Testimony before The House Committee on Veterans' Affairs
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Dear Chairman Takano, Ranking Member Bost, and Members of the Committee:

Thank you for your kind invitation of myself and The Independence Fund to testify before today's hearing, on "*Veteran Suicide Prevention: Innovative Research and Expanded Public Health Efforts*". As the Chairman noted in the press release announcing this hearing, the recent events in Afghanistan "has reopened old wounds for many veterans, their families, caregivers, and survivors". The Independence Fund shares those concerns and welcomes the opportunity to join the Committee and its Members in addressing these issues thoughtfully, yet quickly.

In September 2006, like many American youth who watched the events of 9/11 unfold before them while still a child, I enlisted in the U.S. Army out of Newport Beach, California. I remember wishing I was old enough to enlist at the moment of the attacks. Ready to serve my country and fight back against the radical jihadists who took so many lives that day and hopeful to bring peace and stability to a region that for so long has been ravaged by totalitarian and ruthless warlords who lack any sort of civility and empathy for natural human rights. I was honored to have served three combat tours in Afghanistan, including some of the deadliest fighting in the Afghan War, to include my time with the 82nd Airborne Division and 173rd Airborne Brigade Combat Team.

While all three deployments saw heavy fighting and significant casualties, both Wounded and Killed in Action, one is of significant impact to both me and The Independence Fund, and that is the 2009-10 deployment I served with Bravo Company, 2nd Battalion, 508th Parachute Infantry Regiment. During that deployment, we lost 51 total comrades to enemy action, and 200 wounded, many severely. One of those, Sergeant Mike Verardo, US Army (Retired), was catastrophically wounded by an improvised explosive device on April 24th, 2010 in The Arghandab River Valley, Kandahar Province of Afghanistan. This was two weeks after Sergeant Verardo was wounded by an IED when thrown from his vehicle. He could have gone home after being awarded his first Purple Heart, but he did not want to leave his unit, and returned to our Company to complete our deployment.

Sergeant Verardo, now married to The Independence Fund's Chief Executive Officer Sarah Verardo, who serves as his Caregiver, suffered grievous wounds in that explosion, losing both his left leg and left arm, significant burns, and complex polytrauma. Fortunately, the Army surgeons at Ramstein, Walter Reed, and Brooke Army Medical Center were able to reattach his

arm and save it, but Mike still suffers greatly from those wounds, enduring more than 120 surgeries since being awarded his second Purple Heart.

And the loss did not end with Bravo Company's redeployment from Afghanistan back to Fort Bragg; since that deployment, I have personally witnessed countless suicide attempts and four men with whom I served were lost to suicide.

I left active duty soon after my third deployment to Afghanistan and found myself feeling isolated and struggling with many of the same issues arising out of my Post-Traumatic Stress and combat experiences that many of my fellow Soldiers from Bravo Company struggle with to this day. In my case, I had hung up my uniform, something I had identified with for years, something of which I was proud, to join society again as a civilian. Someone with no Rank no ribbons and no representation of the things I had done and accomplished or who I was for the past several years. The struggles that I would face were not just isolated incidents but issues that had compounded over time. I was lost and, in a hole, and could not climb out. We all make mistakes. Some worse than others. Some of the mistakes I had made unfortunately were of the nature that put me in a bind legally and mentally. Mistakes that would define the next several years of my life and ultimately put me in a position in which I didn't feel as though I wanted to be here any longer and considered an alternatively morbid path.

I was lucky – in my case an individual District Attorney, who would have been every bit in the right to throw the book at me, instead saw I needed a different type of help, personally intervened, and recommended me for Veterans Treatment Court instead of regular judicial punishment. He realized that there were issues beyond my control with which I was struggling and ignoring those would not serve either the values of civil justice or of improving my situation. Because of that, I was given a second chance, one I will never forget, and one I will never take for granted.

Because of that District Attorney's empathy, and because his county in North Carolina had an alternative method of dealing with me, I was given that second chance. And from that second chance, I became much more involved in helping other combat veterans deal with their own feelings of isolation, helplessness, and vulnerability. I didn't know what I could do but I knew there had to be something. So, I started a small working group with other Veterans out of 3rd Special Forces Group. The concept was simple: get those who are struggling out of their house and bring to them a community…a tribe. A tribe of people not that dissimilar to the tribe we shared that was forged in combat. From there I got more connected in the Veteran community. I would use my skills as a carpenter to help build wheelchair accessible ramps for disabled Veterans and Gold Star families, or I would participate in events and races with Adaptive Sports programs alongside the very same corps of people with whom I had served.

Operation RESILIENCY

In the intervening months many of my fellow Soldiers from 2nd Battalion lost their battles with those mental health struggles. Between our return in 2010 and today, more than 10 Solders from 2nd Battalion have died by suicide. It was after a funeral for one of those soldiers in October 2018 that the CEO of The Independence Fund, Sarah Verardo, said, "Enough", contacted the then Director of the VA's Office of Suicide Prevention and Mental Health, Dr. Keita Franklin, and on the back of a napkin one afternoon in Washington, DC, sketched the outline of what is now Operation RESILIENCY, a unique suicide prevention program for US combat Veterans, based upon research by the Israeli Defense Forces struggling with their own problems and suicides, to build upon the power of peer support, and to tap into the exceptionally strong bonds of battle buddies who shared a series of common traumas, to address those traumas with each other's support.

For years, The Independence Fund's operated numerous Caregiver respite and training retreats, adaptive athletic events, and presentations for mechanized all-terrain wheelchairs, requiring extensive travel and logistics coordination. While the VA would provide the suicide prevention expertise for Operation RESILIENCY, The Independence Fund would tap into our extensive logistics and event management experience to make the Operation RESILIENCY retreats successful, meaningful, and successful.

In April 2019, in partnership with The Department of Veterans Affairs, The Independence Fund hosted its first Operation RESILIENCY, with my old unit, Bravo Company of the 2nd Battalion. I was reunited with my fellow soldiers of Bravo Company for a four-day unit reunion where the VA and The Independence Fund built on the program imagined by Sarah Verardo and Dr. Keita Franklin. In that program, the VA provided psycho-educational instruction to the assembled veteran on resiliency skills to address the unique mental health challenges they face as combat veterans.

A key element of this education was hearing from their former unit leadership –Company Commanders, Platoon Leaders, and Senior Enlisted Leaders – that "it is alright to not be alright." The reunion brings together psych-educational training along with social support, an element of physical – fitness –-the full bio-psycho- social model where we provide them tools they can use, when alone, to build resilience and put their challenges into context of their overall lives. We rebuild the unit leadership and esprit de corps through group physical training, group activities, and team building exercises to rebuild the team structure and leadership to which they were accustomed in the past, and to reinforce the obligation each of them have to each other to address their mental health challenges and risks. We provide them the resources, within the Department of Veterans Affairs, the Department of Defense, and the community, to engage in their own care and seek the help they may need. And we follow up these retreats with periodic wellness checks from licensed clinicians and fellow service members, as well as access to The Independence Fund's casework team, to ensure no one is left behind or without help.

Many of the Members of this Committee, as well as members of the Committee staff, have observed our Operation RESILIENCY events. We appreciate your participation and invite any of you or your staff to observe our future retreats as well. While the COVID pandemic forced us to shift much of our effort to online and virtual supports services, we restarted our in-person retreats earlier this year, and at the end of October, we will host our eighth Operation RESILIENCY here in the Washington, DC area with a Military Police Company, and invite you to join us at that event.

We conduct pre- and post-retreat surveys of the participants as part of our reunions. Thus far we have seen a 30% increase in overall resilience among the participants. We will be more than happy to provide this data to the Committee and its Members if you desire. Further, approximately 10-15% of the participants have taken us up on our offers and have sought Department of Defense or Department of Veterans Affairs mental health care. This type of caring outreach and follow-up is so critical to our model.

Moving forward, we plan to conduct six to eight Operation RESILIENCY retreats per year. In June of this year, we conducted our first retreat with a Reserve Component unit, Lima Company, 3rd Battalion, 25th Marines, of the 4th Marine Division, out of Columbus, Ohio. This unit deployed to Fallujah in 2005, suffering terrible losses, but also coalescing after the deployment as a unit. We wish to continue this engagement of Reserve Component units, and especially to conduct National Guard units, given the historical data indicating National Guard personnel and veterans may suffer even higher suicide rates than their active duty and active component veteran counterparts. If any of the Members of this Committee wish to work with us in identifying National Guard tactical combat units with whom to hold an Operation RESILIENCY retreat, we will gladly work with you in that endeavor.

Combat Deployments and Suicide Risk

Operation RESILIENCY grew out of the hypothesis combat deployments, especially multiple combat deployments, and the associated trauma exposure is a significant suicide risk to military veterans. In 2016, the Department of Veterans Affairs reported[1] on suicides amongst combat veterans with data through 2014. The reported data was troubling:

- While the overall veteran suicide rate in 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.

[1] US Department of Veterans Affairs, Office of Suicide Prevention, "Suicide Among Veterans and Other Americans, 2001–2014", 3 August 2016, updated August 2017, https://www.mentalhealth.va.gov/docs/data-sheets/2014/2001-2014-suicide-data-report.pdf

- 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 are cautiously optimistic with the reported reduction in veteran suicide rates in last week's Department of Veterans Affairs annual veteran suicide report[2], it is only a single year of reductions, and does not include the periods of the COVID pandemic or the Afghanistan withdrawal where there are strong indications the mental health of Veterans has been significantly and adversely affected. Further, it comes after more than 20 years of significant increases in veteran suicide rates:

- Between 2001 and 2019, the overall veteran suicide rate has still increased from 23.3/100,000 to 31.6/100,000, more than a 31% increase.
- Amongst 18–34-year-old veterans, the rate has increased from 23.6/100,000 to 44.4/100,000, an 88% increase.
- 18–34-year-old veterans, those most likely to be combat veterans in the post-9/11 generation, represent just over nine percent of all veterans, but they make up 77% of the increase in overall veteran suicides.

Further analysis of this data and the potential risks factor combat deployments contribute to Veteran suicides is clearly indicated. Despite our repeated requests, the Department of Veterans Affairs has not provided the public the raw suicide data used in these reports by more discreet age brackets. While we understand the need to protect the privacy of individual suicide victims, the identify of individual victims can be protected with data cohort sizes of as little as 10 individuals. But the currently available age cohorts provided in the Department's report and data appendix – of 16-to-29-year age segments – are too broad to allow for any truly useful analysis. Under the Obama Administration, it was the norm for federal agencies to provide as much raw data as possible to the public to allow for public analysis of government reports and to do additional analysis from that, usually through the Data.gov website. The lack of publicly accessible data limits the ability of other groups to peer test the claims made by the Department of Veterans Affairs, and to conduct additional research to analyze the risk and protective factors involved with veteran suicide. **If the Department continues to refuse to release such data publicly, The Independence Fund encourages Congress to direct the Department to do so through appropriate legislative action**.

Further, with the 2019 Veteran Suicide Report, the Department indicated it no longer received combat deployment data for veterans against which they could compare for suicides amongst those veterans. Department representatives told staff of The Independence Fund they no longer received such data from the Department of Defense. When The Independence Fund

[2] US Department of Veterans Affairs, Office of Mental Health and Suicide Prevention, "National Veteran Suicide Prevention: Annual Report", September 2021, https://www.mentalhealth.va.gov/docs/data-sheets/2021/2021-National-Veteran-Suicide-Prevention-Annual-Report-FINAL-9-8-21.pdf

queried the Department of Defense as to why they no longer provided such data, they indicated the Department of Veterans Affairs had stopped requesting such data. Regardless the 2014 data from the 2016 report strongly argues for a correlation between combat deployments and veteran suicide risk, which has been likewise correlated in multiple studies, both supported by the VA and independently completed. For example, a meta-analysis of 22 studies conducted the National Center for Veterans Studies at the University of Utah, found a 25% increased risk for suicide-related outcomes among those who have deployed to combat tours, and 43% increased risk for suicide-related outcomes among those exposed to killing or atrocity.[3]

It seems clear to The Independence Fund the risk combat deployments play for veteran suicides must be explored further, and the VA should resume reporting on suicide risk amongst combat veterans, in all their reports, including the annual report. We believe the participants of Operation RESILIENCY may provide a unique population which to study and base such risk analyses from, and we are ready to work with the Department of Veterans Affairs, the Committee, and research institutions to conduct such analysis. Regardless, **if the Department does not undertake such reporting of their own accord, we encourage Congress to direct the Department to do so through appropriate legislative action.**

Access to Mental Health Care

Again, The Independence Fund applauds the swift and focused action by the Department of Veterans Affairs to recognize the unique risks US veterans, especially those who served in Afghanistan, would face as the situation unfolded this summer. It was impressive the VA focused on many of the same issues with which we dealt with in supporting the veterans we serve, such as calling into question the sacrifices individual servicemembers and their comrades made in service to the United States, especially in Afghanistan. We also thought the specific focus on Vet Centers and their experience in dealing with the combat deployments and return issues faced by Vietnam era veterans was imaginative and timely.

Still, I want to be clear – we regularly assist numerous veterans who either cannot get access to VA mental health care, or do not trust it. And both should be addressed by the VA and this Committee. With regards to access to VA mental health care, we field complaints every day from veterans who are told by the VA they will have to wait seven, eight, even 10 weeks, to be scheduled for VA mental health care. When they ask to receive Care in the Community since those timelines are well outside the 20-day access standard for mental health care, the VA staff often tells them Community Care is not available, or that the VA staff does not believe the Community Care alternatives are good enough for veterans.

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[3] Craig J. Bryan PsyD, ABPP, James E. Griffith PhD, Brian T. Pace BS, Kent Hinkson, AnnaBelle O. Bryan BSPH, Tracy A. Clemans PsyD, Zac E. Imel PhD, "Combat Exposure and Risk for Suicidal Thoughts and Behaviors Among Military Personnel and Veterans: A Systematic Review and Meta-Analysis", **Suicide and Life Threatening Behavior**, Volume 45, Number 5, pp 633-549, https://onlinelibrary.wiley.com/doi/10.1111/sltb.12163

Now, it is the VA which sets the term for Community Care contracts, chooses the Community Care providers, and enforces standards of performance for those providers. If there is any problem with the care those providers deliver, it is incumbent on the VA to fix it, but to deny Veterans' access to Community Care mental health care is not in accordance with the Community Care access regulation put in place in 2019, nor with our reading of the Community Care requirements of the MISSION Act, and ultimately can lead to a tragic death by suicide if this is not resolved quickly in the Veteran's favor. This is on top of the reports this Committee has received in prior hearings the VA takes, on average, 19 days just to process a Community Care referral, before they even start the process to identify a provider and schedule the care.

Therefore, The Independence Fund recommends this Committee actively exercise its oversight responsibilities on Community Care, find out how long the VA is taking to process Community Care mental health care referrals, how long between the Veteran's request for care and that care actually being delivered, and if there are additional mental health care providers which the VA is not presently using. I challenge the Committee to test the system themselves – find out how quickly care is available.

The Independence Fund regularly refers Veterans to the Cohen Veteran Network. That network readily and quickly accepts the Veterans we refer, gets them into mental health care quickly, and the satisfaction we hear from the referred Veterans is very high. **If the VA cannot adequately treat disabled Veterans' mental health needs either through Direct VA Care or Community Care with the currently contracted providers, then it should look to other providers, especially non-profit organizations who can help at no charge (at least in the short term) to get Veterans the care they rate and need, when and where they need it**.

Last, just this April, the Government Accountability Office reported that VA suicide prevention teams are overloaded with cases, experience burnout and high turnover, and that the Veterans Health Administration has not conducted a comprehensive evaluation of local suicide prevention teams, has not assessed the challenges these teams face in meeting the extensive requirements placed upon them by higher headquarters. This comes as the VA's mental health crisis services are seeing significant increase in demand: we understand during August there was a 5% increase in the calls to the Veterans Crisis Line, a 10% increase in calls to the Caregiver Support Line, and 9% increase in calls to Vet Centers. This is on top of the reports that texts to the Veterans Crisis hotline jumped 98% in August, and chat messages jumped 40%.[4] And, this is after the 12% crisis line call increase we saw with the COVID pandemic.[5]

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[4] Patricia Kime, "There's Been a Surge in Veterans Contacting the VA Crisis Line Since Afghanistan Collapse", *Military.com*, August 31, 2021, https://www.military.com/daily-news/2021/08/31/theres-been-surge-veterans-contacting-va-crisis-line-afghanistan-collapse.html

[5] Nikki Wentling, "Pandemic prompts an increase in calls to Veterans Crisis Line", *Stars and Stripes*, March 24, 2020, https://www.stripes.com/pandemic-prompts-an-increase-in-calls-to-veterans-crisis-line-1.623576#

Given this and the delays in access to Direct VA mental health care discussed earlier, arguments that these VA programs are fully and adequately funded appear incorrect. Therefore, we implore the Committee to provide these additional funds to Vet Centers, the Veterans Crisis Line, and to expedite the Section 201 community grants, in the Reconciliation Bill currently working through the House. Specifically, we believe the VA needs immediate additional funds to address the unique and emergent mental health needs of US Veterans, especially those who served in Afghanistan. Both the Murphy Amendment to provide additional funds for the same Vet Centers the VA identified as a key element of their Afghanistan Veteran mental health care response plan, and the Bergman Amendment #2 providing additional funds for both the Veteran Crisis Line and to expedite the community provider grant program under Section 201 of the *Commander John Scott Hannon Veterans Mental Health Care Improvement Act of 2019* (PL 116-171), represent key provisions to address the emergent mental health care issues faced by the VA.

Further, we believe HR 5073, the *Revising and Expediting Actions for the Crisis Hotline for Veterans Act*, introduced by Reps. Delgado, Mann, Sherrill, and Miller-Meeks and Senators Tester and Moran as S. 2283 – which would subject the training for Veterans Crisis Line responders to independent agency review and oversight, as well as retrain those responders for high-risk callers, and increase oversight of the response to those calls – deserves the Committee's immediate consideration through a legislative hearing as quickly as possible, and markup as soon as possible after that, given the troubling signs we are seeing with this program.

<u>VA Authority to Rent Treatment Facilities</u>

The Independence Fund was very grateful for the provisions in the Chairman's amendment in the nature of substitute to the Reconciliation Directives included in Senate Concurrent Resolution 14. **Specifically, we were encouraged by the provisions of both Section 12002 and 12003 to reform both Enhanced-Use Lease Authority and Major Medical Facility Leases, respectively. The current requirements VA must allocate all 30 years of rental costs in their first-year budget eliminates any of the advantages of renting facilities and makes the Veterans Health Administration much less responsive to veterans' emerging health care requirements**, such as those seen during the COVID pandemic and the Afghanistan mental health issues. To the extent the VA cannot provide mental health care services for veterans because of lack of treatment facility space, provisions such as this will give the VA the flexibility it needs to best deliver health care to veterans without these unreasonable limitations.

Specifically, the provision of Chairman's amendment which strikes the prohibition in Title 38 US Code Section 8104(a)(2) against using VA funds for a major medical facility lease are desperately needed by the VA, and we strongly support such a provision. However, we are concerned by the provisions of Section 12003(g) which will restore these prohibitions after the temporary leases allowed under this section are completed is not needed. This provision needs to be a permanent change to VA's facility lease authority and not be sunsetted. We would be

happy to work with the VA and the Committee to best design such a permanent change to the lease provisions, and strongly recommend Congress make such changes permanent.

Comorbid Treatment of Substance Abuse and Other Mental Health Issues

The Independence Fund sees many disabled veterans suffer both mental health issues related to their military service (especially combat related issues like Post-Traumatic Stress or Traumatic Brain Injury), and substance abuse problems, often which emerge as a way the Veteran deals with those mental health issues. The Independence Fund actively encourages the Veterans it serves to seek both mental health and substance abuse treatment from the VA and Department of Defense.

The complaint we hear from these Veterans is they feel at their weakest against the temptation of resuming substance abuse while being treated for the comorbid and underlying mental health issues. The process of dealing with, processing, and treating these combat- and trauma-related injuries raises emotional and mental health issues which they've self-treated in the past with substance abuse. The VA's policy that denies them access to inpatient substance abuse treatment while going through this other inpatient treatment appears illogical to use, does not seem to serve any purpose, risks driving the Veteran to relapse back into substance abuse, and raises serious doubts among the Veterans we serve about the efficacy of VA inpatient treatment.

Unfortunately, while we have not been able to find a VA policy that prohibits the simultaneous inpatient treatment of both substance abuse and mental health issues, we've managed numerous cases where VA treatment facilities have said exactly that – they would not provide inpatient mental health care treatment to a Veteran who had not successfully completed substance abuse treatment. Further, those VA treatment facilities said they could not provide comorbid substance abuse treatment for those in inpatient mental health care programs, even where the Veteran had successfully completed substance abuse treatment before.

This appears to fly in the face of reported best practices in the mental health field. For example, the VA's own National Center for PTSD reported the co-occurrence of PTSD and alcohol use disorder was associated with a 46% higher rate of attempted suicide, and a 39.1% higher rate of suicidal ideation, five to 10 times greater than the rates associated with alcohol use disorder alone.[6] And, VA policy appears to be contrary to our experience with these VA treatment facilities, with the VA stating, "Per VA policy, patients with PTSD and SUD should be offered evidence-based treatment for both disorders. Having one should not be a barrier to receiving treatment for the other."[7] Likewise, the Substance Abuse and Mental Health Services

[6] Sonya B. Norman, PhD, and Denise A. Hein, PhD, ABPP, "Behavioral Interventions for Comorbid PTSD and Substance Use Disorder", *PTSD Research Quarterly*, Vol. 31, No. 2, 2020, https://www.ptsd.va.gov/publications/rq_docs/V31N2.pdf

[7] US Department of Veterans Affairs, National Center for PTSD, "Treatment of Co-Occurring PTSD and Substance Use Disorder in VA", https://www.ptsd.va.gov/professional/treat/cooccurring/tx_sud_va.asp

Administration warns, " Lacking recognition of the high prevalence of co-occurring disorders, agencies that develop specialty teams to treat small groups of consumers with co-occurring disorders, consequently, leave many consumers undiagnosed and untreated" and recommend an Integrated Treatment program with cross-training between substance abuse and mental health clinicians and the simultaneous treatment of both these disorders.[8]

Fortunately, there are non-government programs with which we work that do provide such comorbid inpatient treatment, such as Warriors Heart in Texas. Despite the fact Warriors Heart is in-network with TRICARE, and is credentialed and accepts Aetna, Cigna, Blue Cross, Magellan, and several other private health care insurance programs, we've had significant problems getting VA to refer Veterans to this or similar programs through Community Care, even where no comorbid inpatient program exists through Direct VA Care. We've been able to find alternative methods to pay for this treatment, or get the treatment provided at no cost, but given the widespread acceptance of this treatment by TRICARE and private health insurance, we cannot understand why the VA both refuses in some cases to provide comorbid inpatient treatment through Direct VA Care, and refuses, in certain cases, to allow Veterans to access this through Community Care.

The Independence Fund encourages Congress to exercise its oversight of the Veterans Health Administration to determine why the VA does not provide this comorbid inpatient treatment, and work with us and other veteran and military serving organizations to develop either a Direct Care comorbid inpatient treatment program, or to direct VHA to allow this under Community Care.

Conclusion

Again, Mr. Chairman, Ranking Member Bost, and Members of this Committee, I and the Independence Fund deeply appreciate your allowing us to testify before you today. We've welcomed the opportunity to work with your staffs, and believe you are committed to the ensuring Veterans get the care they rate and need, when and where they need it. For that, we thank you.

I will end my discussion today with one offer – **tell us the things I and The Independence Fund can do for and with you and your Committee to best address the needs you've identified for the VA and community to better address the mental health care needs of US Veterans**. We remain as committed as you to address these issues fully and quickly and look forward to working with you to do so today and tomorrow.

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[8] US Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, *Integrated Treatment for Co-Occurring Disorders: Building Your Program*. DHHS Pub. No. SMA-08-4366, Rockville, MD, https://store.samhsa.gov/sites/default/files/d7/priv/ebp-kit-building-your-program-10112019.pdf