**Statement for the Record**

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**Prepared By**

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**For The Veterans Affairs Committee**

**U.S. House of Representatives Hearing**

**“Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans”**

**February 13, 2013**

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the House Veterans Affairs Committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our statement for the record on “Honoring the Commitment: Overcoming Barriers to Quality Mental Health Care for Veterans”.

First, VVA recognizes that the Veterans Health Administration (VHA) has made some significant progress in its efforts to improve the quality of mental health care for America’s veterans. For example, although not all mental health clinical staff has yet been trained, VA should be commended for its system-wide adoption (finally) of evidence-based cognitive behavioral treatment modalities for PTSD. In addition, the development of various web-based program applications and social media mental health outreach campaigns reflect a much better effort to reach America’s veterans. While these efforts are laudable, VVA continues to believe they have not gone far enough.

VVA remains very concerned about three related mental health areas: suicides, especially among the older veterans’ cohort; recruitment, hiring, and retention of VA mental health staff; and timely access to VA mental health clinical facilities and programs, especially for our rural veterans.

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 which include: the development 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; and the hiring and training of additional staff to increase the capacity of the Veterans Crisis Line by 50 percent.

However, the VA’s report of February 1, 2013 on veterans who die by suicide paints a shocking portrait of what’s happening among our older vets (see chart below).



Over two-thirds of veterans who commit suicide are age 50 or older. Among the report’s other findings:

• The average age of veterans who die of suicide is just short of 60; for nonveterans, it’s 43.

• Female veterans who commit suicide generally do so at younger ages than males. Two-thirds of women who killed themselves were under 50 years of age; one-third were under 40 and 13 percent were under 30. For men, the comparable figures were 30 percent, 15 percent and 6 percent.

• About 15 percent of veterans who attempt suicide, but don’t succeed, try again within 12 months.

 VVA asks **why?**

VVA understands that 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 one of the reasons 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. In fact, previously published data on veterans who died by suicide were only available for those who had sought VA health care services. But for the first time, the February 1st report also includes some limited state data for veterans who had not received health care services from VA.

Nevertheless, 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.**

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.

VVA strongly suggests that until VA mental health services develops a nationwide strategy to address the problem of suicides among our older veterans – **particularly Vietnam-era veterans** -- it immediately adopt and utilize the appropriate suicide risk and prevention factors for veterans found in the “National Strategy for Suicide Prevention 2012: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention” that’s available on-line at the web sites for both the Surgeon General’s Office and SAMHSA.

The second item with which VVA has grave concerns is the recruitment, hiring, and retention of VA mental health staff. In its February 1st report, the VA claims to be “currently engaged in an aggressive hiring campaign to expand access to mental health services with 1,600 new clinical staff, 300 new administrative staff, and is in the process of hiring and training 800 peer-to-peer specialists, who will work as members of mental health teams”. Nice words, but VVA asks: Of these 1,600 clinical positions, do they represent new additional staff, or replacements for those who’ve retired or left VA employ? What mental health clinical job categories do these hires represent? And what is the VA’s staffing plan for these hires? In other words how many staff is VA hiring, in what positions, and how many do they currently have? It appears that we need a scorecard to determine what is going on…

And last, but certainly not least, VVA remains concerned about timely access to VA mental health services and programs, especially since the 2012 Inspector General’s report illustrated in incredible clarity how top VA facility and VISN administrators “game the system” to make wait times appear shorter for the veterans they serve. The I.G.’s report said that, rather than starting the clock from the moment a vet asks for mental health care, the VA has been counting from whenever the first appointment became available, adding weeks or months to the wait time. So while the VA was saying 95 percent of vets were seen as quickly as they were supposed to be, nearly 100,000 patients had to wait much longer. At the VA Medical Center in Salisbury, N.C., for example, the average wait was three months.

Once again, on behalf of VVA’s National Officers, Board, and general membership, thank you for your leadership in holding this important hearing on a topic that is literally of vital interest to so many veterans, and should be of keen interest to all Americans who care about our nation’s veterans.

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Dr. Tom Berger is a Life Member of Vietnam Veterans of America (VVA) and founding member of VVA Chapter 317 in Kansas City, Missouri. Dr. Berger served as a Navy Corpsman with the 3rd Marine Corps Division in Vietnam during 1966-68. Following his military service and upon the subsequent completion of his postdoctoral studies, he’s held faculty, research and administrative appointments at the University of Kansas in Lawrence, the State University System of Florida in Tallahassee, and the University of Missouri-Columbia, as well as program administrator positions with the Illinois Easter Seal Society and United Cerebral Palsy.

After serving as chair of VVA’s national PTSD and Substance Abuse Committee for almost a decade, he joined the staff of the VVA national office as “Senior Policy Analyst for Veterans’ Benefits & Mental Health Issues” in 2008. Then in June 2009, he was appointed as “Executive Director of the VVA Veterans Health Council”, whose primary mission is to improve the healthcare of America’s veterans through education and information.

Dr. Berger has been involved in veterans’ advocacy for over thirty years, and he is a member of VVA’s national Health Care, Government Affairs, Agent Orange and Toxic Substances, and Women Veterans committees. In addition, he is a member (and the former Chair) of the Veterans Administration’s (VA) Consumer Liaison Council for the Committee on Care of Veterans with Serious Mental Illness (SMI Committee) in Washington, D.C.; he is also a member of the VA’s Mental Health Quality Enhancement Research Initiative Executive Committee (MHQUERI) based in Little Rock, Arkansas and the South Central Mental Illness Research and Education Clinical Center (SC MIRECC) based in Houston, Texas. Dr. Berger holds the distinction of being the first representative of a national veterans’ service organization to hold membership on the VA’s Executive Committee of the Substance Use Disorder Quality Enhancement Research Initiative (SUD QUERI) in Palo Alto, CA and serves as a committee member on the National Association of Alcohol and Drug Abuse Counselors (NAADAC) veterans’ working group and member of the National Leadership Forum on Behavioral Health-Criminal Justice Services with the CMHS-funded national GAINS Center. He has also served as a reviewer of proposals for the Department of Defense (DoD) “Congressionally Directed Medical Research Programs”. He is a current member of the Education Advisory Committee for the National Center for PTSD in White River Junction, Vermont, as well as a member of the Executive Committee of the National Action Alliance for Suicide Prevention, and a member of the Advisory Board for the National Crisis Center.

Dr. Berger’s varied academic interests have included published research, books and articles in the biological sciences, wildlife regulatory law, adolescent risk behaviors, domestic violence, substance abuse, suicide, and post-traumatic stress disorder. He currently resides in Silver Spring, Maryland.

**VIETNAM VETERANS OF AMERICA**

**Funding Statement**

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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.

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