by 2/2005. 2. Promulgate throughout VA the algorithm for functional decisions on level of nursing and mental health care for older veterans needed (presented in full report of the Older Adult subgroup) over the next year (and then ongoing), as a recommendation by the Secretary for decisionmaking in each VISN. This will be done in conjunction with ongoing efforts in Geriatrics and Extended Care to develop a broad new, compassionate model of nursing home care for Veterans. 3. All nursing home care facilities will have staff educated in and competent to care for patients with both functional and behavioral health problems. In some circumstances, specialized units such as dementia units, or psychogeriatric units may be necessary to meet local needs.	In planning. Programs are being at NHCUs in each VISN to place mental health staff who can ensure that recommendaton #3 is accomplished: educating staff in competent care for patients with both functional and behavioral health problems	3
	Ensure adequate day treatment facilities for SMI veterans.	VISNs without Day Treatment (or equivalent) capacity should add it at the most appropriate facility, based on size and access considerations.	The Uniform MH Services Package includes a strategy for making psychosocial rehabilitation available at all VAMCs. Day treatment with a PSR orientation already implemented in most VISNs	3
		Facilities serving over 1,000 veterans in the psychosis registry without a Day Treatment (or equivalent) facility should add one with appropriate staffing and education. Peer Specialists should be used whenever feasible.	Included in the Uniform MH Services Package	3
		Existing Day Treatment programs with waiting lists will provide resources to eliminate them.	Enhancements in day treatment are included in the Uniform MH Services Package	3

President's New Freedom Commission Goal 2. Mental health care is consumer and family driven.

Commission Recommendation 2.1. Develop an individualized plan of care for every adult with a serious mental illness and child with a serious emotional disturbance.

Develop a performance measure based on percentage of Seriously Mentally Ill (SMI) patients whose family members have been contacted to participate in developing an individualized plan of care. A. Create data capture mechanism for family contacts that include implementation of a clinic stop code for family work and a family education/counseling field on encounter forms.

AA Rec. #	Mental Health Strategies	Initiatives		
2.1.9 A Initiatives 1–5	Ensure that every mental health patient has an individualized treatment plan that includes family involvement in treatment plan and process.	Operationalize Family Education clinic stop code and encounter form procedure code in FY–05; Implement (VISN 10 pilot) Family Involvement Performance Measure nationwide in FY–05.	Planning is underway to evaluate how to capture family involvement in care	3
		The FPE/FE Task Force of MH QUERI outlined the following in FY–05: Develop policy directive on Family Involvement/Education to include issues of confidentiality and expectation that the care plan for all patients with schizophrenia establish at least one family contact or document the reason for its absence.	In planning	3
	Expand seamless transition efforts to fully cover veterans with mental health diagnoses.	1. Assign Transition case managers to focus on mental health programs, based on caseload to WRAMC, Brooke etc. where the bulk of the mental health MEBs and PEBs are conducted; 2. Develop case management program for all DoD "complex care" patients coming into VHA health care system; 3. Include VHA social worker/case manager and patient family in transition planning for DoD personnel with mental health problems who will be transitioning to VHA health care system, with a special focus on pain management; 4. Improve transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system; 5. Improve outcomes for patients eligible for VA services and/or benefits thru use of recovery approach to provision of services.	Care management programs focus on seriously injured	2
		1. Assign Transition Social Workers to focus on mental health including: 2. Survey all MTFs to determine the need for social workers focused on mental health programs; 3. Ensure that Points of Contact at VISN and local treatment systems have appropriate knowledge about mental health programs and capabilities; 4. Have transition social workers followup on referrals at three and six months to ensure effective program placement; Identify VACO point(s) of contact for problem resolution.	Care management programs focus on seriously injured	2
	Mental health assessments are an integral part of all exams of separating military service personnel.	1. Every military man and woman meet individually with a mental health professional as part of the post-deployment and separation exams. 2. An MOU needs to be developed with DoD to spell out authority, responsibility, accountability, and funding for the necessary clinical capacity to be assured.	Ongoing. VA has worked with DoD to support PDHRAs	2

Commission Recommendation 2.2. Involve consumers and families fully in orienting the mental health system toward recovery.

Involve veteran consumers and families in educating staff/veterans/family members on recovery.

AA Rec. #	Mental Health Strategies	Initiatives		
2.2.10 Initiatives 1–2	Seek stakeholder input into mental health programming related to recovery.	For VHA staff educational efforts, MHSHG will ensure that stakeholders are included in planning educational programs related to recovery.	Ongoing	1
		Assess barriers and explore implementation of Vocational Rehab and education for DoD patients with mental health problems while they await their MEBs or PEBs.	Need further guidance on collaborations between VBA and MH	4

Implement administrative incentives that facilitate work with veteran's families.

AA Rec. #	Mental Health Strategies	Initiatives		
2.2.11 / 2.2.12 Initiatives 1–3	Reduce barriers to working with families.	Implement (VISN 10 pilot) Family Involvement Performance Measure, including developing stop codes and other incentives for tracking workload. MHSHG and Mental Health QUERI will review results of VISN 10 performance measure pilot prior to advocating for national performance measure.	In planning	3
		Implement Family Education in every Network through partnership with NAMI (Family to Family Program).	MOU is in concurrence	3
		Offer Family-to-Family Education in partnership with NAMI in every Network. Partner every facility, outpatient clinic and CBOC with corresponding county NAMI Affiliate, or other comparable Family Education program where FFEP is not offered and/or there is an already existing Family Education program; FY–06: Implement FPE in pilot Networks; Implement FPE/FE utilizing technology in pilot Networks; Work: Insure Family Education addresses issues regarding Work Restoration.	In planning	3

Educate staff. A. Begin process of educating staff with a satellite broadcast introducing the current evidence base for the recovery based model of treatment. B. Develop programs for staff use on family psycho-education. C. Educate staff on clinical benefits and effective approaches to working with families, including issues of older couples and intergenerational families.

AA Rec. #	Mental Health Strategies	Initiatives		
2.2.13 A, B, C Initiatives 1–3	Educate staff on the evidence based recovery model of treatment.	MHSHG will work with EES to develop an educational program, including a satellite broadcast, for staff regarding the recovery model of treatment including issues of older veterans, female veterans and other special emphasis groups.	Ongoing	1

AA Rec. #	Mental Health Strategies	Initiatives		
		Train staff on QUERI FPE via EES Broadcast and develop FPE Tool Kit; Disseminate FPE Task Force Tool Kit (planned) which will include working with diverse families to include older couples and intergenerational families.	FPE is being disseminated through with multiple supports	2
		Develop programs for staff use on family psycho-education at the VA Palo Alto MIRECC and NCPTSD (VAPAHCS is the educational site for the National Centers for PTSD).	A number of centers are involved in training	2

Include veteran consumers and family members in facility mental health councils.

AA Rec. #	Mental Health Strategies	Initiatives		
2.2.14 Initiatives 1–3	Establish facility mental health council that include consumer membership.	All facility Mental Health Services will report to MHSHG about membership composition of the facility mental health council.	Additional guidance is required	4
		All facility mental health councils will have at least one veteran consumer and one family member as standing members of the facility mental health council.	Additional guidance is required	4
		To provide guidance to the field, VACO to develop and issue a Directive promoting the establishment of consumer/advocate liaison councils at both VISN and facility levels by 2nd Qtr FY'05. Such a Directive to include language about the communication chain to maximize the effectiveness of the council.	Additional guidance is required	4

Commission Recommendation 2.3. Align relevant Federal programs to improve access and accountability for mental health services.

Develop Peer Support Program as an adjunct to mental health services. A. Explore models of peer support certification (e.g. those developed by Georgia). B. Determine whether a directive on Peer Support is advisable.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.15 A, B Initiatives 1–5	Partner with other Federal agencies to develop peer support programs.	Pilot State Peer Specialist Certification projects (such as Georgia/South Carolina, Hawaii, etc); Peer Support: FY–05: Issue national Information Letter to promote paid Peer-led services programming, (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness. FY–06: Issue national directive with detailed procedural guidance.	A strategy for developing peer support is included within the Uniform MH Services Package	3

AA Rec. #	Mental Health Strategies	Initiatives		
		Establish partnership with SAMHSA and continue participation in Federal partners workgroup at VACO level. Establish nationwide method for reimbursing peer support. Add Work Restoration to Peer Counseling and Vets Helping Vets programs. Oversight of this effort to be conducted by the AASC.	Requires additional guidance	4
		Develop a partnership between the MHSHG and RCS to develop model systems for consumer and family driven services with VHA and to create a national Program of Excellence in Peer Counseling Services within VHA.	Requires additional guidance	4
		VISN 1 MIRECC will develop a "How To" manual on developing a Peer Support program.	Manuals for psychosocial rehabilitation, including peer support, are under development	3
	Transition planning and referral/placement for OEF and OIF returnees	Explore early transfer of patients with mental health problems to the VA treatment system and the use of VA health care providers to conduct MEBs and PEBs.	Plans for DoD VA partnerships are being developed	3

Initiate a national Recovery and Rehabilitation Task Force to develop a "How To" manual on developing a Peer Support Program.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.16	Provide support for the development of a Peer Support Program.	VISN 1 MIRECC will facilitate the following efforts: 1. Family Support/education—Implement family education program in each VISN; educate staff; appoint family POC within each facility. 2. Veteran Advisory Councils/peer support. 3. Change VHA culture to recovery oriented service delivery. Reference AA Recommendation 5.3.61.	In planning, with reassignment to OMHS	3

Develop task oriented veteran-consumer councils in each facility. A. Insure consumer council has communication mechanism to facility leadership.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.17 A	combined with 2.3.14			

Develop paid positions for veterans) within the facility/network to work with Mental Health leadership in developing Peer to Peer Programs.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.18 Initiatives 1–3	Utilize veterans in the provision of mental health care. Reference AA Recommendation 5.3.61.	Hire or identify existing staff as a permanent veteran mental health consumer in the MHSHG and in each Network to work with Mental Health leadership in developing Peer Programming and to represent the consumer perspective in other mental health planning/management initiatives and to serve as peer/MH para professional.	In planning	3
		Pilot Certified Peer Specialists in selected VISNs (suggest VISNs 7 and 20) Pilot Peer Bridgers in selected VISNs (suggest VISNs 2 and 3); Modify current State Certified Peer Specialists training to tailor for VHA implementation nationwide.	A strategy for broad implementation of peer support services is included in the Uniform MH Services Package	3
		Issue national directive on Peer programs; Establish Network performance monitor to require a formal Peer Support Program at each facility serving greater than 2,500 veterans with SMI; FY–06: Establish a clinic stop code for Peer-Led Groups, and a Peer Provider category on encounter forms.	A strategy for broad implementation of peer support services is included in the Uniform MH Services Package	3

Hire veterans as Peer / Mental Health Para Professionals.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.19	See 2.3.18 and 5.3.61.	FY 06. Establish network performance monitor to require a formal paid peer support program at each facility serving greater than 2,500 veterans with SMI. FY 07. Expand that monitor to include facilities with more than 1,200 veterans with SMI.	A strategy for broad implementation of peer support services is included in the Uniform MH Services Package	3

Issue a national directive to facility leadership on the creation of local Peer Support programs. A. Identify a facility coordinator for the development of peer programs. B. Develop a progressive performance measure that addresses incremental steps to the implementation of a facility Peer Support program. C. Create data capture mechanisms for peer support and peer training that include implementation of clinic stop codes and modification of encounter forms to include fields for peer support as well as peer training.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.20 A, B, C	See 2.3.18 and 5.3.61			

Make housing with support more available for those veterans who are homeless or at risk for homelessness, particularly older veterans and those veterans who are new to the system.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.21 Initiatives 1–6	Provide additional homeless housing.	Task HSR&D with creating a Management Consultation Project to develop a demand model for residential services at all facilities. The needs of older veterans and veterans new to the system will addressed in this model.	DOMS have been moved within OMHS. Projecting need is the responsibility of OPP	2
		Work with HUD to maintain current capacity and create new capacity in the HUD/ VASH.	Ongoing	1
		Continue support of joint VA/HUD/ HHS collaborative initiative in chronic homelessness.	Ongoing	1
		Expand grant and per diem and domiciliary care programs.	Ongoing	1
		Develop programs focused on prevention of homelessness and unemployment for DoD patients with mental health problems (Legislative authority may be required).	For planning with DoD COE	3
		Make underutilized space at VA facilities available for community organizations to provide programs.	For program by program evaluation	3

Work with state, local and community partners to increase opportunities for veterans to participate in supported employment programs. Support legislation to increase VA's authority to form partnerships to provide supported employment opportunities for veterans.

AA Rec. #	Mental Health Strategies	Initiatives		
2.3.22 Initiatives 1–3	Increase opportunities for veterans to participate in supportive employment.	Partner with Department of Labor (DOL) to develop Work Restoration services that promote entrepreneurship and private enterprise; Develop contract with Department of Defense (DoD) to expand the CWT Veterans Construction Team (VCT) to assist veterans in restoring lost construction skills; Develop policy and procedures for utilization of non-appropriated CWT Special Therapeutics Rehabilitation Activities Fund (STRAF) to contract with state, local and community partners to provide job development and coaches for Supported Employment services; Increase outreach by providing CWT, IT, CWT/TR programs in shelters for homeless veterans.	Specific elements require reevaluation	4
		Improve outcomes for patients eligible for VA services and/or benefits thru use of recovery approach to provision of services.	Additional guidance is required about recommendation related to benefits	4

AA Rec. #	Mental Health Strategies	Initiatives		
		MHSHG to create a RFP for the development of new or expanded CWT/TR programs and that they be provided with $500,000 annually to support these programs. This alternative centralized funding mechanism would be established and supported to sustain the provision of residential rehabilitation in the CWT/TR program for SMI veterans until authority is restored for use of non-appropriated dollars.	Evaluations of CWT funding are in progress.	3

Commission Recommendation 2.4. Create a comprehensive State Mental Health Plan

Ensure that VISNs participate in State Mental Health Plan development.

AA Rec. #	Mental Health Strategies	Initiatives		
2.4.23 Initiatives 1–3	All VISNs will actively participate in the development of their State mental health plans.	Participate in President's 10 Year Plan to End Chronic Homelessness.	Ongoing	1
		FY–05/06: Partner with state-funded Consumer-run services to provide supports for housing, employment and other community services to veterans.	The state service liaison program needs updating.	3
		VISNs will work with their state(s) and The National Association of State Mental Health Program Directors to develop strategic plans and processes for collaboration of the delivery of mental health service. The VISNs submit their proposals to 10N and the MHSHG for consideration.	The state service liaison program needs updating.	3

Encourage development of state plans that provide supported housing, employment and other community services to veterans.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.24	collapsed with 2.2.23			

Commission Recommendation 2.5. Protect and enhance the rights of people with mental illnesses.

Identify a family point of contact within each facility to coordinate services, education and liaison with National Alliance for the Mentally Ill.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.25	Ensure facility coordination with NAMI.	MHSHG will initiate a Task Force including representatives from the Mental Health QUERI FPE/FE Task Force, and charge it with developing a process for implementing FE.	AN MOU with NAMI is in concurrence	2

Assist with development of an Advanced Directive for every veteran with serious mental illness who desires one. Advanced Directives can designate power of attorney at times the veteran is deemed not competent to make decisions for him/herself.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.26	Across the age span, there will be no disparity between mental health and medical health of veterans in completing a mental health and a medical advanced directive.	Develop and disseminate to the VISNs a mental health advanced directive policy. This policy will address the following issues: Across the age span, there will be no disparity between mental health and physical health in completing a medical advance directive. When data on advanced directive compliance are reviewed by facility, rates of completion for veterans with and without SMI will be compared. If rates are not equivalent, training for staff described under Goal 1 (re. destigmatization) should be repeated for relevant staff, with an emphasis on the rights and abilities of veterans with SMI and veterans of all ages to state their advanced directive wishes.	OMHS is collaborating with Ethics on MH advance directives	3

Partner with academic institutions that have a commitment to the understanding and development of psychosocial rehabilitation (e.g. Robert Wood Johnson Foundation).

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.27 Initiatives 1–3	Provide psychosocial rehabilitation expertise to VHA staff.	Create working group to expand partnerships by participating in research and training activities.	Ongoing	1
		Identify current partnerships through a survey of MIRECCs, PSR fellowship programs, Mental Health QUERI, and field clinicians and researchers.	Ongoing	1
		Partner with OAA to develop VHA psychosocial internships in association with universities and foundations. Increase linkages in Supported Education with state and regional colleges and training schools. Supported education must increase marketability in an ever-changing job market in which all employees rapidly become obsolete as technology continually transforms.	OAA has established 7 psychosocial rehabilitation fellowship programs	2

Explore grants awarded to not for profit groups targeted at Peer Development and Education.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.28 Initiatives 1–2	Refer to 2.3.18	Peer: FY–05: Explore development of a VA Technical Assistance Center for Peer Support Services and/or develop grant/contractual arrangement with established technical assistance organizations.	Ongoing. Technical Assistance for peer support is available from a number of centers	2
		Part of the Special Needs Grant for Homeless Chronically Mentally Ill Veterans MHSHG is requiring nonprofit organizations that receive funding to develop "Vet-to-Vet" peer counseling model. Ten such programs are planned for funding.	OMHS is developing a peer support program for homeless veterans	2

Charge Veterans Benefits Administration (VBA)'s Vocational Rehabilitation Service with identifying and developing opportunities for training veteran/consumers as mental health service providers.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.29	Align VBA work restoration efforts with VHA work restoration efforts.	Expand the partnership with VHA/CWT Program to improve access and services to VR&E programs for veterans with mental illness by development of supported employment models that include veteran/consumers as employment specialists, job coaches, and other support roles. MHSHG will prepare memo to USB from USH with this proposal.	Recommendations for partnership with VBA should be clarified	4

Strengthen and expand local partnerships with NAMI and with National Mental Health Association (NMHA) for consultation on the development of peer facilitated programs.

AA Rec. #	Mental Health Strategies	Initiatives		
2.5.30	Refer to 2.5.25			

President's New Freedom Commission Goal 3. Disparities in mental health services are eliminated.

Commission Recommendation 3.1. Improve access to quality care that is culturally competent.

Develop a culturally competent health care workforce A. Intensify efforts to improve the cultural diversity of health care staff and seek to recruit professional staff that better reflect the veteran enrollee population. B. Institute health professional scholarship programs targeted to attract minority candidates. C. Provide incentives for university affiliates to send undergraduate and graduate health care professional trainees to VA health care sites with large minority populations.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.31 A, B, C Initiatives 1–2	Ensure that VHA workforce is culturally diverse in ethnicity, gender, and age.	The Office of Academic Affiliations to develop and fund health professional scholarship programs targeted to attract minority candidates.	To be reevaluated. OAA has been developing other training initiatives.	4
		The Office of Academic Affiliations to develop incentives for university affiliates to send undergraduate and graduate health care professional trainees to VA health care sites with large minority populations.	Requires additional guidance	4

Request that the Office of Research and Development (ORD) support research on minority mental health treatment. A. Identify areas of research specifically needed to close the gap in providing mental health care for minority veterans.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.32A	Conduct research to assess and remedy potential disparities in treatment for minorities, including ethnicity, gender, age.	SOTA conference with HSR&D and HSR&D COE on minorities will review existing portfolio and develop solicitations as appropriate for research on minority mental health treatment. The research will cover psychobiology of ethnicity, service/treatment disparities, and health related characteristics of other special emphasis groups.	VISN 4 HSR&D COE focuses on health disparities including MH disparities	2

Collaborate in national interagency efforts to address minority issues, staff training needs, and assessment instruments, etc

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.33 Initiatives 1–3	Ensure that there are effective interagency relationships to address minority issues, staff training needs, and assessment instruments, etc.	MHSHG will designate a liaison to other Federal agencies to collaborate with their efforts in this area.	Ongoing. Federal Partners on MH focuses on a broad array of issues	1
		MHSHG will explore options to collaborate with HHS minority offices in this area.	Ongoing. Topic covered as part of Federal Partners work group	2
		VA will initiate collaboration with National Federal Partners' work group in this area.	Ongoing. Topic covered as part of Federal Partners work group	1

Incorporate a cultural competence strategy in the VHA Strategic Plan.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.34 Initiatives 1–2	Ensure that all VHA staff are culturally competent	By January of 2005, the MHSHG to establish a Cultural Competency Task Force to focus on clinician education and health care services. Representation to be from VACO and the field as well as MIRECCs, QUERI and EES. This Task Force to provide an action plan to be implemented by end of FY2006 and to include an evaluation component to assess effectiveness of the implementation in improving cultural competency. Refer to 3.1.31 and 3.1.37.	Task Force developed and has produced an implementation plan that has been approved in PCS. It will be implemented as part of the Universal MH Services	3
		Convene a work group to review literature and track the implementation of the recommendations of the Commission's Cultural Competence Subcommittee, the Surgeon General's Report on Mental Health, Minority Supplement, and evaluate the effectiveness of VA's cultural competence training program.	To be evaluated as part of the implementation of the Uniform MH Services Package	3

Fund EES to develop and implement comprehensive, cultural competence training, including a module on aging, for all VA employees.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.35	Refer to 1.2.7			

Develop a knowledge management system to disseminate timely, program specific education that will keep staff continuously apprised of new information on best practices and research related to racial and ethnic differences in care needs and interventions.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.36 Initiatives 1–3	Enhance the current information dissemination system to speed the dissemination of information on research findings and best clinical and management practices throughout the VHA mental health community.	MHSHG to urge VHA to develop information systems such as data warehouses and associated tools that allow real-time access to clinical data, and to encourage training of managers and providers in use of these tools as well as sharing of best practices.	Planning and preparation	3
		Develop web-based educational programs on best practices and research related to racial and ethnic differences in care needs and interventions.	ORD is developing a major program on personalized medicine	2
		Develop a registry of best practices similar to SAMHSA's National Registry of Effective Programs.	Ongoing MH enhancements and the evolving Uniform MH Services Package disseminate evidence-based practices	2

Partner with Indian Health Service (IHS) to improve access to culturally competent mental health and substance abuse care for American Indian and Native Alaskan veterans.

AA Rec. #	Mental Health Strategies	Initiatives		
3.1.37 Initiatives 1–2	Partner with IHS to improve access to the full continuum of MH care for Native Americans and Alaskan Indians.	VHA will designate a VA liaison to work with IHS to promote this collaboration; specialty groups will be included in the planning.	Ongoing operations	1
		OAA will review and disseminate the cultural competence education pilot in VISN 1 MIRECC. Refer to 3.1.31 and 3.1.34.	Requires re-evaluation	4

Commission Recommendation 3.2. Improve access to quality care in rural and geographically remote areas.

Identify national, state and local partners who are focused on improving health care in rural America. VHA is a stakeholder in any process involving rural health care and should request to participate in national initiatives and activities. This should include any actions taken on the part of the Department of Health and Human Services (HHS) to establish a State rural health initiative, especially those involving National Institute of Mental Health (NIMH), Health Resources and Services Administration (HRSA), IHS or the Substance Abuse and Mental Health Services Administration (SAMHSA).

AA Rec. #	Mental Health Strategies	Initiatives		
3.2.38 Initiatives 1–2	Collaborate with other agencies in delivering quality health care to veterans in rural areas.	VHA to have a designated liaison from the MHSHG to focus on rural mental health care issues and participate in the activities of HHS, NIMH, IHS, HRSA, SAMHSA.	Rural issues are being addressed through multiple mechanisms within VHA	3
		VA liaisons will advocate inclusion of veterans located in rural areas in all state MH plans.	Liaison between VA and state MH systems is being strengthened	3

VHA should pursue a wide range of options for providing rural mental health care; particular attention should be paid to the needs of older veterans living in rural areas. VHA should examine existing and planned community access sites to ensure that they have mental health access that meet veteran's needs. Options for providing mental health services include but are not limited to on site staffing, telemental health, use of mid level providers, partnerships with State agencies, and fee for services with local private providers.

AA Rec. #	Mental Health Strategies	Initiatives		
3.2.39 Initiatives 1–5	Ensure that veterans in rural areas have access to quality mental health care.	Develop internet-based services to facilitate Peer Support services for veterans.	Requires re-evaluation	4
		Case management models in rural areas where MHICM is not feasible/practical will be developed by NEPEC.	Ongoing operations	1
		Design and launch a major demonstration project on telehealth addiction and mental health services for veterans, including recently separated military personnel, living in remote and rural areas.	Telemental health is being expanded and enhanced	3
		VHA to examine existing and planned community access sites to ensure that they have mental health access that meets the veteran needs in those areas. Mental health providers to be available in all CBOCs, and they will provide training using the psychoeducational modules described in the various recommendations above. Tele-mental health options, as described in later recommendations, will be widely available for use of older adults, PTSD, women, SA, etc.	A strategy for delivering MH in rural areas is included in the Uniform MH Services Package	3
		MHSHG will collaborate with SAMHSA's Registry of Effective Programs to establish a parallel mechanism to have a VHA registry of best practices/demonstration programs including, for example, telemedicine programs and practices in remote areas and best practices for rural communities.	VA is in ongoing dialogue with SAMHSA about providing MH services in rural areas	2

VHA should request participation in SAMHSA efforts to identify and disseminate best practices to the rural community.

AA Rec. #	Mental Health Strategies	Initiatives		
3.2.40	collapsed 3.2.39			

There are no items for Commission recommendations 4.1 and 4.2, as these deal with children & schools.

President's New Freedom Commission Goal 4. Early mental health screening, assessment, and referral to services are common practice.

Commission Recommendation 4.3. Screen for co-occurring mental and substance use disorders and link with integrated treatment strategies.

Ensure that every clinician knows that mental health and substance use disorders can and do co-occur with other disorders that they assess and treat.

AA Rec. #	Mental Health Strategies	Initiatives		
4.3.41 Initiatives 1–3	Implement a broad range, self-administered screening for mental health disorders. The screening will be conducted annually throughout the veteran's lifespan by the veteran's primary care team or identified care manager.	HSR&D will evaluate current instruments and pilot a proposed mental health screening instrument.	Processes for screening, followup, and monitoring of outcomes for MH conditions are being developed	2
	Provide education to primary care providers regarding mental health disease management and to mental health providers regarding common medical conditions found in psychiatric patients.	Require 8 hours annually of CMEs on mental health for primary care providers and on medical health for mental health providers. Recommend increasing medicine residency training program requirements for mental health electives and/or training.	MH training for primary care providers is being provided through the Integrated Care programs	2
	Improve diagnosis and treatment of mental health disorders among returning service personnel with serious physical injuries.	Provide outreach to active duty, especially those with life altering injuries, and recently deactivated military personnel and their families to make them aware of VHA and VBA programs and eligibility requirements for persons with mental health problems. Develop partnership between the MHSHG and RCS to lead VHA outreach to special populations; 1. Partner with DoD MTFs to screen all patients for mental health and substance abuse problems; 2. Expand use of clinical reminder currently used to screen for mental health and substance abuse in OIF and OEF veterans to all new patients coming into the VA health care system.	Programs for seamless transition and outreach are operational	1

Ensure that screening and evaluation for these disorders are part of accepted clinical practice for every health care provider.

AA Rec. #	Mental Health Strategies	Initiatives		
4.3.42	collapsed with 4.3.41			

Ensure that diagnosis of a mental health or substance abuse disorder results in an automatic screen for the other disorder as a routine clinical practice.

AA Rec. #	Mental Health Strategies	Initiatives		
4.3.43	See above 4.3.41			

Require cross training in the two areas including the acquisition of a minimum number of CME/CEU credits in the assessment and treatment of the two disorders for mental health and substance abuse service providers and non-specialists in these areas.

AA Rec. #	Mental Health Strategies	Initiatives		
4.3.44 Initiatives 1–2	Mental health and substance abuse providers will be competent in assessment and treatment for both mental health and substance abuse disorders and these competencies will be documented.	MICA Task Force is working on specific recommendations on mandatory CMEs.	Plans for meeting the needs of patients with Dual Diagnoses are included in the Uniform MH Services Package	2
		Link with SAMHSA Co-occurring Disorders Project to develop educational program.	Resource enhancements, education, and strategic planning are in progress. VA is in dialogue with SAMHSA over many issues	2

Commission Recommendation 4.4. Screen for mental disorders in primary health care, across the lifespan, and connect to treatment and supports.

Require annual screening for mental health and substance abuse disorders across the life span by the veteran's primary care team or other providers responsible for the veteran's VA health care. A. Pilot test the clinical reminder developed for veterans from Operation Iraqi Freedom for use as a screen in primary care and specialty care clinics for all recently deployed individuals. B. Evaluate whether early screening and treatment can prevent chronic mental and multi-system illnesses.

AA Rec. #	Mental Health Strategies	Initiatives		
4.4.45 A, B	Require annual screening for Mental Health and Substance Abuse Disorders across the lifespan by the veterans' primary care provider.	Work with MHSHG and MIRECCs to develop and test a comprehensive tool for annual screening.	Annual screening for MH conditions is in place	1

Evaluate the dual diagnosis/co-occurring VA programs to identify best practices and to determine which programs were most effective. Fund research to develop a valid screen for suicide risk and prevention.

AA Rec. #	Mental Health Strategies	Initiatives		
4.4.46 Initiatives 1–4	Suicide prevention.	Endorsement and implementation of the National Strategy for Suicide Prevention (2001) and the Institute of Medicine's report, Reducing Suicide: A National Imperative (2002).	Ongoing	1
		Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.	Ongoing	1
		EES in conjunction with MHSHG develop mandatory education programs for VA health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.	Mechanisms to document mandatory training are being developed	3
		Recommend support for new MIRECC with focus on suicide prevention, in collaboration in other MIRECCs working in this area.	VISN 19 MIRECC and Canandaigua COE are operational	1

Increase collaboration with VBA to provide the full range of supports and services that are needed by patients with mental health, substance abuse and co-occurring disorders.

AA Rec. #	Mental Health Strategies	Initiatives		
4.4.47 Initiatives 1–2	Eliminate the disincentives in the work restoration program for veterans.	MHSHG will evaluate and address these disincentives. Link VA work restoration program to Supported Employment in the Veterans Benefits Administration (VBA) that focuses on competitive work, rapid job search, coupled with job coaching, and training veteran/consumers as mental health service providers. MHSHG will prepare memo to USB from USH with this proposal.	There have been a legal opinion that comp and pension are fully protected while veterans participate in CWT for voc rehab.	1
	Increase collaboration with VBA.	Recommend that VARO Benefits Counselors annually assess all veterans in the G&PD programs to determine eligibility for benefits. MHSHG will prepare memo to USB from USH with this proposal.	G&PD liaisons evaluate veterans clinically to identify those who may be eligible for additional benefits.	2

Work with Residency Review Committees to encourage incorporation of mental health modules into all residency programs.

AA Rec. #	Mental Health Strategies	Initiatives		
4.4.48	Incorporate mental health education and training into residency programs.	The Coordination Council for education program, "Mental Health for Primary Care Providers," described in Action Agenda recommendation 5.3.65, will work through VHA clinical services & OAA to promote inclusion of a mental health module in all residency training programs. The Council will also work with professional organizations to include such a module as a requirement by Residency Review Committees.	Integration of MH and Primary Care, and introduction of MH into other medical care settings lay the groundwork for residency training.	3

Contract with the Institute of Medicine for a literature review to determine effective prevention strategies for mental illness in combat veterans, with and without physical injury. Recommendations should also include an agenda for needed research.

AA Rec. #	Mental Health Strategies	Initiatives		
4.4.49	Determine effective prevention strategies for mental illness in combat veterans with/without physical injuries.	VHA will contract with IOM, and other pertinent agencies, for literature review after consultation with specialty groups.	Research on early intervention or prevention of PTSD is included within the activities of NCPTSD, MIRECC, other VA COEs and the DoD COE. Contracting with IOM may not be necessary	3

President's New Freedom Commission Goal 5. Excellent mental health care is delivered and research is accelerated.

Commission Recommendation 5.1. Accelerate research to promote recovery and resilience, and ultimately to cure and prevent mental illnesses.

Convene an Evidence Based Practices (EBP) Steering Committee to focus on recovery and rehabilitation. Representatives from NIMH and SAMHSA should be invited to participate as committee members. The Mental Health Strategic Health Care Group (MHSHG) should be staffed to coordinate and manage this activity. This steering Committee continuously review advances published in the scientific literature and A. Identify new research that is needed; B. Identify research results that are ready for demonstration projects or pilot testing, and C. Identify models that can be disseminated as EBP or best practices.

AA Rec. #	Mental Health Strategies	Initiatives		
5.1.50 A, B, C Initiatives 1–5.	Emphasize recovery and rehabilitation in mental health care.	MHSHG will propose a structure and resources to facilitate recovery, including supporting the work of the EBP Steering Committee.	Ongoing. Recovery coordinators have been appointed in each VAMHC	2
		1. Establish a joint DoD/VA "Center of Excellence" focused on traumatic brain injury and other life altering injuries; 2. Develop longitudinal tracking system for veterans from OIF and OEF; 3. Evaluate the effectiveness of the mental health transition program.	Ongoing	1
		Pilot and research State Peer Specialist certification programs; Pilot partnership with NY Assoc of Psych Rehab Services to develop Peer Bridgers in VISNs 2 and/or 3.	Peer support programs are in place and will be supported through the Uniform MH Services Package	2
		Task the MIRECCs to review the role and function of Day Hospitals and Day Treatment Center to ensure adequate dissemination of recovery based care in the centers.	Psychosocial Rehabilitation Centers have been developed, and will be disseminated throughout VAMCs	2

AA Rec. #	Mental Health Strategies	Initiatives		
		Identify recovery-oriented research across the age span that is ready to be tested for generalizability or developed into best practice models; Develop demonstration pilots to test implementation strategies prior to national program dissemination.	Ongoing. All RFPs have emphasized use of PSR evidence-base as source of program proposals	1

Facilitate the work of the Steering Committee by tasking the MIRECCs to: A. Identify recovery-oriented research across the age span that is ready to be tested for generalizability or developed into best practice models. B. Develop demonstration pilots to test implementation strategies prior to national program dissemination.

AA Rec. #	Mental Health Strategies	Initiatives		
5.1.51 A, B	Refer to 5.1.50			

Task the National Center for PTSD to develop a research agenda to close the gap in developing prevention and evidence based early interventions for acutely traumatized veterans. Research should have sufficient analytic power to identify racial and ethnic differences in response.

AA Rec. #	Mental Health Strategies	Initiatives		
5.1.52	Develop a research agenda to close the gap in developing prevention and evidence based early interventions for acutely traumatized veterans.	Present suggestions to NCPTSD Scientific Advisory Board & ORD and jointly develop a plan to conduct targeted research.	Ongoing activities of NCPTSD, MIRECC, other VA COEs and DoD COE	1

Emphasize and strengthen the VA mental health research portfolio focused on rehabilitation/recovery; A. Establish a Cooperative Study Program Center of Excellence in Mental Health. The Center(s) will issue Request for Proposals to conduct clinical trials and large-scale demonstration programs. B. Initiate an educational study to evaluate the impact of the Office of Academic Affiliations (OAA) Interdisciplinary Fellowship Program in Psychosocial Rehabilitation training program on shifting the emphasis of care from a traditional medical model to a recovery oriented model. C. Create a Mental Health Liaison position in ORD to develop the behavioral health research agenda and to assist with implementation.

AA Rec. #	Mental Health Strategies	Initiatives		
5.1.53 A, B, C Initiatives 1–6.	Promote research related to rehabilitation and recovery.	Convene a MHSHG/ORD workgroup to analyze the ORD mental health research portfolio and develop solicitations for clinical trials and large-scale demonstration projects in the area of rehabilitation and recovery.	ORD successfully manages mental health—and substance abuse—related projects within its current structures	2
		Establish a Cooperative Study Program Center of Excellence in Mental Health.	To be reevaluated	4

AA Rec. #	Mental Health Strategies	Initiatives		
		Create a Mental Health Liaison position in ORD to monitor the mental health portfolio across research services, to coordinate development of solicitations for new research, and to coordinate mental health research initiatives across services.	Ongoing	1
		Develop position description and hire a high-level scientific program manager to facilitate strategic planning for ORD mental health research, to monitor mental health portfolios in consultation with research leadership and investigators in the field, and to serve as a liaison to mental health leadership and the mental health community.	To be reevaluated	4
		Establish a steering Committee of researchers and chief officers to advise on research efforts in this area.	To be reevaluated	4
	Evaluate the interdisciplinary fellowship program in PSR to determine its impact in disseminating the rehabilitation/recovery model.	Commission an evaluation of PSR fellowship programs to determine program impact on career trajectory, job duties (extent to which current position involves PSR), attitudes toward PSR and recovery, dissemination of PSR and recovery principles to other staff, and perceived barriers and facilitators to implementing PSR and recovery-oriented programs.	The PSR program has recently been expanded to 7 sites and a Hub site has been created to ensure national training consistency and evaluation. Evaluation of its impact is being planned	3

Commission Recommendation 5.2. Advance evidence-based practices using dissemination and demonstration projects and create a public-private partnership to guide their implementation.

Develop a knowledge management system to disseminate almost real-time, program specific education that will keep staff continuously apprised of new information on best practices and research.

AA Rec. #	Mental Health Strategies	Initiatives		
5.2.54	Develop a knowledge management system to link research, guideline development and implementation, clinical tools, sharing of best practices, and real-time data analysis related to racial and ethnic differences in care needs and interventions in order to create continuous expansion of the evidence base and increased knowledge generated by a spirit of inquiry.	See also 3.1.36	Prioritization from senior leadership will be needed to prioritize development of a MH real-time data analysis capability	4

Implement an improved Clinical Practice Guideline (CPG) process to reduce the time between initiation of development and release of a CPG and ensure timely, periodic updates. Invite additional Federal partners to join the CPG effort.

AA Rec. #	Mental Health Strategies	Initiatives		
5.2.55 Initiatives 1–4	Ensure regular and timely updates of mental health CPGs.	Establish a working group to monitor the literature and provide focused additions and revisions for expedited approval. Renew CPGs every 3 years or sooner as indicated by the development of new treatment methodologies.	Ongoing	1
		The National Clinical Practice Guidelines Council will have a member with expertise in evidence-based mental health care.	Ongoing	1
	Expedite the approval of mental health CPGs, including updates.	Once approved by MHSHG and the National Clinical Practice Guidelines Council, final approvals must be completed within 60 days.	First CPG in MH since approval of the MHSP, on Major Depressive Disorder, is being developed. This item should be addressed upon approval of this CPG when completed.	3
		Ensure that draft recommendations from the Medication Advisory Panel (MAP) are approved by the National Clinical Practice Guidelines Council to be consistent with CPGs.	Ongoing	1

Implement QUERI–MH current priorities & major projects including: A. Measure care gaps in depression & schizophrenia B. Develop Nat.Clin.Reminders key care processes for depression, schizophrenia, SA, & co-occurring disorders. C. Develop/implement evidence-based guidelines & perf measures across age span. D. Implement evidence-based antipsychotic practices in schizophrenia, promoting use of appropriate antipsychotic doses & newer atypical antipsychotics, and monitor important side effects. E. Implement evidence-based depression collaborative care model in primary care with particular attention to elderly; evaluate impact on quality/outcomes/cost effectiveness. F. Convene group to review literature/track implementation of recommendations (Commission's Cultural Competence Sub., Surgeon General's Report on MH–Minority Supplement, & evaluate effectiveness of VA's cultural competence trng. program. G. Prioritize interventions that assess applicability of existing family psychoeducation models to vets/families, & studies of interventions including advance directives, behavioral family management, intensive case management or assertive community treatment, and work restoration programs.

AA Rec. #	Mental Health Strategies	Initiatives		
5.2.56 A—G Initiatives 1–11	Promote implementation of research on evidence based practices.	Put treatment initiation, engagement and continuation measures in official VA performance system. Implement benchmarked performance measures.	Ongoing	1
		Appoint a representative from the MHSHG to the national CPG work group.	Ongoing	1

AA Rec. #	Mental Health Strategies	Initiatives		
		Collaborate with Mental Health QUERI to continue development of clinical tools and implementation strategies to improve medication management for schizophrenia and to implement a collaborative care approach.	Multiple centers are contributing to the development of clinical tools	2
		Support Mental Health QUERI, Substance Use Disorders QUERI, and MHSHG Informatics Section to develop and implement clinical practice tools.	Multiple centers are contributing to the development of clinical tools	2
		Support Mental Health QUERI initiatives to measure gaps in depression and schizophrenia care.	Ongoing	1
		Support Mental Health QUERI and SMITREC in creating and analyzing national registries for psychosis and schizophrenia. Collaborate with Mental Health QUERI on development, testing, and implementation of outcomes monitoring.	Ongoing	1
		Solicit new research and promote Mental Health QUERI implementation research efforts in management of individuals with depression or schizophrenia who have comorbid substance use disorders or medical disorders.	Ongoing	1
		Prioritize the study and implementation of psychosocial and recovery-oriented interventions, including family psychoeducation, behavioral family management, intensive case management or assertive community treatment, work restoration programs, and peer support.	Ongoing	1
		Collaborate with the Office of Quality and Performance in developing and implementing evidence-based guidelines and performance measures across the adult age span; Implement an evidence-based collaborative care model for depression in primary care settings with particular attention to the elderly, evaluating its impacts on quality and outcomes and measuring its cost effectiveness.	Ongoing. Integrated care programs have been implemented in more than 100 facilities	2
		Solicit new research and promote Mental Health QUERI implementation research efforts in psychosocial rehabilitation and recovery.	Ongoing.	1
		Implement the QUERI–Mental Health current priorities and major projects in EBPs.	Evidence based practices from multiple sources have been incorporated in MH enhancements	2

Investigate strategies for sustaining treatment adherence and retention for individuals with major depressive disorder and schizophrenia; and strategies for increasing treatment engagement for patients who are not currently in treatment.

AA Rec. #	Mental Health Strategies	Initiatives		
5.2.57	Promote treatment adherence and retention for veterans with Major Depression and Schizophrenia.	Continue to solicit new research in this area through Mental Health QUERI solicitation.	Ongoing. Involving MIRECCs and other centers as well as QUERI	2

Commission Recommendation 5.3. Improve and expand the workforce providing evidence-based mental health services and supports.

Work with the Senate and House Veterans Affairs Committees to enact the physician salary reform legislation to maintain our ability to recruit and retain a high quality psychiatrist workforce.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.58	VHA must have competent MDs, who are adequately reimbursed.	A market survey of MD salaries to be performed in all markets, and the physician pay bill amended to reflect the results of the survey.	MD pay has been increased	1

Implement legislation designating psychologists and social workers as Title 38 hybrid employees.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.59	Done			

Collaborate and affiliate with Historically Black Colleges and Universities (HBCUs) and Hispanic Association of Colleges and Universities (HACUs) to help us in developing diversity in our workforce and cultural competence among the providers.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.60	Expand diversity in the VHA workforce.	Collaborate and affiliate with Historically Black Colleges and Universities (HBCUs) and Hispanic Association of Colleges and Universities (HACUs) to help us in developing diversity in our workforce and cultural competence among the providers. The previously (3.1.34) recommended Cultural Competency Task Force will be responsible for accomplishing this collaboration.	There are multiple ongoing initiatives to increase diversity in the MH workforce	2

Train veterans who have recovered from mental illness in peer support, to develop a cadre of peer counselors.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.61 Initiatives 1–5	VHA will have veterans trained and competent as peer counselors. Reference AA Recommendations 2.3.16, 2.3.18, 2.3.19 and 2.3.20.	1. MH QUERI to develop an RFP in 2005 for the assessment of the effectiveness of peer support. 2. MHSHG recommends the development of peer support programs consistent with the recovery model and would become Centers of Excellence to disseminate best practices.	Peer support programs have been expanded. Evaluations are being planned	2

AA Rec. #	Mental Health Strategies	Initiatives		
		Pilot Peer Specialists and Peer Bridgers models in selected VISNs; FY–07: Develop VHA Peer Certification process and implement nationwide.	Peer support programs have been expanded. A strategy for further expansion is included in the Uniform MH Services Package	2
		Identify additional formal Peer-Specialist training programs (colleges, foundations, etc.) for targeted recruitment into paid Peer-Provider/Specialist positions and for additional peer specialist training venues FY 07.	The need for additional resources to support recruitment of certified peer specialists will be evaluated during the implementation of the Uniform MH Services Package	3
		Work with SAMHSA's Center for Mental Health Services and National Association of State Mental Health Directors to develop strategy for collaborative initiatives to improve veteran access to premier community-based, consumer-run services.	To be reevaluated	4
		Issue national Information Letter promoting and providing broad guidance on the recruitment of peer professionals/para-professionals, and the development of paid Peer-led support services (directly or through contract with community providers) as an adjunct to traditional mental health services at all facilities serving veterans with serious mental illness.	Included in the Uniform MH Services Package	2

Enhance clinical pastoral programs to connect to faith-based initiatives, and to add a spiritual dimension to the biopsychosocial framework, and thus reach the majority of veterans who are religiously committed.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.62 Initiatives 1–2	Spiritual assessment will be a routine part of mental health evaluation, and treatment provided according to the veteran's preference.	Establish MHSHG liaison to the National Chaplain Center to provide input into the Clinical Pastoral Education Program and other training programs. Include education about initial presentation and referral to enhance mental health outreach to veterans. MHSHG Liaison will also participate in activities of the National Chaplain Center Faith Based Initiative.	Requires additional guidance	4
		Link the registry of mental health best practices to the Best Practices in Chaplaincy program.	Requires additional guidance	4

Extend Mental Health Liaison/Consultation to primary and specialty care to support and educate that workforce.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.63 Initiatives 1–2	Implement collaborative care models for MH care.	Implement collaborative care models for depression care, etc. to promote the mental health liaison role and provide multi-modal education on mental health for non-mental health clinicians and staff.	Ongoing	1
		Develop a mechanism to account for liaison and teaching time of mental health providers.	Productivity workgroup has been empanelled	3

The MHSHG should enhance the Mental Health Leaders' training and support the annual meetings of the VISN Mental Health Liaisons.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.64 Initiatives 1–8	Ensure highly competent Mental Health Leadership.	Reestablish and enhance the Behavioral Health Leadership Training program.	Ongoing	1
	Ensure effective organizational leadership in addressing the treatment of mental disorders.	Develop options for effective mental health leadership that will further the goals of the PNFC on mental health incorporate this process into the ongoing patient care services review and add a mental health task force member to that committee for continuity. The Mental Health Chief Consultant will become a member of the NLB and Executive Committee by July/August 2004.	Requires additional guidance	4
		Require that a mental health leader, representing care of veterans with mental disorders, be a member of the highest level decisionmaking body in every VISN.	Ongoing	1
		Extend the mission of the Secretary's Task Force for three years; request this task force submit a progress report to the Secretary by 9/30/04.	Completed.	1
		The PCS will provide quarterly reports to the task force on implementation of the recommendations. Resource needs and budget implications will be addressed in these reports. This information will be utilized in the preparation of the ELDA and FY 2006 budget.	Completed. Such reports were sent during the time the Task Force was meeting.	1
	Promote, expand, and support the annual "Best Practices in Network Mental Healthcare Systems" conference.	Expand the size of the meeting to allow attendance of all VISN mental health leaders and at least one representative from each facility.	Meeting structure was revised to be more inclusive	2
		Each VISN must support the annual attendance of at least one VISN mental health leader or representative. VISN Directors, CMOs and QMOs will be invited.	Meeting structure was revised to be more inclusive	2
		Link ECF program and HPDM for preparation of future MH leaders.	Ongoing	1

EES should develop a CME/CEU training program: "Mental Health for Primary Care Providers;" in coordination with the Mental Health, Geriatrics and Extended Care, and Acute Care Strategic Health Care Groups. These groups could be convened as Coordination Council to oversee development in this area.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.65 Initiatives 1–2	Develop CME/CEU training program on mental health care in the primary care setting.	Form a Coordination Council involving EES, MHSHG, Acute Care SHG, Geriatrics and Extended Care SHG, and Mental Health QUERI to oversee education program and plan implementation of collaborative care for depression.	The Integrated Care program is ongoing	2
		MHSHG and EES will develop training programs for mental health managers, providers, and staff. Programs will emphasize evidence base for collaborative care and recovery programs.	The Integrated Care program is ongoing	1

Expand Office of Academic Affairs and the Mental Health Strategic Healthcare Group's programs for training of interdisciplinary teams and collaborative care. The recovery orientation in these programs should be enhanced and expanded.

AA Rec. #	Mental Health Strategies	Initiatives		
5.3.66	Build on the model Psychosocial Rehabilitation Special (PSR) Fellowship program, expanding it to training at more than the fellowship level.	Work with OAA to expand the PSR Fellowship Program to provide training in life span issues in recovery. The program will fund stipends for a wide variety of mental and physical health disciplines, provide training in sites with interprofessional recovery-oriented care, and include a didactic component on the recovery model and interprofessional collaboration in implementing the model.	PSR fellowship has been expanded to 7 sites. Other forms of training and career development are being evaluated	1

Commission Recommendation 5.4. Develop the knowledge base in four understudied areas: mental health disparities, long-term effects of medications, trauma and acute care.

Enhance research programs and EBP related to treatment of minority veteran populations and cultural competence.

AA Rec. #	Mental Health Strategies	Initiatives		
5.4.67	Increase research that expands the evidence base related to ethnic variability in disease manifestations and treatment response; to inequities in access; and to disparities in evaluation and treatment. Conduct research on gaps in cultural competency and strategies to close gaps.	Solicit research on variation in treatment response among ethnic groups to inform evidence-based guidelines; solicit research on disparities in access and availability of services, treatment practices, and outcomes. Solicit research on cultural competency, including descriptive studies and intervention research.	ORD is implementing a major program in personalized medicine	3

Enhance trauma research related to combat trauma, terrorism, and prevention of chronic PTSD after exposure to traumatic events. Screening, prevention, neurobiology, treatment and recovery should be priorities.

AA Rec. #	Mental Health Strategies	Initiatives		
5.4.68 Initiatives 1–2	Enhance trauma research.	Engage NCPTSD, MIRECCs, ORD, DoD/ USUHS in these projects. Include minority & collaborative care issues.	Ongoing	1
		Establish a joint DoD/VA "Center of Excellence" focused on traumatic brain injury and other life altering injuries; Develop longitudinal tracking system for veterans from OIF and OEF. Trauma research agenda to also include trauma related to MST.	Ongoing	1

Assess the effects of long-term medications: A. Task a Work Group consisting of the Pharmacy Benefits Management (PBM), Mental Health QUERI, Clozapine Center, and Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) to perform a literature review, analyze the Clozapine and Psychosis Registries, and report their findings and recommended actions to the Office of Patient Care Services.

AA Rec. #	Mental Health Strategies	Initiatives		
5.4.69	Develop algorithm for use of atypical antipsychotics.	MHSHG will take responsibility for organizing a work group that will utilize the National Consensus Guidelines to develop an algorithm for: use of atypical antipsychotics with consideration of medical complications and cost, including recommendations for changing therapy when medical complications develop; develop monitors for medical complications related to the use of the atypical antipsychotics; and education of primary care and mental health providers on the complications of atypical antipsychotics.	A work group has recently been formed	3

Assess the VHA's provision of Acute Mental Health Care: A. Develop and test a valid VA demand model for acute inpatient and outpatient mental health care. B. Develop a national electronic database to track veterans who request admission or transfer to a VA acute inpatient mental health facility but are denied admission because of unavailability of a hospital bed or inadequate staffing.

AA Rec. #	Mental Health Strategies	Initiatives		
5.4.70 A, B	See recommendation 1.2.8			

President's New Freedom Commission Goal 6. Technology is used to access mental health care and information.

Commission Recommendation 6.1. Use health technology and telehealth to improve access and coordination of mental health care, especially for Americans in remote areas or in underserved populations.

Expand the charge to the VHA Telemental Health Field Work Group to coordinate the implementation of the 6.1 action agenda items, in conjunction with VISN leadership, VISN mental health clinicians, and VISN telemental health coordinators.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.71 Initiatives 1–2	Expand the charge to the VHA Telemental Health Field Work Group.	The Telemental Health Field Work Group to continue to meet virtually or in person to coordinate the implementation of 6.1 action agenda items, in conjunction with VISN leadership, VISN mental health clinicians, and VISN telemental health coordinators.	Ongoing.	1
		Expand telemental health to target homeless veterans.	Homeless programs continue to be expanded through other mechanisms	2

Commission the VHA Telemental Health Work Group to perform a needs assessment for telemental health services. The needs assessment should focus on identification of underserved veteran populations, access to mental health services in CBOCs and Vet Centers, and provision of specialty mental health and substance abuse consultations in rural and remote areas.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.72 Initiatives 1–5	Improve access through use of technology.	Together, the Office of Care Coordination, the Mental Health Strategic Healthcare Group, VISN Leadership, and each VHA Telemental Health Field Work Group VISN representative will assure that the need for telemental health services are clearly determined, in conjunction with other mental health needs assessments already being undertaken by VISN mental health clinicians, VISN CBOC administrators, and VISN telemedicine coordinators.	Ongoing	1
		Improve transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system.	Ongoing	1
		1. Ensure that all mental health programs within VHA, including RCS, have standardized systems of electronic technology to access information while maintaining confidentiality and informed consent; 2. Explore "at home" mental health care coordination for recently discharged veterans, especially those in rural areas or in areas where specialty care is limited.	Ongoing	1
		Improve the electronic exchange of information from DoD to VA on patients awaiting MEBs and PEBs.	Ongoing	1
		Include questions on screening tools for older veterans to determine difficulties with transportation or other resources that restrict ability to attend outpatient appointments; and to identify needs of caregivers for older veterans who are home bound due to medical problems and/or who have a dementing illness.	Current planning	3

Based on the results of the needs assessment, each VISN should be tasked with the development of a telemental health implementation plan designed to improve access to mental health care within the VISN. A. Each VISN Telemental Health Plan should identify adequate equipment and staffing resources to assure that it can be successfully implemented. B. Implementation of VISN Telemental Health Plans should be assessed through such strategies as VHA performance measures/monitors and official reports to VACO leadership on a regular basis. C. Formalize the registration of telemental health programs throughout VHA.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.73 A, B, C Initiatives 1–5.	Expand mental health telehealth care to all facilities, CBOCs, and Vet Centers.	Each VISN will: submit a Telemental Health plan to Office of Care Coordination (OCC) by 6/30/05; Outcomes approved on National Performance Measures will be developed to assure implementation is successful; All Telemental Programs will be approved by OCC.	Ongoing	1
		Action Agenda Steering Committee to appoint a group to review the data on pilot telemental health use and make recommendations on an outcomes monitoring system and feedback mechanism.	Completed	1
		Together with the Office of Care Coordination, the Mental Health Strategic Healthcare Group and VISN Leadership, each VHA Telemental Health Field Work Group VISN representative will assure that their VISN Telemental Health Plans are viable, and that they identify adequate equipment and staffing resources to assure that it can be successfully implemented.	Ongoing	1
		Together with the Office of Care Coordination, the Mental Health Strategic Healthcare Group and VISN Leadership the VHA Telemental Health Field Work Group will work to assure that implementation of the VISN Telemental Health Plans be assessed through accountability strategies such as official reports to VACO on a regular basis, and the establishment of applicable VHA performance measures/monitors.	Mechanisms for accountability are being developed	3
		Together with the Office of Care Coordination, the Mental Health Strategic health care Group and VISN Leadership, the VHA Telemental Health Field Work Group will extend its annual telemental health service inventory by formalizing the registration of telemental health programs throughout VHA.	Ongoing	1

Expand use of existing telemental health and telehome care technologies as well as develop new technologies, including : A. Identify mental health care coordination opportunities using in-home messaging devices, etc. B. Expand on the existing telemental health collaborations with VHA and the Readjustment Counseling Services. C. Identify existing sharing programs and evaluate telemental health opportunities with the DHHS, IHS, DoD. D. Develop and implement family psychoeducational video programs and telehome care family therapy programs. E. Increase telemental health consultation between mental health specialists at the medical centers and CBOC staff. F. Utilize telemental health technologies that make telemental health and telehome care accessible to the visually and hearing impaired.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.74 A–F Initiatives 1–6	Combine with 6.1.73	A. Together with the Office of Care Coordination (OCC), the Mental Health Strategic Healthcare Group (MHSHG) and VISN Leadership, the VHA Telemental Health Field Work Group will identify mental health care coordination opportunities using in-home messaging devices, mental illness management dialogues, interactive voice response programs, and other new technologies to bring mental health services to the patients' homes, to halfway houses, to homeless shelters, and the state veterans homes.	Home telemental health is currently being developed	1
		Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will expand on the existing telemental health collaborations with VHA and the Readjustment Counseling Services.	To be reevaluated	4
		Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will identify existing sharing programs and evaluate telemental health opportunities with the DHHS, IHS, DoD.	Included in the activities of DoD COE	3
		Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will develop and implement family psychoeducational video programs and telehome care family therapy programs.	Requires additional guidance	4
		Together with the Office of CC, the MHSHG and VISN Leadership, the VHA Telemental Health Field Work Group will increase telemental health consultation between mental health specialists at the medical centers and CBOC staff.	Ongoing.	1
		Together with the Office of CC, the MHSHG and VISN Leadership and Office of Geriatrics and Extended Care, the VHA Telemental Health Field Work Group will utilize telemental health technologies that make telemental health and telehome care compliant with ADA.	Ongoing. Attention continuously paid to ADA requirements.	1

Charge Northeast Program Evaluation Center (NEPEC), the MIRECCs, SMITREC and Health Services Research and Development (HSR&D) with providing outcomes monitoring and feedback regarding national, VISN, and individual facility telemental health and care coordination programs.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.75 Initiatives 1–2	Develop outcomes monitoring and feedback system.	Together, the Office of CC, the MHSHG and VISN Leadership and the VHA Telemental Health Field Work Group to establish a plan to monitor outcomes of telemental health activities, utilizing existing mental health and VHA venues.	In planning	3
		Charge workgroup with exploring outcome measures specifically related to older adults' access and utilization.	In planning	3

Establish a full-time position for a VHA Telemental Health Coordinator. Provide adequate administrative staff and resources for necessary meetings and collaborations.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.76	Provide full time coordination of telemental health care.	The Office of CC and the MHSHG to facilitate adequate leadership and administrative staff resources necessary to successfully implement these action items.	Ongoing	1

Work with the HHS in the review recommended by the Commission of how best to deliver and finance telehealth services.

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.77 Initiatives 1–2	Optimize telehealth mental health delivery both in VA and the private sector.	Work with HHS in the review recommended by the Commission of how best to deliver and finance telehealth services.	Requires additional guidance	4
		Explore financial and other incentives to increase the use of telemental health.	Ongoing.	1

Develop and implement adequate means to accurately capture and reflect workload generated by telemental health and telehome care (stop codes, encounter forms, etc.).

AA Rec. #	Mental Health Strategies	Initiatives		
6.1.78	Capture workload generated by telemental health services.	Develop and implement adequate means to accurately capture and reflect workload generated by telemental health providers. Charge Office of Care Coordination with developing a system of secondary stop codes and guidelines for using correctly to capture data accurately. Ensure mental health review of plans to finalize and implement telemental health stop codes.	Ongoing	1

Commission Recommendation 6.2. Develop and implement integrated electronic health record and personal health information systems.

Establish a Mental Health IT Work Group to enhance VHA's electronic health record (VistA/CPRS and MHP/MHA) and personal health information systems (MyHealtheVet). This group should be charged with the responsibility of developing in more detail the other recommendations included under Action Agenda items 6.2.

AA Rec. #	Mental Health Strategies	Initiatives		
6.2.79 Initiatives 1–2	Establish a MH IT Work Group to work with IDMC and MHSHG.	Charge this group with developing in more detail the other recommendations included under Action Agenda items 6.2.	Requires additional guidance	4
		Develop electronic method to monitor community employment in the CWT supported employment program. Include NEPEC monitoring of Supported Employment.	Ongoing	1

VISTA/CPRS should be modified to provide optimal functionality for the care of veterans with serious mental illness.

AA Rec. #	Mental Health Strategies	Initiatives		
6.2.80 Initiatives 1–2	Ensure that all mental health programs within VHA, including RCS, have standardized systems of electronic technology to access information while maintaining confidentiality and informed consent.	Improve Transition planning, referral/placement and information exchange for patients with mental illness coming into VHA health care system.	Ongoing	1
		Modify CPRS to include the identification of a Primary Mental Health Provider as well as Primary Care Provider.	Requires additional guidance	4

Develop a mental health treatment planning tool. VHA should consider build/buy options including the Commercial Off the Shelf (COTS) product currently being used at several facilities. The treatment planner should facilitate the participation of the patient and his/her family in the treatment planning process. The Mental Health IT Work Group should submit a formal request to the Informatics & Data Management Committee (IDMC) for the development of a treatment planner.

AA Rec. #	Mental Health Strategies	Initiatives		
6.2.81	Develop a MH treatment planning tool.	Mental Health IT Work Group will review treatment planner options including review of the planner developed in VISN 3. The treatment planner will facilitate the participation of the patient and his/her family in the treatment planning process. The Mental Health IT Work Group to submit a formal request to the Informatics & Data Management Committee (IDMC) for the development of a treatment planner.	To be reevaluated	4

Develop MyHealtheVet to better serve the needs of veterans with mental illnesses. A. Provide adequate resources to the Office of Information to ensure continuity and availability of the MyHealtheVet platform. B. Conduct a pilot test or a functional test of the use of mental health patient's use of to assess possible implementation issues unique to this patient population. C. Fund development of a mental health portal as an addition to MyHealtheVet to better serve the needs of veterans with mental illness and their families. D. Develop criteria that veterans and their families could use to evaluate non-VHA mental health information sites (see http://helping.apa.org/dotcomsense/ for an example developed by the American Psychological Association).

AA Rec. #	Mental Health Strategies	Initiatives		
6.2.82 A, B, C, D	Develop a MH component within MyHealtheVet.	The MH IT Work Group will implement this Action Agenda recommendation.	Some initial MH components for MyHealtheVet have been developed and are online. Additional MH components for MyHealtheVet are under development	3

A Comprehensive VHA Strategic Plan of Mental Health Services July 2004

Crosswalking between the U.S. National Strategy for Suicide Prevention, the VHA Comprehensive Mental Health Strategic Plan, and VHA's Suicide Prevention Actions

U.S. National Strategy for Suicide Prevention	VHA Comprehensive MH Strategic Plan	VHA Suicide Prevention Actions and Plans
	Endorse the National Strategy for Suicide Prevention (2001) and the Institute of Medicine's report, "Reducing Suicide: A National Imperative" (2003). Implement their recommendations..	
Promote awareness that suicide is a public health problem that is preventable	Identify Mental Health an Employee Education Services (EES) focus area in 2005. All health care workers should understand that mental health is essential to overall health; reduce stigma by their interactions with veterans and their families; and understand the major suicide risk factors and the principles of suicide prevention	Education and training activities including National Suicide Prevention Awareness Day and Operation Save; Ongoing public education and press releases, developing public service messages, publicizing hotline, collaborating with Federal partners
Develop broad-based support for suicide prevention		
Develop and implement strategies to reduce the stigma associated with being a consumer of mental health, substance abuse and suicide prevention services		
Develop and implement suicide prevention programs	Develop a Suicide Prevention Program for VA patients, families, staff and the community.	VHA has created a national system that includes: 1) Overall enhancement of mental health services; a) Enhanced access to care; b) Integration of mental health and primary care; c) transformation of the specialty mental health care system to focus on rehabilitation and recovery; d) Broad-based training in evidence-based Psychotherapy and pharmacotherapy; e) Outreach and clinical programs to support the engagement of OEF/OIF veterans; 2) Programs specifically addressing suicide prevention; a) Suicide Prevention Hotline; b) Suicide Prevention Coordinators in each Medical Center; c) Programs to identify high-risk patients and enhance their care; d) Training for all staff; e) Community outreach; and 3) Inclusion of suicide prevention activities in the uniform mental health services package that is under development;
Increase access to and community linkages with mental health and substance abuse services		
Develop and promote effective clinical and professional practices	Promote evidence based strategies for suicide assessment and prevention, including emphasis on special emphasis groups. MHSHG will work with HSR&D, NEPEC, and SMITREC to develop and test an electronic suicide prevention database. Develop a national systematic program for suicide prevention. MHSHG develops a plan to educate all staff that interact with veterans, including clerks and telephone operators, about responding to crisis situations involving at-risk veterans. This would include suicide protocols for intake, telephone operators, and other first contact personnel	
Improve and expand surveillance systems	Develop electronic suicide prevention database using institutional surveillance mechanisms that support population-based screening.	SMITREC initiative based on information from the National Death Index; Evolving interactions with the CDC's National Violent Death Reporting System; Validation and utilization of attempt reporting by the Suicide Prevention Coordinators; Exploration of interactions with state or county medical examiners

Crosswalking between the U.S. National Strategy for Suicide Prevention, the VHA Comprehensive Mental Health Strategic Plan, and VHA's Suicide Prevention Actions—Continued

U.S. National Strategy for Suicide Prevention	VHA Comprehensive MH Strategic Plan	VHA Suicide Prevention Actions and Plans
	Develop methods for tracking veterans with risk factors for suicide and systems for appropriate referral of such patients to specialty mental health care.	A Category 2 flag, to be managed by the Suicide Prevention Coordinators is under development. It would serve to facilitate tracking and follow-up.
	Medical Centers establish contacts through the Chaplain Service with faith-based organizations and community resources to assist with culturally competent suicide prevention and other mental health issues at local and national levels.	Deferred by VHA senior leadership
Promote and support research on suicide and suicide prevention	Fund research to develop a valid screen for suicide risk and prevention.	ORD has been meeting with Federal partners to develop a research agenda; research at the VISN 19 MIRECC and the Canandaigua COE is accelerating; nevertheless, developing a valid screen for suicide risk and prevention may prove elusive-instead, VA is pursuing a two stage process, screening for MH conditions and providing clinical evaluations for those identified as having these conditions.
Implement training for recognition of at-risk behavior and delivery of effective treatment	EES in conjunction with MHSHG develop mandatory education programs for V A health care providers about suicide risks and ways to address these risks. Incorporate best practices for suicide prevention.	Ongoing training including Suicide Prevention Awareness Day, Operation Save, Facility-based activities organized by the suicide prevention coordinators; and other EES activities
	Recommend support for new MIRECC with focus on suicide prevention, in collaboration in other MIRECCs working in this area.	Implementation of the VISN 19 MIRECC and Canandaigua Center of Excellence as centers for research, demonstrations, training, and technical, assistance for the system as a whole
Promote efforts to reduce access to lethal means and methods of self-harm		Individualized interventions between providers and/or suicide prevention coordinators with high-risk patients and/or their families; VA policy for gun safety programs is under consideration
Improve reporting and portrayals of suicidal behavior, mental illness, and substance abuse in the entertainment and news media.		Addressed through ongoing collaborations in the Federal partnership on suicide preventions

Information Provided by VA From Discussion with Secretary Peake during Post-Hearing Meeting

In response to Dr. Rudd testimony of increased risk of suicide for wounded warriors.

Discharge Plan, both mental health and wounded warriors (increased risk of suicide) need one. What do we do to ensure followup after discharge of both mental health patients as well as wounded warriors?

Response: The Federal Recovery Coordinators (FRC) actively started working with discharge for patients January 28, 2008. FRCs develop Federal Individualized Recovery Plans (FIRPs) for servicemembers or veterans who have catastrophic wounds, illness and injuries, including mental health issues, which will require longitudinal care, coordination and oversight. Using the Federal Individual Recovery Plan, based on the input of clinical and non-clinical case managers as well as the patient and the family, the Federal Recovery Coordinator (FRC) will ensure that the

servicemember, veteran and family have access to and delivery of support programs and resources for family members and caregivers.

Phase One of the FRC Program, scheduled to be completed in May 2008, targeted those catastrophically wounded, ill or injured arriving from theatre to the military treatment facility (MTF). Phase Two, which will begin immediately after Phase One, is complete, will expand the program's scope to include those servicemembers and veterans who were discharged from an MTF prior to January 2008.

At this time, FRCs are accepting servicemembers/veterans injured prior to January 2008 into the FRCP on a referral basis. As mentioned above, Phase Two will start in June 2008, and will expand the program's scope to include those servicemembers and veterans who were discharged from an MTF prior to January 2008. Identification of this population will be conducted through a review of VA rehabilitation databases, to include spinal cord and blind rehabilitation, along with the polytrauma centers. In tandem, DoD will work through TRICARE in an effort to identify the same population for potential inclusion into the FRCP. Staffing support has been initiated to support this expansion effort. An additional registered nurse is being actively recruited to champion this effort along with additional FRCs whose geographic placement will be based on identified patient needs.

Federal Recovery Coordinators are nurses and masters prepared social workers with experience in Mental Health issues and receive ongoing training which improves their ability to both identify and prioritize those servicemembers and veterans in need of mental health services and programs. Thus they will ensure that the clinical case manager addressed any mental health issues that the patient or family may have.

As of May 13, the Combat Veteran Call Center has made 8,598 calls and has spoken to 2,953 veterans. The percentage of unique veterans spoken with on this initiative is 34.3%.

Information Provided by VA From Discussion with Secretary Peake during Post-Hearing Meeting

In response to Maris testimony.

Reanalysis of data; pulling out base population, including veterans.

Response: The National Violent Death Reporting System (NVDRS) database is owned by CDC. VA uses the information, however, we feel outreach efforts to make its use more prevalent should be initiated by CDC.

To compare information of veterans using VHA health care services with all veterans and all Americans, VA uses information on all veterans' suicides from the NVDRS. The NVDRS has been tracking suicides among veterans and others in an increasing number of States since 2003, in six States since 2003, in 13 since 2004, and in 16 since 2005. Only preliminary information is available for 2006. It is likely that the counts and rates presented for this year will increase as additional case reports are received.

To give a view of suicide rates over time, the NVDRS document attached dated 5–15–08 looks at NVDRS data for all veterans and compares it to information on VMA health care users and all Americans in separate tables for each grouping of NVDRS States.

Calculations for VHA patients were based on causes of death from the National Death Index for veterans from the relevant States identified from clinical and administrative records. Figures for the general populations were derived from the CDC's Web-based Injury Statistics Query and Reporting System (WISQARS) site, again, for the relevant States.

The National Violent Death Reporting System (NVDRS) Update, 5–15–08 11am

For VHA Patients in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)									
	FY03			**FY04**			**FY05**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	10,342	5	**48.3**	11,453	6	**52.4**	12,847	7	**54.5**
Males, 30–64	232,427	88	**37.9**	236,043	89	**37.7**	240,439	83	**34.5**
Males, 65+	255,853	76	**29.7**	239,609	75	**31.3**	235,410	66	**28.0**
All Males	498,622	169	**33.9**	487,105	170	**34.9**	488,696	156	**31.9**
Females, 18–29	4,818	1	**20.8**	5,431	1	**18.4**	5,945	2	**33.6**
Females, 30–64	33,030	8	**24.2**	34,404	6	***17.4***	35,641	6	**16.8**
Females, 65+	6,985	0	**0.0**	6,471	0	**0.0**	6,388	0	**0.0**
All Females	44,834	9	**20.1**	46,306	7	**15.1**	47,974	8	**16.7**

For General U.S. Population in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)—Continued									
	CY03			**CY04**			**CY05**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	2,882,507	520	**18.0**	2,940,762	498	**16.9**	2,979,291	524	**17.6**
Males, 30–64	8,478,693	1,676	**19.8**	8,554,240	1,730	**20.2**	8,626,030	1,697	**19.7**
Males, 65+	1,829,120	512	**28.0**	1,853,752	491	**26.5**	1,885,066	489	**25.9**
All Males	13,190,320	2,708	**20.5**	13,348,754	2,719	**20.4**	13,490,387	2,710	**20.1**

For General U.S. Population in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)—Continued									
	CY03			**CY04**			**CY05**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Females, 18–29	2,811,814	91	**3.2**	2,846,934	109	**3.8**	2,878,825	98	**3.4**
Females, 30–64	8,868,182	515	**5.8**	8,937,771	510	**5.7**	9,008,792	544	**6.0**
Females, 65+	2,617,145	111	**4.2**	2,632,363	87	**3.3**	2,657,046	95	**3.6**
All Females	14,297,141	717	**5.0**	14,417,068	706	**4.9**	14,544,663	737	**5.1**

For All Veterans in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)												
	CY03			**CY04**			**CY05**			**CY06 Partial**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	97,430	51	**52.3**	97,761	48	**49.1**	101,622	40	**39.4**	105,108	40	**38.1**
Males, 30–64	1,728,183	423	**24.5**	1,695,677	412	**24.3**	1,664,851	374	**22.5**	1,631,152	306	**18.8**
Males, 65+	1,171,401	326	**27.8**	1,157,448	314	**27.1**	1,139,862	319	**28.0**	1,125,567	251	**22.3**
All Males	2,997,014	800	**26.7**	2,950,886	774	**26.2**	2,906,335	733	**25.2**	2,861,826	597	**20.9**
Females, 18–29	26,503	3	**11.3**	26,891	4	**14.9**	27,728	3	**10.8**	28,104	7	**24.9**
Females, 30–64	167,872	11	**6.6**	173,324	18	**10.4**	177,874	18	**10.1**	182,547	13	**7.1**
Females, 65+	44,773	1	**2.2**	43,732	2	**4.6**	42,828	2	**4.7**	41,667	3	**7.2**
All Females	239,147	15	**6.3**	243,947	24	**9.8**	248,430	23	**9.3**	252,318	23	**9.1**

For VHA Patients in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)						
	FY04			**FY05**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	22,130	8	**36.2**	25,353	15	**59.2**
Males, 30–64	494,213	202	**40.9**	510,042	180	**35.3**
Males, 65+	460,764	156	**33.9**	454,915	159	**35.0**
All Males	977,106	366	**37.5**	990,311	354	**35.7**
Females, 18–29	11,189	1	**8.9**	12,381	3	**24.2**
Females, 30–64	70,609	9	**12.7**	73,261	12	**16.4**
Females, 65+	13,615	0	**0.0**	12,350	0	**0.0**
All Females	95,414	10	**10.5**	97,991	15	***15.3***

For the General U.S. Population in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)						
	CY04			**CY05**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	5,759,748	1154	**20.0**	5,825,312	1117	**19.2**
Males, 30–64	15,981,610	3647	**22.8**	16,172,388	3593	**22.2**
Males, 65+	3,371,832	971	**28.8**	3,439,314	1029	**29.9**
All Males	25,113,190	5,772	**23.0**	25,437,014	5,739	**22.6**
Females, 18–29	5,487,877	235	**4.3**	5,549,163	236	**4.3**
Females, 30–64	16,507,912	1160	**7.0**	16,702,515	1133	**6.8**
Females, 65+	4,783,669	181	**3.8**	4,843,413	180	**3.7**
All Females	26,779,458	1,576	**5.9**	27,095,091	1,549	**5.7**

For All Veterans in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)									
	CY04			**CY05**			**CY06 Partial**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	190,949	100	**52.4**	198,183	88	**44.4**	204,917	89	**43.4**
Males, 30–64	3,311,746	889	**26.8**	3,261,900	833	**25.5**	3,206,111	750	**23.4**
Males, 65+	2,111,452	592	**28.0**	2,086,273	674	**32.3**	2,066,921	491	**23.8**
All Males	5,614,146	1,581	**28.2**	5,546,357	1,595	**28.8**	5,477,950	1,330	**24.3**
Females, 18–29	51,664	9	**17.4**	53,454	9	**16.8**	54,207	9	**16.6**
Females, 30–64	333,660	39	**11.7**	342,846	37	**10.8**	352,071	30	**8.5**
Females, 65+	75,115	2	**2.7**	73,945	3	**4.1**	72,625	4	**5.5**
All Females	460,438	50	**10.9**	470,245	49	**10.4**	478,902	43	**9.0**

For VHA Patients in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)			
	FY05		
	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	31,966	17	**53.2**
Males, 30–64	594,346	217	**36.5**
Males, 65+	524,948	189	**36.0**
All Males	1,151,261	423	**36.7**
Females, 18–29	15,988	4	**25.0**
Females, 30–64	88,531	14	**15.8**
Females, 65+	14,293	0	**0.0**
All Females	118,811	18	**15.2**

For the General U.S. Population in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)			
	CY05		
	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	6,630,344	1,350	**20.4**
Males, 30–64	18,026,867	4,196	**23.3**
Males, 65+	3,858,225	1,177	**30.5**
All Males	28,515,436	6,723	**23.6**
Females, 18–29	6,318,615	275	**4.4**
Females, 30–64	18,602,682	1,309	**7.0**
Females, 65+	5,406,681	196	**3.6**
All Females	30,327,978	1,780	**5.9**

For All Veterans in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)						
	CY05			**CY06 Partial**		
	Pop.	Suicide Deaths	**Suicides /100,000**	Pop.	Suicide Deaths	**Suicides /100,000**
Males, 18–29	222,255	100	**45.0**	229,855	98	**42.6**
Males, 30–64	3,636,370	931	**25.6**	3,575,055	842	**23.6**
Males, 65+	2,334,819	736	**31.5**	2,313,321	558	**24.1**
All Males	6,193,443	1,767	**28.5**	6,118,231	1,498	**24.5**
Females, 18–29	58,614	9	**15.4**	59,514	10	**16.8**
Females, 30–64	376,875	43	**11.4**	387,015	34	**8.8**
Females, 65+	82,077	3	**3.7**	80,703	4	**5.0**
All Females	517,566	55	**10.6**	527,232	48	**9.1**

For VHA Patients in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)									
	FY03			**FY04**			**FY05**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	Upper		Lower	Upper		Lower	Upper
Males, 18–29	**48.3**	15.7	112.8	**52.4**	19.2	114.0	**54.5**	21.9	112.3
Males, 30–64	**37.9**	30.4	46.6	**37.7**	30.3	46.4	**34.5**	27.5	42.8
Males, 65+	**29.7**	23.4	37.2	**31.3**	24.6	39.2	**28.0**	21.7	35.7
All Males	**33.9**	29.0	39.4	**34.9**	29.9	40.6	**31.9**	27.1	37.3
Females, 18–29	**20.8**	0.5	115.6	**18.4**	0.5	102.6	**33.6**	4.1	121.5
Females, 30–64	**24.2**	10.5	47.7	**17.4**	6.4	38.0	**16.8**	6.2	36.6
Females, 65+	**0.0**	0.0	52.8	**0.0**	0.0	57.0	**0.0**	0.0	57.7
All Females	**20.1**	9.2	38.1	**15.1**	6.1	31.1	**16.7**	7.2	32.9

For General U.S. Population in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)									
	CY03			**CY04**			**CY05**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	Upper		Lower	Upper		Lower	Upper
Males, 18–29	**18.0**	16.5	20.3	**16.9**	15.5	18.5	**17.6**	15.9	19.8
Males, 30–64	**19.8**	18.8	20.7	**20.2**	19.3	21.2	**19.7**	18.7	20.6
Males, 65+	**28.0**	25.6	30.5	**26.5**	24.2	28.9	**25.9**	23.7	28.3
All Males	**20.5**	19.8	21.3	**20.4**	19.6	21.1	**20.1**	19.3	20.8
Females, 18–29	**3.2**	2.6	4.0	**3.8**	3.1	4.6	**3.4**	2.8	4.1
Females, 30–64	**5.8**	5.3	6.3	**5.7**	5.2	6.2	**6.0**	5.5	6.6
Females, 65+	**4.2**	3.5	5.1	**3.3**	2.6	4.1	**3.6**	2.9	4.4
All Females	**5.0**	4.6	5.4	**4.9**	4.5	5.3	**5.1**	4.7	5.4

For All Veterans in the 7 States with NVDRS data for CY2003 (Alaska, Maryland, Massachusetts, New Jersey, Oregon, South Carolina, Virginia)												
	CY03			**CY04**			**CY05**			**CY06**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*		**Suicides /100,000**	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	Upper		Lower	Upper		Lower	Upper		Lower	Upper
Males, 18–29	**52.3**	39.0	68.8	**49.1**	36.2	65.1	**39.4**	28.1	53.6	**38.1**	27.2	51.8
Males, 30–64	**24.5**	22.2	26.9	**24.3**	22.0	26.8	**22.5**	20.2	24.9	**18.8**	16.7	21.0
Males, 65+	**27.8**	24.9	31.0	**27.1**	24.2	30.3	**28.0**	25.0	31.2	**22.3**	19.6	25.2
All Males	**26.7**	24.8	28.5	**26.2**	24.4	28.1	**25.2**	23.4	27.0	**20.9**	19.2	24.0
Females, 18–29	**11.3**	2.3	33.1	**14.9**	4.1	38.1	**10.8**	2.2	31.6	**24.9**	10.0	51.3
Females, 30–64	**6.6**	3.3	11.7	**10.4**	6.2	16.4	**10.1**	6.0	16.0	**7.1**	3.8	12.2
Females, 65+	**2.2**	0.1	12.4	**4.6**	0.6	16.5	**4.7**	0.6	16.9	**7.2**	1.5	21.0
All Females	**6.3**	3.5	10.3	**9.8**	6.3	14.6	**9.3**	5.9	13.9	**9.1**	5.8	13.7

For VHA Patients in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)						
	FY04			**FY05**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	*Upper*		*Lower*	*Upper*
Males, 18–29	**36.2**	15.6	71.2	**59.2**	33.1	97.6
Males, 30–64	**40.9**	35.4	46.9	**35.3**	30.3	40.8
Males, 65+	**33.9**	28.8	39.6	**35.0**	29.7	40.8
All Males	**37.5**	33.7	41.5	**35.7**	32.1	39.7
Females, 18–29	**8.9**	0.2	49.8	**24.2**	5.0	70.8
Females, 30–64	**12.7**	5.8	24.2	**16.4**	8.5	28.6
Females, 65+	**0.0**	0.0	27.1	**0.0**	0.0	29.9
All Females	**10.5**	5.0	19.3	**15.3**	8.6	25.2

For the General U.S. Population in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)						
	CY04			**CY05**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	*Upper*		*Lower*	*Upper*
Males, 18–29	**20.0**	18.9	21.2	**19.2**	18.1	20.3
Males, 30–64	**22.8**	22.1	23.6	**22.2**	21.5	22.9
Males, 65+	**28.8**	27.0	30.6	**29.9**	28.1	31.7
All Males	**23.0**	22.4	23.6	**22.6**	22.0	23.1
Females, 18–29	**4.3**	3.8	4.9	**4.3**	3.7	4.8
Females, 30–64	**7.0**	6.6	7.4	**6.8**	6.4	7.2
Females, 65+	**3.8**	3.3	4.4	**3.7**	3.2	4.3
All Females	**5.9**	5.6	6.2	**5.7**	5.4	6.0

For All Veterans in the 13 States with NVDRS data for CY2004 (Alaska, Colorado, Georgia, Maryland, Massachusetts, New Jersey, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Virginia, Wisconsin)									
	CY04			**CY05**			**CY06 (Partial)**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	Upper		Lower	Upper		Lower	Upper
Males, 18–29	**52.4**	42.6	63.7	**44.4**	35.6	54.7	**43.4**	34.9	53.4
Males, 30–64	**26.8**	25.1	28.6	**25.5**	23.8	27.3	**23.4**	21.7	25.1
Males, 65+	**28.0**	25.8	32.5	**32.3**	29.9	34.7	**23.8**	21.7	26.0
All Males	**28.2**	26.8	29.5	**28.8**	27.3	30.2	**24.3**	23.0	25.6
Females, 18–29	**17.4**	8.0	33.1	**16.8**	7.7	32.0	**16.6**	7.6	31.5
Females, 30–64	**11.7**	8.3	16.0	**10.8**	7.6	14.9	**8.5**	5.7	12.2
Females, 65+	**2.7**	0.3	9.6	**4.1**	0.8	11.9	**5.5**	1.5	14.1
All Females	**10.9**	8.1	14.3	**10.4**	7.7	13.8	**9.0**	6.5	12.1

For VHA Patients in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)			
	FY05		
	Suicides /100,000	*95% CI*	
		Lower	Upper
Males, 18–29	**53.2**	31.0	85.1
Males, 30–64	**36.5**	31.8	41.7
Males, 65+	**36.0**	31.1	41.5
All Males	**36.7**	33.3	40.4
Females, 18–29	**25.0**	6.8	64.1
Females, 30–64	**15.8**	8.6	26.5
Females, 65+	**0.0**	0.0	25.8
All Females	**15.2**	9.0	23.9

For the General U.S. Population in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)			
	CY05		
	Suicides /100,000	*95% CI*	
		Lower	Upper
Males, 18–29	**20.4**	19.3	21.4
Males, 30–64	**23.3**	22.6	24.0
Males, 65+	**30.5**	28.8	32.2
All Males	**23.6**	23.0	24.1
Females, 18–29	**4.4**	3.9	4.9
Females, 30–64	**7.0**	6.7	7.4
Females, 65+	**3.6**	3.1	4.2
All Females	**5.9**	5.6	6.1

For All Veterans in the 16 States with NVDRS data for CY2005 (Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia, Wisconsin)						
	CY05			**CY06 (Partial)**		
	Suicides /100,000	*95% CI*		**Suicides /100,000**	*95% CI*	
		Lower	Upper		Lower	Upper
Males, 18–29	**45.0**	36.6	54.7	**42.6**	34.6	52.0
Males, 30–64	**25.6**	24.0	27.2	**23.6**	22.0	25.1
Males, 65+	**31.5**	29.2	33.8	**24.1**	22.2	26.2
All Males	**28.5**	27.2	29.9	**24.5**	23.2	25.7
Females, 18–29	**15.4**	7.0	29.1	**16.8**	8.1	30.9
Females, 30–64	**11.4**	8.3	15.4	**8.8**	6.1	12.3
Females, 65+	**3.7**	0.8	10.7	**5.0**	1.4	12.7
All Females	**10.6**	8.0	13.8	**9.1**	6.7	12.1

Information Provided by VA From Discussion with Secretary Peake during Post-Hearing Meeting

Cost of Call Center

Response: Currently, the cost for the suicide hotline in FY 2008 is projected to be $2.6 million. However, the funding will increase if and when the calls require additional lines.

Detail of Program Expenses

Specific Purpose Program: Suicide Hotline

Estimated Expenses:	FTEE	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Comments
VA Personnel	37.50	$517,805	$647,760	$642,521	$652,384	$2,460,469	
Contract Personnel (IPA, etc.)							
Contract Services & Misc.		$118,456				$118,456	
Supplies		$1,050	$1,050	$1,050	$1,050	$4,200	
Other		$4,688	$4,688	$4,688	$4,688	$18,752	
Travel		$9,375	$9,375	$9,375	$9,375	$37,500	
Equipment		$5,463				$5,463	
Total Expenditures:	37.50	$656,837	$662,873	$657,634	$667,497	$2,644,840	

VA Personnel (Name)	Grade /Step	Position (Title)	FTEE	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Function (Job Duties)	Station To Receive Funding	Station Number
	11	Social Worker	1.00	$16,833	$16,889	$16,909	$17,170	$67,801		528	528
	09	Other Therapists	1.00	$19,403	$19,468	$19,492	$19,792	$78,155		528	528
	06	Other Health Aides	1.00	$12,443	$12,484	$12,499	$12,692	$50,118		528	528
	01	RN	1.00	$21,528	$21,600	$21,626	$21,959	$86,713		528	528
	05	Other Health Aides	1.00	$7,803	$7,829	$7,838	$7,959	$31,429		528	528
	11	Social Worker	1.00	$18,696	$18,759	$18,781	$19,070	$75,306		528	528
	06	Other Health Aides	1.00	$12,918	$12,961	$12,977	$13,177	$52,033		528	528
	09	Other Therapists	1.00	$14,954	$15,004	$15,022	$15,253	$60,233		528	528
	11	Social Worker	1.00	$16,635	$16,690	$16,710	$16,967	$67,002		528	528

VA Personnel (Name)	Grade /Step	Position (Title)	FTEE	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Function (Job Duties)	Station To Receive Funding	Station Number
	11	Social Worker	1.00	$15,935	$15,988	$16,008	$16,254	$64,185		528	528
	11	Social Worker	1.00	$17,917	$17,977	$17,999	$18,276	$72,169		528	528
	02	RN	1.00	$7,386	$7,411	$7,420	$7,534	$29,751		528	528
	06	Other Health Aides	1.00	$10,468	$10,503	$10,516	$10,678	$42,165		528	528
	11	Social Worker	1.00	$19,156	$19,234	$19,243	$19,539	$77,172		528	528
	01	RN	1.00	$19,749	$19,815	$19,839	$20,144	$79,547		528	528
	11	Social Worker	1.00	$18,594	$18,656	$18,679	$18,966	$74,895		528	528
	05	Nursing Aides	1.00	$9,376	$9,407	$9,419	$9,564	$37,766		528	528
	11	Social Worker	1.00	$17,109	$17,166	$17,186	$17,451	$68,912		528	528
	11	Social Worker	1.00	$17,268	$17,325	$17,346	$17,613	$69,552		528	528
	09	Other Therapists	1.00	$15,826	$15,878	$15,898	$16,142	$63,744		528	528
	3	RN	1.00	$23,026	$23,103	$23,131	$23,486	$92,746		528	528
	3	RN	1.00	$20,593	$20,662	$20,687	$21,005	$82,947		528	528
	2	RN	1.00	$21,038	$21,108	$21,134	$21,459	$84,739		528	528
	2	RN	1.00	$20,867	$20,936	$20,962	$21,284	$84,049		528	528
	11	Other Therapists	1.00	$15,510	$15,562	$15,581	$15,820	$62,473		528	528
	11	Other Therapists	1.00	$15,164	$15,215	$15,233	$15,467	$61,079		528	528
RECRUITMENT	02/11	RN or SW	1.00	$10,361	$19,058	$19,081	$19,375	$67,875		528	528
RECRUITMENT	02/11	RN or SW	1.00	$10,361	$19,058	$19,081	$19,375	$67,875		528	528
RECRUITMENT	02/11	RN or SW	1.00	$10,361	$19,058	$19,081	$19,375	$67,875		528	528
RECRUITMENT	02/11	RN or SW	1.00	$10,361	$19,058	$19,081	$19,375	$67,875		528	528
RECRUITMENT	02/11	RN or SW	1.00		$19,058	$19,081	$19,375	$57,514		528	528

RECRUITMENT	02/11	RN or SW	1.00		$19,058	$19,081	$19,375	$57,514		528	528
RECRUITMENT	02/11	RN or SW	1.00		$19,058	$19,081	$19,375	$57,514		528	528
RECRUITMENT	02/11	RN or SW	1.00		$19,058	$19,081	$19,375	$57,514		528	528
RECRUITMENT	02/11	RN or SW	1.00		$19,058	$19,081	$19,375	$57,514		528	528
RECRUITMENT	02/11	RN or SW	0.50		$9,529	$9,541	$9,688	$28,757		528	528
RECRUITMENT	11	Program Analyst	1.00	$10,591	$19,482	$19,505	$19,806	$69,384		528	528
RECRUITMENT	6	Program Support Asst.	1.00	$6,440	$11,847	$11,861	$12,044	$42,192		528	528
OT				$23,135	$1,750	$1,750	$1,750	$28,385		528	528
Awards				$10,000	$6,000			$16,000		528	528
		Sub Total:	37.50	$517,805	$647,760	$642,521	$652,384	$2,460,469			

Contract Personnel (IPA, etc.)

Personnel	Position	FTEE	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Function	Station To Receive Funding	Station Number
	Sub Total:									

Detail of Program Expenses

Specific Purpose Program: Suicide Hotline—Continued

Contract Services & Misc.

Contract (Service provided)	Contractor	Needed	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Reason for Service (Contract)	Station To Receive Funding	Station Number
Accreditation			$5,000				$5,000		528	528
Lifeline			$111,456				$111,456		528	528
Advertising			$2,000				$2,000		528	528
	Sub Total:		$118,456				$118,456			

Note: Actual Services which are under a contract (copier maintenance, phone service, etc.). Any service provided by the local facility and charged to the program are listed under Supplies or Other. Also List in order of priority to your program.

Supplies	Purpose	Needed	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Comments	Station To Receive Funding	Station Number
Office supplies			$1,050	$1,050	$1,050	$1,050	$4,200		528	528
	Sub Total:		$1,050	$1,050	$1,050	$1,050	$4,200			

Note: Includes paper, pens, toner, etc. along with any additional supplies which are consumable and need to be replaced. Also List supplies in order of priority to your program.

Other	Purpose	Needed	Qtr 1	Qtr 2	Qtr 3	Qtr 4	Total	Reason for expense	Station To Receive Funding
Education/tuition/registration		$4,688	$4,688	$4,688	$4,688	$18,752		528	528
	Sub Total:	$4,688	$4,688	$4,688	$4,688	$18,752			

Note: Any item not covered under contracts or supplies (not to include equipment which is covered below). Also List in order of priority to your program.

Detail of Program Expenses

Specific Purpose Program: Suicide Hot Line—Continued

Travel									
Personnel (Name)	**Traveling to**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total**	**Reason for Trip**	**Station To Receive Funding**	**Station Number**
Employee travel		$9,375	$9,375	$9,375	$9,375	$37,500		528	528
	Sub Total:	$9,375	$9,375	$9,375	$9,375	$37,500			
Note: Please include as much detail on each separate trip and the personnel taking the trips as possible. Also List Travel in order of priority to your program.									

Equipment	**Purpose**	**Qtr 1**	**Qtr 2**	**Qtr 3**	**Qtr 4**	**Total**	**Reason Equipment is needed**	**Station To Receive Funding**	**Station Number**
Filing cabinet		$1,100				$1,100		528	528
Security System		$4,363				$4,363		528	528
	Sub Total:	$5,463				$5,463			
Note: Equipment consist of items which bear an actual VA property tag all other items go under “Supplies” or “Other”. Also List Equipment in order of priority to your program.									

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
May 21, 2008

The Honorable James B. Peake, M.D.
The Secretary Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "The Truth About Veterans' Suicides" on May 6, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on July 7, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

Questions for the Record

The Honorable Bob Filner, Chairman
House Committee on Veterans' Affairs
May 6, 2008

The Truth about Veteran Suicides

Question 1(a): In testimony before the Committee, the VA presented data regarding suicide rates for the general population and veteran users grouped into three cohorts: 18–29; 30–64; and, 65+. Please provide a detailed explanation to the Committee to explain why these particular age cohorts were chosen.

Response: To ensure consistency with other Veterans Health Administration (VHA) data on suicides, age groups selected by the National Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) were used.

Question 1(b): Please provide the Committee with the data presented at the May 6, 2008 hearing grouped by the following age cohorts: 20–24; 25–29; 30–34; 35–39; 40–44; 45–49; 50–54; 55–59; 60–64; 65–69; 70–74; and, 75+.

Response: The table below provides: Number of Suicides by Age Group Among Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans Compared to U.S. General Population [1]

Age Groups	Observed # Suicides	Expected # Of Suicides [2]	Standardized Mortality Rate [3]	95% confidence interval [4]
20–24	38	23.6	1.61	1.14–2.21
25–29	37	32.7	1.13	0.80–1.56
30–34	19	15.1	1.26	0.76–1.97

[1] Age based on age in 2005. Suicides, n=144, were identified among a cohort of 490,346 OEF/OIF selected for mortality follow-up through 2005.

Age Groups	Observed # Suicides	Expected # Of Suicides [2]	Standardized Mortality Rate [3]	95% confidence interval [4]
35–39	18	14.8	1.21	0.72–1.92
40–44	14	18.7	0.75	0.41–1.26
45–49	5	10.6	0.47	0.15–1.10
50–54	7	5.2	1.34	0.54–2.75
55–59	6	3.5	1.72	0.63–3.74
60–64	0	—	—	—
65–69	0	—	—	—
70–74	0	—	—	—
75-+	0	—	—	—

A2 Expected based on U.S. general population.
A3 Standardized Mortality Ratio (SMR) is the ratio of observed to expected with adjustment for race, sex, age, and calendar year period.
A4 95 percent confidence interval (C.I.).
There were no OEF/OIF veteran suicides in the age groups older than 55–59, therefore expected numbers and SMRs were not presented.

Question 2: On December 12, 2007, the Committee held a hearing entitled "Stopping Suicides: Mental Health Challenges within the U.S. Department of Veterans Affairs." Please provide to the Committee a detailed explanation of the specific steps and actions undertaken by the VA to improve mental health care and services since December 13, 2007. Please exclude any steps and actions that the VA had planned to undertake prior to December 12, 2007.

Response: Since December 13, 2007, the following actions were initiated to improve mental health care:

- Expansion of the suicide prevention coordinator staffing into teams is underway, with increased access in community based outpatient clinics (CBOC)
- Expansion of mental health staff
- Expansion of sites of care—CBOCs
- Expansion of veteran centers
- Collaborating with the Defense Center of Excellence (DCoE) on mental health and traumatic brain injury (TBI) by providing a Deputy Center Director and a mental health subject matter expert
- Funding to expand VA's substance use disorder outpatient intensive care programs by adding 28 new sites and a substance use disorder care specialist to every post traumatic stress disorder (PTSD) team or specialty program if one doesn't already exist

Question 3(a): An *Associated Press* article dated April 15, 2008, entitled "Dallas Veterans' Hospital Shutters Psych Ward after Fourth Patient Suicide of Year" states that "[t]he fourth suicide this year among mentally ill patients treated at the Dallas VA Medical Center has led the hospital to close its psychiatric ward to new patients, and investigators from the national Veterans Affairs office are expected to arrive next week to assess safety." Please provide the Committee with the results of this investigation to date. If the results of this investigation have not been finalized, please provide the preliminary findings and recommendations of these investigators.

Response: The Medical Inspector Final Report #2008–D–654 dated May 20, 2008 (Quality of Care Review, Veterans Affairs Medical Center (VAMC) Dallas, Texas, Veterans Integrated Service Network 17) is attached.

[The Medical Inspector Final Report #2008–D–654 dated May 20, 2008, entitled "Quality of Care Review, Veterans Affairs Medical Center (VAMC) Dallas, Texas, Veterans Integrated Service Network 17," will be retained in the Committee files.]

Question 3(b): Please provide the Committee with a detailed explanation regarding the VA's plans to address this situation.

Response: On April 5, 2008, the Dallas VAMC, formally known as the Department of Veterans Affairs (VA) North Texas Health Care System (VANTHCS), temporarily stopped admitting new patients to the two inpatient psychiatry units (a 22-bed unit located on 3 South and a 29-bed unit located on 3 North) following two previous inpatient suicides on February 5, 2008 and April 4, 2008. Patients re-

mained on the units until completion of their course of treatment to ensure continuity of care. The temporary stand down was put in place to allow adequate time for a thorough review of mental health staffing and environment of care issues.

On April 16–17, and April 22–23, 2008, the Office of Medical Inspector (OMI) and the Office of Mental Health, respectively, visited the Dallas VAMC to evaluate the mental health program. The OMI and Office of Mental Health teams made several recommendations for safety improvements, including environment of care enhancements, staffing/program enhancements, and organizational/cultural changes needed to enhance patient safety. The Dallas VAMC leadership embraced these recommendations and has implemented an action plan successfully correcting all deficiencies.

On May 8, 2008, Veterans Integrated Service Network (VISN) 17 responded to Office of Mental Health's recommendations with a detailed action plan. All items on the list were either completed or closed out in compliance and confirmed with the Deputy Chief of Mental Health prior to re-opening the inpatient units. VISN 17 also consulted with the National Center for Patient Safety (NCPS). NCPS determined that the Dallas VAMC's plan for enhanced safety checks and increased staffing on the units should mitigate the risk of suicide.

On May 19, 2008, following renovations, the 3 South inpatient unit was reopened. New admissions were capped to two per day, with exceptions for patients hospitalized under the order of protected custody. While the unit was closed to new admission, patients were assessed in the emergency department and outpatient clinics and transferred for inpatient hospitalization as needed to the Waco VAMC and local psychiatric hospitals. A social worker coordinated admissions and discharges to ensure continuity of care. Mental health staff was proactive in providing information to the receiving facilities and remained in communication with the facilities throughout the hospitalization.

Over the past 6 months, Dallas VAMC has invested $250,000 in the inpatient units to provide upgrades to the environment of care to decrease suicide risks. An additional $250,000 has been spent on furniture to also reduce suicide risk. These improvements included the following: replacing windows and door hardware, clipping ceiling tiles in bedrooms, installing camera systems in hallway, changing bathrooms fixtures, enclosing plumbing and electrical wiring, and removing tall furniture and nightstands. Continuous improvements and modifications are being made to the environment of care.

The Dallas VAMC is actively recruiting permanent additional staff and reorganizing the Mental Health Department. Education for all existing and new staff hired on integrating principles of psychosocial recovery and suicide prevention is being conducted and will continue. The Dallas VAMC regularly consults the Office of Mental Health in preparation for the reopening of 3 North. The tentative opening date for 3 North is fiscal year (FY) 2009. Outsourcing of services will discontinue once the unit is re-opened and fully staffed.

Question 3(c): Please provide the current level of mental health care services at the Dallas facility

Response: The chart below provides the current level of mental health services at the Dallas facility.

Question 3(d): What is the expected level of services at the Dallas facility in one year?

VA North Texas Health Care System (Dallas) Mental Health Services	
• Inpatient acute care • Intensive outpatient group therapies • Alcohol/drug recovery counseling • Anger management • Evaluation and treatment of PTSD • Geriatric psychiatry • Memory problems • Homeless domiciliary • Compensated work therapy (CWT) • Community residential care program (CRCP) • Programs to help ex-offenders reintegrate back into society • Assisted housing veterans	• Health care for homeless veterans • Outreach for homeless veterans • Special programs for women veterans suffering from trauma • Support groups for wives of veterans with PTSD • Day treatment • Suicide prevention coordinators (Dallas/Bonham/Fort Worth) • Recovery services that help promote veteran empowerment, development of life and work skills, supportive family and social networks and improved problem solving • Trauma team (military sexual trauma, PTSD)

Response: In FY 2009, the Dallas VAMC will provide the full spectrum of mental health services as indicated in the chart above including the reopening of 3 North.

Question 3(e): What is the length of time the VA plans to outsource these services to other VA facilities in North Texas, Waco, and Temple?

Response: The inpatient mental health services will continue to be outsourced in FY 2009 until the renovations of the 29-bed unit is on 3 North and the 22-bed unit on 3 South are complete and the facilities are in full compliance with national patient safety measures.

Question 4(a): A Dallas Morning News article dated January 18, 2005, entitled "Dallas VA Hospital is Nation's Worst" states that the "Dallas veterans hospital is so dirty, dangerous, and poorly managed, Federal investigators have found that it ranks as the worst such medical center in the country." Please provide the Committee with information regarding the current ranking of the Dallas facility.

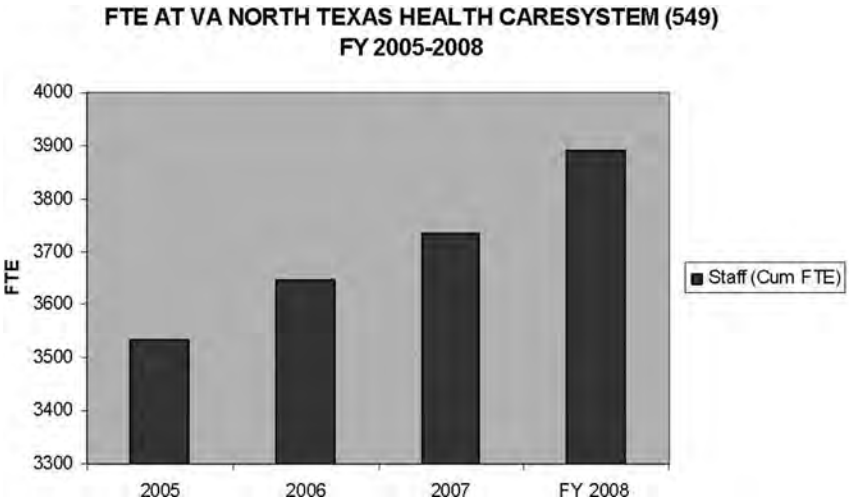
Response: In May 2008, VA Office of Quality and Performance issued a second quarter FY 2008 Facility Aggregated Report ranking Dallas 123 out of 139.

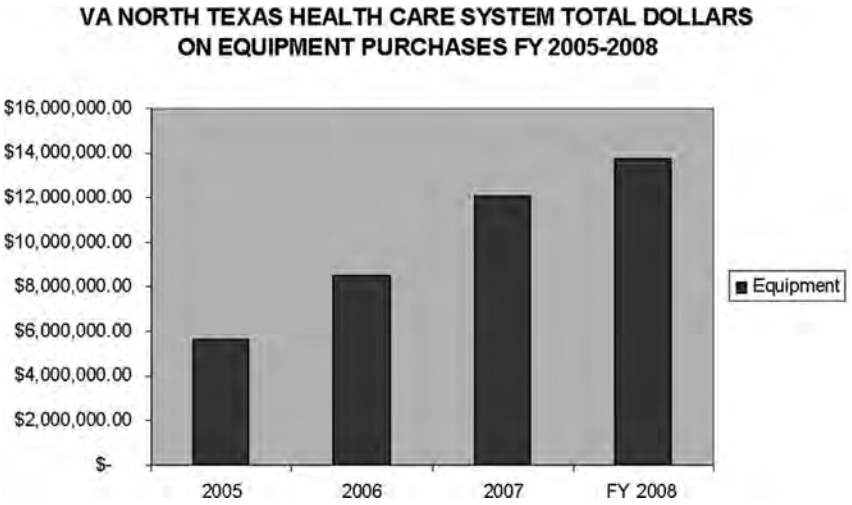
Question 4(b): Please provide the Committee with a detailed explanation of the specific steps undertaken by the VA since 2005 to improve the Dallas VA Medical Center.

Response: Since 2005, the Dallas VAMC has taken steps to improve the organization. The graph below shows the total budget, staffing and equipment purchases from 2005 through 2008. Since 2005, the total budget increased by 21 percent, staffing increased by 10 percent and equipment purchase expenditures were 145 percent.

VANTHCS Operational Budget**	FY 2005	FY 2006	FY 2007	FY 2008
Medical	$408,470,538.30	$461,669,051.57	$484,666,641.06	$530,439,213.09
Administration	$ 54,860,479.67	$ 50,051,586.51	$ 57,226,061.12	$ 42,143,425.62
Facility	$ 50,477,600.71	$ 56,877,468.86	$ 64,230,384.76	$ 49,410,582.70
Total	**$513,808,618.68**	**$568,598,106.94**	**$606,123,086.94**	**$621,993,221.41**

**Includes general purpose/specific purpose/Consolidated Mail Out Pharmacy





Since 2005, the Dallas VAMC has improved its infrastructure and its ability to provide high quality of care. Its capital budget has increased by 30 percent since 2005. Below is a detailed list of its minor and non-recurring Maintenance (NRM) projects and capital funding for VA North Texas Health Care System.

FY 2005—FY 2008 Minor Projects:

FY Approved	Facility	Project Title	Total Project Cost
2005	Dallas	Patient Privacy/UFAS Deficiencies, Ph 8	$2,200,000
2005	Dallas	Relocate Geropsychiatry	$6,050,000
2006	Dallas	Transitional Care Unit	$3,630,000
2007	Dallas	MRI Addition for Research	$6,299,000
2008	Dallas	Upgrade Mental Health Ph 2	$6,984,475

FY 2005—FY 2008 Non-Recurring Maintenance (NRM) Projects:
FY 2005

Facility	Project Title	Total $ Obligated
Dallas	Correct Electrical Panel Deficiencies	$ 219,565.00
Dallas	SCI Vocational Rehab	$ 69,000.00
Dallas	Dallas Pharmacy Clean Room Renovation	$ 33,000.00
Dallas	Bldg. #1 & #2 Connection Corridor Renovation	$ 60,000.00
Dallas	Clinical Admission Renovation	$ 44,610.00
Dallas	Mental Health Offices	$ 35,000.00
Dallas	Modular Bldgs. 5/6 Installation	$ 325,000.00
Dallas	Increase Provider/Patient Care Space	$ 125,000.00
Dallas	GU Renovation	$ 65,000.00
Dallas	CWT Modular Bldg. Site Utilities	$ 187,603.00
Dallas	Replace PRV Stations	$ 261,784.00
Dallas	Sump Pump Replacement	$ 170,000.00
Dallas	Install Elevator Monitoring System	$ 168,083.00
Dallas	EP/Cath Renovation	$ 150,000.00
Dallas	Dallas Roof Repairs	$ 164,850.00
Dallas	HVAC Campus Upgrade	$ 81,180.00
Dallas	Asbestos Abatement	$ 174,938.00
Dallas	Renovate Canteen BSMT, Ph. II	$ 50,000.00
Dallas	Plan For Improvement (PFI)	$ 168,196.00
Dallas	Correct Fire Alarm/Sprinkler Def.	$ 571,113.00
Dallas	ER Nursing Triage	$ 15,000.00
Dallas	Duct Cleaning	$ 423,300.00
Dallas	HVAC Campus Upgrade	$ 81,180.00
Dallas	FY05 Facility Lump Sum	$ 293,364.00
Total		**$ 3,936,766.00**

FY 2006

Facility	Project Title	Total $ Obligated
Dallas	HVAC Campus Upgrade	$ 2,037,620.00
Dallas	Pneumatic Tube Installation	$ 74,149.00
Dallas	B–1/B–12 Electrical Deficiencies	$ 242,062.00
Dallas	Mental Clinical Unit	$ 439,400.00
Dallas	Diabetes/Women's Clinic	$ 236,330.00
Dallas	5A Telemetry	$ 65,049.00
Dallas	Bldg. 2, Chaplain Corridor	$ 86,652.00
Dallas	Dental Renovation	$ 61,199.00
Dallas	QM Renovation	$ 70,866.00
Dallas	Correct Steam Condensate	$ 82,873.00
Dallas	Dallas Roof Repairs	$ 29,506.00
Dallas	HVAC Campus Upgrade	$ 2,057,620.00
Dallas	Replace Dallas UGST	$ 146,000.00
Dallas	Correct HVAC Def. Phase III	$ 172,043.00
Dallas	Asbestos Abatement	$ 140,221.00
Dallas	Renovate Canteen BSMT, Ph. III	$ 85,769.00
Dallas	USP 797 Dallas Pharmacy Clean Room	$ 29,207.00
Dallas	Plan For Improvement (PFI)	$ 79,000.00
Dallas	Correct Fire Alarm/Sprinkler Def.	$ 47,609.00
Dallas	ER Nursing Triage	$ 54,247.00
Dallas	Replace CPVC CA Sprinkler Piping	$ 49,623.00
Dallas	Correct Steam Condensate	$ 64,059.00
Dallas	Replace CPVC CA Sprinkler Piping	$ 29,000.00
Dallas	FY06 Facility Lump Sum	$ 335,273.00
Total		**$ 6,715,377.00**

FY 2007

Facility	Project Title	Total $ Obligated
Dallas	Bonham Electrical Deficiency Corrections	$ 43,475.00
Dallas	Bonham Fire Sprinkler	$ 235,332.00
Dallas	Replace/Repair Ductwork Insulation	$ 99,897.00
Dallas	Bonham Roof/Repair Replacements	$ 219,979.00
Dallas	Repair Campus Asphalt Roadway and Sidewalks	$ 161,339.00
Dallas	Correct Cooling Tower Deficiencies	$ 68,932.00
Dallas	USP 797 Dallas Pharmacy Clean Room	$ 218,000.00
Dallas	Polytrauma Program Renovation	$ 218,824.00
Dallas	Brachytherapy	$ 30,148.00
Dallas	9th Floor Building #2 Call Center	$ 83,504.00
Dallas	QM/PP #8 Domino Moves	$ 124,070.00
Dallas	Remove Lithotripter Equipment	$ 50,066.00
Dallas	Correct Steam Condensate	$ 495,533.00
Dallas	Dallas Roof Repairs	$ 229,462.00
Dallas	Correct HVAC Deficiencies, Bldg 2	$ 68,578.00
Dallas	Asbestos Abatement	$ 85,513.00
Dallas	Plan For Improvement	$ 200,894.00
Dallas	TCU Utilities Infrastructure	$ 1,638,711.00
Dallas	Relocate Pharmacy Cache	$ 30,500.00
Dallas	B.2 Steam and Condensate Return Upgrade	$ 335,092.00
Dallas	Fuel Oil Tank Replacement Dallas/Bonham	$ 114,848.00
Dallas	B.2 IT Upgrade	$ 335,093.00
Dallas	B.2 Chill Water Upgrade	$ 346,598.00
Dallas	1.5T MRI SITE PREP	$ 253,486.00
Dallas	Repair/Replace Campus Insulation	$ 343,104.00
Dallas	Fisher House Site Preparation	$ 397,407.00
Dallas	GI Recovery Expansion	$ 143,303.00
Dallas	Radiology Renovation Phase I	$ 3,000.00
Dallas	Human Resources (HR) Modular	$ 471,651.00
Dallas	MAS Modular Building	$ 471,651.00
Dallas	Mental Health Modular	$ 383,124.00
Dallas	ASCO Upgrade Phase I	$ 272,181.00

FY 2007

Facility	Project Title	Total $ Obligated
Dallas	Additional NRM Mental Health Modular Bldg	$ 448,608.00
Dallas	Correct Bldg 1 HVAC Deficiencies Phase 1	$ 70,513.00
Dallas	Correct Bldg 1 Electrical Deficiencies	$ 47,131.00
Dallas	OR Vascular Equipment Site Prep.	$ 49,790.00
Dallas	Dallas Roof Repairs, Bldg 2	$ 229,462.00
Dallas	Replace Chiller #2	$ 1,710,823.00
Dallas	Install Steam trap Monitoring System	$ 46,418.00
Dallas	Power Factor Correction	$ 16,300.00
Dallas	Building 1 Exterior Renovation Phase 1	$ 20,381.00
Dallas	Building 2 Exterior Renovation Phase 2	$ 67,734.00
Dallas	FY07 Facility Lump Sum	$ 2,834,226.00
Total		**$ 13,714,681.00**

FY 2008

Facility	Project Title	Planned Design Cost	Planned Construction Cost
Dallas	Install steam trap monitoring system	$ 50,000	$ 200,000
Dallas	East Site Utilities		$ 400,000
Dallas	Building 2 Exterior Renovation Ph.1	$ 45,000	$ 250,000
Dallas	Lot 27 Site Utilities		$ 400,000
Dallas	Correct Steam Condensate Ph.2	$ 0	$ 500,000
Dallas	Replace deteriorated Bldg. 2	$ 60,000	$ 706,000
Dallas	SCI Pool Lift Upgrade		$ 356,000
Dallas	Replace CPVC in Clinical Addition	$ 100,000	$ 800,000
Dallas	Polytrauma Renovation	$ 150,000	$ 1,350,000
Dallas	Window Repair/Replacement	$ 70,000	$ 753,000
Dallas	Correct HVAC Deficiencies, Bldg 2	$ 65,000	$ 536,201
Dallas	Correct Bldg. 1 HVAC Deficiencies Ph1	$ 50,000	$ 450,000
Dallas	Correct Bldg. 1 Electrical Deficiencies	$ 50,000	$ 412,500
Dallas	Replace Elevators Bldg. 1	$ 90,000	$ 900,000
Dallas	Chill water Replacement Upgrade*	$ 60,000	
Dallas	Bldg 43 Sprinkler Pipe Installation*	$ 40,000	
Dallas	Pharmacy Prescription Disp Area*	$ 20,000	
Dallas	Upgrade Dallas Campus Site work Phl*	$ 90,000	
Dallas	Replace Campus Fire Alarm System*	$ 100,000	
Dallas	Bldg 1 Replace FCU and Controls Ph.1 *	$ 42,000	
Dallas	Boiler Plant Repl*	$ 200,000	
Total		**$1,282,000**	**$ 8,013,701**

* Only planned designed costs for FY 2008

FY 2007 and FY 2008 Emergency Supplemental:

FY 2007 and FY 2008 Emergency Supplemental NRM		
Station	**Project Title/Description**	**Total Cost**
Dallas	Dallas Roof Repairs	$ 816,000.00
Dallas	Correct B.2 HVAC Def	$ 604,780.00
Dallas	Repair/Replace Campus Insulation	$ 400,000.00
Dallas	Correct B.1 HVAC Def (Ph1)	$ 520,514.00
Dallas	Correct B.1 Electrical Deficiencies	$ 462,500.00
Dallas	Replace Chiller #2	$ 1,800,000.00
Dallas	Window Repair/Replace	$ 753,000.00
Dallas	B.1 Exterior Renovation Ph.2	$ 450,000.00
Dallas	Replace Elevators B.1	$ 900,000.00
Dallas	Polytrauma Renovation	$ 1,500,000.00
Total		**$ 8,206,794.00**

VA North Texas Capital Budget for FY 2005–2008:

VA North Texas Capital Budget	
FY 2005 Dallas VERA NRM Allocation	$ 5,945,530.00
FY 2005 Dallas Supplemental Appropriation for NRM	$ 2,200,000.00
Total	**$ 8,145,530.00**
FY 2006 Dallas VERA NRM Allocation	**$ 6,450,000.00**
FY 2007 Dallas VERA NRM Allocation	$ 5,663,301.00
FY 2007 Dallas Emergency Supplemental Allocation	$ 2,581,985.71
FY 2007 Dallas Energy Funds	$ 700,000.00
FY 2007 Dallas Mental Health (Modular Building)	$ 831,732.00
Total	**$ 9,777,018.71**
FY 2008 Dallas VERA NRM Allocation	$ 3,137,240.00
FY 2008 Dallas Supplemental Add-on Allocation	$ 2,400,000.00

VA North Texas Capital Budget—Continued	
FY 2008 Dallas Mental Health Allocation	$ 10,000.00
FY 2007/2008 Dallas Emergency Supplemental Allocation	$ 5,001,701.00
Total	**$ 10,548,941.00**
Total Capital Funding	**$ 34,921,489.71**

The Dallas VAMC is a complexity Level I facility, providing tertiary care services to over 102,000 unique patients, which makes it VA's 3rd largest health care system in terms of number of unique patients treated. The Dallas VAMC is a teaching hospital, providing a full range of patient care services with state-of-the-art technology as well as advanced education and research. Through its strategic partnership with University of Texas Southwestern Medical Center and Baylor College of Dentistry, Dallas VAMC helped train more than 740 medical residents and eight dental residents in FY 2007. The Dallas VAMC has affiliation agreements with over 100 agencies and institutions, providing training to approximately 2,000 students.

Question 4(c): Please provide the Committee with a list including the names of the director and the senior leadership of the Dallas VA Medical Center during 2004 and 2005, and if still employed by the VA, their current titles and responsibilities.

Response: In 2004, Dallas VAMC leadership consisted of the following:

Medical Center Director: Alan G. Harper, retired March 2005.
Associate Director: William E. Cox, transferred to Clarksburg VAMC as Director, January 2005. He currently has full delegated line authority and responsibility for executive level management of the Clarksburg VAMC and its community outpatient clinics.
Assistant Director: Daniel K. Heers, retired April 2005.
Chief of Staff: Robert Cronin, reassigned to staff physician, Medical Services in March 2005. He currently treats patients in the Nephrology Clinic and on the inpatient wards for kidney diseases.
Chief Nurse: Burlean Huff was the Acting Executive Nurse for Dallas from January 2005 to September 2005 until recruitment of Associate Director of Nursing. He retired December 2007. This position converted into the Associate Director of Nursing.

In 2005, Dallas VAMC leadership consisted of the following:

Medical Center Director: Betty Bolin Brown transferred to Employee Education System in Shreveport, LA on April 2007. She is the Executive Scholar for the Employee Education System.
Current Medical Center Director: Joseph M. Dalpiaz, effective May 2007 has full delegated line authority and responsibility for executive level management of the VA North Texas Health Care System (VANTHCS).
Associate Director: Jeff Milligan, Associate Director, effective September 2005, has the responsibility for the direction, evaluation and control of all administrative activities in the medical center.
Assistant Director: Daniel K. Heers, retired April 2005. Eric D. Jacobsen, Assistant Director effective December 2005 his responsibilities include direction of human resources and information resources management, logistics, facilities and health care environment management and health services administration.
Chief of Staff: Robert Cronin, Chief of Staff since January 2005, and reassigned in March 2005 to Staff Physician, Medical Service where he is responsible for treating patients in the Nephrology Clinic and on the inpatient wards for kidney diseases. John Sum-Ping, MD, Acting Chief of Staff effective 2005 through November 2006. Dr. Sum-Ping is currently Chief, Anesthesiology and Pain Management Service at VANTHCS and manages all of the anesthesiology and pain management operations at VANTHCS. Clark R. Gregg effective November 2006 is the current Chief of Staff responsible for managing clinical operations.
Associate Director of Patient Care Services: Sandra Y. Griffin, effective September 2005 is the current Associate Director for Nursing Service having oversight for the daily clinical and administrative operations of the Nursing Service.

Question 5: The email sent on March 20, 2008, by a VA employee at the Temple Texas VAMC, suggested that diagnoses of "adjustment disorder" be given instead

of diagnoses of PTSD. Please provide the Committee with the number of adjustment disorder diagnoses and PTSD diagnoses by facility since 2001.

Response: The attached spread sheet provides data related to adjustment disorder diagnoses and PTSD diagnosis by facility, separately for each year from 2001 through 2008.

Question 6(a): Recently, *CBS News* reported that a VA team leader in Texas suggested mental health professionals should diagnose patients with "adjustment disorder" rather than post-traumatic stress disorder in order to save time and money treating veterans. Secretary Peake has characterized this email as "inappropriate." An email by Dr. Katz dated February 13, 2008, entitled "Not for the *CBS News* Interview Request" has also been characterized as inappropriate. Please provide to the Committee the training materials provided to VA employees regarding proper electronic mail behavior.

Response: Email training is provided annually to VA employees and contractors through the VA cyber security awareness training program. VA annual cyber security awareness training is mandatory for all VA employees, contractors, students, and volunteers. This requirement is specified in law through the Federal Information Security Management Act (FISMA) of 2002 and the Office of Management and Budget (OMB) Circular A–130, Appendix III. VA-wide compliance statistics are reported each year in accordance FISMA and to OMB. VA employees can access the Cyber Security Awareness Course on the VA Intranet. Attached is the course script for the VA National *Rules of Behavior*.

[The Course Script entitled, "VA National Rules of Behavior," Developed by the U.S. Department of Veterans Affairs, Office of Information and Technology, Cyber Security Service, and the Presentation entitled, "VHA Privacy Policy Training, FY 2008," will be retained in the Committee files.]

Question 6(b): Please provide the Committee with the training materials provided to VA employees regarding what constitutes appropriate behavior and accountability or individual actions, especially with regards to electronic mail.

Response: The VA *Rules of Behavior* document that each VA employee is required to sign prior to gaining access to VA IT systems outlines the proper use of VA email. Attached is a copy of the *Rules of Behavior document*.

Question 6(c): Please provide the Committee with the number of disciplinary actions, including the reason for the disciplinary action, undertaken by the VA since 2002 involving electronic mail or in response to individual actions that the VA has determined to be inappropriate.

Response: The Department does not track reasons for disciplinary actions.

Question 7(a): It has been clearly demonstrated that the Department of Defense and VA must work together to address issues that face departments, such as suicide, mental health and substance abuse treatment. Given such demonstrated need: Please provide the Committee with a detailed list of specific programs being developed by both departments to jointly address these issues.

Response: VA and the Department of Defense (DoD) have collaborations on the following:

- VA and DoD produced joint *Clinical Practice Guidelines* (CPG) on major depressive disorder (MDD), PTSD, and substance use disorders since the first MDD CPG in 1996.
- VA and DoD collaborated on the creation of the mental health questions in the post deployment health re-assessment (PDHRA). The questions on PTSD, for example, are identical to those used as the standard PTSD screen administered to all veterans and are part of VA's OEF/OIF automated screening tool.
- DoD participated with VA and other entities in developing a plan for improving PTSD clinical research methodology subsequent to the recent Institute of Medicine (IOM) report on PTSD treatments.
- VA and DoD are collaborating on the activities of the Defense Center of Excellence (DCoE) for psychological health and TBI. A VA clinician is the new Deputy Director of the DCoE. VA will collaborate on future DCoE research.

Question 7(b): Please provide the Committee with a detailed explanation of the individual or joint efforts by both departments to collect data on suicides or to do a comprehensive study on suicides. If there have not been any efforts, please explain the lack of such efforts.

Response: There is an effort underway across Federal agencies, including VA, DoD, Substance Abuse and Mental Health Services Administration, Center for Disease Control, and the National Institutes of Health to examine suicide prevention efforts across systems. A panel of experts has been assembled to advise a Blue Ribbon Work Group on Suicide Prevention in the Veteran Population (Work Group) who will examine current knowledge as well as gaps in knowledge regarding suicide prevention. The Work Group is meeting in mid-June with a final report due 15 days following the meeting. New joint efforts to collect data on suicides based on the recommendations of the Work Group will be developed from these deliberations.

Another joint effort between VA and DoD is collaboration on the development of a joint Web site for suicide prevention. The goal of building such a site is to provide linkage with multiple resources appropriate for servicemembers, veterans, and their families.

In addition, the Center of Excellence at Canandaigua and the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at Ann Arbor are planning a study to use population based data on suicide and suicide attempts to develop real time tracking systems of suicidal behavior for veterans in VA.

The Center of Excellence at Canandaigua is planning a study of the reliability of the suicide behavior template data, which includes data on suicide attempts and completions reported by the suicide prevention coordinators. Reliability will be established through the use of vignettes that present a series of diverse scenarios of veterans in psychological or emotional distress. A rating scale based on consensus from a consortium of Center of Excellence experts will be developed in order to define an appropriate assessment of the veteran depicted in each scenario. These vignettes will be rated by the suicide prevention coordinators. This will allow us to examine both the inter-rater reliability and reliability with the expert consensus response.

The Center of Excellence at Canandaigua, in collaboration with SMITREC at Ann Arbor, will also conduct a study to establish concurrent validity of the Suicide Behavior Template using administrative and clinical data. This collaborative study will include establishing the predictive validity of the reported measures of suicidal behavior using repeat attempts or death from suicide.

The Center of Excellence at Canandaigua and the SMITREC at Ann Arbor, Michigan are planning a study of the data from VA's 24-hour suicide crisis line to determine if there are new, emergent veteran populations at risk for suicidal behaviors. Both younger veterans and veterans in rural or underserved areas will be evaluated as part of this study as to mental health care needs of both groups that VA should address.

Question 8(a): VHA testified before the Subcommittee on Health on January 17, 2008, regarding Mr. Boswell's bill H.R. 4204, the "Veterans Suicide Study Act." The testimony given was very critical of the bill as far as what the bill would accomplish as written. Specifically, VHA stated that "[w]e do not believe the study required by this bill would generate information that would further our understanding of how to effectively screen and treat veterans who may be at risk of suicide. It would merely provide us with the rates for this cohort of veterans. VA has studied suicide rates for multiple cohorts of veterans and, through such efforts, has already identified the major clinical risk factors for suicide". VHA also stated that this bill, as drafted, would not afford VA the flexibility needed to develop a thorough and useful study. Is this still the position of the VA?

Response: We do not believe the study required by this bill would generate information that would further our understanding of how to effectively screen and treat veterans who may be at risk of suicide. It would merely provide us with the rates for this cohort of veterans. VA has studied suicide rates for multiple cohorts of veterans and has already identified the major clinical risk factors for suicide. In fact, we recently completed such a study for OEF/OIF veterans. Using the data generated from those studies, we have developed protocols and processes to mitigate those risk-factors. For these reasons, we do not support section 103.

Further, certain requirements mandated by the bill make its implementation not feasible. As now drafted, it would not afford VA the flexibility needed to develop a thorough and useful study. To design and carry out a study that is best designed to provide usable information to address the issue of veteran suicide rates, we believe the Secretary should determine the organization(s) with which the Department should coordinate the study. For instance, the Center for Disease Control (CDC) studies suicide rates among the general population, while VA's role has been to validate the information compiled by CDC.

Additionally the 180-day timeframe is not realistic, as there is currently a 2-year time lag in the information released by CDC on suicide rates. We estimate the cost of this bill to be $1,580,006 in FY 2008 and $2,078,667 over a 10-year period.

Question 8(b): Is VA developing a large scale study on the OEF/OIF veteran population to track suicides?

Response: VHA's Environmental Epidemiology Service is conducting a large scale study of suicides among OEF/OIF veterans. Study results are expected within the next 6 months.

Question 8(c): Does VA believe this needs to be done? If not, why not?

Response: VA believes this study should be conducted.

Question 9(a): In a July 2005 briefing by the Veterans Health Administration on "Modeling and Strategic Planning for Mental Health and Substance Abuse Services" slide 14, entitled "Negative Gaps," states that: VISNs will not address gaps where the FY 2013 or 2013 forecast demand is less than the FY 2003 actual demand with one exception

—In those markets in which enrollment is projected to decline for the FY 2003 actual demand by more than 10% in FY 2013 and/or by more than 20% in FY 2023, the VISN should develop plans to reduce services in line with the projected declines in demand.

Does this accurately reflect the current policy of the VHA? If not, when was this policy changed and for what reasons?

Response: Since the 2005 presentation, our planning process for mental health and substance abuse services has significantly evolved with the creation of the VHA Comprehensive Mental Health Strategic Plan (MHSP), which was signed as policy by the Secretary in November 2005. The plan calls for expansion and enhancement of mental health services to fill gaps in mental health care, and to use the best practices in care that will offer the greatest likelihood of decreasing mental health symptoms and improving overall functioning and well-being of veterans with mental health problems. There is no current policy that would fit the information as described in this query.

Question 9(b): What is the current strategic plan of the VHA regarding mental health and substance abuse, especially with regards to planning for future infrastructure and employment needs? Has this planning changed since 2005?

Response: The MHSP of 2005 is the current strategic plan of VA regarding mental health and substance abuse services. It provides guidance for infrastructure and employment needs, along with many other elements of enhanced mental health care. The MHSP continues to be implemented aggressively, with collaboration across many offices in VHA to guide that process, including the Office of Mental Health Services, working within Patient Care Services (PCS) and involving many other offices within PCS; the Office of the Assistant Deputy Under Secretary for Health for Policy and Planning; and the Office of the Deputy Under Secretary for Health for Operations and Management.

Additional guidance for implementation of the MHSP is under development. A VA handbook on Uniform Mental Health Services outlines services available to all veterans seeking or identified as needing mental health care. This handbook is an outgrowth of our extensive experience in implementing enhanced mental health services and reflects the MHSP. The handbook delineates the essential components of the mental health program that are to be implemented nationally, to ensure that all enrolled veterans, wherever they obtain care, have access to needed mental health services. It also specifies those services that must be accessible through each VAMC and each CBOC, and delineates that services must be made available through collaborative fee basis and contract relationships for veterans who are not close enough to receive care directly from VA facilities. By establishing the requirements of what services must be available to each veteran, no matter where in VHA they receive care VHA is ensuring a patient-centric uniform mental health services package to meet the care needs for each veteran.

Question 10(a): The recent RAND report, "Invisible Wounds of War," defined "minimally adequate exposure to psychotherapy" (as part of the definition for minimally adequate care) in the following manner:

Minimally adequate exposure to psychotherapy. was defined as having had at least 8 visits with a "mental health professional such as a psychiatrist, psychologist or counselor" in the past 12 months, with visits averaging at least 30 min-

utes. Criteria for *minimally adequate courses of treatment* were adapted from the National Comorbidity Study Replication (Wang et al., 2005). Does the VA agree with this definition? Why or why not?

Response: This definition is not a sufficient representation of adequate treatment and is limited in a number of significant respects, as follows:

- This definition is very broad and could include a wide variety of psychotherapies that have not been empirically established or shown to be effective, such as supportive counseling or other talk therapies that do not focus on promoting changes in thinking, behavior, or emotional functioning in a sustained way, as other psychotherapies have been demonstrated to do. Significantly, the above definition was initially developed by Wang et al. (2005) for measuring patterns of services, not for evaluating or establishing standards of care. Moreover, the references cited for the authors' definition were to practice guidelines that specifically recommend established evidence-based psychotherapies, such as cognitive-behavioral therapy (CBT).
- In addition to including psychotherapeutic interventions that have not been scientifically established, the definition could also include case management, counseling, and other similar interventions that are not standard treatments for the core symptoms of PTSD, depression, and other mental health conditions.
- The definition of what may be considered adequate psychotherapeutic treatment is inconsistent with widely accepted practice guidelines for psychotherapy. This includes guidelines established by the American Psychiatric Association and the Agency for Health Care Policy and Research, as well as the VA/ DoD Clinical Practice Guidelines for PTSD and depression. These guidelines recommend the delivery of evidence-based psychotherapies, such as CBT for depressive and anxiety disorders, and cognitive processing therapy (CPT) and prolonged exposure (PE) therapy for PTSD. Both CPT and PE are highly recommended in the VA/DoD Clinical Practice Guidelines, indicating that the intervention is always indicated and acceptable. This was affirmed by a recent report on evidence-based treatments for PTSD by the Institute of Medicine. These practice guidelines also generally recommend 12–16 sessions of 50–90 minutes each, as opposed to the standard of eight 30-minute sessions included in the definition in the RAND report.

Psychotherapies identified as "evidence-based," including CBT, CPT, and PE, are psychotherapies that have been shown in randomized clinical trials to be more effective than other forms of psychotherapy, such as supportive counseling. Evidence-based psychotherapies are structured with established protocols and have manuals to help guide the treatment process. They also have the benefit of being time-limited. Moreover, evidence-based psychotherapies typically provide long-term benefits and have thus been found to be cost-effective.

Data on mental health care delivery in VA indicate that psychotherapy, particularly individual psychotherapy, is provided at levels of frequency and intensity well below those recommended in practice guidelines. Evidence-based psychotherapy appears to be especially under-used. Unfortunately, psychotherapy codes in medical records do not indicate the specific type of psychotherapy provided, so precise data on the delivery of evidence-based psychotherapies in VA is unknown. However, a recent survey of VA program leaders found that lack of implementation of evidence-based psychological treatments was due, in large part, to limited knowledge and skills and lack of administrative support (Willenbring et al., 2004).

VA has recently developed several national initiatives to train VA mental health providers in the delivery of a number of evidence-based psychotherapies for a variety of mental health conditions, including CPT and PE for PTSD, CBT for depression and anxiety, and social skills training for serious mental illnesses. CPT was the first funded initiative, initially funded in early FY 2007. In May 2008, VA began the training rollout for all mental health professionals.

Question 10(b): On average, over the last 5 years, how many visits with a psychiatrist, psychologist or counselor could a veteran expect over the course of one year, and what is the average length of each visit?

Response: The following table provides summary data of veterans who received mental health services in an outpatient mental health program from FY 2003 through FY 2007:

Veterans with a MH Dx* seen as an Outpatient by Fiscal Year			
FY	**Veterans with a MH Dx Seen by MH Provider**	**Total Outpatient Encounters with MH Provider for Veterans with MH Dx**	**Avg Number of Outpatient Encounters with MH Provider for Veterans Seen by MH Provider**
FY03	708,882	7,345,328	10.4
FY04	771,235	7,514,644	9.7
FY05	831,890	7,914,211	9.5
FY06	878,246	8,489,263	9.7
FY07	944,969	9,387,070	9.9

*Outpatient Diagnoses 290.x-319.x excluding Tobacco Use 305.1x

Data provided by VSSC on June 23, 2008 using VA Outpatient Workload and Enrollment Data. Fee data not included. Veterans Only.

The duration and intensity of treatment varies depending on the acuity level of the veteran. Typically in the early stages of recovery veterans are seen more frequently for both medication management and psychotherapy. As the veteran progresses and becomes more stable, the frequency and duration of treatment decreases. The duration of medication management sessions range from 15—60 minutes. Most psychotherapy sessions are 60 minutes but they also can be 30 minute brief treatment sessions, or they may be up to 90 minutes for some sessions of PE therapy for PTSD. Group therapy sessions tend to be 60 minutes.

ATTACHMENT TO QUESTION 5

VA Uniques with a Record Diagnosis of PTSD and/or Adjustment Disorder in FY01
(includes inpatient and outpatient services provided within VA with a primary or secondary diagnosis)

	Uniques with PTSD and/or Adj Disorder	Uniques with PTSD Dx		Uniques with PTSD Dx Only (w/o Adj Disorder Dx)		Uniques with Adj Disorders Dx		Uniques with Adj Disorders Dx Only (w/o PTSD Dx)		Uniques with PTSD Dx and Adj Disorder Dx	
		N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
VHA	257,332	193,954	75.4%	180,006	70.0%	77,326	30.0%	63,378	24.6%	13,948	5.4%
(V01) (402) Togus, ME	2,494	2,132	85.5%	1,978	79.3%	516	20.7%	362	14.5%	154	6.2%
(V01) (405) White River Junction, VT	1,426	1,114	78.1%	1,055	74.0%	371	26.0%	312	21.9%	59	4.1%
(V01) (518) Bedford, MA	1,155	917	79.4%	829	71.8%	326	28.2%	238	20.6%	88	7.6%
(V01) (523) VA Boston HCS, MA	6,655	4,435	66.6%	3,957	59.5%	2,698	40.5%	2,220	33.4%	478	7.2%
(V01) (608) Manchester, NH	1,206	1,013	84.0%	964	79.9%	242	20.1%	193	16.0%	49	4.1%
(V01) (631) Northampton, MA	1,442	1,236	85.7%	1,183	82.0%	259	18.0%	206	14.3%	53	3.7%
(V01) (650) Providence, RI	1,952	1,729	88.6%	1,687	86.4%	265	13.6%	223	11.4%	42	2.2%
(V01) (689) VA Connecticut HCS, CT	2,444	2,062	84.4%	1,983	81.1%	461	18.9%	382	15.6%	79	3.2%
(V02) (528) Albany, NY	2,535	1,951	77.0%	1,730	68.2%	805	31.8%	584	23.0%	221	8.7%
(V02) (528) Bath, NY	852	648	76.1%	595	69.8%	257	30.2%	204	23.9%	53	6.2%
(V02) (528) Buffalo, NY	2,396	1,648	68.8%	1,532	63.9%	864	36.1%	748	31.2%	116	4.8%
(V02) (528) Canandaigua, NY	1,227	995	81.1%	946	77.1%	281	22.9%	232	18.9%	49	4.0%
(V02) (528) Syracuse, NY	1,698	1,209	71.2%	1,112	65.5%	586	34.5%	489	28.8%	97	5.7%
(V03) (526) Bronx, NY	1,090	850	78.0%	812	74.5%	278	25.5%	240	22.0%	38	3.5%
(V03) (561) New Jersey HCS, NJ	3,344	2,848	85.2%	2,739	81.9%	605	18.1%	496	14.8%	109	3.3%

(V03) (620) VA Hudson Valley HCS, NY	1,536	1,369	89.1%	1,213	79.0%	323	21.0%	167	10.9%	156	10.2%
(V03) (630) New York Harbor HCS, NY	4,879	3,327	68.2%	2,959	60.6%	1,920	39.4%	1,552	31.8%	368	7.5%
(V03) (632) Northport, NY	1,794	1,375	76.6%	1,281	71.4%	513	28.6%	419	23.4%	94	5.2%
(V04) (460) Wilmington, DE	988	717	72.6%	664	67.2%	324	32.8%	271	27.4%	53	5.4%
(V04) (503) Altoona, PA	503	329	65.4%	313	62.2%	190	37.8%	174	34.6%	16	3.2%
(V04) (529) Butler, PA	407	249	61.2%	236	58.0%	171	42.0%	158	38.8%	13	3.2%
(V04) (540) Clarksburg, WV	1,652	1,452	87.9%	1,342	81.2%	310	18.8%	200	12.1%	110	6.7%
(V04) (542) Coatesville, PA	2,735	1,655	60.5%	1,444	52.8%	1,291	47.2%	1,080	39.5%	211	7.7%
(V04) (562) Erie, PA	513	354	69.0%	324	63.2%	189	36.8%	159	31.0%	30	5.8%
(V04) (595) Lebanon, PA	1,540	1,000	64.9%	891	57.9%	649	42.1%	540	35.1%	109	7.1%
(V04) (642) Philadelphia, PA	2,996	2,711	90.5%	2,604	86.9%	392	13.1%	285	9.5%	107	3.6%
(V04) (646) Pittsburgh, PA	2,337	1,985	84.9%	1,863	79.7%	474	20.3%	352	15.1%	122	5.2%
(V04) (693) Wilkes-Barre, PA	1,628	1,120	68.8%	1,063	65.3%	565	34.7%	508	31.2%	57	3.5%
(V05) (512) Baltimore HCS, MD	2,925	1,651	56.4%	1,436	49.1%	1,489	50.9%	1,274	43.6%	215	7.4%
(V05) (613) Martinsburg, WV	1,972	1,476	74.8%	1,320	66.9%	652	33.1%	496	25.2%	156	7.9%
(V05) (688) Washington, DC	2,226	1,905	85.6%	1,765	79.3%	461	20.7%	321	14.4%	140	6.3%
(V06) (517) Beckley, WV	961	765	79.6%	733	76.3%	228	23.7%	196	20.4%	32	3.3%
(V06) (558) Durham, NC	2,411	2,105	87.3%	2,027	84.1%	384	15.9%	306	12.7%	78	3.2%
(V06) (565) Fayetteville, NC	1,246	1,041	83.5%	1,011	81.1%	235	18.9%	205	16.5%	30	2.4%
(V06) (590) Hampton, VA	1,703	1,500	88.1%	1,441	84.6%	262	15.4%	203	11.9%	59	3.5%
(V06) (637) Asheville, NC	1,680	1,482	88.2%	1,397	83.2%	283	16.8%	198	11.8%	85	5.1%
(V06) (652) Richmond, VA	1,321	948	71.8%	890	67.4%	431	32.6%	373	28.2%	58	4.4%
(V06) (658) Salem, VA	1,521	1,282	84.3%	1,210	79.6%	311	20.4%	239	15.7%	72	4.7%

VA Uniques with a Record Diagnosis of PTSD and/or Adjustment Disorder in FY01—Continued
(includes inpatient and outpatient services provided within VA with a primary or secondary diagnosis)

	Uniques with PTSD and/or Adj Disorder	Uniques with PTSD Dx		Uniques with PTSD Dx Only (w/o Adj Disorder Dx)		Uniques with Adj Disorders Dx		Uniques with Adj Disorders Dx Only (w/o PTSD Dx)		Uniques with PTSD Dx and Adj Disorder Dx	
		N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
(V06) (659) Salisbury, NC	2,696	2,090	77.5%	1,964	72.8%	732	27.2%	606	22.5%	126	4.7%
(V07) (508) Decatur, GA	2,895	2,700	93.3%	2,616	90.4%	279	9.6%	195	6.7%	84	2.9%
(V07) (509) Augusta, GA	1,856	1,606	86.5%	1,562	84.2%	294	15.8%	250	13.5%	44	2.4%
(V07) (521) Birmingham, AL	2,310	2,001	86.6%	1,864	80.7%	446	19.3%	309	13.4%	137	5.9%
(V07) (534) Charleston, SC	1,403	1,166	83.1%	1,131	80.6%	272	19.4%	237	16.9%	35	2.5%
(V07) (544) Columbia, SC	3,707	2,611	70.4%	2,302	62.1%	1,405	37.9%	1,096	29.6%	309	8.3%
(V07) (557) Dublin, GA	1,456	1,276	87.6%	1,163	79.9%	293	20.1%	180	12.4%	113	7.8%
(V07) (619) Montgomery-West, AL	2,046	1,773	86.7%	1,695	82.8%	351	17.2%	273	13.3%	78	3.8%
(V07) (679) Tuscaloosa, AL	1,814	1,718	94.7%	1,676	92.4%	138	7.6%	96	5.3%	42	2.3%
(V08) (516) Bay Pines, FL	4,285	2,950	68.8%	2,775	64.8%	1,510	35.2%	1,335	31.2%	175	4.1%
(V08) (546) Miami, FL	3,024	2,051	67.8%	1,937	64.1%	1,087	35.9%	973	32.2%	114	3.8%
(V08) (548) West Palm Beach, FL	2,191	1,652	75.4%	1,558	71.1%	633	28.9%	539	24.6%	94	4.3%
(V08) (573) Gainesville, FL	4,897	3,470	70.9%	3,181	65.0%	1,716	35.0%	1,427	29.1%	289	5.9%
(V08) (672) San Juan, PR	1,969	976	49.6%	929	47.2%	1,040	52.8%	993	50.4%	47	2.4%
(V08) (673) Tampa, FL	6,006	3,791	63.1%	3,398	56.6%	2,608	43.4%	2,215	36.9%	393	6.5%
(V09) (581) Huntington, WV	1,806	1,623	89.9%	1,594	88.3%	212	11.7%	183	10.1%	29	1.6%
(V09) (596) Lexington, KY	1,788	1,482	82.9%	1,382	77.3%	406	22.7%	306	17.1%	100	5.6%

(V09) (603) Louisville, KY	1,857	1,017	54.8%	866	46.6%	991	53.4%	840	45.2%	151	8.1%
(V09) (614) Memphis, TN	1,588	1,073	67.6%	935	58.9%	653	41.1%	515	32.4%	138	8.7%
(V09) (621) Mountain Home, TN	2,154	1,658	77.0%	1,580	73.4%	574	26.6%	496	23.0%	78	3.6%
(V09) (626) Middle Tennessee HCS, TN	3,466	2,656	76.6%	2,502	72.2%	964	27.8%	810	23.4%	154	4.4%
(V10) (538) Chillicothe, OH	1,612	1,173	72.8%	1,031	64.0%	581	36.0%	439	27.2%	142	8.8%
(V10) (539) Cincinnati, OH	2,006	1,586	79.1%	1,422	70.9%	584	29.1%	420	20.9%	164	8.2%
(V10) (541) Cleveland—Wade Park, OH	4,347	2,752	63.3%	2,452	56.4%	1,895	43.6%	1,595	36.7%	300	6.9%
(V10) (552) Dayton, OH	1,776	1,206	67.9%	1,087	61.2%	689	38.8%	570	32.1%	119	6.7%
(V10) (757) Columbus, OH	937	601	64.1%	565	60.3%	372	39.7%	336	35.9%	36	3.8%
(V11) (506) Ann Arbor, MI	885	689	77.9%	659	74.5%	226	25.5%	196	22.1%	30	3.4%
(V11) (515) Battle Creek, MI	1,983	1,506	75.9%	1,371	69.1%	612	30.9%	477	24.1%	135	6.8%
(V11) (550) Danville, IL	2,108	960	45.5%	837	39.7%	1,271	60.3%	1,148	54.5%	123	5.8%
(V11) (553) Detroit, MI	1,225	738	60.2%	661	54.0%	564	46.0%	487	39.8%	77	6.3%
(V11) (583) Indianapolis, IN	1,247	751	60.2%	667	53.5%	580	46.5%	496	39.8%	84	6.7%
(V11) (610) Northern Indiana HCS, IN	981	675	68.8%	651	66.4%	330	33.6%	306	31.2%	24	2.4%
(V11) (655) Saginaw, MI	723	526	72.8%	491	67.9%	232	32.1%	197	27.2%	35	4.8%
(V12) (537) Jesse Brown VAMC (Chicago), IL	2,938	1,750	59.6%	1,589	54.1%	1,349	45.9%	1,188	40.4%	161	5.5%
(V12) (556) North Chicago, IL	1,300	872	67.1%	759	58.4%	541	41.6%	428	32.9%	113	8.7%
(V12) (578) Hines, IL	1,219	858	70.4%	807	66.2%	412	33.8%	361	29.6%	51	4.2%
(V12) (585) Iron Mountain, MI	388	350	90.2%	344	88.7%	44	11.3%	38	9.8%	6	1.5%
(V12) (607) Madison, VVI	863	702	81.3%	668	77.4%	195	22.6%	161	18.7%	34	3.9%
(V12) (676) Tomah, VVI	917	815	88.9%	786	85.7%	131	14.3%	102	11.1%	29	3.2%

VA Uniques with a Record Diagnosis of PTSD and/or Adjustment Disorder in FY01—Continued
(includes inpatient and outpatient services provided within VA with a primary or secondary diagnosis)

	Uniques with PTSD and/or Adj Disorder	Uniques with PTSD Dx		Uniques with PTSD Dx Only (w/o Adj Disorder Dx)		Uniques with Adj Disorders Dx		Uniques with Adj Disorders Dx Only (w/o PTSD Dx)		Uniques with PTSD Dx and Adj Disorder Dx	
		N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
(V12) (695) Milwaukee, WI	1,756	1,267	72.2%	1,121	63.8%	635	36.2%	489	27.8%	146	8.3%
(V15) (589) Columbia, MO	1,025	805	78.5%	755	73.7%	270	26.3%	220	21.5%	50	4.9%
(V15) (589) Eastern KS HCS, KS	2,510	1,795	71.5%	1,473	58.7%	1,037	41.3%	715	28.5%	322	12.8%
(V15) (589) Kansas City, MO	1,804	1,161	64.4%	1,026	56.9%	778	43.1%	643	35.6%	135	7.5%
(V15) (589) Wichita, KS	880	752	85.5%	730	83.0%	150	17.0%	128	14.5%	22	2.5%
(V15) (657) Marion, IL	1,254	1,075	85.7%	1,047	83.5%	207	16.5%	179	14.3%	28	2.2%
(V15) (657) Poplar Bluff, MO	1,074	858	79.9%	825	76.8%	249	23.2%	216	20.1%	33	3.1%
(V15) (657) SI. Louis, MO	2,074	1,374	66.2%	1,307	63.0%	767	37.0%	700	33.8%	67	3.2%
(V16) (502) Alexandria, LA	775	628	81.0%	592	76.4%	183	23.6%	147	19.0%	36	4.6%
(V16) (520) Biloxi, MS	3,776	2,812	74.5%	2,599	68.8%	1,177	31.2%	964	25.5%	213	5.6%
(V16) (564) Fayetteville, AR	1,693	1,474	87.1%	1,384	81.7%	309	18.3%	219	12.9%	90	5.3%
(V16) (580) Houston, TX	2,524	2,187	86.6%	2,114	83.8%	410	16.2%	337	13.4%	73	2.9%
(V16) (586) Jackson, MS	1,120	810	72.3%	786	70.2%	334	29.8%	310	27.7%	24	2.1%
(V16) (598) Little Rock, AR	3,549	2,279	64.2%	2,032	57.3%	1,517	42.7%	1,270	35.8%	247	7.0%
(V16) (623) Muskogee, OK	1,784	1,547	86.7%	1,515	84.9%	269	15.1%	237	13.3%	32	1.8%
(V16) (629) New Orleans, LA	2,961	2,774	93.7%	2,743	92.6%	218	7.4%	187	6.3%	31	1.0%
(V16) (635) Oklahoma City, OK	2,619	2,055	78.5%	1,904	72.7%	715	27.3%	564	21.5%	151	5.8%

(V16) (667) Shreveport, LA	2,205	1,294	58.7%	1,108	50.2%	1,097	49.8%	911	41.3%	186	8.4%
(V17) (549) Dallas, TX	4,653	3,197	68.7%	2,953	63.5%	1,700	36.5%	1,456	31.3%	244	5.2%
(V17) (671) San Antonio, TX	4,448	3,612	81.2%	3,383	76.1%	1,065	23.9%	836	18.8%	229	5.1%
(V17) (674) Temple, TX	2,885	2,433	84.3%	2,356	81.7%	529	18.3%	452	15.7%	77	2.7%
(V18) (501) Albuquerque, NM	4,263	3,169	74.3%	2,909	68.2%	1,354	31.8%	1,094	25.7%	260	6.1%
(V18) (504) Amarillo, TX	832	707	85.0%	696	83.7%	136	16.3%	125	15.0%	11	1.3%
(V18) (519) Big Spring, TX	527	486	92.2%	479	90.9%	48	9.1%	41	7.8%	7	1.3%
(V18) (644) Phoenix, AZ	3,789	2,552	67.4%	2,302	60.8%	1,487	39.2%	1,237	32.6%	250	6.6%
(V18) (649) Northern Arizona HCS	1,220	716	58.7%	601	49.3%	619	50.7%	504	41.3%	115	9.4%
(V18) (678) Tucson, AZ	1,825	1,282	70.2%	1,233	67.6%	592	32.4%	543	29.8%	49	2.7%
(V18) (756) EI Paso, TX	1,179	953	80.8%	898	76.2%	281	23.8%	226	19.2%	55	4.7%
(V19) (436) Fort Harrison, MT	1,085	921	84.9%	895	82.5%	190	17.5%	164	15.1%	26	2.4%
(V19) (442) Cheyenne, WY	688	561	81.5%	546	79.4%	142	20.6%	127	18.5%	15	2.2%
(V19) (554) Denver, CO	3,536	3,076	87.0%	2,919	82.6%	617	17.4%	460	13.0%	157	4.4%
(V19) (575) Grand Junction, CO	773	421	54.5%	347	44.9%	426	55.1%	352	45.5%	74	9.6%
(V19) (660) Salt Lake City, UT	1,621	1,424	87.8%	1,365	84.2%	256	15.8%	197	12.2%	59	3.6%
(V19) (666) Sheridan, WY	543	447	82.3%	414	76.2%	129	23.8%	96	17.7%	33	6.1%
(V20) (463) Anchorage, AK	684	538	78.7%	522	76.3%	162	23.7%	146	21.3%	16	2.3%
(V20) (531) Boise, ID	1,065	1,027	96.4%	1,022	96.0%	43	4.0%	38	3.6%	5	0.5%
(V20) (648) Portland, OR	4,225	3,604	85.3%	3,357	79.5%	868	20.5%	621	14.7%	247	5.8%
(V20) (653) Roseburg, OR	1,851	1,592	86.0%	1,525	82.4%	326	17.6%	259	14.0%	67	3.6%
(V20) (663) VA Puget Sound, WA	6,081	5,465	89.9%	5,221	85.9%	860	14.1%	616	10.1%	244	4.0%

VA Uniques with a Record Diagnosis of PTSD and/or Adjustment Disorder in FY01—Continued
(includes inpatient and outpatient services provided within VA with a primary or secondary diagnosis)

	Uniques with PTSD and/or Adj Disorder	Uniques with PTSD Dx		Uniques with PTSD Dx Only (w/o Adj Disorder Dx)		Uniques with Adj Disorders Dx		Uniques with Adj Disorders Dx Only (w/o PTSD Dx)		Uniques with PTSD Dx and Adj Disorder Dx	
		N	% of Total	N	% of Total	N	% of Total	N	% of Total	N	% of Total
(V20) (668) Spokane, WA	1,281	1,132	88.4%	1,099	85.8%	182	14.2%	149	11.6%	33	2.6%
(V20) (687) Walla Walla, WA	903	698	77.3%	631	69.9%	272	30.1%	205	22.7%	67	7.4%
(V20) (692) White City, OR	812	749	92.2%	730	89.9%	82	10.1%	63	7.8%	19	2.3%
(V21) (358) Manila, PI	192	189	98.4%	187	97.4%	5	2.6%	3	1.6%	2	1.0%
(V21) (459) Honolulu, HI	1,515	1,331	87.9%	1,221	80.6%	294	19.4%	184	12.1%	110	7.3%
(V21) (570) Fresno, CA	1,366	894	65.4%	812	59.4%	554	40.6%	472	34.6%	82	6.0%
(V21) (612) N. California, CA	4,272	3,706	86.8%	3,481	81.5%	791	18.5%	566	13.2%	225	5.3%
(V21) (640) Palo Alto, CA	3,247	2,580	79.5%	2,319	71.4%	928	28.6%	667	20.5%	261	8.0%
(V21) (654) Reno, NV	1,114	728	65.4%	670	60.1%	444	39.9%	386	34.6%	58	5.2%
(V21) (662) San Francisco, CA	2,592	2,014	77.7%	1,874	72.3%	718	27.7%	578	22.3%	140	5.4%
(V22) (593) Las Vegas, NV	2,206	1,504	68.2%	1,350	61.2%	856	38.8%	702	31.8%	154	7.0%
(V22) (600) Long Beach, CA	1,599	857	53.6%	762	47.7%	837	52.3%	742	46.4%	95	5.9%
(V22) (605) Lorna Linda, CA	2,146	1,912	89.1%	1,837	85.6%	309	14.4%	234	10.9%	75	3.5%
(V22) (664) San Diego, CA	2,050	1,846	90.0%	1,815	88.5%	235	11.5%	204	10.0%	31	1.5%
(V22) (691) West Los Angeles, CA	5,877	3,940	67.0%	3,407	58.0%	2,470	42.0%	1,937	33.0%	533	9.1%
(V23) (437) Fargo, ND	434	341	78.6%	332	76.5%	102	23.5%	93	21.4%	9	2.1%
(V23) (438) Sioux Falls, SD	632	462	73.1%	445	70.4%	187	29.6%	170	26.9%	17	2.7%

(V23) (568) Black Hills HCS, SD	1,007	718	71.3%	650	64.5%	357	35.5%	289	28.7%	68	6.8%
(V23) (618) Minneapolis, MN	2,415	1,806	74.8%	1,727	71.5%	688	28.5%	609	25.2%	79	3.3%
(V23) (636) Central Iowa, IA	1,026	551	53.7%	468	45.6%	558	54.4%	475	46.3%	83	8.1%
(V23) (636) Iowa City, IA	1,057	662	62.6%	629	59.5%	428	40.5%	395	37.4%	33	3.1%
(V23) (636) Nebraska-W Iowa, NE	1,322	979	74.1%	949	71.8%	373	28.2%	343	25.9%	30	2.3%
(V23) (656) St. Cloud, MN	1,616	1,339	82.9%	1,213	75.1%	403	24.9%	277	17.1%	126	7.8%

ATTACHMENT TO QUESTION 6(B)

September 18, 2007 **VA Handbook 6500**
Appendix G

Department of Veterans Affairs (VA) National Rules of Behavior

1. Background

a. Section 5723(b)(12) of title 38, United States Code, requires the Assistant Secretary for Information and Technology to establish "VA National Rules of Behavior for appropriate use and protection of the information which is used to support Department's missions and functions." The Office of Management and Budget (OMB) Circular A–130, Appendix III, paragraph 3(a(2)(a) requires that all Federal agencies promulgate rules of behavior that "clearly delineate responsibilities and expected behavior of all individuals with access" to the agencies' information and information systems, as well as state clearly the "consequences of behavior not consistent" with the rules of behavior. **The National Rules of Behavior that begin on page G–3, are required to be used throughout the VA**.

b. Congress and OMB require the promulgation of national rules of behavior for two reasons. First, Congress and OMB recognize that knowledgeable users are the foundation of a successful security program. Users must understand that taking personal responsibility for the security of their computer and the VA data that it contains or that may be accessed through it, as well as the security and protection of VA information in any form (e.g. digital, paper), are essential aspects of their job. Second, individuals must be held accountable for their use of VA information and information systems.

c. VA must achieve the Gold Standard in data security which requires that VA information and information system users protect VA information and information systems, especially the personal data of veterans, their family members, and employees. Users must maintain a heightened and constant awareness of their responsibilities regarding the protection of VA information. The Golden Rule with respect to this aspect of an employee's job is to treat the personal information of others the same as they would their own.

d. Since written guidance cannot cover every contingency, personnel are asked to go beyond the stated rules, using "due diligence" and highest ethical standards to guide their actions. Personnel must understand that these rules are based on Federal laws, regulations, and VA Directives.

2. Coverage

a. The attached VA National Rules of Behavior must be signed annually by all VA employees who are provided access to VA information or VA information systems. The term VA employees includes all individuals who are employees under title 5 or title 38, United States Code, as well as individuals whom the Department considers employees such as volunteers, without compensation employees, and students and other trainees. Directions for signing the rules of behavior by other individuals who have access to VA information or information systems, such as contractor employees, will be addressed in subsequent policy. VA employees must initial and date each page of the copy of the VA National Rules of Behavior; they must also provide the information requested on the last page, sign and date it.

b. The VA National Rules of Behavior address notice and consent issues identified by the Department of Justice and other sources. It also serves to clarify the roles of management and system administrators, and serves to provide notice of what is considered acceptable use of all VA information and information systems, VA sensitive information, and behavior of VA users.

c. The VA National Rules of Behavior use the phrase "VA sensitive information". This phrase is defined in VA Directive 6500, paragraph 5q. This definition covers all information as defined in 38 USC 5727(19), and in 38 USC 5727(23). The phrase "VA sensitive information" as used in the attached VA National Rules of Behavior means:

> All Department data, on any storage media or in any form or format, which requires protection due to the risk of harm that could result from inadvertent or deliberate disclosure, alteration, or destruction of the information. The term includes information whose improper use or disclosure could adversely affect the ability of an agency to accomplish its mission, proprietary information, records about individuals requiring

protection under various confidentiality provisions such as the Privacy Act and the HIPAA Privacy Rule, and information that can be withheld under the Freedom of Information Act. Examples of VA sensitive information include the following: individually identifiable medical, benefits, and personnel information, financial, budgetary, research, quality assurance, confidential commercial, critical infrastructure, investigatory, and law enforcement information, information that is confidential and privileged in litigation such as information protected by the deliberative process privilege, attorney work-product privilege, and the attorney-client privilege, and other information which, if released, could result in violation of law or harm or unfairness to any individual or group, or could adversely affect the national interest or the conduct of Federal programs.

d. The phrase "VA sensitive information" includes information entrusted to the Department.

3. Rules of Behavior

a. Immediately following this section is the VA approved National Rules of Behavior that all employees (as discussed in paragraph 2a of Appendix G) who are provided access to VA information and VA information systems are required to sign in order to obtain access to VA information and information systems.

Department of Veterans Affairs (VA) National Rules of Behavior

I understand, accept, and agree to the following terms and conditions that apply to my access to, and use of, information, including VA sensitive information, or information systems of the U.S. Department of Veterans Affairs.

1. GENERAL RULES OF BEHAVIOR

a. I understand that when I use any government information system, I have NO expectation of Privacy in VA records that I create or in my activities while accessing or using such information system.

b. I understand that authorized VA personnel may review my conduct or actions concerning VA information and information systems, and take appropriate action. Authorized VA personnel include my supervisory chain of command as well as VA system administrators and Information Security Officers (ISOs). Appropriate action may include monitoring, recording, copying, inspecting, restricting access, blocking, tracking, and disclosing information to authorized Office of Inspector General (OIG), VA, and law enforcement personnel.

c. I understand that the following actions are prohibited: unauthorized access, unauthorized uploading, unauthorized downloading, unauthorized changing, unauthorized circumventing, or unauthorized deleting information on VA systems, modifying VA systems, unauthorized denying or granting access to VA systems, using VA resources for unauthorized use on VA systems, or otherwise misusing VA systems or resources. I also understand that attempting to engage in any of these unauthorized actions is also prohibited.

d. I understand that such unauthorized attempts or acts may result in disciplinary or other adverse action, as well as criminal, civil, and/or administrative penalties. Depending on the severity of the violation, disciplinary or adverse action consequences may include: suspension of access privileges, reprimand, suspension from work, demotion, or removal. Theft, conversion, or unauthorized disposal or destruction of Federal property or information may also result in criminal sanctions.

e. I understand that I have a responsibility to report suspected or identified information security incidents (security and privacy) to my Operating Unit's Information Security Officer (ISO), Privacy Officer (PO), and my supervisor as appropriate.

f. I understand that I have a duty to report information about actual or possible criminal violations involving VA programs, operations, facilities, contracts or information systems to my supervisor, any management official or directly to the OIG, including reporting to the OIG Hotline. I also understand that I have a duty to immediately report to the OIG any possible criminal matters involving felonies, including crimes involving information systems.

g. I understand that the VA National Rules of Behavior do not and should not be relied upon to create any other right or benefit, substantive or procedural, enforceable by law, by a party to litigation with the United States Government.

h. I understand that the VA National Rules of Behavior do not supersede any local policies that provide higher levels of protection to VA's information or information systems. The VA National Rules of Behavior provide the minimal rules with which individual users must comply.

i. I understand that if I refuse to sign this VA National Rules of Behavior as required by VA policy, I will be denied access to VA information and information systems. Any refusal to sign the VA National Rules of Behavior may have an adverse impact on my employment with the Department.

2. SPECIFIC RULES OF BEHAVIOR

a. I will follow established procedures for requesting access to any VA computer system and for notification to the VA supervisor and the ISO when the access is no longer needed.

b. I will follow established VA information security and privacy policies and procedures.

c. I will use only devices, systems, software, and data which I am authorized to use, including complying with any software licensing or copyright restrictions. This includes downloads of software offered as free trials, shareware or public domain.

d. I will only use my access for authorized and official duties, and to only access data that is needed in the fulfillment of my duties except as provided for in VA Directive 6001, Limited Personal Use of Government Office Equipment Including Information Technology. I also agree that I will not engage in any activities prohibited as stated in section 2c of VA Directive 6001.

e. I will secure VA sensitive information **in all areas** (at work and remotely) and in any form (e.g. digital, paper etc.), to include mobile media and devices that contain sensitive information, and I will follow the mandate that all VA sensitive information must be in a protected environment at all times or it must be encrypted (using FIPS 140–2 approved encryption). If clarification is needed whether or not an environment is adequately protected, I will follow the guidance of the local Chief Information Officer (CIO).

f. I will properly dispose of VA sensitive information, either in hardcopy, softcopy or electronic format, in accordance with VA policy and procedures.

g. I will not attempt to override, circumvent or disable operational, technical, or management security controls unless expressly directed to do so in writing by authorized VA staff.

h. I will not attempt to alter the security configuration of government equipment unless authorized. This includes operational, technical, or management security controls.

i. I will protect my verify codes and passwords from unauthorized use and disclosure and ensure I utilize only passwords that meet the VA minimum requirements for the systems that I am authorized to use and are contained in Appendix F of VA Handbook 6500.

j. I will not store any passwords/verify codes in any type of script file or cache on VA systems.

k. I will ensure that I log off or lock any computer or console before walking away and will not allow another user to access that computer or console while I am logged on to it.

l. I will not misrepresent, obscure, suppress, or replace a user's identity on the Internet or any VA electronic communication system.

m. I will not auto-forward e-mail messages to addresses outside the VA network.

n. I will comply with any directions from my supervisors, VA system administrators and information security officers concerning my access to, and use of, VA information and information systems or matters covered by these Rules.

o. I will ensure that any devices that I use to transmit, access, and store VA sensitive information outside of a VA protected environment will use FIPS 140–2 approved encryption (the translation of data into a form that is unintelligible without a deciphering mechanism). This includes laptops, thumb drives, and other removable storage devices and storage media (CDs, DVDs, etc.).

p. I will obtain the approval of appropriate management officials before releasing VA information for public dissemination.
q. I will not host, set up, administer, or operate any type of Internet server on any VA network or attempt to connect any personal equipment to a VA network unless explicitly authorized ***in writing*** by my local CIO and I will ensure that all such activity is in compliance with Federal and VA policies.
r. I will not attempt to probe computer systems to exploit system controls or access VA sensitive data for any reason other than in the performance of official duties. Authorized penetration testing must be approved in writing by the VA CIO.
s. I will protect Government property from theft, loss, destruction, or misuse. I will follow VA policies and procedures for handling Federal Government IT equipment and will sign for items provided to me for my exclusive use and return them when no longer required for VA activities.
t. I will only use virus protection software, anti-spyware, and firewall/intrusion detection software *authorized by the VA* on VA equipment or on computer systems that are connected to any VA network.
u. If authorized, by waiver, to use my own personal equipment, I must use VA approved virus protection software, anti-spyware, and firewall/intrusion detection software and ensure the software is configured to meet VA configuration requirements. My local CIO will confirm that the system meets VA configuration requirements prior to connection to VA's network.
v. I will never swap or surrender VA hard drives or other storage devices to anyone other than an authorized OI&T employee at the time of system problems.
w. I will not disable or degrade software programs used by the VA that install security software updates to VA computer equipment, to computer equipment used to connect to VA information systems, or to create, store or use VA information.
x. I agree to allow examination by authorized OI&T personnel of any personal IT device [Other Equipment (OE)] that I have been granted permission to use, whether remotely or in any setting to access VA information or information systems or to create, store or use VA information.
y. I agree to have all equipment scanned by the appropriate facility IT Operations Service prior to connecting to the VA network if the equipment has not been connected to the VA network for a period of more than three weeks.
z. I will complete mandatory periodic security and privacy awareness training within designated timeframes, and complete any additional required training for the particular systems to which I require access.
aa. I understand that if I must sign a non-VA entity's Rules of Behavior to obtain access to information or information systems controlled by that non-VA entity, I still must comply with my responsibilities under the VA National Rules of Behavior when accessing or using VA information or information systems. However, those Rules of Behavior apply to my access to or use of the non-VA entity's information and information systems as a VA user.
bb. I understand that remote access is allowed from other Federal government computers and systems to VA information systems, subject to the terms of VA and the host Federal agency's policies.
cc. I agree that I will directly connect to the VA network whenever possible. If a direct connection to the VA network is not possible, then I will use VA-approved remote access software and services. I must use VA-provided IT equipment for remote access when possible. I may be permitted to use non-VA IT equipment [Other Equipment (OE)] only if a VA–CIO-approved waiver has been issued and the equipment is configured to follow all VA security policies and requirements. I agree that VA OI&T officials may examine such devices, including an OE device operating under an approved waiver, at any time for proper configuration and unauthorized storage of VA sensitive information.
dd. I agree that I will not have both a VA network connection and any kind of non-VA network connection (including a modem or phone line or wireless network card, etc.) physically connected to any computer at the same time unless the dual connection is explicitly authorized in writing by my local CIO.
ee. I agree that I will not allow VA sensitive information to reside on non-VA systems or devices unless specifically designated and approved in advance by the appropriate VA official (supervisor), and a waiver has been issued by the VA's CIO. I agree that I will not access, transmit or store remotely any

VA sensitive information that is not encrypted using VA approved encryption.

ff. I will obtain my VA supervisor's authorization, in writing, prior to transporting, transmitting, accessing, and using VA sensitive information outside of VA's protected environment.

gg. I will ensure that VA sensitive information, in any format, and devices, systems and/or software that contain such information or that I use to access VA sensitive information or information systems are adequately secured in remote locations, e.g., at home and during travel, and agree to periodic VA inspections of the devices, systems or software from which I conduct access from remote locations. I agree that if I work from a remote location pursuant to an approved telework agreement with VA sensitive information that authorized OI&T personnel may periodically inspect the remote location for compliance with required security requirements.

hh. I will protect sensitive information from unauthorized disclosure, use, modification, or destruction, including using encryption products approved and provided by the VA to protect sensitive data.

ii. I will not store or transport any VA sensitive information on any portable storage media or device unless it is encrypted using VA approved encryption.

jj. I will use VA-provided encryption to encrypt any e-mail, including attachments to the e-mail, that contains VA sensitive information before sending the e-mail. I will not send any e-mail that contains VA sensitive information in an unencrypted form. VA sensitive information includes personally identifiable information and protected health information.

kk. I may be required to acknowledge or sign additional specific or unique rules of behavior in order to access or use specific VA systems. I understand that those specific rules of behavior may include, but are not limited to, restrictions or prohibitions on limited personal use, special requirements for access or use of the data in that system, special requirements for the devices used to access that specific system, or special restrictions on interconnections between that system and other IT resources or systems.

3. Acknowledgement and Acceptance

a. I acknowledge that I have received a copy of these Rules of Behavior.

b. I understand, accept and agree to comply with all terms and conditions of these Rules of Behavior.

_____ _____

[Print or type your full name] Signature

_____

Date

_____ _____

Office Phone Position Title

Questions for the Record

The Honorable Stephanie Herseth Sandlin

Question 1: What can the VA do to address the health care needs of Guard and Reserve members, who account for more than half of all veterans who took their own lives after returning from Iraq or Afghanistan?

Response: In order to ensure that Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) combat veterans receive high quality health care and coordinated Department of Veterans Affairs (VA) services and benefits as they transition from the Department of Defense (DoD) to VA, VA and the National Guard developed a creative partnership. Late in 2005, following the signing of a memorandum of un-

derstanding (MOU) between the National Guard and VA, the National Guard hired 54 (now 60) National Guard transition assistance advisors (TAA) to serve as VA/National Guard liaisons in the field at the State level, assisting National Guard service members and their families in accessing VA benefits and services. In February 2006, the newly hired National Guard/VA TAAs were trained by VA staff about VA benefits and services at the Veterans Benefit Administration (VBA) Academy in Baltimore. The purpose of the training was to enhance the outreach skills of the TAAs by learning about VA benefits and services and to connect them with VA resources and staff members in the field at the VA medical centers (VAMC) and the regional offices (RO). This knowledge will assist them in helping Guard/Reserve members in obtaining VA benefits and services and address access issues in the 50 States and 4 territories. Annual refresher training was held in January 2007 and 2008 in conjunction with the National Guard Family Program Conference. The TAAs have been the critical link in facilitating access to VA by National Guard/Reserves in each of the 50 States and 4 territories (Puerto Rico, Virgin Islands, Guam and District of Columbia) and providing VA with critical information on numbers of returning troops, location, homecoming and reintegration events. TAAs also facilitate enrollment of returning troops into the Veterans Health Administration (VHA).

The National Guard is presently expanding the TAA program with a goal of two TAAs for States with large number of deployed troops. The VHA OEF/OIF Outreach Office continues to collaboration with the 60 TAAs at monthly teleconferences, through quarterly newsletters, and monthly identification of success stories and best practices in the States. Outreach staff work with VA experts at annual training events to ensure they are updated on changes in VA services/benefits. TAAs facilitate the development and maintenance of State coalitions using the State Triad Leadership of the Adjutant General, State Director of Veterans Affairs (DVA) and VA to integrate and coordinate the delivery of VA services and benefits to Guard and Reservists in each State. Over 47 States have developed State MOUs through the Leadership Triad of the State Director DVA, Adjutant General and VA. These State partnerships are the foundation for State coalitions with participation by community and State organizations to address the coming home needs of the Guard and the Reserve members.

In addition VA operates a system of over 200 community based counseling centers, known as Vet Centers, located near where veterans and their families reside. Vet Centers are staffed by small multi-disciplinary teams of dedicated providers, many of which are combat veterans themselves, providing a broad range of counseling, outreach, and referral services to OEF/OIF veterans in order to help them readjustment to civilian life. Services include individual counseling, group counseling, marital and family counseling, bereavement counseling, medical referrals, assistance in applying for VA benefits, employment counseling, guidance and referral. alcohol/drug assessments, information and referral to community resources, military sexual trauma counseling and referral, outreach and community education.

On May 2, 2008 VA began contacting nearly 570,000 OEF/OIF combat veterans to ensure they know about VA medical services and other benefits. The Department will reach out and touch every veteran of the war to let them know it is here for them. The first of those calls are going to an estimated 17,000 veterans who were sick or injured while serving in Iraq or Afghanistan. If any of these 17,000 veterans do not now have a care manager to work with them to ensure they get appropriate health care, VA will offer to appoint one for them.

Question 2: What is the VA doing, and what should the VA be doing to address the unique mental health care needs of younger veterans?

Response: VA has several resources to train staff to better understand the needs of younger veterans and their families. These resources include:

- *My HealtheVet.* Younger veterans use the Internet to obtain information and communicate. We have developed mental health content for My HealtheVet and continue to expand that content.
- VA also has clinical programs geared to returning veterans, many of whom are younger, such as:
  - Serving returning veterans mental health needs teams (SeRV–MH teams) to address issues of younger veterans and families in clinical care. Monthly conference calls are held for the SeRV–MH team and include discussion of various issues, such as non-traditional scheduling to meet the needs of working or school engaged patients, and care needs of younger families.
  - Additionally, as many younger veterans are married and may have young children. The new Housing and Urban Development/VA supported housing

(HUD/VASH) voucher program offers opportunities for housing of homeless veterans with families.

- The Iraq Clinician War Guide, developed by the National Center for Post Traumatic Stress Disorder (NCPTSD) in collaboration with DoD in 2004, is posted on the NCPTSD Web site, as well as being used in VA training sessions across the country.
- A national conference, Evolving Paradigms in Treating Combat Veterans. Was developed as a joint VA/ DoD training effort in 2007.
- Conferences for Veterans Integrated Service Networks (VISN) 5 and 6 staff were held in 2006/2007 with a focus on Family Transition Meetings. Training to other VISNs is being planned.
- Many younger veterans have families with young children, and reintegration into the family after deployment to a combat zone can be stressful for the veteran's family. We have used the Sesame Street project, "Talk, Listen, Connect", to help families of servicemembers and veterans guide their children's adjustment to a parent who returns form Iraq or Afghanistan. Copies of the video and accompanying materials are currently available at all VA facilities and we will be disseminating additional copies to staff system-wide to train them to use this valuable tool.

Question 3: What should the VA be doing to address the mental health care needs of veterans, especially veterans in rural or underserved areas?

Response: The Center of Excellence at Canandaigua and the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at Ann Arbor, Michigan are planning a study of the data from VA's 24-hour Suicide Crisis Line to determine if there are new, emergent veteran populations at risk for suicidal behaviors. Both younger veterans and veterans in rural or underserved areas will be evaluated as part of this study as to mental health care needs of both groups VA should address.

VA also has increased availability of mental health services in community based outpatient clinics (CBOC) designed to bring care closer to the veterans. As of the end of the first quarter of fiscal 2008, 93 percent of CBOCs reported mental health visits. All 21 VISNS have some form of VA/State-community collaborations including telemental health or VA staff placements in community health or mental health centers; Tribal or Indian Health Service clinical sites. VA's Office of Mental Health Services and Office of Rural Health are collaborating to improve access to services for veterans in remote areas, including an increased effort at telemental health capabilities. VA has authorized facilities to arrange for fee basis and contract services in situations where timely services cannot be provided by existing VA facilities.

Questions for the Record

The Honorable John J. Hall

Question: When a veteran gets a prescription or has to order a refill there is no way for a doctor to expedite the delivery of the medication which can take 10 days. Someone needing an anti-depressant should be able to get that sent quickly by allowing the doctor to overnight the delivery. Why can't his be done?

Response: At the request of a Department of Veterans Affairs (VA) prescriber, VA medical center pharmacy staff will make urgently needed prescription medications available to patients within 24 hours of notification, using the most appropriate means available. This requirement applies to all points of service including community based outpatient clinics (CBOC).

Current practice within VA system: Newly prescribed medications are available immediately through VA pharmacies or through non-VA contract pharmacies serving VA CBOCs. Refills for previously filled prescriptions are primarily available through VA's consolidated mail outpatient pharmacies (CMOP), or alternately through VA medical center pharmacies. Current CMOP prescription refill processing times average 5 days after the refill is requested (1 day to send data to CMOP; 1.5 days to fill the prescription; and 2.5 days to mail/ship the package to the patient).

Current practice outside the VA system: VA has contracts with community pharmacies to provide urgently needed outpatient CBOC prescriptions, or to provide medications when the VA medical center does not offer 24/7 outpatient pharmacy services. VA's current contract pharmacy prescription volume is approximately 300,000 per year.

Ongoing Emphasis: A VHA policy Directive intended to reemphasize VA's practice of providing urgently needed outpatient medications in a timely manner has been

approved. The new Directive was distributed to the field in May 2008. Enclosed is a copy of Directive 2008–028, *Access to Urgently Needed Outpatient Prescription Medications*.

VA/DoD Partnering: VA's requirements have been included in the Department of Defense's (DoD) TRICARE retail pharmacy network (TRx) which will allow VA to use DoD's 50,000 retail pharmacies to fill urgently needed outpatient prescriptions if a VA pharmacy is not available. It is expected that VA will be able to begin using the TRx retail contract sometime in late 2009.

Vet centers refer veterans to the local VA medical centers for medical care and follow up of prescriptions if needed. In the mental health mental status evaluation, any indicators of need for medical psychiatric or primary care are automatically referred to the medical center. If the veteran is on medications and have challenges in getting prescriptions filled, they are referred to the local VA medical center or CBOC.

Department of Veterans Affairs **VHA DIRECTIVE 2008–028**
Veterans Health Administration
Washington, DC 20420 **May 16, 2008**

ACCESS TO URGENTLY NEEDED OUTPATIENT PRESCRIPTION MEDICATIONS

1. PURPOSE: This Veterans Health Administration (VHA) Directive defines expectations for access to urgently needed outpatient prescription medications.

2. BACKGROUND:

a. *Urgently needed outpatient medications* are medications that, in the clinical judgment of the prescriber, if not taken within 24 hours of determining the need of those medications have the potential to result in serious patient harm.
b. Local restrictions on the use of overnight mail or package delivery service to deliver urgently needed outpatient prescription medications have the potential to cause unnecessary hospital visits, hospitalizations and patient harm.

3. POLICY: It is VHA policy that at the request of a VA prescriber, VA medical center pharmacy staff will make urgently needed outpatient prescription medications available to patients within 24 hours of notification, using the most appropriate means available. This requirement applies to all points of service including Community Based Outpatient Clinics.

4. ACTION:

a. *Facility Director*. The facility Director, or designee, is responsible for ensuring written policies are established to address the timely delivery of urgently needed outpatient prescription medications.
b. *VA Prescriber*. The VA prescriber must notify the pharmacy when a new prescription or refill is urgently needed due to a change in the patient's clinical condition. ***NOTE:*** *If the prescriber determines that medication is needed sooner than 24 hours, the prescriber needs to make arrangements for the patient to receive urgent medical care or instruct the patient to contact the local emergency medical care system.*
c. *Chief of Pharmacy*. The Chief of Pharmacy must contact the patient or the patient's representative to determine the most appropriate means to make the prescription available and must take all necessary steps to make the prescription available. This may include:
   1. Making the prescription available at a VA pharmacy for pick up.
   2. Providing the prescription through a non-VA pharmacy under contract to VA.
   3. Mailing or shipping the medication overnight via commercial or government carrier.

THIS VHA DIRECTIVE WILL EXPIRE MAY 31, 2013

5. REFERENCES: None.

6. FOLLOW-UP RESPONSIBILITY: The Pharmacy Benefits Management Services office (119) is responsible for the content of this Directive. Questions may be referred to (202) 4617326.

7. RESCISSIONS: None

Michael J. Kussman, MD, MS, MACP
Under Secretary for Health

DISTRIBUTION: CO: E-mailed 5/19/08
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Questions for the Record

The Honorable Shelley Berkley

Question 1: What are we doing to follow through with a veteran after it has been identified that they have a mental health issue to decrease their risk of committing suicide?

Response: For veterans found to be at risk for suicide, the Veterans Health Administration (VHA) supplements basic mental health services with increased monitoring and intense treatment directed toward reducing suicidality, as well as the underlying mental health problem. For a veteran identified as having a mental health problem, the most basic approach to decreasing the risk of suicide is to provide appropriate, evidence-based treatment for the mental health problem. To ensure veterans' mental health needs are addressed, VHA has been enhancing the mental health services it provides through substantial increases in the allocation of funds, and has hired almost 4,000 new mental health staff members over the past 3 years. Between 2005 and 2007, there was a 10.3-percent increase in uniques, and a 7.6-percent increase in encounters.

Question 2: How much of the Joshua Omvig Suicide Prevention Act (aside from the establishment of the suicide hotline) has been initiated since its enactment in November 2007?

Response: The Comprehensive Program for Suicide Prevention Among Veterans Report (Public Law 110–110) was submitted to Congress in February 2008 and is attached for your review. In the report we stated that we are able to monitor risk and needs and respond to them under existing legal authority. Since the report was released the Department of Veterans Affairs (VA) has the following updated information:

Requirement: Designation of Suicide Prevention Counselors—To support the identification of patients at high risk, the suicide prevention coordinators have been collecting information from providers, other staff, and community contacts about veterans who have survived suicide attempts. In preliminary findings, we have identified approximately 1,000 attempts per month. To address the increased needs for these vulnerable veterans, VA has implemented standardized approaches to enhancing care while, at the same time, encouraging innovation and creativity.

Further developments in process at this time include tests of the coordinators inter-rater reliability and its sensitivity in the identification of suicide attempts. Both will be necessary before the number of attempts (or reattempts) in a facility can be used as a measure for epidemiological or quality improvement purposes.

Requirement: Hotline—From the time the veterans' Hotline was established in July, 2007 until the end of May, 2008, we received 49,544 calls. From the start of 2008 until the end of May we received 40,165 calls, with 16,436 confirmed as coming from veterans and 2,543 from family members or friends. These led to 3,240 referrals to the suicide prevention coordinators at VA facilities and 909 "rescues" requiring emergency services.

Attached: Report to Congress on Comprehensive Program for Suicide Prevention Among Veterans

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REPORT TO CONGRESS

PUBLIC LAW 110–110

COMPREHENSIVE PROGRAM FOR SUICIDE PREVENTION AMONG VETERANS

Department of Veterans Affairs

February 2008

Report to Congress on VA's Implementation of 38 U.S.C. § 1720F, "Joshua Omvig Veterans Suicide Prevention Act"

Issue: Implementation of section 3(b)(1) of Public Law 110–110, the "Joshua Omvig Veterans Suicide Prevention Act," requires the Department of Veterans Affairs (VA) to submit a report to Congress not later than 90 days after November 5, 2007, on the Department's implementation of its comprehensive suicide prevention program, as established by 38 U.S.C. § 1720F.

Information on the status of the implementation of the VA comprehensive program for suicide prevention

Requirement: Establishment—The Secretary shall develop and carry out a comprehensive program designed to reduce the incidence of suicide among veterans incorporating the components described in this section.

VA Response: Recommendations for suicide prevention programs within VA were included in the 2004 VA Comprehensive Mental Health Strategic Plan. Implementation began shortly after the plan was approved and suicide prevention programs in VA medical centers were accelerated in spring 2006. Ongoing activities have been monitored by Office of Inspector General as documented in report number 06–03706–126 from May 10, 2007.

Requirement: Staff Education—In carrying out the comprehensive program under this section, the Secretary shall provide for mandatory training for appropriate staff and contractors (including all medical personnel) of the Department who interact with veterans. This training shall cover information appropriate to the duties being performed by such staff and contractors. The training shall include information on—(1) recognizing risk factors for suicide; (2) proper protocols for responding to crisis situations involving veterans who may be at high risk for suicide; and (3) best practices for suicide prevention.

VA Response: VA held its first Suicide Prevention Awareness Day for all VA medical centers in April 2007, which included a program that focused on recognizing risk factors for suicide, proper protocols for responding to crisis situations involving veterans who may be at high risk for suicide, and best practices for suicide prevention. It held its second Suicide Prevention Awareness Day in September 2007, and scheduled the event during National Suicide Prevention Week. The program consisted of required training for all staff on general principles of suicide prevention, and the use of specific new VA resources: the national VA Suicide Prevention Hotline and the Suicide Prevention Coordinators who are located at each VA medical center. VA Suicide Prevention Awareness Day is now an annual event held during Suicide Prevention Week each September. VA has also held several regional conferences on suicide prevention attended by mental health providers, primary care clinicians, administrators, and a wide range of other medical center staff members. Additional mandatory training initiatives are being developed for fiscal year (FY) 2008, including a Web-based curriculum with associated written materials for all staff with patient contact.

A major responsibility of Suicide Prevention Coordinators is coordination of local training in suicide prevention. This includes providing training for both providers and non-clinical staff with patient contact. Suicide Prevention Coordinators also provide special training to staff members who respond to telephone calls. Additional education and training includes outreach to the community, with a focus on "guide" training, designed for non-clinical staff who interact with veterans to help them better understand suicide risk and to assist veterans in accessing needed services.

Requirement: Health Assessments of Veterans—In carrying out the comprehensive program, the Secretary shall direct that medical staff offer mental health in their overall health assessment when veterans seek medical care at a Department medical facility (including a center established under section 1712A of this title) and make referrals, at the request of the veteran concerned, to appropriate counseling and treatment programs for veterans who show signs or symptoms of mental health problems.

VA Response: VA policy for all new Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) veterans upon their initial visit to VA medical centers or clinics is to screen them for depression, Post-Traumatic Stress Disorder (PTSD), and problem drinking. Screening for depression and problem drinking is required on an annual basis for all veterans, and screening for PTSD is required annually for the first 5 years after enrollment, and every 5 years afterward. Whenever veterans screen positive for one of these conditions, they must receive a followup clinical evaluation that considers both the condition(s) related to the positive screen, and the risk of suicide. When this process confirms the presence of a mental disorder or suicide risk, veterans must be offered mental health treatment. Whenever there is a referral or request for mental health services, veterans must receive an initial evaluation within 24 hours. When this evaluation identifies urgent need, treatment must be provided immediately; otherwise, veterans must receive a full diagnostic and treatment planning evaluation and the initiation of care within 2 weeks.

Requirement: Designation of Suicide Prevention Counselors—In carrying out the comprehensive program, the Secretary shall designate a suicide prevention counselor at each Department medical facility other than centers established under section 1712A of this title. Each counselor shall work with local emergency rooms, police departments, mental health organizations, and veterans service organizations to engage in outreach to veterans and improve the coordination of mental health care to veterans.

VA Response: Each VA medical center is required to appoint a full-time Suicide Prevention Coordinator. The primary responsibility of the Suicide Prevention Coordinator is to support the identification of patients at high risk for suicide, and to ensure that their monitoring and care are intensified. Other responsibilities include training and education, both within VA and in the community.

Requirement: Best Practices Research—In carrying out the comprehensive program, the Secretary shall provide for research on best practices for suicide prevention among veterans. Research shall be conducted under this subsection in consultation with the heads of the following entities: (1) The Department of Health and Human Services. (2) The National Institute of Mental Health. (3) The Substance Abuse and Mental Health Services Administration. (4) The Centers for Disease Control and Prevention.

VA Response: The Mental Illness Research, Education and Clinical Center (MIRECC) at Denver, Colorado, and the Center of Excellence in Mental Health and PTSD at Canandaigua, New York, focus specifically on suicide prevention. Ongoing studies are addressing suicide risk factors, validation of suicide ideation screening instruments, structure/quality of mental health care and its relationship to suicide prevention, and risk factors for suicide as it relates to depression. Findings from two major studies were presented at the House Veterans' Affairs Committee (HVAC) hearing on December 12, 2007. One, conducted by VA's Office of Environmental Epidemiology, investigated the mortality and causes of death in returning OEF/OIF veterans. Another, conducted by VA's Serious Mental Illness Research Education and Clinical Center, studied rates of suicide, risk factors, and their local variability in all of those receiving health care from VA. Research under development by the Center of Excellence at Canandaigua, includes clinical trials on the effectiveness of peer support for suicide prevention, and psychological autopsy studies involving linkages of VA medical centers with local coroners or medical examiners.

VA plans to support several additional research programs and activities aimed at reducing and preventing suicide, including new research solicitations and a periodic update of a literature synthesis of best practices for suicide prevention. In January 2008, a new research solicitation was initiated seeking studies to validate screening instruments and to identify successful strategies and interventions for suicide prevention.

VA has convened a new targeted working group, the Interagency Working Group to Inform Research on Suicide Prevention, comprised of experts from the Department of Health and Human Services, National Institute on Mental Health, Substance Abuse and Mental Health Services Administration, Centers for Disease Control and Prevention, and the Department of Defense to assess the current state of knowledge and their respective relevant portfolios of research in order to provide recommendations on specific efforts that should be undertaken by VA.

Requirement: Sexual Trauma Research—In carrying out the comprehensive program, the Secretary shall provide for research on mental health care for veterans who have experienced sexual trauma while in military service. The research design shall include consideration of veterans of a reserve component.

VA Response: Ongoing research supported by the Office of Research and Development that is specific to sexual trauma includes studies examining sexual violence and gynecologic health; screening and treatment responses; risks, outcomes, and

services for women; and a longitudinal study of Military Sexual Trauma; and effects on PTSD and Health Behavior. These studies include a wide range of subjects, including National Guard and Reserve component veterans. Male veterans are also targeted in a study addressing sexual assault prevalence among Gulf War veterans suffering from PTSD.

Requirement: 24-Hour Mental Health Care—In carrying out the comprehensive program, the Secretary shall provide for mental health care availability to veterans on a 24-hour basis.

VA Response: VA policy requires 24/7 mental health coverage in all VA emergency departments and 24-hour urgent care centers. Twenty-four hour coverage for veterans who do not have ready access to these services is facility based and may include access to local or regional call centers, or to providers covering inpatient units. National coverage is available for all veterans through the Suicide Prevention Hotline.

The Veterans Health Administration is developing a uniform policy that will require each medical center or clinic that does not have an emergency department or 24/7 urgent care center to designate one or more nearby VA or community-based facilities to provide 24/7 emergency mental health coverage. Elements of the policy already approved ensure that: (1) providers and responders to telephone calls to the facility make veterans aware of coverage; (2) facilities develop contracts or memoranda of understanding with the designated emergency departments to facilitate bidirectional communication; and (3) contracts or memoranda of understanding to ensure that veterans receiving care in the designated facilities are transferred back to VA as soon as it is medically appropriate. Elements still under development include issues related to payment for emergency services and hospitalizations.

Requirement: Hotline—In carrying out the comprehensive program, the Secretary may provide for a toll-free hotline for veterans to be staffed by appropriately trained mental health personnel and available at all times.

VA Response: VA has partnered with the Substance Abuse and Mental Health Service Administration to include services for veterans in its Suicide Prevention Hotline program. When calls are made to the national toll-free Suicide Prevention Hotline, a message states that if the caller is a United States military veteran, or if the call pertains to a veteran, the caller should press "1." With this action, the veteran or person calling is immediately connected to VA's suicide prevention call center at Canandaigua, which is staffed by VA mental health professionals who have real-time access to veterans' electronic medical records.

Additionally, staff members at the Veterans Benefits Administration Call Center have received training on managing callers with warning signs of suicide. They immediately transfer these calls to the hotline call center.

Requirement: Outreach and Education for Veterans and Families—In carrying out the comprehensive program, the Secretary shall provide for outreach to and education for veterans and the families of veterans, with special emphasis on providing information to veterans of Operation Iraqi Freedom and Operation Enduring Freedom and the families of such veterans. Education to promote mental health shall include information designed to—(1) remove the stigma associated with mental illness; (2) encourage veterans to seek treatment and assistance for mental illness; (3) promote skills for coping with mental illness; and (4) help families of veterans with—(A) understanding issues arising from the readjustment of veterans to civilian life; (B) identifying signs and symptoms of mental illness; and (C) encouraging veterans to seek assistance for mental illness.

VA Response: Through its Readjustment Counseling Service (Vet Centers), VA has hired 100 OEF/OIF peer specialists to complement its existing peer outreach program to provide education and outreach to returning veterans. Staffs from Vet Centers attend each post-deployment health reassessment to provide information about the availability and effectiveness of VA services. This allows Vet Centers to facilitate counseling services. Vet Centers also provide extensive outreach services to National Guard and Reserve units, and to the community to provide education about readjustment and related mental health issues, and the availability of care.

VA has funded over 90 OEF/OIF teams in mental health to provide further outreach and education in VA facilities, in National Guard and Reserve units, and in the communities. The messages they deliver are related to destigmatizing mental illness, increasing knowledge of the symptoms and warning signs of mental disorders, and ensuring that veterans and families are aware that effective, high-quality mental health treatment is readily available in VA facilities.

Other sources of information for veterans and families include the Internet (e.g., www.ncptsd.va.gov, the National Center for PTSD's Web site), and numerous media reports.

Requirement: Peer Support Counseling Program—(1) In carrying out the comprehensive program, the Secretary may establish and carry out a peer support counseling program, under which veterans shall be permitted to volunteer as peer counselors—(A) to assist other veterans with issues related to mental health and readjustment; and (B) to conduct outreach to veterans and the families of veterans. (2) In carrying out the peer support counseling program under this subsection, the Secretary shall provide adequate training for peer counselors.

VA Response: VA provides a number of distinct types of peer counseling in a number of different contexts.

Vet Centers have recently hired 100 returning veterans as OEF/OIF peer specialists to provide outreach, education, and counseling to returning veterans and their families. These OEF/OIF veterans complement the counseling and outreach services provided by an even larger number of ex-veterans who serve as staff members in Vet Centers. The services provided by Vet Centers are based on problem-focused, not diagnosis-focused, care for readjustment problems. Peer counseling is a key component of the overall program. Training for the OEF/OIF peers specialists is provided through the Vet Center program.

VA's homeless program established the Peer Housing Location Assistance Group (PHLAG) program as a 2-year pilot program started in late 2006, and is located at six VA medical centers. The program utilizes formerly homeless veterans trained as peer specialists to provide assistance to homeless veterans completing residential treatment programs. They also assist homeless veterans to locate community housing and make a successful transition to independent living. Veterans Integrated Service Network 5's (VISN) MIRECC trained the peer specialists and is evaluating the outcome of the pilot program.

VA's specialty care programs include peer support services for patients with serious mental illness. Beginning in FY 2005, 123.5 Full-time Equivalent (FTE) peer support technicians have been funded from mental health enhancement funds in 47 mental health programs across 27 states. Peer Support Technicians provide a variety of peer support services under the supervision of a mental health provider in homeless programs, therapeutic employment programs, residential programs, and day programs. Peer Support Technicians assist veterans in identifying personal recovery goals and in determining necessary steps to achieve their goals; teach problem solving techniques; assist and support skills training; and help veterans locate VA and community resources. Having availed themselves of mental health services, Peer Support Technicians share their own experiences and the skills, strengths, by serving as positive role models to other veterans working on their own recovery from serious mental illness. Several states offer certification as peer support specialists. VA facilities have developed training and continuing education for Peer Support Technicians utilizing both internal VA resources, as well as non-VA training entities. Peer support technicians and their supervisors obtain additional information and support from monthly conference calls. Two national face-to-face training meetings have been conducted on peer support and a third conference is planned for later in FY 2008.

Requirement: Other Components—In carrying out the comprehensive program, the Secretary may provide for other actions to reduce the incidence of suicide among veterans that the Secretary considers appropriate.

VA Response: VA's comprehensive program for suicide prevention must be viewed as a dynamic activity that will evolve over time as new information becomes available on needs, opportunities, and best practices. The two Centers of Excellence with their capacity for research and technical assistance (Denver and Canandaigua), the ongoing studies on rates and risk factors being conducted by the Office of Environmental Epidemiology and the Serious Mental Illness Research Education and Clinical Center, the hotline call center, and the Suicide Prevention Coordinators at each medical center, constitute a core infrastructure to support the identification of needs, and the development of opportunities to allow enhancement of the program over time.

To allow ongoing scanning of the clinical and scientific literature, as well as activities in the field, both within VA and in community-based programs, VA has appointed a Suicide Prevention Steering Committee cochaired by the Deputy Chief Patient Care Services Officer for Mental Health and the Director of the Center of Excellence at Canandaigua and with multidisciplinary staffing from relevant VA program offices. The steering committee has been charged with identifying opportunities for program development. Additional input from outside agencies comes from the Interagency Working Group to Inform Research on Suicide Prevention convened by VA's Office of Research and Development, and from VA's active participation in the workgroup on suicide prevention of the Federal Partnership on Mental Health.

Information on the time line and costs for complete implementation of the program within 2 years.

VA's comprehensive program on suicide prevention, as specified in the Joshua Omvig Veterans Suicide Prevention Act has been completely implemented. It is a dynamic program that will evolve over time in response to needs and opportunities. The basic structures and processes required by the Act have already been established and implemented.

Expenditures for the suicide prevention program include $.97 million for the Hotline; $1.97 million for the Center of Excellence in Canandaigua; $2.20 million for the Mental Illness Research, Education and Clinical Center in Denver; $90,000 for the Serious Mental Illness Research, Education and Clinical Center for monitoring of suicide rates and risk factors; and $14.32 million for Suicide Prevention Coordinators. The expenditures for suicide prevention for FY 2008 will be more than $19.55 million.

A plan for additional programs and activities designed to reduce the occurrence of suicide among veterans.

VA's comprehensive program for suicide prevention must be viewed as a dynamic activity that will evolve over time as new information becomes available on needs, opportunities, and best practices. The two Centers of Excellence with their capacity for research and technical assistance (Denver and Canandaigua), the ongoing studies on rates and risk factors being conducted by the Office of Environmental Epidemiology and the Serious Mental Illness Research Education and Clinical Center, the hotline call center, and the suicide prevention coordinators at each medical center, constitute a core infrastructure to support the identification of needs, and the development of opportunities to allow enhancement of the program over time.

VA also established a Suicide Prevention Steering Committee, convened the Interagency Working Group to Inform Research on Suicide Prevention, and participates in the workgroup on suicide prevention of the Federal Partnership on Mental Health, all to support the ongoing enhancement of its comprehensive program for suicide prevention.

Recommendations for further legislation or administrative action that the Secretary considers appropriate to improve suicide prevention programs within the Department of Veterans Affairs.

VA is able to monitor risk and needs and respond to them under existing legal authority. VA does not recommend further legislative action.

Committee on Veterans' Affairs
Washington, DC,
May 21, 2008

Michael Shepherd, M.D.
Physician, Office of Healthcare Inspections
Office of Inspector General
U.S. Department of Veterans Affairs
Washington, DC 20420

Dear Michael:

In reference to our Full Committee hearing on "The Truth About Veterans' Suicides" on May 6, 2008, I would appreciate it if you could answer the enclosed hearing questions by the close of business on July 7, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax your responses at 202–225–2034. If you have any questions, please call 202–225–9756.

Sincerely,

BOB FILNER
Chairman

CW:ds

U.S. Department of Veterans Affairs
Washington, DC
July 2, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your May 21, 2008, letter to Dr. Michael Shepherd, Senior Physician, Office of Healthcare Inspections, Office of Inspector General, following the May 6, 2008, hearing on "The Truth About Veterans' Suicides." Enclosed is Dr. Shepherd's answer to the additional hearing question.

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

GEORGE J. OPFER
Inspector General

Enclosure

Question from the Honorable Stephanie Herseth Sandlin
For Michael Shepherd, M.D.
Senior Physician, Office of Healthcare Inspections
Office of Inspector General, U.S. Department of Veterans Affairs

Before the Committee on Veterans' Affairs
United States House of Representatives Hearing
"The Truth about Veterans' Suicides"
May 6, 2008

Question: In your written statement, you indicated that there are ongoing enhancements in the availability of mental health services at community-based outpatient clinics (CBOCs) that may help mitigate vocational and logistical challenges facing some veterans residing in more rural areas. What are the "ongoing enhancements" that are taking place at CBOCs?

Answer: Because mental health conditions may require multiple modes of therapy and in some cases multiple weekly visits, treatment for veterans residing in rural areas is especially challenging. Traveling long distances to appointments can interfere with work and academic obligations which can diminish the ability and incentive for veterans to seek or stay involved in treatment programs. VA reports having taken the following steps to expand access to mental health care, which includes rural areas:

- Increasing CBOC and Outreach Clinic Program sites over the past few years. Outreach clinics are "part-time" VA clinic or contract sites that do not have enough patient volume to sustain full-time hours. Mental health services are also available at outreach sites.
- Planning to open 44 new CBOCs and 23 new Vet Centers over the next 2 years.
- Expanding telemental health from use in 259 CBOCs in fiscal year 2007 to 295 CBOCs in fiscal year 2008.
- Changing the mission of the Veterans Integrated Service Network 16 Mental Illness, Research, Education, and Clinical Center to focus on improving access to evidenced-based mental health practices in rural and other underserved populations.

While this indicates some increase in rural VHA mental health presence, the intent of my statement was to point out the need for continued progress in this important area.

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