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Testimony of
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Legislative Hearing

The Independence Fund

Dear Chairman Takano, Representative Roe, and Members of the Committee, thank you very much for allowing The Independence Fund to testify before your Committee. I am Bob Carey, Chief Advocacy Officer of The Independence Fund, headquartered in Charlotte, North Carolina, with additional offices in Washington, DC and Sacramento, CA.

Demographics of Veteran Suicide

As we discussed in our testimony before this Committee last November, there is still much discussion regarding the potential causes of the spike in veteran suicide rates, the protective and risk factors surrounding veteran suicide, and how veteran suicide fits into the overall issue of suicide rates across the country. While some argue this is a broad multilayered, complex, national problem, we believe the data provided by the VA in their annual suicide report tells a more direct story.

Specifically, we believe the greatest risks factors for veterans are key demographic factors such as being young, male, and combat deployed veterans. While the rate of veteran suicide has risen precipitously across every age and gender demographic in the veterans community, for the 18-34-year-old veterans, it's risen most significantly:

- While the overall veteran suicide rate rose 30% from 2005 to 2017, the 18-34-year-old veteran suicide rate rose 77%.

- Between 2005 and 2017, and additional 342 veterans died from suicide annually. But 320 of those 342 additional veteran suicide deaths were veterans age 18-34 – in other words, while 18-34-year-old veterans make up only 10% of the veteran population, they represent 94% of the increase in veteran deaths.

Unfortunately, the last year the VA reported on suicide deaths for combat deployed veterans was the 2016 Report, with data through 2015. With the release of the 2019 report, the VA indicates they no longer receive deployment data from the Department of Defense so that they can conduct data analysis of the relationship of suicide deaths with combat deployments. As an aside, we would urge the Committee to explore this data issue further and make every effort to

restore both the data flow and reporting on specific suicide rates, by age group and gender, for combat deployed veterans through 2014. Regardless, the current literature that examines deployment as a risk factor points toward deeply troubling facts:

- While the overall veteran suicide rate for 2014 was 32.8/100,000, for combat deployed veterans it was 47.8/100,000, 46% higher.

- The 18-24-year-old combat deployed veteran suicide rate was 110.3/100,000 and the male 18-24-year-old combat deployed veteran suicide rate was 124/100,000.

- Put another way, **the 18-24-year-old male combat deployed veteran suicide rate is three to four times higher than the overall veteran suicide rate, and seven to eight times higher than the non-veteran overall suicide rates.**

While we support many of the bills being considered today, and wholeheartedly support House passage of S. 785 as passed by the Senate, we do not see adequate attention being paid to issue of younger, combat deployed veterans' risk for suicide. First and foremost, **we recommend the Committee consider directing the Department of Defense to resume reporting on combat deployments of suicide victims, as they did through 2017, and to direct the Department of Veterans Affairs to include combat deployments in the demographic analysis of veteran suicide cases.**

Operation RESILIENCY

Given the concentration of veteran suicide increases, both in rate and number, amongst younger male veterans, especially those combat deployed, The Independence Fund (TIF) and the Veterans Health Administration Office of Mental Health and Suicide Prevention (OMHSP) partnered in February of this year to launch Operation RESILIENCY. Operation RESILIENCY brings together veterans of tactical combat units (company to battalion size) which experienced intense combat downrange, and who are now experiencing high suicide rates back home. Through psycho-educational suicide prevention training and social activities designed to rebuild a team spirit and "battle-buddy" camaraderie, Operation RESILIENCY tests the hypothesis that the same esprits d 'corps and unit cohesion necessary for mission accomplishment can now be used by unit members to hold each other accountable for suicide prevention and to build trust and resiliency in pushing back against feelings of isolation and lack of connection.

TIF and OMHSP has three goals for these retreats:

- Social connectedness, belongingness, and community connection;

- Connection with tangible services and resources;

- Increasing self-efficacy, confidence, competence to manage their needs and help them thrive; and

- Reestablish the strong fraternal relationships of a combat unit that may be able to provide peer support suicide prevention services in the future.

To support that, TIF and OMHSP worked together to develop a training program and survey that will adequately address the needs of the individual's resiliency. The training resources were supervised by OMHSP's Education & Training department, based upon the Air Force's Resilience Program (USAF Resilience).

Further, Operation RESILIENCY uses a pre- and post-retreat survey system to check program efficacy and to see where we need to concentrate future efforts. Surveys were provided prior to the training, immediately following the completion of the retreat, and 30 days following the retreat. The surveys have two major objectives:

- Determine if the participants have the knowledge/ability to identify and address stressors in their lives that compete with their individual resiliency.
- Determine what worked and what did not work for them to improve their individual resiliency.

The surveys determined a Basic Resilience Scale (BRS) score. The BRC is a commonly used tool within Behavioral Health that indicates an individual's ability to bounce back or recover from stress. OMHSP is currently compiling the data for the surveys which will provide insight into the group's attitude, knowledge, and comfort utilizing the skills that were developed during the retreat. Initial survey results are promising for the efficacy of the program, showing significant increases in resilience and belief in support systems amongst the participants. For example, results from a recent retreat in Houston indicate strong improvements, including an almost 25% increase in a feeling of connection to VA healthcare resources, and a 50% increase in a feeling of connection to community resources.

	Pre-Retreat	Post Retreat
Support by Family/Friends	83%	91%
Support by battle buddies	89%	100%
Satisfaction with Support System Family/Friends	80%	80%
Satisfaction with current healthcare providers	46%	60%
Connection to family/friends	71%	75%
Connection to VA healthcare Resources	26%	34%
Connection to Community healthcare Resources	40%	60%

The results of "connection to VA healthcare resources" and "community healthcare resources" before and after the retreat are particularly important for today's discussion on the Improve Well Being for Veterans Act, and how programs such as Operation RESILIENCY can integrate with broader community resource coordination programs.

To date, The Independence Fund's (TIF) held four unit retreats with tactical US Army units and plans on hosting five or six per year moving forward. Further, during the COVID shutdown,

we've been continuing virtual wellness check calls and group discussions online, with significant participation and satisfaction with the program. We have National Guard and Marine units also scheduled for unit retreats and are actively recruiting future units with female members to explore specific support programs for female veterans as well. After we determine it is safe to resume these in-person retreats, Members of this Committee and staff are more than welcome to attend. To date we've had senior officials at the Department of Veterans Affairs, five Members of Congress and Senators, the Staff Director of the PREVENTS Task Force, and numerous Congressional Committee and personal office staff attend our retreats.

The Issue of Geographic Exclusivity for Community Grant Programs

Last year, TIF, joined by five other veteran and mental health organizations, reached out to both the bill sponsors and the Committee staffs soon after the *Improve Well Being for Veterans Act* was introduced in August. We expressed our concern about the sufficiency of a grant program focusing on geographic regional coordination services alone in combatting veteran suicide, and proposed language to broaden the eligible grant programs and organizations to those working with non-traditional and innovative approaches to suicide prevention, such as Operation RESILIENCY, which may not neatly fit into a geographic regional model.

Anecdotally, many of our participants in Operation RESILIENCY eschew both the VA health care systems and local community service providers. They do not approach the VA because they do not understand how to apply for services, do not believe they need mental health treatment, or because of a sense of shame over seeking such help. They do not approach the local communities because they believe no one in the local community understands their unique experiences and challenges as combat veterans.

Operation RESILIENCY provides a safe space where these veterans, with their battle buddies, are able to grapple with post war-time issues, often times for the first time in a deliberate way and accept the idea they may need to seek additional help. One of the mantras of the unit's former senior leadership which we attempt to drive home is the idea that, "It's OK to not be OK." Once the unit participants open up to the possibility of seeking help, Operation RESILIENCY then provides a facilitator role or a vehicle to help presents them with initial access to these VA and community resources, allowing them to do so at their pace, and grow in their trust of these support systems.

In the overall context of the national discussion and national call to action which this Administration has called for through the PREVENTS Task Force, and which the Improve Act attempts to support with these grants, we view Operation RESILIENCY as something of a gateway for combat veterans – who otherwise likely would not seek VA or community assistance no matter how well those programs are funded – to gain exposure to these programs in a way that will more likely be accepted and integrated into their future plans. Therefore, we do not believe expanding the grant programs under the Improve Act to non-geographically oriented programs to be competition to those regional coordinating systems, but instead supports and necessary supplements to it.

Concurrent with this Committee's legislative markup of the Improve Act last December, TIF was joined by 14 other veteran and suicide prevention organizations asking the Committee to,

"…ensure any grant funding legislation reported allow grants from organizations not organized along geographic or regional support models, with equal access to such grants as those organizations which are organized along geographic or regional models."

Unfortunately, those requests were not incorporated in the final version of the *Improve Act* passed by Committee.

S. 785, *The Commander John Scott Hannon Veterans Mental Health Care Improvement Act*

The Senate Veterans Affairs Committee incorporated much of *The Improve Act* in both the version it marked up last January, and in the version passed unanimously by the Senate last month. Working with both the Majority and Minority on the Committee, TIF was able to secure sufficient relaxations of the geographic boundary requirements to make programs like Operation RESILIENCY, and those run by the organizations who joined us in the attached letter, eligible to apply for such grant programs.

While it's not everything we or other organizations hoped to see in the final version of S. 785, TIF believes S. 785, as passed unanimously by the Senate, is a carefully crafted compromise that addresses many of the concerns raised by Chairman Takano during the HVAC deliberations in November and December of last year in a sophisticated way. As it garnered unanimous support in SVAC and the Senate attempting to improve upon it further may lead to nothing being passed at all as available legislative time runs out. Therefore, **TIF is fully supportive of House passage of S. 785 as passed by the Senate.**

We understand HVAC and SVAC are in negotiations regarding a compromise to pass S. 785, and if that has been accomplished before today's hearing, great. But if not, we believe the House should proceed to floor consideration and passage of S. 785 as passed by the Senate.

Additional Bills Under Consideration

Given the ongoing negotiations as of the date of the mandated submission of this testimony (September 8), we would like to comment on some of the other bills under consideration at this hearing, especially some key sections of the *COMPACT Act*. While many of these bills are bills TIF would support, we believe that only upon passage of S. 785, or an acceptable negotiated compromise between the Senate and the House, should this Committee move to consider them. However, if that passage is secured, TIF would fully endorse many of these, encourage our grassroots followers to call for their support, and would advocate for their passage in the 116th Congress. But again, only when S. 785, or an acceptable negotiated compromise, is passed by both Chambers.

Regardless, today is the hearing for consideration of these bills, and TIF finds it necessary to state there are some bills, and sections of *The COMPACT Act*, which it cannot support:

1. **ACCESS Act (**based on the ANS for HR 5697 on the depository webpage): There seems to be some confusion amongst those discussing the issue of "bad-paper" discharges, and the source of those discharges. Most bad-paper discharges are Other Than Honorable (OTH)

and General Discharges, awarded by administrative procedures with limited and expedited due process reviews. TIF supports automatic administrative reviews for upgrade of OTH and General discharges for veterans diagnosed with PTSD, TBI, or other behavioral health issues. During such review periods, TIF supports veterans having access to VA behavioral health care.

However, Bad Conduct Discharges (BCDs) and Dishonorable Discharges (DDs) are only awarded by duly constituted federal courts – in this case military courts martial, with a jury of peers and full Constitutional protections. The ACCESS Act would also provide VA behavioral health care to military personnel awarded these punitive discharges. TIF cannot support that in any form. Further, we find it ironic that other parts of the COMPACT Act will deny the delivery of health care to veterans with Honorable Discharges (per the limitations on Section 202 grant funds being used for mental health care), but provide medical care to veterans kicked out of the military by Courts Martial. That does not seem reasonable.

2. **COMPACT Act, Section 101**, **Expansion of health care to all veterans in first year after discharge**. Giving access to all veterans, regardless of service-connection, will swamp the system and push veterans with established service-connection further back in the queue.

3. **COMPACT Act, Section 201**, **Lethal Means Training**. Requiring VA personnel to affirmatively work with veterans and families to limit access to lethal means when they are at risk of suicide is too ill-defined, and a gross overreach of their medical responsibilities. The definitions of "at risk" later in the COMPACT Act and in general use at the VA would place virtually every veteran at risk of suicide. The VA already suffers from a reputation as "gun grabbers" driving many veterans away from seeking VA mental health care. We believe this will significantly increase the number of veterans who avoid the VA.

4. **COMPACT Act, Section 202, IMPROVE Act Substitute**. TIF worked extensively with the Senate Veterans Affairs Committee on the language of this section, especially with regards to the issue of geographic exclusivity of grant applicants, as we did with the House Veterans Affairs Committee last year. Our concerns were not addressed by the House Committee last year but accepted and incorporated, in part, by the Senate Committee. Given that, key elements of Section 202 we cannot support include:
   a. Matching fund requirements.
   b. Requiring the use of the Collective Impact Model.
   c. Coordination of grant applications with local VA Suicide Prevention Coordinators; we believe this will corrupt the grant application and review process and lead to pre-selection of grants by VA Suicide Prevention Coordinators before applications are even made.
   d. The requirement for the Secretary to make a "financially responsible" determination for grant applying corporations, but not other organizations. We don't believe this should apply to ANY grant applicant as a matter of initial eligibility – if the Secretary believes they need to review the financial responsibility of the grant applicant, they can do that through the normal grant reporting and auditing system.
   e. Any deviation from the Senate passed S. 785 language on providing emergency care for grant served individuals. As it is, TIF believes this is an unnecessary restriction of care by

grantees to veterans, that could potentially place veterans in danger by not getting necessary care from a source with which they are working. But this language was carefully crafted, and in TIF's opinion, elegantly addresses some of the crucial concerns raised by Chairman Takano in the House Committee's deliberations last year. To further amend this language will likely collapse the entire negotiated settlement.

5. **COMPACT Act, Section 206, State Grants**. To provide State grants for essentially the same purpose as the Section 202 grants, but not subject those grants to the same limitations as mandated under the Section 202 grant seems contrary to the Committee's stated requirements for such grant programs. Again, to provide an additional grant program for one subset of potential grant applicants covered in the Section 202 grant program can disrupt what was carefully negotiated language in the Senate-passed version of S. 785. We believe this section should be set aside to give the Section 202 grant programs a chance to get established and executed.

6. **VA Clinical TEAM Culture Act**: This appears to single out non-VA community care providers for more onerous training requirements than VA providers. Further, it appears to establish arbitrary numbers of clinical domains to be covered. VA Community Care provider training should be spelled out in the community care contracts and should be no greater than that required of VA providers, and only applied where it is applicable to the Community Care provider.

7. **VA Telehealth Expansion Act**: This bill focuses far too much effort on text only telehealth systems and hub-based telehealth systems. These are key weaknesses of the current VA telehealth system. Instead, if this is to be considered, then VA needs to be forced to push out commercial off the shelf, device agnostic, full video capable, home-based, telehealth systems which can run off of someone's cell phone, tablet, or computer, without requiring a patient log-in through MyHealtheVet or any other VA portal.

8. **VA Lethal Means Safety Training Act**: To require caregivers to go through lethal means safety training as a condition of their benefits would be a gross overreach on the part of the VA and unrelated to their responsibilities as caregivers. Further, it is going to intensify veteran mistrust of the VA with regards to the 2nd Amendment rights and lead many of them to believe the VA wishes to deny them access to all their firearms and to turn their caregivers into agents of the VA against them.

9. **VA Precision Medicine Act**: This will likely lead to the prophylactic segregation and treatment of veterans; such "precision medicine" results will "mark" veterans as suicide risks, and lead them to being targeted for certain treatments, or disqualification for others, and target them for various lethal means access measures which will lead veterans to believe their medical diagnoses is being used against them. There needs much stronger privacy and care option protections, protections I don't believe can be provided in this current legislation.

There are also several measures being considered at this hearing which TIF supports, but as stated above, we believe the consideration of these additional measures should only come

after the House passage of S. 785 as passed by the Senate, or some acceptable negotiated compromise by today's hearing.

1. VA Zero Suicide Demonstration Project Act
2. VA Police Improvement and Accountability Act
3. Rep. Roy's 2nd Amendment Act
4. VA Child Care Protection Act
5. Rep. Roe's Veterans 2nd Amendment Protection Act
6. Veterans Prostate Cancer Treatment and Research Act
7. Expanded Care Hours Act
8. Burn Pits Exposure Recognition Act
9. American Indian and Alaska Native Veterans Mental Health Act
10. Mental Health Staffing Act

Again, Mr. Chairman, Representative Roe, and Members of this Committee, thank you for this opportunity, and we look forward to working with you more closely as we finalize this legislative language.