United in Speaking Truth to Power

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Statement of
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on behalf of
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on
Veteran Suicide Prevention: Maximizing Effectiveness and Increasing Awareness
Before the House Committee on Veterans Affairs, Health Subcommittee

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Chairman Dunn and Ranking Member Brownley:

"Never think there was ever anything more that you could have done."

I've read that line a hundred times looking for some hidden clue that would tell me if it were true or not. One of *my* Vietnam veterans had died by suicide and left me a note. He had been a combat Marine suffering from Posttraumatic Stress Disorder (PTSD) and I was his assigned social worker. The survivor guilt over the men lost in the war and the nightmares filled with gunfire ate away his spirit. Any sparkle of kindness or hope he felt would flash across his face as quick as lighting. He was alienated from family and friends, so his treatment team was all he felt he had. He saw vodka as a refuge that let his mind drift back to those buddies on that battlefield. It eventually also took his body in 1989. The Vietnam War had ended 15 years before, but its body count was still rising.

For the better part of the next 30 years that statement would continue to puzzle me. Not because I think I failed him personally, but because I think that our healthcare professions and organizations failed him. I have dedicated my career to combat trauma recovery and resilience. I did my first (peer reviewed) clinical presentation on *Suicide and Vietnam Veterans* in 1990 at a Society for Traumatic Stress Studies conference. At the time, suicide was the 10th leading cause of death in America taking about 38,000 lives. For Vietnam veterans, it was the second leading cause of death behind accidents. The tools for assessing military combat trauma and PTSD were burgeoning with limited attention on addressing suicidal thoughts and behaviors. The best practice was a "no suicide contract."

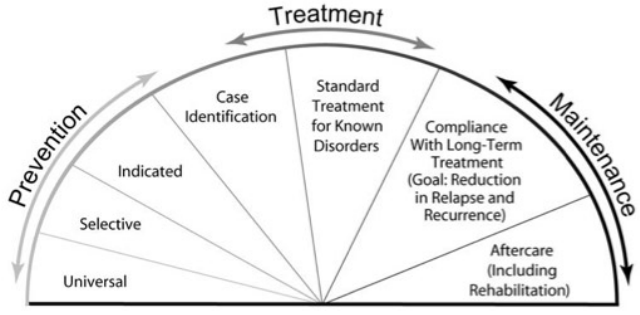
After the Gulf War, Clinical Pathways for PTSD treatment were being developed, and VA reported an increase in Gulf War Veterans who were dying by suicide. This was still a time when being in the military was a protective factor against suicide and the rates were significantly lower for the active duty. However, I remember sitting in a meeting at VA Central Office while Dr. Han Kang noted that female veterans had died by homicide with greater frequency. When I questioned those suicide and homicide rates, I was told that it reflected lifestyle choices and maladaptive behaviors on the part of those veterans. VA was blaming deceased victims. VA

refused to fund further studies to see if these female homicides were like "copicides.[1]" When I looked at the VA 2017 suicide data that showed an increase in women veterans who have died by suicide, I was left wondering if a generation later, women have moved from choosing dangerous relationships to their own firearm proficiency. I guess we will never know because, as with much of the VA data, it does not inform research or intervention priorities.

The June 2018 VA National Suicide Data Report; 2005-2015 is extremely confusing and contradictory to previous data reports released by VA in several ways. The report itself while describing methodologic enhancements says, "These were applied for all years to support comparisons over time." But then it says, "These updates may limit direct comparisons of current results with previously reported findings." How did VA make enhancements that limit trend analysis? The report then adds in military suicide data that it has never reported upon before. Did the Department of Defense (DoD) coordinate on this data release and where is their explanation of those numbers? Are these numbers duplicated in the DoD Suicide Event Report (DODSER)? Are the agencies now double counting or over-inflating suicide mortality? The report notes that in some cases, the VA was unable to confirm Title 38 status, but given the advent of the Suicide Data Repository that matches to the DoD manpower data, how is this possible? Congress should ask DoD to comment on these military deaths being reported by the VA. Regarding opioids, Figure 31 seems to be erroneous in its reporting of Opioid Use Disorder as it appears to have flatlined at 0 for the last decade, which contradicts Figure 32. VA should be asked to explain or correct these data points given the deadliness of opioids in this country today. However, the most concerning statistic in this report is the notation that *"Veterans who use VHA[2] services had a higher rate of suicide death than non VHA Veterans, overall Veterans and non-Veterans. Veteran VHA patients with a MH/SUD[3] diagnosis who accessed mental health treatment services had higher rates of suicide than other Veteran VHA patients."* In its 2016 report, VA said, *"VHA users has a decreased suicide rate with a mental health diagnosis. Overall VHA user rate decreased in suicide.* In the 2014 report, VA said, *"VHA reported decreases in suicide rates, including mental health."* This reverse trend should be alarming. For several years, VA touted its successes in treating suicidal veteran. If this was in fact not true or mental health care had degraded so much so that veterans who use VHA are more likely to die by suicide, a true overhaul and immediate accountability is demanded. VA MUST be able to align suicide data to program effectiveness and the congressional funding allocated. Furthermore, this data is not the result of psychological autopsies, which would provide much more in-depth analysis of each veteran who has taken his/her own life, especially if they were enrolled in VHA.

Decades ago, the Institute of Medicine (now the National Academy of Medicine) developed a "protractor" framework for a continuum of health care. It is a

Figure 1. Continuum of Health Care



Source: Reprinted with permission from Reducing Risks for Mental Disorders. Copyright 1994 by the National Academy of Sciences, Courtesy of the National Academy Press, Washington, DC.

[1] A method of attempting suicide by acting agg
[2] Veterans Health Administration
[3] Mental Health/Substance Use Disorder

simplistic model because it is easy to see where you should be as a clinician or an organization. It helps shape an understanding of mission and priorities so that the data can be used to inform funding decisions. Think of it more like a fan that opens and closes at the necessary points. I used it to inform a strategic plan, when the DoD asked me to lead the effort in establishing the Defense Suicide Prevention Office (DSPO) in 2011 and by 2014 we were seeing an eking downward in some of the mortality numbers. But 2 years later, when Pentagon experts classified military suicide as the "new normal"[4] because there was no clear pattern to the data that explained the increases in suicides, I was horrified because that simply was not true.

Today, the VA just as the Secretary of Defense needs "universal" suicide prevention policies and curriculums to standardize the messaging and training, but without over-using one tool, like the Columbia Suicide Severity Rating Scale as a panacea. It needs "selective" interventions that takes data points and creates opportunities for engagement, such as peer support. I once incorporated predictive analytics to assess wellness within the armed forces, so we could hone in on Service members with "indicative" accumulating risk factors and a velocity of change. I was glad to see VA embrace this approach even after it was abruptly cancelled by DoD soon after I left DSPO, wasting an invested $4 million in development and losing hundreds of nodes of wellness data on over 2 million active and reserve components. However, if VA could map wellness risks, it could use a peer support model to conduct well-being checks, which the Henry Ford Healthcare System was showing great success implementing. They had reduced their patient suicide rate to zero by providing caring contacts. It meant not waiting for someone to engage in help-seeking behavior but re-lensed the organization's focus onto its help-offering behavior. Encouraging help-seeking behavior and stigma reduction campaigns were getting to be too trite with little effectiveness.

But, there is the rub. Senior leaders like awareness campaigns and spend millions of dollars on them. They make a big splash in the media. It is measurable in how many outputs - "views" or "hits" websites or social media pages get but does not generate outcomes. Leaders get to report to Congress on their success. Yet, suicide has been the 10th leading cause of death in America for 30 years. Research published by several sources including Stanford University, University of Michigan, and in a specific study on suicide published by the University of Southern California (USC) found that, "*…suicides could be prevented if persons with mental illness were provided care. Instead of doing that, the mental health industry's main tool in reducing suicide takes the form of public service announcements, brochures, hotlines, and speeches targeted to the general population. …. But those charged with overseeing the funds, refuse to measure rates of suicide to see if the funds are having an impact. Instead they measure tangential issues like "attitudes" and number of presentations made. The money is wasted."*[5] These campaigns do not work because they cannot change behavior and sometimes the unintended consequence is that they normalize the suicidal behavior they are trying to abate – a phenomenon known as suicide contagion. Yet, VA has spent over $100 million on a "Digital Strategies" contract to contractors affiliated with a former Assistant Secretary for Public Affairs. Each year, the VA's Office of

[4] Zoroya, G. Experts worry that high military suicide rates are "new normal." USA Today. June 12, 2016
[5] Jaffe, J.D. (2014) Preventing suicide in all of the wrong ways. Center for Health Journalism. USC Annenberg. https://www.centerforhealthjournalism.org/2014/09/09/preventing-suicide-all-wrong-ways

Suicide Prevention rebrands the Veterans Crisis Line Campaign with a new onslaught of slogans – this year's theme is "Be There". In years past, the slogan has been "It's Your Call", "The Power of One", and "It Matters". Each year millions of dollars are spent on new posters, magnets, brochures, coaster, and other giveaways. The Make the Connection campaign warehouses 736 videos[6] that are posted on Facebook and other social media platforms. These videos, albeit emotionally impactful, are only so until the viewer scrolls to the next posting. And upon searching the video "likes" and "shares" there are an inordinate number of VA employees and contractors in the mix – giving an inflated sense of impact within the veteran community. Comments are usually encouraging but are nebulous. Does VA really need to spend millions of dollars producing 700 videos while there is a shortage of clinicians?

Furthermore, the most recent IDIQ[7] contract vehicle created by VA; Veteran Enterprise Contracting for Transformation and Operational Readiness (VECTOR) will spend $25 Billion on 68 companies over the next 10 years. Billions of dollars will be spent on more management initiatives, that include deliverables like trade shows, conferences, advertising/marketing, public relations, outreach, video and film production, surveys and other management tools. It is unknown how VA will assure task order compliance and quality assurance oversight for 68 companies over the next 10 years to mitigate any waste, fraud, and abuse. It is also unknown if any of the billions spent on VECTOR will in fact demonstrate an ability to save a single life. Although the advantage of an IDIQ is it allows flexibility to get things done in a timely manner, it does not require enunciated statements of work with performance metrics that can track outcomes. Congress should hold annual hearings on VECTOR to know what outcomes VA is getting for the billions it will be spending on non-patient care activities. Will there be a report?

None of this facilitates treatment outcomes as described by the above-mentioned USC study in the same way that money spent on hiring mental health providers, upgrades to the Veterans Crisis Line, increasing peer support counselors and suicide prevention coordinators or conducting root cause analyses and psychological autopsies when a veteran has died by suicide could do. While billions of dollars are being divert from actual patient care, Whistleblowers of America (WoA) hears from providers all over the country on how those funding shortfalls have obstructed their ability to provide actual suicide prevention and intervention to veterans.

Staffing shortages exist throughout the VA system, including the Readjustment Counseling Services (RCS). While Vet Centers served a total of 287,095 Veterans, Service members, and Military Families in FY2017 and provided 1,960,900 no-cost visits for readjustment counseling, military sexual trauma counseling, and bereavement counseling services, it has done so at great compromise to quality care. Vet Centers are under a mandate to see 30 patients a week and meet other performance metrics, while still attending staff meetings, documenting chart notes, writing claims support letters or referrals, and providing case management services or face an adverse personnel action. One Vet Center counselor documented over 33 anonymous RCS employee quotes that categorized their work environment as, *"ruthlessly fixated on productivity; not optimal for patient care; focus has changed from clinical care to cumbersome bureaucratic*

[6] https://maketheconnection.net/stories-of-connection

[7] Indefinite Deliverable/Indefinite Quantity

record keeping; unethical practices; coming in on my days off to catch up on documentation; sleepless; harassing; retaliatory; vindictive; or *traumatizing*. Counselors reported impacts to their own emotional and physical wellbeing and low morale because of the stress and many respondents were leaving or retiring so as not to burn out and make judgment errors. However, most compelling were those who reported on the numbers of veterans who stopped coming to the Vet Center because of the "*impersonal environment."* A veteran shared his protest letter to his Vet Center with WoA.

Other examples of observations shared with WoA:

A VA doctor recently bemoaned that she spends more time looking at her computer screen than at patients while in sessions, so she can answer all of the alerts. She believes that loss of eye contact and ability to read body language impairs her ability to focus on the veteran's mental status because her back is to the veteran most of the time.

At one VA Medical Center, a suicide prevention coordinator reported that they do not have time to complete suicide assessments or write prevention plans with every veteran who potentially needs one because of the case load and its complexity. She had 35 patients at one time. Administrators directed to note patients as "moderate risk" for suicide so as not to raise red flags in the system. When a veteran died by suicide on VA property, her supervisor refused to conduct a root cause analysis because that would be too time consuming. While on another ward across the country, a nurse reported that she is often left alone at night on a ward with seriously mentally ill patients and recovering addicts, if one of the patients attempts suicide, he/she must be sent to the Emergency Room, which requires the enlistment of another patient to push a wheelchair since she cannot leave the ward unattended and no other staff is available to arrive urgently. She has Narcan on the ward, but not the key to the cabinet to get it.

Community Based Outpatient Clinics (CBOCs) are just as challenged. One social worker reported that patients are not properly diagnosed, and some are in danger of not being properly followed up on. Another counselor commented that even when we have access to the Choice Program, the VA doctor still has to write the referral, it needs administrative approval, and then the contractor has to process the request and contact the veteran to schedule an appointment. By the time that happens months later, the veteran could be dead.

A father lamented that his son went to the VA hospital to get help, but he was turned away because there was no available bed. He was given an appointment for several weeks away. He went back to the ER and sat all night without being seen. In the morning, he killed himself in the parking lot. The father, also a veteran, felt enormous guilt for having sent his son to the VA and was now feeling suicidal himself. This highlights how family member suicide and survivors have little visibility in the VA system since their needs are mostly met in the private sector, which impairs a holistic approach to suicide prevention within the VA community and ignores a primary risk factor for a family history of suicide.

Additionally, it has come to the attention of WoA that the DSPO designated $5.5 Million from its DoD line item in its 2016 President's Budget for "Veterans Suicide Prevention." However, there is no audit trail for this money. What DoD or VA actually did and who spent the money is

unclear. It is never mentioned again. However, no one yet at DoD has been able to explain why it needed VA to execute its funds or for what purpose. Was there a shortfall in the VA suicide prevention budget? Did Congress not provide VA enough funding?

WoA recognizes that suicide prevention is the new cottage industry. With government money flowing, there is no shortage of contractors, nonprofits, or private enterprises looking for those dollars. All too often appropriated dollars for quality of life programs, such as those set aside for suicide prevention are awarded by government officials for contracts and jobs to their friends and family. This practice is so commonplace, it's dubbed "the friends and family plan" by many throughout the system. If a program manager or contracting officer does not "go along to get along" then the retaliation can be severe as too many who have contacted WoA have come to learn. WoA has heard from hundreds of VA whistleblowers that exposing medical errors, patient care mismanagement, waste, fraud, and/or abuse of funds or authority, or any other type of wrongdoing becomes an involved, complicated, expensive, and life altering process. This Committee has passed legislation in honor of Dr. Chris Kirkpatrick, a Tomah VA Medical Center psychologist who died by suicide after suffering retaliation in the wake of his reporting suspected overmedication of the hospital's mental health clinic's patients. So, you know that reporting wrongdoing is "career suicide" for those who place their patient's care above their own livelihood. These employees are the powerless in the face of institutional wrongdoing, incompetence, or bureaucratic policy when veterans' lives are at stake, but you are not. This Congress can do more to save veterans and their families from suicide and reducing program costs by exerting greater oversight and accountability over the funds appropriated to VA and the alignment of intervention programs to the data. There is more we can do.

Thank you for considering this statement.