

Mr. Chairman and members of the committee, I appreciate the opportunity to speak on the issue of barriers to quality mental health care for Veterans. As revealed in the Department of Veterans Affairs 2012 Suicide Data Report, Veterans continue to die by suicide at tragically high rates, with an estimate of 22 deaths per day. However, the true scope of the problem is only realized by coupling VA and active-duty data. As has been widely reported, there were 349 suicides among active-duty service members in 2012, with that total exceeding combat deaths (and the rate doubling since 2004). Prior to Iraq and Afghanistan, military service was actually protective, with military suicide rates noticeably lower than general population rates likely secondary to pre-enlistment screening, unit cohesion, the influence of a remarkable sense of purpose, and a warrior identity. A decade of war has changed many things. It is important to recognize that Veteran suicides may actually be underreported, with reliable data only available in 21 states and data from two of our largest states (Texas and California) not included in the report. I have serious concerns that these numbers will continue to grow in the coming months and years, primarily a function of converging forces that can both be anticipated and managed more effectively.

Although I applaud the transparency and thoroughness of the VA Suicide Data Report and progress made to date, I believe it critical for the committee to put the data into context. It is correct that suicide rates among Veterans (VHA users) have been relatively stable over the course of the past 12 years, with an overall rate of 35.9/100,000 in 2009 (and a male suicide rate of 38.3). It is critical to recognize, though, that the rate is three times the national rate of 12.0 in 2009 and double the male suicide rate (19.2) for the general population. It is also reported that although the suicide rate among Veterans rose 22 percent over the past decade the general population rate rose 31 percent. Please understand, though, that the Veteran suicide rate is already so high that the rate of growth should naturally slow. Similarly, the drop in the percentage of our nation’s suicides accounted for by Veterans is important (from 25 percent to 21 percent), but that means that one in five suicide deaths in the general population is by a Veteran despite the lowest military service rates in U.S. history. Perhaps most worrisome among findings is that younger Veterans appear to be dying by suicide at disproportionate rates (when compared to the percent of Veterans in the contributing states), with rates more comparable in older age groups. This data might reflect a persistence of problems from activity-duty to Veteran status for Iraq and Afghanistan Veterans in particular. My concern is that the data need to be accepted for what they represent, a very serious and significant health problem among Veterans. Contrast and comparisons to the general population, although limited, help us recognize the magnitude and persistence of the problem. These data should challenge us to do better not reassure us the problem is under control. These data should challenge us to think about doing things differently, not simply funding “more of the same”. These data can be added to almost a decade worth of findings that indicate what we have been doing has not been particularly effective.

As indicated in the report, since 2009 approximately 30 percent of callers to the national crisis line have endorsed thoughts of suicide, down from 40 percent. Although the drop could suggest progress, it is more likely that the crisis line is not actually attracting the highest risk callers. Are we reaching those at greatest risk for suicide? The persistence of high suicide rates would suggest the VA might need to explore other options for identifying and reaching those at greatest risk. The fact that 80 percent of those with non-fatal events were seen 4 weeks prior to the event suggests the need to target the continuity and intensity of care, along with raising the question of whether or not heightened risk is readily recognized by clinicians. If it is, we need to improve access, the frequency, and continuity of care. We know the VA provides high quality care. Access to predictable, frequent follow-up care is an issue to target. Similarly, the fact that 90 percent were seen in an outpatient setting suggests the need to target primary care and outpatient mental health as the focal points. The fact that the greatest risk is among Veterans over age 50 speaks to the chronicity of many of these mental health problems and the importance of not just crisis care, but ongoing long-term treatment. In order to reduce wait times and provide accessible, predictable, long-term care the VA will need to explore partnerships with private community providers. Continued centralization within VA healthcare needs to be challenged.

I am convinced that the bulk of the problem is not a clinical one. We have to do a better job of managing those at risk, providing easy and frequent access to care, and convincing Veterans to stay in care. The more difficult we make it to get or stay in care, the more Veterans will die by suicide. I believe that among the most significant barriers to care for Veterans is the lack of meaningful transitional services for those evidencing heightened risk while on active duty, only to be discharged and left alone to navigate the maze of government services. The tragic suicide of Russell Shirley demonstrates the problem. I recently spoke with Russell’s mother and one of his close friends. His mother consented to me sharing his story. Russell was a son, a husband, a father and a soldier. He served his country proudly and bravely in Afghanistan. Although he survived combat, he came home struggling with post-trauma symptoms and traumatic brain injury. With a marriage in crisis and escalating symptoms, Russell turned to alcohol, with the net outcome a DUI and eventual discharge. Russell lost his family, his career, his identity, and eventually put a gun to his temple and pulled the trigger in the presence of his mother. His mother now struggles with her own brand of PTSD. Russell’s high risk status was easily recognized. In order to help struggling soldiers like Russell, we need to connect them not just the VA system, but people in the system. The DoD and the VA need to work hand in hand to improve transitional services for high-risk service members being discharged or voluntarily separating. With significant budget cuts likely, these numbers will only grow. The VA needs to experiment with partnerships in local communities that allow Veterans to receive accessible and long-term care near home rather than having to travel great distances. Instead of building an even bigger and less flexible and responsive healthcare bureaucracy, now is the time to experiment with new and creative alternatives.

For the first time in history, we have conducted clinical trials with active-duty service members struggling with PTSD, depression and suicidality. Early results are promising. Can we find a way to provide treatment prior to designating a Veteran as “disabled”, as we know that once someone is identified as disabled it is unlikely that status will ever change? This also speaks to the chronic nature of the problems revealed in the VA report, i.e. the highest suicide rates among those over age fifty. As the drawdown in Afghanistan continues and the DoD grapples with smaller budgets and force reductions there will be more tragedies like that experienced by the family of Russell Shirley unless we find ways to ease the transition from activity duty to VA services, improve access, retain Veterans in treatment, and experiment with alternatives to permanent disability status.

It is important to recognize that behind every statistic quoted above there is a large collection of friends and loved ones. I have included a photo of Russell with his children at the end of this document so you and I can remember the Americans touched by this problem.

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