



VETS HELPING VETS SINCE 1974

THE ULTIMATE FALLOUT:

SUICIDE PREVENTION CARE DENIED TO AT-RISK VETERANS DUE TO MISCONDUCT IN SERVICE

Written testimony by Swords to Plowshares

for

House Veterans Affairs Committee

“Service should not lead to suicide: Access to VA’s Mental Health Care”

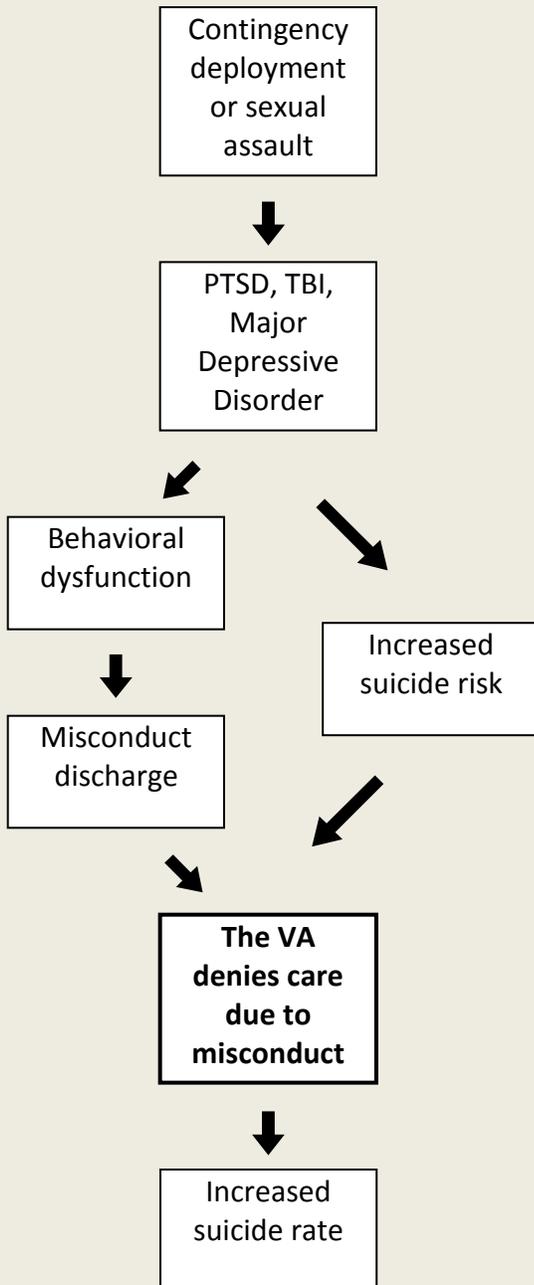
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VA regulations prohibit the Agency from providing timely access to care and services to some former servicemembers who are most at risk of suicide. This arises when servicemembers acquired behavioral dysfunctions as a symptom of PTSD, TBI, or deployment stress, and where the military characterized such behavioral dysfunction as misconduct. Many of these are servicemembers that the public would expect to receive care and support, including servicemembers who deployed to contingency operations or survived trauma. The VA routinely denies care to these servicemembers because of their conduct in service.

This testimony describes the nexus between in-service misconduct and suicide risk, the delay and denial of VA care to this at-risk group, and the solutions available to Congress.

The Suicide Pipeline

25% of active-duty suicide victims have a record of misconduct, but the VA denies eligibility to 80% of veterans discharged for misconduct.



See text for citations to research

The Human Toll

The VA knows the names of hundreds of people that were denied care due to misconduct and who later committed suicide.¹ This can be avoided for veterans like these:

T. H.²

He deployed with the 82nd Airborne for the first Gulf War, where he earned the CIB for clearing bunkers and did vehicle and casualty recovery on the "Highway of Death." After his return he started experiencing PTSD. He attempted suicide once during service. He felt that he was unable to receive care, and was denied permission to take leave to be cared for by his family. He left anyway, and when he voluntarily returned he was given an OTH discharge. He has attempted suicide twice since separation. Still denied VA care.

Kash Alvaro³

A soldier deployed to Afghanistan who acquired PTSD and TBI so severe that it triggered seizures and heart palpitations. He was given an OTH discharge while waiting for a medical separation. His unit had not provided transportation to his medical appointments, had written that his seizures were faked, and had not approved his request to be assigned to a Warrior Transition Unit. He was discharged after he had isolated himself in his apartment for two weeks. Granted VA care only after media attention.

T.W.

He volunteered for the Marines and deployed to Vietnam twice. He earned two purple hearts and was hospitalized for "nervous shock" on his first tour. On his second, he had a breakdown and started a fight with MPs. He was given an OTH discharge. Without psychiatric care, he started illegal drug use, became homeless, and attempted suicide once. Still denied VA care.

Competency of Swords to Plowshares to testify on this issue:

Swords to Plowshares has been assisting veterans with access to VA health care and related services for four decades. This gives us a detailed, on-the-ground knowledge of how the VA's administrative procedures operate.

Swords to Plowshares is a veterans service organization in San Francisco.⁴ Swords to Plowshares has been serving the veteran population since 1974. From its inception it has served veterans marginalized by society and rejected by the VA: it served Vietnam veterans with PTSD before the VA recognized this as a condition; it has provided housing and assistance to homeless veterans since the 1980s; and it is one of the few organizations that have provided representation to veterans with so-called "bad paper", discharges that are less than honorable and can interfere with access to VA benefits and civilian employment. Swords to Plowshares currently operates emergency and permanent supportive housing to over 300 veterans a year; assists over 400 veterans obtain other housing each year; has employment and training services; case management services; and provides legal services to over 400 veterans a year.⁵

Swords to Plowshares has worked extensively with veterans seeking access to VA health care. For homeless veterans, access to VA health care is the most important benefit that the VA offers. Our legal staff helps veterans obtain access to VA health care through direct advocacy with VA hospitals, through VBA claims, and through petitioning the DOD for a review of discharge characterization. This gives us a close understanding of the law around both VA eligibility and discharge review, as well experience with how they affect veterans in practice.

TESTIMONY

The rate of suicide for veterans outside of VA care is increasing. In 2010, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.⁶ Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide. The VA is failing in its mission to prevent suicide among veterans by denying life-saving care to a high-risk group of servicemembers.

Section I explains why veterans at risk of suicide are at high risk of receiving a misconduct discharge. Section II explains how the VA excludes the large majority of veterans in this situation. Section III explains who this increases suicide risk. Section IV proposes solutions to this problem, including suggested legislative text on page 11.

I. Why servicemembers at risk of suicide are likely to receive misconduct discharges

Congress has given the VA responsibility for deciding which servicemembers should be granted “veteran” status and therefore be eligible for health care when they have been discharged for misconduct. The number of servicemembers separated with discharges that put them at risk of VA delays varies between 9% in 2002 and 4% in 2011. It also varies by service: in 2011 the Marine Corps discharged 8% in this way while the Air Force discharged less than 1% in this way. The largest number of affected discharges are those characterized as “Other Than Honorable” (OTH). From 2001 to 2011, 115,000 servicemembers received OTH discharges.⁷

Not all misconduct discharges are justly awarded. There are many cases of servicemembers with mental health disabilities acquired in service, some exhibiting suicidal risk, whose service does not necessarily protect them from receiving misconduct discharges characterized as “Other Than Honorable.” These servicemembers, at high risk of suicide, are likely to be denied VA care.

Mental health disabilities acquired in service may lead to misconduct discharges

The misconduct that leads to an OTH discharge is often behavior symptomatic of acquired mental health disorders such as Post-Traumatic Stress or Traumatic Brain Injury. For example, Marines with PTSD from combat exposure are 11 times as likely to be separated with a misconduct discharge.⁸ This section explains how that happens.

PTSD, TBI, and Major Depression produce behavioral dysfunction through an exaggerated startle response, inability to control reflexive behavior, irritability, or attraction to high-risk behavior.⁹ Some of the medicines used to treat the conditions may induce fatigue or

lethargy that also interferes with basic functioning. In fact, interference with social and occupational functioning is a primary measure of the severity of these conditions.¹⁰

For servicemembers on active duty, these behavioral disorders may result in infractions of unit discipline. This may include non-prescription drug use as a form of self-medication, aggression towards co-workers or family members, or impairment as side effects of prescription drug use. Any of this conduct may be a basis for misconduct discharges characterized as “Other Than Honorable” (OTH) or “Bad Conduct” (BCD).

These behavioral disorders are not always recognized by the services as symptoms of acquired mental health disorders. The servicemember may not yet be diagnosed, or the command may not believe that the conduct is due to in-service trauma. If the military service is in the process of separating the servicemember for a disability, the services may suspend the medical separation process and give an immediate misconduct discharge if any misconduct occurs and the servicemember volunteers to be separated rather than be court-martialed.¹¹ A 2012 Army study found that the commander of Warrior Transition Units at Ft. Bliss showed a “primary attitude” that was “punitive, like a correctional facility.”¹²

These same mental health disabilities increase suicide risk

The same mental health disabilities that may lead to misconduct discharges are associated with increased suicide risk.¹³ PTSD in veterans is associated with elevated suicide risk both for those with PTSD diagnoses¹⁴ and those with PTSD symptoms that fall below the threshold for a PTSD diagnosis.¹⁵ Veterans with TBI are 55% more likely to die by suicide.¹⁶ Service members with prior deployments are more likely to attempt suicide, even when controlling for the existence of other mental health disorders.^{17, 18} Other predictors of suicide risk also involve behavioral dysfunction, such as Major Depressive Disorder, Substance Abuse, and Intermittent Explosive Disorder.¹⁹

Direct evidence linking misconduct discharges to suicide risk

Self-harm is often the culmination of a progression that starts with disciplinary infractions and proceeds to more major misconduct. This has been acknowledged by some of the services²⁰ and has been shown in data: 25% of suicide victims have some record of in-service misconduct.²¹ When that misconduct occurred during service, they may have received discharges that interfere with their access to timely VA care.

Both anecdotal evidence and official policy show that the military services have discharged servicemembers for misconduct when they should have been retained. According to a 2010 report on suicide in the Army, one of its strategies for deterring suicidal behavior is aggressive citation and investigation of behavioral disorder that results in misconduct, and separation from the service when it arises.²² In other words, it is the Army’s policy to give

misconduct discharges to the servicemembers most at risk of suicide. They then become the VA's responsibility.

II. How the VA denies and delays care to servicemembers with misconduct discharges

Denial of care under VA standards

Not all those who served are recognized by the VA as veterans. A servicemember is only a veteran in the eyes of the VA if they were discharged "under conditions other than dishonorable."²³ This does not refer to a Dishonorable Discharge provided by the service. It refers to an overall judgment of the quality of service to be made by the VA after separation from the military. Congress has never defined for the VA what service should be treated as "dishonorable"²⁴, leaving it to the VA to define this term through regulation and adjudication.

Under current standards, the VA has very broad discretion to determine whether service was "under conditions other than dishonorable" if the servicemember's discharge was "Other Than Honorable" or "Bad Conduct."²⁵ According to its current regulations, the VA decides that service was dishonorable if misconduct was "willful and persistent" or if it involved "moral turpitude."²⁶ The standard is very low. Misconduct can be "willful and persistent" if it involved only two incidents of misconduct or if it was a single episode of unauthorized absence.

The VA is not required to consider whether in-service misconduct was due to deployment or mental health disabilities. The VA may overlook "minor" misconduct if service was "otherwise faithful, honest and meritorious."²⁷ However, deployment to a contingency operation, or several deployments, is not considered "meritorious" service by the VA because this was merely the servicemember's assigned duty.²⁸ The VA only considers deployment to be "meritorious" if there were documents acts of exceptional conduct. There are no other provisions in VA regulation or policy that require it to consider mitigating circumstances when deciding if misconduct was "dishonorable."²⁹

In practice, the VA finds that most service that ends in an OTH discharge was dishonorable: 80% of its decisions deny "veteran" status.³⁰

Delay of care under VA procedures

For servicemembers given OTH or BCD discharges, the VA presumes that they are not veterans until shown otherwise. When a servicemember appears at a VHA facility requesting services, his or her status is "non-veteran" and the initial response of VHA staff to servicemembers with OTH or BCD discharges is denial. We have heard directly and second-hand from clients that VA staff respond to requests for services by saying "you are not a veteran" and "you are dishonorable." This is premature, as the VA has not yet determined whether their

service was dishonorable. It also discourages servicemembers, particularly those at risk of suicide, from further pursuing eligibility for care.

The VA is required to evaluate service whenever a potentially ineligible servicemember seeks benefits; however, VHA personnel routinely violate this policy. VHA policy instructs Eligibility and Enrollment staff to initiate a request to the VBA to evaluate the service of people with OTH or BCD discharges.³¹ However, VHA staff at the San Francisco VAMC have told us directly that they do not do so. Instead, they advise the servicemember to seek a discharge upgrade from the military service; they do not even inform servicemembers of the VA's duty to evaluate their service. When our staff have specifically requested that they initiate this process for servicemembers, VHA staff have refused to do so and have proceeded only after the involvement of an attorney. For servicemembers that do not seek the help of an advocate, VHA staff are effectively denying all eligibility, denying even the possibility of recognition as a "veteran."

If a servicemember insists on having his eligibility reviewed, that request will be handled in the slowest adjudication track. The task of determining "veteran" status is considered an "Administrative Adjudication" by the VBA. These issues are handled by "non-rating" teams. The VBA has shifted staff onto "rating" teams in response to the claims backlog, leaving "non-rating" teams understaffed. Currently, issues in the "non-rating" team are taking twice as long as "rating" issues.³² Therefore VA compensation claims, as slow as they are, are handled twice as fast as the question of whether a servicemember is even a "veteran." At the Oakland Regional Office, these issues take an average of about two and a half years to complete.

The VA does not provide medical care while it performs an evaluation of service.³³ The VHA has discretion to provide care on a "humanitarian basis" if the servicemember signs a contract agreeing to pay for the services if required;³⁴ however, the VHA does not routinely offer this while the VA is evaluating character of discharge.³⁵ For urgent services, such as emergency psychiatric care and emergency homeless services, this delay amounts to a denial of the service sought.

III. Why the VA's practice increases the risk of veteran suicide

The data above shows the correlation between suicide risk, in-service misconduct, and denial of access to VA care: deployment increases risk of PTSD, TBI and substance abuse; all of those conditions increase the risk of receiving a misconduct discharge; and those conditions also increase risk of suicide. Therefore for the VA's denial and delay of care for veterans with misconduct disproportionately affects servicemember at risk of suicide.

Exclusion from VA care further increases risk of suicide. The VA's successful suicide prevention efforts have lowered the rate of suicide among veterans enrolled in VA care.³⁶ However, the rate of suicide for veterans outside of VA care is increasing. In 2010, the latest

data available, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.³⁷ Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide.

The VA knows these people by name. The VA has a list of servicemembers who have committed suicide, based on state death reports. Some of them at some time asked the VA to evaluate their service and grant them VA care. The VA rejected them 85% of the time.³⁸ That means the VA turned away at least 448 servicemembers who went on to commit suicide. The actual number is certainly higher, because the VA list does not collect deaths from all states, and because it doesn't include people who sought care at VA hospitals and where the staff turned them away without filing an eligibility request.

IV. Solutions

Providing timely care to suicidal veterans with misconduct discharges requires four solutions. These do not require large changes to VA obligations and would align VA practice with public expectations.

1. Issue: The VA denies most requests for assistance regardless of whether their condition was related to in-service mental health conditions and regardless of whether the servicemember had significant deployment service.

Solution: The VA should enact presumptions to give the benefit of the doubt to certain categories of servicemembers most at need of care: those who mental health disabilities acquired in service and those who were deployed to contingency operations. See below for suggested text. The VA should presume that they served under conditions other than dishonorable unless evidence clearly shows otherwise. Effectively, this requires the VA to consider whether the misconduct that led to the discharge was the result of a mental health disorder, and it requires the VA to give credit for the inherently laudable service of a contingency deployment. Creating this clear rule would also accelerate the decision-making process by reducing the amount of investigation required of VA raters and provide immediate care to those most at risk of suicide.

2. Issue: The VA does not provide care prior to deciding whether service was “under conditions other than dishonorable.”

Solution: The VA should be instructed to provide health care and housing assistance to servicemembers pending original determination of “veteran”

status. See below for suggested text. Anyone who enlisted and served deserves the benefit of the doubt, and they should not be denied health care for years waiting for the VA to decide whether they are veterans. This will allow the VA to provide essential care immediately, without delaying care while it evaluates character of discharge, ensuring that no servicemembers at risk of suicide are turned away or left on the street merely because of a bureaucratic delay.

3. Issue: The VHA routinely fails to initiate a decision.

Solution: The VHA should automatically start a request for a “Character of Service” determination when a servicemember with an OTH or BCD discharge requests health care. While this is already official VHA policy, this is routinely ignored. It is more likely that this will be followed if the VA enacts the provision recommended above.

4. Issue: The VBA places those decision it its slowest decision-making lane.

Solution: The decision of whether someone is even a veteran should be a priority for the VA. Whether a servicemember is even a “veteran” is a fundamental question that deserves to be prioritized. The VA should create a “Flash” for claims with this issue and move them into expedited lanes.

These solutions would not require a major change to current VA obligations. There is a relatively small number of servicemembers who receive discharges that make the presumptively ineligible for VA care: from 2001 to present, about 6% of servicemembers received OTH or BCD discharges. The eligibility changes proposed above would create presumptions of eligibility for the subset of these who were deployed to contingency operations or who have a mental health condition acquired in service. This is not a significant increase in the number of people under VA care, but it will disproportionately target the servicemembers at risk of suicide.

The solutions would align VA practice with public expectations. In our experience, the public is unaware that servicemembers who deployed to combat or who have severe disabilities might not be eligible for VA support.

V. Conclusion

Our current wars have created tens of thousands of people injured by the conditions of their service. Often this results in behavioral disorders that may appear as “misconduct” to their chains of command. There is a pipeline from in-service mental health trauma to behavioral dysfunction to misconduct discharge, and it ends with veterans at risk of suicide denied access to

VA support. The VA's administrative processes deny immediate care to these servicemembers, and creates bureaucratic barriers to critical care that can save lives. Certain behavior may be incompatible with continued military service, but we also recognize that those servicemembers who once served honorably deserve and need our support after they separate. Congress gave the VA the duty to extend services to those servicemembers. Their slow bureaucratic process and their refusal to follow their own rules effectively deny care and dignity to those servicemembers. They deserve better.

SUGGESTED LEGISLATIVE TEXT

SEC. __. EVALUATION OF VA ELIGIBILITY FOR SERVICEMEMBERS WITH MENTAL HEALTH DISABILITIES OR WITH SERVICE IN CONTINGENCY OPERATIONS.

(a) Section 5303B is added: “Evaluation of conditions of discharge –

(1) Servicemembers who acquired mental health disabilities during service shall be presumed to have served under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(2) Servicemembers who were deployed to a contingency operation shall be presumed to have been discharged under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(3) The presumptions in this section do not overcome the prohibitions in 38 USC 5303(a).

(b) Tentative eligibility for essential care – The VA shall extend benefits under Chapter 17 and Chapter 20 to former servicemembers pending the outcome of character of discharge determinations. No overpayments will be assessed for services provided during this period.

¹ Conversation with VHA Analyst, June 27 2014, reporting that a list of veteran suicide deaths compiled by states includes 448 who had received misconduct discharges and had asked the VA to review their service, and for whom the VA had denied eligibility.

² Swords to Plowshares client.

³ Profiled in "Other Than Honorable", Colorado Springs Gazette <http://cdn.csgazette.biz/soldiers/day1.html>.

⁴ www.swords-to-plowshares.org

⁵ <http://www.swords-to-plowshares.org/wp-content/uploads/Swords-2013-Infographic.pdf>

⁶ "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.

⁷ "Administrative Separations" at <http://www.dod.mil/pubs/foi/recent.html>

⁸ Highfill-McRoy et al. "Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines", BMC Psychiatry 2010, 10:88.

⁹ James et al. (2014), "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI", *Military Medicine*, 179, 4:357; Elbogen et al. (2014). Violent behavior and post-traumatic stress disorder in US Iraq and Afghanistan Veterans. *The British Journal of Psychiatry*, Advance online publication. doi: 10.1192/bjp.bp.113.134627; Tateno et al., "Clinical Correlates of Aggressive Behavior After Traumatic Brain Injury", *The Journal of Neuropsychiatry and Clinical Neurosciences* 2003;15:155-160. doi:10.1176/appi.neuropsych.15.2.155.

¹⁰ See "General Ratings Formula for Mental Disorders" 38 CFR 4.150 (2009).

¹¹ For example, AR 600-235 Ch. 10.

¹² Quoted in "Other Than Honorable", Colorado Springs Gazette <http://cdn.csgazette.biz/soldiers/day2.html>.

¹³ Sareen et al. (2005). "Anxiety disorders associated with suicidal ideation and suicide attempts in the National Comorbidity Survey." *Journal of Nervous and Mental Disease*. 193, 450-454.

¹⁴ Jakupcak et al. (2009). "PTSD as a Risk Factor for Suicidal Ideation in Iraq and Afghanistan War Veterans." *Journal of Traumatic Stress*, 22, 303-306. doi: 10.1002/jts.20423

¹⁵ Jakupcak et al. (2011). "Hopelessness and Suicidal Ideation in Iraq and Afghanistan War Veterans Reporting Subthreshold and Threshold PTSD", *Journal of Nervous and Mental Disease*, 199, 272-275.

¹⁶ Brenner et al. (2011). "Suicide and traumatic brain injury among individuals seeking Veterans Health Administration services." *The Journal of head trauma rehabilitation* 26.4: 257-264.

¹⁷ Nock, et al. (2014). "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)." *JAMA Psychiatry*;71(5):514-522.

¹⁸ Kline et al. (2011). "Suicidal ideation among National Guard troops deployed to Iraq: the association with postdeployment readjustment problems." *The Journal of nervous and mental disease*. 199(12):914-20.

¹⁹ Nock, et al. (2014). "Prevalence and Correlates of Suicidal Behavior Among Soldiers: Results From the Army Study to Assess Risk and Resilience in Servicemembers (Army STARRS)." *JAMA Psychiatry*; 71(5): 514-522.

²⁰ See U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report" July 28, 2010.

²¹ U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, page 43

²² U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, passim. and page 70 ("Recommended actions: Enforce separation actions for high risk behavior.")

²³ 38 USC 101(2)

²⁴ Congress has required the VA to deny benefits to certain veterans based in part on their conduct in service, e.g. 38 USC 5303(a), 38 USC 5303(d), 38 USC 5303A. However these do not define "dishonorable" service. They are additional eligibility requirements that apply even if a servicemember is found to have service under other than dishonorable conditions.

²⁵ Congress has not defined the term "dishonorable" in statute. The Court of Appeals for Veterans Claims characterized the VA's regulations that attempt to define the term as "very broad" in *Manuel v Shinseki*, 10-1858 (Vet. App. 2012).

²⁶ 38 CFR 3.12(d)

²⁷ 38 CFR 3.12(d)(4)

²⁸ Title Redacted by Agency, 03-09 368, Bd. Vet. App. (June 19, 2009).

²⁹ See "Benefits Adjudication", VA Manual M21-1MR, *passim*.

³⁰ The Veterans' Disability Benefits Commission, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century (2007), page 97.

³¹ See "Note" in "Eligibility Determination", VHA Handbook 1601A.02, page 5 (Nov. 5, 2009).

³² See "Non-rating activity days pending" in *ASPIRE Benefits Dashboard* at <http://www.dod.mil/pubs/foi/recent.html>.

³³ 38 CFR 17.34 (establishing a narrow provision for "tentative eligibility determinations" that do not apply where the character of discharge is in question).

³⁴ 38 CFR 17.102(a)

³⁵ The VHA eligibility determination manual does not include an instruction to make this available. See "Eligibility Determination", VHA Handbook 1601A.02, page 4-5 (Nov. 5, 2009).

³⁶ "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.

³⁷ "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.

³⁸ Data provided by VA Analyst, June 2014.