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Statement for the Record

on behalf of

Whistleblowers of America

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Before the House Committee on Veterans Affairs

Chairman Takano and Ranking Member Bost:

Thank you for holding this hearing on "Veteran Suicide Prevention: Innovative Research and Expanded Public Health Efforts." Over the last 5 years, I have been outspoken about fraud, waste, and abuse with congressional appropriations that I witnessed and discussed with other employees at the Departments of Defense (DoD) and Veterans Affairs (VA) regarding the execution of suicide prevention money. Simply stated, there has been too much corruption and mismanagement with this suicide prevention funding with serious repercussions. When that money is wasted or misspent, veterans die by suicide because they cannot access the right level of care that they desperately need.

When the President's Roadmap to Empower Veterans and End a National Tragedy of Suicide PREVENTS Roadmap was released a few years ago, it called for a public health approach to suicide prevention and placed VA in the lead of all federal agencies. This transition seems to have taken the lead for public health suicide prevention away from the Department of Health and Human Services (HHS) Substance Abuse and Mental Health Services Administration

(SAMHSA) and added it to VA's mission. According to the SAMHSA website[1] its mission is that it "*leads public health efforts to advance the behavioral health of the nation.*" As SAMSHA has traditionally been the subject matter experts in publishing policy, guidance, and research on suicide, this appears to be a duplicative effort and a loss of institutional knowledge and expertise in public health. Although I am sure SAMHSA has been cooperative in the PREVENTS effort, the burden it placed on the VA to change its focus is concerning because VA's primary mission should be treatment and not necessarily public health. If VA was meeting all of its treatment goals, then this might be forgivable, but as we know, it is not. The bottom line is that too many veterans seeking VA care still die by suicide. We need real access to care and proven interventions not smoke-and-mirrors or snake oil approaches to suicide prevention. For the nation, SAMHSA is the expert at vetting these programs and their efficacy. In addition, HHS/SAMHSA have the authority over the implementation for the National Suicide Prevention Strategy and have spent decades on these efforts. It funds the Action Alliance[2] that tracks milestones in suicide prevention for the nation based upon the goals and objectives in the National Strategy it published almost 10 years ago.

According to the VA website, PREVENTS has nine priority areas and reports its milestones.[3] It appears to have spent millions on more videos[4], signing ceremonies, and other outreach to communities across the country and documents hundreds of engagements, yet it does not specifically highlight how these inputs and outputs create outcomes in suicide prevention. You can sign up to be an ambassador, but then what change is affected seems to lack follow up. I sat

[1] https://www.samhsa.gov/about-us
[2] https://theactionalliance.org/10th-anniversary
[3] https://www.va.gov/PREVENTS/accomplishments.asp
[4] VA already spends million on the Veteran Crisis Line awareness campaign and the Make the Connection campaign, which has a library of over 800 videos.

in on several PREVENTS virtual meeting this last year and got slides and video links to share. This was all very good information, however, duplicative of information produced for the Veterans Crisis Line and Make the Connection campaign videos. Furthermore, after fully reviewing the PREVENTS Roadmap and all of the supporting documentation sent to me, there was no mention of inpatient care. The one thing that veterans who show up in emergency rooms are looking for is to be admitted. Instead, too many veterans report that they are handed pills and an outpatient appointment for several weeks later. VA Police Officers who have contacted WoA were irate that the failure of VA emergency rooms to admit veterans into care or to provide them with urgent care pushes the distraught veteran back into the parking lot for the police to deal with. These officers find veterans sitting in their cars, wandering the campus, sometimes armed and dangerous other times just needing someone to talk to. Although these officers have had suicide prevention training, they cannot approach every veteran sitting in a car or on a bench. Besides the 4th Amendment right rules that they are sworn to follow, this should not be their role.

For many VA clinical whistleblowers, there is no doubt that prevention money directed or redirected to awareness campaigns and management initiatives[5] means a reduced access to care. What is the purpose of creating ads and videos or giving out branded tchotchkes when the ability to respond to those inquiries is impaired? The Veterans Crisis Line (VCL) has made progress over the years, but there are still major issues to address in its technology and staffing. In a June 2021 hearing, Senator Tester noted that Senate legislation on the VCL would require “VA to address dangerous gaps in the system, fully train responders on how to properly assess risks and take action with high-risk callers, and help VA successfully transition to the 3-digit, national

[5] Such as the VECTOR IDIQ https://www.govconwire.com/2021/02/va-issues-on-ramp-solicitation-for-25b-vector-management-business-support-idiq/ with its $25 Billion of expenditures.

suicide prevention hotline."[6] The technology, staffing and training for the VCL should be a top funding priority along with the resources need for those referrals. Once a veterans has contacted the VCL, what is the VCL clinician supposed to do? Usually, they make a referral for care. Many times, the veteran needs inpatient care. But there is a serious lack of inpatient beds across the VA system and in the private sector and not enough trained clinicians. A veteran may be transported to the nearest hospital and then released 72 hours later and sent home to await admittance into a VA inpatient behavioral health program. This process can take six weeks of being at home on high doses of medication that leaves the veteran so sedated that they need spouses and other caregivers to assist in performing their activities of daily living. Several veterans and their friends and family have made such complaints from places like California, Tennessee, Florida, and Indiana when they have been left frightened to deal with their loved ones at home. The news over the last few years has been fraught with veterans who have died by suicide at VA campuses[7]when they have not been able to properly access care. These are the most preventable deaths among veterans.

As a social worker, I have treated veterans since the early 1980s. Suicide was the 10th leading cause of death in America forty years ago and not much has changed with that statistic. So, when we think of public health approaches and utilizing the private sector what makes us think that the private sector has better answers or more capacity? Turmoil in the private sector is relevant by the recent slew of resignations at the American Association of Suicidology[8] over conflicts of interest and lack of transparency. This is the organization of leading subject matter experts who

[6] https://www.veterans.senate.gov/newsroom/majority-news/tester-moran-take-bipartisan-action-to-improve-veterans-crisis-line
[7] https://www.washingtonpost.com/news/national/wp/2019/02/07/feature/the-parking-lot-suicides/?utm_term=.3a01df419256
[8] https://www.speakingofsuicide.com/2021/08/16/american-association-of-suicidology/

cannot manage their own affairs while the VA turns to these kinds of community groups for assistance it must be vigilant. Plus, the lack of inpatient psychiatric beds, untrained clinicians, and staff shortages, especially in the age of COVID-19 means that the public health and the private sector have their own challenges that the VA needs to be careful in its investments and partnerships. The VA money spent on suicide prevention contracts and grants should receive greater oversight from this Committee. Maybe VA should let SAMHSA do its public health job and instead concentrate on its primary mission of providing patient care?

There is documented evidence that there are millions of dollars unaccounted for from VA and DoD budgets totaling over $30 million (from 2016-2020 review by WoA).[9] To begin, this Committee once asked the Government Accountability Office (GAO) to conduct a study on these expenditures (after I made disclosures in 2016). The GAO December 2018 report[10] documented that $6.2 million in funding was obligated but not executed by VA senior leaders. However, no explanation has ever been publicly released as to what happened to those funds. This issue may be over and forgotten, but the management patterns and accountability for such funding should have better oversight. What happens to all of the funding that Congress sends to VA for mental health and suicide prevention? Congress should require VA to report on its suicide prevention allocations and distributions as well as funding not spent (returned to the Treasury), reallocated to other programs, and funding left on firm fixed price contracts. In such an approach, there would be full accountability for funds such as the $6.2 million.

As the founder of Whistleblowers of America, I have spoken to dozens of VA clinicians who tell me that they are directed by their supervisors to document “mild”, or “moderate” suicide risk,

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[9] The DoD budget and its suicide prevention efforts has cross-over into the veteran space because the data and surveillance should ensure unique counts and rates while also handing over treatment and follow up care.
[10] https://www.gao.gov/assets/gao-19-66.pdf

but not “severe” because that would trigger a requirement for a higher level of care, which the hospital is not funded to provide. This issue is dealt with more in depth in a GAO report[11] on suicide prevention staffing issues documenting caseloads with up to 200 patients and inaccuracies in what the actual staffing needs are to provide quality care. Other clinicians have reported that they were direct not to tell veterans about a co-morbid diagnosis, such as a traumatic brain injury (TBI) to avoid the costly interventions that the VA would otherwise require, but the facility cannot afford to provide or are too short staffed to implement. In November 2020, a VA whistleblower, Dr. Fred Sautter went public with his story that CBS covered[12] because 400 veterans lacked a proper TBI evaluation and were not treatment. There was a substantial number on that list who died without knowing that their pain and suffering could be treated. Dr. Sauter wanted VA to investigate how many of those deaths were suicides or self-inflicted. Another VA clinician, this time a Vet Center Counselor, Ted Blickwedel went public with a story on NBC[13] claiming that productivity standards by the Readjustment Counseling Services (RCS) was impairing the quality of care provided to veterans with PTSD and suicidal ideation. The GAO[14] substantiated his complaint and found that having to meet productivity standards meant a reduction in time spent on each case and a reduction in the quality of care clinicians could provide, which also meant that they had less time to assess suicide. His advocacy efforts led to the recent introduction of H.R. 3575 and S.1944. WoA supports the passage of this initiative to better hold RCS accountable to its clinicians and the veterans they treat. The Vet Center program was initially created to be a place where veterans could go and feel safe and supported. Some of the Rhode Island Vet Center veterans where Ted Blickwedel

[11] https://www.gao.gov/assets/gao-21-326.pdf
[12] https://www.cbsnews.com/news/veterans-traumatic-brain-injuries-va-new-orleans-whistleblower/
[13] https://www.nbcnews.com/health/health-care/former-therapist-va-hurting-mental-health-care-combat-veterans-its-n1075781
[14] VA Vet Centers: Evaluations Needed of Expectations for Counselor Productivity and Centers' Staffing | U.S. GAO

worked have stepped forward to talk about the fractured quality in care and the wait times to get seen as problematic. We should listen to these veterans and prioritize the treatment and other interventions that they seek instead of more campaigns.

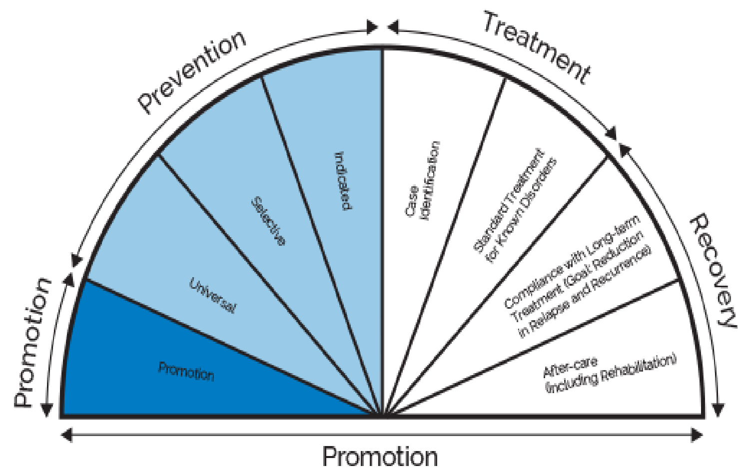
We agree that innovation and ancillary support programs are important, but not without evaluation and proven outcome measures. VA needs a good research approach to suicide prevention and mental health that complements its treatment protocols. But there are still too many flaws with its data collection and analysis. Again, the GAO[15] found errors in VA suicide data. The GAO documented and stood by its recommendation that VA conduct root cause analysis of suicides or a psychological autopsy when a veteran dies on a VA campus even after VA disagreed with the GAO finding. Congress should mandate this recommendation. In addition, WoA believes that VA should track and comprehensively report on its employees who attempt or have died by suicide as required in the Chris Kirkpatrick Act since many of these employees are also veterans. The experience of a hostile work environment leaves a majority of workers who have responded to a WoA survey feeling suicidal. VA could be an employer leader if it did more to document these cases, especially as they relate to whistleblower and veteran status of the employee and find ways to provide less adversarial interventions.

Innovative ancillary initiatives (such as equine therapy) have an important place in the toolkits that address mental health issues but should not replace bed days of care and intensive inpatient programs for the most suicidal patients. There are evidence-based treatment protocols for the most severely suicidal veterans who may also have PTSD, TBI and substance abuse issues. They should be able to access care without hesitation. Traditional therapies work, but VA needs trained and skilled psychiatrists, psychologists, social workers, nurses, suicide prevention

[15] https://www.gao.gov/products/gao-20-664

coordinators, peer support counselors, and Veteran Crisis Line responders to provide the appropriate level of care to a suicidal veteran.

As Congress looks at the VA's budget for suicide prevention and mental health care in the coming year, it should carefully consider where in the Continuum of Care[16] (See Diagram inserted for context) VA should be primarily focused. There is no doubt that there is a great need for health promotion and prevention techniques, but not at the expense of treatment and recovery. If these slices of the pie equate to expenditures, then for VA, they should not be equal slices. The bigger slices should be in patient care because that is the VA primary mission. Congress should evaluate how much is being spent on actual inpatient and outpatient treatment as a priority over public health and awareness campaigns and seek a cost benefit analysis of these programs that go beyond "clicks" and "links" as measures of effectiveness. In addition, the use of public private partnerships, which can be an invaluable tool for expanding capacity can also open the door for organizations with questionable expertise or experience to have a voice at the table if not properly vetted and accredited. VA whistleblowers are aware of cases where these partnerships appear to be "lead generators" for contract work and provide no direct benefit to a veteran. These voices sometimes represent interests of for profit entities or small business consultancies that focus on high cost activities (i.e.: filing videos) that are more likely to be another communication campaign versus



[16] Originally created by the Institute of Medicine (IOM)

an evidence-based best practice intervention. These partnerships and sole sourced contracts lack transparency since there is little announcement or open competition into their creation. There has also been a revolving-door of former VA officials who wind up on these contracts without proper vetting or proof of effectiveness. Therefore, before VA does anything else, there should be increased accountability to track how the federal government is growing its treatment capacity in the private sector.

Once access to outpatient and bed days of care are fully funded and available to any veteran in crisis then VA should engage in public health and these other management initiatives. In the meantime, SAMHSA should be the lead on health promotion and prevention. Health promotion and universal messaging is the bailiwick of HHS and SAMHSA while VA should refocus its priorities on treatment and recovery. There is no doubt that if the Administration is not holding its own programs accountable for internal spending and effective outcomes, veterans will continue to die by suicide until we do something real. We need more than posters and bumper sticker solutions.

Jacqueline Garrick, LCSW-C, SHRM-CP, WPA is the founder of Whistleblowers of America (WoA), a 501C3 dedicated to trauma-informed peer support for employees who have experienced retaliation, discrimination and harassment in the workplace and are suffering the psychosocial impacts. WoA has connected with almost a thousand employees, veterans, and families over their traumatic experiences.

Ms. Garrick was the founding Director of the Defense Suicide Prevention Office during her appointment to the Pentagon. She was prior House Committee on Veterans Affairs staff, along with a tenure at the Veterans Disability Benefits Commission and the American Legion as their Deputy Director for Health Care. In addition, Ms. Garrick was a US Army Social Work Officer. Her MSW is from Temple University.