

**UNDERSTANDING AND
PREVENTING VETERAN SUICIDE**

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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UNDERSTANDING AND PREVENTING VETERAN SUICIDE

FRIDAY, DECEMBER 2, 2011

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

The Subcommittee met, pursuant to notice, at 10:04 a.m., in Room 334, Cannon House Office Building, Hon. Ann Marie Buerkle [chairwoman of the Subcommittee] presiding.

Present: Representatives Buerkle, Stearns, Roe, Michaud, Reyes, and Donnelly.

OPENING STATEMENT OF CHAIRWOMAN BUERKLE

Ms. BUERKLE. Good morning.

And welcome to this morning's Subcommittee on Health hearing. Today we meet to search for answers to the most haunting of questions: What leads an individual who honorably served our Nation, out of helplessness and hopelessness, to take their own life, and how do we prevent such a tragedy from happening to one who has bravely worn the uniform and defended our freedom?

Suicide is undoubtedly a complex issue, but it is also a preventable one, and I am deeply troubled by its persistent prevalence in our military and veteran communities. The statistics are sobering: Eighteen veterans commit suicide each day, with almost a third receiving care from the Department of Veterans Affairs at the time of their death. Each month, there are 950 veterans being treated by the VA who attempt suicide. The number of military suicides has increased since the start of Operations Enduring Freedom and Iraqi Freedom, with data from the Department of Defense indicating servicemembers took their life at an approximate rate of one every 36 hours from 2005 to 2010. We continue to hear tragic stories despite significant increases in recent years in the number of programs and resources devoted to suicide prevention among our servicemembers and our veterans.

Today we will hear from the VA that they are making strides in identifying at-risk servicemembers and veterans and providing treatment for mental health and other disorders that can lead to suicide. Yet no matter how great our programs or services are, if they do not connect with those who are in need, they do no good at all. The VA and the DoD continue to struggle with persistent obstacles, including data limitations, cultural stigma, access issues, a lack of partnerships with community providers, and outreach that

relies on the servicemember, veteran, or loved one to initiate treatment.

We must do more to reach out to our veterans inside and outside of the VA and DoD health care systems to ensure that all those who need help get it. They have earned it, and they deserve it before time runs out.

Until a family no longer must bear the pain of losing a loved one, we are failing, and not enough is being done.

I thank you all very much for joining us this morning. And now it gives me pleasure to introduce and recognize the Ranking Member, Mr. Michaud.

**OPENING STATEMENT OF HON. MICHAUD, RANKING
DEMOCRATIC MEMBER**

Mr. MICHAUD. Thank you very much, Madam Chair.

I, too, would like to thank everyone for attending today's hearing. It is a tragedy that our servicemembers and veterans survive the battlefield abroad only to return home and fall to suicide. Since 2007, this committee has held five hearings regarding this issue of veterans suicide, and the figures continue to increase at an alarming rate, far greater than the comparable suicide rate among the general population. The Center for a New American Security in their recent publication study, entitled "Losing the Battle: The Challenges of Military Suicide," says that from 2005 to 2010, servicemembers took their own lives at a rate of approximately one every 36 hours. This statistic is troubling, but it pales compared to the VA's estimate that one veteran dies by suicide every 80 minutes.

While I commend the VA's effort to reduce the suicide rate, particularly with the success of its veterans crisis hotline, challenges still remain. Through this hearing, we will examine the steps the VA is taking to strengthen data collection to pinpoint veterans who may be at risk and to offer effective intervention. In this process, we will also seek to better understand the reasons why more and more servicemembers and veterans are taking their own lives, and what VA and DoD are doing to put a stop to more suicides.

I would like to thank our panelists for appearing before us this morning. Particularly, I would like to commend Dr. Kemp for her leadership. Under her direction, the VA has made great strides in its suicide prevention efforts. Dr. Kemp's work is award-winning, and she has been named Federal Employee of the Year in 2009.

I would also like to thank Maine Army National Guard for submitting written testimony and for their effort to ensure that every soldier has access to care that they need. The Maine Army National Guard already has a close working relationship with the suicide prevention staff at Togus VA Hospital. This is a relationship that must be replicated at the national level, through cooperation between the VA and the DoD.

Unfortunately, as the Maine Army National Guard testimony points out, too many soldiers, including those not eligible for VA benefits and those who do not have health insurance, struggle to find care. I look forward to hearing from all our witnesses today to discuss how we can improve the access to treatment and prevention efforts to best serve our Nation's veterans.

I want to thank you, Madam Chair, for having this very important hearing today and look forward to working with you as we move forward to address these very critical issues. I yield back the balance of my time.

Ms. BUERKLE. Thank you very much.

Before we begin, I would like to yield just a moment to Dr. Roe, who I understand has a special constituent in the audience that he would like to recognize.

OPENING STATEMENT OF HON. ROE

Mr. ROE. Thank you, Madam Chairman.

And thank you for holding this hearing. It is actually not a constituent. He is somebody I actually met on the phone at first and then had a chance, the privilege to meet him in Memphis last fall.

And Ron, would you stand, please?

Madam Chairman, this is Ron Zelaski. He is a veteran of the Marine Corps. And he walked across America barefooted to raise awareness for veteran suicides. And as he walked he wore a large sign that you will see displayed in this committee room stating that 18 vets a day commit suicide. In order to bring attention to PTSD in the military, given today's hearing topic, I wanted to make sure that we invited this veteran and recognize his tremendous efforts on the military suicide and PTSD.

Ms. BUERKLE. Without objection.

Mr. ROE. Thank you.

And Ron, just from another veteran, and a veteran that just returned from Afghanistan about 6 weeks ago, the way that this is treated today, the way PTSD is acknowledged and treated today is totally different than the end of Vietnam, when I got out of the military.

And I think we had a vacuum of 20 years of which we ignored our veterans, and you being one of them, me being one of them. That is not happening now, and it is not happening now thanks to people like yourself, who took the time out to make this tremendous sacrifice for your fellow veterans.

So I want to thank you, and I want this room to give Mr. Zelaski a great round of applause.

I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

And thank you, Mr. Zelaski, for being here, for your service to our Nation, and for what you are doing to raise awareness on behalf of our veterans.

Before I welcome our first panel, I would like to express my extreme disappointment that the National Institute of Mental Health declined to participate as a witness this morning in our second panel. Although a formal letter of invitation to testify was sent on November 7, committee staff was informed on November 23 that bureaucratic obstacles in clearing a statement would prevent the agency from being a part of today's discussion.

I find this unacceptable, especially given NIMH's partnership with the Department of Army to administer the largest study on suicide and behavioral health in the military, "The Army Study to Assess Risk and Resilience in Servicemembers." Our military deserves better.

In addition, I would like to note that unfortunately our Department of Defense witness, Colonel Castro, is unable to be with us this morning due to an illness. Today we will begin this serious discussion. Given its importance and the critical need for VA and DoD to work together in collaboration I fully expect to follow up with additional hearings and oversight that will include DoD as a partner in the new year.

Now, I would like to invite our first panel to the witness table. It is always a pleasure to welcome the members of our veterans service organizations to share their expertise with us. With us today are Commander René Campos, the deputy director of government relations for the Military Officers Association of America; Mr. Tom Tarantino, a senior legislative associate for the Iraq and Afghanistan Veterans of America; Dr. Thomas Berger, the executive director of the Veterans Health Council for the Vietnam Veterans of America; and Ms. Joy Ilem, the deputy national legislative director for the Disabled American Veterans.

Thank you all very much for joining us this morning for this very important conversation.

Ms. BUERKLE. Commander Campos, we will start with you. Please proceed.

STATEMENTS OF COMMANDER RENÉ A. CAMPOS, USN (RET.), DEPUTY DIRECTOR, GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA; TOM TARANTINO, SENIOR LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; THOMAS J. BERGER, PH.D., EXECUTIVE DIRECTOR, VETERANS HEALTH COUNCIL, VIETNAM VETERANS OF AMERICA; AND JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS.

STATEMENT OF COMMANDER RENÉ A. CAMPOS, USN (RET.)

Commander CAMPOS. Madam Chairman and distinguished Members of the Subcommittee, on behalf of the 370,000 members of the Military Officers Association of America, I am grateful for the opportunity to present testimony on MOA's observations concerning the VA suicide prevention programs and efforts.

MOA thanks the Subcommittee for its interest in this extremely difficult issue and for your commitment to the health and well-being of our veterans and military families. In conducting my research for this hearing, we were really struck by the tremendous amount of work that has been done, the steadfast determination of the VA central office staff, and Secretary Shinseki's personal involvement in synchronizing the agency's suicide prevention efforts is quite visionary. The two most impressive initiatives are the VA suicide prevention campaign, and thanks to Dr. Kemp, the National Veterans Crisis Line.

Despite the improvements, the VA concedes barriers still exist to advancing suicide prevention to the level needed. Veterans and family members we talked to have seen great progress in improving policies and programs. But they have seen it at the national level. They don't always see these programs and policies implemented consistently across all VA medical facilities.

Here are some of the experiences veterans and their families have told us. One caregiver spouse of a veteran with PTSD said that it took the VA 2 months to schedule an appointment just to get a fee-based referral for her husband, who had some difficulty with sleeping. Now the veteran must wait until May 2012 for the VA to do a required sleep study. The caregiver questions why it has taken almost a year for the VA to give her husband the care he needs, especially since the VA knows that difficulty sleeping is a risk factor, and her husband has a history of suicide attempts.

Another caregiver spouse of a veteran with PTSD and TBI told us that when my husband attempted suicide in March, the VA doctor told me to go to the ER, but the ER had no beds and said he may have to wait 24 hours before one was available. They gave me no alternatives. I was scared, and no one in the VA did anything to help us or help me know what to do in a situation like that.

Finally, one severely disabled veteran with TBI said that he was frustrated because his provider seldom talked to him or asked him how he is doing. He usually talked to the caregiver: I just want them to know that I can contribute to my care. When they don't talk to me, it makes me feel like they don't care about me.

MOA urges Congress to take immediate action on three recommendations which will further enhance VA's suicide prevention efforts as well as address other systemic issues. One, require VA and DoD to establish a single strategy and joint suicide prevention office that reports directly to the department secretaries through the senior oversight committee. Congress has been VA's and DoD's greatest champion on promoting collaboration after Walter Reed. We need that level of oversight now.

Two, authorize funding to expand VHA mental health capacity and capability in order to improve access and delivery of quality and timely care and information. There needs to be research that includes a longitudinal study of the economic and societal costs of veteran suicide in this country.

And three, authorize additional funding to expand outreach and marketing efforts to encourage enrollment of all eligible veterans in VA health care, with special emphasis on the Guard and Reserve, rural veterans, and high-risk populations. In other words, there needs to be a long-term investment in outreach and marketing to improve VA's image and its brand if we are going to attract veterans to the system.

MOA believes that there is a business case for addressing suicide that should consider the impact of national security and the long-term costs to society of failing to do so. We have no doubt, with the will and the sense of urgency from Congress, the administration, DoD, and the military services and VA, we can win the war on suicide. After all, our veteran and military medical systems have eliminated some tremendous barriers, with unprecedented results in saving lives on and off the battlefield. We owe these heroes and their families our full commitment, and eliminate remaining barriers to mental health care so they can obtain the optimal quality of life.

MOA's encouraged by the significant progress made by the VA. We thank the Subcommittee for your leadership and your support in helping our Nation's veterans and their families. Thank you.

[The prepared statement of Commander Campos appears on p. 38.]

Ms. BUERKLE. Thank you, Commander Campos.

Mr. Tarantino, you may proceed.

STATEMENT OF TOM TARANTINO

Mr. TARANTINO. Thank you, Madam Chairwoman, Ranking Member Michaud, Members of the Committee.

On behalf of Iraq and Afghanistan Veterans of America's 200,000 member veterans and supporters, I want to thank you for inviting me to speak on this pressing issue facing veterans and their families, and that is the staggeringly high rate of suicide, not just amongst veterans, but servicemembers as well.

My name is Tom Tarantino, and I am the senior legislative associate for IAVA. I proudly served in the Army for 10 years, beginning my career as an enlisted Reservist, and ending as an active duty cavalry officer. Throughout these 10 years, my single most important duty was to take care of other soldiers. In the military, they teach to us have each other's back both on the battlefield and off. Although my uniform is now a suit and tie, I have been proud to work with Congress to continue to have the backs of America's veterans and servicemembers.

Today's hearing on suicide really couldn't have come at a more critical time. The Defense Department recently reported that 468 active duty and Reserve soldiers, sailors, airmen, and Marines committed suicide in 2010. Overall, the DoD tracked 863 suicide attempts, and the rate for veterans is likely much higher. Although we have this limited data about servicemembers, there remains a fundamental gap when it comes to understanding veteran suicide. One of the greatest challenges in understanding and preventing veteran suicide is this lack of full data. If we don't know the entirety of the problem, how could we ever hope to solve it?

Even in this age of information and technology, we have no way of tracking veterans, unless they interact with some social service that happens to ask about their military service. Frankly, this is unacceptable. To address this problem, we have to look a little bit outside the box. IAVA recommends that we need to collect this data, and we should do it by expanding existing services, like the Centers for Disease Control and Prevention's National Violent Death Reporting System.

Currently, the CDC collects data on all manner of violent deaths, including suicide, in 16 States. Veteran status can be reported to the CDC, either through the death certificate or by information collected by the medical examiner. If we expand this database to all 50 States and require medical examiners to report veteran status to the CDC, then we can get a much clearer picture of the problem and know where to better target our limited resources.

A critical step to understanding how we can stop veteran and servicemembers suicides is to understand that suicide itself is not the whole issue. Suicide is the tragic conclusion of the failure to address a spectrum of challenges that veterans face. These challenges are not just mental health injuries. They include challenges finding employment, reintegrating into family and community life, dealing

with health care and benefits bureaucracies that, frankly, are almost as traumatic as the injuries themselves.

Fighting suicide is not just about preventing the act of suicide. It is about providing a soft and productive landing for veterans when they return home. The problems of mental health care in the VA system have been pretty well documented. The VA reports that 18 veterans in their care commit suicide every day, and wait times for mental health care, as Commander Campos mentioned, are still unacceptably high. And there is just not enough mental health care providers to meet the need.

We also know that many veterans may not be seeking care because of the stigma attached to mental health injuries. Multiple studies confirm that veterans are concerned about seeking care because it could impact their career both in and out of the military.

To combat this, IAVA recommends that the VA and the DoD partner with experts in the private and nonprofit community to fund a robust, aggressive outreach campaign. This campaign needs to focus on directing veterans to services, such as the veterans centers, as well as local community-based and State-based services. It should be integrated into local campaigns, such as San Francisco's new veterans 311 campaign for their city. This campaign needs to be well funded and reflect the best practices and expertise of both the mental health and the advertising fields.

It drives me nuts every time the VA asks me, how do you reach out to veterans? I tell them stop reaching out to veterans. Reach out to people. And why are you asking me? Go ask the people who know how to sell toothpaste. They can put your campaign in front of 40 million eyeballs. Me, not so much.

Providing a smoother transition from the military to civilian world is critical in preventing veteran suicide. Ensuring veterans access to mental health care is connected to other issues that can contribute to a veterans' sense of stability throughout their transition home. We must tackle the other contributing factors, such as employment and homelessness, that could increase the risk of veterans who are vulnerable to suicide.

The responsibility of building a support network doesn't necessarily lie with the military and the veterans' families alone. Preventing veteran suicide is about easing the transition from military to civilian life. And it is our collective responsibility as a community. Our veterans are not just readjusting to their families or connecting with other veterans; they are coming back to jobs. They are using the GI Bill to go to school and study at local colleges. And they are seeking care and services from businesses and providers across the community and outside of the veterans network.

We must focus on extending this understanding not just to spouses, but also to society at large. Teachers and professors should know what students of theirs are veterans or the children of veterans and servicemembers. Businesses should invest in the leadership of returning veterans by hiring them. Health care providers must understand the injuries facing these incredible men and women.

By promoting awareness, we can ensure that our entire community is able to support veterans throughout their transition back to civilian life and help stem this tide of veteran suicide. By accu-

rately measuring the problem, by improving access to mental health care, and tackling the transition from military to civilian life and creating a robust community of support, we may be able to significantly reduce the number veterans that attempt to commit suicide every year.

Veteran suicide does not have a silver bullet solution. No one bill is going to solve this problem. But better practices are out there. And we don't want to have to ask ourselves if there was something more we could have done. Thank you very much for your time and attention. I will be glad to take your questions.

[The prepared statement of Mr. Tarantino appears on p. 45.]

Ms. BUERKLE. And thank you, Mr. Tarantino.

Dr. Berger, you may proceed.

STATEMENT OF THOMAS J. BERGER, PH.D.

Mr. BERGER. Good morning, Madam Chairman, Ranking Member Michaud, and members of the House Veterans' Affairs Subcommittee on Health. Vietnam Veterans of America thanks you for the opportunity to present our views on understanding and preventing veteran suicide. We want to also thank you for your overall concern about the mental health care and issues affecting America's troops and veterans.

I beg your indulgence. When I got up this morning to get ready to come down here, I turned on my little BlackBerry here, and I had a message from a colleague who lives in the north central States of the U.S. My colleague is also the mayor of a small town in this State, and a member of VVA National Board. And this is the message I received this morning: Sergeant so and so, 31 years old, from, will be buried at Arlington Cemetery. U.S. Army, two tours in Iraq, one tour in Afghanistan. Walked into the emergency room at, in this particular city and the State, and stated to a nurse on duty that someone outside needed help. He went outside and shot himself in the chest. On his arm was a note. He had written his blood type, A-negative, and he had written, "Please use my organs for someone more worthy than me."

I am a little bit upset this morning to come in, obviously, and talk about this issue after receiving this email this morning. We have been here before. We are 10 years into the war, ladies and gentlemen. I appreciate the comments of my colleagues here, and I won't belabor the fact that there have been some excellent efforts made by Dr. Kemp and her division there. And I will leave it at that. But I will try to take the rest of my allotted time and talk about VVA's concern with suicide within the system.

It is very challenging, as we have heard, to determine an exact number of suicides. Many times suicides are not reported, and it is very difficult to determine whether or not a particular individual's death was intentional. For a suicide to be recognized, obviously examiners must be able to say that the deceased meant to die. And there are other factors that contribute to the difficulty, including differences among States as to who is mandated to report a death, as well as changes over time in the coding of mortality rates. But those aren't the problems.

The problems, okay, and VVA has long believed in the links between PTSD and suicide, and in fact, there is plenty of research

studies out there to suggest that suicide risk is highest in persons with PTSD. Others claim that suicide risk is higher in individuals because of related psychiatric conditions. But a study published by the National Co-Morbidity Survey showed that PTSD alone out of six anxiety diagnoses was significantly associated with suicide ideation or attempts.

Now, some studies point to PTSD as the cause of suicide, suggesting that high levels of intrusive memories can also predict the relative risk of suicide. Anger and impulsivity are two more factors that are on the list and, as you well know, are part of the symptomology for PTSD.

Other research says that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt, particularly amongst Vietnam vets.

All of this brings us full circle to what VVA has been saying for at least the last 6 years. If both DoD and VA were to use the PTSD assessment protocols and guidelines, as strongly recommended by the Institutes of Medicine back in 2006, then our veteran warriors would receive the accurate mental health diagnoses needed to assess their suicide risk status.

Thank you. I will be glad to answer any questions.

[The prepared statement of Mr. Berger appears on p. 48.]

Ms. BUERKLE. Thank you, Dr. Berger.

Ms. Ilem, you may proceed.

STATEMENT OF JOY ILEM

Ms. ILEM. Thank you, Madam Chair and Members of the Subcommittee.

I am pleased to present the DAV's views on suicide prevention efforts in the Department of Veterans Affairs. We appreciate the Subcommittee's continued focus on this difficult issue and on the effectiveness of VA's mental health services.

Suicide is a complex phenomenon, one in which VA and DoD have struggled in finding preventative solutions and effective strategies in the shadow of wars. DAV observes that VA and DoD have made visible and positive efforts to address the unique challenges in meeting the mental health needs of post-deployed active military personnel and newly returning veterans.

Both agencies are populated with dedicated practitioners and specialists, researchers, policymakers, and other leaders who continue developing new approaches to address suicide and attend to the other serious emotional and behavioral consequences of war. However, despite these obvious efforts and the notable progress they have registered, it is clear that more needs to be done.

All the experts tell us that effective suicide prevention must begin with strategies for routine mental health screening and early intervention for everyone, accompanied by ready access to comprehensive primary care and specialty treatments for any suspected serious problems identified. If not readily addressed, or untreated, problems of these types can easily compound and become chronic. Delay in treatment may lead to a host of personal and social problems, including early discharge from the military or other job loss, family breakup, homelessness, criminal incarceration, and even suicidal thoughts and actions.

In our opinion, VA has made valid efforts for early identification and effective treatment of behavioral problems in returning war veterans. Likewise, Congress provided VA significant increases in resources to institute system-wide changes, expand mental health staffing, integrate mental health services into its primary care system, develop a specific suicide prevention program, expand programs for PTSD, substance use disorders, and training on evidence-based psychotherapies.

As we understand it, the goal of VA's strategy is to promote healthy outcomes and strengthen family unity, with a focus on recovery. In addition to the goal of recovery, VA has now adopted a patient-centered model of care. These are the changes veterans say they want, and we believe all of these efforts are moving VA in the right direction. But over the past several years, a number of congressional hearings have been held, studies conducted, and informal surveys done related to the effectiveness of VA mental health services, including questions about how to alleviate the known access problems, stigma, gaps in services, and other identified barriers to VA care. The results help us frame the problem, but they do not solve it.

Based on the number of factors all of us are keenly aware of, it appears that real challenges still block VA's goals of meeting the most severe needs of a minority of new veterans who require intensive therapies and who consume significant blocks of time of VA practitioners. In VA, these are the same professionals who must also meet the mental health needs of a large population of older veterans with chronic and severe mental illness in a constrained resource environment.

Growth in demand for mental health services impacts all of VA's providers and patients. Unfortunately, it appears that VA is still struggling to figure out the right balance to ensure it identifies those few crucial cases with a high risk of suicide, while still meeting the needs of other new veterans and the older chronically ill populations in a clinically appropriate way for all, all while preventing suicides as the most pressing public issue.

With even more troops returning home by the end of the year and many who will likely transition to veteran status, this is an extremely complex mandate to meet, yet VA is attempting to do it and must succeed.

In closing, DAV believes VA is moving in an appropriate direction, but must find a way to hear directly from veterans trying to gain access to the system to better understand their unique needs and desires for treatment and services, and then tailor programs accordingly. We also believe that listening to veterans' feedback and making necessary changes are going to be essential to recreating a VA mental health system that meets veterans where they are, that works for them, and is effective in achieving the recoveries they all seek.

Likewise, VA leadership must acknowledge and address the challenges its providers are bringing to light. We encourage VA leadership to build on that knowledge to come, and to be more forthcoming in dealing with the challenges it faces. But despite DAV's concerns as expressed here in my written statement, we do recog-

nize the lifelong dedication of the leaders of VA's Office of Mental Health and VA practitioners in the field.

We appreciate their tireless commitment to improving the system for all veterans in need, old and new.

Madam Chairman, this completes my statement. I am happy to answer any questions you may have.

[The prepared statement of Ms. Ilem appears on p. 50.]

Ms. BUERKLE. Thank you very much, and thank you to all of our panelists. I will now yield myself 5 minutes for questions.

Dr. Berger, you mentioned that for years your organization has advocated the use of the PTSD assessment protocols and guidelines. Could you discuss these standards and how you think that they would improve the situation and the quality of care for our veterans?

Mr. BERGER. If I may, Madam Chair, a little bit of history. The VA itself commissioned a group of some of the most distinguished mental health experts in the country, including some people who are on the staff of the VA itself, some years ago, in the early 2000s, about 2005 or so, to take a look at and develop a series of guidelines and protocols to diagnose and assess PTSD. They did so. And in my written testimony, I have the link to that document.

Subsequently, there was no directive in any aspect or area of the VA to utilize this document that they had paid all this money for and utilized the time and services of these brilliant minds. All right. We still have reports of people being assessed on the basis of a 30-minute interview, where most of the time the clinician is taking personal information. Those are the kinds of things that the guidelines, in our opinion, the protocols that were developed were meant to minimize. But they still exist.

Granted, since the IOM report was issued, there are many more clinicians who aware of the guide and protocol, but largely because of our efforts to educate them on this through our network of State council chapters and that sort of thing. So that is where it stands at the present time. And we just wish that it would be utilized by both DoD and VA. And we feel that if the correct assessment and diagnosis is made, then they can move onto the suicide risk assessment, and everything should just follow along.

Ms. BUERKLE. Thank you, Dr. Berger.

I would like to think that there is no lack of will to get to the root of this problem and to get our veterans the services they need to avoid these suicides. So I would ask each one of you, what to you is the biggest gap or the biggest reason we are not getting this problem solved? It is getting worse instead of better. What is the one thing we need to focus on? I would like to hear, if you could just tailor your remarks so all four of you get the opportunity to respond, I would appreciate it. Thank you.

We will start with Commander Campos.

Commander CAMPOS. Yes, ma'am. I think that is a very valid question. And I think admittedly in recent hearings, and as early as yesterday, VA admits that, and what we found in our research is that there are definitely policies and programs in place, but the challenge to VA is the execution and the implementation of these policies. It is a decentralized system. And I think what we are hearing is that there is so much focus now at the medical facility

level of getting the numbers, and getting people seen, and so on, that I think that it has become more of an assembly line process. And it is creating, I think, havoc in the system.

And then you have the pockets of where there aren't enough resources and staffing and facility infrastructure that the system is overwhelmed, and the resources and the staffing and all the other needs to support the system are not out there consistently.

So I think for VA to get to a system of being veteran-centric, they are going to have to step away from focusing on investigation, looking at the numbers, and start looking at the veterans themselves and what their needs, and letting them be part of the discussion.

Ms. BUERKLE. Thank you.

Mr. Tarantino.

Mr. TARANTINO. I know this is going to kind of sound lame, but outreach and awareness. I mean, bottom line, the VA has good programs. It has the crisis line. It has the new Making Connections program, which I think is pretty slick and pretty cool. The problem is nobody knows what the VA does. Nobody barely even knows that the VA exists. If you go outside and pull a hundred people off the street, ask them what NASA does, I guarantee you, you are going to get 90 of them are going to give you a pretty decent answer. And NASA affects a fraction of the percent of the population directly in this country.

Six percent of the population would be directly affected by the VA. You would be lucky if maybe 10 out of those hundred would be able to tell you what VA does and what programs they have. It is because as a community, we are so insular. We are insular to the veterans community, the military community.

As the veterans population is dynamically shrinking, we have to stop that, and we have to change the way we think about outreach to veterans. And we have to reach out to families, to the community. Why? There is not that many of us in my generation of veterans. And guess what, I am a soldier; I am also kind of a knucklehead. I am not the one who is going to go out and seek help. It is going to be my girlfriend, my mom, my best friend. Those are the people you have to reach out to. And that is where we need to focus our efforts to stem the tide of this.

Ms. BUERKLE. Thank you.

My time has expired.

I now yield to the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair.

Dr. Berger, you had mentioned the fact that the VA has come full circle. And you talked about DoD and VA using the PTSD assessment protocol and guidelines. That was one of his recommendations. I would like to ask the other three individuals whether or not you agree with that assessment, that that is a good place to start.

Commander CAMPOS. I don't think I have the expertise to really address that. But I don't think we ever go wrong by including VA and DoD collectively and collaboratively in addressing this issue.

Mr. TARANTINO. Yes.

Ms. ILEM. I think what Dr. Berger indicated, where the research indicates that direct link with higher risk of suicide for those with PTSD. So certainly it is absolutely critical to make sure that people do get diagnosed or at least addressing that there is a readjust-

ment issue that needs to be dealt with to be able to get the proper treatment and to avoid and prevent any further—suicide or other negative behaviors that can really impact them.

Mr. MICHAUD. Thank you.

My next question for all of you then, we have heard testimony about how the different VA facilities do things differently. In terms of accountability, oversight, monitoring, and evaluation of what the VA is doing to implement strategies across the system so that our veterans are getting the proper health care needs, is there anything that you think we should be doing specifically, or advice you would have for the VA as far as the accountability and oversight and monitoring?

Ms. ILEM. Dr. Schoen has indicated that one of her goals in coming into the VA system, is the new development of a two-pronged approach, one focused on policy issues and the other focused on driving those policies out to the field and making sure implementation is achieved is critical. So I would be interested to hear more from her on the second panel in terms of how they think that is going.

I know VA is trying to work on the standardization of the package that they developed for mental health to have a robust package in place at all locations and to decrease variance. But the absolutely critical piece is who is connecting with the field, listening to the feedback from providers and the directors and the leadership in the field. Where are they having the problem in doing something, what is the problem? You know, is it lack of staff? Lack of resources or just a significant increase in veterans coming in? So I think it can be unique in every location, some places have a problem and others don't. But having those two offices connecting up is essential.

Mr. BERGER. I would like to support my colleague in his earlier comments about outreach. The fact of the matter is that almost 70 percent of America's veterans do not use the VA for lots of different reasons. So we are not getting the word out there. And the word that is getting out there, or the image that is projected because of the shortness in resources and variability and accessibility of program concerns, the vets aren't coming in.

VA has to do a better job in terms of its outreach program for the stuff that it does offer to get to the veterans. And let's get away from this development of policies and all these other kinds of things that seem to get in the way of actually getting out there to our veterans and make sure that they get the message that this is the system that was developed and is in place for them.

Commander CAMPOS. I did have an opportunity to talk to a DoD mental health professional before the hearing. And I know that there are folks out there who really want to work closer with VA. I know VA wants to work closer with DoD. And these are leadership issues. And this mental health professional said the best thing we can do, especially when we know people that are at high risk when they leave the military service is to do that warm handoff to the VA where that veteran will go to. They want to do it. But again, sometimes the barriers and bureaucracies get in the way. And I think that there are people in the VA system who really—

who are veterans themselves, and I think they can actually probably find some of the solutions that plague the VA bureaucracy.

Mr. MICHAUD. Thank you.

Thank you, Madam Chair.

Ms. BUERKLE. Thank you.

I now yield 5 minutes to the gentleman from Tennessee.

Mr. ROE. Thank you. I don't understand why NIMH wouldn't be here. And I think we need to have an explanation. That boggles my mind. But anyway, Mr. Michaud and I, I guess 2 and a half years ago went to Afghanistan. And we went back to Afghanistan about 6 weeks ago to look at where the injuries occur at the point of the spear, follow those physical and psychological injuries to Landstuhl—to the forward surgical hospital, to Kabul or Leatherneck, to Landstuhl, and this Monday, I was at Walter Reed, Bethesda. And next week I am meeting with Dr. Brown, who is a psychiatrist at the VA at Mountain Home, to try to close the loop so I have made full circle.

What is happening now in Afghanistan, and I assume in Iraq, the 101st Airborne Division really made a real effort in TBI and PTSD to get on top of that early. And what they found by doing that, and I won't go through all the things we saw, but they actually got the fighter back in the war, back into battle sooner by being proactive in treatment. So I think that is being done.

And Dr. Berger, I mean, that is heartbreaking that email you just read. I know that that doesn't affect one person. That affects that family. That family will deal with that every Christmas for the rest of their lives, that family member will be.

Tom, you had mentioned about getting information out. Yesterday, we had, I don't know whether you know Jim Young or not, but Google has—you probably do—Google has two people DoD assigned to help in their Google search engine to get information out, which is how a lot of young people are treated in theater, for instance. Many of them are in isolated places, and they use telehealth. And a lot of our younger soldiers, not like me—I mean, I couldn't do that—but they enjoy, or it is easier for them, because of the stigma of PTSD, they much prefer that. And in some instances, that works very well. I think that could work here Stateside very well, where you have overly burdened VAs. So that is one thing.

I know there is an organization we also went to this week, Not Alone; I am sure you are aware of them, too. They are in 20-something States now, who on their own outside the VA are another resource for veterans to reach to if they know that they are there. So I think this new way to approach people with this right here. Any way. I mean, everybody has got a cell phone now just about in this country. And that is one way we could communicate better, I think.

And Tom, if you would, I was intrigued by the 311 campaign. What are they doing there?

Mr. TARANTINO. Well, as you know, many cities have a 311 campaign that allows you to access all manner of city services. New York has one. I think Houston has one, you know, Chicago. And in San Francisco, we were contacted by the former mayor and asked, you know, we have a lot of veterans in San Francisco. We have a lot of veterans services, but we need a way to get our citi-

zens to these services. And so we worked with them to develop a campaign where when you call 311, if you are a veteran, you press—I can't remember what the exact number is, one or two—and you get sent on a separate track, meaning you have a shorter queue, you get sent to a separate track of veterans services, you have unique access. And that works, not just on the phone, but it works online as well. And I know, coming from the Bay area myself and from the State of California, they actually do this with all their social services. If you are a vet, there is a separate line, there is a separate track that you go through. And the services are more tailored to you. And the idea of integrating national and VA services is the VA has the power to be omnipresent. They have the power to set minimum standards for care and services. But it doesn't mean that we can't use the multiple touch points and interactions that are actually happening in communities that we don't know about because we are not tracking it. And I am not talking about contracting; we are just talking about partnerships for care. And I think by developing that type of model where, you know, city services and State services have some sort of integration, or at least have some sort of cross-talk and communication with VA services, then you can actually catch a lot more people before they get to that tragic conclusion of suicide.

Mr. ROE. Commander Campos, we talked with Commander Evans at Bethesda on Monday. And she was of the opinion that a lot of times—I know you are looking at another layer—but I wonder if the resources aren't there now, and instead of creating another bureaucracy, just organize the resources that we have. Because that was one of the problems that they were dealing with, there were so many ways of—you know, the veterans, wounded warriors dealing with seven, eight, nine, 10 people, and it got confusing for them. It would be confusing for me to deal with eight different people making rounds on me every day. Usually, when I made rounds in the hospital, there was a nurse and myself would come by and see you, and you would know what was going on. These veterans are facing multiple people that come in to see them. So I would like to work with you on that. I think that is a great idea. But I wonder if we couldn't just organize what is already there.

The last thing—and I know my time has expired, I will be very quick—do we know the incidence of suicide among veterans 5, 10, 15, 20, 30 years ago? And is what we are doing changing it? Are we collecting data better now than we used to? That is the thing that it is hard for me to understand. You know, before, did we just not have the information? And are we doing a better data collecting now making it look higher?

Mr. BERGER. I think there are more States, for example, that have responded to the call to report violent deaths, has been hinted at, more accurately than there were in my generation of veterans. But the fact remains that it is still, because it is some corners of the country and some corners of the States, it is just simply not reported as a suicide. And until we can get some kind of way to address that, I don't know if we are going to—

Mr. ROE. See what I am saying? Was it apples to apples?

Mr. BERGER. Exactly.

Mr. ROE. My time has expired. I yield back.

Ms. BUERKLE. Thank you, Dr. Roe.

I now yield to the gentleman from Texas, Mr. Reyes.

Mr. REYES. Thank you, Madam Chair, and thank you for calling this hearing. And I had a question for my colleague, Dr. Roe. When you asked unanimous consent to enter into the record Ron's information, is it the letter to the Veterans Committee?

Mr. ROE. Yes. I think that is it.

Mr. REYES. If it is not, I would ask the same unanimous consent. And the reason is because, Ron, thank you so much for—I got the opportunity to talk to him yesterday. I had never met him before, but I had heard of him. And so I appreciate the work that you have done. And in his letter to the Veterans' Affairs Committee, there are a number of recommendations that he makes and he identifies that track very well with what our panelists have said here this morning. And in the interests of transparency, I am a life member of both the VVA and the DAV. But I wanted to add, being a Vietnam veteran, having come back during the tumultuous time when we were not received as well as, thank God, today's veterans are, one of the constant questions that is asked, at least in my district, by some of our same veterans groups is a question of, you know, with the kind of support that—outpouring of support that veterans are seeing today, it is incredible that we are still going through all of these issues. But I try to explain to people, you know, we don't have all the information. Because as I, too, go to Afghanistan, Pakistan, Iraq, Kuwait; anecdotally I get information from active duty personnel that they are still reluctant to come forward with concerns of PTSD and sometimes TBI because they think—they want the military as a career, and they think it is going to hurt their career. I really do believe it is important, and our Ranking Member here can attest to it, when we had the full Committee hearing, one of the recommendations that I made to Chairman Miller is we have to bring in Secretary Shinseki and Secretary Panetta so that we can work on these many recommendations that all our veterans organizations have long recognized. We have to have a single effort, a single program of working between the DoD and the VA, especially today when we are looking at tough budgets. I asked staff, because one of the—I have been on this committee since I have been in Congress. I had to take a leave of absence when I was chairman of the Intelligence Committee. But my interest has always been there, being a veteran, and having, by the way, Dr. Berger, a brother that served also in Vietnam that absolutely refuses to go to the VA. And his rationale, and he suffers like many of us with that jungle rot that periodically comes up because of stress, he refuses because he says, "Listen, I served my country not so that my country would take care of me for the rest of my life." So he is very independent that way. And a number of veterans are. In the 16th District of Texas, I have a full-time staff member that is actually going out throughout the homeless population and the rescue mission and things like that to ask people if they are veterans so we can get that information to them. But some of them just absolutely, for many different reasons, some of them, because they are obviously suffering from PTSD and other types of mental illnesses, need to be brought in.

So I was curious, I know my time is short, in 5 minutes, with all of things that we have to deal with, it is very short, but Dr. Berger, do you have any observations on that?

Mr. BERGER. Well, first of all, Congressman, thank you for your service, and welcome home, brother.

Mr. REYES. Thank you.

Mr. BERGER. Secondly, and to be quick about this, my colleague Tom Tarantino mentioned something that is quite understated, and you hinted at it also, and that is the brotherhood and sisterhood that exists between veterans out there. Veterans talk to one another. And maybe we will hear something about this a little bit later on. But in any case, one of the ways of getting the word out is veteran to veteran. Okay? Despite all the signs on the buses and late night videos and all that sort of thing, the fact of the matter is if Tom calls me—I know Tom—and says, I am having some problems with this or whatever, you know, I will talk to him, and maybe even suggest that he go—find out where he lives and suggest that he go. And if I know a clinician there or whatever, and say you need to ask for—veteran to veteran helps a lot.

Mr. REYES. And Madam Chairman, if I can just have a second, in his letter to the Veterans' Affairs Committee, Ron also makes mention of something that Tom did. And that is the number of times, as he walked across the country, that mothers and wives and relatives turned around to commiserate with him, to hug him and cry with him about their loved one that was suffering with PTSD, or had suffered with PTSD. All of these issues are so important. That is why I say, let's, if we don't do anything else in this Congress, let's get Secretary Shinseki and Secretary Panetta here before this committee so we can start working towards one single understanding and probably a number of different single programs in all these different areas that are absolutely related. It is not always about money because, you know, we funded that independent budget when we were in the majority every year. And the organizations were very grateful. But it certainly has not brought us to a point where we are any more successful today, regrettably.

So thank you again, Madam Chairman.

Ms. BUERKLE. Thank you. I now yield 5 minutes to the gentleman from Florida.

Mr. STEARNS. Thank you, Madam Chair. A question. When you look at the statistics of 18 deaths from suicides per day and then about five of the deaths from suicides per day among veterans receiving care. Dr. Berger, are the care we give veterans who are actually participating in a program, is it working? I mean, with five of the 18 deaths per day are coming from veterans actually receiving the care, and then when you look at the statistics where about 11 percent of those who attempted suicide did not succeed or have made repeated attempts with an average of 9-month follow-up, so the question is, does the Veterans Administration have a program that is working?

Mr. BERGER. At the present time, there is so much variability across the spectrum of mental health services, not only in the training of the clinicians and at the programs that are available, plus just general physical access, and I think all of that enters into it. And so I would say there is room for lots of lots of improvement.

Mr. STEARNS. On a 1-to-10 scale, how would you rate the Veterans success in preventing suicides?

Mr. BERGER. Four.

Mr. STEARNS. That is a fail.

Mr. BERGER. Yes, sir.

Mr. STEARNS. So what you are really doing this morning is indicting the Veterans Administration, which—I understand what you are saying, and I am sympathetic, because when I read these statistics that is alarming to think that five people of the 18 actually are getting clinical care. So your rating it at 4 indicates that the Veterans Administration is not providing the services.

Even if we get the veterans there, even if we get the communication and the education that Tom has talked about, once they get there, they still were not successful. And so—and is it possible the reason is because there are so many programs that are not working together, or is it possible that the actual procedures are not working or we just don't know enough about suicide.

Mr. BERGER. That is correct, we don't know if they are working. I would point out again the accessibility. I mean, we heard on the Senate side the other day the difficulties that some veterans are suffering getting into the proper treatment program. It may be days, it may be weeks, it can be months. And when you have somebody who has been through trauma, as the research suggests, serious combat trauma, who needs help, you can't wait 6 weeks for your initial appointment.

Mr. STEARNS. And, in fact, if a person has to wait, it might contribute because he gets frustrated, he or she gets frustrated, and to say there is no hope here and I am going to have to sit around for weeks, possibly months, is that possible?

Mr. BERGER. Yes, sir.

Mr. STEARNS. What would be the longest wait that you have experienced or that you are familiar with that a veteran who has suicide tendency has had to wait to get treatment?

Mr. BERGER. Eight months.

Mr. STEARNS. Eight months, okay. Because I see here it is talking about—there is something about 9 months in some of the fact sheets here. Well, let me ask you this: This is a more difficult question. Is the suicide rate from Iraq and Afghanistan worse than it was from Vietnam and Korea, or is it just that we don't have the data?

Mr. BERGER. We don't have the data, as Congressman Roe pointed out. The information gathering or data collection 40 years ago, 35 years ago, is a lot different than it is now, although the technologies have improved, reporting has improved. It is difficult to compare. One thing we do here is that for a couple of years after the cessation of hostilities in Vietnam, there was an increase in suicides. That is more anecdotal than anything. But at the same time we are sort of hearing that anecdote now beginning to arise. And I have concerns professionally when all these folks come home, if they don't have access to what they need in terms of mental health services, and that includes accurate scientific-based or evidence-based treatment programs when they need them, we are going to have real problems. And we got, what, half a million coming home here in the next month?

Mr. STEARNS. Right. Well, Madam Chair, it seems to me that we can solve as Members of Congress with money to the administration to get an educational component so the veteran coming home will know of its availability. We can actually probably convince a lot of veterans to perhaps take the test when they leave the DoD. But what I am worried about is once they get in the VA, you are telling me there is no accurate information to show that the program that they have implemented is working, there is no statistical information that has been investigated to show how successful, and then two, in a larger sense it is not working, it is failing.

Mr. BERGER. Sir, if there is an outcome measurement being conducted I am not aware of it. And then we need to hear from the appropriate VA officials if indeed such information exists. And then I might be willing to revise my grading scale.

Mr. STEARNS. Okay. Well, I think you got to be honest here. And I just want, before I close, Madam Chair, to ask each one do they agree with Dr. Berger? You don't have to agree with his 4 rating, but in general, do you agree with what his assessment is? Just say yes or no.

Commander CAMPOS. Yes, sir.

Mr. TARANTINO. Yes, sir.

Ms. LEM. Yes. Many challenges.

Mr. STEARNS. All right. Thank you. Thank you, Madam Chair.

Ms. BUERKLE. Thank you. I now yield to the gentleman from Indiana, Mr. Donnelly.

Mr. DONNELLY. Thank you, Madam Chair. One of the points has been the issue of isolation and that we will work to put programs together, but 70 percent of the vets don't want to have that initial contact. And Tom's point about media and reaching out and touching other family members about getting our other vets included, what are your—and Dr. Berger, you talk about vet to vet, that that is the way, or one of the ways to help get this. For that 70 percent, what other ideas do you have to reach out to our vets, the vets who aren't going to join DAV or VFW or the American Legion who aren't connecting to the VA but who struggle every day?

Mr. TARANTINO. Well, Congressman, I can talk a little bit about some of the lessons we have learned from IAVA's ad council campaign. That was very successful in reaching out to vets and their families who otherwise might not have paid attention. The commercials that we produced and the PSAs that we have produced weren't done because Tom Tarantino or Paul Rieckhoff are smart guys, and we know what we are doing. We do in our space, but we are not innovators in the advertising space. This was done because the Ad Council brought in professionals from BBDO and Sachi & Sachi, people who know how to communicate, people who set the standards in this country for how we publicly communicate.

And we were able to, over the course of a couple of years, bring in our knowledge base from the veterans community, match it with their knowledge base from the advertising community and create an outreach campaign that spoke to virtually everyone who saw it, whether you are a vet or a civilian. And that is something that the government really doesn't do at all, and when they do do it, they do it poorly, and it is not very well researched and it is not focused. And I think a lot of times we trade expedience for quality. You

want to get this campaign out, we got to get it out in 6 months, and that is the metric for success. Well, a bad campaign out too soon is just still a bad campaign. So why aren't we taking the time to focus test this? Why aren't we talking to industry leaders? Why aren't we going out into the technology community and thinking what can we do? Where are people communicating online and why aren't we going there? Why aren't we buying targeted *Facebook* ads?

Facebook, it is the most advanced advertising platform known to man. They know absolutely everything about you. And it is not an accident that all the ads that show up on the right side of your screen are all stuff that you are interested in. There is no reason why we can't be reaching out in ways like that. Using technology and using these best practices to laser target into military communities, veterans communities, military families, we just don't do that, and I don't know why.

Mr. BERGER. I would just only add to what Tom said earlier. This is a community effort as well. It is not just getting the ads put together, or the outreach programs put together. You have to have the involvement of the community. When you are dealing with that element, that demographic element, almost 70 percent are not going to the VA. I mean, you have to have people in your community talking about this stuff using the methodologies that are developed at the national level.

Mr. DONNELLY. A lot of us have rural areas too, and I think staff going out and trying to locate our vets. And in some of the rural areas, it is not always the easiest thing to do with the *Facebook* techniques that you talk about and other techniques. Do you know of any, or have you heard of any specific targeted efforts in rural areas so our vets who may be almost, or off the grid, in effect, how do we locate them?

Ms. ILEM. VA did bring to our attention and gave us a demo just last week of their new Making the Connection campaign. I think that would be worth asking the next panel about specifically. It seemed in the rollout to be testimonials from veterans, from family members and others.

So certainly it is a Web-based tool with lots of resources and seems to be able to be manipulated to be tailored to the specific person's interest. So I think that is one way. That definitely could be available in the rural community.

Mr. DONNELLY. And Madam Chair, what are the great concerns is truly we will do everything we can as a committee as the VA, but when 70 percent of our veterans are living their lives and we are not touching them we have to figure out a much better way to touch them. I yield back.

Ms. BUERKLE. Thank you very much. We have been called to vote. We have about 2 minutes left to vote and the votes should take about an hour. What we would like to do is recess this hearing and then reconvene at around 12:15. If you could all join us for our second panel, please come back at 12:15 and we will reconvene this hearing. Thank you.

[Recess.]

Ms. BUERKLE. We are reconvening our hearing of the Subcommittee on Health. If I can invite our second panel to come to

the table. I thank you all very much for your patience for the little bit of disruption in this morning's hearing. Joining us on our second panel is Dr. Margaret Harrell, Senior Fellow and Director of the Joining Forces Initiative for the Center for a New American Security; Dr. Katherine Watkins, Senior Natural Scientist for the RAND Corporation; Dr. Janet Kemp, the National Suicide Prevention Coordinator for the Department of Veterans Affairs, accompanied by Dr. Antoinette Zeiss, the Chief Consultant for Mental Health for the U.S. Department of Veterans Affairs. Colonel Carl Castro, as I mentioned earlier, is not able to be with us this morning.

Ms. BUERKLE. Thank you all very much. I am very eager to begin our discussion. Dr. Harrell, if you could proceed.

STATEMENTS OF MARGARET C. HARRELL, PH.D., SENIOR FELLOW AND DIRECTOR, JOINING FORCES INITIATIVE CENTER FOR A NEW AMERICAN SECURITY; KATHERINE E. WATKINS, M.D., SENIOR NATURAL SCIENTIST, THE RAND CORPORATION; JAN E. KEMP, RN, PH.D., NATIONAL MENTAL HEALTH DIRECTOR FOR SUICIDE PREVENTION, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS, ACCOMPANIED BY ANTOINETTE ZEISS, PH.D. CHIEF CONSULTANT FOR MENTAL HEALTH VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF MARGARET C. HARRELL

Ms. HARRELL. Thank you. Madam Chairwoman, Ranking Member Michaud and Members of the Subcommittee, thank you for the privilege of testifying today. It is an honor to be here. While the topic at hand is suicide prevention among veterans, I must underscore the importance of considering both veteran and servicemember suicide. We can only be sure that strides have been made when the frequency of suicide decreases amongst both of these populations. There is, for an example, a possibility that a decrease in suicide among servicemembers could represent expeditious out processing of servicemembers struggling with mental health wounds of war. Only the joint consideration of both servicemember and veteran outcomes will highlight reasons for increased concern or will identify success. Addressing suicide among servicemembers and veterans is vital to the health and sustainability of the all-volunteer force. It will take a collaborative effort by DoD, VA, Federal and State legislatures and communities to curb suicide amongst those who have served. Our leaders in the DoD and VA deserve recognition for their actions to reduce these tragedies, and I am confident that my co-panel members will articulate many of the excellent efforts taken in this regard.

Despite their best efforts however challenges remain. In my submitted testimony I highlight multiple challenges and proposed recommendations. I focus upon four of those challenges here. The first challenge is the lack of accurate accounting of veteran suicide and the reliance on incomplete and delayed data. We recommend Congress establish reasonable time requirements for States to provide their death data to the CDC and that Department of Health and Human Services ensure that the CDC is resourced sufficiently to

expedite compilation of these data. Additionally the DoD, the VA and HHS should coordinate efforts to analyze veteran suicide data annually. A second challenge pertains to the national shortage of mental health care and behavioral health care professionals, a factor linked to higher ratings of suicide. Congress should require the VA to establish deadlines by which all 23 VHA regions will be manned to the recommended level of care providers. Additionally, and especially in the meantime, the VA should increase their use of existing public-private partnerships to provide care to the extent that such partnerships would expedite evidence-based care to veterans.

A third challenge pertains to the geographic moves that are a feature of military life. Separating servicemembers also often relocate their families as they leave the military. Because mental health care providers are licensed on a State-by-State basis a move across state lines can preclude continued care from the same provider. When a care provider and a patient develop a relationship and that relationship is severed by a move, individuals are often reluctant to begin treatment anew. Thus we recommend Congress establish a Federal preemption of State licensing such that mental health care can be provided across State lines for those instances in which veterans, servicemembers or military family members have an established preexisting care relationship.

The fourth challenge is the decentralized multitude of suicide prevention programs in the National Guard. The solution is inefficient and at risk of reduction or elimination. Such is the case in Minnesota where there exists both the highest number of National Guard suicides this year and also dwindling resources to address their problem. We recommend the consideration of a system-wide centrally funded prevention approach.

In conclusion, my testimony is extracted from a CNAS policy brief entitled *Losing the Battle, the Challenge of Military Suicide*. America is currently losing its battle against suicide by veterans and servicemembers. As more troops return from deployment the risk will only grow. To honor those who have served and to protect the future health of the all volunteer force, America must renew its commitment to its servicemembers and veterans. The time has come to fight this threat more effectively and with greater urgency. Thank you for addressing your attention to this critically important battle.

Ms. BUERKLE. Thank you very much, Dr. Harrell.

[The prepared statement of Margaret Harrell appears on p. 57.]

Ms. BUERKLE. Dr. Watkins.

STATEMENT OF KATHERINE WATKINS, M.D.

Dr. WATKINS. Thank you, Chairman Buerkle, Representative Michaud and distinguished Members of the Subcommittee, it is an honor and a pleasure to be here. I know that members frequently get calls from their constituents about how to access VA services. And increasing access to care is incredibly important. However, it is equally important to provide good care once a veteran does access care, and it is about this that I am going to talk to you today. Preventing suicide is difficult. The best evidence we have about preventing suicide is to provide quality mental health care.

In this testimony, I will summarize key results from a study conducted by RAND and the Altarum Institute on the quality of mental health care provided by the VA to veterans with mental illness and substance abuse disorders. I will then propose specific steps which could be taken by the VA to improve the quality of mental health care, steps which, if taken, could help to reduce suicide risk among our Nation's veterans. My written testimony provides more detail on our specific findings and our additional recommendations. In response to the question by Representative Stearns about the quality of VA care, our study actually found that the quality of mental health and substance abuse care provided by the VA is as good or better than the care provided by both the public and the private sector.

However, there is still room for significant improvement. Let me give you an example. Although our study found that veterans with mental illness are assessed for suicide ideation and if they are found to have suicide ideation are given appropriate care, providing good care for people who are already suicidal is not enough. It is important to provide them good care before they become suicidal, both because providing good care is important in its own right and because high quality care might prevent people from becoming suicidal in the first place. It is in this area that the VA could improve their performance.

My first recommendation that comes directly from the results of our study is to increase the proportion of veterans who receive the recommended length of pharmacotherapy. Taking psychiatric medications consistently and for the recommended length of time is important, because for both depression and bipolar illness, taking psychiatric medication prevents suicide. We found that more than half of study veterans who began medication treatment did not receive the recommended length of treatment, and more than two-thirds of those on maintenance treatment did not take their medications consistently. This can be improved. There are systematic methods for increasing adherence which the VA is not using. For example, the use of clinical registries which allow clinicians to track medication compliance could be incorporated into the VA's medical record system with relatively little effort.

A second recommendation is to implement uniform assessment and standardized written treatment plans. In the case of uniform assessment, we found that while the VA had high levels of assessment for suicide, in other areas, performance was poor and more variable. For example less than two-thirds of the mentally ill were assessed for problems with housing and employment, and there were large differences between the best performing VISNs and the worst performing VISNs. This is important because homelessness and unemployment are both risk factors for suicide. The VA's employment policies are vague. If you are a veteran with mental illness who has an employment problem, it is unclear where you should go to for help. The VA needs to clarify what constitutes need for housing and employment services and clearly define the role of the Veterans Health Administration and the Veterans Benefit Administration with regard to work and housing.

We found that written treatment plans were incomplete and difficult to locate, and, in some cases, did not appear to be present at

all. This is a problem. Written treatment plans are essential for communication between providers because they tell providers in short succinct ways what problems a patient has and what is being done for those problems. Although we understand that VA Office of Mental Health Services has recently purchased treatment planning software implementation of the software has been held up because of lack of computer personnel at the VA Office of Information Technology.

In conclusion, I would like to say that the VA has substantial capacity to deliver mental health and substance abuse treatment to veterans and it outperforms the private sector on most quality indicators. This most likely demonstrates the significant advantages that accrue from an organized nationwide system of care. Nonetheless, the VA is falling short of its own implicit expectations. Our study revealed ways in which the VA could build upon their current system with marginal effort to improve quality and potentially prevent suicide.

Thank you for the opportunity to testify today and to share the results of our research.

Ms. BUERKLE. Thank you, Dr. Watkins, for your testimony.

[The prepared statement of Katherine Watkins appears on p. 63.]

Ms. BUERKLE. Dr. Kemp, if you would like to proceed please. Thank you.

STATEMENT OF JAN E. KEMP

Ms. KEMP. Chairwoman Buerkle, Ranking Member Michaud and Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss VA's efforts to reduce suicide among America's veterans. I am accompanied today by Dr. Antoinette Zeiss, the Chief Consultant for Mental Health. And at this point, honestly, I am going to put down my prepared statement and talk to you a little bit from my heart. It has been a very moving hearing and I think I have some important things to say. First, I want to thank you all for the kind words about the suicide prevention program and my personal efforts. And I think that speaks to the people up in Canandaigua, New York who work 24 hours a day 7 days a week answering that phone and making those connections, and the suicide prevention coordinators across the country who work tirelessly to connect people into care and to really make a difference.

And while I truly accept your kind words for them, because they work really hard, I have to tell you it makes me feel a little bit like a fraud and a little bit humbled by what you have said, because veterans are still dying by suicide, which means we have more work to do. And as long as one veteran any day of the year dies by suicide who is receiving care in the VA, I haven't done my job well enough. And I will continue to persevere to get that job done.

That being said, we have had some exciting news this week. We have recently gotten the 2009 data, and you have heard from the other witnesses how tragic that is that it is almost 3 years old. But we did get the 2009 data very recently from the CDC, and have looked at that data, balanced it up against veterans who get care within the VA system and we are very encouraged by what we are

seeing in 2009, which was a couple years after we implemented the very beginnings of our suicide prevention program. And it is encouraging to know that this perceived epidemic of veteran suicide rates that we keep hearing about truly is not happening for veterans who are getting care in the VA, that rates in certain age groups and population groups, in fact, are decreasing. And when we look at our most at-risk patients, like you all have talked about, we are making a difference. Those rates are going down. And in the group of patients who get mental health care in the VA our suicide rates are decreasing. And we know that is because we are paying attention to them and we have them involved in our enhanced package of care and they are being followed by suicide prevention coordinators, they are getting evidence-based psychotherapies. We know that treatment works and that is extremely hopeful and is enough for us to keep going and to keep making these changes that we are headed towards and to know we are in the right direction. And we have a long ways to go. I am not going to sit here and tell you we think things are fine because we don't. We have high standards that we have set.

And as you have said, we are not meeting our own standards, and we need to continue to strive to do that and then we will set higher ones. And that is a promise. It also points out that there is a group of veterans that while their rates are staying stable, we haven't seen the decrease in. And those are veterans who are not currently getting mental health services. And I think that that really makes what my good friends from the VVA and the IAVA talked about critically important, and that is outreach. And the things that we have put into place so far are having an effect but we have to do more, and we will continue to do that and we will work with them and get their input and their ideas. And I don't think they actually know how valuable they have been up to this point. I think that the influence Tom Tarantino and Tom Berger have had on our current campaigns has been tremendous and we thank them for that, and we ask them to keep hanging in there with us.

We are getting it right and we are going to continue to get it right. And I am going to end my testimony with a story that maybe talks about how we do get it right. And there are as many of these stories as there are stories of people where we honestly get it wrong, and somehow we have to bridge that gap and I promise to do that. In August of this year, we heard from our benefits people that they got an email inquiry from a veteran who was currently living in Germany. And his question to them was if I kill myself, will my wife and children still get their benefits. And this was an email question through our email IRIS help line.

Having had the training and knowing that that was a warning sign, they notified the people in the crisis line that this veteran may be in trouble. The people at the crisis line called this veteran in Germany, they found him, they talked to him, they talked to his wife. Truly he was in a great deal of distress, he was having a lot of physical pain, he wasn't getting the care he needed, but he thanked us for calling him and moved on. Something didn't sit right in the responder's mind after he hung up that call and he called him back. And truly, the veteran had left his house and his

wife said I don't know where he is and I can't find him. We did track him down. We found him.

In the meantime, we had contacted the wounded warrior project people, people who also partner with us to provide services, who arranged for transportation from Germany to the United States for this veteran if he would agree to come. We contacted a suicide prevention coordinator in California who found him placement in a program. We called him back. Between us and his wife, we talked him into services. We got him on a plane, we got him into California and as of 90 hours later he was in care, in treatment and is alive today. While that is an extraordinary story, again, it is only one of many, many that we could tell over the past 3 years. And we can't stop until those stories don't need to be said anymore. That people get the services way ahead of time, they get the care that they need and that dying by suicide is not an option for America's veterans, and that is our goal.

So Madam Chairwoman, thank you for the opportunity to be here. Our services will continue. We greatly appreciate your support in this area. And Dr. Zeiss and I are prepared to answer your questions.

Ms. BUERKLE. Thank you very much, Dr. Kemp. And thank you for speaking from the heart. So often the Committee is frustrated by folks who stick to their script and it is almost irrelevant to the testimony that was heard before them. So thank you very much and thank you for what you do.

[The prepared statement of Jan Kemp appears on p. 71.]

Ms. BUERKLE. Dr. Harrell, my question to you is, in your testimony, you testified that we seem to know more about suicide among our military rather than our veterans. Can you explain why you think that is?

Ms. HARRELL. Yes. Thank you. I would be happy to. As Dr. Kemp did note, they have recently received data for 2009, but the data that they received was for those veterans who did receive VA care. The estimate of 18 suicide deaths amongst our veterans every day represents, in large part, extrapolations from the States' death data. In other words, there are 16 States that note on their death certificate whether an individual who has died had served previously in the military. For the other 34 States, the estimate is just that, it is an estimate, it is an extrapolation. So not only when we say 18 deaths a day is that extrapolated for the majority of States, but it is 3 years delayed. And so that is why I assert that we really don't know enough about our veterans that are dying by suicide. We do not, for example, know whether those deaths represent veterans of Iraq and Afghanistan, or whether those are Vietnam veterans that are dying by suicide. We don't know who they are.

Ms. BUERKLE. Thank you. Dr. Watkins, in your testimony, you talked about adherence to a drug protocol and how important that is. And you mentioned that there are no clinical registries within the VA system. And clinical registries are pretty basic with regard to tracking patients and their compliance with a program. Can you speak to that, as well as speaking to the assessment and the treatment plans or the lack thereof?

Dr. WATKINS. Well, the VA does have registries but they are not clinical registries. And what I mean by a clinical registry is some-

thing that an individual clinician or an individual administrator can use to pull up all their patients with a particular diagnosis. So, for example, all their patients with depression. And then they can easily see who has missed an appointment, who hasn't filled their medication. And then you could go and do outreach and try to target that particular patient. That is what I mean by clinical registries. And I think that could be incorporated into their medical record fairly easily and could go a long way to identifying people who are dropping out of treatment.

In terms of the assessment, when we did the study, there was no standardized packet of assessments, so we found a lot of variability around what people were getting. For example, I told you about the housing and employment services. The differences between the best performing VISNs and the lowest performing VISN was 26 points. So I think that there is something being done by the best performing VISNs that is not being done by the worst performing VISNs. And I believe that a central directive that says this is what an assessment should consist of, every veteran needs to get this assessment, here are some templates that are going to help you make sure you remember to do those assessments that could really be beneficial. Because like I said, they do a great job. I think 95 percent of the veterans were assessed for suicide. That is really terrific. And when they found someone who was suicidal, they got good treatment, they got appropriate referral. But we have to go beyond, we have to figure out how to prevent people from becoming suicidal. People don't all of a sudden become suicidal, it starts before then, usually with a mental illness.

Ms. BUERKLE. Dr. Kemp, would you like the opportunity to perhaps speak about if there are any initiatives in the VA with regard to those kinds of registries that would have a database of those who have indicated they are suicidal and on medication?

Ms. KEMP. We currently have, and then I will let Dr. Zeiss explain from a broader mental health perspective what we are doing. For patients who have expressed some degree of suicidal ideation, hopefully before they become actually suicidal or have a plan, et cetera, we do include them in what we call our high risk database. And this high risk designation allows us to put chart notifications on their charts so all providers are aware of their concerns. It pushes them into a different level of care and enhanced package of care, we call it. And we do monitor them for a period of time after this designation. The gap, as is pointed out, is defining ways and figuring out ways to move these people into that level of care sooner. And to do that we have developed treatment planning, software that Dr. Zeiss will talk about the implementation of and other mechanisms within mental health to assess that and make that happen.

We are excited about our recent integration of mental health into our primary care teams with our patient-centered model and we have done a considerable amount of training and will continue to train these teams of people so that perhaps we can catch people earlier in their whole health care process where they wouldn't need to be referred to mental health to get those kind of services and those kinds of care, that it would happen from their primary care team.

Ms. BUERKLE. Thank you. My time is expired and I want to give my colleagues a chance to ask questions and then I will come back. I am sure I will have a second round of questions. I now yield to the gentleman from Maine, Mr. Michaud.

Mr. MICHAUD. Thank you very much, Madam Chair. This question is for the panelists, all of you. You heard VBA earlier. What are your thoughts on their recommendations that both the VA and the DoD should use the PTSD protocol and guidelines suggested by the IOM, any comments?

Ms. HARRELL. I would like to defer evaluation of that tool to those with specific medical expertise. But I would like to encourage the extent, any extent possible that the DoD and the VA join forces on this effort.

Dr. WATKINS. I can't speak to the validity of that tool, but I think it would be a mistake to focus all of your efforts on PTSD. I actually think there are higher rates in people with bipolar disorder, substance abuse and depression, and so it is really critical that you look at those as well.

Ms. KEMP. I am going to let Dr. Zeiss talk about the PTSD tool.

Ms. ZEISS. Well, I am glad that Dr. Berger brought up that tool. It was developed by the National Center for PTSD that is part of VA. And there are two versions of it. One is a clinical assessment tool and the other is for use in doing an interview in the context of a CNP diagnostic interview. And I have really made it a priority to try to bring this tool into focus for our assessments. I think it is an excellent tool. And I appreciate the persistence that VBA has shown in ensuring that it stays in focus. And since I have been chief consultant the National Center for PTSD has a national mentoring program for PTSD to increase the consistency of care and utilization of best practices, and they are doing training throughout the country in use of this clinical tool.

And we also have a study that has been completed looking at it in the context of CNP exams that was very positive in terms of its utility. So there is more for us to do, absolutely, but I think we are on that track. I also agree with what Dr. Watkins said, that we can't just attend to PTSD, there are other disorders that need very significant attention. But for those with PTSD, I do think consistent reliable valid assessment is very important.

Ms. KEMP. So the short answer to that question is yes. But in addition to that, the DoD and VA currently are developing clinical practice guidelines along those same lines specifically for suicide prevention. And we will jointly implement those as soon as they are done.

Mr. MICHAUD. My next question actually is for Dr. Kemp. You have 300 vet centers. They provide a great service for all veterans, as well as active duty Vet centers have active duty personnel come in on their furlough days to get help and mental health addressed. My concern being is, are you fully staffed in all those vet centers with the appropriate personnel?

Ms. KEMP. I would have to defer that to Dr. Batres from our readjustment counseling service. But my experience is yes, they are incredibly awesome and responsive people. The readjustment counseling service which the vet centers fall under have also developed an on-line peer support call center which we use at the crisis line

to move callers back and forth from and we support each other. Another huge attribute to this system are the soon-to-be 90 mobile vet centers that travel across the country providing care to people in remote and distant areas. I think that the pieces are in place and if we can get them to the veterans and veterans to them, we are well on our way to making sure things happen.

Mr. MICHAUD. My next question requires simply a yes-or-no answer. The Military Office Association of America recommended that it require the VA and the DoD to establish a single strategy in a joint suicide prevention office that reports directly to the Department secretaries through a senior oversight committee. Do you support that proposal?

Ms. HARRELL. Yes.

Dr. WATKINS. Yes.

Ms. KEMP. Not the way it is written.

Mr. MICHAUD. Thank you, Madam Chair.

Ms. BUERKLE. Thank you. I now yield 5 minutes to the gentleman from Texas for questions.

Mr. REYES. Thank you, Madam Chairman. I was curious for your comments on what can be done to improve outreach to our service-members. Particularly, we have heard a number of comments today in the context of younger veterans versus the older veterans and the lack of a tracking system. So can you, do you have any thoughts on that, any recommendations?

Ms. KEMP. Of course I have thoughts. We have made huge strides in the past 3 years providing outreach in different access modes to younger veterans. We realize that they communicate differently and we have to go to them, we can't wait for them to come to us. To that end, we have developed a veterans chat service. This is actually the first formal announcement that this month we opened a texting service so people can text the crisis line. It is having a remarkable response and going really well. We have *Facebook* pages. We monitor those pages. We have *Facebook* monitors who look for people in difficulty. We have partnered with and contracted with a nationally well-known advertising firm to help us develop some messages and new marketing strategies. We have rebranded the suicide prevention hotline into the veterans crisis line in order to better portray what we do and reach people, and the results of that have been tremendous. And we have put in PSAs out there that have been well received, some newer ones.

You have heard references to the Make a Connection Campaign which is incredible actually. And we partnered with the entertainment council to make that happen and make that happen right. Dr. Sonya Batten is organizing that program and is doing an exceptional job. But it is the tip of the iceberg. And I think what we need is to continue to listen and not only listen, but get help and support from people like IAVA and Student Veterans of America, and as Tom said, from people. I mean, veterans are people, and we need to listen and get their input and find out how to get that message across. And I don't think we are going to have an answer tomorrow, but we have to start putting what we know now into effect like we have been, and just keep going and pushing and not stop putting the resources into that area.

I mean, it bothers me a great deal when I hear about veterans who don't know what the VA does. I mean, there is no reason for that in America today.

Mr. REYES. What about the comment, I think it was Dr. Berger that made, which I have found to be true as well, in terms of veterans relating to veterans? How do we bridge that? Is this texting, is that intended to do that?

Ms. KEMP. I think it helps. And I think other ways that we do it are very formal and then also very informal. And we do have peer support processes set up at all of our facilities, we have our vet centers who provide that vet-to-vet communication, we have veterans who work on our crisis line and in our facilities who provide that vet-to-vet sorts of options for people. Right now we are working kind of behind the scenes to develop what I am calling some buddy programs.

Sometimes I think veterans don't need a peer counselor or want a peer counselor, but they might want a buddy, they might want a friend, they might want someone they can call in the middle of the night who will go bowling with them or take a walk with them or just tell them that things are okay. And I think we have to help those relationships form. So I think we can work in arenas like that. The veteran service organizations like VVA have been very supportive in helping us think about those sorts of programs.

So I think that is the direction we have to go. And we have to really work with our communities. Veterans live in communities. There is a move in America right now, I think, to become involved and to make a difference and it behooves us now to help people do that.

Mr. REYES. Thank you, Madam Chair. Thank you.

Ms. BUERKLE. Thank you. I am going to yield myself 5 minutes for questions. If you will indulge us, we will have a second round of questioning. Dr. Watkins, I was very impressed and really struck by the fact that in your testimony, you talked about those who have committed suicide have contact with either a primary care or a mental health provider prior to the year that they committed suicide.

So much of what we are talking about today is awareness among our veterans and our military that there are services. But now these folks were in the system. So I would like, if you would, to speak to that as to were there any reasons why that would occur that they are actually in the system, they are getting care and yet they still committed suicide.

Dr. WATKINS. Yes. That study didn't actually look at what the quality of the care that they were getting, that was not our study, I am referring to a different one there. But I think what it points to is the opportunity that exists for intervention and the importance of providing good quality care once the person walks in the door. I think what we know and what Dr. Kemp and Dr. Zeiss said, is that if they get to specialty mental health care it seems like they are getting good care and the rates of suicide are going down. It is in the primary care settings that that is not happening. And so perhaps we need to focus our efforts on providing good quality care in the primary care settings.

Ms. BUERKLE. Based upon your research, how would you do that within the primary care arena?

Dr. WATKINS. I think one of the most important things is registries. So again, a way to allow the individual clinician easily, not with the assistance of a computer programmer, but in real-time at their desk to be able to pull up their panel of patients and see who missed their appointment. Because probably it is those people who are missing appointments or are not showing up or who are missing their medication refills, those are probably the ones who are struggling the most. That is a hypothesis, but I think it makes sense. I think that attention to infrastructure is really critical. The VA has a wonderful medical record system but it could do more. And it is amazing to me that the bottleneck seems to be the computer programming. Like that they have treatment planning software but it can't be incorporated because the computer programmers—

Ms. ZEISS. It is now.

Dr. WATKINS. It is now? That is terrific. So it took several years. That seems unacceptable.

Ms. BUERKLE. This question is for Dr. Kemp. The VA has established mandatory screening for depression. We were just talking about it is not all PTSD, it is depression, it is substance abuse. So you have mandatory screening for depression, but does VA conduct periodic reviews to assess and to see where those patients are?

Ms. KEMP. Those screens are done on a minimum of an annual basis. And if someone does screen positive for depression or PTSD, that requires at least a basic assessment for suicide and suicide ideation.

Ms. BUERKLE. Dr. Watkins, would your registry take care of that if they had been assessed for depression, they have been diagnosed with depression, if there was a registry in place, then that would continue to monitor?

Dr. WATKINS. They would go into the registry, and someone could follow them. And that might be a person who you might want to screen—if for some reason, that person chose to not have treatment, which some veterans may choose to not have treatment, maybe that registry would clue the clinician in so that every month an outreach, some kind of outreach call was done. And the veteran—or maybe they showed up for their podiatrist appointment. You know, then the podiatrist would know and might say, okay, let's check in with you and see how you are doing. It is that kind of wraparound services that I think—what I call a clinical registry would help.

Ms. BUERKLE. Thank you.

Dr. Kemp, just in my few seconds that I have left, section 304 of the public law 111-163, the Caregivers and Veterans Omnibus Health Services Act of 2010, provided that the VA establish a program to provide mental health services to members of the immediate family of OIF and OEF veterans. I think what we have heard this morning and this afternoon is that the family is such a big part of this, and understanding symptoms, and what to do with all of the information that they are perceiving. Has this program been implemented?

Ms. KEMP. Yes. We are able to provide those services to include families in our care for veterans. As a matter of fact, all really high-risk veterans are required to provide us—required is a loose term—with family contacts that we then work with to help us and help them recognize signs of when they might be getting into trouble, when they are at higher risk.

We are also working very closely with our department of social work, who is working right now with SAMSA to help identify modes of referral and to community resources for families when we are not able to do that to assure that those services get done.

Ms. BUERKLE. Thank you.

Our information is a little bit contrary to that and indicates that that has not been implemented for the families. So if you could specifically, and maybe you don't have the information now, which VA centers have you implemented that to include immediate family outreach?

Ms. KEMP. Yeah. I will take those questions, if I could, for the record, and get those responses back to you.

Ms. BUERKLE. Thank you very much.

I now yield to the gentleman from Maine, the Ranking Member, Mr. Michaud.

Mr. MICHAUD. Thank you very much. Yeah, I would be very interested also in seeing that information. So what you are saying is you have the rules and regulations already adopted for that section, and it is underway.

Ms. KEMP. It is underway.

Mr. MICHAUD. Are the rules and regulations all adopted?

Ms. KEMP. The policies and procedures are already in place that allow us to respond to that recommendation. And again, I think you are going to see, like you have heard before, that there are varying degrees of implementation. I think there is variability among the system. And we will help figure out where it is happening and where it is not.

Mr. MICHAUD. I would be very interested in that, because I am under the same understanding, that it has not been implemented.

I guess this one is for Dr. Watkins. Just reading over the testimony from Lieutenant Colonel Michael Pooler from the Maine Army National Guard—I am disappointed DoD is not here today, but I don't know if you have done any studies that was raised in his testimony, where he talks about those who buy TRICARE have a very difficult time finding clinicians who will see them. And many clinicians that want to help soldiers find the process to become a TRICARE provider extremely cumbersome. He goes on to state that someone other than the providers needs to maintain the TRICARE Web site to ease the frustrations soldiers find when they are looking for help. Have you done any research on TRICARE and the effects?

Dr. WATKINS. That is a great question. And I think that is research that needs to happen. We don't know the quality of care provided by TRICARE—the quality of mental health care provided by TRICARE or the DoD. And that is a really important study that I think needs to be done.

Mr. MICHAUD. Thank you.

And I guess it is more of a comment, Madam Chair, is reflecting on when we did a codel a number of years ago to Iraq and Afghanistan, and this is a concern I have when you look at, particularly in the Department of Defense, is every trip we have been on, I would always ask the generals when they give us a briefing is, what are they doing personally to help destigmatize the problem with PTSD and those that have traumatic brain injury? And the second part of the question is whether or not they need any additional help. And the response I get over and over again is the same response we have here in D.C., is things are fine; we have the resources we need; we are taking care of them. The problem being is right after that meeting, someone with much lesser rank pulled me aside and says, we are not getting the help that we need. And the suggestion was that I talk to the clergy.

And for the rest of that trip and every other trip since then I did talk to the clergy. And the interesting thing is the fact that more and more soldiers are going to them. So evidently there is a disconnect between those that are in the decision-making mode to provide help for the soldiers. If they tell us that things are okay, and really, they are not, and if you look at the statistics with the increased amount of suicides among our active military today, then I think we have to look at doing things differently, and how can we provide those services for the active military personnel as well as our veterans? And when I read Lieutenant Colonel Pooler's testimony with the problems that they are seeing within the TRICARE system, I think we can do a much better job than what is currently being done. But if we do not have the folks that are in that decision-making process recognizing that, then I think we have that extra hurdle we have to get over.

I noticed, Dr. Watkins, you were a little——

Dr. WATKINS. I think you need data. I think you don't know. I mean, that is really what our VA study was, was an independent evaluation from outside the VA looking in. And I think that is what makes it so powerful. Because I think you don't know what is going on, in that you have basically anecdotal evidence about what is going on with TRICARE and what is going on with the DoD. And unless you get data, you really don't know. And I think it speaks to what Dr. Harrell said about suicides; you have to have data before you really know what is going on. So I would encourage you to think about getting data about what is happening, the quality of mental health care provided by TRICARE and provided by the DoD. Because then you can go on and make a difference.

Ms. BUERKLE. Thank you. I have one last question for all three of our panelists. Part of what we heard this morning, and I have heard this on several occasions in other hearings, are that there are a lot of services out there, but they are not well coordinated, and they are not collaborating their services. So the veteran, and Dr. Roe mentioned it earlier, is maybe visited by 10 people at his bedside rather than one point person. So where is the balance in all of this? I would like to give all of you the opportunity to respond.

Ms. HARRELL. Madam Chairwoman, I am not quite sure how to answer where the balance is in all of that. I would confirm your perception that there are many programs out there. I think, in

many cases, the multitude of programs are a result of the recognition that this is a crisis before us. And as a result, we have programs running in parallel with one another, inefficiencies resulting, and the risk of programs, especially at the State level, being canceled due to competing resources.

Dr. WATKINS. I think you need to ask the veteran what they want. Some veterans may want 10 people coming in. Other people may want one. I think what you don't want is duplication. And one of the things we found in our study was that this common electronic medical record, if you move across a VISN, across a region, like say you are a snowbird and you move from Minnesota to Florida, your VA provider in Florida has a great deal of difficulty accessing your records from Minnesota. That is not easy to do. And so that Florida provider has to redo all the assessment. They can't count on, they can't learn from what has already been done before.

So, in terms of trying to prevent duplication, I think making a common portal or having—a common portal exists, but making it easier for clinicians to access the data across VISNs or, you know, within different medical centers within a VISN, I think would go a long way toward preventing duplication. And that would be a first step.

Ms. BUERKLE. Dr. Kemp, before you have the opportunity to answer that question, why is it so difficult for the information to be transferred from VISN to VISN? If you know, or if you could provide us with that information.

Ms. KEMP. Actually, I am going to have to find out. Because I can travel from VISN to VISN and see anyone's record. And I can see anyone's record from my office in Canandaigua or Washington, D.C. And I know from working in the field and being the clinician, I never had difficulty finding information out about patients that were being seen somewhere else. So I suspect that we might have some provider education issues that we need to address. If the providers that Dr. Watkins talked to were having trouble, we perhaps need to explain better how to do that. But the capability is there for that to happen.

Dr. WATKINS. My understanding is that part of it has to do with how the patient is counted, right, who gets credit for the patient. And it has to do with having the appropriate authority to be able to access that common portal. Anyway, we can—

Ms. KEMP. It is a new problem.

Ms. BUERKLE. If you could, Dr. Kemp, we would really appreciate that information and your assessment of follow-up to Dr. Watkins.

Ms. KEMP. Certainly. Certainly.

Ms. BUERKLE. And did you have an answer to the balance question?

Ms. KEMP. Of course. Actually, I think there isn't. That is a tough question. And I think there is a fine line between multiple services and not coordinating those services and choices. And I think we sometimes lose attention to the fact that veterans do have choices. And they don't have to come to the VA; they don't have to get care from particular people. And we need to make sure they know about those choices.

We do need to coordinate care within systems, while still protecting patients' privacies. And so that is a fine line that we need

to walk. I think, most importantly, we need to know about all of the services that are available and the programs available so that we have a wide range of options to be able to provide people.

Ms. BUERKLE. Thank you.

And I would say we talked earlier, someone mentioned mentoring and a system like AA has, having someone stay with you. I know that there is a relatively new program Team Red, White, and Blue, and that is what they believe. They believe that that person coming out of military, that new veteran needs someone to be with them to monitor all of these different aspects of their life, and to really mentor them and help them with that transition. So it seems to me there is an appreciation of the needs out there. But one of the problems we have is just coordinating them all. And then, as Dr. Watkins mentioned, making sure it is what the veteran wants.

I would be interested to know in your study, Dr. Watkins, that Rand Corporation did, if there were conversations with the veterans, are they getting what they need? Did they identify areas where they would like to see things a little different?

Dr. WATKINS. That is so interesting. We did do a telephone survey of 7,000 veterans, where we called them up and asked them about their experience with VA care. And what is interesting is actually most veterans were really satisfied. We also asked about timeliness, which has to do with how long did you have to wait for an appointment? And did you get an appointment as soon as you wanted? And if it was an emergency, did you get an appointment as soon as you wanted? And again, over half, most of them said that their care was timely. So, again, I think it is interesting what data provides versus what—because I think you will always have some people who don't get what they need. But when you have data, it allows you to put it in context.

Ms. BUERKLE. And I think the sad part of that is the folks who apparently needed the services who do commit suicide aren't getting what they need.

Dr. WATKINS. Exactly. It should be a hundred percent.

Ms. BUERKLE. That is why we are here today.

Before we adjourn our hearing this afternoon, I would like you to turn your attention to the monitors for an airing of the VA's latest public service announcement addressing suicide prevention.

[Video shown.]

Ms. BUERKLE. Our message here today with this hearing is that to any servicemember, veteran, or civilian loved one listening today, suicide is never the right answer. If you are hurting, hope and help are available to you at any time. Please call the VA crisis hotline number at 1-800-273-TALK, and press one if you are a veteran.

With this, I ask unanimous consent that all members have 5 legislative days to revise and extend their remarks and include any extraneous material.

Without objection, so ordered. I want to thank all of you again, to our first panel and our second panel, for being here today, and for all of the members in the audience for joining today's conversation.

As I mentioned earlier, this is just the beginning of a very important conversation. And we will work to get DoD and the National Institute of Mental Health in here, along with, it was suggested by some of my colleagues that we get Secretaries Shinseki and Pannetta in here for a hearing as well. So we will continue this conversation. It is of the utmost importance. And our veterans deserve that.

Before we adjourn, I would just like to ask you to always remember the men and women who serve our Nation so valiantly and keep us safe.

And to all of our veterans, this is a good opportunity to thank them for their service. To any veterans in the room today, thank you very much for your service to this Nation.

With that, our hearing is adjourned.

[Whereupon, at 1:22 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Ann Marie Buerkle, Chairwoman, Subcommittee on Health

Today we meet to search for answers to the most haunting of questions—what leads an individual who so honorably served our Nation, out of helplessness and hopelessness, to take their own life and how can we prevent such a tragedy from happening to one who has bravely worn the uniform and defended our freedom.

Suicide is undoubtedly a complex issue, but it is also a preventable one and I am deeply troubled by its persistent prevalence in our military and veteran communities.

The statistics are sobering—eighteen veterans commit suicide each day with almost a third receiving care from the Department of Veterans Affairs (VA) at the time of their death. Each month, there are 950 veterans being treated by the VA who attempt suicide. The number of military suicides has increased since the start of Operations Enduring Freedom and Iraqi Freedom (OEF/OIF), with data from the Department of Defense (DoD) indicating servicemembers took their lives at an approximate rate of one every 36 hours from 2005 to 2010.

We continue to hear tragic stories despite significant increases in recent years in the number of programs and resources devoted to suicide prevention among our servicemembers and veterans.

Today we will hear from VA and DoD that they are making strides in identifying at risk servicemembers and veterans and providing treatment for mental health and other disorders that can lead to suicide.

Yet, no matter how great programs and services are, if they do not connect with those who need them, they do no good at all. VA and DoD continue to struggle with persistent obstacles including data limitations, cultural stigma, access issues, a lack of partnerships with community providers, and outreach that relies on the servicemember, veteran, or loved one to initiate treatment.

We must do more to reach out to veterans inside and outside of the VA and DoD health care systems to ensure that all those who need it get the help they earned and deserve before time runs out.

Until a family no longer must bear the pain of losing a loved one, we are failing and not enough is being done.

I thank you all for joining us this morning. I now recognize our Ranking Member, Mr. Michaud for any remarks he may have.

Prepared Statement of Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health

I would like to thank everyone for attending today's hearing.

It is a tragedy that our servicemembers and veterans survived the battle abroad only to return home and fall to suicide. Since 2007, this Committee has held five hearings regarding the issue of veterans' suicide, and the figures continue to increase at an alarming rate, far greater than the comparable suicide rates among the general population.

The Center for a New American Security, in a recently published study entitled, "Losing the Battle: The Challenges of Military Suicide," says that from 2005 to 2010, servicemembers took their own lives at a rate of approximately one every 36 hours. This statistic is troubling, but it pales in comparison to VA's estimate that one veteran dies by suicide every 80 minutes.

While I commend the VA's efforts to reduce the suicide rate, particularly with the success of its Veterans Crisis hotline, challenges still remain. Through this hearing, we will examine the steps the VA is taking to strengthen data collection, to pinpoint veterans who may be at risk, and to offer effective intervention. In this process, we

will also seek to better understand the reasons why more and more servicemembers and veterans are taking their own lives and what VA and DoD are doing to put a stop to more suicides.

I'd like to thank our panelists for appearing before us this morning. Particularly, I'd like to commend Dr. Jan Kemp for her leadership. Under her direction, the VA has made great strides in its suicide prevention efforts. Dr. Kemp's work is award winning, and she was named the Federal Employee of the Year in 2009.

I'd also like to thank the Maine Army National Guard for submitting written testimony and for their efforts to ensure that every Soldier has access to the care they need. The Maine Army National Guard already has a close working relationship with the Suicide Prevention staff at Togus VA hospital. This is a relationship that must be replicated on the national level through cooperation between the VA and the DoD. Unfortunately, as the Maine Army National Guard testimony points out, too many soldiers—including those not eligible for VA benefits and those who do not have health insurance—struggle to find care.

I look forward to hearing from all our witnesses today to discuss how we can improve access, treatments, and prevention efforts to best serve our Nation's veterans. Thank you, Madam Chair, and I yield back.

**Prepared Statement of Hon. Silvestre Reyes, Democratic Member,
Subcommittee on Health**

Thank you Madam Chair and thank all of you for coming here today to talk about this issue that is plaguing our veteran community. It seems like every time we talk about this issue, the problem is getting worse and not better. The fact that there are nearly 950 suicide attempts per month by our brave men and woman who have served this country is more than just a problem. It is a crisis.

If I remember correctly, in 2006 that is about half the number of attacks our servicemembers endured a month in Iraq. Our soldiers, enabled by congressional action, found a way to reverse that trend. All they needed was the right tools like mine resistant vehicles and upgraded body armor to do their job and defeat the enemy. We were able to get that equipment to them at a pace most people didn't think was possible.

What we need to do now is identify what tools these veterans need to fight the enemy within. So please help us figure out what we need to do to protect those who have protected us, and we will do our part to ensure they get it as soon as possible.

**Prepared Statement of Commander René A. Campos, USN (Ret.), Deputy
Director, Government Relations, Military Officers Association of America**

A decade of war has placed unprecedented demands and stressors on our warriors and their families that will leave scars and unintended consequences for generations to come.

The Departments of Veterans Affairs (VA) and Defense (DoD) have long been faced with the daunting challenge of meeting a significant range of medical and rehabilitation issues. MOAA is particularly concerned about the exponentially growing need to address mental health, behavioral and cognitive conditions, in light of the rising rates of suicides, alcohol and substance use, and a variety of other issues playing out among veterans, servicemembers and their families.

A number of reports support our concerns:

- 2008 VA *"Blue Ribbon Work Group on Suicide Prevention in the Veteran Population"*
- RAND Health/National Defense Research Institute
 - 2008 *"The Invisible Wounds of War"*
 - 2011 *"The War Within, Preventing Suicide in the U.S. Military"*
 - 2011 *"Addressing Psychological Health and Traumatic Brain Injury Among Servicemembers and Their Families"*
- 2011 Center for a New American Security (CNAS) Report *"Losing the Battle: The Challenge of Military Suicide"*

The current statistics are disturbing and point to an even greater need to wage an all out battle to end suicide. This will require a sustained national commitment at all levels of government if we are to rid veterans of the psychological and traumatic physical conditions that are threatening their lives and the health and well-

being of their families. Sadly these statistics represent the heroes who protect our country and our freedoms:

- 20 percent of suicides in the U.S. are former servicemembers
- One currently serving member died every 36 hours during the period 2005–2010
- 18 veterans die a day—that is one suicide every 80 minutes

Recommendations

MOAA offers three specific recommendations to address current barriers to care:

- ***Require VA-DoD to establish a single strategy and a joint Suicide Prevention Office that reports directly to the Department Secretaries through the Senior Oversight Committee (SOC).***
- ***Authorize funding to expand VHA mental health capacity and capability in order to improve access and delivery of quality and timely care and information.***
- ***Authorize additional funding to expand outreach and marketing efforts to encourage enrollment of all eligible veterans in VA health care, with special emphasis on Guard and Reserve members, rural veterans, and high-risk populations.***

MADAM CHAIRMAN AND DISTINGUISHED MEMBERS OF THE SUBCOMMITTEE, on behalf of the 370,000 members of the Military Officers Association of America (MOAA), I am grateful for the opportunity to present testimony on MOAA's observations concerning the Department of Veterans Affairs' (VA) suicide prevention programs and efforts.

MOAA does not receive any grants or contracts from the Federal Government.

MOAA thanks the Subcommittee for its interest in this extremely difficult issue and for your leadership in looking out for the health and well-being of our veterans and family members. We also commend the VA for its staunch commitment to enhancing mental and behavioral health programs by working with DoD and other government and non-government entities to help veterans and their families improve their physical and psychological well being.

Overview of VA Suicide Prevention Programs and Efforts

A number of reports and activities have been published in the last 7 years that shine a spotlight on veteran and military suicide and VA's prevention efforts.

In 2008, the RAND Corporation's Center for Military Health Policy Research released a report on "*The Invisible Wounds of War*." The report highlighted the mental health and cognitive needs of combat veterans, focusing on three wounds: post-traumatic stress disorder (PTSD), depression, and traumatic brain injury (TBI).

The report states that, "Unless treated, PTSD, depression, and TBI can have far-reaching and damaging consequences. Individuals afflicted with these conditions face higher risks for other psychological problems and for attempting suicide . . . there is a possible link between these conditions and homelessness . . . the consequences from lack of treatment or under-treatment can have a high economic toll."

RAND made four recommendations that get at these issues:

1. Increase the cadre of providers who are trained and certified to deliver proven (evidence-based) care, so that capacity is adequate for current and future needs.
2. Change policies to encourage more active duty personnel and veterans to seek needed care.
3. Deliver proven, evidence-based care to servicemembers and veterans whenever and wherever services are provided.
4. Invest in research to close information gaps and plan effectively.

Like RAND, our Association believes that restoring veterans to 'full mental health' will be important to reduce long-term economic societal costs.

RAND's *Invisible Wounds of War* was the first study of its kind to estimate that PTSD and depression among servicemembers will cost the Nation up to \$6.2 billion in the 2 years after deployment. The study concludes that investing in proper treatment would provide even larger cost savings—savings that would come from increases in productivity, as well as from reductions in the expected number of suicides.

Additionally, The Journal of Clinical Psychiatry reported that the economic burden of depression to this country was estimated to be \$43.7 billion in 1990. By 2000 the cost burden rose to \$53.9 billion, which included direct treatment costs, lost earnings due to depression-related suicides, and indirect workplace costs.

In June 2008, the Secretary of the VA convened a *Blue Ribbon Work Group on Suicide Prevention in the Veteran Population* to advise on the research, education and program improvements to the prevention of suicide. The Work Group consisted of five Executive Branch representatives, two of which were from DoD.

MOAA was encouraged by the Group's findings. According to the report, the Veterans Health Administration (VHA) had a comprehensive strategy in place and a number of promising initiatives and innovations for preventing suicide attempts and completions.

The Group recommended that VHA:

1. Establish an analysis and research plan in collaboration with other Federal agencies to resolve conflicting study results in order to ensure that there is a consistent approach to describing the rates of suicide and suicide attempts in veterans.
2. Revise and reevaluate the current policies regarding mandatory suicide screening assessments.
3. Proceed with the planned implementation of the Category II flag (patient is at high risk for suicide), with consideration given to pilot testing the flag in one or more regions before full national implementation.
4. Ensure that suicides and suicide attempts are reported and that procedures are consistent with broader VHA surveillance efforts.
5. Ensure that specific pharmacotherapy recommendations related to suicide or suicide behaviors are evidence-based.
6. Continue to pursue opportunities for outreach to enroll eligible veterans, and to disseminate messages to reduce risk behavior associated with suicide.
7. Ensure confidentiality of health records.
8. Ensure ongoing evaluation of the roles and workloads of the Suicide Prevention Coordinator positions.

This year a Center for a New American Security (CNAS) report entitled, "*Losing the Battle: The Challenge of Military Suicide*," published some disturbing statistics, noting that suicide among veterans and servicemembers present challenges to the health of America's all-volunteer force. The report addressed the obstacles for confronting suicide. Although most of the 13 recommendations CNAS offered are focused on DoD and the Military Services, most are applicable to VA, such as:

1. Ensuring transfer of mental health information when members relocate
2. Eliminating the cultural stigma associated with mental health care
3. Holding leaders accountable
4. Increasing mental health and behavioral health care professionals, and addressing gaps in programs for drilling Guard and Reserve units
5. Establishing reasonable time requirements for states to provide death data to the Centers for Disease Control (CDC), and that Health and Human Services (HHS) should ensure CDC is resourced sufficiently to expedite the compilation of national death data. VA, DoD and HHS should coordinate annual analysis of veteran suicide data.
6. Sharing of suicide data between VA, DoD and HHS, including discussion with Veterans Affairs and Armed Services Committees to develop a provision to address veteran suicides.

Two other reports were published this year by RAND's Health/National Defense Research Institute and sponsored by the Office of the Secretary of Defense. The first report, "*The War Within, Preventing Suicide in the U.S. Military*," was intended to enhance the Department's suicide prevention programs and efforts. The second report, "*Addressing Psychological Health and Traumatic Brain Injury Among Servicemembers and Their Families*," provided DoD a comprehensive catalog of existing programs currently sponsored or funded by the Department to address psychological health and TBI. MOAA believes the recommendations of these two reports are also applicable to VA:

1. Increasing and improving the capacity of the mental health care system to deliver evidence-based care
2. Changing policies to encourage more veterans and servicemembers to seek needed care
3. Delivering evidence-based care in all settings
4. Investing in research to close knowledge gaps and plan effectively
5. Taking advantage of programs' unique capacity for supporting prevention, resilience, early identification of symptoms, and help seeking to meet the psychological health and TBI needs of servicemembers and their families

6. Establishing clear and strategic relationships between programs and existing mental health and TBI care delivery systems
7. Examining existing gaps in routine service delivery that could be filled by programs (formal needs assessment and gap analysis of programs)
8. Reducing barriers faced by programs
9. Evaluating and tracking new and existing programs, and using evidence-based interventions to support program efforts

VHA mental health officials estimate there are approximately 1,600–1,800 suicides per year among veterans receiving care in the health system and upwards of 6,400 per year among all veterans. One of the key goals of VA's Mental Health Strategic Plan, implemented in 2004, was to reduce suicide among the veteran population. Out of that plan came a National Suicide Prevention Center of Excellence, a national suicide prevention hotline, a patient record flagging system, and suicide prevention programs in each medical facility.

Speaking at a joint VA-DoD Suicide Prevention Conference last year, VA Secretary Eric Shinseki said every veteran was susceptible to suicide.

"The emotional wounds are no less common than physical injuries; however, they are more difficult to diagnose which adds to the challenge of suicide prevention," said Shinseki. He went on to say that the suicide problem was one of the 'most frustrating' leadership challenges he faces. "Of the 18 veterans who commit suicide each day, five of those veterans are under the care of the VA. Losing five veterans who are in treatment every month, and then not having a shot at the other 13 who for some reason haven't come under our care, means that we have a lot of work to do."

There are a number of predisposing risk factors associated with suicide and mental health disorders that can be diagnosed and treated. Some of these risk factors include:

- PTSD
- Relationship problems
- Financial difficulties
- Substance abuse and addiction
- Ongoing depression
- Social isolation
- Recent illness and/or hospitalization
- Difficulty Sleeping
- Access to firearms

Today, VA has two primary program areas targeting suicide prevention, the National Suicide Prevention Program and the Office of Mental Health Services. Some additional initiatives the Department has implemented include:

- Hiring thousands of additional mental health providers
- Launching a Suicide Prevention Campaign
- Establishing a Veteran's Crisis Line
- Instituting a National Suicide Prevention Coordinator Program
- Directing a suicide prevention safety plan (SPSP) and Practices for high risk patients
- Implementing policy requiring annual depression screening for veterans using VA health care
- Conducting a VA-DoD Suicide Conference
- Establishing a VA-DoD online Suicide Prevention Resource Center

Progress and Challenges

In conducting our research for this hearing, MOAA was struck by the tremendous level of work that had been done, especially in the last 3 years. The steadfast determination of the VA Central Office staff and Secretary Shinseki's personal involvement in synchronizing the agency's national suicide prevention efforts is quite visionary.

MOAA gives VA high marks for rebranding its suicide prevention hotline and establishing a National Veterans Crisis Line. Dr. Janet Kemp, VA's National Suicide Prevention Coordinator is to be commended for standing up the suicide hotline, earning her recognition as the 2009 Federal Employee of the Year. The initiative resulted in more than 5,000 immediate rescues. The crisis line is one of the best initiatives according to Dr. Kemp, answering over 450,000 calls and making more than 16,000 life-saving rescues. An anonymous chat service was added to the crisis line and has helped more than 20,000 people.

Additionally, in less than a year VA has expanded agreements from 18 to 48 states to have veteran status on death certificates. Colorado and Illinois have yet to sign an agreement with VA.

Despite these improvements, the VA concedes barriers still exist that challenge its ability to advance suicide prevention to the level needed.

According to a VA Inspector General's "Combined Assessment Program Summary Report: Re-Evaluation of Suicide Prevention Safety Plan Practices in Veterans Health Administration Facilities," released on March 22, 2011, the VA implemented a number of requirements for taking care of patients identified to be at high risk for suicide. One requirement is that there be a written safety plan that should be placed in the medical record, and, that a copy of the plan is given to the patient. The VA IG noted that generally Department's suicide prevention safety plans (SPSP) were comprehensive but the completion of safety plans for all high-risk patients and the timeliness of the plans needed improvement.

In October 2011, The Washington Post published an article titled, "*VA Lacks Resources to Deal with Mental Health, Survey Finds*." The article stated, "Over 70 percent of the survey respondents to a preliminary survey of VA social workers, nurses and doctors think the Department lacks the staff and space to meet the growing numbers of veterans seeking mental health care. More than 37 percent said they are unable to schedule an appointment in their clinic within the mandated 14-day standard."

Senator Patty Murray (D-WA), chairwoman of the Senate Veterans Affairs Committee requested the survey after conducting a hearing this past summer where veterans diagnosed with mental health issues described long waits for treatment in the VA. In a letter to the Department, Senator Murray wrote, "While I understand the Department has concerns that this survey is not comprehensive, after the countless Inspector General and GAO reports, hearings, public laws, conferences, and stories from veterans and clinicians in the field, it is time to act."

MOAA could not agree more. VA and our entire country must address barriers to mental health if we are to win the war on suicide.

Some of the most significant barriers that impede progress are:

- Limitations on mental health capacity and capability, impacting access and quality and timely care (e.g., funding, resources, staffing, hours of operation, infrastructure).
- Lack of total system accountability, oversight, monitoring and evaluation. VA Central Office (VACO) has a comprehensive strategy and policies, but implementation across the health care system is inconsistent and outcomes vary greatly.
- Limitations in data sharing and documentation of information.
- VA and DoD veteran "warrior cultures".
- Limited opportunities for maximizing collaboration, cooperation, and communication to ensure continuity of care and services in a seamless manner.
- Cultural and societal stigma prevents individuals from seeking care.
- Experiences with unprofessional or uncaring VA employees who don't treat veterans with compassion and respect.
- Medical system policies, procedures and logistical challenges make it difficult for veterans and their families to understand and navigate, especially during times of crisis. The VA culture tends to assume because employees understand how VA works, others should know as well.

Some of these barriers are outside of VA's span of control, as noted in the reports mentioned above.

MOAA believes addressing veteran suicides requires an immediate response and a unified strategy coordinated between the VA, DoD and other Federal agencies. VA and DoD have had difficulty over the years in keeping up with demand for medical benefits and services from OIF/OEF veterans. As operations start winding down in these theaters we can expect demand to continue for a number of decades, and generations to come.

Our country must do all it can to help VA and DoD to ensure our servicemembers have seamless mental health services as they separate or retire from the military—something more than just giving them a Web site or toll free number to call when they need help.

Veterans' families, caregivers and children also deserve special attention because of the tremendous burdens they must carry when dealing with the psychological wounds of their loved ones.

Identifying servicemembers who are at high risk and providing them treatment is critical as these individuals will one day be veterans. The sooner we help these

individuals in and out of uniform the better the long-term outcomes will be for veterans, their families and society as a whole.

What Veterans and their Families Tell Us

Veterans and family members we talk to have seen much progress in improving policies and programs at the national level. However, they don't always see these policies and programs implemented or interpreted consistently at all VA medical facilities.

The real tragedy for some veterans who really need help is that they may give up or lose trust in the system. This may be particularly true for severely wounded, ill or injured veterans and their families dealing with the burdens of complex medical conditions.

Here are what veterans and their families told us about their experiences:

PTSD Veteran and Caregiver-Spouse

- The veteran entered the VA system in 2008 as a high-risk patient for suicide and is still at risk today.
- The Caregiver's current issue is addressing the veteran's difficulty sleeping. It took the VA 2 months to schedule an appointment just to get a fee based referral outside the VA. Now the veteran must wait until May 2012 for VA to do a required sleep study. This Caregiver questions why it takes almost a year for her husband to get the care he needs, especially when VA knows that difficulty sleeping is a risk factor for suicide and the veteran has a history of suicidal ideations.
- "I don't trust VA. My Federal Recovery Coordinator (FRC) and I are constantly fighting with people in the VAMC every step of the way. It's like the VA is fighting with itself—why can't they just do what is right? VA is in the business of saving lives and it shouldn't be focused so much on saving money," said the Caregiver.
- Recommendations to improve care:
 - The FRC should have more authority to make things happen in the VA—they are an integral part of the team and likely to have a better understanding of the veteran's mental condition.
 - Access to mental health services
 - Veterans with mental health issues should have greater access to fee based services if it takes longer than 2 weeks to get an appointment.
 - Veterans should have more control over their appointments—VA needs to do a better job of accommodating their schedules.

TBI Veteran and Caregiver-Mother

- This severely injured veteran with TBI and a number of physical disabilities had to wait weeks to get the attention of a VA provider from the time of his first thoughts of suicide. It took his mother forcing the issue before VA would see him.
- "The VA tries to treat my son like other patients, but normal protocols don't work. He has half of his brain capacity; he can't talk or communicate normally about how he is thinking or feeling, but he does think and feel, he just can't communicate it the way most people do," she said.
- The Caregiver said, "there were been times the VA medical staff have made comments or their actions hurt her son deeply—one VA provider told her in front of her son that he would never be more than a vegetable." Other providers continue to try pushing her son to institutionalized care because that's what the system normally does for veterans with this level of disability. The veteran's bad experiences at the VA have made it difficult for him to want to do any type of therapy today.
- This Caregiver tries to keep her son as active as possible so he won't get depressed. She says he's lonely and doesn't have any friends so it is easy for him to slip into depression.
- Recommendations to improve care
 - Family-caregivers for a veteran with severe brain injury need access to services in times of crisis and need the knowledge and tools on how to deal with suicidal ideations. Providers should be open to using alternative therapies or approaches to help veterans with communication challenges. Providers need to be flexible and may need to look outside the VA if services are not available. Providers must do all they can to draw the veteran into the treatment.
 - Veterans should always be treated with compassion and respect—never as though they are on an assembly line.

PTSD/TBI Veteran and Caregiver-Spouse

- The veteran suffers from a number of serious physical conditions as well as PTSD and TBI.
- There have been two incidents of suicidal ideations. The first one was pain related. The second one was in March of this year.
- “When my husband attempted suicide in March the VA doctor told me to take him to the ER. But the ER had no beds and said he may have to wait 24 hours before one was available. They gave me no alternatives. I was scared and no one in the VA did anything to help us or help me know what to do in a situation like this,” said the caregiver. She went on to tell us that the typical VA response is to give the patient a machine or medication. “We just want VA to treat us like they care.”

Another severely wounded veteran who is an amputee and has TBI told us he was frustrated because his providers seldom talk to him or ask him how he’s doing. Their questions and comments are usually directed at his Caregiver-spouse as though he isn’t even in the room. He said, “I just want them to know I can and want to contribute to my care—when they don’t talk to me it makes me feel like they don’t care about me.”

According to all these veterans and family members, they are unaware if their veteran’s record is flagged or ever has been flagged as a high-risk patient or if the medical record contains a suicide prevention safety plan.

MOAA Recommendations

MOAA concurs with CNAS and RAND that suicide among veterans and servicemembers challenges the health of our all-volunteer force. CNAS points to some compelling questions for our country to consider:

- *If military service becomes associated with suicide, will it be possible to recruit bright and promising young men and women at current rates?*
- *Will parents and teachers encourage young people to join the military when veterans from their own communities have died from suicide?*
- *Can an all-volunteer force be viable if veterans come to be seen as broken individuals?*
- *And how might climbing rates of suicide affect how Americans view active-duty servicemembers and veterans—indeed, how servicemembers and veterans see themselves?*

While MOAA supports many of the recommendations and findings in the reports, studies and investigations mentioned above, the sheer volume of recommendations requires prioritizing efforts for improving VA’s suicide prevention program. Therefore, MOAA encourages Congress to focus its attention immediately on three specific recommendations which will further enhance VA’s suicide prevention efforts as well as help address other systemic issues in its health care system.

MOAA urges:

- ***Requiring VA-DoD to establish a single strategy and a joint Suicide Prevention Office that reports directly to the Department Secretaries through the Senior Oversight Committee (SOC).***

A joint office would be responsible for developing, implementing and integrating strategies, policies and procedures, and providing oversight and evaluation of suicide prevention programs and efforts. Congress needs to continue to be VA’s and DoD’s greatest champion for promoting collaboration, cooperation and communication across and between the two agencies.

A sense of urgency and oversight are needed to address the issue of veteran suicide at all levels of the government. There needs to be a level of commitment similar to that given to wounded warrior issues which came out of the Walter Reed Army Medical Center incident. VA has done a lot to engage with DoD to identify high-risk servicemembers so that a warm hand-off can be made to facilitate continuity of care. But the agency acknowledges a number of challenges still exist because of cultures and the different policies and programs that vary across the DoD and the Military Services.

- ***Authorizing funding to expand VHA mental health capacity and capability in order to improve access and delivery of quality and timely care and information.***

Clearly, reports and studies continue to highlight problems with accessing care and shortages in mental health staffing and infrastructure. The VA should invest in staff training, recruiting, and retention programs in order to maintain the highest

quality workforce and system of care. Caregivers and family members should be provided training, information and tools on how to deal with suicidal ideations and mental health issues.

Congress should fund research to evaluate the efficacy of suicide prevention programs to include a longitudinal study of the economic and societal costs of veteran suicide in this country.

Veterans should have more control over scheduling appointments. The VA must be flexible in delivering care to meet the needs of veterans, including allowing fee based care in emergencies or when wait times exceed 2 weeks.

- ***Authorizing additional funding to expand outreach and marketing efforts to encourage enrollment of all eligible veterans in VA health care, with special emphasis on Guard and Reserve members, rural veterans, and high-risk populations.***

VA recognizes it needs to do a more effective job in working with outside community and faith-based organizations and other government agencies, beyond its current work with veteran and military organizations and other agency partnerships. The VA should reward local medical facilities for expanding their collaborative efforts. A long-term investment in outreach and marketing to improve its image and VA brand is needed to more effectively target these veteran populations.

Conclusion

MOAA believes there is a business case to be made for addressing suicide that should consider the impact on national security and the costs to society.

MOAA has no doubt that, with the will and sense of urgency from Congress, the Administration, the DoD/Military Services, and the VA, we can win the war on suicide. Our veterans and military medical systems have eliminated some tremendous barriers with unprecedented results in saving lives on and off the battlefield. We owe these heroes and their families our full commitment to eliminate remaining barriers to mental health care so they can obtain an optimal quality of life.

MOAA is encouraged by the significant progress made by the VA, and we thank the Subcommittee for your leadership and support in helping our Nation's veterans and their families.

Prepared Statement of Tom Tarantino, Senior Legislative Associate, Iraq and Afghanistan Veterans of America

On behalf of Iraq and Afghanistan Veterans of America's 200,000 member veterans and supporters, thank you for inviting me to speak on one of the most pressing issues facing veterans and their families: the staggeringly high rate of suicide among servicemembers and veterans.

My name is Tom Tarantino and I am the Senior Legislative Associate with IAVA. I proudly served 10 years in the Army, beginning my career as an enlisted Reservist, and leaving service as an Active Duty Cavalry Officer. Throughout these 10 years, my single most important duty was to take care of other soldiers. In the military, they teach us to have each other's backs, both on and off the field of battle. And although my uniform is now a suit and tie, I am proud to work with this Congress to continue to have the backs of America's servicemembers and veterans.

Today's hearing on suicide could not have come at a more critical time. The Army recently reported 30 potential suicides among active duty soldiers and non-activated reservists in October, and 25 potential suicides within the same group in September. These are some of the highest numbers we have seen from the Army since it began releasing suicide data in 2009—and that's just one branch. The Defense Department recently reported that 468 active duty and reserve soldiers, sailors airmen, and Marines committed suicide in 2010. Overall, the Department of Defense tracked 863 suicide attempts. The rate for veterans is likely much higher.

Although we have this limited data about servicemembers, there remains a fundamental gap when it comes to understanding veteran suicide. The VA does not regularly release data on the number of veterans that commit suicide and there is almost no information about veteran suicide among the forty-seven percent of veterans of Operations Enduring Freedom and Iraqi Freedom who never interact with the VA. We therefore only have blurry snapshots of the problem. For example, the VA estimated that in 2009, 6000 veterans committed suicide. It has also said that on average, 950 suicides are attempted each month by veterans who are receiving some type of VA treatment. That's an average of 31 veterans attempting suicide per

day. And again, these tragic numbers only capture the limited segment of veterans who interact with the VA.

One of the greatest challenges in understanding and preventing veteran suicide is this lack of full data. If we don't know the entirety of the problem, how can we solve it? Even in this age of information and technology, we still have no way of tracking veterans unless they interact with a social service that happens to ask about their military service. This is unacceptable. To address this problem, we must think outside the box. IAVA recommends collecting this data by expanding existing services like the Center for Disease Control and Preventions' National Violent Death Reporting System. Currently, the CDC collects data on all manner of violent death—including suicide—in 16 states. Veteran status can be reported to the CDC either through the death certificate or by information collected by the medical examiner. By expanding the database to all 50 states, and requiring medical examiners to report veteran status to the CDC, we can get a clearer picture of the problem.

A critical step to understanding how we can stop veteran and servicemembers suicides is to understand that suicide itself is not the whole issue. Suicide is the tragic conclusion of the failure to address the spectrum of challenges returning veterans face. These challenges are not just mental health injuries; they include challenges of finding employment, reintegrating to family and community life, dealing with health care and benefits bureaucracy and many others. Fighting suicide is not just about preventing the act of suicide, it is about providing a "soft and productive landing" for our veterans when they return home.

The conflicts in Iraq and Afghanistan have resulted in a high incidence of mental health injuries among returning servicemembers. According to a RAND study, nearly one third of Iraq and Afghanistan veterans will develop combat-related mental health issues. Many of these cases will go untreated, and if allowed to fester, develop into severe Post-Traumatic Stress Disorder.

The problems with Mental Health Care within the VA system have been well-documented over the past few years. The VA reports that 18 veterans in their care commit suicide every day. Wait times for mental health care remain unacceptably high, and there are not enough mental health providers to meet the need.

A recent RAND survey of veterans in New York state revealed that many veterans face difficulty navigating the complex systems of benefits and services available to them. While this survey was specific to New York veterans, the results are indicative of veterans' experiences nationwide. Veterans reported that they do not know how to find the services they need or apply for the benefits they have earned. Even when they are able to find services appropriate for their needs, many vets report frustration in accessing these services. Some veterans report long waiting periods to get an appointment at the VA, while others with frequent appointments have reported having to repeatedly re-tell their stories and experiences to a number of different providers. These delays and lack of continuity certainly cannot help a veteran already suffering from mental health issues. This survey also revealed difficulty in accessing services is not limited to the VA; most respondents could not identify a state agency or non-profit that provided direct mental health services.

We also know that many veterans may not be seeking care because of the stigma attached to mental health injuries. Multiple studies confirm that veterans are concerned about how seeking care could impact their careers, both in and out of the military. Concerns include the effect on their ability to get security clearances and how co-workers and supervisors would perceive them. It is critical that we continue to work to reduce this stigma.

To combat this, IAVA recommends that the VA and DoD partner with experts in the private and nonprofit sector to develop a robust and aggressive outreach campaign. This campaign should focus on directing veterans to services such as Vet Centers, as well as local community and state based services. It should be integrated into local campaigns such as San Francisco's veterans 311 campaign. This campaign should be well-funded and reflect the best practices and expertise of experts in both the mental health and advertising fields. For our part, IAVA has partnered with the Ad Council to launch a public service awareness campaign that is focused on the mental health and invisible injuries facing veterans of Iraq and Afghanistan. Part of this campaign focuses on reducing the stigma of seeking mental health care. We are happy to share our best practices from this campaign to aid in this effort.

Tackling Transition: Providing A Stable Environment For Veterans' Transition

Providing a smoother transition from the military to the civilian world is crucial in preventing veteran suicide. Ensuring veterans' access to mental health care is connected to other issues that can contribute to a veterans' sense of stability

throughout their transition home. We must tackle the other contributing factors—such as unemployment and homelessness—that could increase the risk for vets who are vulnerable to suicide.

Finding employment is one of the top challenges facing veterans during their transition from military to civilian life. In 2010, the average unemployment rate for OIF/OEF-era veterans was a staggering 11.5 percent, almost 2 percentage points higher than the national average. This rate is trending even higher so far this year. This leaves veterans wondering where the next pay check will come from, unable to support their families, and unsure of long-term career prospects. Congress wisely addressed this problem recently by passing the VOW to Hire Heroes Act. While this legislation is a critical piece of the puzzle, we must remain vigilant to ensure that the critical programs in the VOW to Hire Heroes Act are implemented.

Some veterans also struggle to find a permanent home. The VA reported that there were more than 13,000 Iraq and Afghanistan veterans homeless in October 2010. Having a place to call home is a foundation upon which to build one's life. Without a home, finding employment, maintaining relationships, and receiving mental health care become more difficult. The number of homeless veterans is already too high. We need to act now to end veteran homelessness. There is no excuse.

Addressing the spectrum of challenges facing veterans during their transition home will go a long way to create a sense of stability for veterans that may be vulnerable to suicide. This is a place you can step up to create a network of support for every veteran as they return home. This robust community of support should be the first line of defense against veteran suicide.

Building A Community of Support

A community of support starts with the families of veterans and servicemembers. These families need to be prepared—and supported—to help smooth the transition of their returning servicemember. In RAND's study of New York veterans, thirty-five percent of military spouses reported that they struggled to reintegrate the returning servicemember into day-to-day family life. Families also reported feeling unprepared for the return of the servicemember; many noted that they did not know what symptoms and behaviors to look for. While there are many resources currently available to assist military families, they are often difficult to navigate and complex to understand. We need to place more emphasis on outreach, education and support for military families so that they in turn can support a returning servicemember.

The responsibility of support does not lie on our military and veteran families alone. Preventing veteran suicide and easing the transition from military to civilian life is our collective responsibility as a community. Veterans consistently report difficulty relating to their civilian peers. In a particularly poignant example, one RAND respondent stated,

“When I'm faced with civilians who don't understand what I've been through, it's really difficult to try [to] get on the same level with them without making [myself] feel pathetic.”

His statement tells us two things: (1) we must connect vets to fellow vets that have gone through similar experiences, and (2) we should raise awareness across the civilian community about the experience of these veterans and their families, and the challenges they face reintegrating into the civilian world.

IAVA has been a leader in connecting veterans to their counterparts across the country. One of the signature features of the wars in Iraq and Afghanistan is that less than 1 percent of Americans have served in either. One of IAVA's top priorities is to connect veterans in local communities and across the country through traditional events and our exclusive Community of Veterans online community. Through IAVA's awareness campaign, in partnership with the Ad Council, we push the message to veterans that they are not alone: there is a community of vets that understands their experiences and has their backs.

But our veterans are not just readjusting to their families or connecting with other veterans. They are coming back to their jobs, using their GI Bill to study at local colleges, and seeking care and services from businesses and providers across the country. We also must focus on extending understanding to spouses and society at large. Teachers and professors should know which of their students are veterans, or the children of veterans or servicemembers. Businesses should invest in the leadership of returning veterans by hiring them. Health care providers must understand the injuries facing these incredible men and women. By promoting awareness, we can ensure that our entire community is able to support our veterans throughout their transition back to civilian life and help stem the tide of veteran suicide.

By accurately measuring the problem, improving access to mental health care, tackling the transition from military to civilian life, and creating a robust community of support for our veterans, we may be able to significantly reduce the number

of veterans that attempt and commit suicide each year. Veteran suicide does not have a “silver bullet” solution. But better practices are out there. We don’t want to ask ourselves if there was something more we could have done.

Thank you for your time and attention.

**Prepared Statement of Thomas J. Berger, Ph.D., Executive Director,
Veterans Health Council, Vietnam Veterans of America**

Chairwoman Buerkle, Ranking Member Michaud, and Distinguished Members of the House Veterans Affairs Subcommittee on Health, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on “Understanding and Preventing Veteran Suicide”. We should also like to thank you for your overall concern about the mental health care of our troops and veterans.

Consider the facts: earlier this spring, troubling data showed an average of 950 suicide attempts by veterans who are receiving some type of treatment from the VA. Seven percent of the attempts are successful, and 11 percent of those who don’t succeed on the first attempt try again within 9 months. These numbers show about 18 veteran suicides a day and about five by vets receiving VA care. These numbers are simply unacceptable to both the veterans’ community and the American public.

Although statistics on suicide deaths are not as accurate as we would like because so many are not reported, as veterans of the Vietnam War and those who care for them, many of us have known someone who has committed suicide and others who have attempted it. VVA believes this to be a very real public health concern that needs solutions now.

To be fair, since media reports of suicide deaths and suicide attempts began to surface back in 2003, the VA has developed a number of strategies to reduce suicides and suicide behaviors that include: the establishment of the Veterans Crisis Hotline and Chatline (in partnership with the Substance Abuse and Mental Health Administration) and a social media campaign emphasizing VA crisis support services; the creation of suicide prevention coordinator (SPCs) positions at all VA medical facilities whose duties include education, training, and clinical quality improvement for VHA staff members; increased screening and monitoring of individuals who have been identified as being at high risk for suicide; and a few research efforts utilizing cognitive-behavioral interventions that target suicidal ideation and behaviors. While these efforts are laudable, VVA continues to believe they have not gone far enough.

So let’s cut to the chase: it is very challenging to determine an exact number of suicides. Some troops who return from deployment become stronger from having survived their experiences. Too many others are wracked by memories of what they have experienced. This translates into extreme issues and risk-taking behaviors when they return home, which is why veteran suicides have attracted so much attention in the media. Many times, suicides are not reported, and it can be very difficult to determine whether or not a particular individual’s death was intentional. For a suicide to be recognized, examiners must be able to say that the deceased meant to die. Other factors that contribute to the difficulty are differences among states as to who is mandated to report a death, as well as changes over time in the coding of mortality data.⁽¹⁾

In addition, according to the American Foundation for Suicide Prevention, in more than 120 studies of a series of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their death. The most important interventions are recognizing and treating these underlying illnesses, such as depression, alcohol and substance abuse, post-traumatic stress and traumatic brain injury. Many veterans (and active duty military) resist seeking help because of the stigma associated with mental illness, or they are unaware of the warning signs and treatment options. These barriers must be identified and overcome.

However, VVA has long believed in a link between PTSD and suicide, and in fact, studies suggest that suicide risk is higher in persons with PTSD. For example, research has found that trauma survivors with PTSD have a significantly higher risk of suicide than trauma survivors diagnosed with other psychiatric illness or with no mental pathology.⁽¹⁾ There is also strong evidence that among veterans who experienced combat trauma, the highest relative suicide risk is observed in those who were wounded multiple times and/or hospitalized for a wound.⁽²⁾ This suggests that the intensity of the combat trauma, and the number of times it occurred, may indeed influence suicide risk in veterans, although this study assessed only combat trauma, not a diagnosis of PTSD, as a factor in the suicidal behavior.

Considerable debate exists about the reason for the heightened risk of suicide in trauma survivors. Whereas some studies suggest that suicide risk is higher due to the symptoms of PTSD,^(3,4,5) others claim that suicide risk is higher in these individuals because of related psychiatric conditions.^(6,7) However, a study analyzing data from the National Co-morbidity Survey, a nationally representative sample, showed that PTSD alone out of six anxiety diagnoses was significantly associated with suicidal ideation or attempts.⁽⁸⁾ While the study also found an association between suicidal behaviors and both mood disorders and antisocial personality disorder, the findings pointed to a robust relationship between PTSD and suicide after controlling for co-morbid disorders. A later study using the Canadian Community Health Survey data also found that respondents with PTSD were at higher risk for suicide attempts after controlling for physical illness and other mental disorders.⁽⁹⁾

Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide.⁽³⁾ Anger and impulsivity have also been shown to predict suicide risk in those with PTSD.⁽¹⁰⁾ Further, some cognitive styles of coping such as using suppression to deal with stress may be additionally predictive of suicide risk in individuals with PTSD.⁽³⁾

Other research looking specifically at combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt, especially amongst Vietnam veterans.⁽¹¹⁾ Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war, and these thoughts can often overpower the emotional coping capacities of veterans.

Researchers have also examined exposure to suicide as a traumatic event. Studies show that trauma from exposure to suicide can contribute to PTSD. In particular, adults and adolescents are more likely to develop PTSD as a result of exposure to suicide if one or more of the following conditions are true: if they witness the suicide, if they are very connected with the person who dies, or if they have a history of psychiatric illness.^(12,13,14) Studies also show that traumatic grief is more likely to arise after exposure to traumatic death such as suicide.^(15,16) Traumatic grief refers to a syndrome in which individuals experience functional impairment, a decline in physical health, and suicidal ideation. These symptoms occur independent of other conditions such as depression and anxiety.

All of this brings us full circle to what VVA has been saying for years—if **both DoD and VA** were to use the PTSD assessment protocols and guidelines as strongly suggested by the Institutes of Medicine back in 2006 (<http://iom.edu/Reports/2006/Posttraumatic-Stress-Disorder-Diagnosis-and-Assessment.aspx>),⁽¹⁷⁾ our veteran warriors would receive the accurate mental health diagnoses needed to assess their suicide risk status.

Once again, on behalf of VVA National President John Rowan and our National Officers and Board, I thank you for your leadership in holding this important hearing on this topic that is literally of vital interest to so many veterans, and should be of keen interest to all who care about our Nation's veterans. I also thank you for the opportunity to speak to this issue on behalf of America's veterans.

I shall be glad to answer any questions you might have.

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VIETNAM VETERANS OF AMERICA

Funding Statement

November 29, 2011

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any Federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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Prepared Statement of Joy J. Ilem, Deputy National Legislative Director, Disabled American Veterans

On behalf of the 1.2 million members of the Disabled American Veterans (DAV), all of whom are wartime disabled veterans, I am pleased to present our views to the Subcommittee on suicide prevention efforts in the Department of Veterans Affairs (VA) and the Department of Defense (DoD).

The increase in suicide among members of the military and veterans, and the innumerable tragic accounts by family members struggling to deal with the aftermath of suicide of a loved one, have raised deep concerns among military leaders, VA health care officials and policy makers, certainly including this Subcommittee. Every suicide by a servicemember or veteran is tragic, and accentuates the need for every effort to be made at multiple levels to prevent it. Unfortunately, suicide is a complex phenomenon and one that mental health experts have struggled to find solutions and strategies to prevent.

According to researchers, suicide seems to most often occur due to a combination of mental health stresses and societal triggers such as a marital or relationship breakup, a job loss or loss of social status, and is often coupled with overuse of alcohol or other intoxicating substances. The same mindset that can cause a person to take his or her own life is often the mindset that also prevents help-seeking behavior. Sadly, there are no easy fixes or answers to this problem, but according to one expert, “in order to prevent suicides, the complexity of behaviors and drivers of those behaviors need to be understood and addressed . . . and this requires collecting and analyzing standardized data.”¹

Mental health experts note that emphasis on several critical building blocks for any effective suicide prevention effort would be early intervention and routine mental health screening for all post-deployed military personnel and veterans, along with ready access to robust primary mental health care and specialty treatment programs for post-traumatic stress disorder (PTSD) and substance-use disorder. However, experts also note that having sufficient mental health programs and providers is not enough—identifying those at risk for suicide would be vital to prevention. Ongoing research is a critical component to assist in the development of evidenced-based screening and risk assessment measures to accurately identify high risk individuals, and in developing prevention strategies. Likewise, an effective communication strategy to increase awareness about what constitutes mental health, aimed at changing attitudes and behaviors about seeking services for mental health challenges, is another key component to addressing this problem.

According to VA, its basic strategy for suicide prevention requires ready access be made available to veterans for high quality mental health services supplemented by programs designed to help individuals and families engage and participate in care, and to address suicide prevention in the high-risk patients that treatment efforts identify.² VA has put in place policies requiring clinicians to conduct routine screenings for depression, PTSD, problem drinking and history of military sexual trauma for all veterans enrolled in VA health care. VA has reported that veterans who screen positive for PTSD are more than four times as likely to indicate suicidal thoughts as veterans without PTSD. For these reasons, if a screening is positive for depression or PTSD, an additional suicide risk assessment is conducted. According to VA, for each veteran identified as at high risk for suicide, a suicide prevention safety plan is developed, components of an enhanced care mental health package are implemented, and the veteran’s medical record is flagged so that all providers are alerted to the suicide risk for the veteran.³

Every VA medical center is staffed with a suicide prevention coordinator. VA has recently re-branded its suicide hotline into a campaign promoting a broader “Veterans Crisis Hotline,” which includes a chat service and a suicide prevention resource center maintained jointly with the DoD on the internet. VA has also been moving forward with programs aimed at reducing stigma and getting veterans to reach out for help. The VA Office of Mental Health Services (OMHS) recently rolled out its new mental health public awareness campaign called *Making the Connection*. This unique campaign is targeted at veterans of all eras of military service, their family members and friends and features personal testimonials from veterans who have struggled with physical injuries and post-deployment mental health challenges following service—and the positive outcomes they have experienced regarding their treatment and personal recovery. The Web site offers mental health information, resources and support as a way of encouraging veterans to seek help when needed. The goal of the campaign is to reduce stigma in seeking help and to build greater

¹ The Hon. Jonathan Woodson, M.D., Asst. Secretary of Defense for Health Affairs, U.S. Department of Defense, Testimony before the United States House of Representatives Committee on Armed Services, Hearing on “Current Status of Suicide Prevention Programs in the Military.” (September 9, 2011).

² Department of Veterans Affairs, Fact Sheet: VA Suicide Prevention Program, Facts about Veteran Suicide. (April 2011).

³ Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans’ Affairs, Hearing on “Mental Health: Bridging the Gap Between Care and Compensation for Veterans.” (June 14, 2011).

awareness of the numerous resources available to improve the lives of our Nation's veterans. DAV appreciates this progress, and we are hopeful the new campaign is successful and improves access and support for needed services for veterans and family members. Despite the implementation of these programs and policies the continuing and troubling suicide rate of veterans still begs the question of what more can be done.

VA estimates that there are approximately 1,600 to 1,800 suicides per year among veterans receiving care within VHA and as many as 6,400 per year among all veterans. This estimate would mean approximately 18 veterans nationally die from suicide per day and five deaths by suicide per day among veterans receiving care in VHA.⁴ Additionally, there are 950 suicide attempts per month among veterans receiving care as reported by VHA suicide prevention coordinators (based on data collected from October 1, 2008 through December 31, 2010). In promoting its Veterans Crisis Hotline, VA notes that, as of July 2011, it has received over 400,000 calls, of which over 5,000 were from active duty servicemembers; VA responded to over 16,000 chats and referred over 55,000 veterans to local VA suicide prevention coordinators for same-day or next-day services; over 225,000 calls received were from family members or those concerned about a loved one. Additionally, VA asserts that the Hotline initiated over 15,000 "rescues," and that there have been over 7,000 rescues of actively suicidal veterans as of April 2011.^{5,6}

Madam Chairwoman and Members of the Subcommittee, this concludes my testimony on behalf of DAV. I would be pleased to respond to your questions.

VA reports that in FY 2010, more than 1.25 million individual veterans were treated in a VA specialty mental health program, medical center, clinic, inpatient setting or residential rehabilitation program. According to VHA guidelines, all new patients requesting or referred for mental health services must receive an evaluation within 24 hours, and undergo a more comprehensive diagnostic and treatment planning evaluation within 14 days. To meet increasing mental health demand, VA has hired over 7,500 full time professional staff since 2005, and during the last 3 years has trained over 4,000 staff to provide psychotherapies with the strongest evidence for successful outcome for PTSD, depression and other conditions.⁷ Unfortunately, despite the significant increase in resources provided by Congress in recent years for veterans' mental health care and VA's efforts to increase staff and implement and improve its primary and specialized mental health programs, we often hear from veterans that are experiencing difficulty gaining access to the mental health treatment they need at a crisis point. We agree with the Congressional Research Service that VA's internal policy requiring providers to make initial assessments within 24 hours, and to begin treatments within 14 days for requested mental health care, is probably not being carried out uniformly and universally.⁸ For these reasons, DAV has recently initiated an informal mental health survey of up to 15,000 veterans focused on access to VA mental health services and the quality of care they are receiving. Although informal, it is our hope that the results of this survey, publicized through our DAV social media sites to all veterans, will provide a snapshot of veterans' experiences, their perceptions of access to VA mental health services, and their satisfaction levels with the treatments and programs that VA offers.

A comparable but much smaller query of VA mental health professionals was conducted at the request of Senate Committee on Veterans' Affairs following a July 2011 hearing that examined the gaps in VA mental health care. The resulting August 2011 report, a very small sample due to the quick turnaround time requested, queried 319 general outpatient mental health providers for each facility within five Veterans Integrated Service Networks (VISNs); and 272 responded. Alarming, al-

⁴John D. Daigh, Jr., M.D., Assistant Inspector General for Health Care Inspections, Office of Inspector General, U.S. Department of Veterans Affairs, Testimony before the United States Senate Committee on Veterans' Affairs, Hearing on "VA Mental Health Care: Closing the Gaps." (July 14, 2011).

⁵Antoinette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans' Affairs, Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." (June 14, 2011).

⁶Department of Veterans Affairs, Fact Sheet: VA Suicide Prevention Program, Facts about Veteran Suicide. (April 2011).

⁷Antoinette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans' Affairs, Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." (June 14, 2011).

⁸Suicide, PTSD, and Substance Use Among OEF/OIF Veterans Using VA Health Care: Facts and Figures, Congressional Research Service, July 18, 2011.

though not surprising based on the feedback DAV has been receiving, over 70 percent of the respondents reported that their facilities had insufficient mental health staff resources to meet veterans' demands for care, and almost 70 percent indicated that their sites had shortages in physical space to accommodate mental health services. Nearly 40 percent reported they cannot schedule an appointment in their own clinics for a new patient within 14 days, and 46 percent reported that lack of off-hour appointment times was a barrier to care. Over 50 percent reported that growth in patient workloads contributed to mental health staffing shortages, and more than 26 percent noted that the demand for Compensation and Pension examinations diverted clinicians from providing direct care.

Based on the results of this VA internal survey and continuing reports from veterans themselves, it appears that despite the significant progress—specifically an increase in mental health programs and resources, and the number of mental health staff hired by VA in recent years—significant gaps still plague VA's efforts in mental health care. The impact of these gaps may fall greatest on our newest war veterans, many of whom are in need of urgent services.

In the active duty ranks, the Department of Defense (DoD) has also been coordinating data collection systems, mental health programs and research studies in an effort to reduce stigma in seeking mental health care and to prevent suicides in the active duty force. Some measureable progress can be seen in the suicide rate among the services, but overall the numbers still remain troubling. DoD acknowledges that providing mental health support to active duty troops is critical in suicide prevention. Likewise, its experts also confirm that effective, accessible, and supportive clinical care for mental, physical, and substance-use disorders are protective factors in preventing suicides. For these reasons, DoD reports it has updated its policies regarding early detection and intervention for combat and operational stress reactions in the deployment theaters. In 2007, the Department initiated a surveillance system to capture suicide data from the Services in a more central and standardized way. In addition to this effort, DoD reports that the Department and VA have developed a partnership to improve mental health access and care to servicemembers, veterans and their families. For the past 10 months, DoD and VA have been collaborating and implementing a DoD/VA joint strategy consisting of 28 strategic actions with specific milestones and outputs. DoD has also partnered with VA in hosting an annual suicide prevention conference that provides an opportunity for the departments to share information and strengthen the provider network across the two health care systems.⁹

On this very note, DAV is disappointed to report that Section 401 of Public Law 111-163 has not been implemented 18 months after enactment. This measure requires VA to amend its regulations to enable current members of the armed forces who served on active duty in Operations Enduring or Iraqi Freedom eligible for the readjustment counseling that VA currently provides to veterans under title 38, United States Code, section 1721A. We understand this authority is still in the proposed rulemaking stage; however, we have heard this document was recently forwarded to DoD for required joint concurrence. Thus, even though Congress acted, these military personnel cannot avail themselves of a service that their peers in the veteran population have reported to be very effective in dealing with their readjustment needs. Because stigma and confidentiality still remain a significant barrier for many active duty personnel needing mental health care post-deployment, we ask VA and DoD to expedite this mandate so the Readjustment Counseling Service can open its doors to those on active duty who qualify for the counseling benefit. Again, early intervention has been found to be a key to avoiding long-term mental health conditions and other negative outcomes related to untreated post-deployment readjustment issues. VA's Vet Center Readjustment Counseling Service Program (a non-medical model) and the more recently established Justice Program/Veterans Courts have been very popular among veterans with a focus on peer to peer outreach and treatment versus incarceration respectively. VA estimates it will have approximately 300 Vet Centers operational by the end of 2011, along with 70 mobile Vet Centers for veterans living in rural communities.¹⁰ We believe these resources

⁹The Hon. Jonathan Woodson, M.D., Asst. Secretary of Defense for Health Affairs, U.S. Department of Defense, Testimony before the United States House of Representatives Committee on Armed Services, Hearing on "Current Status of Suicide Prevention Programs in the Military." (September 9, 2011).

¹⁰Antonette Zeiss, Ph.D., Acting Deputy Patient Care Services Officer for Mental Health, Veterans Health Administration, U.S. Department of Veterans Affairs, Testimony before the United States House of Representatives Committee on Veterans' Affairs, Hearing on "Mental Health: Bridging the Gap Between Care and Compensation for Veterans." (June 14, 2011).

would be of great benefit to active duty servicemembers who need readjustment counseling but may not receive it due to bureaucratic delay.

DoD tasked the RAND Corporation to evaluate information about military suicides, identify the agreed upon elements that should be part of a state-of-the-art suicide prevention strategy, and recommend ways to make sure the programs and policies provided by each military service reflect the best practices. This request culminated in a February 2011 report from RAND, *"The War Within: Preventing Suicide in the U.S. Military,"* which concluded that people with substance-use disorders and heavy alcohol users face an increased risk for suicide, along with persons with traumatic brain injury or head trauma, those suffering from hopelessness or experiencing certain life events such as relationship problems. Additionally, it was found that availability of firearms correlates positively with suicide. RAND researchers reviewed a wide range of prevention programs but found that while promising practices exist, much still remains unknown about what constitutes a best practice. Based on available literature and discussions with experts, RAND indicated that a comprehensive suicide prevention program should include the following six practices:

- Raise awareness and promote self-care;
- Identify those at high risk;
- Facilitate access to quality care;
- Provide quality care;
- Restrict access to lethal means; and
- Respond appropriately.

RAND made a series of 14 recommendations in its report and noted research suggests that suicide can be prevented. Recommendations include: the establishment of proper tracking and data systems; research; the delivery of high-quality care for those with behavioral health problems and those who are at imminent risk for suicide; proper communication to ensure potential at-risk population is informed and aware of the advantages of using behavioral health care; determining the adequate number of behavioral health specialists needed; and mandate training on evidence-based or state-of-the-art treatment for mental health care providers.

In October 2011, the Government Accountability Office (GAO) issued a report titled, *VA Mental Health: Number of Veterans Receiving Care, Barriers Faced, and Efforts to Increase Access*, covering veterans who used VA from FY 2006 through FY 2010. According to the report, approximately 2.1 million unique veterans received mental health care from VA during this period. Although the number steadily increased due primarily to growth in OEF/OIF/OND veterans seeking care, GAO noted that veterans of other eras still represent the vast majority of those receiving mental health services within VA. In 2010 alone, 12 percent (139,167) of veterans who received mental health care from VA served in our current conflicts, but 88 percent (1,064,363) were veterans of earlier military service eras. GAO noted that services for the OEF/OIF/OND group had caused growth of 2 percent per year in VA's total mental health caseload since 2006.

Key barriers identified in the GAO report that hinder veterans from seeking mental health care included: stigma, lack of understanding or awareness of mental health care, logistical challenges to accessing care, and concerns that VA's care is primarily for older veterans. GAO found that stigma is also a factor that may discourage veterans from accessing mental health care—especially those who have concerns that their careers could be negatively affected if employers found out that they were receiving mental health treatment. VA indicates it is aware of these barriers and continues to implement efforts to increase veterans' access to mental health care, including its integration of mental health services into primary care.

Clearly, 10 years of war have taken a toll on the mental health of American military forces. Combat stress, PTSD and other combat- or stress-related mental health conditions are prevalent among veterans who have deployed to war environments in Iraq and Afghanistan. Regrettably, as was learned from our experiences in other wars, especially the Vietnam conflict, psychological reactions to combat exposure are common. Experts note that if not readily addressed, such problems can easily compound and become chronic. Over the long term, the costs mount due to impact on personal, family, emotional, medical, and financial damage to those who have honorably served our Nation. Delays in addressing these problems can culminate in self-destructive circumstances, including substance-use disorders, incarceration, and suicide attempts. Increased access to mental health services for many of our returning war veterans is a pressing need, particularly in early intervention services for substance-use disorders and provision of evidence-based care for those with PTSD, depression, and other consequences of combat exposure.

Unique aspects of deployments to Iraq and Afghanistan, including the frequency and intensity of exposure to combat, guerilla warfare in urban environments, and the risks of suffering or witnessing violence, are strongly associated with a risk of chronic PTSD. Applying lessons learned from earlier wars, VA anticipated such risks and mounted earnest efforts for early identification and treatment of behavioral health problems experienced by returning veterans. VA instituted system-wide mental health screenings, expanded mental health staffing, integrated mental health into primary health care, added new counseling and clinical sites, and conducted wide-scale training on evidence-based psychotherapies. VA also has intensified its research programs in mental health. However, critical gaps remain today, and the mental health toll of this war is likely to grow over time for those who have deployed more than once, do not seek or receive needed services, or face increased stressors in their personal lives following deployment.¹¹

Testimony by RAND, other researchers, and VA has addressed the physical and mental health impact of these wars based on the unique nature of the wars, particular wartime risks and multiple military deployments for many servicemembers. The current plethora of data to date on our newest generation of war veterans related to increased rates of PTSD, depression, substance-use disorders, high risk-taking behaviors, and traumatic brain injury are well known—but despite all the information available, Dr. Charles W. Hoge, a leading researcher on the mental health toll of the conflicts in Afghanistan and Iraq, observes that VA is not reaching large numbers of returning veterans, and high percentages of veterans who do seek care drop out of treatment. In a recent analysis, Hoge wrote, “. . . veterans remain reluctant to seek care, with half of those in need not utilizing mental health services. Among veterans who begin PTSD treatment with psychotherapy or medication, a high percentage drop out. . . with only 50 percent of veterans seeking care and a 40 percent recovery rate, current strategies will effectively reach no more than 20 percent of all veterans needing PTSD treatment.”¹²

DAV agrees with Dr. Hoge’s view that VA must develop a strategy of expanding the reach of treatment, to include greater engagement of veterans, understanding the reasons for veterans’ negative perceptions of mental health care, and “meeting veterans where they are.”¹³

VA attempts to meet the needs of wartime veterans with post-deployment mental health challenges through two parallel treatment models: a nationwide network of medical centers and outpatient clinics that offer a more traditional medical and psychiatric approach with recent integration of mental health into primary care; and, community-based storefront Vet Centers that use a non-medical psychological model to provide readjustment counseling and related services to combat veterans and to their immediate families. In some locations, the two programs work together closely; in others, there is only limited coordination. Veterans are free to choose one model over the other or a combination of both services. However, the differences in approach may help explain why some veterans do not pursue VA treatment, and why those who do often discontinue it. While DAV strongly supports the Vet Center program, we also believe VA must maintain a robust mental health system as a part of VA medical care. Both programs are critical to veterans struggling with chronic mental illnesses and especially to new veterans who are in need of readjustment services.

New veterans generally report having had positive experiences with Vet Centers and their staffs, a high percentage of whom are themselves combat veterans and who convey an understanding and acceptance of combat veterans’ problems. While these centers do not provide mental health services in the traditional sense, their strengths tend to fill the gaps reported by younger veterans regarding mental health care in VA medical centers and primary care clinics.

Dr. Hoge echoes several of these points in urging what amounts to a call for a more veteran-centric approach to treating PTSD and other war-related conditions:

Improving evidence-based treatments . . . must be paired with education in military cultural competency to help clinicians foster rapport and continued engagement with professional warriors . . . Matching evidence-based components of therapy to patient preferences and reinforcing narrative processes and social connections

¹¹ Brett T. Litz, National Center for Post-Traumatic Stress Disorder, Department of Veterans Affairs, “The Unique Circumstances and Mental Health Impact of the Wars in Afghanistan and Iraq,” A National Center for PTSD Fact Sheet (January 2007). http://www.nami.org/Content/Microsites191/NAMI_Oklahoma/Home178/Veterans3/Veterans_Articles/5uniquecircumstancesIraq-Afghanistanwar.pdf.

¹² Charles W. Hoge, MD, “Interventions for War-Related Posttraumatic Stress Disorder: Meeting Veterans Where They Are,” *JAMA*, 306(5): (August 3, 2011) 548.

¹³ *Ibid.*

through peer-to-peer programs are encouraged. Family members, who have their own unique perspectives, are essential participants in the veteran's healing process and also need their own support.¹⁴

Since the beginning of the conflicts in Iraq and Afghanistan, VA has faced a number of daunting challenges in providing care to a new generation of war veterans—particularly in post-deployment readjustment and in mental health. Initially, the needs and expectations of OEF/OIF/OND veterans and their families proved to be different from those of veterans who had typically been under VA care. We believe new veterans and their families want the DoD and VA to transform their approaches to post-deployment mental health services, and to stress family-centered treatment rather than focus solely on individual veterans—a paradigm shift for VA. Over its history, VA has concentrated primarily on the single veteran patient to the exclusion of family in almost all cases. But this new generation of veterans is younger, technologically savvy, and demands improved access to information via the Internet, access to state-of-the-art prosthetic items, expertise in trauma care, and advanced rehabilitation methods. They also expect support for their family caregivers and better transition and collaboration between DoD and VA in policies for family caregivers. Likewise, Congress, advocacy groups, and community stakeholders, including groups in the private sector offering specialized services, have been very active in pressing for change in how VA relates to community providers and how it furnishes care in its mental health and rehabilitative services.

Last year, the VA OMHS introduced a public health model for VA to meet the mental health needs of OEF/OIF/OND veterans with the precept that most war veterans will not develop chronic mental illness if VA concentrates on early intervention, de-stigmatization, use of effective mental health models, and makes greater outreach efforts. The goal of VA's strategy is to promote healthy outcomes and strengthen families, with a focus on resilience and recovery. This initiative requires VA to evolve from its more traditional medical model to an approach that would be less reliant on establishing a diagnosis and developing a treatment plan, and more on helping veterans and their families regain or retain an overall balance in their physical, social and mental well-being despite the stresses of military deployments. Most important, the strategy calls for VA to reach out to veterans in their communities, adjust its message, make access easier and on these veterans' terms, and reformat programs and services to meet the needs of veterans and their families, rather than expecting veterans to fit into VA's traditional array of available services.¹⁵

In preparing for this hearing, DAV observed that DoD and VA clearly have made concerted efforts to address the challenges each Department faces in meeting the mental health needs of post-deployment active duty personnel and wartime veterans. Also, both agencies are populated with dedicated mental health experts, researchers and policymakers who continue to develop solutions to prevent suicide and the less devastating but still serious emotional and behavioral consequences of exposures to war. However, despite both Departments' obvious efforts and progress, much more needs to be accomplished to fulfill the Nation's commitments to veterans who are challenged by serious and chronic mental illnesses, and those needing post-deployment mental health readjustment services. Based on studies noted earlier in this statement, it appears DoD may have less difficulty collecting data to analyze the need for policy changes simply because DoD maintains access to data on the active duty population including pertinent demographic information, recorded facts on wartime and other hardship deployments, marital status, health information and personal stressors. However, DoD is burdened by a number of barriers unique to the military services that prevent military personnel from coming forward for help. The fear of being perceived as "weak;" worry over losing rank; being identified as unreliable in stressful or hazardous situations; and anxiety about being discharged in disgrace—all these fears contribute to a reticence in military service personnel who are struggling, from revealing their feelings to others or to seek help inside their command structure. DoD leaders have publicly acknowledged these types of cultural obstacles do in fact exist and that DoD is still working to address them systemically.

On the other hand, VA is challenged with access to veterans' data for those who have not come to VHA for care. Because veterans are private citizens, and privacy of medical and personal information is the governing law, VA is at a distinct disadvantage in gaining extensive data on mental health status, suicide rates and

¹⁴ Hoge, "Meeting Veterans Where They Are," 551.

¹⁵ Harold Kudler, VA/DoD/State and Community Partnerships: Practical Lessons on Implementing a Public Health Model to Meet the Needs of OEF/OIF Veterans and Their Families, VA Course on Implementing a Public Health Model for Meeting the Mental Health Needs of Veterans, PowerPoint presentation (Baltimore, MD, July 28, 2010).

other relevant information about the general veteran population. However, based on clinical and research experience with enrolled veterans, what VA does know can be very beneficial for all veterans. Experts note that timely, early intervention services can improve veterans' overall quality of life, address substance-use problems, prevent chronic illness, promote recovery, and minimize the long-term disabling effects of undetected and untreated mental health problems. We encourage VA to build on that knowledge and to be more transparent in dealing with the daunting challenges it faces in overcoming the existing gaps in its mental health programs and in the crucial need to address suicide, which has become so pressing. DAV believes VA is moving in an appropriate direction but needs to know more by learning directly from veterans trying to access the VA system (as well as those who don't) to better understand their unique needs and desires for treatment and services. Listening to veterans' feedback is essential to creating a system that meets them where they are, works for them, and is effective in achieving the recovery they seek.

As a final thought, we recommend the Subcommittee review VA's implementation of sections 102–105 of the Veterans' Mental Health and Other Care Improvements Act of 2008, Public Law 110–387, a measure DAV strongly supported as a part of our Stand Up For Veterans initiative. These requirements, if implemented faithfully by VA, would go a long way toward addressing many of the lingering issues discussed in this testimony today. Also, we recommend a close review by your professional staff of our discussion in the FY 201. Independent Budget (IB) on the topics of mental health and transition needs of OEF/OIF/OND veterans, as well as the new discussion of those subjects in the upcoming IB for FY 2013.

**Prepared Statement of Margaret C. Harrell, Ph.D., Senior Fellow and
Director, Joining Forces Initiative, Center for a New American Security**

Madam Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee: Thank you for the privilege of testifying today. It is an honor to be here. Military suicide, that of both servicemembers and veterans, is a tragedy that affects more than the individual. Each suicide devastates a family, a unit, and a community. There are also implications beyond the local.

Military suicide is a national security issue. George Washington said, "The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional to how they perceive the Veterans of earlier wars were treated and appreciated by their nation." If Washington was correct, suicide among servicemembers and veterans threatens the health of the all-volunteer force. Mentors and role models, including parents, teachers and, importantly, veterans, play a critical role in the enlistment decisions of young men and women. We should realize that these mentors and role models will not steer youth toward the military if they perceive damage to servicemembers or a failure to address the mental health care needs of those who have served their country.

While the topic at hand is suicide prevention among veterans, I urge the Committee to recognize the importance of considering both veteran and servicemember suicide. This recommendation is based upon more than the recognition of suicide as a tragic outcome; it is based upon the pragmatic recognition that we can only be sure that improvements have been made when the frequency of suicide decreases amongst both of these populations. There is, for example, a possibility that a decrease in the frequency and number of suicides among servicemembers could represent only expeditious out-processing of servicemembers struggling with mental health wounds of war. Likewise, a decrease in veteran suicide, once we have greater visibility of these outcomes, could reflect the shifting of suicides to the time prior to military discharge. Only the joint consideration of both servicemember and veteran outcomes will highlight reasons for increased concern or will identify success.

There does not currently exist a systematic combined analysis of servicemember and veteran suicide. Neither the Department of Defense (DoD) nor the Department of Veterans Affairs (VA) fully consider or analyze suicide in one another's population. Given the potential implications of veteran suicide for the all-volunteer force, both the VA and the DoD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, we should recognize that veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation.

This testimony derives from a CNAS policy brief, *Losing the Battle: The Challenge of Military Suicide*, which discussed the stark numbers of the veterans and servicemembers who die by suicide every day. The policy brief also identified obstacles to

improvement and made recommendations to address these obstacles. This testimony focuses upon the recommendations most applicable to the veteran community.

It is important to note that the U.S. military and veteran population cannot avoid the stark reality of suicide entirely. Servicemembers and veterans reflect the broader American public, which not only suffers from suicide, but also stigmatizes mental health care. Further, some servicemembers enter military service with mental health challenges and we should not conclude that serving in the military caused these suicides.

This testimony also notes that leaders in the services and the VA deserve recognition for their actions to reduce the rate of suicide among servicemembers and veterans. Senior military leaders have exerted considerable effort in recent years to acknowledge and confront the challenge of suicide. The VA and each of the military services have emphasized the development of suicide prevention programs, education about the risk of suicide and the most effective ways to prevent it. The DoD suicide prevention programs, with slogans such as “Never Leave a Marine Behind” and “Never Let Your Buddy Fight Alone,” resonate with servicemembers by being service-specific and embedded in their service cultures. The services ensure that the necessary tools, such as hotlines, are readily available. The VA’s Veterans Crisis Line is especially important in this regard. In its first 3 years, the hotline received more than 144,000 calls involving veterans and saved more than 7,000 actively suicidal veterans.¹ Challenges remain nonetheless.

Servicemember and Veteran Suicide

From 2005 to 2010, servicemembers took their own lives at a rate of approximately one every 36 hours.² While suicides in the Air Force, Navy and Coast Guard have been relatively stable and lower than those of the ground forces, U.S. Army suicides have climbed steadily since 2004. The Army reported a record-high number of suicides in July 2011 with the deaths of 33 active and reserve component servicemembers reported as suicides. Suicides in the Marine Corps increased steadily from 2006 to 2009, dipping slightly in 2010.

The VA estimates that a veteran dies by suicide every 80 minutes,³ but is impossible, given the paucity of current data, to determine the suicide rate among veterans with any accuracy or to understand which veterans are dying.

The Relationship Between Military Service and Suicide

Although the number of military suicides has increased since the start of the wars in Afghanistan and Iraq, the prevailing wisdom has been that suicides are not linked directly to deployment.⁴ However, recent analysis of Army data demonstrates that soldiers who deploy are more likely to die by suicide.⁵ Data have long indicated definitive links between suicide and injuries suffered during deployment. Individuals with traumatic brain injury (TBI), for instance, are 1.5 times more likely than healthy individuals to die from suicide.⁶ Additional factors that heighten risk include chronic pain and post-traumatic stress disorder (PTSD) symptoms such as depression, anxiety, sleep deprivation, substance abuse and difficulties with anger management.⁷ These factors are also widely associated with deployment experience in Afghanistan and Iraq.

Some psychiatric experts argue that there is an indirect relationship between suicide and military service during wartime. In the psychiatric field, one school of thought, known as the interpersonal psychological theory of suicide, suggests that the following three “protective” factors preclude an individual from killing oneself:

¹ Text refers to period from July 2007 to March 2010. Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide.

² Department of Defense, “The Challenge and the Promise: Strengthening the Force, Preventing Suicide, and Saving Lives,” Final Report of the DoD Task Force on Prevention of Suicide by Members of the Armed Forces (August 2010), provides data through 2009. The 2010 data are from the Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011).

³ Department of Veterans Affairs, Fact Sheet: VHA Suicide Prevention Program, Facts About Veteran Suicide (March 2010).

⁴ This relationship has not been evident in prior analyses and is not evident in suicide data from the Navy, Air Force, Marine Corps or Coast Guard.

⁵ Sandra A. Black et al., “Prevalence and Risk Factors Associated with Suicides of Army Soldiers 2001–2009,” *Military Psychology* 23 no. 4 (July 2011), 433–451.

⁶ Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, “Recent VHA Findings Regarding TBI History and Suicide Risk” (October 29, 2009) Department of Veterans Affairs, Memorandum from Deputy Under Secretary for Health for Operations and Management, “Recent VHA Findings Regarding TBI History and Suicide Risk” (October 29, 2009).

belongingness, usefulness and an aversion to pain or death.⁸ Any one of these protective factors normally is sufficient to prevent suicide. Traditionally, military service has had a protective quality: Military servicemembers have been less likely to die by suicide than civilians. It appears now, however, that the nature of military service—especially during wartime—may weaken all three protective factors.⁹ The cohesion and camaraderie of a military unit can induce intense feelings of belonging for many servicemembers. Time away from the unit, however, may result in a reduced or thwarted sense of belonging, as individuals no longer have the daily support of their units and feel separate and different from civilians. This is especially true for Guardsmen, Reservists, and for veterans.

The responsibility inherent in military service, the importance of tasks assigned to relatively junior personnel and the high level of interaction among unit members establish the importance and usefulness of each unit member, particularly in an operational environment. In contrast, the experience of living in a garrison environment (for active component personnel) or returning to a civilian job (for Guardsmen, Reservists and veterans) or, worse, unemployment, can introduce feelings of uselessness. Individual accounts of military suicide both in the media and in interviews with us echo this sentiment. Over and over, these accounts show that individuals withdrew, felt disconnected from their units and their families, and perceived themselves as a burden.

The third protective factor—an aversion to pain or death—is especially important in considering military suicide, because military service is one of the few experiences that can override this factor. Repeated exposure to military training as well as to violence, aggression and death dulls one's fear of death and increases tolerance for pain.¹⁰ Thus, the very experience of being in the military erodes this protective factor, even for servicemembers who have not deployed or experienced combat, in part because servicemembers experience pain and discomfort from the beginning of their training.¹¹ By removing some of the protective factors of suicide, therefore, military service, especially during wartime, may predispose an individual toward suicide.

Challenges and Recommendations

There are obstacles to addressing suicide that should be resolved. Some of these obstacles are especially difficult to eliminate. Many of the recommendations we have made pertain specifically to servicemember suicide, for two reasons. First, we know more about servicemember suicide than about suicide amongst veterans. The lack of understanding about suicide among veterans reduces the likelihood of actionable recommendations. Second, reducing the challenges to mental health among servicemembers should also improve the mental health of recently discharged veterans.

Challenge I: Americans lack a complete accounting of veteran suicide. The estimation of veteran suicides is extrapolated from extremely limited data. Specifically, states provide death data to the Centers for Disease Control (CDC) for inclusion in the National Death Index, but only 16 U.S. states indicate veteran status in their data.¹² The number of veteran suicides from the remaining 34 states is extrapolated to estimate the overall number of veteran suicides.¹³ Further, the current numbers are extrapolated from 3-year-old data.

An effort is underway to match the Social Security numbers in the national death data with DoD files to identify veterans included in the data. This effort provides the capability to analyze the data and characterize the veteran victims of suicide. It will thus be possible to quantify veteran suicide and contribute an understanding of the number of suicides among Post-9/11 veterans, as compared with veterans of earlier generations. This analysis could also permit an understanding of whether veterans kill themselves soon after leaving the military.

⁸ Thomas Joiner, *Why People Die by Suicide* (Cambridge, MA: Harvard University Press, 2007).

⁹ See the discussion of these effects in Edward A. Selby et al., "Overcoming the Fear of Lethal Injury: Evaluating Suicidal Behavior in the Military through the Lens of the Interpersonal-Psychological Theory of Suicide," *Clinical Psychology Review* 30 no. 3 (April 2010), 298–307.

¹⁰ Craig J. Bryan et al., "Challenges and Considerations for Managing Suicide Risk in Combat Zones," *Military Medicine* 175 no. 10 (October 2010), 713–718; and Edward A. Selby et al., "Overcoming the Fear of Lethal Injury."

¹¹ C. J. Bryan et al., "A Preliminary Test of the Interpersonal-Psychological Theory of Suicide Behavior in a Military Sample," *Personality and Individual Differences* 48 no. 3 (February 2010), 347–350.

¹² The states are Alaska, Colorado, Georgia, Kentucky, Maryland, Massachusetts, New Jersey, New Mexico, North Carolina, Oklahoma, Oregon, Rhode Island, South Carolina, Utah, Virginia and Wisconsin.

¹³ Even if all states indicate veteran status, suicides will still be underreported because of the vulnerability of civilian death data to the social stigma of suicide.

Recommendation: Given the potential implications of veteran suicide for the all-volunteer force, the DoD should seek to understand which veterans, and how many veterans, are dying by suicide. In particular, the DoD, as well as the VA and the country at-large, should recognize that many veterans who left the service only shortly before they killed themselves may have suffered from unaddressed mental health wounds incurred while in service to their nation. Congress should establish reasonable time requirements for states to provide death data to the CDC, and the Department of Health and Human Services (HHS) should ensure that the CDC is resourced sufficiently to expedite compilation of national death data. The DoD, the VA and HHS should coordinate efforts to analyze veteran suicide data and should conduct these analyses annually.

Challenge II: As servicemembers return home from deployment, they complete a post-deployment health assessment (PDHA). As part of this assessment, they are asked questions about their physical and mental health, such as, “Did you encounter dead bodies or see people killed or wounded during this deployment?” and “During this deployment, did you ever feel that you were in great danger of being killed?” There are also self-evaluative questions, such as, “Are you currently interested in receiving information or assistance for a stress, emotional or alcohol concern?” While we do not question the contents of the assessment, its administration has been problematic.

A 2008 study found that when Army soldiers completed an anonymous survey, reported rates of depression, PTSD, suicidal thoughts and interest in receiving care were two to four times higher as compared to the PDHA. Likewise, our interviews with veterans uncovered numerous accounts of returning servicemembers whose unit leaders advised them to fabricate answers. Individuals across all services have been told, “If you answer yes to any of those questions, you are not going home to your family tomorrow.” This may be factually correct, but it neglects to inform servicemembers of the implications of answering untruthfully—namely, that they will have difficulty receiving treatment or compensation for mental health problems that appear after their service. As an improvement, the 2010 National Defense Authorization Act requires trained medical or behavioral health professionals to conduct the PDHA evaluations individually and face-to-face, in the hope that servicemembers will respond honestly to a trained health professional.¹⁴

Recommendation: Unit leaders should encourage members to complete the PDHA truthfully and should underscore that an honest answer will allow them to link any future mental health problems requiring treatment to their military service. This is especially important for veterans, as the PDHA informs decisions regarding their eligibility for mental health care after they separate from service.

Challenge III: There is a national shortage of mental health care and behavioral health care professionals, a factor linked to higher rates of suicide. According to the VA, suicide rates decreased by 3.6 deaths per 100,000 in seven regions¹⁵ where staff numbers increased to levels recommended in the 2008 Veterans Health Administration Handbook.¹⁶ Sixteen regions are still not manned to these levels, however. Additionally, for the Army, only 80 percent of the psychiatrist and 88 percent of the social worker and behavioral health nurse positions are filled. With respect to psychologists, 93 percent of positions are filled.¹⁷ Military hospital commanders have temporary authority to hire psychologists and social workers and behavioral health nurses on an as-needed basis, but a shortage of care providers precludes them from easily filling that gap. This shortage is a national issue, which affects the availability of care providers for the DoD and the VA. It also affects veterans’ families, who seek treatment from the civilian health care system to cope with the strain of reintegration.

Recommendation: Congress should permanently establish expedited or direct hire authority allowing military hospitals to hire behavioral health care providers. Congress should require the VA to establish deadlines by which all twenty-three VHA regions will be manned to the recommended levels of behavioral health care providers. Additionally, and especially in the meantime, the VA should increase their use of existing public-private partnerships to provide mental health care, to the extent that such partnerships would expedite evidence-based care to veterans.

¹⁴ The National Defense Authorization Act for FY 2010, Public Law 111–84, sec. 70.

¹⁵ The Veteran Health Administration (VHA) is a subordinate organization to the Department of Veterans Affairs. The VHA is divided into 23 regions called Veterans Integrated Service Networks.

¹⁶ Department of Veterans Affairs, Veterans Health Administration Handbook 1160.01 (September 11, 2008).

¹⁷ Army personnel numbers are as of July 2011, from communication with Army Medical Command representative (September 29, 2011).

Challenge IV: Permanent change of station (PCS) moves are a feature of military life. Individuals also often relocate their families as they leave the military. However, because professional organizations license mental health care providers on a state-by-state basis, a geographical move across state lines can preclude continued care from the same provider. When a care provider and a veteran, servicemember or family member invest in developing a care relationship, and that relationship is severed by a move, patients are often reluctant to begin treatment anew.

Recommendation: Congress should establish a Federal pre-emption of state licensing such that mental health care can be provided across state lines for those instances in which military servicemembers or family members have an established pre-existing care relationship.

Challenge V: The programs and services designed to understand and reduce servicemember and veteran suicide should complement one another and gain both efficiency and effectiveness from interacting synergistically. Obtaining veteran suicide data and understanding the circumstances surrounding individuals who die by suicide depends on the states and the HHS, as well as on the participation of the VA and the DoD.¹⁸ Within DoD, the military services and components do not regularly and consistently share information. Information should also be shared between the House Armed Services Committee (HASC) and the Senate Armed Services Committee (SASC), who interact primarily with DoD and the Senate Committee on Veteran Affairs and the House Veterans Affairs Committee, who interact primarily with the VA.

Recommendation: The DoD, the VA and HHS should share data and information pertaining to suicide. The military services' leaders should meet regularly to discuss issues and approaches pertaining to suicide, and to share lessons learned. The Senate Committee on Veterans Affairs and the House Veterans Affairs Committee should embrace the opportunity to work with the SASC and HASC, with the intent of developing provisions for the NDAA to address the problem of veteran suicide.

Challenge VI: The health and survival of servicemembers hinges on the removal of the stigma associated with mental health care. This stigma exists in both military and civilian culture. In the military, it prevents many servicemembers from seeking help to address mental health care issues; 43 percent of soldiers, sailors, airmen and Marines who took their own lives in 2010 did not seek help from military treatment facilities in the month before their deaths.¹⁹ The percentage of servicemembers seeking help has improved—from 40 percent in 2008 and 36 percent in 2009 to 57 percent in 2010—but the stigmatization of mental health care remains an issue.²⁰ Military leaders recognize the importance of removing this stigma. Indeed, recently retired Chairman of the Joint Chiefs of Staff Admiral Mike Mullen identified the stigma of PTSD as the greatest challenge confronting troops returning from war in Iraq and Afghanistan,²¹ and other DoD leaders at the highest levels have urged servicemembers to seek mental health care as needed. Nevertheless, the stigma persists.

This culture is unlikely to change quickly. Leaders have not provided sufficient guidance about how to remove the stigma associated with depression and suicidal thoughts, and they have not consistently disciplined servicemembers who belittle or ridicule members with mental health issues.²² Removing the stigma for PTSD, an invisible injury, will be especially difficult, given that some servicemembers do not even consider TBI, which is physically evident and recognizable, a “real injury.”²³ Yet the stigma must be removed to address and treat PTSD and TBI, both of which are linked to suicide. The effect of military culture will also inform and bear upon the perspectives and behavior of veterans even after they leave the military service.

¹⁸ The CDC is subordinate to the HHS.

¹⁹ Fifty-seven percent of DoD suicides were seen at a military treatment facility in the month prior to their deaths. Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2010 Annual Report (September 2011), 23.

²⁰ Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2009 Annual Report (2010), 29; and Department of Defense, *Department of Defense Suicide Event Report*, Calendar Year 2008 Annual Report (2010), 26.

²¹ Stephanie Gaskell, “Stigma of Posttraumatic Stress Disorder Is Greatest Challenge of Returning Troops: Mullen,” *Daily News* (April 19, 2010).

²² See, for example, the following news article for a publicized account of such ridicule: http://www.q13fox.com/news/kcpq-suicide-rate-spiking-at-jointbaselewis-mchord-20110817_0_1023250.story.

²³ The authors interviewed veterans who did not mention their own TBI in response to the question, “Were you physically wounded during deployment?” When interviewees mentioned TBI in subsequent conversations, they would typically explain that their initial answer only included “real injuries.”

Recommendation: Military leaders must eliminate the stigma associated with mental health care and hold unit leaders accountable for instances in which individuals are ridiculed for seeking treatment.

Challenge VII: Misuse of prescription medication is another obstacle to addressing the problem of military suicide. Approximately 14 percent of the Army population is currently prescribed an opiate.²⁴ Forty-five percent of accidental or undetermined Army deaths from 2006 to 2009 were caused by drug or alcohol toxicity,²⁵ and 29 percent of Army suicides between 2005 and 2010 included drug or alcohol use.²⁶

Data collected from civilian populations indicate that adults aged 18–34 are the most likely to have attempted drug-related suicides,²⁷ and that 58.9 percent of drug-related suicide attempts resulting in visits to an emergency room involve psychotherapeutic drugs.²⁸ Another 36 percent of emergency room visits for suicide attempts involve pain medications.²⁹ If we anticipate similar rates among military servicemembers, it is important to address the excess prescription medicine among military servicemembers. Yet, there is no opportunity to do so. When military doctors prescribe an alternative medication or dosage from what a servicemember was previously prescribed, there is no request made for the servicemember to return the remainder of his or her prior medication. Instead, military doctors dispense additional medications, because only law enforcement personnel can conduct “take-back” programs for medications. On January 26, 2011, the Army Vice Chief of Staff requested that the Drug Enforcement Administration (DEA) permit the Army’s military treatment facilities and pharmacies to accept excess prescription medicine for disposal.³⁰ The request was denied.

Recommendation: The DEA should grant the DoD authority to accept and destroy excess prescription medication from military servicemembers. Given this authority, the Office of the Army Surgeon General should initiate an effort with the Navy, Air Force and Coast Guard surgeon generals to develop policies and practices regarding how best to account for, and regain possession of, excess prescription medications. Such a drug take-back program will be targeted to the military services, but could also help ensure that servicemembers do not transition out of the military with surplus prescription medications.

Challenge VIII: The DoD approach to suicide prevention depends heavily on what experts refer to as “gatekeeper strategies.” The Army, for example, asserts that “[t]here is no other aspect of [its suicide prevention] that is more important for preventing negative outcomes than the vigilance of the individual commander, supervisor, Soldier, law enforcement agent or program/service provider. Leaders, supervisors, and ‘Buddies’ represent the first level for surveillance of high risk behavior.”³¹ Although medical and academic experts identify gatekeeper approaches as one of the most promising strategies,³² the limitations of this approach are notable for the Guard and Reserve, where there are long monthly gaps between drill periods when leaders and peers do not have the opportunity to watch for warning signs. Yet studies indicate that even the smallest amount of contact can reduce the risk of suicide.³³ These findings suggest that even postcards or text messages from unit leaders between drill weekends can help prevent suicides.

Recommendation: The DoD should address weaknesses in gatekeeper-based programs for drilling Guard and Reserve units. Specifically, Guard and Reserve units should develop a leadership communication plan that addresses the stresses on

²⁴ U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report* (August 2010), 45. Also, the Army estimates that 30,401 soldiers would test positive for a medical review officer-reviewable drug, with 3,925 representing illicit use. *Ibid.*, 44.

²⁵ *Ibid.*, 4.

²⁶ *Ibid.*, 43.

²⁷ 2004 data, as reported by Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults* 34 (2006), 5, <http://www.oas.samhsa.gov/2k6/suicide/suicide.pdf>, as of September 9, 2011.

²⁸ Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults*, 6.

²⁹ Substance Abuse and Mental Health Services Administration, *The OAS Report: Suicidal Thoughts, Suicide Attempts, Major Depressive Episode & Substance Use among Adults*, 6.

³⁰ Peter W. Chiarelli, Vice Chief of Staff, U.S. Army, letter to Joseph T. Rannazzisi, Deputy Assistant Administrator, Drug Enforcement Administration, Office of Diversion Control (January 26, 2011).

³¹ U.S. Army, *Health Promotion Risk Reduction Suicide Prevention Report*, 46.

³² Mann et al., “Suicide Prevention Strategies: A Systematic Review.”

³³ Alexandra Fleischmann et al., “Effectiveness of Brief Intervention and Contact for Suicide Attempters: A Randomized Controlled Trial in Five Countries,” *Bulletin of the World Health Organization* 86 no. 9 (September 2008), 703–709.

units and details the frequency and method (written, electronic or telephone) by which small unit leaders should remain in contact with their subordinates. Leaders should pay closer attention to this communication following a deployment. Such communication could especially help save the lives of our country's "affiliated veterans," those who periodically return to uniform, either for drill or mobilization and deployment.

Challenge IX: Assessing which suicide prevention strategies are effective requires systematic efforts to understand military suicide. Yet these efforts are thwarted by the existence of too many programs. Suicide prevention programs in the National Guard are a decentralized multitude that the Adjutant General (TAG) of each state and U.S. territory initiates and manages. This grassroots solution is inefficient given that, while some states had more suicides than others, overall the Army National Guard averages slightly more than one suicide per state annually. Although the individual programs may use evidence-based approaches, it will be difficult to demonstrate which suicide prevention programs are effective with the military community or efficacious in reducing suicide, because the small numbers do not support rigorous analysis. Even more important, these programs risk reduction or elimination due to dwindling state resources. This is the case of Minnesota, where there exists both the highest number of National Guard suicides, and also dwindling resources to address their problem.³⁴

Recommendation: The National Guard should reduce the number of unique suicide prevention programs, and consider adoption of a systemwide, centrally funded, prevention approach.

Conclusion

Addressing suicide among servicemembers and veterans is integral to the fitness and sustainability of the all-volunteer force. It will take a collaborative effort by DoD, VA, Federal and state legislatures, and communities to curb suicide among those who have served the United States. The military must take better care of its own. Although a goal of no suicides is unachievable, the increasing number of suicides is unacceptable. Additionally, although the benefits and services available from the VHA will likely remain the best system of care for veterans, the DoD has moral responsibility to acknowledge and understand former servicemembers.

The CNAS policy brief, from which my comments are extracted, is entitled *Losing the Battle: The Challenge of Military Suicide*. America is currently losing its battle against suicide by veterans and servicemembers. As more troops return from deployment, the risk will only grow. To honor those who have served and to protect the future health of the all-volunteer force, America must renew its commitment to its servicemembers and veterans. The time has come to fight this threat more effectively and with greater urgency. Thank you for addressing your attention to this critically important battle.

Prepared Statement of Katherine E. Watkins, Senior Natural Scientist, The RAND Corporation^a

Suicide Prevention Efforts and Behavioral Health Treatment in the Veterans Health Administration^b

Chairman Buerkle, Representative Michaud, and distinguished Members of the Committee, thank you for inviting me to testify today. It is an honor and pleasure to be here. In this testimony, I will briefly summarize the evidence that mental illness has a strong association with suicide and that providing high-quality behavioral health treatment can reduce the risk of both attempted and completed suicide. Then I will describe the results of a recent study of the quality of behavioral health care provided by the Veterans Health Administration (VHA) to veterans with men-

³⁴ Mark Brunswick, "Anti-Suicide Program for Military Runs Low: Shortfall Comes as Minnesota Guard Fights High Suicide Rates," *Star Tribune*, October 2, 2011.

^aThe opinions and conclusions expressed in this testimony are the author's alone and should not be interpreted as representing those of RAND or any of the sponsors of its research. This product is part of the RAND Corporation testimony series. RAND testimonies record testimony presented by RAND associates to Federal, state, or local legislative committees; government-appointed commissions and panels; and private review and oversight bodies. The RAND Corporation is a nonprofit institution that helps improve policy and decision-making through research and analysis. RAND's publications do not necessarily reflect the opinions of its research clients and sponsors.

^bThis testimony is available for free download at <http://www.rand.org/pubs/testimonies/CT370.html>.

tal illness and substance use disorders and discuss the implications of this study's findings for suicide prevention. I will conclude by proposing specific steps which VHA could take to improve the quality of care provided to veterans with mental illness and substance use disorders—steps which, if taken, could further reduce suicide risk among our Nation's veterans.

While suicide remains a rare event that is difficult to predict, studying the characteristics of individuals who attempt and complete suicide allows us to identify common risk factors and thus direct efforts toward prevention. Research studies have shown that over 90 percent of suicide victims have a diagnosable mental illness.¹⁻⁵ In the veteran population, depressive disorders, post-traumatic stress disorder (PTSD), bipolar I disorder and drug and alcohol disorders are risk factors for both attempted and completed suicide.⁶⁻¹⁰ In one study, among veterans being treated at a VA hospital after a suicide attempt, a review of their medical records indicated that 31.8 percent had a diagnosed alcohol disorder, 21.8 percent had a drug use disorder, 21.2 percent had a psychotic disorder, and 18.5 percent had a depressive disorder.¹⁰ Another study of veterans who completed suicide showed that bipolar disorder posed the greatest estimated risk of suicide among men, and substance use disorders posed the greatest risk among women.¹¹ While most individuals with mental illness do not complete suicide, the strong association between mental disorders and suicide suggests that among those with vulnerability to suicide, untreated or worsening mental disorders may be causally related to suicide. Examples of vulnerability include a genetic predisposition to suicide and hopelessness.¹²⁻¹⁵

Identification and treatment of mental disorders is important because appropriate treatment for mental disorders may reduce the risk of suicide. Most of the data supporting this assertion come from cross-sectional studies which show an association between treatment and reduced risk. Among veterans who received a new diagnosis of depression, suicide attempt rates were lower among patients being appropriately treated with antidepressants than among those who were not.^{16,17} Among individuals with bipolar disorder, continued treatment with mood-stabilizing drugs is associated with a decreased rate of completed suicide compared to brief or interrupted treatment with these medications, and the rate of suicide decreases consistently with the number of additional prescriptions.¹⁸ Lithium and clozapine, two important pharmacotherapies for mental disorders, may have specific suicide-prevention qualities.^{19,20} There are no studies of whether appropriate treatment for PTSD or for substance use disorders reduces suicide risk, although intoxication can exacerbate impulsivity and hopelessness, and many suicide attempts occur in the context of substance use.⁶ This is an area where further research is needed. A recent RAND review of suicide prevention efforts in the U.S. military concluded that the strongest empirical evidence for preventing suicide involved providing high-quality mental health treatment.²¹

The majority of individuals who die by suicide have contact with either a primary care or mental health provider in the year prior to the suicide, and nearly half have contact in the month before suicide.²² In one study of veterans who had contact with VA treatment services and who completed suicide, all were outpatients at the time of death, 60 percent were hospitalized for psychiatric reasons in the year before death and 83 percent of those who were hospitalized completed suicide within 2 months of hospital discharge.⁶ In another study of 968 veterans who completed suicide in the community, 22 percent had received health care in the VA system in the year prior to death; of these, 58 percent had not seen a mental health professional.²³ These studies suggest that there are opportunities for health care providers to intervene, provide appropriate care, and possibly prevent suicide.

In 2005, the VA commissioned RAND and the Altarum Institute to conduct a comprehensive evaluation of the VA's mental health and substance use treatment system.²⁴⁻²⁶ The results reported below describe care provided in fiscal years (FY) 2007 and 2008. We do not have data on whether the quality of care has changed since then.

In FY 2008 there were 906,394 veterans receiving care at the VHA for one or more of the following diagnoses: schizophrenia, bipolar I disorder, PTSD, major depressive disorder, and substance use disorders. Although they represented approximately 3.8 percent of the estimated number of all living veterans and 16.5 percent of all veterans who used VHA services in FY 2008, they accounted for 34.4 percent of all VHA costs. Approximately half had either multiple mental health conditions or a co-existing physical condition. The majority of utilization and costs were for the treatment of physical health conditions.

To evaluate quality of care, the research team developed 88 performance indicators,²⁷ or measures of the quality of care. We used indicators to assess the degree to which recommended care was delivered and to identify gaps in quality. Some indicators applied only to a single diagnosis, such as antidepressant use in major de-

pression, and some applied across diagnoses, such as assessment for suicide ideation. Where there was sufficient sample size, we evaluated performance by Veterans Integrated Service Network (VISN), age, gender, rural/urban residence and Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) status.

Below I discuss study findings as they may relate to suicide prevention. Results are reported as VHA national averages. VISN level performance was estimated to identify average VISN performance and to test whether each VISN was significantly above or below the average VISN performance. A list of VISN number and region is provided at the end of the document (see Table 1). Evidence-based treatments are treatments that have been demonstrated through research to be effective.

Evidence-Based Treatment for Major Depression

Among veterans with major depression, treatment with antidepressants is associated with decreased suicide risk. Almost half (48 percent) of veterans beginning a new treatment episode for major depression filled prescriptions for a 12-week supply of antidepressant medication; 20 percent did not fill any prescription for antidepressants during the appropriate time frame. There was a 20 percentage point difference between the highest and lowest performing VISNs for this performance indicator. Six VISNs (9, 15, 19, 20, 22 and 23) performed significantly better than the VISN average. Another seven VISNs (3, 5, 7, 8, 12, 16 and 18) performed significantly below the VISN average. Those veterans least likely to have the requisite 12-week supply were younger, rural, and had served in OEF/OIF. While some veterans may not want antidepressants, the observed variation of 20 percentage points across VISNs suggests that care can, and should, improve in those VISNs with lower rates.

To minimize the likelihood of relapse, antidepressants need to be continued for 4 to 9 months. However, only 31.2 percent of veterans in a new episode of treatment for major depression filled prescriptions for a 6-month supply of antidepressant medication; and 17.1 percent filled no prescriptions for antidepressant medication. The remaining 51.3 percent of veterans filled a prescription, but for less than a 6-month supply. While some veterans may choose to terminate treatment prematurely, research suggests that clinical interventions such as telephone outreach can improve medication adherence²⁸ and outcomes. Adherence means using the medication as prescribed.

Among all study veterans who were beginning a new episode of treatment, only 38.3 percent received at least one psychotherapy visit. Among those with major depression who were receiving psychotherapy, 30.9 percent received psychotherapy that had elements of cognitive behavioral therapy, an evidence-based treatment for major depression. For those veterans receiving psychotherapy, increasing the delivery of evidence-based psychotherapy could improve outcomes and decrease suicide risk.

Evidence-Based Treatment for Bipolar I Disorder

Continuous treatment with a mood stabilizer medication is the mainstay of treatment for bipolar I disorder and is associated with a decreased rate of completed suicide.^{18,29,30} Thirty-two percent of veterans with bipolar I disorder received continuous treatment with a mood stabilizer, 81.2 percent received intermittent treatment and 18.8 percent did not receive any treatment with a mood stabilizer. The difference between the highest and lowest performing VISNs was 12.1 percentage points. Seven VISNs (1, 6, 11, 15, 19, 20) had proportions that were higher than the average VISN and an equal number of VISNs (3, 5, 8, 12, 16, 18 and 21) had proportions that were lower. Eight percent of veterans with bipolar I disorder received inappropriate treatment of an antidepressant without use of a mood stabilizer, a practice associated with higher levels of suicidal behavior.²⁹ Veterans over age 65 or under age 35, and OEF/OIF veterans were at greatest risk for not receiving appropriate care.

Research suggests that use of lithium as a mood stabilizer may have specific suicide-prevention properties. However the therapeutic range within which the beneficial effects of lithium outweighs its toxic effects is quite narrow, and there is substantial clinical consensus that lithium levels should be monitored. Among patients with bipolar I disorder who were beginning treatment with lithium, (N=2,562 out of a total number of 65,090 with bipolar I disorder and 14,285 veterans in a new treatment episode), 51.6 percent received lithium drug level monitoring in a timely manner.

Evidence-Based Treatment for PTSD

Although PTSD increases suicide risk, it is unknown whether treatment for PTSD reduces suicide risk. This is an important area for further research. We found that 20 percent of veterans with PTSD who were receiving psychotherapy had docu-

mentation that at least one psychotherapy visit contained elements consistent with cognitive behavioral therapy, an evidence-based treatment for PTSD. Significantly fewer veterans at one VISN (VISN 10) had documentation of any visits with elements of cognitive behavioral therapy. Among veterans not receiving psychotherapy who were beginning a new episode of treatment for PTSD, 26 percent received an adequate trial of selective serotonin reuptake inhibitors, a class of antidepressants.

Evidence-Based Treatment for Schizophrenia

Continuous treatment with antipsychotic medication is critical for preventing relapse and rehospitalization³¹ among patients with schizophrenia. Approximately 37 percent of veterans in the schizophrenia diagnostic cohort received continuous treatment with an antipsychotic medication. Over 80 percent filled at least one prescription for an antipsychotic medication and 18.1 percent did not receive any antipsychotic medication. There was significant variation across VISNs, with the percentage difference between the highest and lowest performing VISN being almost 20 percentage points. Seven VISNs (1, 10, 11, 15, 19, 20, and 23) significantly exceeded the VISN average; an equal number of VISNs (3, 5, 7, 8, 16, 18, and 22) had 12-month supply fill rates significantly lower than the VISN average.

Evidence-Based Treatment for Drug and Alcohol Disorders

Numerous clinical trials have proven brief interventions to be effective for individuals with alcohol abuse. In our study, fifty-nine percent of veterans with alcohol abuse or dependence had documentation that they received a brief intervention for their alcohol use, 35 percent had a documented referral to mental health specialty care, and 5 percent were already in specialty care. Overall, 71 percent had documentation of appropriate care. VISN 9 had a significantly lower proportion of veterans with documentation of appropriate care. There is substantial empirical support for pharmacotherapy for individuals with alcohol dependence. For veterans beginning treatment for alcohol dependence, 6 percent received pharmacotherapy.

Assessment for Suicide Ideation and Employment and Housing Problems

Identification of and attention to psychosocial stressors are key components of high-quality psychiatric care and may also decrease suicide risk. In cross-sectional studies, psychosocial stressors such as unemployment are associated with attempted and completed suicide.^{9,32-39} Among the mentally ill, homelessness is also associated with suicide. In a study of 7,224 homeless individuals with mental illness, rates of lifetime suicide attempts were above 50 percent; 26.9 percent of the sample had a suicide attempt that resulted in a medical hospitalization.³⁵ While it is unknown whether interventions to decrease unemployment and homelessness would decrease suicide risk, attention to these issues is a critical part of quality mental health care. Identifying whether clinical interventions to address homelessness and unemployment among the mentally ill reduce risk is an important area for further study.

The mental health assessment of a new patient should include an evaluation of suicide ideation and the patient's psychosocial support system.^{40,41} We found that 82 percent of veterans in the study were assessed for suicide ideation. Three VISNs (4, 6 and 7) had significantly higher proportions of documentation of suicide ideation assessment, and two VISNs (2 and 19) had significantly lower proportions. Among veterans with identified suicide ideation, 96.4 percent had documentation of appropriate follow-up.

Assessment of psychosocial needs includes finding out whether the patient had an acceptable physical shelter and whether or not the patient had purposeful daily activity. Among study veterans beginning a new episode of treatment, 60 percent had documentation of an assessment of housing needs, 62 percent had documentation of an assessment of employment needs, and 44 percent had documentation of both assessments. Compared to the average VISN, VISN 10 had a significantly greater proportion of veterans who had documentation of both assessments (57.9 percent) and VISN 18 had a significantly lower proportion (31.8 percent). This variation across VISNs (26 percentage points) was the largest for any indicator. More veterans with a documented need were offered housing services (81 percent) than were offered employment services (28 percent).

Supported Employment and Social Skills Training

Certain evidence-based forms of psychosocial rehabilitation, such as social skills training, increase the capacity of individuals with severe mental illness to live independently. Among veterans with schizophrenia who received any psychosocial treatment, 16 percent had documented receipt of social skills training. Supported employment is a type of intervention that helps individuals with severe mental illness get and maintain employment, and has a robust evidence base. Among veterans with bipolar disorder, schizophrenia or major depression with psychosis, 1.9 percent used

supported employment during the study period. While there was variation across VISNs, no VISN was higher than 3 percent.

Summary and Recommendations

In general, the quality of care provided by the VHA is as good as or better than public or privately-funded care, and of note, most veterans with mental illness are being assessed for suicide and receiving appropriate follow-up. However, in other areas, the quality of care does not meet implicit VA expectations, and there is significant room for improvement. The best evidence to date regarding suicide prevention supports providing quality mental health care. Therefore our recommendations address how the VHA might improve the quality of care for veterans with mental illness and substance use disorders, which may decrease suicide risk.

Increase proportion of veterans who receive recommended length of pharmacotherapy.

More than half of study veterans who began medication treatment did not receive the recommended length of treatment, and more than two-thirds of those on maintenance treatment were non-adherent. This is important because adherence to medication improves outcomes and decreases suicide risk.

Clinical registries are tools that individual clinicians and administrators can access in real time, without technical assistance, and use to systematically monitor symptoms and improve adherence. Clinical registries are not the same as the registries the VA currently has for psychosis and depression. The use of clinical registries is an area with strong potential for quality improvement, since they can be used to track individuals with a specified set of health conditions over time in order to assess how a patient is responding to treatment and whether they are missing appointments or medication refills.

Recommended Strategies: We recommend that the VHA take the following steps:

1. Investigate the basis for low rates of medication adherence among the veteran population, with an emphasis on strategies to improve continuity.
2. Conduct an environmental scan to identify best practices related to clinical registries, with a particular focus on mental-health-specific implementation.
3. Procure or develop a clinical registry module for the VA's medical records system that minimizes the need for additional data entry and maintains ease of use and high-level tracking of evidence-based care.
4. Provide training in, and establish formal expectations for, use of registries.

Increase proportion of veterans with documented assessment of housing and employment needs and establish responsibility for housing and employment services.

Less than two-thirds of veterans with one of the five mental illnesses studied have a documented assessment of their housing and employment needs. Housing and employment policies lack sufficient detail to identify whether the Veterans Health Administration or the Veterans Benefits Administration is responsible for services.

Recommended Strategies: Two actions are recommended:

1. Develop a standardized documentation template for assessment of psychosocial needs.⁴²
2. Clarify what constitutes need for housing and employment services, and clearly define the role of the VHA and the Veterans Benefits Administration with regard to work and housing.

Establish formal expectations for quality measures.

For most mental health treatments, there are no agreed-upon benchmarks to distinguish between levels of performance. Without articulated benchmarks, it is not possible to come to definitive judgments about quality or to judge whether the VA is meeting performance expectations.

Recommended Strategies: We recommend the following actions:

1. The VA should use a combination of empirical evidence on current performance, expert opinion, and performance data from comparable systems to set target benchmarks. At minimum, this benchmark should be the performance of the best-performing VISN.
2. Performance expectations should include a specific definition of the evidence-based treatment and what counts as meeting the benchmark.

Implement standardized, individualized treatment planning documents.

Treatment plans are incomplete and difficult to locate. In some cases they may not exist. There is no standardized way of documenting patient participation in treatment decisions.

Recommended Strategies: Two actions are recommended:

1. Implement and require the use of standardized, individualized treatment-planning documents that may be linked to problems most often associated with a particular diagnosis, services being offered, and the patient's goals for recovery. The VHA Office of Mental Health Services has recently purchased treatment-planning software but dissemination has been held up because of lack of personnel to integrate the software with the current electronic health record.
2. Incorporate the capacity for patients to comment on and document their participation in treatment planning.

Prioritize efforts to make patient's entire health record accessible through a common portal, both across and within VISNs.

Some VISNs have an electronic health record system that allows any provider within the VISN to access the patient's chart in real time. Other VISNs do not have this capability and it is difficult to access health records across VISNs. This difficulty can potentially impair the quality of care veterans receive if they move or receive treatment in multiple locations.

Recommended Strategy:

1. Prioritize efforts to make patients' entire health records accessible through a common portal to allow unfettered access and input by all clinicians caring for them across medical centers and VISNs in real time. The VA should direct the Office of Information Technology to ensure that clinicians can access patient data, regardless of where the patient receives care.

Develop and disseminate national standards for evidence-based treatments.

It is important that treatments be delivered with fidelity, or as they were designed to be delivered. Evidence-based treatments for which the VHA Office of Mental Health Services has disseminated written national standards appear to be implemented with more fidelity than treatments for which the VHA has not disseminated national standards. Specifying what is expected when a particular evidence-based treatment is delivered is an important first step in ensuring treatment fidelity and effectiveness.

Recommended Strategies:

1. Develop and disseminate national implementation standards for evidence-based treatments.
2. Use results from the extensive research conducted by VA implementation-science researchers to address the gaps identified by the evaluation. The VA is unique in that it has a number of health-services research and development programs, as well as quality-improvement programs. Better communication between VA researchers and VA clinical services could help make use of VA expertise in this area.

Conduct additional research using the linked data set developed by the evaluation.

Despite the comprehensiveness of our evaluation, a great deal more could be learned. We observed significant variations in performance across every characteristic we examined, sometimes by more than 25 percentage points. Understanding the cause of these variations could allow the VHA to develop strategies to help lower-performing VISNs improve. Knowledge of which practices and quality-improvement strategies are associated with the greatest increases in quality (outcomes) per unit cost could help the VA become more efficient.

Some priority areas for further research suggested by our results are below.

1. What is the basis for variations in care that we observed? To what extent are they a function of poor documentation rather than variation in performance?
2. What can be learned from high-performing or low-performing sites?
3. What are the costs associated with quality improvement?
4. How can high quality be achieved in the most cost-efficient manner?

We do not know how suicide can be prevented, but the best evidence to date supports providing quality mental health care. The VA has substantial capacity to deliver mental health and substance use treatment to veterans with mental illness, and it outperformed the private sector on most quality indicators, which most likely demonstrates the significant advantages that accrue from an organized, nationwide system of care. Nonetheless, the VA is falling short of its own implicit expectations for providing the highest quality of care for our Nation's veterans. Our study revealed ways in which the VA could build upon its current system of care with marginal effort to improve quality and potentially prevent suicides.

Thank you again for the opportunity to testify today and to share the results of the research. Additional information about our study findings related and recommendations can be found at: http://www.rand.org/pubs/technical_reports/TR956.html.

Table 1: Total FY 2008 VA Mental Health Program Evaluation Veterans, by VISN

VISNF	VISN Name
1	New England Health Care System
2	VA Health Care Network Upstate New York
3	VA New York/New Jersey Health Care System
4	VA Stars and Stripes Health Care Network
5	VA Capitol Health Care Network
6	Mid-Atlantic Health Care Network
7	VA Southeast Network
8	Florida/Puerto Rico Sunshine Health Care Network
9	VA Mid-South Health Care Network
10	VA Health Care System of Ohio
11	Veterans in Partnership Network
12	VA Great Lakes Health Care Network
15	VA Heartland Network
16	South Central VA Health Care Network
17	VA Heart of Texas Health Care Network
18	VA Southwest Health Care Network
19	VA Rocky Mountain Network
20	VA Northwest Network
21	VA Sierra Pacific Network
22	VA Desert Pacific Health Care Network
23	VA Midwest Health Care Network

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Chairwoman Buerkle, Ranking Member Michaud, and Members of the Subcommittee: Thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) efforts to reduce suicide among America's Veterans. I am accompanied today by Antonette Zeiss, Ph.D., Chief Consultant for Mental Health, VHA. My testimony today will cover four areas: first, recent data on suicidality in Veterans and VA's Suicide Prevention Program; second, VA's Veterans Crisis Line and Veterans Chat (an online resource); third, VA's outreach and informational awareness efforts to reduce suicide among Veterans; and finally, VA's impact on reducing suicide among high risk Veterans.

Let me begin by saying how very important this issue is to VA and all of us in the VA health community. We believe even one suicide among our Servicemembers or Veterans is one too many. According to the recently released “Charting the Future of Suicide Prevention: A 2010 Progress Review of the National Strategy and Recommendations for the Decade Ahead” prepared by the Suicide Prevention Resource Center and Suicide Prevention Action Network, the Veterans Health Administration (VHA) has “developed a comprehensive strategy to address suicides and suicidal behavior that includes a number of initiatives and innovations that hold great promise for preventing suicide attempts and completions.” The Review was developed by the Suicide Prevention Resource Center (a national suicide prevention education organization), with funding from the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration (SAMHSA) for the National Action Alliance for Suicide Prevention. The Action Alliance is the public-private partnership advancing the National Strategy for Suicide Prevention and was launched in September 2010. The Review cites VA as becoming one of the most vibrant forces in the U.S. suicide prevention movement, implementing multiple levels of innovative and state-of-the-art interventions, backed up by a robust research capacity. We have initiated several programs that put VA in the forefront of suicide prevention for the Nation. Chief among these are:

- Establishment of a national Crisis Line, Chat Service, and texting option, including a major advertising campaign to provide the Crisis Line phone number and Web site to all Veterans and their families;
- Placement of Suicide Prevention Coordinators (SPC) at all VA medical centers;
- Development of an enhanced package of care for high risk Veterans;
- Expansion of mental health services;
- Integration of primary care and mental health services; and
- Creation of a new “Make the Connection” campaign to help make it easier to seek mental health assistance.

I will discuss these initiatives in detail later in my testimony.

VA’s Suicide Prevention Program

In response to the urgent need for suicide prevention efforts, VA has significantly expanded its suicide prevention program since 2005, when it initiated the Mental Health Strategic Plan and the Mental Health Initiative Funding. In 2006, VA provided training on evidence-based interventions for suicide and provided funding to begin integrating mental health care into primary care settings and expanding services at community-based outpatient clinics (CBOC) for treatment of mental health conditions such as post-traumatic stress disorder (PTSD), and substance use disorders (SUD). In 2007, VA began providing specific funding and training for each facility to have a designated SPC; it also held the first Annual Suicide Awareness and Prevention Day and opened the Veterans Crisis Line (then referred to as the National Veterans Suicide Prevention Hotline) in partnership with SAMHSA.

VA also established access standards that require prompt evaluation of new patients (those who have not been seen in a mental health clinic in the last 24 months) with mental health concerns. New patients are contacted by a clinician competent to evaluate the urgency of the Veteran’s mental health needs within 24 hours of their first referral. If it is determined that the Veteran has an urgent care need, appropriate arrangements (e.g., an immediate admission) are made. If the need is not urgent, the patient must be seen for a full mental health diagnostic evaluation and development and initiation of an appropriate treatment plan within 14 days. VA accomplishes its access standards more than 95 percent of the time. In 2007, VA initiated system-wide suicide assessments for those Veterans screening positive for PTSD and depression in primary care; instituted training for Operation S.A.V.E. (which trains non-clinicians to recognize the SIGNS of suicidal thinking, to ASK Veterans questions about suicidal thoughts, to VALIDATE the Veteran’s experience, and to ENCOURAGE the Veteran to seek treatment); and required SPCs to begin tracking and reporting suicidal behavior. In addition, VA added more SPCs in its larger medical centers and CBOCs, doubling the number of dedicated suicide prevention staff in the field. By 2008, VA had re-established a monitor for mental health follow-up after patients were discharged from inpatient mental health units, developed an on-line clinical suicide risk training program, and held a fourth regional conference on evidence-based interventions for suicide.

VA also added the development of an enhanced package of care for high risk patients. Evidence clearly demonstrates that once a person has manifested suicidal behavior, he or she is more likely to try it again. As a result, VA also has put in place sensitive procedures to enhance care for Veterans who are known to be at high risk for suicide. Whenever Veterans are identified as surviving an attempt or are other-

wise identified as being at high risk, they are placed on the facility high-risk list and their chart is flagged such that local providers are alerted to the suicide risk for these Veterans. In addition, the SPC will contact the Veteran's primary care and mental health provider to ensure that all components of an enhanced care mental health package are implemented. These include a review of the current care plan, addition of possible treatment elements known to reduce suicide risk, ongoing monitoring and specific processes of follow-up for missed appointments, individualized discussion about means reduction, identification of a family member or friend with the Veteran's consent (either to be involved in care or to be contacted, if necessary), and collaborative development with the Veteran of a written safety plan to be included in the medical record and provided to the Veteran. In addition, pursuant to VA policy, SPCs are responsible for, among other things, training of all VA staff who have contact with patients, including clerks, schedulers, and those who are in telephone contact with Veterans, so they know how to get immediate help when Veterans express any suicide plan or intent.

The enhanced care package also includes mandates for follow-up after the high risk designation and safety planning. In 2009, VA launched the Veterans Chat Service to create an online presence for the Veterans Crisis Line. VA developed and disseminated training programs for safety planning and has continued to monitor all of these efforts and implement facility-specific strategies over the past few years. VA has also released new training programs concerning issues in specific populations, such as geriatrics and women.

VA has augmented the original SPC placement at every facility and large CBOCs with additional suicide prevention team staff, and these staff members are an important component of our mental health staffing. The SPCs ensure local planning and coordination of mental health care and support Veterans who are at high risk for suicide, provide education and training for VA staff, do outreach in the community to educate Veterans and health care groups about suicide risk and VA care, and provide direct clinical care for Veterans at increased risk for suicide. One of the main mechanisms to access enhanced care provided to high risk patients is through the Veterans Crisis Line, and the linkages between the Crisis Line and the local SPCs. For example, when a Veteran, in crisis, calls the Crisis Line, he or she is provided a referral for immediate care, a high risk flag is placed on the chart and the Veteran is provided high risk services. The Crisis Line staff follows up to assure that this care is provided.

VA cannot accomplish this mission alone; instead, it works in close collaboration with other local and Federal partners, including SAMHSA in the Department of Health and Human Services (HHS), and brings together the diverse resources within VA, including individual facilities such as the Center of Excellence in Canandaigua, New York and a Mental Illness Research and Education Clinical Center in Veterans Integrated Service Network (VISN) 19 (Denver, CO). We also work closely with community agencies across the country. The DoD and VA are working together on a number of issues and the VA is a member of the DoD Suicide Prevention and Risk Reduction Workgroup. The DoD/VA Nomenclature and Data Working Group is moving toward common definitions of fatal and non-fatal suicide events, and working toward a joint database to better capture the impact of suicide on the military community as a whole.

During fiscal year (FY) 2011, VA's SPCs reported 16,976 suicide attempts among patients and non-patients, 779 of which were fatal (4.5 percent). One of the premises of the VA suicide prevention program is that we can make a difference in Veterans who have attempted suicide and are known to be at high risk. The percentage of those who died from suicide (and reported by VA's Suicide Prevention Coordinators) with a report of previous suicide attempts decreased from 31 percent in FY 2009 to 27 percent in FY 2010 and FY 2011. This suggests that the strategy of implementing the enhanced care package with our high risk patients has been effective.

It is not possible to determine if the reported cases are representative of suicidality in VA's patient population, but we do know that suicidality can be both an acute and a chronic condition. Those who survive attempts are at high risk for reattempting and dying from suicide within a year, so it is essential that we engage survivors in intensified treatment to prevent further suicides. It is precisely because of this concern that VA has initiated the post-discharge follow-up for patients leaving its inpatient mental health units. The data reported above include self-reporting of previous suicide attempts that have not been validated by VA, and all estimates are based on events reported in the SPC database and may not represent the complete number of suicide attempts among Veterans. Also, the records of suicide attempts for 136 Veterans were incomplete and omitted from this analysis.

VA's Vet Centers also fulfill a critical role in reducing the risk of Veteran suicide. Vet Centers promote access to care by helping Veterans and families overcome bar-

riers that impede them from utilizing other benefits or services. Vet Centers remain a unique and proven component of care by providing an alternate door for combat Veterans not ready to access the VA health care system. There are currently 296 Vet Centers operating with four more scheduled to open by the end of 2011. This will bring the total to 300 Vet Centers across the country and in surrounding territories (the U.S. Virgin Islands, Puerto Rico, Guam, and American Samoa). Thirty-nine (39) of these Vet Centers are currently located in rural or highly rural areas. In addition, seventy (70) Mobile Vet Centers provide early access to returning combat Veterans through outreach to a variety of military and community events, including demobilization activities.

Crisis Line and Veterans Chat Service

VHA's Crisis Line started in July 2007, and the Veterans Chat Service was started in July 2009. To date the Crisis Line has:

- Received over 500,000 calls;
- Initiated over 18,000 rescues;
- Referred over 73,000 Veterans to local VA SPCs, for same day or next day services;
- Answered calls from over 6,700 Active Duty Servicemembers;
- Responded to over 31,000 chats; and
- Initiated a pilot program that uses text messaging that is reaching a new group of Veterans who are much more likely to use text messaging than to call.

The Crisis Line has 20 active phone lines and is staffed with mental health professionals and support staff to provide services 24 hours, 7 days a week, 365 days a year. After receiving a call from a Veteran, Servicemember or family member, the responder conducts a phone interview to assess the Veteran's emotional, functional, and psychological condition. The responder then determines the level of the call, namely whether it is emergent, urgent, routine, or informational.

Calls requiring emergency services necessitate keeping the caller (or the person about whom the caller is concerned) safe; urgent care requires same day services at a local VA facility; and routine calls require a consultation by the local SPC. Consults occur if a Veteran consents to a consultation or if emergency services are required; these consults are simply alerts to the SPC and do not mean the Veteran is suicidal. Even if the Veteran is already engaged in treatment, a consultation can be done to alert the SPC to changes in the Veteran's circumstances or to other needs he or she may have.

The online version of the Crisis Line, the Veterans Chat Service, enables Veterans, family members and friends to chat anonymously with a trained VA counselor. If the counselor determines there is an emergent need, the counselor can take immediate steps to transfer the visitor to the Hotline, where further counseling and referral services can be provided and crisis intervention steps can be taken. Veterans Crisis Line and Chat Service are intended to reach out to all Veterans, whether they are enrolled in VA health care or not.

Outreach and Awareness of VA's Suicide Prevention Efforts

This past year, VA looked hard at its plan to communicate to Veterans and their families the highlights of the Suicide Prevention program as well as those of the Crisis Line and Chat Service. VA and SAMHSA continue to work together to ensure all Americans in emotional distress or suicidal crisis have a single confidential number (1-800-273-8255) to call for help. After much deliberation and consultation with Veterans and users, VA determined that to reach more Veterans and to relay the message that treatment works, it would strategically rebrand the national Veterans Suicide Prevention Hotline. An important component of this comprehensive effort involved a new name: *Veterans Crisis Line*, which establishes a unique identity for this critical service. Research informed VA's decision to rebrand the service as a crisis line, thus lowering the threshold from "suicide" to "crisis" for Veterans, Servicemembers, and their families to encourage them to make that critical first call for help. The rebranding is an integrated national outreach effort to increase awareness and use of the Veterans Crisis Line and confidential online chat service, support and promote broader VA suicide prevention efforts, and promote help-seeking behaviors among Veterans at risk of suicide and other mental health problems. The new messaging reinforces the confidentiality of the Veterans Crisis Line for Veterans, Servicemembers, and their families, who may be the first to realize a Veteran is in crisis. Messaging efforts also involve all Service branch representatives to provide messages and "looks" to materials that are Servicemember specific.

As discussed previously, VA's SPCs do a tremendous amount of work to raise awareness about warning signs associated with suicide and the availability of treat-

ment and support. For example, in a typical month, VA's SPCs provide approximately 700 informational and outreach programs in their local communities. As a result, VA identifies approximately 1,500 high risk Veterans a month and adds them to the High Risk List. Between 90 and 95 percent of these Veterans complete safety plans and are involved in the enhanced care package.

In addition to these measures, VA has been aggressively advertising this information and improving outreach to Veterans and family members alike. Suicide prevention outreach needs to use carefully tailored and targeted messaging. Unlike outreach for many other health issues which rely on underscoring the prevalence of the problem, outreach for suicide prevention that emphasizes rising suicide rates among Veterans runs the risk of normalizing suicidal behaviors, helping to convince Veterans in crisis that considering suicide is a normal or even expected response to their challenges—and possibly leading to an increase in suicide attempts. Through our messaging efforts, VA provides effective and safe outreach that focuses on affirming Veterans' strength and resilience and reinforcing help-seeking behavior.

In recent years, VA has supported a series of public education campaigns designed to increase awareness of crisis resources and promote seeking help among Veterans experiencing distress. VA has evaluated each of these campaigns in an effort to understand the impact of public education efforts on calls to crisis services and attitudes related to crisis service use. In a series of studies, VA evaluated the impact of implementation of the Veterans Crisis Line on total call volume to VA and non-VA crisis services, comparisons of call volume in campaign implementation and control communities, and associations between exposure to public education campaign media and willingness to use crisis services when experiencing distress. Results from these assessments have demonstrated strong relationships between implementation of the Veterans Crisis Line and increased use of VA and non-VA toll-free crisis services, significantly increased call volume in communities where concentrated public education campaigns have been implemented, and an increased willingness to use crisis services following exposure to public education media. Together, results from these studies provide consistent evidence of the impact of public education campaigns on awareness and use of crisis services. VA is continuing to assess the impact of public education campaigns for both the Veterans Crisis Line and the Make the Connection campaign in a series of studies designed to measure the impact of repeated exposure to media material among high risk and general populations and the efficacy of media messages tailored to individual histories. A total of four Public Service Announcements have been released and widely distributed. VA spends approximately \$4.5 million on this public awareness campaign annually.

VA's Impact on Reducing Suicide

On the macro level, one way to evaluate the impact of VA mental health care and VA's suicide prevention program is to evaluate suicide rates. However, before addressing this issue, it is important to consider who accesses VA health care. For this, it is useful to refer to findings on those Veterans returning from Afghanistan and Iraq who participated in the Post-Deployment Health Re-Assessment (PDHRA) program administered by DoD. Between February 2008 and September 2009, approximately 119,000 returning Veterans completed PDHRA assessments using the most recent version of DoD's PDHRA form. Of the more than 101,000 who screened negative for Post-Traumatic Stress Disorder (PTSD), 43,681 (43 percent) came to VA for health care services. Among 17,853 who screened positive for PTSD, 12,674 (71 percent) came to VA for health care services. These findings demonstrate that Veterans screening positive for PTSD were substantially more likely to come to VA for care. Findings about depression were similar. Both sets of findings support earlier evidence that those Veterans who come to VA are those who are more likely to need care and to be at higher risk for suicide. The increased risk factor for suicide among those who came to VA is often referred to as a case mix difference. We have just received the 2009 death data from the National Death Index and have begun to look at these numbers in relationship to Veterans who receive care in VA. We are encouraged by these data, which indicate that there is no increase in rates among VA users despite national increases, especially in middle-aged men. We believe that this indicates that our strategies are having an effect. There are some overall positive indicators that include:

- Suicide rates among Veterans who use VA health care have decreased since 2001.
- There is a decrease in suicide rates among Veterans under 30 who use VA health care relative to Veterans who do not use VA services, in those states that report through the National Violent Death Reporting System (NVDRS).
- There is a recent decrease in rates in men aged 40–59 receiving care from VA relative to rates of men of this age in America as a whole.

Specific information obtained from the 2009 data, for Veterans who use VA health care, includes:

- In FY 2009, the suicide rate per 100,000 person-years among all VA health care users was 35.9, as compared to 36.6 in FY 2008. Among males, it was 38.3, versus 38.7 in FY 2008. Among females, it was 12.8, versus 15.0 in FY 2008.
- In FY 2009, there were 22 suicides among male Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) Veterans age 18–24. The suicide rate in this group was 47.1 per 100,000. By comparison, in FY 2008, there were 32 suicides and a rate of 75.4 per 100,000.
- In FY 2009, the suicide rate among individuals with mental health or substance use disorder diagnoses was 56.4 per 100,000, as compared to 23.5 among patients without these diagnoses. The resulting rate ratio was 2.4. This continues a steady trend of reducing rate ratios observed since FY 2001, when the rate among patients with mental health or substance use disorder diagnoses was 78.0 as compared to 24.7 among patients without these diagnoses (rate ratio of 3.2)

VA's Ongoing Research to Identify Risk Factors for Suicide Prevention and Treatment

VA's research portfolio includes studies focused on identifying risk factors for suicide, prevention, and treatment. Risk factors being studied include co-morbid disorders, medications, and behaviors. A few specific examples include:

- In one study, VA researchers seek to determine the prevalence of suicide ideation, plans, and attempts resulting in medical treatment among Veterans currently enrolled in VA's health care system. The researchers will also collect data on a limited number of established risk factors and characteristics unique to military service that can be used to understand correlates of non-fatal suicidal behaviors.
- A VA Suicide and Self-Harm Classification System and Clinical Tool is being evaluated to determine the feasibility for implementation in diverse VA treatment settings and to assess its impact on health care system processes pertaining to the assessment and management of suicide risk.
- The VISN 2 Center of Excellence, in Canandaigua, NY, in collaboration with the National Center for Homelessness among Veterans, is conducting a study of risk factors for suicide among Veterans with a history of homelessness or housing instability. Characteristics of service utilization, the independent effect of homelessness, and differences in risk associated with psychiatric diagnoses are being studied through the use of homeless intake assessments, non-fatal suicide event data, and data obtained from the National Death Index.
- VA researchers are determining the role of a brain chemical called serotonin in suicide and seek to discover whether alterations in levels of this chemical impact suicide.
- The Suicide Assessment and Follow-up Engagement: Veteran Emergency Treatment Project (SAFE VET) is a clinical demonstration project that focuses on providing a brief intervention and follow-up for suicidal Veterans who present to the Emergency Department and Urgent Care Services and who do not require hospitalization. This study also permits us to longitudinally follow risk factors in Veterans identified as being at moderate risk for suicide.
- Motivational Interviewing to Prevent Suicide in High Risk Veterans is a study to test the efficacy of an adaptation of Motivational Interviewing to Address Suicidal Ideation (MI-SI) on the severity of suicidal ideation in psychiatrically hospitalized Veterans at high risk for suicide. The researchers also are examining the impact of MI-SI on risk factors for suicide in Veterans, such as treatment engagement and psychiatric symptoms.
- Many completed studies addressing suicide epidemiology have been published by VA investigators, providing important information related to risk factors.
- VA is also doing extensive work in traumatic brain injury (TBI), including how Veterans with a TBI may be at risk for mental health issues and suicide. Our work in TBI will also give us a broader knowledge about suicide in general.

Conclusion

Madam Chairwoman, as my testimony demonstrates, VA's efforts to provide comprehensive suicide prevention services are comprehensive and continuously improving. Since our suicide prevention effort began in 2005 we have revisited it often to make sure it continues to meet our Veterans' needs, made adjustments when necessary, and will continue to do so as new research helps us uncover new ways to prevent these tragedies. It is clear our mission will not be fully achieved until every

Veteran contemplating suicide is able to secure the services he or she needs. The Department appreciates Congressional support of our work in this area. I am prepared to answer your questions.

**Prepared Statement of Colonel Carl Castro, Ph.D., Director,
Military Operational Medicine Research Program, U.S. Army
Medical Research and Materiel Command, and Chair, Joint Program
Committee for Operational Medicine, Department of the Army,
U.S. Department of Defense**

Madam Chairwoman, Members of the Committee, thank you for the opportunity to discuss the joint Department of Defense (DoD) and Department of Veterans Affairs' (VA's) efforts to advance our understanding of how to prevent suicide. We acknowledge Congress' concern and thank you for your support, which allows the DoD and VA to continue their commitment to better understand suicide and develop effective prevention and treatment interventions based on that knowledge. Our efforts demonstrate our obligation and dedication to the men and women of our Armed Forces, to their Families who serve with them, and to the millions of military personnel who have served us in the past.

Suicide is a significant public health problem, identified as the third leading cause of death in young people and the 11th overall leading cause of death in the U.S. population. Traditionally, military suicide rates have been significantly lower than general population rates. However, in 2008, Army suicide rates (19.6/100,000) exceeded the age-adjusted civilian rate and outnumbered combat deaths for the first time since 2003 (Armed Forces Medical Examiner, 2008). However, the reason for the increase in Army suicides remains unknown.

Rigorous empirical research is necessary to understand why military suicides occur and how to identify and help individuals at risk for suicide. Only evidence-based empirically validated methods for screening, assessment, prevention and treatment interventions will be successful in preventing suicides. There are currently no validated suicide screening and assessment measures.

Military Suicide Prevention Research Program

In 2007, Defense Health Program (DHP) funding supported multiple military suicide research studies that were initial studies to test brief cognitive therapy for treating individuals who had been hospitalized for suicide attempt. In 2008, DHP funding was dedicated to several military suicide studies focused on developing our ability to optimize screening and assessment of risk, psychotherapeutic treatments, and methods to decrease suicide. In the next few years, the results of these studies will be available to inform policy recommendations as well as methods for preventing and treating suicidal individuals. Almost all of the DHP funded military suicide research studies include VA involvement, including either VA principal investigators, VA recruitment sites, or VA collaborators on the research team.

In March 2009, the U.S. Army Medical Research and Materiel Command's (USAMRMC) Military Operational Medicine Research Program (MOMRP) and the Army Surgeon General's office led a series of workshops with leading suicidologists and military and Federal stakeholders, including the VA, to determine the state of science of suicide prevention research. The workshops led to the development of a research strategy with recommendations provided to MOMRP and the Joint Program Committee, which is composed of DoD, National Institutes of Health, and VA leadership as well as academic representatives. The research recommendations were in 4 focused areas: suicide risk screening and assessment; universal prevention training; indicated interventions to manage suicide behavior; and recommendations for revisions to the Post Deployment Health Assessment and Post Deployment Health Reassessment. The workshops also involved the U.S. Army Public Health Command (PHC), which has resources dedicated to epidemiological study and tracking of Army suicides.

The DoD developed and implemented a Military Suicide Prevention Research Program, which represents an approximately \$110 million investment, since 2008. Following the recommendations generated from the workgroups, and consistent with the Army and DoD suicide prevention strategies, the Military Suicide Prevention Research Program employs a comprehensive strategic approach to provide evidence-based, rigorously evaluated, screening, assessment, and suicide prevention interventions. The DoD and VA collaborate on many aspects of the Military Suicide Prevention Research Program, which also involves extensive collaboration among other government organizations, academia, and national organizations such as the Amer-

ican Foundation for Suicide Prevention and the American Association for Suicidology Research.

Military Suicide Research Consortium

In September 2009, the DoD established a first of its kind, multidisciplinary Military Suicide Research Consortium (MSRC). This effort is funded by the Office of the Assistant Secretary of Defense for Health Affairs, managed by the USAMRMC, and co-directed by Dr. Peter Gutierrez, of the Veterans Integrated Service Network 19 Mental Illness Research Education and Clinical Center of the Denver Veterans Affairs Medical Center, and Dr. Thomas Joiner, of Florida State University. The co-directors are world renowned experts in suicidology. The MSRC was initially funded in the amount of \$17 million with the aim of enhancing the military's ability to quickly identify individuals and units at risk for suicide and provide effective evidence-based prevention and treatment strategies.

The MSRC includes core infrastructure as well as funded research efforts aimed at rapidly developing and validating effective suicide screening, assessment, and prevention interventions. The studies that are funded by the MSRC are all required to use a minimum set of common measures so that data can be pooled across the studies. This larger data pool can then be analyzed to determine empirically if there are different sub-types of suicide, a vital question to answer for both improvement of assessment techniques and developing targeted interventions. The participating VA researchers are on the cutting edge of suicide prevention and treatment research. The MSRC complements the Army Study to Assess Risk and Resilience (Army STARRS) in Servicemembers effort which is primarily descriptive (epidemiologic) in focus.

Army STARRS

In order to better understand the factors related to suicide, the Department of the Army and the National Institute of Mental Health (NIMH) are involved in an ongoing multidisciplinary collaboration to conduct a large scale epidemiological study of suicide in the military. This effort is being led by Dr. Robert Ursano from the Uniformed Services University of the Health Sciences and Dr. Murray Stein from the University of California, San Diego. This \$65 million project (\$50 million from Army and \$15 million from NIMH) is the largest epidemiologic study of mental health, psychological resilience, suicide risk, suicide-related behaviors and suicide deaths in the military. The findings from this effort will be used to inform current and future suicide prevention efforts to enhance their effectiveness.

Way Ahead

Despite the current investment in suicide prevention research, there is much more work to be done in the area of suicidology. The strategic research plan calls for further DoD and VA collaboration to conduct research that comprehensively addresses necessary components: screening and surveillance; prevention training; assessment, treatment, and management of suicidal individuals. Future research will focus on developing evidence-based universal prevention (e.g., peer based, family based, community based, military-ecologically based). Additionally, current prevention efforts need to be evaluated for effectiveness.

Future research is also needed to establish psychometrically sound, theory-driven screening measure(s). Basic science to validate underlying psychological and biopsychological theories of suicide will help to drive prevention and treatment efforts. Further research is required to establish evidence-based indicated interventions to prevent and manage suicide behavior (e.g., caring outreach, collaborative assessment and management, safety planning, collaborative care models, etc.) across clinical care settings (e.g., Emergency Department, Behavioral Health, Primary Care, etc.).

Madam Chairwoman and Committee members, the DoD continues work with the VA to perform and manage world-class medical research and development for a population that demands and deserves the best care available. Thank you again for the Congress' and this Committee's continued support and commitment to research dedicated to ensuring our Warfighters are getting the best empirically proven cutting edge training and services. And thank you for the opportunity to be with you today. I look forward to your questions.



Prepared Statement of Paula Clayton, M.D., Medical Director, American Foundation for Suicide Prevention

Chairwoman Buerkle, Ranking Member Michaud, and Members of the Committee. Thank you for inviting the American Foundation for Suicide Prevention (AFSP) to provide a written statement on the issue of suicide and suicide prevention among our nation's veterans. My name is Paula Clayton. I am AFSP's medical director. As such, I work with AFSP's Scientific Council to oversee the research and educational programs of the foundation and to apply evidenced based knowledge to these programs and to the programs that deal with suicide prevention.

Prior to becoming medical director, I was an academician. I trained in psychiatry and joined the faculty at Washington University School of Medicine in St. Louis Missouri and then became chairman of the department of psychiatry at the University of Minnesota School of Medicine, a job I held for nearly 20 years. That was followed by becoming a professor of psychiatry at the University of New Mexico. In all positions, my research, teaching and patient care concentrated on patients with major depression and bipolar illness and those who were recently bereaved. Since approximately 15 percent of patients diagnosed with a mood disorders die by suicide, the outcome of suicide is one I and all psychiatrists work to prevent. Becoming medical director of the foundation was a natural extension of my accumulation of knowledge about the subject.

AFSP is the leading national not-for-profit, grassroots organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. You can see us at www.asfp.org.

To fully achieve our mission, AFSP engages in the following Five Core Strategies: (1) Funds scientific research, (2) Offers educational programs for professionals, (3) Educates the public about mood disorders and suicide prevention, (4) Promotes policies and legislation that impact suicide and prevention, (5) Provides programs and resources for people with mental disorders and for survivors of suicide, and involves them in the work of the foundation.

We are pleased today to focus in my statement on identifying at-risk veterans, data collection, providing effective intervention and treatment, and meeting the ongoing challenges of veteran suicide prevention.

Chairwoman Buerkle, Ranking Member Michaud, suicide in America today is a public health crisis. Consider the facts:

- More than 36,000 people died by suicide in 2008, the last year of the CDC report. And these numbers have been rising yearly.
- Approximately 20 percent of these deaths were veterans, although they only make up 1 percent of our population.
- Suicide is the 4th leading cause of death in the United States for adults 18–65 years old and is the third leading cause of death in teens and young adults from ages 15–24.
- Male veterans are twice as likely to die by suicide as male non-veterans. On average 18 veterans commit suicide each day, which means that every 80 minutes a veteran dies by suicide. Sadly, only five of these veterans are in the care of the VA.
- Men account for 80 percent of all completed suicides in America.
- Depression, alcohol and substance abuse, Post-Traumatic Stress Disorder and traumatic brain injury are real medical conditions.

We need to convince veterans that seeking help for mental illness and substance abuse problems is a sign of strength not weakness. The keys to improving these statistics are reducing the stigma associated with mental illness, encouraging help-seeking behavior, and being aware of warning signs and treatment options.

Suicide is the result of unrecognized and untreated mental disorders. In more than 120 studies of a series of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their deaths. The most common is major depression, followed by alcohol abuse and drug abuse, but almost all of the psychiatric disorders have high suicide rates.

So the major risk factors for suicide are the presence of an untreated psychiatric disorder (depression, bipolar disorder, generalized anxiety and substance and alcohol abuse), the history of a past suicide attempt and a family history of suicide or suicide attempts. The most important interventions are recognizing and treating these disorders. Veterans have strong biases against doing that. These must be identified and overcome.

Whether a civilian or a veteran, there are signs that health care professionals look for, what we call risk factors. In addition to those above, they include:

- Difficulties in a personal relationship;
- A history of physical, sexual or emotional abuse as a child;
- Family discord;
- Recent loss of a loved one;
- A recent arrest;
- Sexual identity issues;
- Availability of firearms.

Protective factors or interventions that work, again in the general population and for veterans include:

- Regular consultation with a primary care physician;
- Effective clinical care for mental and physical health, substance abuse;
- Strong connections to family and community support;
- Restricted access to guns and other lethal means of suicide.

The VA has adopted a broad strategy to reduce the incidence of suicide among veterans. This strategy is focused on providing ready access to high quality mental health and other health care services to veterans in need. Congress needs to fund the VA to deal with these current and future mental health care needs in the next five, ten, fifteen and 20 years. This effort is complemented by helping individuals and families engage in care and addressing suicide prevention in high risk patients. The VA cannot do it alone, and groups like the American Foundation for Suicide Prevention are helping in this important effort. AFSP is pleased to report that while our country and the VA have a long way to go, help is available.

In the summer of 2007 the VA began a crisis line for veterans and military servicemembers, in conjunction with the National Suicide Prevention Lifeline (1-888-273-TALK). Veterans, military servicemembers, and persons who are calling about someone in either of these populations are directed to press "1," thereby having their call directed to a team of crisis line counselors at the VA in Canandaigua, NY. In the first 3 years, more than 144,000 calls were received at this call center, and the volume of calls to the Veterans Crisis Line has continued to grow. Although it is not possible to accurately estimate the number of lives that have been saved as a direct result of the Veterans Crisis Line, call records maintained by the VA point to the diverse needs that are being met among the target population by this well-trained, skillful corps of counselors.

In 2009, the VA began offering an online Veterans Chat service to augment the Veterans Crisis Line and provide access to information and services to veterans, military personnel and their loved ones who prefer internet-based communication to the telephone. In mid-2010, AFSP and the VA began discussing whether completing an online assessment instrument prior to engaging with a Chat Counselor might help users more easily and specifically communicate their needs and problems to the Counselor, thereby increasing the quality of the Chat. Such an option was thought to have particular potential for those veterans and servicemembers who find it difficult to identify and clearly describe what they are feeling and experiencing. These discussions led to the launch of the Veterans Self-Check Quiz in April 2011. This program is an adaptation of AFSP's highly successful, evidence-based Interactive Screening Program, an anonymous, web-based method for identifying college and university students who are at-risk for suicide, and connecting them to a counselor who can engage them to get treatment. This program is based on the premise that at-risk persons often have beliefs and attitudes which create barriers to treatment, which must be addressed and resolved before the person will be responsive to offers of help.

For the last 7 months, the Veterans Self-Check Quiz has been offered on the National Suicide Prevention Lifeline Web site as a third way of getting help, the first two being calling the Crisis Line or directly contacting the online Veterans Chat service. A link provided on the Lifeline homepage directs the user to an AFSP-developed secure Web site where the user can anonymously complete an online questionnaire that deals with depression, stress, drug and alcohol use, PTSD, traumatic brain injury, and suicidal thoughts and behaviors. Submitting the Self-Check Quiz generates a signal to the Chat Counselors in Canandaigua, NY that a Quiz has been received and needs to be responded to. The user is directed to stay on the Web site to receive the Counselor's personal response, which typically occurs in 15-30 minutes. Educational and informational materials and videos can be accessed directly from the Web site and perused by users while they are waiting.

In their responses, Chat Counselors provide feedback to the user about Quiz answers of particular concern and make recommendations about help-seeking. Users are particularly encouraged to explore options by entering into a Chat with the counselor, using a link to the Veterans Chat service. A Reference Code, which is

automatically assigned to each Self-Check Quiz and communicated to both the user and counselor, allows tracking of those users who come into a Chat directly from the Self-Check Quiz.

In the initial 6 months of the program, almost 6,000 Self-Check Quizzes were submitted, the large majority of which were from veterans. A high percentage of the submitted Quizzes suggested serious suicide risk. Using the Reference Codes, one-third of those who submitted the Quiz could be identified as having engaged in a follow-up Chat. A significant increase in Chat volume that paralleled the introduction of the Self-Check Quiz suggests that many more users may have entered a Chat days or maybe even weeks after submitting the Quiz without providing the Reference Code that would have signaled that a Quiz had been submitted. Analysis of the data from the initial 6-month period has just begun and results will be reported as soon as these are available.

AFSP applauds the VA in its use of this innovative, proactive approach to reach out to veterans and servicemembers who, for a variety of reasons, are not themselves initiating contact with the VA as they are struggling with mental health problems. We look forward to continuing this collaboration with the VA, using the findings from the pilot implementation to make enhancements to the program, and exploring ways to make this outreach effort even more effective.

In this regard, we might consider experimenting with a small-scale implementation of the program at a local VA medical center or other facility. AFSP's campus-based Interactive Screening Program has shown that a mental health professional in the Counseling Center of the student's own university can very effectively use the anonymous online interactions to help students address their barriers to help-seeking and engage them to pursue in-person treatment, at least initially with that same counselor. It is worth exploring whether the Self-Check Quiz could be effectively used on the local level to reach out to and engage veterans to seek treatment for mental health problems that put them at risk for suicide.

The VA has gone on to develop other suicide prevention programs and to educate their health workers about suicide risk factors and ways to intervene.

Unfortunately, they face enormous challenges.

First of all, only about one-third of our veterans are in VA care. Those who are employed frequently choose to use the private insurance their employers provide and are therefore not in the VA care system. Others are unemployed; a condition in itself associated with higher suicide rates. Even tracking these men and women is difficult, much less gathering information about the deaths.

Second, a number of veterans are homeless or perhaps in jail, and they need a different intervention plan. The VA now reports that 107,000 veterans are homeless on any given night.

In order to meet the multiple challenges that the VA faces in both suicide education and prevention, AFSP recommends consideration of the following four research initiatives and or interventions.

Number one, the most informative way to learn about suicides is through an investigation, after death, called a "psychological autopsy." This procedure, as referred to earlier, allows investigators to go in to a home in the month after the suicide, and using a structure interview, to question all the family members, physicians, perhaps friends and clergy, about the events that were occurring at the time of the suicide. It allows the investigator to decide, putting all the interviews together, what were the signs and symptoms that the veteran was displaying prior to his death. Was he depressed, sleeping poorly, losing weight, talking about being a burden, becoming more irritable? Was he drinking, using drugs, prescription or otherwise, that may have contributed to his mood and his lack of control? Was he fighting with his family, isolating, in an accident, ill, in pain, been arrested or had trouble with the law? Given that information on a randomly chosen group of veterans, the VA could develop a clearer picture of the mental disorders that lead a veteran to suicide and plan intervention programs based on those findings. I am not sure we even know the means by which veterans die by suicide. Although in most of the 120 psychological autopsy studies done they are concentrated in one city or country, it is possible to train several teams to do this for the country, thereby allowing a "team ready" approach to the issue. If they found, for instance, that 15 percent of the veterans had enough behavioral problems that the police were called, then training policeman to be particularly careful and aware on such a call that this may be a veteran in trouble and in need of a psychiatric evaluation would be paramount. The police, in many states, are able to take people who are dangerous to themselves and others to an evaluation facility.

Number two, another proven successful intervention is to train primary care physicians and nurse assistants to diagnose and treat depressed patients with antidepressants. There are at least four communities where this has shown to de-

crease the suicide rate, the most impressive being one carried out by the World Health Organization in four different underdeveloped countries. The VA could and should begin immediately to train the collateral primary care and ER physicians and their personnel to recognize and treat depression or alcohol or substance abuse and every veteran's chart should have this information in front or on the screen as it is opened. There are also drug screens and liver function tests that might lead a caregiver to suspect there is a drug or alcohol abuse problem. Knowing, from the psychological autopsy study, what the veteran is suffering from would help plan this intervention, too.

Number three, we need to give our veterans "real" jobs. Dr. Peter Kramer of Brown University recently wrote, "The Best Medicine Just Might Be a Job." He reports that study after study correlates unemployment with suicidality. When soldiers leave the military, they lose what the service provides: purpose, focus, achievement, responsibility, and the factor that the Center for New American Security report calls "belongingness." The workplace can be stressful, but especially for the mentally vulnerable, there is no substitute for what jobs offer in the way of structure, support and meaning.

Number four, many studies have indicated that preventing easy access to lethal means, like firearms, is an effective way to prevent suicide. Soldiers are taught to use guns and most have them available. Just as it is believed that physicians, as professionals, have knowledge and easy access to other lethal means (drugs) and therefore have the highest suicide rates of any profession, veterans have the knowledge of and access to guns, another lethal means. VA hospital and all medical personnel should be taught to ask veterans about whether they have guns in their houses and encourage the doctor or others to discuss with at-risk veterans and their family members how to store the guns safely, with gunlocks or separated ammunition and guns, or even encourage temporary removal of the weapon. A program could be planned for medical personnel and others on what they should ASK A VET?

AFSP would like to commend the U.S. Department of Veteran Affairs and Dr. Jan Kemp for their leadership and vision in constructing and implementing this program designed to help our veterans contemplating suicide. They and we still have much more to do. We urge this Subcommittee, the full Committee and the entire Congress to fully support the VA and Dr. Kemp in their important efforts by funding them at the highest levels possible, not just next year, but for many more years in the future. This is essential: once we identify veterans needing help, VA professionals must be available to assist them now, tomorrow, next week.

Chairwoman Buerkle, Ranking Member Michaud, suicide among veterans is an absolute crisis. Depression can be fatal. Excessive drinking or drug use can be fatal. The fatality is mainly by suicide. Culturally sensitive but sustained efforts with multiple approaches offer our best hope to get veterans into treatment. We must reduce this fatal outcome. The American Foundation for Suicide Prevention is ready and willing to offer our expertise and advice to the U.S. Department of Veterans Affairs, this Committee and to all members of Congress as you make the important decisions on how to reduce suicide among our veterans.

**Prepared Statement of Lieutenant Colonel Michael Pooler, USA, Deputy
Chief of Staff, Personnel, Maine Army National Guard**

Thank you, Congressman Michaud for allowing the Maine Army National Guard to submit written testimony on suicide. Suicide prevention is taken very seriously in the Maine Army National Guard from the top down. Unfortunately, since 2009, the Maine Army National Guard has had two suicides. Though we do not have specific numbers, we know that numerous interventions have occurred that have saved lives. As training continues, interventions will increase. Leaders across the state are keenly aware of the problem and are working together to reduce the stigma and create a help-seeking environment. We view the increase in interventions as confirmation that our attempt to create an environment where Soldiers, families and commanders recognize the signs of suicide and ask for help without fear of retribution as very positive progress.

Support Staff and Organizational Training

Our support staff consists of a variety of Federal and contracted personnel. Our primary Federal employees consist of two Army National Guard chaplains, a Suicide Prevention Program Manager, one Army National Guard behavioral health officer, and two substance abuse personnel. Our primary contracted personnel are: a Direc-

tor of Psychological Health, two Military Family Life and Children Consultants, a Military One Source representative, a Personal Financial Counselor and several Family Program contractors who run a 24/7 assistance hotline. Each has a part in finding help for our Soldiers and Families.

The Army National Guard has a Resiliency, Risk Reduction and Suicide Prevention (R3SP) Campaign Plan designed to coordinate various programs to ensure our Soldiers bounce back from adversity. A critical part of this is the Comprehensive Soldier Fitness program with Master Resiliency Trainers and Resiliency Training Assistants. These Soldiers support unit commanders in training Soldiers to be resilient through various means. Another component of the R3SP program is the Suicide Prevention Program Manager, who is the conduit between the National Guard Bureau and the State of Maine to coordinate and facilitate intervention training. Applied Suicide Intervention Skills Training (ASIST) is conducted semi-annually for selected servicemembers. ASIST has strategically placed trained Soldiers in units across the state to be the eyes and ears of commanders to observe the signs of suicide and provide interventions for those with suicidal ideation. ASIST is enhanced by Ask, Care, Escort (ACE), an Army-wide intervention program. ACE teaches every Soldier the warning signs of suicide, how to ask the suicide question, the nature of care needed by a suicidal Soldier, and when and how to escort such Soldiers to health care professionals to save lives. ACE is unit led, supported by unit commanders, and promotes a “buddy-care” mentality that encourages help-seeking by those going through crises or struggling with addictions. ACE is a mandatory 1-hour training block taught annually at the company level.

Suicide prevention takes many forms. Since relationship issues and substance abuse are frequently associated with suicidal thinking and behavior, we have stepped up efforts to strengthen relationships and reduce alcohol and drug abuse. Our chaplains conduct four to five Strong Bonds events annually aimed at married couples and single Soldiers to build healthy and enduring relationships. Our Counter Drug Program works tirelessly to educate and influence Soldiers, recruits, and families in the dangers and warning signs of addiction.

We also have the Maine Military and Community Network which works with clergy, law enforcement, and volunteer groups to support our Soldiers and families. A key component of this is the Maine Military Clinical Outreach Network where we train clinicians on the military culture and attempt to find civilian providers to see our Soldiers at a free or reduced rate. The Governor’s Military and Community Leadership Council also works at the policy level to coordinate comprehensive support for all our servicemembers in Maine.

Access to assistance

The Army National Guard is organized to train and deploy Soldiers; therefore, we do not have any staff dedicated to treat our Soldiers. Our staff is trained to help Soldiers find treatment; however, as a rural state, treatment options are limited and our only access to a military medical treatment facility is in another state.

Nationally in the Army National Guard, in 2009 and 2010, roughly one half of Soldiers that committed suicide did not deploy, which determines VA eligibility.¹

VA eligible Soldiers. We have a close working relationship with the great Suicide Prevention staff at Togus VA Hospital and the regional Vet Centers. The staff is easy to reach, ready to help, and eminently qualified. They have become a reliable and competent resource and benefit for us; however, from our perspective, they seem to be extremely understaffed.

Non VA eligible Soldiers that buy TRICARE. We are finding that many Soldiers with suicidal ideations have not deployed, so they are not eligible for VA support. Even though Soldiers are eligible to buy TRICARE at a very reasonable price, most do not. However, even those that buy TRICARE, have a very difficult time finding clinicians who will see them. Many clinicians that want to help Soldiers find the process to become a TRICARE provider extremely cumbersome and the \$27.50/hour reimbursement does not cover basic overhead, so we lack the number of counseling providers needed for our Soldiers. There needs to be a concerted effort to recruit and retain not only behavioral health providers, but also the gatekeepers to support the primary care providers. Also, someone other than the providers needs to maintain the TRICARE Web sites to ease the frustrations Soldiers find when looking for help. Much of the information on the Web site is outdated.

Soldiers without health insurance. Obviously, this is a population that creates the biggest challenge. Our staff works tirelessly contacting providers to find someone to help at a reduced rate or free.

¹AR3SP Update, 29 JAN 11, Army National Guard Bureau, COL Greg Bliss.

What Works

The most effective approach is to create an environment where Soldiers feel they can ask for help without fear of repercussion or stigma and we work to continuously improve this environment. We provide the training to recognize the signs, where to get help and how to get Soldiers the support needed.

Community coordination and support allow the Guard to find the resources available for our Soldiers. This has saved lives.

Contractors provide continuity of support because our full time force of Soldiers will eventually deploy.

Respectfully submitted.

Prepared Statement of Richard McCormick, Ph.D., Senior Scholar, Center for Health Care Policy, Case Western Reserve University, Cleveland, OH

Suicide is a tragedy. It is the ultimate ending for some of the very large numbers of veterans who face the challenges and problems that result from deployment and combat.

The Department of Veterans Affairs (VA) and the Department of Defense (DoD) have worked hard to develop programs to reduce suicidal behavior among returning servicemembers and veterans. Still, the challenge remains to discover and implement additional measures to further reduce the risk of suicidal behavior.

Research has established that the suicide of a particular individual is very difficult to predict and anticipate. We do, however, have increasing knowledge about the conditions that precede and contribute to suicidal behavior and other serious emotional problems, such as PTSD and depression, in veterans and servicemembers. These include notably:

- Problems in marital and other important relationships
- Hazardous use of alcohol and other drugs
- Risky/impulsive behaviors including: gambling, hazardous driving, and outbursts of angry behavior

Research has shown that all of these problems occur in returning servicemembers and veterans, and that all are related to the degree of exposure to stress during time in service and immediately after.

The harmful use of alcohol is a major public health problem, and is a particularly serious problem for those serving in the current war on terror. A recent report on 48,481 active duty, reserve and national guard indicates that rates of heavy weekly drinking (9%), binge drinking (53.4%), and problems related to alcohol use (15.2%) were particularly high in Reserve and National Guard members who are veterans immediately after return from deployment (Jacobsen, Ryan, Hooper, et al, 2008). Both the degree of exposure to combat and the degree of exposure to human trauma are related to increased drinking (Kilgore et al, 2008; Wilk et al 2010). Surveys of active duty military members have noted that between 6.3 percent and 8.1 percent report at least one gambling related problem in their lifetime (Steenbergii et al 2008). In a study of returning OIF/OEF servicemembers, the intensity of combat experience and exposure to violent human trauma were predictive of verbal and physical aggression towards others 3 months after deployment (Kilgore et al, 2008). Aggressive and unsafe driving are significant problems for active duty members (Kilgore et al 2008). Even controlling for age personnel deployed to Iraq have higher rates of dangerous driving than older veterans.

These problems are often among the first indicators of serious distress. If left unattended they can fester and expand to other areas of the veteran's life and functioning. As the problems snowball, helplessness and hopelessness can set in, leading to suicidal behavior.

A comprehensive program of early prevention for suicide and other serious emotional problems should include readily accessible, hassle-free assistance with these problems. Historically, the Vet Centers have been more assertive in addressing these early problems than has the VA core medical care system. With some notable exceptions, VA medical centers and clinics have traditionally focused on diagnosable pathology. If services such as marital counseling or early intervention into hazardous drinking exist, they may be embedded in other programs.

Further complicating the prevention effort is a lack of awareness, and at times limited motivation, of the veteran to address the early precursor problems. Present programs, including the Vet Centers, rely on the veteran seeking help for a self-identified problem.

More can and needs to be done to identify and offer early intervention for problems which have been demonstrated to be related to later serious emotional problems and suicidal behavior.

The first practical steps would be to build on current efforts in the VA and DoD to screen for early occurring problems. VA currently screens all patients in primary care for hazardous alcohol use, depression and PTSD. Positive screens for depression and PTSD are expected to trigger further screening and intervention, including identifying and addressing suicidal behavior. Returning servicemembers, including those in reserve components, are screened immediately after deployment and again within 90 days for general mental health issues, including PTSD and alcohol use. VA outreach workers are present at screens for those in the reserve components when they are conducted at their home training sites.

Short reliable and valid screening tools exist for other early identifiable problems including relationship issues, problem gambling and other risky behaviors. Screening for these additional problems would raise the awareness of veterans, significant others and providers of care. It would also assure that a conversation is initiated about these problems and early intervention considered in all venues where veterans may be encountered, including primary care settings and outreach efforts.

Screening is a necessary, but not sufficient, step in a comprehensive prevention effort. Still greater challenges exist in assuring that those who screen positively are in fact engaged into an appropriate level of intervention. Hazardous alcohol use provides the currently best documented example of this issue. A recent study of 1508 OIF/OEF veterans using VA medical, surgical or mental health services found that 40 percent screened positive for hazardous alcohol use (Calhoun, Elter, Jones, et al, 2008). This study also documented that only 31 percent of those who screened positively for an alcohol use problem ever received a follow-up intervention to address the problem.

This lack of follow-up underscores the need to assure that readily accessible intervention services exist, and that all providers are aware of them and able to seamlessly refer to them.

VHA's recent efforts to increase the placement of mental health staff in primary care settings provides the platform to deliver accessible services to intervene with these early problems.

Suicide prevention efforts in VA and DoD could be enhanced by the following:

- Expand screening efforts to include a wider variety of problems and behaviors that are potentially related to serious emotional problems including suicidality
- Assure that readily accessible services are available to intervene immediately when a problem is identified, and that these services are widely advertised to both veterans and providers
- Assure that all staff understand that addressing these behaviors is a critical part of providing comprehensive health care prevention services in the health care setting, they are not someone else's responsibility
- Increase the awareness of veterans and their significant others about these early indicator problems and urge them to bring them up with their health care provider (this could include, for example, handouts in primary care areas)
- Conduct periodic quality assurance studies assessing whether veterans screening positively for problems actually access interventions services

Expanding screening efforts and establishing robust marital/relationship programs, specific programs addressing hazardous drinking, and programs tailored to other risky behaviors would involve further funding. Establishing these programs is part of our responsibility to restore returning veterans to full function. It needs to be done immediately, since the need is now before they can fester into additional serious issues, including, for some, suicidal behavior. This immediate investment is also the wise fiscal choice, since it will offset not only human suffering, but future greater health care costs.

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Statement of John E. Toczydowski, Esq., Philadelphia, PA

Mr. Chairman and Honorable Members of the Committee:

My name is John Toczydowski. I am not a veteran, but I am from a military family, my father, my grandfather and my uncles having proudly served. Today, I am here to speak with you specifically about my father, who served in Vietnam from 1964-1970. He committed suicide on December 17, 2010 as the result of post-traumatic stress disorder and physical ailments directly related to his service in Vietnam.

Three specific questions need answers. One, how and why did this happen? Two, how can we prevent or reduce the number of incidences of veteran suicide in the future? Three, how can we aid surviving family members if and when veteran suicide occurs?

1. *Background*

Little did I know my father's death on December 17, 2010 was set in motion in 1964. My father volunteered for service in Vietnam, and entered the conflict in army security. I know very little about his specific activities in the war; as you will hear later, he did not often speak of these events. I do know that he provided bombing coordinates for American offensives and worked in/on special operations.

When my father returned home in 1970, it was to an unpopular war, a wife, the thought of a soon-to-be adopted son (me), and no knowledge, instruction or education on benefits or help from the Department of Defense or the Veterans Administration, aside from the GI bill. For years and years, my father suffered with the memories of war without solace or outlet. Except for anger. And temper. And smoking. And alcoholism. In fact, every night, my father drank between 6-12 beers trying to drown out his memories.

In 1992, my father first tried to kill himself, overdosing on prescription drugs. Luckily for him, and for my mother, brother and I, he survived. We did not, however, all live happily ever after. Still not realizing the scope of the problem, still not being aware of potential treatment and support options, and with my father still not discussing the core of the problem, we made it only four (4) short years before he once again attempted suicide. This time, he went into a program and began seeing a psychiatrist, Timothy C. Smith, M.D.

From 1996 until my father's employment with the Veterans Administration in 2003, he treated with Dr. Smith and never once mentioned his Vietnam service. Call it denial or call it guilt—whichever, he was either too proud or too wounded to talk. I attach to this record a letter from Dr. Smith outlining his treatment and diagnosis in 2003; I find it instructive as to the depth both of my father's post-traumatic stress disorder and his efforts to hide it, bury it and deny it.

Once my father began working in the Philadelphia office of the Veterans Administration, he learned that he was not alone, as the thought for over 33 years. He began to speak with other veterans, learn of the benefits and services available to him, and realize that help would and could be had. Of course, work at the VA was a double-edged sword for my father; while he found a built-in support group, each and every story from Vietnam, Iraq and Afghanistan worsened his PTSD symptoms. But he rallied.

The rally slowly came to an end as my father's physical limitations began to catch up with him. After several hospitalizations and with a clearly declining mental faculty, my mother came home on December 17, 2010 to find my father dead from two bullet wounds. This fight, many years longer than the one in Vietnam, was over.

2. How and Why Did This Happen?

We will never know for sure exactly what happened to my father. The evidence, however, leads to a few simple conclusions. One, my father certainly endured the "horrors of war," both with regard to his own activities that might have resulted in collateral damage to the civilian population in Vietnam and seeing his own army-mates die. As time went on, the few people he held close from Vietnam also wasted away and died from illness, some related to the war and some not. Two, upon his return to the United States, his feelings of guilt and isolation were increased and ratified. He came home as an unpopular soldier in an unpopular war. He knew little or nothing of potential benefits available to him, other than the GI Bill, which he used to complete his college education at night. He never spoke to my mother or anyone else about what he did in Vietnam, where he went or what he saw, internalizing it all and "protecting" us from it. Three, once my father began applying for benefits, there were impediments at every step. He filed multiple appeals to obtain his 100 percent disability rating for a service-connected disability. He fought for recognition of the ill effects of Agent Orange. At every turn, there were obstacles . . . it was as though he was fighting another war.

3. How do we Help Reduce the Number of Veterans' Suicides?

In order to reduce the number of veteran suicides, the first step is better record-keeping. We all know the statistics put out by the Veterans Administration: an Iraq/Afghanistan veteran kills himself every 80 minutes. Vietnam-era suicides were once thought to be in the 50,000–100,000 range, though testimony on the subject from the CDC and others estimates the number to be approximately 9,000. On the other hand, the data points being used in any such studies are old, are based on limited tracking statistics, fail to account for new understanding of the impact of Agent Orange, PTSD, and other illnesses, and generally need to be extrapolated from unreliable data. We need a better record-keeping system in order to specifically identify the causes of death among veterans.

The second step requires a better support group for veterans, whether from the military itself, the government or both. Isolation is clearly at the heart of many veterans' issues, including suicide. From the weeks just before discharge through the return home, all efforts should be made to keep the veteran engaged. Counseling. Benefit instruction. Support groups. Even before discharge, perhaps military cohesion units would be of benefit. We thrust our military back into civilian society ill-equipped to deal with the many issues confronting them: employment, disability, family . . . how do we possibly expect them to transition well?

Step three is to ease the obstacles placed in front of veterans in applying for and receiving their benefits. As this Committee is aware, the long-standing view of the process is one of benevolence and paternalism between the Veterans Administration and the veterans. This view, in light of budgetary constraints and more complex claims, is no longer valid or appropriate. In terms of disability claims alone (ignoring, for the moment, any other claims, including surviving spouse claims, death ben-

efit claims, etc.), the backlog of cases has risen to approximately 756,000 (as of April 2011). The number of claims over 125 days old totals approximately 450,000. Veterans wait an average of 6 months to receive entitled benefits. My mother is nearly 1 year out from her husband's death, and she is still no closer to receiving a decision on her DIC benefits. Thankfully, she has social security and life insurance to keep her afloat in the meantime, a luxury many other widows do not have.

The nightmare does not end there. Over 20 percent of these claims are on appeal. Appeals take an average of 527 days to forward to the initial appellate level (the BVA), with another 274 days for the BVA to process the appeal. The remand rate of cases going forward from the BVA to the CAVC approaches an astonishing 80 percent.

In an effort to allow for the earlier intervention of lawyers into the process, Congress passed The Veterans Benefits, Health Care and Information Technology Act of 2007. Interestingly, the Veterans Administration and Disabled American Veterans were two of the most ardent *opposers* of this legislation. Why? The reasons are too numerous to count, but the simplistic belief is the veterans' organizations want to keep control, keeping claims out of the hands of lawyers, and the Veterans Administration is consistently working at counter-purposes with its own veterans. Veterans are entitled to due process, and, frankly, it is not the reality for most. More efforts need to be made to appropriately and fairly evaluate claims in a more efficient and effective manner.

4. *How Surviving Families Cope?*

As the son of a man who committed suicide, I can tell you that the questions never go away. Why didn't I see? What could I have done? What if I made one more call, or came by the house one more time? The last thing survivors need to cope with is the morass of an outdated, outmoded and unfriendly bureaucracy.

My father had the benefit of working for the Veterans Administration. Had he not, I am not sure I would have been able to get off the ground in terms of identifying proper benefits. Death benefits. DIC. Funeral benefits. Life Insurance. TSP. The list goes on and on, and each winds up in a different location with different forms. Can you image the barriers to those with limited technological access, little education, and little experience dealing with the government? Those with no money get no help from the lawyers either, as fees are not applicable until the first level of appeal.

The requirements to receive these benefits can be onerous as well. The DIC requires, for example, that a veteran die of a service-related disability for which he was 100 percent disabled for a period of 10 years or longer. Well, what about the veteran who commits suicide as the result of PTSD but did not receive his 100 percent disability rating until 8 years before his death due to filing 4 appeals? Is that system fair to the memory of the injured veteran? To his family?

5. *Conclusory Remarks*

Abraham Lincoln, in his second inaugural address, said: "To care for him who shall have borne the battle and for his widow and his orphan." Our Veterans Administration, our non-profit support organizations and our government need to do eliminate the feelings of isolation and abandonment our veterans feel when returning from service; educating our veterans in the financial, medical and other benefits available to them; and removing unnecessary and unfair impediments to receipt of those benefits and the due process due veterans. While we will likely never eliminate veteran suicide, a more friendly, more caring process will certainly go a long way in reducing the increased risk factors. Thank you.

MATERIAL SUBMITTED FOR THE RECORD

Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health, Committee on Veterans' Affairs to Col Carl Castro, Ph.D., Director, Military Operational Medicine Research Program Research Area Directorate III, U.S. Army Medical Research & Materiel Command, U.S. Department of Defense

December 5, 2011

COL Carl Castro, Ph.D.
 Director, Military Operational Medicine Research Program
 U.S. Army Medical Research and Materiel Command, and
 Chair, Joint Program Committee for Operational Medicine
 U.S. Department of Defense
 1400 Defense Pentagon
 Washington DC 20301-1400

Dear COL Castro:

In reference to our Subcommittee on Health Committee hearing entitled "Understanding and Preventing Veteran Suicide" that took place on December 2, 2011, I would appreciate it if you could answer the enclosed hearing questions by the close of business on Friday, January 20, 2012.

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 Jian Zapata at jian.zapata@mail.house.gov, and fax your responses to Jian at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

Michael H. Michaud
*Ranking Democratic Member
 Subcommittee on Health*

CW:jz

**Questions for the Record from the
 House Committee on Veterans' Affairs Subcommittee on Health
 Hearing on *Understanding and Preventing Veteran Suicide***

Questions for the Record

1. It has been clearly demonstrated that DoD and VA must work together to address issues that face both departments, particularly suicide, mental health and substance abuse treatment. Given such demonstrated need:
 - a. Please provide the Committee with a detailed explanation of any 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.
2. What is being done to address the unique mental health care needs of recently returning servicemembers?
3. What can be done to improve outreach to servicemembers and veterans needing mental health care services, especially those veterans most at-risk?
4. What are your thoughts on the Military Officers Association of America's recommendation to: Require VA-DoD to establish a single strategy and a joint Suicide Prevention Office that reports directly to the Department Secretaries through the Senior Oversight Committee (SOC)?
5. Many of the experts have stated that early intervention is critical in the prevention and treatment of mental health conditions such as Post-Traumatic Stress Disorder. What programs do the Departments have in place to flag, intervene and monitor at risk servicemembers who are transitioning to VA? Is there a "warm hand-off"?

6. At the September 9, 2011, House Committee on Armed Services hearing on suicide prevention programs in the military, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs at DoD, mentioned the DoD/VA Integrated Mental Health Strategy (IMHS) that they have been working to put in place over the last 10 months.
 - a. Can you comment further on what was recommended? Of the numerous action items outlined in this strategy, what pieces are still outstanding?
7. The Maine National Guard submitted testimony for the record in which they outline their Resiliency, Risk Reduction and Suicide Prevention Campaign Plan. What sort of resiliency training is DoD incorporating in its prevention efforts?
8. How many more mental health providers are needed to meet demand?
9. What do you need from us to assist you in addressing the mental health issues of today?

Response from Col Carl Castro, Ph.D., Director, Military Operational Medicine Research Program Research Area Directorate III, U.S. Army Medical Research & Materiel Command, U.S. Department of Defense, to Hon. Michael H. Michaud, Ranking Democratic Member, Subcommittee on Health, Committee on Veterans' Affairs

Member: Congressman Michaud

Witness: USA COL Castro

Question: #1

Question: It has been clearly demonstrated that DoD and VA must work together to address issues that face both departments, particularly suicide, mental health and substance abuse treatment. Given such demonstrated need: (a) Please provide the Committee with a detailed explanation of any 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.

Answer: The DoD and the VA have been working together for some time to address the issue of suicide prevention, as well as those associated high risk behaviors that surround both fatal and non-fatal suicide events. The DoD and VA currently share data in multiple instances. In particular, the DoD/VA Suicide Nomenclature and Data Working Group has developed an action plan to create a joint DoD/VA Suicide Data Repository that will merge existing data from multiple sources to create common identifiers and data elements, fill gaps in knowledge, identify common risk factors, and present a longitudinal view across the active and veteran populations. This effort will result in a single source for all suicide events and self-directed violence across the Departments as well as help inform programs and policies related to suicide prevention in the future.

Question: #2

Question: What is being done to address the unique mental health care needs of recently returning servicemembers?

Answer: The Department of Defense (DoD) has revised its deployment mental health assessment process to provide comprehensive person-to-person mental health assessments at pre-deployment and within 6 months, 1 year, and 2 years after return from deployment. These procedures comply with requirements in the National Defense Authorization Act (NDAA) for Fiscal Year 2012 (Section 702). The three post-deployment mental health assessments must be performed either by licensed mental health professionals or by designated personnel trained and certified to perform the assessments. These mental health assessments include an analysis of self-reported responses to mental health questions on symptoms of depression, posttraumatic stress disorder (PTSD), and alcohol misuse; detailed follow-up on positive responses to previous mental health diagnoses and medication use; and exploration of other reported emotional, life stress, or mental health concerns. During a confidential dialog with the Servicemember, the provider would conduct an assessment of the risk for suicide or violence, offer education on relevant mental health topics, administer brief interventions, and make recommendations for follow-up assessment and care, when indicated.

After returning home from deployment, help for any mental health issues, including depression and PTSD, is available through the Military Health System for active duty and retired Servicemembers, or through the Department of Veterans Affairs

(VA) for non-retired veterans. Active duty, National Guard, and Reserve Servicemembers who separate and who served in support of a contingency operation are eligible for TRICARE's Transitional Assistance Management Program (TAMP), which provides health benefits for 180-days to assist Servicemembers and their families with the transition to civilian life. Partnerships with the VA exist, such as the Recovery Coordination Program, where Recovery Care Coordinators assist with Servicemember transition from DoD to VA care, treatment, and rehabilitation. The DoD *inTransition* program is a free, voluntary, and confidential coaching and assistance program that provides a bridge of support for Servicemembers while they are transitioning between health care systems or providers.

Each Service has a comprehensive program to address the reintegration needs of wounded, ill, and injured Servicemembers, including the Army Wounded Warrior Program, the Marine Wounded Warrior Regiment, Navy's Safe Harbor Program, and the Air Force Wounded Warrior Program. Across DoD, the Military Family Life Consultants program helps prevent family distress by providing education and information on family dynamics, parent education, available support services, and the effects of stress and positive coping mechanisms. Military OneSource has counselors standing ready 24/7 by phone and email and are available for face-to-face counseling. The DoD Yellow Ribbon Reintegration Program was established to address the needs of National Guard and Reserve Servicemembers and their families by facilitating access to support and reintegration services. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) has a number of education and outreach programs, to include DCoE's Outreach Center, "24/7 Help," which provides information and resources on psychological health and traumatic brain injury, and the Afterdeployment.org Web site that assists Servicemembers and their families in managing post-deployment challenges.

The Services have each developed garrison and training programs to mitigate the effects of combat-related stress. The Army implemented the Comprehensive Soldier Fitness Program Army-wide; the Air Force uses the Landing Gear program; the Navy has an Operational Stress Control program; and, the Marine Corps uses a program called Operational Stress Control and Readiness, or "OSCAR." Each of these programs seeks to prepare Servicemembers to better cope with combat and deployment stress before, during, and after deployment. On a more holistic level, the Office of the Chairman of the Joint Chiefs of Staff has promoted the Total Force Fitness model to address the need for a synchronized, DoD-wide approach to strengthen resilience and maintain optimal military force readiness. This model advocates that leadership at all levels of DoD take steps to strengthen the comprehensive health of Servicemembers across eight domains (Behavioral, Social, Physical, Environmental, Medical, Spiritual, Nutritional, and Psychological) and to subsequently establish holistic fitness programs within their commands and organizations.

Question: #3

Question: What can be done to improve outreach to servicemembers and veterans needing mental health care services, especially those veterans most at-risk?

Answer: In order to facilitate early identification of and referral for mental health concerns, DoD employs a robust, prospective, person-to-person mental health surveillance program. VA and DoD are jointly reviewing mental health screening policies and procedures with the end goal of tracking and optimizing follow-up on positive screens for posttraumatic stress disorder (PTSD), suicidal and homicidal ideation, alcohol abuse and dependence, and depression. Enhanced case management and follow-on support of Servicemembers will serve to eliminate gaps in care between DoD and civilian medical facilities.

In addition, DoD provides many outreach and early intervention programs to ensure continuity of care, to raise awareness among Servicemembers, to train civilians treating Servicemembers, and to increase leadership involvement in behavioral health efforts. Examples of these programs include:

- *inTransition*: A voluntary program supporting Servicemembers moving between health care systems or providers while receiving behavioral health care. *inTransition* offers information, non-medical counseling, education, and advice services for eligible beneficiaries, encouraging them to make use of available behavioral health services. The program employs a "warm hand-off" technique in referring and following up with Servicemembers and Veterans.
- Yellow Ribbon Reintegration Program (YRRP) is a program that assists Guard and Reserve Servicemembers and their families to connect with local resources before, during, and after deployments, especially during the reintegration phase. Yellow Ribbon events (the Returning Warrior Workshops developed by

the Navy Reserve) typically take place in non-military venues. Local VA facilities have a strong presence at these events, often enrolling Servicemembers in VA health care and scheduling appointments when needed.

- *The Real Warriors Campaign* (<http://www.realwarriors.net/>) is a public education campaign that reinforces the notion that seeking help is a sign of strength. It was launched by DCoE to combat stigma related to seeking mental health treatment in the military.
- *Afterdeployment.org* (www.afterdeployment.org) was developed by DCoE, with an emphasis on 'normalizing' post-deployment adjustment problems, and encouraging help-seeking behavior among servicemembers and veterans with invisible wounds.
- VA launched a mental health outreach campaign called *Make the Connection* (<http://www.maketheconnection.net/>) which was designed to increase awareness and trust in VA's mental health services and aims to reduce stigma about seeking mental health services.
- VA's Readjustment Counseling Service (RCS) Mobile Vet Center program is another initiative to help meet this commitment. As a successful, long-running behavioral health support program, Mobile Vet Centers provided outreach and readjustment counseling services at 1,800 events in FY 2010 and 3,600 events in FY 2011. The events were national, State, or locally organized events, including demobilization events for Active duty servicemembers. DoD and VA are working together to expand the program to increase the mental health services available to servicemembers and Veterans, especially those in rural areas. RCS put an additional 20 Mobile Vet Centers (MVCs) into service.

A recently completed Report to Congress entitled "A Study of Treatment of Active and Reserve Components for Post-Traumatic Stress Disorder" noted several areas where outreach for Servicemembers can be further strengthened, including:

- Expanding existing programs that provide for early identification and treatment, such as the Re-Engineering Healthcare In Primary Care Program (REHIP) which enables DoD primary care providers to screen and treat health-seeking patients in primary care clinics for PTSD, suicidal ideation, and depression while integrating behavioral health care providers into routine medical care.
- Embed mental health providers into line units alongside leaders to facilitate communication between line leaders and PH resources.
- Increase awareness, via targeted outreach, about the impact of mental health diagnoses on one's career. Barriers to seeking treatment may be reduced by educating Servicemembers that a mental health diagnosis does not always equate to medical retirement or separation from the military.

Finally, to advance the integration of mental health services into primary care, DoD and VA held a joint conference titled, "Behavioral Health/Mental Health Services Roll Out in the Medical Home: Clinical, Administrative and Implementation Priorities and Best Practices." The conference brought together 305 clinical, administrative and research leaders from VA and DoD facilities across the country to share lessons learned and to encourage growth of integrated care services in the VA and DoD.

Question: #4

Question: What are your thoughts on the Military Officers Association of America's recommendation to: Require VA-DoD to establish a single strategy and a joint Suicide Prevention Office that reports directly to the Department Secretaries through the Senior Oversight Committee (SOC)?

Answer: We agree that the DoD and VA need to work closely together to address the suicide issue, and have already organized to meet that goal. The DoD and the VA have been working together for some time to address the issue of suicide prevention, as well as those associated high risk behaviors that surround both fatal and non-fatal suicide events. The DoD established a Defense Suicide Prevention Office (DSPO) to serve as a focal point for collaboration with the VA and provide oversight for the strategic development, implementation, standardization, and evaluation of DoD suicide programs, policies, surveillance activities. The DSPO will also have a full time VA liaison staff member embedded with the DoD team to assist in identifying and addressing high risk transition population issues.

For example, the DoD and VA currently share data in multiple instances. In particular, the DoD/VA Suicide Nomenclature and Data Working Group has developed an action plan to create a joint DoD/VA Suicide Data Repository that will merge

existing data from multiple sources to create common identifiers and data elements, fill gaps in knowledge, identify common risk factors, and present a longitudinal view across the active and veteran populations. This effort has been briefed to the Senior Oversight Committee and its associated Subcommittees. The objective is to provide a single source for all suicide events and self-directed violence across the Departments as well as help inform programs and policies related to suicide prevention in the future.

Question: #5

Question: Many of the experts have stated that early intervention is critical in the prevention and treatment of mental health conditions such as Post-Traumatic Stress Disorder. What programs do the Departments have in place to flag, intervene and monitor at risk servicemembers who are transitioning to VA? Is there a “warm hand-off”?

Answer: In order to facilitate early identification of and referral for mental health concerns, the Department of Defense (DoD) employs a robust, prospective, person-to-person mental health surveillance program. Mandatory mental health assessments are conducted before deployment (Pre-Deployment Health Assessment or Pre-DHA), and after deployment (Post Deployment Health Assessment or PDHA; Post Deployment Health Reassessment or PDHRA; and one- and two-years post-deployment as part of the Periodic Health Assessment or PHA). The Department of Veterans Affairs (VA) and DoD is jointly reviewing mental health screening policies and procedures, including the PDHA/PDHRA/PHA, with the end goal of tracking and optimizing follow-up on positive findings.

DoD provides many outreach and early intervention programs to ensure continuity of care, to raise awareness among Servicemembers, to train civilians treating Servicemembers, and to increase leadership involvement in behavioral health efforts. These programs include:

- inTransition: Managed by the Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, inTransition is a voluntary program supporting Servicemembers moving between health care systems or providers while receiving behavioral health care. The program employs a “warm hand-off” technique in referring and following up with Servicemembers and Veterans. Additional information can be found at: (<http://www.health.mil/InTransition/default.aspx>).
- Yellow Ribbon Reintegration Program (YRRP): Another significant DoD/VA outreach and prevention program is the YRRP. The YRRP is a program that assists Guard and Reserve Servicemembers and their families to connect with local resources before, during, and after deployments, especially during the reintegration phase. Yellow Ribbon events (the Returning Warrior Workshops developed by the Navy Reserve) typically take place in non-military venues. Local VA facilities have a strong presence at these events, often enrolling Servicemembers in VA health care and scheduling appointments when needed.
- VA Suicide Hotline: Veterans Crisis Line (started July 2007) and Chat Service (started July 2009) are intended to reach out to all Veterans and Servicemembers, whether they are enrolled in VA health care or not. The Crisis Line is staffed with mental health professionals and support staff to provide 24-hours services. After receiving a call, the responder conducts a phone interview to assess psychological condition. The responder then determines whether the call is emergent, urgent, routine, or informational. Calls requiring emergency services necessitate keeping the caller safe; urgent care requires same day services at a local VA facility; and routine calls require a consultation by the local Suicide Prevention Coordinator (SPC). The online version of the Crisis Line, the Veterans Chat Service, enables Veterans, Servicemembers, family members and friends to chat anonymously with a trained VA counselor. If the counselor determines there is an emergent need, the counselor can take immediate steps to transfer the visitor to the Crisis Line, where further counseling and referral services can be provided and crisis intervention steps can be taken.

Question: #6

Question: At the September 9, 2011, House Committee on Armed Services hearing on suicide prevention programs in the military, Dr. Jonathan Woodson, Assistant Secretary of Defense for Health Affairs at DoD, mentioned the DoD/VA Integrated Mental Health Strategy (IMHS) that they have been working to put in place over the last 10 months. (a) Can you comment further on what was recommended?

Of the numerous action items outlined in this strategy, what pieces are still outstanding?

Answer: An important activity within the DoD/VA Integrated Mental Health Strategy (IMHS) focuses on exploring methods to disseminate knowledge of suicide risk and prevention practices through prevention programs, coordinated training and collaboration with entities outside of DoD and VA.

The following activities have been completed thus far:

- To assist in the dissemination of suicide prevention practices, programs, and tools, the DoD Suicide Prevention and Risk Reduction Committee (SPARRC) Web site <www.suicideoutreach.org/sparrc> was launched in October 2010. The Web site streamlines suicide prevention resources for easy access to a clearing-house of information. It serves as a comprehensive resource with access to hot-lines, treatments, programs, forums and multimedia tools designed to support all Servicemembers, Veterans, families and health professionals. Additionally, the Web site includes links to Service-specific suicide prevention resources, as well as reliable and accurate information on a range of suicide prevention related topics.
- The 2011 DoD/VA Annual Suicide Prevention Conference was held in Boston, Massachusetts on March 13–17, 2011. The theme of this conference was “All the Way Home: Preventing Suicide among Servicemembers and Veterans.” The conference provided an opportunity to disseminate practical tools and innovative research in the area of suicide. In addition, it educated representatives from across DoD and VA on the current practices and studies related to suicide prevention. Four tracks were offered to focus on practical applications and innovations: clinical, multi-disciplinary, family/peer to peer, and research.

The 2012 DoD/VA Annual Suicide Prevention Conference will be held in Washington DC on June 20–22, 2012. The theme of this conference will be “Back to Basics: Enhancing the Well-Being for our Servicemembers, Veterans, and their Families”. Three tracks will be offered: clinical, research, and practical applications.

Suicide prevention related activities that are in progress include:

- Dissemination of a toolkit intended to provide DoD/VA program managers with the tools to empower family members to play a more significant role in the DoD/VA suicide prevention effort. The toolkit includes an inventory and evaluation of current suicide prevention communications to families, and highlights key programs that are effective in providing information to this target audience. It also provides a variety of approaches for DoD, the Services, and VA to optimize the communication to families of Servicemembers and Veterans about the warning signs of suicidal behavior and the range of resources families have at their disposal to obtain the help they need.
- Data will be collected in February and March 2012 to inventory and review National Guard and Reserve suicide prevention, intervention, and post-vention programs. The data will be used to populate a resiliency and prevention program database intended to avoid duplication of effort, permit ease of reporting to leadership and facilitate their expanded implementation should that be indicated.

Question: #7

Question: The Maine National Guard submitted testimony for the record in which they outline their Resiliency, Risk Reduction and Suicide Prevention Campaign Plan. What sort of resiliency training is DoD incorporating in its prevention efforts?

Answer: The Chairman of the Joint Chiefs of Staff has issued guidance that institutes “The Total Force Fitness (TFF)” framework as the over-arching DoD wellness and resiliency training model. The TFF framework is the methodology for understanding, assessing, and maintaining the fitness of the Armed Forces. The TFF framework consists of eight domains and five guiding tenets. The TFF domains include Physical, Environmental, Medical and Dental Fitness, Nutritional, Spiritual, Psychological, Behavioral and Social Fitness. The tenets include the belief that fitness should strengthen resilience in families, communities and organizations. The TFF framework and its tenets are designed to keep Servicemembers resilient and flourishing in the current environment of sustained deployment and combat operations as serves as a basis for resiliency training across the Department.

Resiliency training currently includes the Army’s Comprehensive Soldier Fitness (CSF) Program, the Navy’s Total Family Fitness and the Combat Operational Stress Program, the Air Force’s Total Airman Comprehensive Fitness Program, and the

Army National Guard Resiliency, Risk Reduction and Suicide Prevention (R3SP) program. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) has also played an active role in shaping the Department's suicide prevention and resiliency training efforts, and holds a yearly Warrior Resilience Conference targeted for the senior NCO cadre.

Question: #8

Question: How many more mental health providers are needed to meet demand?

Answer: The Military Health System (MHS) Chief Human Capital Office has established a methodology to determine the gap differential in Mental Health Provider staffing. This methodology establishes a standardized means of comparing the differences between the manpower positions authorized and assigned (positions filled) in occupations which include: Psychologists, psychiatrists, social workers, mental health nurses, mental health nurse practitioners, tech/counselors, and other mental health providers.

Within the DoD, we review the status on a quarterly basis and this review includes Army, Navy, Air Force, and JTF-CAPMED military, civilian, and contractors staffing. The latest update which reflects status as of 4Q11 (as of September 30, 2011) is shown. Our gap is determined by comparing the authorized numbers with the assigned numbers. The Services then develop an action plan to close the gap.

MHS-WIDE	Needs	Assigned	Percent filled
Psychologist	1726.5	2063	119.5%
Psychiatrist	823.5	771	93.6%
Social Worker	2547	2349	92.2%
Mental Health Nurse	600	618	103.0%
Mental Health Nurse Practitioner	92	59	64.1%
Other Licensed MH Provider	59	64.5	109.3%
Tech/Counselor	3372	2959	87.8%
Total	9220	8884	96.3%

Within the MHS, a 3 year review of mental health provider staffing reveals a 34.8 percent increase from FY 2009 through FY 2011. We anticipate a growing need for additional mental health provider staffing due to emerging requirements.

	2009	2010	2011
Psychologist	1,520	1,815	2,063
Psychiatrist	652	758	771
Social Worker	1,789	2,082	2,349
Nursing (including NP)	570	580	677
Other Licensed MH Provider	97	66	65
Tech Counselor	1,962	2,199	2,959
GRAND TOTAL	6,590	7,500	8,884

From FY 2009 through FY 2011 +34.8 percent increase.

Whether more authorized mental health billets are needed to meet demand can only be answered by each military Service. As they make those decisions, the Services have access to the Psychological Health Risk-Adjusted Model for Staffing (PHRAMS), an application developed to forecast psychological health staffing requirements/needs in the Military Health System.

The PHRAMS application and user guide were first released to the Services in January 2010 for use in planning for future psychological health staffing needs. Updates to PHRAMS have been ongoing, with version 4 estimated for release to the Services in August 2012.

July 2010, GAO Report 10-696 "Enhanced Collaboration and Process Improvements Needed for Determining Military Treatment Facility Medical Personnel Requirements" cited PHRAMS as representing "the culmination of a collaborative manpower requirements effort to develop a standardized, more consistent approach across the Services for determining mental health personnel requirements." The report also stated "Key organizational issues, like strategic workforce planning, are most likely to succeed if, at their outset, top program and human capital leaders set the direction, pace, and tone and provide a clear, consistent rationale for the transformation.

Question: #9

Question: What do you need from us to assist you in addressing the mental health issues of today?

Answer: Recent advances in the study of suicide and its treatment in Veterans and Active Duty Servicemembers, which stem from the assiduous support of Congress and the American people, may herald a turning point in the management of this longstanding public health problem. The assistance of the House Veterans Affairs Committee has been instrumental in this effort. Ongoing attention to this matter will be essential to maintaining the momentum our labors have fostered to date.

We are learning that military members represent a unique cohort with respect to suicide. Military suicide rates have been far more variable than age-adjusted civilian rates. On balance, military rates have been consistently lower than civilian rates since collection of these data was initiated. This regular finding was attributed to a "warrior effect," that embraces discipline, fidelity to peers, resilience, rigorous accession standards, and pursuit of an honorable mission. However, the excursions of Army suicides to rates above the civilian rate, and military suicides exceeding combat deaths, raise important questions for military and civilian leaders.

Editorials by well-regarded researchers in top psychiatric publications, including the Journal of the American Psychiatric Association and the Journal of the American Academy of Child and Adolescent Psychiatry, express a view that suicide may be the next public health menace needing to be systematically categorized and managed. Leaders in many fields have come to realize that suicide is a multifactorial problem that cuts across disciplines. Optimization of personnel policy, attunement to unit cohesion, resilience and personal accountability for behavior, intrepid leadership, and focused evidence-based medical interventions, based on real-time data, will all be part of a solution.

The fruits of our initial data collection will enlighten our intervention programs to prevent suicide. DoD/VA efforts, which have been fostered by the abiding support of your committee, are leading the way on research fronts. The DoD's Military Suicide Prevention Research Program (\$110 million investment since 2008), Army Study to Assess Risk and Resilience (\$50 million from Army and \$15 million from NIMH) have already added to an exponentially growing body of knowledge in suicidology.

Ongoing DoD/VA efforts in suicide research and treatment, which will include validated suicide screening and assessment tools and treatments that can be shown to save lives, will be vital to consolidating our nascent gains. Answers will not be simple, nor will they be related to a stunning innovation. However, DoD will continue to seek a measured and multidisciplinary solution, which should be defined as a sustained decrease in current rates to a level well below the civilian norms.

