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**STATEMENT OF
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OF THE
DISABLED AMERICAN VETERANS
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
MAY 12, 2016**

Chairman Miller, Ranking Member Brown and Members of the Committee:

On behalf of DAV (Disabled American Veterans) and our 1.3 million members, all of whom are wartime injured or ill veterans, I am pleased to present our views at this hearing, related to the effectiveness of the mental health and suicide prevention programs of the Department of Veterans Affairs (VA), future actions that may be needed to reduce suicide among high-risk veteran populations, including women veterans and veterans who are not currently enrolled in or accessing VA services, and the progress VA has made implementing the Clay Hunt Suicide Prevention for American Veterans (SAV) Act, Public Law 114-2.

In last week's *Washington Post*, Harvard Psychology Professor Matthew Nock, a noted researcher on suicide, published a column worth considering on the topic before the Committee today. Professor Nock concluded in describing the present state of knowledge about suicide:

There are many well-intentioned prevention programs out there, but we have very little data on which ones work and which ones don't. ...[W]e have no programs backed up by evidence from randomized controlled trials, the highest standard, showing that they stop people from ever attempting suicide. Our best bet for preventing suicide is to ramp up research and hopefully shed more light on this troubling phenomenon.

According to the Centers for Disease Control and Prevention (CDC), suicide is not a health care problem but rather, a public health and societal problem. The World Health Organization states that suicide is the 10th leading cause of death in the United States and worldwide more than 800,000 people commit suicide every year. The CDC recommends adoption of a public health model to best deal with conditions that might lead to suicidal ideation. For these reasons DAV is pleased that VA has adopted a modified public health model in its attempt to improve suicide prevention efforts in the veteran population.

Public health uses a population approach to improve health on a large scale. A population approach means focusing on prevention efforts that impact groups or populations of people as a

whole, versus treatment of individuals. Second, public health focuses on preventing suicidal behavior or even ideation, before it ever occurs (primary prevention), and addresses a broad range of risk and protective factors. Third, public health holds a strong commitment to increasing understanding of suicide prevention through science, so that we can develop new and better approaches and solutions. Finally, public health values multi-disciplinary collaboration, which brings together many different perspectives and experience to strengthen the solutions for many diverse communities.

VA Mental Health and Suicide Prevention Programs

The Vietnam War and the more recent lengthy wars in Iraq and Afghanistan have taken a toll on the mental health of the military service branches, and veterans who have returned from these operations. Combat stress and often severely disabling combat-related mental health readjustment are prevalent among Vietnam veterans and our newest generation of warfighters from Operations Enduring Freedom/Iraqi Freedom/New Dawn (OEF/OIF/OND) veterans.

Unique aspects of deployment, including the frequency and intensity of exposure to violence, injury and death, asymmetrical warfare from urban to desert to jungle environments, and suffering through or witnessing the reality of war, a truism from World War II until today, are strongly correlated with the risk of chronic post-traumatic stress disorder (PTSD) and other mental health sequelae. While veterans who served in Iraq and Afghanistan make up only a fraction of the VA patient population, they are absorbing a significant proportion of VA's specialized mental health resources. Since the wars began 15 years ago, over 2.7 million service members have deployed, more than 1.9 million are now veterans eligible for VA health care, and about 1.2 million have actually obtained VA care in some form. More than 57 percent who have received VA health care received a mental health diagnosis, prominently including PTSD. As of the end of 2015, VA was compensating nearly 830,000 veterans from all war eras for PTSD.

Applying lessons learned from prior wars, VA mounted efforts at early identification and treatment of behavioral health anomalies in enrolled OEF/OIF/OND veterans by instituting system-wide mental health screenings, adding new counseling and clinical sites, and conducting wide-scale training in evidence-based psychotherapies. While these are positive steps and VHA has made progress in disseminating knowledge about evidence-based treatment that does not guarantee implementation of such treatments. For these reasons we recommend VA collect information on the use of evidence-based psychotherapies to ensure system-wide availability of such services.

Over the past decade the VA Office of Mental Health has promoted a comprehensive set of mental health services, while VA facilities were seeing a significant increase in the number of veterans seeking care. VA has integrated a mental health presence into primary care in its Patient Aligned Care Team (PACT) model, with a goal of minimizing barriers to this specialized care, and aimed at reducing stigma. From FY 2008 to March 2014, VA provided more than 3.6 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 942,000 veterans. Also, VA provided specialty mental health services to more than 1.5 million veterans in fiscal year (FY) 2014.

The Government Accountability Office (GAO) and others have identified key barriers that deter veterans from seeking mental health care, including stigma, lack of understanding or awareness of the potential for improvement, lack of child care or transportation, and work or family commitments. Research shows early intervention and timely access to mental health care are key to improving quality of life, promoting recovery, obviating long-term health consequences, and minimizing the disabling effects of mental illness –and the risk for suicide.

In recent years, VA’s mental health programs, including its suicide prevention efforts, have been both praised and criticized. Nevertheless, the Committee should note that VA offers an array of mental health services that is unparalleled in any other health system or individual institution in the country. The scope, depth, and breadth of VA’s multivariate approaches deserve recognition. However, as noted above, VA’s most significant challenge is to ensure that the dozens of developed models used in evidence-based care (many of which emerged from VA’s own intramural research) are uniformly available in every Veterans Integrated Service Network—a situation that also has been criticized by both internal and external observers. Variability is the result of a number of factors including insufficient staff levels; archaic human resources operations governing personnel recruitment; availability of specialized practitioners, and lingering VA organizational and cultural challenges. DAV believes VA is making good-faith efforts to address the problems that are within its control, but Congress and the Administration need to do their part to ensure VA has the legislative authority, tools and resources to solve these specific problems.

VA increased staffing of new mental health providers following a 2012 Office of Inspector General (OIG) report on the Veterans Health Administration, titled “Review of Veterans’ Access to Mental Health Care” (<http://www.va.gov/oig/pubs/VAOIG-12-00900-168.pdf>). In fact, VA has the highest number of mental health providers in an integrated health care system (over 5,200 employed practitioners) with specific expertise and training in post-deployment-related mental health conditions, such as PTSD. These practitioners are reinforced by investigators in VA’s Research and Development Service, as well as the unique asset of the VA National Center for PTSD. VA is able to coordinate comprehensive primary and specialty care services for veterans with substance-use disorders, traumatic brain injury (TBI), and other co-occurring disorders that are tailored to meet veterans’ complex health and mental health needs.

The goal of increasing staffing was to shorten waiting times for access to mental health services, and address numerous known barriers to care. However, it is unclear if all enrolled veterans are receiving the types of services they want or need—when and where they need them. Veterans, especially younger veterans, indicate they would prefer a variety of new services over medication, such as web-based life coaching and skills-building tools, intensive evidence-based therapies, as well as non-medical/non-traditional therapies, such as complementary and alternative medicine (CAM) options (i.e., yoga, meditation, acupuncture, Tai Chi). While VA is steadily increasing the availability of these new non-medical approaches, there is variability across the system related to access to CAM services.

In addition to the PACT approach, VA uses Patient-Centered Community Care (PCCC) in mental health to maximize utilization of integrated health services when enrolled veterans are

unable to access direct VA care. DAV prefers VA to be the provider of these specialized services whenever possible, but immediate access to care is the most critical factor for a veteran in a mental health or emotional crisis. However, we believe VA should properly triage and make a determination for every patient based on the unique findings in each case, and develop a mental health treatment plan that meets the veteran's needs, whether in-house, in the community, or in a hybrid arrangement. A 2014 report by the RAND Corporation indicates that only 13 percent of evaluated mental health providers (not limited to VHA providers) met study criteria for readiness to provide veteran-friendly, high-quality care. According to RAND, providers working within the VHA or a military setting were more likely than others to meet the criteria, which may raise questions for some about increasing the use of non-VHA care. The report recommends conducting better assessments of civilian provider capacity, assessing the impact of trainings in cultural competency on provider capacity, expanding access to effective trainings in selected evidence-based approaches, and facilitating providers' use of evidence-based approaches.

Mr. Chairman, DAV has previously testified that, in most cases, sending veterans with war-related mental health issues out of the system is not the answer. This group can particularly benefit from VA's expertise in treating PTSD, substance-use disorders, TBI and other post-deployment transition challenges. Giving a card to a veteran with mental health challenges and leaving him or her to search for services in the community, absent VA care coordination, increases the risks for these vulnerable veterans. If veterans with mental health issues need access to care outside of the VA system, we urge VA to have routine follow-up with the veteran to ensure the patient is receiving quality care from a provider with expertise in treating veterans.

Over the years, VA has received both praise and criticism for its suicide prevention efforts and mental health services. Some veterans have undoubtedly fallen through the cracks and others have testified before Congress that VA's suicide prevention efforts were inadequate, describing barriers in access to care and the lack of time for clinicians to provide intensive evidence-based treatments for those who do access care. Veterans and family members have testified before this committee on several occasions talking about horrible failures in the system and the need to do more to ensure we do not lose another veteran to suicide. I am sure those failures weigh heavy on the many dedicated and compassionate VA mental health providers and program directors who are responsible for serving our nation's veterans. But more importantly, what can be done to ensure that any veteran who needs help gets it?

Continued evaluation of the system and a goal of continuous improvement is essential. We are pleased that VA has placed special emphasis on suicide prevention through an aggressive anti-stigma and outreach campaign, and has launched services for veterans involved in the criminal justice system. Peer Specialists, mental health consumer councils, and family and couples counseling services have also been evolving and spreading throughout VA. We have also been encouraged that VA has extended clinic hours for patients, placed VA staff on college campuses and at universities. VA's web-based self-help resources and mobile apps have been very popular and VA's coaching into care campaign focused on assisting family members and friends to get veterans the help they need has logged thousands of calls.

A 2010 progress report on the National Strategy for Suicide Prevention described the VA as "one of the most vibrant forces in the U.S. suicide prevention movement, implementing

multiple levels of innovation and state of the art interventions, backed up by a robust evaluation and research capacity.” More recently, *Psychiatric Services*, a peer-reviewed journal of the American Psychiatric Association, published a report showing that the quality of mental health care provided by VA is superior to that provided to a comparable population in the private sector.

According to the study, “in every case, VA performance was superior to that of the private sector by more than 30 percent. Compared with individuals in private plans, veterans with schizophrenia or major depression were more than twice as likely to receive appropriate initial medication treatment, and veterans with depression were more than twice as likely to receive appropriate long-term treatment.” The authors concluded that “findings demonstrate the significant advantages that accrue from an organized, nationwide system of care. The much higher performance of the VA has important clinical and policy implications.”

VA’s current suicide prevention efforts based on a public health framework, has three major components: (1) surveillance, (2) risk and protective factors, and (3) intervention. Suicide prevention interventions aim to reduce risk factors and/or enhance protective factors that have been identified; interventions may target high-risk groups or individuals, identified based on known risk factors. Easy and quick access to care is a protective factor against suicide, and recent laws have included provisions aimed at increasing veterans’ access to VA-provided or VA-funded care, including mental health care.

VA policy requires that mental health care be made available 24 hours per day in VA facilities or at local community hospitals; that new patients referred for mental health services receive an initial assessment within 24 hours and a full evaluation appointment within 14 days; and that follow-up appointments for established patients be scheduled within 30 days of initial contact. Likewise, VA has extended its care through tele-mental health capabilities so the veteran can more easily receive needed services. A full-time suicide prevention coordinator is assigned to each VA medical center and large community-based outpatient clinic. The coordinator is responsible for tracking high risk veterans (all attempters, and patients with serious suicidal ideation or others clinically determined to be at risk for suicide) as well as tracking appointments and coordinating enhanced care. The extent to which these policies are in practice broadly should continue to be a major oversight concern of this Committee. The one area we recommend VA put more focus on is crisis management. When a veteran is experiencing a mental health crisis and asking for help, there must be ready access to a mental health specialist and/or specialized program. Other areas VA should focus on include negative perceptions and concerns veterans may have about VA care, and challenges in scheduling appointments. VA should utilize its peer specialists to follow up with veterans waiting for care. According to VA, peer-to-peer interactions have been extremely helpful to the patient and treating clinicians.

In November 2011, VA launched an award-winning, national public awareness campaign called *Make the Connection*, which is aimed at reducing the negative perceptions associated with seeking mental health care and informing veterans, their families, friends, and members of their communities about VA resources (www.maketheconnection.net). As of July 2015, the campaign has had over 8.8 million website visits, 227,909 uses of the VA resource locator, 12 million video views, and more than 33 million Facebook comments, shares, and post likes.

The Veterans Crisis Line is another successful component in VA's suicide prevention efforts. However, despite the measurable success with answered calls, dispatched emergency services and referrals to care, service problems were identified earlier this year in a VA Office of Inspector General report. Specifically, complaints included some calls going unanswered, lack of immediate assistance, delayed arrival of emergency services, and difficulty using the call line during a crisis. Continued evaluation and program improvement is needed. For these reasons, we are pleased that an outside evaluation of the VA's mental health care system is now underway, as mandated by the Clay Hunt SAV Act, to be completed by the end of fiscal year (FY) 2017. Going forward, these evaluations will be continued on an annual basis.

Challenges also persist in suicide surveillance including timeliness of data, consistent classification of deaths as suicides, and the accuracy of information reported. Addressing these gaps is not a responsibility of VA but more so of the states' vital records agencies, coroners and medical examiners. These units of state and local government are under no federal mandate to report all suicides to any federal agency, including VA or even the CDC.

It is widely believed that inconsistent reporting of suicides across jurisdictions, as well as underreporting of suicides in general, limit the effectiveness of surveillance efforts. Classification of a death as a suicide requires a determination that death was both self-inflicted and intentional. Also, suicides may be underreported when the manner of death is misclassified as "undetermined" or "accidental" (e.g., poisonings or single-occupant automobile accidents). Additionally, each jurisdiction (state, city, Indian Tribe, or territory) governs its own rules for investigating deaths, leading to variability not only in classification but in reporting.

Based on these findings, the GAO has recommended the VA implement processes to improve the completeness, accuracy, and consistency of data reported to the VA's Behavioral Health Autopsy Program (BHAP) system, and in particular, that VA rely more on outside data sources (e.g., the DOD) to identify decedents as veterans if they are not enrolled in the agency's numerous services and benefits programs.

High-Risk Veteran Populations Including Those Not Enrolled or Accessing VA Care, and Women Veterans

The veteran population is currently estimated at 21.7 million individuals. Of these, only 31 percent of all veterans use the VA health care system (6.7 million users). Based on this fact, it will continue to be a challenge for VA to provide successful outreach to veterans that do not use VA but who may need VA's specialized mental health services. There have been several examples highlighted in the media about military units that have suffered losses to suicide without veterans getting any help in the VA or in the private sector. This past weekend, to contribute to the ongoing suicide prevention efforts for our nation's veterans, DAV along with a coalition of non-profits sponsored a "Spartan Weekend" for ill and injured veterans, which centered on the promise that they would not take their own life without reaching out to someone for help. The goal is to help isolated veterans reconnect with their battle buddy, unit members and other veterans who may need care. The event reached 1.8 million Facebook and other social media users and resulted in a number of veterans reaching out for help.

Meeting the unique needs of women veterans has been a priority for DAV. According to VA, over the past decade, there has been a 154 percent increase in the number of women veterans accessing VHA mental health services. Women veterans comprise 9 percent of the total veteran population but constitute the fastest growing veteran sub-population. Since 2000, the number of women veterans using VA health care has more than doubled. VA offers a comprehensive array of mental health and specialized post-deployment mental health services to women and VA's Uniform Mental Health Services Handbook requires that mental health services be provided as needed to women veterans at an equivalent level to that of their male counterparts system-wide, and that providers be capable and competent to meet the unique needs of women.

VA conducts annual, comprehensive assessments of suicide deaths that occur among veterans using VA health services. These assessments evaluate gender differences in suicide rates. According to VA, suicide rates among women veterans have increased in recent years, yet are lower than suicide rates among male veterans. VA continues to conduct important research to identify risk factors and patterns of suicide in veterans, including those that may be linked to gender. In one recent study, VA researchers found rates of suicide to be higher among women who report having experienced military sexual trauma (MST), contrasted with those who did not.

VA partnered with 23 states to report information from death certificates on veteran deaths by suicide to learn more about patterns and rates. Recently, this effort allowed VA researchers to evaluate preliminary estimates of suicide rates, including those who do and those who do not use VA health care services. These estimates were based on information for the years 2000 through 2010 and include gender-specific information, including:

- Suicide rates were nearly six times higher in women veterans than in civilian women.
- Suicide among all women veterans was 34.6 per 100,000 in 2010. This rate increased 40 percent since 2000, from 24.7 per 100,000.
- The suicide rate among male veterans was 36 per 100,000.

In 2010, women veterans who used VA health services were 75 percent less likely to die by suicide than women veterans who did not use VA health services. This data suggests that VA's mental health programs for women, including suicide prevention efforts, are showing a positive impact. VA also found that for women veterans, there is a greater likelihood of using firearms as the method of suicide, (i.e., women veterans who die by suicide are 18 percent more likely than civilian women to use firearms as the instrument of death). Furthermore, the firearm suicide rate among women veterans has increased faster and to a greater degree than suicide rates among women veterans using other methods. This type of gender-specific data collection can aid VA in improving mental health services for our women veterans.

As documented in DAV's 2014 report, *Women Veterans: the Long Journey Home*, women's military and wartime deployment experiences and reintegration processes are inherently different from those of their male counterparts. Research indicates that both men and women may develop PTSD as a response to combat exposure, but women are more likely to manifest depression as a co-occurring disorder. Women are less likely than men to display anger

and resort to substance use. Women are more likely to develop depression, or an eating or anxiety disorder, but without a diagnosis of PTSD. Findings also show that when women return from deployment, the camaraderie and support from their male peers is often short-lived, resulting in isolation for many. Studies have shown that peer support is important to a successful transition, but women report they often cannot find a network of women who can relate to their military or wartime service.

While VA is recognized for its longstanding expertise in specialized mental health and post-deployment mental health services, it has struggled to establish system-wide access to gender-specific group counseling, residential treatment, and specialty inpatient programs to serve women. Improved access to these programs is essential for recovery and effective reintegration, therefore VA must ensure all outpatient and residential programs have environments that can accommodate women with safety, privacy, and respect. Existing programs should be re-evaluated to ensure they are appropriately tailored to meet the unique mental health care and post-deployment transition challenges women experience in serving in war.

Update on the Clay Hunt SAV Act, Public Law 114-2

The Clay Hunt Suicide Prevention for American Veterans (SAV) Act included provisions to:

- Extend for one year the existing five-year post-discharge period of open eligibility for VA health care for combat veterans covering illnesses that have not been medically proven to be related to their military service;
- Increase access to mental health care by creating a peer support and community outreach pilot program including an interactive website of available resources;
- Create a pilot program to repay loan debt of psychiatry students for VA recruitment purposes; and
- Conduct an annual evaluation of VA mental health and suicide prevention program.

Based on our understanding, VA is still working to implement most of the provisions in the Clay Hunt SAV Act. The VISNs have been chosen for establishing a community peer outreach network, developing website resources is in progress, the educational loan language is still pending in the regulatory process and the RFP or Request for Proposals for the Independent Evaluation has gone out.

DAV Recommendations

- DAV urges Congress and the Administration to ensure ample resources are provided for VA mental health programs, including comprehensive treatment for serious mental illness and sexual trauma, readjustment counseling, peer-to-peer programs, promotion of evidence-based treatments for post-traumatic stress disorder, and specialty substance-use disorder services to provide effective mental health care for all veterans needing such services.
- VA should continually strive to improve access and services for veterans in crisis and those seeking VA primary mental health care and specialized programs. VA should

continue its targeted outreach, anti-stigma, and early intervention efforts, and routine screening for new veterans returning from wartime deployments.

- VA should continue research in mental health to study gaps in care and develop best practices in screening, diagnosis, and treatment for post-deployment readjustment, as well as studies focused on understanding and reducing suicide in the veteran population.
- VA should conduct health services research on effective stigma reduction, differences in gender readjustment, suicide prevention, and treatment of acute co-occurring PTSD, mild traumatic brain injury, and substance-use disorders in combat veterans.
- VA should increase innovative programs such as telehealth for increasing access to gender-sensitive mental health treatment programs for women veterans.
- VA should develop a standardized approach to transition women with serious mental health deficits, including those who have experienced sexual assault, from DOD to VA care.
- Congress should expand the authority for the VA Readjustment Counseling Service's women veterans retreat program. The VA Office of Research and Development should study the program to determine its key success factors, its effectiveness as an alternative treatment regimen, and whether it can be replicated in other settings.

Closing

Despite obvious improvements, it is clear that more progress needs to be achieved by VA to fulfill the nation's obligations to veterans who are challenged by serious and, in some cases, chronic mental illness—particularly in all eras of war veterans, including younger veterans who are confronted by post-deployment repatriation and transition challenges. Currently, there is a pressing need for timely access to mental health services for many returning injured and ill veterans, particularly in early intervention services for veterans with substance-use disorders, and for evidence-based treatments for those with PTSD, suicidal ideation, depression and other consequences of combat exposure. If these symptoms are not readily addressed at onset, they can easily compound and become chronic and lifelong. Delays or failures in addressing these problems can result in risky behavior, job and family disintegration, incarceration, homelessness, and suicide.

DAV appreciates the efforts made by VA to improve the safety, consistency, and effectiveness of mental health care programs for all veterans. We urge VA to continue research on suicide prevention efforts and finding innovative ways to engage all veterans. We also appreciate that Congress continues to provide funding to VA in pursuit of a comprehensive set of services to meet the mental health needs of veterans, in particular veterans with wartime service who present post-deployment readjustment needs. To this end, we urge the Committee's continued oversight of VA's progress in fully implementing its Mental Health Strategic Plan.

Chairman Miller and Members of the Committee, this concludes my statement. DAV appreciates the opportunity to provide this testimony, and I would be pleased to address any of the topics discussed in this statement.