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**STATEMENT OF  
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BEFORE THE  
COMMITTEE ON VETERANS' AFFAIRS  
UNITED STATES HOUSE OF REPRESENTATIVES  
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Mr. Chairman and Members of the Committee:

Thank you for inviting DAV (Disabled American Veterans) to testify at this legislative hearing of the House Committee on Veterans' Affairs. DAV is a non-profit veterans service organization comprised of more than one million wartime service-disabled veterans that is dedicated to a single purpose: empowering veterans to lead high-quality lives with respect and dignity. Thank you for inviting DAV to testify about the majority's discussion draft and H.R. 3495, the Improve Well-Being for Veterans Act today.

Everyone in this room understands that suicide is an extremely complex issue that will not be successfully addressed by any one proposal, idea, or intervention—particularly for the veterans' population, which is at elevated risk for suicide and suicidal ideation. In response, the bills before us today are multifaceted attempts to respond to this extremely difficult issue by reaching outside of the Department of Veterans Affairs (VA) to allow community providers to develop new and innovative programs that may be more accessible to veterans who have traditionally not used VA and their family members—specifically, those 14 out of 20 suicides by veterans who do not seek care in VA, which the Department estimates will occur each month.

We can also agree to the urgency of the situation. It's clear that the 20 veterans we need to reach this month cannot wait long for Congress and VA to act. But in this case, the Government has taken steps to address this critical issue with the establishment of the President's Roadmap to Empower Veterans to End a National Tragedy of Suicide (PREVENTS) interagency task force (or Task Force), which has been charged with identifying a public health strategy that will bring all the resources of the federal government to bear on this epidemic affecting our nation's veterans. The Task Force will also recommend strategies to integrate private partners into suicide prevention efforts. The PREVENTS recommendations are due in March 2020—just a few months from now. DAV believes the Task Force's guidance should provide the strategic direction for any new interventions in suicide prevention.

The Task Force is concentrating on several lines of effort including lethal means, partnerships, research strategies, state and local action, workforce and professional development and communications aimed at universal, selective and indicated audiences to change the culture of treatment seeking. VA also has a public health suicide prevention strategy developed for 2018-2028 that focuses on empowerment, clinical and community prevention, treatment and supportive services, and research and surveillance. While we have expressed some concerns about VA's readiness to take on this public health mission, it is in keeping with public health models that rely upon awareness, and changing the culture by addressing stigma and perceptions to increase the likelihood individuals affected will seek or encourage others in need of care to get the help they need, and above all—measuring against clearly defined goals.

The heart of any public health strategy lies in the metrics it establishes and measures at baseline and periodically during and after an intervention. DAV is gratified that both bills make use of work groups that would include veterans' service organization representation among other subject matter experts to establish such metrics. Looking at grantees' effects on the population they target will require them to tightly define their catchment area and the types of veterans they will serve. They will also have to make some well-founded assumptions about those they do not reach and measure changes in the whole population throughout the intervention. If grantees do not see evidence of positive changes from their programs, they will have to recalibrate their strategies. As much as possible, the programs should also be replicable so that effective programming taking place at one site could be used elsewhere for a similar population.

DAV continues to believe that it is in the best interest of veterans that these grantees make some connection to VA. VA and the Department of Defense (DoD) have reviewed evidence-based practices that have been deployed throughout both systems including at points of entry to screen and capture at-risk service members and veterans. These practices are—at least—holding the line on rates of suicide among veterans that may be among the most complex and severely affected. VA has created risk identification strategies, such as the REACH VET program, which uses predictive modeling and medical record data to identify and target intervention for veterans that are at high risk of suicide and most likely to act. Additionally, VA uses appointed suicide prevention coordinators at every VA medical center to help identify the resources that can help them recover. VA has identified evidence-based practices such as cognitive behavioral therapy to treat conditions tragically linked to suicidal behavior such as post-traumatic stress disorder, depression, substance use disorders and homelessness. The Veterans Crisis Line has intervened in thousands of instances to forestall tragedies and refer our veterans to local resources for care. While DAV shares the frustration many in Congress have expressed about not being able to move the needle and lower the rate on the staggering rates of suicide in the veteran population, we believe that without VA efforts we could be looking at an even worse scenario.

The bill and discussion draft before us today offer two contrasting options that create a role for private or other public providers to stem the tide. Both H.R. 3495 and

the discussion draft, however, seem to operate from the perspective that veterans not using the VA want nothing to do with it, which in DAV's view is a flawed assumption. We understand from VA's surveys that veterans are often unclear about their eligibility for services or even their veteran status. In its most recent report, 2010 National Survey of Veterans: Understanding and Knowledge of VA Benefits and Services (November 2011), the National Center for Veterans Analysis and Statistics found lowered rates of understanding of health care eligibility among non-enrollees, varying from 15% to about a third who claimed to understand the health care services for which they were eligible.<sup>1</sup> In 2018, National Academies of Sciences, Engineering and Medicine Evaluation of the VA Mental Health Services also found 40% of veterans not using VA mental health were unsure of their eligibility for services. Lack of awareness of VA and eligibility is clearly still a barrier to many veterans who may be eligible and greatly benefit from VA's specialized health care and mental health services.

VA has had real success publicizing the Veterans Crisis Line, which has responded to hundreds of thousands of veterans' calls, texts, and emails. We believe it is successful because there is a **clear source all veterans can access for help** while eligibility and lack of awareness have obscured veterans' access to VA. DAV would be in favor of Congress allowing VA to serve as an initial point of contact for any individual in crisis who has served in the military, Reserves or National Guard. If VA medical facilities find they are ineligible, and they are not in immediate crisis they could refer them to other partners, including possibly grant providers. But clear "no wrong door" messaging that would allow those in immediate need a place to go for help. Using VA as the entry point to grant providers would better ensure its ability to make appropriate referrals and coordinate care and services for veterans at risk of suicide.

We believe both the bill and the discussion draft would benefit from aiming interventions at more targeted patient populations. While both bills are clearly drafted to incorporate all of the risk factors that might be present in veterans with suicidal ideation, these risk factors should not define eligibility for services. DAV would argue that even the most resilient among us have one or more of these risk factors, histories or life events. For example, the 2015 National Firearm Survey found almost half of the veterans' population (44.9%) owns one or more firearms—most often for protection, but sometimes for sports and recreation such as hunting.<sup>2</sup> A quarter of all Americans will divorce. Almost all of us will suffer through the loss of loved ones and have stressful life events. Yet, as drafted, exposure to any one of these factors would define a veteran as "at risk" of suicide. Using these overly broad factors to target veterans, effectively targets no one. While it is important to understand these factors and build risk identification strategies and treatment plans around them, DAV believes, for these initial grants, the presence of any of the defined health risk factors (mental health challenges, substance use disorders, serious or chronic health conditions or pain and traumatic

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<sup>1</sup> [https://www.va.gov/vetdata/docs/SpecialReports/2010NSV\\_Awareness\\_FINAL.pdf](https://www.va.gov/vetdata/docs/SpecialReports/2010NSV_Awareness_FINAL.pdf) accessed November 15, 2019.

<sup>2</sup> Cleveland, E. , et al. "Firearm ownership among American veterans: findings from the 2015 National Firearm Survey." *Inj. Epidemiol* 2017 Dec; 4:33.

brain injuries) would create a big enough umbrella to allow almost anyone in need of services to participate.

Mr. Chairman, we similarly appreciate the broad scope of services that could be offered both through a bill similar to the discussion draft and that of General Bergman. But we are concerned that without more structure and a detailed plan, the cash assistance program in H.R. 3495 may be prone to waste, fraud and abuse. It has been attested that this program was modeled after the Supportive Services for Veterans Families (SSVF) grant assistance program. We agree that SSVF has been effective in combating and sometimes preventing homelessness as one program within a constellation of other programs and services that provide veterans who are homeless or at imminent risk of homelessness. Because it is a homeless service, veterans have also met certain qualifications—including demonstrating fiscal need, and there are established protocols for administering and monitoring the program and veterans in receipt of services.<sup>3</sup> The cash assistance program in General Bergman's bill requires no qualifications for cash awards, and offers no assurances that the individual is even a veteran to qualify for cash assistance. The language in the bill states that the Secretary *may* make information about veteran status and use of VA medical care available, but it does not require the grantee to ask for or use this information to provide cash assistance. DAV believes many veterans in fiscal circumstances dire enough to affect suicidality may qualify for the SSVF program. We also know homelessness is a risk factor for suicide so building out this existing program may also assist in suicide prevention in the homeless population. DAV recommends that Congress simply add more resources to the existing SSVF program—an application for this funding could be coordinated through the grantee if a veteran's need dictated and the eligibility criteria, financial and managerial controls for this program are already established.

DAV is also concerned with the clinical care services that are outlined in General Bergman's bill. These services would provide a confusing overlay to the new Veterans Community Care Program, just as VA medical centers have finished market plans and are beginning the process of establishing their community provider networks enacted through the MISSION Act of 2018. DAV has recommended using best practices, such as VA's maternity care protocol, to manage care for veterans as they transition between VA and private sector facilities.<sup>4</sup> VA's maternity care coordinators administer the protocol to ensure VA remains in contact with veterans throughout labor and delivery process in private sector facilities and assure that veterans are receiving necessary and timely care and receive access to other VA services for which they are eligible, such as pharmaceuticals, prosthetics and mental health care. Suicide prevention coordinators should establish similar protocols as veterans identified at risk of suicide access community care through VA partners. The Community Care Network providers will also have additional criteria to better assure access and quality for veterans. We would have no similar assurances of access or quality of providers receiving grant funding for suicide prevention services.

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<sup>3</sup> VHA Directive 1162.07 Supportive Services for Veterans Families (January 23, 2018).

<sup>4</sup> VHA Handbook 1330.03, Maternity Health Care and Coordination

If the Committee wants to use these grants to reach out to veterans not using VA services, it should ensure that the grantees are in areas where VA has low market penetration and that are distant from VA health care resources including medical centers, community-based outpatient centers, Vet Centers and community network providers. This would ensure that grantees are filling gaps in coverage and reaching veterans who do not have good options for mental health care.

I'd like to give you an example of a grant program that is working to reduce suicides among veterans. DAV's Charitable Service Trust, an affiliate of DAV, which strives to meet the needs of injured and ill veterans through financial support of direct programs and services for veterans and their families, is funding a local DAV chapter making a difference in the lives of veterans in a remote and rural Arkansas county. Learning of the high rate of suicide among veterans in their county, DAV's chapter commander and deputy commander, a licensed clinician, set a goal lowering the rate of veterans' suicide in the area. They began by exploiting or establishing community ties to other veterans' groups, churches, business leaders, and health care providers, and providing personal outreach, individual or group counseling, to veterans who identify a need for these services. They refer a few veterans with the most complex needs to the VA. The County coroner's office is working with this DAV chapter, identifying veterans' deaths from probable suicides so they measure the effects of their interventions. According to feedback, their efforts are working, with rates of suicide having dropped since their efforts began. These two local heroes happen to have the requisite skills and personal means to allow them to devote countless hours to this program without compensation, which creates an extraordinary circumstance in this area that may not be replicable elsewhere. While there are some extraordinary features of this program, other features adding to their success are:

- Deep community ties to health and supportive resources and ongoing relationships with veterans in the area.
- A public health strategy that measures and monitors its efforts on an ongoing basis.
- High-touch services that counteract isolation and work to integrate veterans into their communities.
- Lack of other health providers, including VA medical centers in the area, making their services a critical resource to the community.

In closing, DAV sees the benefit of this approach and supports the concept of assisting groups or supportive networks that can make a positive difference in the life of at-risk veterans and hopes that the Committee takes our views into account when considering these bills.

Thank you Mr. Chairman. This concludes my testimony I will be happy to respond to any questions you or the Committee may have.