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**STATEMENT OF
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BEFORE THE
HOUSE COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
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On behalf of DAV (Disabled American Veterans) and our more than one million members, all of whom are wartime injured or ill veterans, thank you for inviting DAV to submit testimony for the record for today's hearing to discuss the findings of the Department of Veterans Affairs (VA) most recent suicide data. We appreciate the Committee's attention to this critical topic.

Suicide prevention is not "just" a VA and Department of Defense (DOD) problem because it affects everyone and every community. According to VA's most recent report on suicide, its numbers within the military and veteran community have remained relatively static in spite of all of the new programs, services and community partnerships put together to reduce it or stop it altogether. For this reason, we must take a look beyond the data, to examine what VA is doing to prevent suicide, the efficacy of its suicide prevention programs, what it is doing to reduce or eliminate suicide, and its suicide prevention efforts in its partnerships within the community and other Federal agencies.

One way VA is attempting to lower the rates of suicide is its social media campaigns to increase awareness and the provision of tools for veterans, their families, and those working with veterans. One of these campaigns between VA and DOD is the "Be There" campaign. "Be There," in summary, means feeling comfortable to address someone you think may be in distress, knowing what to do and who to call, and being there to hear the needs of that person. We know that suicidal behavior is often related to the consequences of problems like failed relationships, combat exposure, illegal substance use, terminal disease, poor physical health, low or no income, job stress, physical or sexual trauma, and legal or housing stress. "Be There" and other awareness and prevention campaigns could be the first steps in lowering the rates of suicide, by arming more individuals with the knowledge and confidence to speak up and recognize when they, a loved one or someone they know is struggling.

A simple way we can all make a difference within our communities is by asking the question, "Are you ok; are you thinking of harming yourself?" "Be there" to listen for

the response, and if necessary, to keep them safe. In acknowledgment of suicide prevention month, DAV recently provided S.A.V.E. training at our Service and Legislative Headquarters in Washington, D.C. Personnel having received the training have been provided with resources to aid them in feeling comfortable enough to address a fellow staff member, veteran, friend or neighbor who they perceive may be experiencing distress. Through the support of the VA's Office of Suicide Prevention, staff members who participated in the training received items with the VA Crisis Line number, 1-800-273-8255, along with other relevant information to aid a person in crisis. This line connects persons in need to first responders trained to deploy lifesaving conversation skills or actions, who know what to do, and have access to life saving interventions such as activating EMS or the police, and stabilization methods to follow up with additional screening and/or treatment as needed.

VA's Suicide Report

VA's study found that the general trends in veteran suicide have remained relatively consistent at about 20.6 veteran suicides per day, and about 6 of the 20 were recent users of VHA services. DAV recently released a new report, *Women Veterans: The Journey Ahead*. This report highlights research data to indicate the importance of looking more closely at subpopulations of veterans such as women. While women veterans are at lower risk of suicide than their male peers, VA's recent study indicated that women veterans are two times more likely to commit suicide than women who have never served. In contrast, male veterans have 1.3 times increased risk of suicide. Women veterans' rate of suicide is also increasing much faster than their male peers.

As we examine the findings of VA's most recent report on veterans' suicide, the efficacy of its current suicide prevention programs, community involvement, and the identification of veterans shown to be at highest risk, we must also evaluate how these programs and services meet the needs of women veterans. Women veterans represent a small portion of veterans; however, they continue to be the fastest growing cohort, not only in the Veterans Health Administration (VHA), but also in the active duty and Reserve components of the military.

Women veterans continue to die from suicide each year at twice the rate of women that have not served. However, there is a difference in the method these two cohorts choose when committing suicide. Women who have not served tend to use less lethal means of self-directed violence, such as suffocation or poisoning. Women veterans have a higher tendency to use firearms, resulting in higher rates of fatality. In addition, while male veterans' use of firearms was relatively stable, women veterans' use increased from 34.3 to 39.9 between 2005 and 2015.

VA Approach a Public Health Model

VA has adopted a public health model for addressing veterans' suicide, which is impressively outlined in its recently released *National Strategy for Preventing Veteran Suicide 2018-2028*. This model relies upon using a population-focused approach; focusing on primary prevention; using science to inform policy; and multidisciplinary collaborations that develop solutions for diverse populations. VA's plans include bolstering health and empowerment in veterans and their families; taking steps to prevent veterans from committing suicide, including reducing access to firearms for those veterans at the greatest risk; treating those at risk of suicide; and creating systems of surveillance, research and evaluation to support preventive efforts.

With this understanding, VA has partnered with the American Foundation for Suicide Prevention (AFSP). AFSP is a community effort led through state chapters to reach the approximately 10.2 million (only 6 million use VA health care) out of 19.9 million veterans that do not use VA benefits or services. The AFSP places an emphasis on teaching providers about identifying those at risk, determining their level of risk, and appropriate actions to take for individuals at risk of suicide, gun safety, and post-vention (interventions for survivors following a death by suicide), and is one of the five initiatives identified by VA to combat veteran suicide from within the community.

VA continues to fine tune its REACH—VET (Recovery Engagement and Coordination for Health—Veterans Enhanced Treatment) program, which uses predictive analytics to assist its providers in identifying and intervening in patients identified as being at high risk of suicide. DAV believes this is a state of the art program rivaling or even besting programs in large-scale private sector health maintenance organizations. DAV endorses the recommendation within our new report on Women Veterans that in updating its Clinical Practice Guidelines for Assessment and Management of Patients at Risk for Suicide with DOD, the guidelines work group should assess the scientific basis and publish recommendations on gender-based differences in risk, protective factors and treatment efficacy for suicide prevention. Gender-focused risk factors such as lack of social support or a history of sexual abuse may factor into VA's predictive analytics. In addition, the growing use of firearms in self-directed violence seen in women signals the need to provide firearm safety training to all at-risk veterans.

Initiatives to combat veteran suicide from within the community include the Mayor's Challenge, which features partnerships between VA, Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA), and the Mayors of eight cities in its initial phase. The goal of the Mayor's Challenge is to reduce suicides among service members, veterans and their families using a public health approach to suicide prevention including building awareness of problems and knowing where to get help.

Suicide prevention effort has also been extended to some college campuses where veterans are taking classes. The Veterans Integration to Academic Leadership (VITAL) program provides mental health services to student veterans on college campuses. In 2017, VITAL programs served 124 college and university campuses, and assisted 2,012 new student veterans on those campuses. Although suicide rates are generally higher for veterans using VHA, veterans not using VHA have higher risks of suicide relative to non-veteran peers. Unfortunately, these veterans are also harder to reach. For this reason, DAV is pleased to see emphasis on partnerships within the community to combat suicide.

Military Sexual Trauma

High rates of military sexual trauma (MST) among women may also factor into reasons some women veterans are at high risk for suicide. Among VHA users, 20 percent of women compared to 1 percent of men report military sexual trauma. In fiscal year (FY) 2017, DOD reports having received a 9.7 percent increase in the reporting of sexual assaults. DAV's Women Veterans report recommends that DOD work with other federal agencies and outside experts to evaluate and disseminate effective approaches to creating gender equity within a male-dominated workplace. Additionally, DOD should take an aggressive stand against sexual harassment and assault in the military by holding commanders accountable for creating a positive culture of inclusion and respect and sponsoring women's empowerment.

The effects of MST are often felt many years after service women and men have left the military. Once service members transition into their communities, DOD, VA and community providers must work together to be sure all veterans receive the care they deserve.

Exceptional care must continue in the veteran's pursuit of benefits related to MST. In August 2018, the Office of Inspector General (OIG) issued a report (17-05248-241) that found that nearly half of denied MST-related claims from reviewed cases were not properly processed in accordance with Veterans Benefits Administration (VBA) policy, possibly resulting in the denial of benefits to these survivors of military sexual trauma. MST-related claims can be complicated, difficult to develop and often appear to lack the necessary evidence to warrant a grant of service connection. DAV supports recommendations made by the OIG for VA to revert back to ensuring its Veterans Service Representatives and Rating Veterans Service Representatives that are processing MST-related claims, have up to date, issue-specific training on MST. Furthermore, all denied MST claims during the period of the OIG report are reviewed and assessed for accuracy.

VA provides MST-related care to survivors free of charge, and regardless if service connection has been established through VA's disability compensation process.

Veterans having experienced MST should be referred to VA to receive treatment and related services.

Need for Gender Specific and Sensitive Care

Women veterans also need patient care environments that they perceive as safe, private and inviting. They need knowledgeable gender-specific care providers who understand their issues and the health and mental health conditions in addition to their gender-specific needs. Women providers should be available to women veterans who request them, along with peer specialists who have similar experiences who can help them navigate services. DAV believes that VA provides comprehensive services and a whole health model approach that is best for women veterans. VA's wraparound services, military competencies, integrated system and holistic approach to care make it superior to care in the private sector.

Assessing the Effectiveness of VA Mental Health Programs and Ability to Identify At-risk Veterans.

A critical step in ensuring VA's ability to deliver the high quality mental health care that veterans have not only earned through their service, but also deserve, is highly dependent on having appropriate resources including personnel and capital assets to meet the demand for this specialized care. OIG released a report (17-00936-385) in September of 2017, that ranks the shortage of psychologists as third out of the top five occupations with the largest staffing shortages over the last four years. In the OIG's more comprehensive report (18-01693-196), released in June of 2018, the most frequently cited shortages were in the Medical Officer and Nurse occupations; a lack of qualified applicants, non-competitive salaries, and high staff turnover were cited as the most common reasons for the shortage. VA must have adequate resources to allow it to not only compete with salaries within the private sector, but also attract qualified candidates. With mental health conditions being cited as the third most frequently diagnosed category of conditions at VA for male and female patients, it is imperative that mental health providers be adequately staffed at VA facilities.

In response to these OIG reports, VA has implemented the Mental Health Hiring Initiative, and committed to hiring more than 1,000 more psychiatrists, psychologists and other mental health professionals. DAV Resolution 129 adopted at our most recent National Convention calls for a simple-to-administer alternative VHA personnel system, in law and regulation, which governs all VHA employees, applies best practices from the private sector to human capital management, and supports pay and benefits that are competitive with the private sector. We acknowledge VA's efforts and responses to the shortage of critical personnel in mental health, and we encourage the Department to continue its efforts in establishing innovative ways to not only attract, but retain qualified mental health professionals.

One way VA has leveraged its mental health capabilities, and increased veteran access to mental health care is through its “Anywhere to Anywhere Telehealth” initiative. As part of a federal health care system, VA providers are able to treat patients across the country unrestrained by state-specific telehealth laws and licensing. Leveraging telecommunication technology to provide mental health care to remote veterans greatly enhances veterans’ access to care. Telehealth has been implemented in over 900 sites of care with high rates of satisfaction from providers and patients electing its usage. More than 450,000 veterans receiving care at VA have used home and clinical video telehealth. According to VA, mental health services that have been provided to veterans via clinical video telehealth (TeleMental Health) have reduced acute psychiatric VA bed days of care by 39 percent. VA also reported a 32 percent decrease in hospital admissions while boasting a 92 percent approval rate by veterans.

DAV Resolution No. 293, adopted at our most recent National Convention calls for program improvements, data collection and reporting on suicide rates among service members and veterans; improved outreach through general media for stigma reduction and suicide prevention; sufficient staffing to meet demand for mental health services; and enhanced resources for VA mental health programs, including Vet Centers, to achieve readjustment of new war veterans and continued effective mental health care for all enrolled veterans needing such services.

VA’s REACH—VET program was piloted in October of 2016, and was fully implemented in April of 2017. This program was designed to identify veterans in need of care, and provide care as early as possible by using predictive analytics to flag charts of veterans who may be at risk for suicide. Once a veteran has been identified, his or her VA mental health or primary care provider reaches out to check on the veteran’s well-being, and reviews their condition(s) and treatment plans to determine if enhanced care is needed. By identifying at-risk veterans early, it allows VA to provide treatment before a crisis can occur, and decreases the likelihood of more serious conditions developing later. In May of 2017, VA reported that all VHA medical centers are working with those veterans at the highest risk; 0.1 percent of the veteran population, which includes about 6,400 veterans, roughly 46 per facility. Over time, the focus will expand to include those at a more moderate risk for suicide.

DAV views the REACH—VET program as a valuable tool for VA mental health providers in identifying veterans who are most at risk for suicide and connecting with them. It is important to ensure that once the connection is established, and the needs have been assessed, that there is a clear path for the veteran to receive the care that they need in a timely, efficient way. It is important that every opportunity is taken to eliminate barriers to this care and that these veterans receive the care that they have earned, and need. These veterans should continue to have their needs assessed until they no longer meet the criteria placing them in the highest risk for suicide.

Expanding Access to Veterans with Discharges Characterized as Other Than Honorable

According to the Government Accounting Office (GAO) report 17-260, more than 57,000 veterans that had been separated from service due to misconduct during fiscal years 2011 through 2015, had been diagnosed within two years prior to separation with post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), or certain other conditions that could be associated with misconduct. Because their service had been characterized as other than honorable, these veterans lacked access to VA health care for many years. In January of 2018, the VA Secretary concurred that this problem should be remedied and authorized emergency mental health care for veterans with other-than honorable discharges. This should allow VA to intervene with a new subgroup of veterans who may be at high risk of suicide.

Inter-agency Initiatives

In January 2018, the President signed Executive Order 13822, “Supporting Our Veterans During Their Transition From Uniformed Service to Civilian Life,” directing the DOD, VA, and Homeland Security to develop a plan to ensure that all new veterans receive mental health care for at least one year following their separation from service. In implementation, the first goal of these three organizations is to facilitate seamless access to mental health treatment for transitioning service members. Goal two is to provide access to suicide prevention resources to transitioning service members and veterans through collaborative communication, and outreach efforts to veterans service organizations (VSO), and other stakeholders. The final goal is to leverage interagency partnerships to educate those who have recently transitioned about eligibility for VA mental health care services.

Several key initiatives have resulted from this interagency partnership. The Concierge for Care is a health care enrollment initiative that connects with former service members shortly after they separate from the service. The Military Once Source, provides tools to help plan for deployments, educational and employment resources, and resilience tools to include medical counseling and other consultations in military life. The “Be There” peer support call and outreach center, helps provide access to a number of tools including help with relationships, family and financial counseling. Whole Health groups is an initiative that focuses the overall health of the veteran, desired health goals, and collaboration between the provider and veteran in making a plan around the veteran’s desired goals. This may also include a connection to the community in the fulfillment of those goals. Whole Health groups have been established at all VA medical centers, which will help identify areas of life that are affecting veterans’ lives, through communication between the veteran and his or her health care team to set goals, build a plan around those goals, and connect with the community. These interventions may be an important way of addressing newly

separating veterans within a year of discharge, who are known to be at high risk of suicide.

Readjustment Counseling Service—VA Vet Centers

VA Readjustment Counseling Service (RCS) is home to VA Vet Centers. Vet Centers are one of VA's most popular and widely used programs. Qualifications to utilize these centers include veterans having served in any combat theater of hostility, those having experienced MST, those having served as a member of an unmanned aerial vehicle crew that provided direct support to operations in a combat zone or area of hostility, and for family members of veterans and service members who require counseling for military-related issues such as bereavement counseling for families having experienced an active duty death. According to RCS, Vet Center staff participated in over 40,000 outreach events during FY 2016.

Currently, there are a total of 300 "brick and mortar" Vet Centers located in every state, the District of Columbia, American Samoa, Guam and Puerto Rico. RCS staff members also deliver readjustment counseling services in other areas away from these traditional facilities through the use of its Vet Center Community Access Points (CAPS) and Mobile Vet Centers. CAPS are places where clinicians are able to provide readjustment counseling from other locations in accordance with the needs of that community. In FY 2016, RCS operated more than 740 CAPS which was reported to be a 25 percent increase from the previous fiscal year. Mobile Vet Centers allow RCS staff to deploy within the community to different locations to offer readjustment counseling where veterans are. Events such as gatherings hosted by VSOs or other stakeholders allow additional opportunities to reach veterans that may not receive care from VA for one reason or another, and provide them with the counseling services they need. RCS maintains a fleet of 80 Mobile Vet Centers that are designed to extend RCS staff ability to provide readjustment counseling to more locations within the community to qualifying veterans.

One of the least well-known services that RCS provides within the community is emergency response. In the aftermath of shootings, floods and other disasters, the Vet Center staff frequently partners with Red Cross to provide clinical support in the affected communities. Most recently, Vet Center staff participated in responses to the West Virginia flooding, and the Dallas and Orlando shootings. According to RCS, more than 500 veterans and 60 family members were provided services at these sites, and through a leveraged partnership with Red Cross, provided referral and services to over 3,500 citizens of affected areas.

Peer Support

Peer Specialists in VA are generally veterans in recovery from a mental health or co-occurring condition(s) who have been trained and certified to help others with similar

conditions. These veterans may be actively engaged in their own recovery and may volunteer or be hired to provide peer support to other veterans who are engaged in mental health treatment.

Peer specialists draw upon their own recovery experience to inform their support of veterans. The shared experience of military service tends to foster trust between the Peer Specialist and the veteran with whom they are working. Roles of the peer specialist are varied and include facilitating groups, role modeling, providing outreach and support, teaching coping skills, case management and acting as liaison between the veteran and mental health team.

VA peer support groups have also been seen as invaluable tools in helping veterans cope with symptoms of PTSD, depression, and other mental health related issues. Veteran peer support groups are an opportunity for interaction with people who share similar life experiences. This is especially important for women veterans, whose small numbers within each care facility may make it harder to find other women with whom to relate. While trained volunteers are a valuable resource, employing Peer Specialists often requires higher levels of commitment and engagement with veterans, care teams, in addition to accountability for the roles and responsibilities of the position that may exceed what can be expected of a volunteer. DAV supports Peer Specialists; however, we recommend that VA define specific outcome measures for the Women Veterans Peer Specialist program, including if they successfully connect veterans to mental health services, whether those services include evidence-based therapies, and whether participants had greater adherence to treatment and were more satisfied with their care. VA should continue to evaluate a variety of models to meet needs expressed by women veterans, including the integration of peer counselors in women veterans' comprehensive primary care teams.

In closing, DAV believes that VA and DOD have made important strides in understanding and addressing the issue of suicide among America's veterans. Unfortunately, the unchanged rates of suicide among veterans—and even increases in certain subpopulations such as women and younger veterans—make clear there is more work to be done. Within VHA programs, sufficient resources—staff, space and funding—are essential to ensure all veterans have access and are evaluated and treated within a reasonable timeframe. Veterans in crisis must be assessed immediately. VHA must continue to address staffing issues and other barriers to care such as transportation and child care that affect some veterans' ability to access care. VA and DOD must also ensure that programs are appropriately tailored for women veterans whose needs may be somewhat different than their male peers. VA and DOD must ensure its community partners are trained and effectively assisting in suicide prevention efforts and understand the special risk factors for veterans and when they should be referred to VA for help. Finally, VA must also continue its efforts to increase Americans' awareness of this crisis among veterans so we can all help to end it.

We appreciate the opportunity to provide this statement for the record. We ask the Committee to consider our views and statements as it addresses the issue of suicide prevention in the veteran population. I am pleased to address any questions from the Chairman or other Members of the Committee.