SERVICE SHOULD NOT LEAD TO SUICIDE: ACCESS TO VA'S MENTAL HEALTH CARE

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SERVICE SHOULD NOT LEAD TO SUICIDE: ACCESS TO VA'S MENTAL HEALTH CARE

Thursday, July 10, 2014

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, D.C.

The committee met, pursuant to notice, at 9:15 a.m., in Room 334, Cannon House Office Building, Hon. Jeff Miller [chairman of the committee] presiding.

Present: Representatives Miller, Lamborn, Bilirakis, Roe, Runyan, Benishek, Huelskamp, Coffman, Wenstrup, Cook, Walorski, Jolly, Michaud, Brown, Takano, Brownley, Titus, Kirkpatrick, Ruiz, Negrete McLeod, Kuster, O'Rourke, and Walz.

Also Present: Representatives Peters, and Sinema.

OPENING STATEMENT OF JEFF MILLER, CHAIRMAN

The CHAIRMAN. This hearing will come to order. Before we begin I would like to ask unanimous consent for our colleagues, Representative Scott Peters from California and Representative Kyrsten Sinema from Arizona to sit at the dais with us and participate in the proceedings today. Without objection, so ordered.

I would like to welcome everybody to today's full committee oversight hearing entitled, "Service Should Not Lead to Suicide: Access to VA's Mental Health Care."

Following a committee investigation which uncovered widespread data manipulation and accompanying patient harm at Department of Veterans Affairs medical facilities all across this nation, this committee has held a series of full committee oversight hearings over the last several weeks to evaluate the systemic access and integrity failures that have consumed the VA health care system. Perhaps none of these hearings have presented the all too human face of VA's failures so much as today's hearing will. A hearing that I believe will show the horrible human costs of VA's dysfunction and I daresay corruption.

At its heart access to care is not about numbers, it is about people. Recently the committee heard from a veteran who had attempted to receive mental health care at a VA community based outpatient clinic in Pennsylvania. This veteran was told repeatedly by the VA employee he spoke with that he would be unable to get an appointment for six months. However, when that employee left another VA employee leaned in to tell this veteran that if he just told her that he was thinking of killing himself she would be able to get him an appointment much sooner, in just three months instead of six. Fortunately that veteran was not considering suicide. But what about those veterans who are? How many of the tens of

thousands of veterans that VA has now admitted have been left on waiting lists for weeks, months, and even years for care were seeking mental health care appointments? How many are suicidal, or edging towards suicide as a result of the inability to get the care that they have earned?

Despite significant increases in VA's mental health and suicide prevention budget, programs, and staff in recent years, the suicide rate among veteran patients has remained more or less stable since 1999 with approximately 22 veterans committing suicide every single day. However, the most recent VA data has shown that over the last three years rates of suicide have increased by nearly 40 percent among male veterans under 30 who use VA health care services, and by more than 70 percent among male veterans between the ages of 18 and 24 who use VA health care services.

This morning we are going to hear testimony from three families: the Somers, the Selkes, and the Portwines, who will tell us about their sons Daniel, Clay, and Brian. Three Operation Enduring Freedom and Operation Iraqi Freedom veterans who sought VA mental health care following combat. Each of these young men faced barrier after barrier in their struggle to get help. Each of these young men eventually succumbed to suicide. In the note he left behind Daniel Somers wrote that he felt his government had abandoned him and referenced coming home to face a system of dehumanization, neglect, and indifference. VA owed Daniel, and Clay, and Brian so much more than that.

With that, I yield to our Ranking Member Mr. Michaud for his opening statement.

[THE PREPARED STATEMENT OF JEFF MILLER APPEARS IN THE APPENDIX]

OPENING STATEMENT OF MICHAEL MICHAUD, RANKING MINORITY MEMBER

Mr. MICHAUD. Thank you very much, Mr. Chairman, for holding this very important hearing. We have had many discussions and debates about how to deliver the best health care services to our nation's veterans and how to ensure accountability within the leadership ranks of the Department of Veterans Affairs. Over the course of these recent hearings and discussions we have touched on a number of important issues. But one that we have not zeroes in on too much yet has been access to mental health care and suicide prevention services for our veterans. That is why this hearing today is so important. And I would like to thank all of the panelists for joining us today. But particularly I want to thank the family members joining us who have lost a loved one.

I know that speaking about a loss of a loved one, particularly a child, can be an incredibly difficult and exhausting experience. But in this case I think we have to listen to your stories, identify what went wrong, and we can take action to ensure that those failures are not repeated again. So I want to thank you very, very much for joining us today to share your stories.

Eighteen to 22 veterans commit suicide each day. In my opinion that is 18 to 22 brave men and women each day who our system has let down in some capacity. It is totally unacceptable. When a

veteran has experienced depression or other early warning signs that may indicate mental health issues or even suicide, that must be treated like an immediate medical crisis. Because that is exactly what it is. Veterans in that position should never be forced to wait months on end for a medical consult. Because quite frankly that is time that they may not have.

We have taken steps to help put in place programs and initiatives aimed at early detection and we have significantly increased our funding. The Department of Veterans Affairs funding on mental health has doubled since 2007 but it is not working as well as we had hoped. And we have to figure out why, and how we can correct these problems.

Our veterans are the ones paying the price for this dysfunction. A 2012 IG report found that VHA data on whether it was providing timely access to mental health services is totally unreliable. And a GAO report from that year not only confirmed that disturbing finding, but also said that inconsistent implementation of VHA scheduling policy made it difficult, if not impossible, to get patients the help that they need when they need it. That is why we have to look at this situation. That is a problem that we have seen repeatedly as we dig into the VA's dysfunctions, and enough is enough.

Our veterans and their families deserve a VA that delivers timely mental health services that cover a spectrum of needs, from PTSD, to counseling for family members, to veterans, to urgent round the clock response to a veteran in need. A recent VA OIG report found that in one facility patients waited up to 432 days, well over a year, for care.

For once again, we are finding that our veterans deserve much better than the care that they are receiving in all of the areas that we must address. We have to look at it comprehensively. And I would argue that fixing mental health services is among the most important area. And I look forward to a productive discussion that will begin today as we look forward to trying to solve some of the problems with a dysfunctional department that we have seen over the last several months.

And once again, Mr. Chairman, I want to thank you very much for having this very important hearing and for the panelists for coming today to tell your stories. With that, I yield back the balance of my time.

[THE PREPARED STATEMENT OF MICHAEL MICHAUD APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much to the ranking member. We are humbled and honored to be joined by our first panel of witnesses this morning. Family members of the three veterans who sadly and tragically lost their lives to suicide, and I am sure that I speak for each of my colleagues when I say that each of you have our deepest sympathies for your loss. I am both grateful and at the same time angry that you have to be here to share your stories of your sons with each of us. So if you could approach the witness table, please?

Joining us is Dr. Howard and Jean Somers, the parents of Daniel Somers; Susan and Richard Selke., the parents of Clay Hunt; and Peggy Portwine, the mother of Brian Portwine. We are also joined

on our first panel by Josh Renschler, a veteran of the United States Army who will share his very personal story of attempting to seek mental health care through the Department of Veterans Affairs. Thank you, sir, for your service, and for being here today. Dr. and Mrs. Somers, please proceed with your testimony.

STATEMENT OF HOWARD AND JEAN SOMERS

Mrs. SOMERS. Chairman Miller, Ranking Member Michaud, and committee members, we are grateful for this opportunity to testify today. We are especially pleased to see Arizona Representative Ann Kirkpatrick; and Daniel's Representative Kyrsten Sinema; and our own California Representative Scott Peters; who have been great allies to us in our efforts to advance reforms of the VA based on the experiences of our son.

Dr. SOMERS. As many of you know our journey started on June 10, 2013 when Daniel took his own life following his return from a second deployment in Iraq. At that time he suffered from Post Traumatic Stress Disorder, Traumatic Brain Injury, and Gulf War Syndrome. Daniel spent nearly six futile and tragic years trying to access the VA health and benefits systems before finally collapsing under the weight of his own despair. We have attached the story of Daniel Somers to our testimony, which provides the details of his efforts and we hope you will read it if you have not already done so.

Today it is our objective to begin the process which will ultimately provide hope and care to the 22 veterans today who are presently ending their lives.

Mrs. SOMERS. Just over a year ago and four days after Daniel's death, feeling fortunate that we at least had a letter from him, Howard and I, Howard is a urologist and I spent 30 years in the business of health care, sat down with Daniel's wife, who has a Bachelor of Science in nursing, and his mother-in-law who is a psychiatrist. Together we felt uniquely qualified to prepare a 19-page report that we titled Systemic Issues at the VA. We have shared that document with several of you over the last year and it is also attached to our testimony.

The purpose of the report remains the same as when we wrote it, to improve access to first rate health care at the VA; to make the VA accountable to veterans it was created to serve; and to make every VA employee an advocate for each veteran.

Dr. SOMERS. At the start Daniel was turned away from the VA due to his National Guard Inactive Ready Reserve status. Upon initially accessing the VA system he was essentially denied therapy. He had innumerable problems with VA staff being uncaring, insensitive, and adversarial. Literally no one at the facility advocated for him. Administrators frequently cited HIPAA as the reason for not involving family members and for not being able to use modern technology.

Mrs. SOMERS. The VA's appointment system, know as VISTA, is at best inadequate. It impedes access and lacks basic documentation. The VA information technology infrastructure is antiquated and prevents related agencies from sharing critical information. There is a desperate need for compatibility between computer sys-

tems within the VHA, the VBA, and the DoD. Continuity of care was not a priority. There was not succession planning.

Dr. SOMERS. No procedures in place for warm hand offs, no contracts in place for locum tenens, and a fierce refusal to outsource anyone or anything.

At the time Daniel was at the Phoenix VA, there was no pain management clinic to help him with his chronic and acute fibromyalgia pain. There were few coordinated interagency goals, policies, and procedures. The fact that the formularies of the DoD and VA are separate and different makes no sense since many DoD patients who are stabilized on a particular medication regimen must rejustify their needs when they transfer to the VA. There were inadequate facilities and an inefficient charting process.

Mrs. SOMERS. There was no way for Daniel to ascertain the status of his benefits claim. There was no VHA/VBA appointments system interfacing, nor prioritized proactive procedures. There was no communication between disability determination and vocational rehabilitation. This report is offered in the spirit of a call to action and reflects the experiences of Daniel with VA program services beginning in the Fall of 2007 until his death last June through our eyes.

Dr. SOMERS. As seen through our eyes. Our concern then was that the impediments and deficiencies which Daniel encountered were symptomatic of deeper and broader issues in the VA, potentially affecting the experiences of a much broader population of servicemembers and veterans. Unfortunately this has been proven true as dramatically evidenced by recent revelations.

Many of the reforms outlined in our report will require additional funding for the VA. But with that new funding should come greater scrutiny and a demand for better measurable results.

Mrs. SOMERS. There is, however, an alternative to attempting to repair the existing, broken system. We believe Congress should seriously consider fundamentally revamping the mission of the VA health system. In the new model we envision the VA would transition into a center of excellence, specifically for war related injuries, while the more routine care provided by the rest of the VA health care system would be open to private sector service providers, much like Tricare. That approach would compel the current model to self-improve and compete for veterans' business. This would ultimately allow all veterans to seek the best care available while allowing the VA to focus its resources and expertise on the treatment of complex injuries suffered in modern warfare. Dr. Somers. We thank you for your time and would be happy to further discuss our recommendations and suggestions. We sincerely hope that the systemic issues raised here will provide a platform to bring the new VA administration together with lawmakers, VSOs, veterans, and private medical professionals and administrators for a comprehensive review and reform of the entire VA process. And if the VA Committee or Congress as a whole make the decision to involve other stakeholders in a more formal reform process, we would be honored to be among those chosen to represent the views of affected families. Thank you.

Mrs. SOMERS. Thank you.

[THE PREPARED STATEMENT OF HOWARD AND JEAN SOMERS APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you both for your testimony. Mr. and Mrs. Selke, you are recognized for five minutes.

STATEMENT OF SUSAN AND RICHARD SELKE

Mrs. SELKE. Thank you. Chairman Miller, Ranking Member Michaud, and distinguished members of the committee, thank you for the opportunity to speak with you today about this critically important topic of mental health care access at the VA, suicide among veterans, and especially about the story and experience of our son, Clay. My name is Susan Selke, and I am accompanied here by my husband Richard. I am here today as the mother of Clay Hunt, a Marine Corps combat veteran who died by suicide in March, 2011 at the age of 28.

Clay enlisted in the Marine Corps in May, 2005 and served in the infantry. In January of 2007 Clay deployed to Iraq's Anbar Province, close to Fallujah. Shortly after arriving in Iraq Clay was shot through the wrist by a sniper's bullet that barely missed his head. After he returned to Twenty nine Palms in California to recuperate, Clay began experiencing symptoms of Post Traumatic Stress, including panic attacks, and was diagnosed with PTS later that year.

Following the recuperation from his gunshot wound, Clay attended and graduated from the Marine Corps Scout Sniper School in March of 2008. A few weeks after graduation Clay deployed again, this time to Southern Afghanistan.

Much like his experience during his deployment to Iraq, Clay witnessed and experienced the loss of several fellow Marines during his second deployment.

Clay received a 30 percent disability rating from the VA for his PTS. After discovering that his condition prevented him from maintaining a steady job, Clay appealed the 30 percent rating only to be met with significant bureaucratic barriers, including the VA losing his files. Eighteen months later, and five weeks after his death, Clay's appeal finally went through and the VA rated Clay's PTS 100 percent.

Clay exclusively used the VA for his medical care after separating from the Marine Corps. Immediately after his separation, Clay lived in the Los Angeles area and received care at the VA Medical Center there in L.A. Clay constantly voiced concerns about the care he was receiving, both in terms of the challenges he faced with scheduling appointments as well as the treatment he received for PTS which consisted primarily of medication. He received counseling only as far as a brief discussion regarding whether the medication he was prescribed was working or not. If not, he would be given a new medication. Clay used to say, "I am a guinea pig for drugs. They will put me on one thing, I will have side effects, and they put me on something else."

In late 2010 Clay moved briefly to Grand Junction, Colorado where he also used the VA there, and then finally home to Houston to be closer to family. The Houston VA would not refill the prescriptions that Clay had received from the Grand Junction VA be-

cause they said that prescriptions were not transferrable and a new assessment would have to be done before this medications could be represcribed. Clay had only two appointments in January and February of 2011 and neither was with a psychiatrist. It was not until March 15th that Clay was able to see a psychiatrist at the Houston VA Medical Center. But after that appointment, Clay called me on his way home and said, "Mom, I cannot go back there. The VA is way too stressful and not a place I can go. I will have to find a Vet Center or something."

Just two weeks after his appointment with the psychiatrist at the Houston VA medical center, Clay took his life. After Clay's death I personally went to the Houston VA Medical Center to retrieve his medical records and I encountered an environment that was highly stressful. There were large crowds. No one was at the information desk. And I had to flag down a nurse to ask directions to the medical records area. I cannot imagine how anyone dealing with mental health injuries like PTS could successfully access care in such a stressful setting without exacerbating their symptoms.

Clay was consistently open about having PTS and survivor's guilt and he tried to help others coping with similar issues. He worked hard to move forward and found healing by helping people, including participating in humanitarian work in Haiti and Chile after the devastating earthquakes. He also starred in a public service advertising campaign aimed at easing the transition for his fellow veterans and he helped wounded warriors in long distance road biking events. Clay fought for veterans in the halls of Congress and participated in Iraq and Afghanistan Veterans of America's Annual Storm the Hill in 2010 to advocate for legislation to improve the lives of veterans and their families.

Clay's story details the urgency needed in addressing this issue. Despite his proactive and open approach to seeking care to address his injuries, the VA system did not adequately address his needs. Even today we continue to hear about both individual and systemic failures by the VA to provide adequate care and address the needs of veterans. Not one more veteran should have to go through what Clay went through with the VA after returning home from War. Not one more parent should have to testify before a congressional committee to compel the VA to fulfill its responsibilities to those who have served and sacrificed.

Mr. Chairman, I understand that today you are presented the Suicide Prevention for American Veterans Act. The reforms, evaluations, and programs directed by this legislation will be critical to helping the VA better serve and treat veterans suffering from mental injuries from War. Had the VA been doing these thing all along, it very well may have saved Clay's life.

Mr. Chairman, Richard and I again appreciate the opportunity to share Clay's story and our recommendations about how we can help ensure the VA will uphold its responsibility to properly care for America's veterans. Thank you.

[THE PREPARED STATEMENT OF SUSAN AND RICHARD SELKE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you both for your testimony this morning. Ms. Portwine, you are recognized for five minutes.

STATEMENT OF PEGGY PORTWINE

Ms. PORTWINE. Thank you, Mr. Chairman, Mr. Michaud, distinguished committee members. My son Brian Portwine gave 100 percent to every task he performed and his military service was no exception. By the time he was 19 years old Brian was awarded the Purple Heart and the Army Commendation Medal. I am before you today to share Brian's story.

At 17 Brian enlisted in the Army. After his training in infantry, he was deployed to Baghdad where he patrolled in Sadr City on the Haifa Streets. It was an extremely daunting serviced. This occurred before the surge of troops. During this tour, Brian lost 11 brothers.

While serving in Iraq in 2006, Brian's Bradley tank was struck by an RPG. The flames swiftly engulfed the tank. The driver was knocked unconscious and the men fought for their lives as the driver was unable to hydraulically lower the ramp. The five soldiers scrambled through the flames, manually lowered the ramp, and exited, all with injuries. Brian suffered a blast concussion along with lacerations to his face and legs due to shrapnel and bone fragments. This was his first experience with traumatic brain injury.

On yet another mission Brian and his First Sergeant were patrolling in Humvee when his Sergeant signaled for Brian to switch seats with him. They switched seats so Brian was now in the passenger seat. Twenty minutes later an IED hit the Humvee on the driver's side, killing his First Sergeant, and throwing Brian from the vehicle.

Besides these two incidents he experienced six other IED explosions during his 15-month deployment. I would like to pause here and ask is this not enough to warrant a thorough evaluation and further testing? The powers that be apparently thought of sending Brian to Walter Reed Hospital, but did not. Are these experiences with the physical and mental injuries not enough to possibly exempt him for another deployment? Apparently the VA felt his care was iffy enough to stamp a no go on his clearance form but then it was crossed out and written go. How and why this decision was made is beyond me

After his first deployment Brian was ecstatic to be home again. He enrolled in Daytona State College. He worked in the admissions counseling office. He created videos to share resources with students, hosted events, and linked students with part-time employment around their school schedules. But Brian suffered with short term memory loss. He would have to write everything on his computer, his iPhone, or his calendar. Many times his friends told me when he was out with them he would say, "Where are we going again? You know I have got scrambled brains from Iraq." To help cope he posted all his events on his computer, his calendar, and his phone.

In 2010 the military recalled Brian one month before the college year ended. Brian immediately dropped his classes that he excelled in. When I asked him why he said, "Mom, there is no point. You have to get your mind in a completely different place. You have no idea what is coming."

During the second deployment Brian did not email or call home to any family or friends. Little did we know how he was struggling

with anxiety attacks, panic attacks, traveling the same roads as the first tour. He knew the stigma of admitting PTSD, as all soldiers do. So they just man up and move on.

Upon returning from the second deployment Brian was evaluated. He was diagnosed with PTSD, TBI, depression, and anxiety. At this time I would like you to refer to the documents that you received, Brian's medical documents. It is documented that Brian could not remember that questions asked from the therapist during the interview. He had extensive back pain. He could not sleep. He felt profound guilt. He suffered from low self-esteem and as a result he was a risk for suicide. Nonetheless he was just immediately discharged and told to follow up. How in the world you can ask someone who cannot remember the questions asked to follow up with the VA is beyond me.

Brian deteriorated quickly from December, 2010 to May 27, 2011 when he took his life. He could not stand how he would be angry, depressed, anxious. But he did not know how to cope. It took a to1l on his relationships. If the DoD and VA assessed Brian for suicide risk, it was their duty to treat him but he received nothing. He applied for disability but was unable to wait.

Brian's unit has lost three others besides himself to suicide since the 2006 to 2008 tour. As you know, suicides surpassed combat fatalities for the first time in history. It is a very slippery slope from PTSD and TBI to death, something our VA should realize.

Our soldiers never hesitated in their mission to protect, serve, and sacrifice for our country. Now it is time for the VA to prove their commitment to our soldiers. I never knew of Brian's PTS, TBI, or suicide risk. I think he felt, "If I can survive two tours of Iraq, I can survive anything." I think it is a life threatening situation like this and it should be shared with the family so we are able to help. The VA needs to work with the service organizations, including the families in the plan for care.

I am requesting, I am begging this committee to pass Act 2182, the Suicide Prevention for Americans Act. This has been a most devastating war in history in terms of suicide. Our whole nation continues to suffer and everyday we continue to lose 22 Brians a day.

I promised my son at his funeral that I would stop this injustice. These are quality young men who potentially had so much to offer society. Please pass this Act 2182 and support any legislation that gives our soldiers and timely and loving care that they deserve. Thank you.

[THE PREPARED STATEMENT OF PEGGY PORTWINE APPEARS IN THE APPENDIX]

The Chairman Thank you, Ms. Portwine. Sergeant Renschler, you are recognized for your statement.

STATEMENT OF SERGEANT JOSH RENSCHLER

Sergeant RENSCHLER. Chairman Miller, Ranking Member Michaud, members of the committee, I appreciate the opportunity to discuss VA mental health care. And I certainly want to acknowledge the loss and the courage of these family members ensuring that they were not in vain. And I struggle with the similarities of

the stories. As an infantryman who lost so many in the Iraq War in injures, and struggled with thoughts of suicide from overwhelming chronic pain and other injuries, I just thank you all for being here.

My experience with the VA health care system began in 2008. Sorry.

The CHAIRMAN. That is okay. You have got plenty of time.

Sergeant RENSCHLER. After I was medically retired from the Army due to severe injuries from a mortar blast in Iraq. Excuse me. I have been a patient but I am also an advocate for other warriors who are struggling with deployment related traumas. For a period of about 12 months I did receive excellent mental health care at a VA facility. It provided easy, one-stop access through a deployment health model staffed by medical, mental health, pharmacy, and social work providers. Unfortunately, though, hospital administrators decided that this well-staffed interdisciplinary care was too costly. Now veterans at the facility go through an impersonal intake assessment process and then have to find their way around a sprawling facility to access the care that they need. For many warriors just navigating around the facility is anxiety provoking in itself, and for others it is so frustrating that they just drop out of care altogether.

There is lessons to be learned here. First, veterans with mental health issues will seldom open up and discuss painful, private issues with a clinician that they have never met. They are more likely to discuss surface level issues, like difficulty sleeping. It takes time to build the trust to talk about the deeper issues. And not every clinician is skilled at winning the trust, or insightful enough to sense when there is deeper problems. Working with a team increases the likelihood of someone to see something that others may have missed.

This has implications for suicide prevention as well. Veterans will rarely volunteer to clinicians that they are contemplating suicide and there are not necessary obvious signs that a veteran is a suicide risk. One thing is for sure, we will not prevent suicides by doctors mechanically going down a mandatory list asking questions like have you contemplated suicidal thoughts lately, or harming others. Sometimes there is red flags that an astute clinician can spot, like the break up of a relationship or other major life events that could lead a person to take a desperate act. But in a treatment system where I get sent to Building 3 for a neurologist for chronic back pain, Building 61 to see a psychiatrist for sleep problems, and Building 81 to see a social worker for relationship issues, no one is getting the full picture. So it is likely that no one is going to see if my life is spinning recklessly out of control.

As an integrated health care system the VA can provide the kind of care that I want to receive from an interdisciplinary health team. There the team members shared observations and could see potential problems before they became explosive. So I think that the most important step that the VA can take to prevent suicide is to dramatically improve its mental health care delivery.

Access is certainly an issue but we have to ask ourselves, access to what? Access to mental health care is not enough unless that care is effective. For example, providers who work with combat vet-

erans need to understand the warrior mentality and they may have to work hard to earn that veteran's trust. If a clinician lacks that cultural awareness, or has too many patients to give each enough time, veterans will get frustrated and drop out of treatment.

Also, veterans who are not ready for intense exposure based therapy will drop out of these multi-week treatment programs even though they are hailed as evidence-based therapy. The bottom line is that the VA care must be veteran centered. That has to mean recognizing each veteran's unique situation and individual treatment preferences and building a flexible system to meet the veteran's needs and preferences, not the other way around.

The warriors that I am describing do not come into treatment for PTSD or anxiety when the textbooks say that they should. Most do not come in to treatment until they have reached a crisis point in their lives. Certainly a veteran in distress who finally asks for help for a combat incurred mental health condition needs to get into treatment immediately. But we will not solve that problem by establishing an arbitrary requirement like a 14-day rule. It does not help a warrior who is at the end of his rope to get assessed within 14 days but not actually begin treatment within three months. This is the way that the VA has currently implemented such policies. They have added additional steps to get into treatment so that you can see someone within 14 days. They have added a second intake process so now you intake-to-intake to finally get the treatment that you need.

I know that some believe that the way to solve the veteran problem is to expand veteran access to non-VA care. I really personally doubt that that is any kind of silver bullet solution. The two big concerns with that is first detailed in my full statement. Many reports and studies point to a national shortage of mental health providers within the community. Secondly there is real quality of care issues here. VA could certainly benefit from a greater use of purchased care where and when it is available, and when it can be effective. But it would not help veterans just to be seen by providers who are not equipped to provide effective care, whether because of lack of training in treating combat related PTSD, or cultural competence, or any other reason. Again, it is not just a matter of access, but access to what? It has to be effective treatment. I do believe that there are VA facilities that are providing veterans with timely access to effective patient centered care but it is not systemwide.

From my perspective the starting point for VA leadership at all levels is to adopt the principle that providing timely, mental health care for those with service incurred mental health conditions must be a top priority. The VA achieved that with its efforts to combat veteran homelessness recently. That tells me the VA can have a real impact when the direction and priorities are clear. When artificial performance requirements do not create distortions, and when clinicians have latitude to provide good care.

Improving mental health care definitely requires a comprehensive approach. One part of that approach in my view should be to institute the kind of interdisciplinary team based model I described earlier. But the core of any approach has to center on the veteran and that patient's needs and preferences. We need a system that

serves the veteran, not one that requires the veteran to accommodate the system.

I hope that this hearing brings us a step closer to that kind of VA care system. And I thank you for the time, and I would be happy to answer any further questions that you may have.

[THE PREPARED STATEMENT OF JOSH RENSCHLER APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Sergeant. Thank you, again, to all of the witnesses. Sergeant, if I could go back to you since you were the most recent person to testify. You talked about the interdisciplinary care team that you had for 12 months. And then after that you alluded to the fact that the hospital director or somebody said that it cost too much to do it that way. I think we would all benefit from you elaborating a little bit about how that occurred and what did you transfer to? What type of a care?

Sergeant RENSCHLER. Yes, sir. In 2008 to 2009 the VA rolled out I believe four different deployment health care models nationwide. The deployment health care model that I speak of was one that was rolled out in Washington State for the American Lake VA Medical Center and it was put together by Dr. Steve Hunt with the VA. And this model provided one wing of a hospital floor in which an interdisciplinary care team for deployment health, Post 9/11 veterans exclusively, that had a pharmacist, social workers, psychiatrists, psychologists, and primary care on one team and weekly they would meet to discuss the caseload of that team. And the wait times were short for care, the quality of care was up, the management of our medications were the best that we had seen within the VA.

However, after 12 months the team began to dissipate. And what I was told and have been told since by Dr. Steve Hunt and others within the VA is that this was a temporarily funded program and it was too costly to provide this level of care to exclusively Post 9/11 veterans within the VA Center when a facility director has to provide care for all veterans, to set aside the amount of funding that it required to provide this level of care for only one portion of that population was not practical.

The CHAIRMAN. Mr. and Mrs. Somers, I would like for you to elaborate if you would just a little bit on the fact that you talked about Daniel having innumerable problems with VA staff being uncaring, insensitive, and adversarial. Saying literally no one at the facility advocated for him. Could you give us any specific examples, or generic examples?

Mrs. SOMERS. Absolutely. Probably the most—if I do not make it through this Howard will finish—probably the most egregious event was when Daniel presented to their ER——

Dr. SOMERS. It took Daniel a lot to go to the VA facility and some of the things that have been mentioned here were part and parcel of the fact. I mean, even along the highway in Phoenix there were speed traps on the highway. And when the lights flashed, that would give him flashbacks. Even if he was not the speeding, if he was going by on the highway at the time. So it was very difficult for him to drive down to the VA. It is busy. But he presented there in crisis. He presented to one of the departments, to the Mental

Health Department. He said he needed to be admitted to the hospital. Now this is something that we have been told by his wife, who as Jean mentioned has a B.S.N. in Nursing, and his mother-in-law who is a psychiatrist. And he told them this on multiple occasions. So he was told that the Mental Health Department, they had no beds. And he was told by the same department that there were no beds in the Emergency Department.

So this brings up another few issues. But the fact is that he went into the corner, he was, he laid down on the floor, he was crying. There was no effort made to see if he could be admitted to another facility. There are two major medical centers within a mile and a half of the Phoenix VA. The VISN issue is another issue that we need to discuss at some point. But he was told that you can stay here, and when you feel better you can drive yourself home. That is just an example of the lack of advocacy, the lack of compassion that we know that not only Daniel has encountered through the VA system. We have met other veterans, specifically in Oklahoma City, who had very, very similar circumstances at different VAs.

The CHAIRMAN. Do you know if he ever spoke to any VA official about how he was treated?

Dr. SOMERS. We do not. The other problem, of course, is that these visits are never, the appointment system is so antiquated that things are not even documented. There is no way to go back into the system and to document a contact in the system. So no, as far as we are aware, Daniel did not speak to anybody at the VA about this. It is just something he would not do. He just would not do. It was a feeling of I tried, and this is just another example of what the pressures that are brought to bear. We brought not only the VHA but the VBA issues into account. And these are just things that altogether just became overwhelming.

Mrs. SOMERS. My believe is that he still had that military mentality. You know, this is what somebody in authority told you. I have to accept it. I cannot go above and beyond. I just need to accept what they are telling me.

The CHAIRMAN. Thank you. Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman. Once again, I want to thank the panel for coming today to talk about your stories and your family. And I really appreciate it. I know it cannot be easy.

So Dr. Somers, my question is can you go into further detail on about why you think it is important to encourage every veteran suffering with PTS and other combat related mental health issues to supply a list of points of contact and get a HIPAA waiver?

Dr. SOMERS. Interesting that you say HIPAA. Because once somebody says HIPAA that sort of stops the conversation. We have been trying to deal with this issue because it takes a village, a large village, to not only treat but to recognize and to approach our veterans who might be in crisis. We feel it is critically important to expand what we call the support network. And actually at this point a HIPAA change would be wonderful. We really, we ran a medical practice and Jean can tell you that what we have come to learn is what HIPAA really says is not what, is not how, well is not how it is practiced. People are afraid of HIPAA. So they take the regulation that is actually there and they take it to the nth de-

gree. And really you do have some options under HIPAA, especially if you feel that somebody is a threat to himself or to his family or to the community where you can reach out to family members or a caregiver in a situation like that.

But we feel it is absolutely critical to identify prior to deployment, certainly during deployment, and after deployment what we call the support network so that these people can be educated as to what experiences their loved one, or maybe it is not even a loved one. Maybe it is a high school football coach, or maybe it is your, you know, math teacher, or maybe it is your best friend from the second grade. But so these people can be educated as to what the experiences might have been, what the signs and symptoms of crisis might be, and educated to the fact that you do not take no for an answer. And if you see that somebody is in trouble that you can direct them to the proper treatment, to the proper authority, to the proper medical facility. And that is not actually something that you have to worry about with HIPAA. So that is one way that we feel that HIPAA does not even come into the equation.

HIPAA would come into the equation when you are in treatment. And we really feel that if you are treatment and there is an issue, then the therapist should certainly take the opportunity to contact the closest people to the patient.

Mr. MICHAUD. Thank you. My second question related to HIPAA, because actually I heard a case where even though it is the Department, the Veterans Administration, where VHA employees could not talk to VBA employees and they used the excuse of HIPAA. Have you heard that, have you had that problem with your son?

Dr. SOMERS. Well we have not heard that that was a HIPAA issue. We just felt that it was a total communication break down issue, the fact that the computer systems were not compatible within the VA system itself. And the fact that as far as we know Phoenix still uses a postcard system for appointments. And nobody could document the fact that postcards were even sent. And we know for a fact that after Daniel died, and the suicide prevention coordinator contacted his widow, and they were talking, and they were going to send her some information as to what kind of counseling facilities were available for her, and she asked where are you going to send it? They in their system had an address that was four years old. And he had been involved with the VBA and with the VHA over that entire period of time.

Mr. MICHAUD. Thank you. I guess my time is quickly running out. For Mr. and Mrs. Selke, how long had Clay been taking medication for his PTS and how long was he denied medication through the VA?

Mrs. SELKE. He began taking medication in 2007 when he was back at Twenty nine Palms recuperating from the gunshot wound in Iraq. My understanding is that he, again, received medication that he needed when he was active duty. His care seemed to be good and he felt comfortable with it. When he transitioned to VA care he was never denied medication. What happened when he moved to Houston he was told that they could not refill his prescription that had, that followed him from the L.A. VA and he had been in Grand Junction, Colorado for a short time. He basically was having to start over as a new patient. And I had this rein-

forced yesterday in a meeting, that it was, that was one of his major frustrations and that I have heard from fellow veterans of his. That when they go to another facility they have to go back through everything. All the, you know, just recounting everything. And it, that seems ridiculous to have to have that type of redundant system.

When he was told in Houston that they could not refill his prescription, he was told you need to call the VA that prescribed it, wrote the prescription earlier, and see if they will refill it for you. He was leaving the country. He was going to Haiti for a couple of weeks and he needed to have enough medication while he was gone. And Clay was proactive enough and was able to do that. He just was determined, and he said okay, and he took care of it. And he did get it from the Grand Junction VA. When he came back from Haiti and went to his appointment in February, that was with a psychologist, a clinical psychologist. And my understanding was he was never, he was not given a new prescription until he saw the psychiatrist on March 15th. So his first appointment was January 6th, second appointment February 10th or 11th, finally March 15th, sees a psychiatrist.

Also part of that issue was when he was active duty Lexapro was finally found to be the drug that worked best for him. Name brand drug, no generic. But they, he had been on Paxil, he had been on Zoloft, he had been on just a variety of drugs. Lexapro seemed to work the best with the least side effects. When he came out of active duty and into the VA system, apparently generic drugs are the drugs of choice and he was given. I believe it is the generic for Celexa, which is close but it is not the same thing. At that time there was not a generic for Lexapro. When he arrived at the Houston VA and asked for a refill, and also somewhere in those first couple of appointments he said that he would like to go back on Lexapro as that worked better for him with less side effects, when he met with the psychiatrist he said, okay, I understand from your background that that has worked before. And he did give him a prescription for Lexapro.

So Clay leaves on March 15th the psychiatrist's office, goes downstairs to the pharmacy at the VA to fill his prescriptions. He spent two hours in the pharmacy. He was called up to the pharmacy desk to pick up his prescriptions and given the Ambien for sleep. I have more on that that I want to share with you. And then given, told that they cannot give him Lexapro, they do not stock it because it is not a generic, that it will have to be mailed to him. So it was mailed to him sometime within the next week, I think they told him a week to ten days that he would get this.

A couple of issues there. If you know about anti-depressant, anti-anxiety medications, you cannot stop them cold. You cannot wait for it to come in the mail and then expect that it is going to work quickly. It takes a while for these to work. They have to stay built up in your system. He was extremely frustrated. He called me, as I said in my testimony, on the way home and said, "I just, I cannot go back there."

The doctor at the Houston VA, I have spoken with him several times since Clay's death. He has been very forthcoming. I appreciate very much the information that he has given me. Something

in our last conversation, which was just a couple of weeks ago that I had not heard before, I had been concerned about Ambien. There have been just a lot of conversations among parents and spouses and family members of veterans who have died of suicide and they have been on Ambien for sleep problems. Whether there is a connection or not, I do not know. But it is a high number that are given that when they have sleep problems. And sleep problems are a common, huge problem with Post Traumatic Stress. The doctor the other day in talking about specifically Ambien and sleep medications, he said, well actually Ambien would not be the best drug for the type of sleep problems, and I believe the term is hyperarousal but I am not 100 percent sure on that, for the type of sleep problems that come from Post Traumatic Stress. The nightmares, and flashbacks, and that sort of thing. There is another drug, it starts with a P. I do not have it with me. It is like——

Sergeant Renschler Prazosin.

Mrs. SELKE. Prazosin. And he said that really is the drug that actually works best for that type of sleep difficulty. And I was so stunned that I could not ask the question, well why did you not prescribe that drug for him as opposed to Ambien that he had been given over and over different times before? So that haunts, that has been something that has haunted us for three years.

Because in that two-week window, something went wrong. Clay had moved back home. He had just returned from Haiti doing volunteer work, which gave him great, just great hope. That was great therapy for him. He had started a job. He had bought a truck. The Friday before he had called and asked me to meet him and he bought a truck for work. And by Thursday the next week, he was dead. We were with him over the weekend on that Saturday. The whole family at various points during the day saw him. He had lunch with his dad. We went to a movie, Richard and I went to a movie with him that evening. I could, I just, I just could not believe it, that within five days he was dead.

So we know he suffered Post Traumatic Stress, we know he was treated for it. He was very open about it, sought help. And that, that two-week window is just a mystery that haunts us. And we have done everything we can to try to find out answers. So——

The CHAIRMAN. Thank you. Mr. Lamborn for five minutes.

Mr. LAMBORN. I want to thank you all for being here. You have given so much. And I thank you, I know the committee thanks you, and I know our country thanks you.

I would like to ask about the role of families in treatment and therapy. I have a constituent who came to me and her husband was stationed with the 10th Special Forces at Fort Carson, Colorado, where I represent. And he took his life. And she is an advocate for a program that has a holistic approach involving families, whether it is parents or spouses. And I would like to ask any one of you who has insight as to whether there should be more of a role for families in the treatment programs that are offered through the VA? Or is there a lack there?

Mrs. SOMERS. We certainly during the time that Daniel was with the VA, certainly feel that there was a lack. And again, we feel it has a lot to do with fear of repercussions under the HIPAA law and also a total misunderstanding of what the law currently is. And I

would like to take your point further and say it should not just be family. I think we would all like to say we did not have dysfunctional families, but we know that there are dysfunctional families out there and that is why we started using the term support network. A lot of young men and women undoubtedly joined the service to get away from families, but it does not mean that they do not have a support network. So we would kind of like to get away from the whole blood, kinship viewpoint and say it is a support network.

I think it goes without saying, I recently read a report by National Association of Mental Illness. There is no question that family involvement is beneficial. There is just no question. It becomes more of an issue I believe, and it is why Howard and I have actually been trying to work with the DoD to get them to identify a support network. Because certainly in Daniel's case, Daniel was a geek. But he was at his absolute healthiest, mentally and physically, after he joined the Army. And he went through basic training, he was in great shape. If they could have identified right then, and said, Daniel, give us a support network for you. Who would you write down? You know, I mean, he had really, really good friends. We hope we would have been on it. Certainly his wife would have been on it. His mother-in-law probably would have been on it, his brother-in-law. It would have been so helpful to have that list then. Because when he got back home he was not capable of that anymore. I like to say, you know, not from a legal standpoint, but he had diminished capacity. He was not making correct decisions.

Mr. LAMBORN. Okay, okay. Anyone else? Mr. Selke.

Mr. SELKE. Thank you. Our experience, like most, probably a lot of families is, we did not know what PTS was. We had no idea. Clay was again very open about it, told us that he had been diagnosed with it, told us that he was on medication, seeking counseling. But we did not know the ramifications of that. And like most of our warriors, they are strong. And so he was, you know, put on a real good act. Had we known the extent of even what he talked to his counselors about, the idea that the Somers have broached about regardless of the HIPAA legalities of that, for if in fact somebody has that conversation with their, that counselor, somebody outside of that counselor and the patient needs to know. The patient could identify somebody who would then be able to be aware of what is going on and to say, you know, this person needs help.

Clay, looking back, there was all kinds of things going on in his life that were just red flags. And we did not know. And there is a lot of literature out there, there is a lot of information. I believe that any family who has an individual involved in the military after they come back, or really kind of anytime, they should probably just assume that there may be some sort of PTS involved there.

The suicide deal, Clay actually had a conversation with Susan. And said, "Hey Mom, you know, I thought about it but I would never do that to you all." You know, he actually addressed the issue and then lied about it, you know, to us. So the family plays a huge part in really being advocates for the individual and being

able to just watch, and watch for signs, and then maybe be able to do something about it.

Mr. LAMBORN. Well in conclusion I would just have to say the VA needs to learn best practices and have programs available that include families everywhere.

Mrs. SELKE. If I could add something to that? Going back through Clay's medical records, for whatever reason when he died I immediately wanted his medical records. I just wanted to read everything I could and try to grasp what was going on. He had apparently as early as November or December of 2009 spoken to someone in the VA in the L.A. VA about suicidal ideation, suicidal thoughts. That is on one of his reports at the end of 2009. He had separated from the Marines at the end of April, 2009. I knew nothing of that. We did not learn until the Fall of 2010 when he told us. He said, "I have struggled with this thought, but I could never do that to you all. I just cannot." And I do not think, I think in his mind he believed, "I am thinking these thoughts but I could never do that." As far as we know there were two times during the Fall of 2010 that he did have enough serious suicidal thoughts that he did reach out. One time he called and talked with me. Another time he spoke with a close friend. And then after that second time he shared with me, you know, that, or with all of us.

So we knew, in 2010 at the end of the year we knew that he had struggled with suicidal thoughts and we also knew that he was on medication and were assuming that with Post Traumatic Stress and suicidal thoughts and that the VA knew best how to take care of him. I begged him, "Please, let us go to private care. We will pay for it. We know great psychiatrists, counselors in Houston. Let us do that." He would not do that. He was adamant. He said, "I have served in the Marine Corps for four years. My medical care is to come from the VA. They owe that to me. I do not want to go to private care. I want to talk to someone who has either been in War or knows about War and Post Traumatic Stress and the things that I have seen and done in War. I do not want to go to private care." And that was just his personal feeling. We have heard that from other veterans as well. That is, as difficult as the system is, that is their comfort zone and they need to be, feel that they can be taken care of.

Mr. LAMBORN. Thank you so much. Thank you. My hearts go out to you.

The CHAIRMAN. Mr. Takano, you are recognized for five minutes.

Mr. TAKANO. Thank you, Mr. Chairman. It is very difficult to listen to your stories and I am very touched by them. So I definitely want to thank all of the families for being here today.

So let me ask this, Ms. Selke, I believe a lot of veterans have that same feeling. And therefore I do believe that we have to, it is incumbent upon us to make sure that we get it right at every facility. Because veterans are expecting that. They do not want to see this be a burden to their families financially. I am very much open to making it easier for non-VA care to be available and with that I wanted to ask Dr. Somers, you are also a medical doctor, Dr. Somers.?

Dr. SOMERS. I am a urologist.

Mr. TAKANO. Okay. Can you, can you tell me about the state—you are from the Phoenix area?

Dr.SOMERS. Actually, I practiced in Phoenix. We currently live in San Diego.

Mr. TAKANO. Oh, in San Diego. I am from Riverside, which is north of San Diego, as you know. I went to visit my own VA in Loma Linda. They are able to get veterans to see a family practitioner in 24 hours if need be. I am not so sure about mental health care or a psychiatrist. They indicated to me there is a shortage of psychiatrists. And I recently visited a new Kaiser facility and the director of that Kaiser facility told me that, I asked him if there was a, what shortages he was experiencing, and he identified behavioral health and psychiatry. Can you tell me if there is, if there are general shortages in your area of these kinds of practitioners?

Dr. SOMERS. There is a shortage of mental health professionals nationwide. And there are many issues that go into it. Certainly reimbursement is one. We know one of the people that Daniel has been seeing because, and this is another issue of continuity of care, he was forced to go outside the VA system just because he could not be seen in Phoenix. There was just no availability, no mental health available. And I think you have to divide psychiatry and psychology. And I think with these people who are suffering from PTSD, it is the psychologists and the psychiatric social workers who are providing most of the care as opposed to the psychiatrists themselves. But psychiatry and psychology are incredibly important and what happens is if we try to recruit into the VA then the community is losing that mental health component. And it is a huge issue. It is an issue that has to be addressed by our medical schools, by society in general. But it is not just an issue here and there.

Mr. TAKANO. Well here is the thing. Dina Titus and I, Representative Titus and I, and O'Rourke have offered a bill that would increase the number of residencies at VA hospitals. And of course I expect a number of those residents, if we approve it, a number of those residents would stay——

Dr. SOMERS. Right.

Mr. TAKANO [continuing]. And practice at the VA, but also some of them would go into the community as well.

Dr. SOMERS. Right.

Mr. TAKANO. You know, my thing is if, even if we do approve non-VA, make it more easy, easier for——

Dr. SOMERS. Right.

Mr. TAKANO [continuing]. Vets to use that areas like mine, they are still going to have trouble finding that care, you know, in the community.

Dr. SOMERS. They will. And they are going to have trouble, even if you have people in the community you are going to have trouble finding people in the community who are aware of military culture, and who are aware of the issues that veterans face. And again, that just brings up another whole issue, a whole other series of issues.

Mr. TAKANO. Well, I wish I had more time. Maybe I could get your information to my staff.

Dr. SOMERS. Absolutely.

Mr. TAKANO. Because I am trying to understand also your criticisms of the Vista medical records. There is also an issue of the interoperability with the VA and non-VA practitioners, right? So——

Dr. SOMERS. Right. And then that is something that we address also, especially if we are going to be trying to, with the PC3 program, and with the other issues that are being promulgated now, there has to be communication between the VA and the providers who are seeing the veterans who are being referred out. So huge, huge——

Mr. TAKANO. Huge issues.

Dr. SOMERS. [continuing]. Issues that have to be addressed.

Mr. TAKANO. Sergeant, I think I understand your point of view as well about your doubts about, you know, radically restructuring it. We have got to try to get it right in the VA facilities because of that expectation that the Selkes' son had, you know, that was their comfort zone. So we have got to, I think, do both things at once. Make sure that every VA center has, you know, excellent mental health care as well as try to provide some options.

Sergeant RENSCHLER. Yes, sir. My concern with a bill that just increases the number of practitioners at a hospital, we are not solving the issue with effectiveness of care. So it really has to be a systematic approach to solve the efficacy of what care is being provided as well as the numbers to accommodate the sheer overwhelming amount of veterans that are trying to access that already broken system. So I just wanted to add that, sir.

Mr. TAKANO Thank you. Mr. Chairman?

The CHAIRMAN. Dr. Roe, you are recognized for five minutes.

Dr. ROE. Thank you, Mr. Chairman. And I think as a father of three and a veteran I appreciate your courage to come here today and speak. It is really heartwarming. And I know that it is very difficult for you to do, and it has been difficult to sit and listen to the testimony. There are a good number of veterans sitting up here. I am a veteran of the Vietnam era. And I just want to thank you for that, and being here. And I can tell you this past weekend I returned to something very joyous for me. It was a reunion of a bunch of young boys growing up in the sixties who were all Eagle Scouts. And all but one was there that, of our friends, and he did not make it out of Vietnam. So I can tell you that this loss that you have, that you are sharing with us, is very, very helpful. But that loss will go with you, as it does for my friend of almost 50 years. So thank you for your courage to be here. I know it is very difficult.

And Sergeant Renschler, I think you bring up a great point, all of you have today, in the coordinated effort that you brought forward. That team approach I think was very good and I certainly do understand what the VA was saying was that if this works for the OEF veterans, it should work for all veterans. And the majority of the suicides that are occurring are veterans of my age. So I think that this needs to be expanded if that method that you put forward, it looked like it worked extremely well, should be looked at.

Dr. and Mrs. SOMERS. bring up an incredible point. I know Dr. Somers you probably dealt with some, as I did, some primary care in your practice when you were a urologist. You do not just get to

be a urologist. Your patients get to know you. And they share a lot of things with you. And dealing with this is very complicated. As you all point out, and Ms. Selke so eloquently pointed out, is that this approach of caring for people with PTS or chronic mental illness is extremely difficult. Dr. Somers and I can go into the operating room and remove a tumor. That is easy. This is much more difficult to do. And those signs and symptoms are very difficult to spot. Because Ms. Selke, you saw your son when he was actually, you thought, doing very well that week before he passed. And I think as a doctor that has been one of the things that troubled me all of my career, was trying to figure out when you would have a patient that would take their life was why did this happen? And many times that week or two before things seemed to be going well. You thought things were getting better.

I think, Dr. Somers, you and your wife brought up something I think that is extremely important, that a good friend is probably as important as a good doctor. A good person to lean on. And I think you have to do what Sergeant Renschler was talking about, to have this very sophisticated team together for people in need. But you also just need someone. It may not be a family member, like you pointed out, it could be a coach, or a pastor, or whomever it might be in your life. It could be a family member. And I think putting all that together is a real challenge. And I know we will hear later from the VA about what they plan to do. But any further thoughts along that line would be helpful. If anybody would like to share just some of your thoughts about what we could do.

Ms. PORTWINE. I think it is important for the transition program. I know that before Brian went to Iraq, the first tour, he went to California where they have a base where they teach them, like they make it like a Iraqi town. So they learn how to control crowds, take buildings, and all that. But when they come back, it is just boom, you are there for a week and then you are out in the community. There is no transition. Why cannot they use those centers that they use to send them where they could have psychiatrists, psychologists, and look at them, give them assignments, see if anybody has poor concentration, poor memory. You know, and use these resources that we have. You know say, okay, now you need to go do laundry, give them a list of things to do. See if they are able to do that and observe them. We cannot just take them like cattle and put them through a bunch of questions and then let them go in the community where they do not have their brothers to confide in. When they come back they have put their life on the line to trust these other brothers. They would die for them. They come home, they do not have anybody they are going to trust that much. And nobody that has not been in war is going to understand so they do not open up. The most people they open up to is their brothers.

Michigan has a program called Buddy to Buddy that they put together one veteran, you know, that has been home with the veteran so that if they have any problems they are going to open up to that person much more than they are a therapist. Or have group therapy. Let the veterans talk among themselves. They could, you know, have a group of eight, ten veterans and then have group therapy. And maybe they could confide in each other. Because it is going to take a while to build up trust with a therapist, if you do.

Dr. ROE. I totally agree. Thank you very much for your courage in being here today. Mr. Chairman, I yield back.

The CHAIRMAN. Ms. Brownley, you are recognized. I apologize. Ms. Kirkpatrick, you are recognized for five minutes.

Ms. KIRKPATRICK. Thank you, Mr. Chairman. I want to thank all of your for your courage in being here today. And I appreciate what you said about once a diagnosis is made and medication is prescribed, staying on that medication. And I really want to know how often our veterans have to refill those prescriptions. And I would just like to hear from each of you what you have learned about that experience. Are they given a 30-day supply? They have to go constantly back? Sergeant, can we start with you? And then we will just work our way down the panel.

Sergeant RENSCHLER. Yes, ma'am. So at our facility in Washington State, medications are given on a 30-day supply. There is an option for mail refills. The system is pretty confusing and I normally mess it up pretty well so my wife has to manage that for me for the most part. You have to be able to put in a request three weeks before you need it and I usually forget until I am about to run out. And so then I am off my meds for a long period of time, which is never good.

As far as the other medication issues that have been discussed, continuity of medications from one facility to the next, I am in the southern part of Washington State. And people who are coming up from Portland, Oregon, which is about an hour away, are on medications that are not transferrable to the VA facility where I am at. And so they have to start all over as a guinea pig, as what was discussed earlier, trying medications that they may have already tried in the past to get to the point where they are able to approve a non-formulary medication that they had at another facility, as well as the transition from DoD to VA care. It took about four years for the DoD to balance about nine medications for myself. And when we transitioned to VA care many of those medications were not on the formulary and we had to go back to the guinea pig phase again, and we ended up on 14 in order to utilize medications available through the VA. So it is, there are many issues as we are talking about that.

Ms. KIRKPATRICK. That is just unbelievable. Any other families want to——

Ms. PORTWINE. Brian was never put on any medication. They diagnosed that he had depression, Traumatic Brain Injury, PTS, but he was never put on any medication. He was put on medication for his back when he was thrown from the Humvee, Naprosyn, and a muscle relaxer, and that was just temporary. But they never even prescribed, screaming out three times a week with nightmares and having your brothers wake you up, and then telling the therapist how embarrassing that was, I think you need to be on some medication.

Ms. KIRKPATRICK. Agreed.

Mr. SELKE. These medications are so subtle and they are so particular to the individual, it is just mind boggling that there is not an easy way to identify and work with the individual vet to determine exactly what the cocktail, if you will, looks like, and then be able to without, you know, to just seamlessly transfer that to wher-

ever that vet is. These people are young and they are on the move. And you know, they are all over the place.

Ms. KIRKPATRICK. Right.

Mr. SELKE. And so that, those barriers just need to be taken down.

Ms. KIRKPATRICK. Dr. and Mrs. Somers?

Dr. SOMERS. Yes, thank you. And thank you, Representative Kirkpatrick, for being such a support and a help for us. There is multiple issues that have to do with the medications. Just the fact that the formularies are not the same is a huge issue. And it just does not affect veterans at the VA system. There are veterans who are retired from the military who see physicians both at the VA and the DoD. So they are seeing people at both different medical centers and they cannot be on similar medications from one to the other because the formularies are not the same.

The problem is that not only does the VA use 99 percent generics, but they use the cheapest generics. So Daniel, who had not only PTSD and TBI, but full blown Gulf War Syndrome, which included irritable bowel, had only certain medications that he could tolerate. So maybe the chemical in the medication is the same, but the bonding agent is different. Maybe he is on a medication that he only has to take once or twice a day, but the VA gets a better price, so now he has to take it three or four times a day. And the change in the medication changes everything. So I mean the issues, the issues are just huge. It is not only that, and the other thing that we have heard, and from unimpeachable sources, is that VAs vary, as we heard, with their pharmacy policies. There are some VAs where you can go and you can get a brand name medication with no problem. Other VAs that essentially it is possible to get a brand name medication. So, I mean, that just brings up this huge issue that we have, is why there is so much variation in the entire system, why we cannot have more uniformity within the VA system as a whole.

Ms. KIRKPATRICK. Thank you, Dr. Somers. My time is up. And thank you.

Dr. SOMERS. Sorry.

Ms. KIRKPATRICK. But let me just conclude by saying your testimony is heartbreaking and I can barely hold back my tears, and I thank you for being here. I yield back.

The CHAIRMAN. Thank you. Mr. Runyan, you are recognized for five minutes.

Mr. RUNYAN. Thank you, Chairman. And thank all of you for sharing your stories and truly being great Americans and great patriots because your stories are going to help people in the future. And thank you for all that.

A couple of points, and I think Dr. Somers was just talking about it. And I think we see it all day. And we talked about this in the hearing the other night. It almost seems like the VA is so fragmented that there is no overwhelming mission from the top with flexibility below. That is, and I think we are admitting there is a structural breakdown in how you are actually going to conduct business. And that is really where we are at, whether you are talking VHA or VBA. It is the same issue. And we have yet to hear,

I think next week we are digging into some of the VBA issues, also. It is a culture.

And one other point and then I will ask one question. And I know Mrs. Somers was talking about it, and Dr. Roe also validated it. When you talk about community and you talk about support networks, these men and women are spending more time away from the health care facility than they are in the health care facility. So friends, family members, you know, classmates, buddies all have to be part of the healing process. We are not doing that. And I know the term holistic has come up a few times. I think Sergeant mentioned it a couple of times. It is part of the healing process. There is no silver bullet to cure somebody. You have got to be able to help them in many different ways.

That being said, in the VA's testimony they mention suicide prevention coordinators are supposedly placed at all VA medical centers and the large clinics. They are supposed to follow up with veterans that are at high risk. Were any of your sons ever contacted in that first month after they were designated high risk by a VA suicide prevention coordinator?

Mrs. SOMERS. We are not aware of that. I mean, the fact that they did not even know where he lived would bear proof of that.

Dr. SOMERS. And that is one of the issues that we are dealing with also, and that goes into the whole support network issue. Is that, and we have spoken to so many, so many families in the same situation, is that Daniel was married. And that basically shut us out of the equation. And that is where if we had the opportunity, if we could do some changes in this misinterpreted HIPAA regulation where we could have been more in touch with his therapist and they would have felt free to talk to us, where we feel that we could have been more help. But since he was married it was as if we did not exist.

Ms. PORTWINE. I think that is an important point is like when Brian was injured in the tank explosion, I was notified. You know, it was three in the morning and they called me from Fort Hood saying that he was injured, where they had taken him, you know, he is back with his unit, you know. But yet you diagnose somebody with PTSD and TBI, which are, can be life threatening injuries, and nobody notifies you. I mean, that just does not make sense to me.

Mr. RUNYAN. Anyone else?

Mrs. SELKE. Your point or question of being flagged as a high risk, this is something that came up that really baffled us, I guess. When Clay was transitioning or moving to Houston and starting to go the VA in Houston, his records apparently from what I was told, those records were not seamlessly electronically sent. They did not have his records from L.A., and that is where the bulk of his time was once he had gotten out of the Marines. So as I looked back through those medical records, as I said there were at least two or three times in there that it is talked about, and he talks and admits to having had suicidal thoughts. So I assume that he was flagged, would have been flagged, as a high risk. I mean, it says on the medical record high risk highlighted. When he comes to Houston VA, nobody knows he is a high risk. The psychiatrist did not have anything other than Clay saying this is what my past his-

tory has been and this is the medication I have been on. So that is a great point as to when are they flagged as a high risk? Do any family members know that? The only way I ever knew that anybody called him a high risk was when I got his medical records and poured over them after he had died.

Mr. RUNYAN. Thank you. Chairman, I yield back.

The CHAIRMAN. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman. And I want to join my colleagues in thanking all of you for being here and sharing your stories and certainly through your stories about your sons, it certainly to me I feel their patriotism through your stories, and their overall most sincerest commitment and service to our country. So thank you for being here.

I wanted to ask Sergeant Renschler a question. And so in your service when you were in theater, was there any support system in place for you to go to get any kind of, you know, mental health support while you were there? Hearing Brian's story, it was very gut wrenching to hear it. And, you know, just to wonder if Brian had a place to go to while he was in theater, how helpful that might have been in terms of his time there and his transition coming home?

Sergeant RENSCHLER. Ma'am, thank you. When I deployed was 2003. It was right after the initial surge. It was a completely different war theater. We really did not have anything set and established at that time. So to answer the question, no there was not anything. However, again, I work with many, many veterans currently and active duty members. And I have been told in recent deployments in Afghanistan that after major events take place there is sometimes availability to have a type of a crisis debrief. It is somewhat available. It is not streamlined, it is not across the board, but it has been implemented on some level.

Dr. SOMERS. If I may? The problem is that we know that there is an effort in the DoD to destigmatize mental health issues. But if you are in theater, I would venture to guess that it is going to be incredibly rare for somebody to take advantage of that, because all of a sudden they are going to be taken off duty. And the whole idea to destigmatize it is to say, okay, you come in for treatment, but then once you are better then you will be able to rejoin your unit or you will be able to regain your security clearance. But while you are under treatment you are not with your unit and you have lost your security clearance. So I mean, the issue is a huge issue. And we know from people that we have spoken to that the people at the top are aware of this and they are trying to deal with it. But there is just so much you can do on a boots on the ground level.

Sergeant RENSCHLER. Well, if I may? So there is two separate levels here. There is a crisis response, much like a CISM team that can go out and basically say, hey, this is what happened, these are the normal reactions to this type of a situation, if you experience this find somebody to talk to. So more of an education, immediate response. And that effort has been available. As he stated, most military servicemembers and veterans, as I stated earlier in my testimony, are not going to go and say, gee, that was a horrible experience, I think I should talk to somebody before I have issues.

They are going to wait until it becomes a crisis point in their life and debilitating in nature before they seek treatment.

Ms. BROWNLEY. I just feel like if it was part of the culture being in theater that there is kind of constant dialogue that is going on. That that would have to be helpful to the men and women who are there. But——

Ms. PORTWINE. Brian did tell me one time when they were on the 15-month tour there was one time that they lost four people in one mission. And when he was out there the morale was very low after that, because these were people that were high up, First Sergeants, and the Lieutenant and that. So they sent someone in and when the soldiers would go in and talk with them, he asked the same question. Well, was it sort of like a movie? And that just insulted them almost. As just like, why would you ask such a silly question? So they all shut down. And I think by not processing those thoughts then you are going to internalize them so they are never dealt with. I think even before they are in theater, I think in basic training, they should be taught PTSD and while they are deployed, and to report on each other for their own good, and in transitioning home. I do not think we can say it enough. That is my opinion on it.

Ms. BROWNLEY. Yes, thank you, thank you. I think it just confirms that, you know, we prepare our men and women to go and serve, and to go to War. We do not prepare them very well to transition back.

Dr. Somers, you talked about HIPAA and the barriers to HIPAA, and we have talked about the family involvement piece. You mentioned also modern technology—am I . . .? I yield back. I apologize.

The CHAIRMAN. Thank you very much. Dr. Huelskamp, you are recognized for five minutes.

Dr. HUELSKAMP. Thank you, Mr. Chairman. I just want to say thanks to the moms and dads and the Sergeant for your riveting testimony. I look forward to asking the VA some follow-up questions, and I yield back, Mr. Chairman.

The CHAIRMAN. Thank you very much. Ms. Kuster, you are recognized for five minutes.

Ms. KUSTER. Thank you, Mr. Chairman. And thank you to all the families for being with us today. I think for many of us sitting here today the pain is to recognize your commitment to give meaning to your sons' lives. I am a mother of two sons, 22 and 25. I cannot fathom what you are going through. But I want you to know that we will do our part to give meaning to their lives. And it just makes me feel that personally I am becoming more and more anti-war, pro-veteran. And I think our country has had those priorities misplaced, getting us into conflict but not being focused on the cost, society costs to our country and to the population. These extraordinary young men and the promise that they held, going to Haiti, and making a difference right here.

So I am going to focus in, because I think from your experience you can really help the VA and the DoD to understand what could make a difference, and I want to commend you all for the specificity of your recommendations. But in particular I have been trying to understand best practices and whether there is any effort within the VA where there are practices that are known, ground

therapy for example, or the types of medications that are helpful. Have any of you in any of your discussions, whether within the VA or since then, the experience that you have had meeting with people, have any of you come across any effort to share best practices with the transition, particularly around PTS and TBI, and just the trauma. How we can help people coming back from this level of trauma. And I do not know, maybe we could start with the Sergeant. If you are aware of any types of programs that are effective?

Sergeant RENSCHLER. Thank you, ma'am. There are great things that are effective. But the problem is—even though we can group veterans together in a large sum, and combat veterans, and another category, it is hard to label one program as effective for all. So many find group therapy programming very successful. Many find combat veteran support groups very helpful. Some find one-on-one peer mentoring very effective and helpful. This is why when we are talking about evidence-based therapies, best practices of the VA, pushing CBT, CPT, these things can be deemed as best practices. But many veterans are not ready to go through such intensive therapy. They would rather pace themselves. And so while it can be very effective at squashing the problem, I cannot really say that there is one thing that is straight across the board going to work for everybody. And that is why I stress the importance of a team that works together to bring together what is best for each individual veteran in a veteran centered care rather than a systematic care that the veteran has to adhere to.

Ms. KUSTER. So you are looking at a more individualized approach, but a team approach. And I think, Ms. Portwine, you mentioned that others on the team may see something in the care.

Sergeant RENSCHLER. Yes, ma'am.

Ms. KUSTER. I also want to visit this issue of HIPAA. Because I am an attorney. I have worked 25 years in health care. There is definitely a waiver process. And this happens in private sector medicine. Do you, are any of you aware of, and through your review of the records after the fact, or have any of you experienced the VA asking the patient at any point in their service for a waiver to identify people that they would be willing to have their medical records shared with?

Mrs. SOMERS. I know we had specific—Daniel ended up going outside the VA because his psychiatrist retired and they said we do not have anybody for you to see. And at the time he was having suicidal ideation so his mother-in-law, who is a private sector psychiatrist, referred him to somebody that she knew in the community. As he was seeing that person we actually asked him can we be a part of what is happening, he said he would ask her, but my guess is that he never asked her. And we never got the feedback. It was just embarrassing, is probably the closest word we could come to for him to have to share that information.

Ms. KUSTER. Sure, I understand.

Mrs. SELKE. I can speak to that a little bit as well. Going through Clay's medical records from Houston, from the VA, there was a form in that assessment and there is a question that says do you want us to or will you allow us to, I think it just said do you want your family to be contacted regarding your care, and he had checked no. And as difficult as that was to read, I know, you

know, I know him. And it is, I cannot even imagine, and I really, I just cannot even imagine. These people are so strong in the first place to raise their hands and say I will go, and they go to war. And they have these injuries. And especially with the mental injuries, it is so difficult to feel that you are a burden on other people. And I know Clay felt that even though he knew how much he was loved, unconditionally. Any of us would do anything to help him. But he was 28 years old. He had been a Marine scout sniper. He, you know, it was, you just want to be able to take care of yourself. And get the medical care you need. So it did not surprise me to see that. But there was a question of would you allow your family.

Ms. KUSTER. Thank you. My time is up. So I am sorry to interrupt you. Thank you, Mr. Chair. I yield back.

The CHAIRMAN. Thank you. Mr. Coffman, you are recognized for five minutes.

Mr. COFFMAN. Thank you, Mr. Chairman. And I think, first of all thank you so much for the service of your sons, and Sergeant, in your case, your own service. And my heart goes out to you for your losses as a veteran myself.

A question that I have is, do you think, certainly Sergeant in your case, and then for the parents, in the cases of your sons, was VA overmedicating them in lieu of giving them therapy? Sergeant, why don't I start with you? And then I will work this way.

Sergeant RENSCHLER. Sir, thank you for that question. This is really a culture that begins with DoD and extends into the VA. It is an issue that we battle with on a daily basis as we provide support and service to veterans and active duty members where I am at in my local area. Part of what I do through the ministry that I am in is providing support groups through the chaplain's channels. So I deal with this very closely on both sides. Medication is no longer being used as a tool to subdue the symptoms, but we work on the deeper issues.

Mr. COFFMAN. No, what does the VA do?

Sergeant RENSCHLER. The VA specifically utilizes medication——

Mr. COFFMAN. Okay, that is my question.

Sergeant RENSCHLER [continuing]. To control it and keep them, suppress the symptoms——

Mr. COFFMAN. Okay.

Sergeant RENSCHLER [continuing]. Without working on the deeper issues, sir.

Mr. COFFMAN. Thank you. Please.

Ms. PORTWINE. Brian was never put on any medication, only for his back when he had that problem.

Mr. COFFMAN. Okay. Okay, yes.

Mrs. SELKE. Yes, Clay was on quite a bit of medication. And as I said, he termed that he felt like a guinea pig, just constantly being given something different.

Mr. COFFMAN. Do you think that they chose medications then in lieu of——

Mrs. SELKE. Sure.

Mr. COFFMAN [continuing]. Therapy? One on one therapy?

Mrs. SELKE. Yes. The only one on one therapy that he spoke of that seemed to be effective, at a certain point in L.A. he went to

a Vet Center and had a counselor there that he really liked, and felt that he finally found somebody he could talk with.

Mr. COFFMAN. Okay.

Mrs. SOMERS. From Daniel's point of view, I think part of his problem was that he also had Gulf War Syndrome, which manifested with so many physical symptoms. So yes, he had a 24-inch by 24-inch drawer full of pill bottles, but I think it was because he was having such incredible interactions between the different drugs that he was taking for PTS and the Gulf War Syndrome.

Dr. SOMERS. And Daniel was not being seen by——

Mrs. SOMERS. VA——

Dr. SOMERS [continuing]. VA psychiatrist after six months after he was home, just because he never got the postcard that he was supposed to get to assign him another provider.

Mr. COFFMAN. How much of the stress or the factors leading to suicide do you think might have been related to the fact that, I mean, I can tell you having been to Iraq, I mean, first Iraq War, and then the second, that when you come home there is a huge sort of, I guess maybe separation anxiety. That you were with, that you develop these interdependent bonds and this team around you, and all of a sudden it is just gone. It is just gone. And people fall into very dark and deep depressions sometimes. And I think it is easier for those that come back and then they have a long period of active duty with the same people that they served with. And I am wondering if you might comment? We will start with this side of the table.

Mrs. SOMERS. This is a problem certainly with National Guard. Daniel was a member of California National Guard with the military intelligence.

Mr. COFFMAN. Mm-hmm.

Mrs. SOMERS. They are routinely separated from their main unit and assigned to other units. Daniel went to Iraq with an M.P. unit out of Texas, so he was already not with the unit that he trained with. He went to Iraq. When he came back his wife had moved to Arizona to be with her parents, so he is California National Guard, deployed through Texas, and then ended up in Arizona. So he had no support group whatsoever close by. It would have been phone call and email.

Mr. COFFMAN. Yes.

Dr. SOMERS. And this is a known issue. I mean, Reserves and National Guard, it is a huge issue. And not to take away, of course, from regular servicemembers, and in all branches of the service. But it is a much bigger issue for those who do not have the opportunity to come back to a defined facility and spend time like you said with the people they were deployed with.

Mr. SELKE. Great question. The bonds that these men and women form in combat are just incredible. And so it is very difficult for them to leave service and come back to their communities. Clay probably stayed in, he really struggled about going home to Texas or staying in California. I think the reason, one of the reasons he stayed there for a while was because his close friends, Marines, were staying there, and continuing in his life.

One of the tragedies in Clay was he moved back to Texas and he really wanted to consider going into working for the fire depart-

ment, a paramedic, that sort of thing, and was having some struggles with that. After he died we found out that I think three, three of his group were actually in the greater Houston area. And one of them particularly had actually gone through all the steps, he was like a year ahead of him, going into the fire department. And it really could have helped. Just the knowledge that those people are there would have helped. So there is a big break there in leaving service and going back into the community.

Ms. PORTWINE. When Brian went first he was with 1st Cav, and that was a deployment that was supposed to be 12 months, and then they extended it to 15. Of course he was very, very tight with all those brothers, and they still are very, very connected online and text and everything. When he was in college then for the year, then when he was called back the second time his unit was already home for the year. So he was put with Louisiana National Guard. And he had no idea, those were completely new people. So you can imagine then when you are already damaged, and you wake up screaming three times a night, and have anxiety and panic attacks, that, you know, very difficult. I think he did bond with the people, he was very social. But it was not the same type of fun he had with the first group.

Sergeant RENSCHLER. I think it has been stated well. And just to highlight on that, the Battle Buddies system is so culturally ingrained in the military community and you really become a family unit with those around you that you serve with. And separating from that, and especially our wounded as they are shuffled from their units into a warrior transition battalion they are separated from that family unit. Even though they are with other servicemembers, it is different. And then they transition out and they lose connection all together for the most part and begin to isolate themselves after that loss. And that is a very difficult thing. And I think that is why programs such as the VA's Peer Mentor Navigator Program are so essential, is we should look at that and look at the way it is being implemented, and improve upon that. Because servicemembers and veterans connect best with other veterans, especially those who have shared experiences and that can help each other navigate through the difficulties that they experience within the system.

Mr. COFFMAN. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. O'Rourke for five minutes.

Mr. O'ROURKE. Thank you, Mr. Chairman. And I would like to join my colleagues in thanking you, and just telling you that what you have shared with us today is so powerful. Sergeant Renschler, your story, the story of Brian and Clay and Daniel, I hope will force us and the administration and this country to treat this issue with the respect that it deserves, with the attention that it deserves. And to get the results that our veterans deserve. And beyond the power of the stories, which are just, it is just hard to put into words the effect that they are having on me and I think my colleagues on this committee, you have also come to the table with solutions and proposals to improve the system.

I love the idea that we think about the VA restricting its responsibilities to becoming a center of excellence for war related injuries. I have not thought about that before. And I do not know what the

effect would be. And I would love to hear from other veterans and veteran service organizations. But I love that you are thinking about a big idea to transform a system that is obviously not working today but has not worked for a very long time, from everything that I have learned so far. This idea of an interdisciplinary approach to taking care of veterans when they return, I would like to know more about that. And I think it makes a lot of sense given your earlier testimony. The buddy to buddy system that you brought up, identifying a support network when these servicemembers are still enlisted, are all excellent ideas.

So what I would like to ask you is, I have received so much more value from this testimony today than I ever have from a representative of the VA, including the reasons why we should be focused on this, the ideas and suggestions on how to fix it. So I would like to ask each of you, if there was some formal process to involve you in fixing the VA, would you like to participate? And then secondly if you have any other ideas, because there have been so many good ones that have come through so far that we have not raised today. I would love to give you an opportunity to share that. And maybe we can start with Dr. Somers and work down.

Dr. SOMERS. Well you know we want to be part of, if we can, whatever efforts. And we submitted as part of our testimony 15 pages of problems and potential solutions. So there are a lot of really good people who can be very beneficial to try to help the system. You know, we just do not have the time to get into specifics right now. But to answer your question, for sure we would like to be involved if at all possible.

Mr. O'ROURKE. Thank you.

Mrs. SELKE. Absolutely. We would be happy to do whatever we can to help. I want to kind of shift the focus a little bit off of us as parents who have lost sons and lost children. Words cannot describe that. But I sit here and look at Sergeant Renschler and listen to his story and we are surrounded by veterans behind us, a lot of them from the IAVA group. If there is any blessing or silver lining in Clay's death, we have become friends with so many of these young veterans that have enriched our lives. I do not know where I would be without them. I mean that sincerely. They just have enriched our lives so much. So whatever we can do. We cannot do anything to bring back Clay or Brian or Daniel. But what we can do is do something, whatever it is, to make life better for Sergeant Renschler and for all these veterans behind us and all of them all across the country. All veterans, not just the Iraq and Afghanistan, but all of them. We should not have to be reminded of that. And yet we seem to have to be reminded that we need to do a better job. So we are happy to do whatever we can to help.

Mr. O'ROURKE. Thank you.

Mr. SELKE. Anytime, anyplace, we are available. Part of the process for us to heal and I think for everybody at this table is to have the opportunity to go beyond our personal losses and to address the veteran community as a whole. And to do whatever we can to take care of those fine men and women. And so that, the opportunity to be in this community here, and be able to talk, and be able to be heard by people who hopefully have the, I believe certainly have

the heart and hopefully have the ability to make some things happen.

The VA is very, very complicated. It is a huge animal. I know there is a lot of things that need to be dealt with. There is a lot of really, really good stuff, and there are some big problems. I think if we can just focus on the individuals, just focus on them as people in need, as patients, on their care. What do they need today? And then build the system and modify the system, do whatever based on that. I think that will take us a long way. The focus needs to be these veterans, totally.

Mr. O'ROURKE Thank you. My time is expired, but Ms. Portwine and Sergeant Renschler, would you like to just briefly indicate whether you would like to continue to be involved and perhaps in a more formal way to include your ideas and experiences in this process of reforming it?

Ms. PORTWINE. It would be an honor. It would be an honor for me to help make a change for the veterans to be. It would be like paying it forward.

Mr. O'ROURKE. Thank you.

Sergeant RENSCHLER. Certainly I echo the anytime, anyplace. I not only bring my own battlefield perspective but that of all the veterans that I work with, and I can only offer that much. But thank you.

Mr. O'ROURKE. Thank you. Thank you, Mr. Chair.

The CHAIRMAN. Thank you. Mr. Cook, you are recognized for five minutes, sir.

Mr. COOK. Thank you, Mr. Chair. I want to thank the group for being here. I know this is really, really tough. Sergeant, for your input, this is tough to listen to. And it is even tougher for you guys.

The comment about the parents not knowing. I am not surprised. A lot of people the worst thing in the world, when, after my second Purple Heart I did not want my parents to know what was going on. And this is going to be the problem that I think all of you are sharing, that common denominator. You know, everybody that goes through these experiences are going to have huge psychological problems. But who are they going to share it with? Are they going to share with a psychiatrist or a psychologist that does not understand the military culture, the veteran culture? They are not going to open up. You know, you need that connection. I think the Sergeant made a great point. And your comments about the Wounded Warrior Program, where they have that. The actual battalion where when somebody has got a problem they go into that system there. And I just want to get your feelings. And maybe I am going down the wrong road. Because I think they need it, as somebody that has a problem they need an ombudsman. Somebody that is going to look out for their interests. That if they are at a particular hospital, they can go to the administrator. They can go to anybody and say, hey, wait a minute, this is an immediate situation. This is general quarters and we have to have a meeting right now or somebody is going to die on your watch. And can you comment a little bit more on that? It is pretty much what you were talking about, Buddy to Buddy, the same things over and over and over again. But to cut through the red tape right then and there with individuals that understand the severity of the problem.

Sergeant RENSCHLER. Yes, sir. This is a crucial element, is to have somebody to come alongside of the severely injured, cut through that red tape, and get treatment now. This is something that we have experienced first hand. I have experienced, I shared it with some of the folks from the Wounded Warrior Project recently. I had a veteran that we did a crisis intervention on attempted suicide, and we had to remove him from his primary residence. We got him to a position of stability and I found out that he had never accessed care at the VA facility. So I told him that that is the next step. He went down and he was actually denied treatment and told that he would be able to be seen in three months after telling somebody he had attempted suicide the night before. And I went down there and met with that veteran and we walked in, and I said this is an unacceptable answer. And we got the department head to come out and say I will intake him today. We have a program we can start him in next week. And that saved that veteran's life that day. But there are thousands more a day that are getting the no and not getting that extra answer because they do not have somebody to advocate for them. And I am not saying that to toot my own horn. I am saying that if we had more people out there advocating for these veterans we would be able to save a lot of lives and get better care.

Mr. COOK. Yes. I just got back from, I went down to Camp Lejeune, where I was, I spent a lot of time down there. And I saw some of the folks, including my platoon sergeant, who was my platoon sergeant 47 years ago. And we talked about the infantry unit, and you never forget the Marines that you lost. 13 May, 1967, horrible, horrible day. You never forget their names, the occasion. Just like you are never going to forget this. But what you have to do is try and make the system better. And right now I think it is broken in terms of not capturing those individuals and those thoughts, their morale is just down to the point where they are going to do something bad. And if we do not correct it now, it is our fault. So——

Dr. SOMERS. Yes, it is a systems issue within the VA. And our feeling that everybody who works in the VA should have only one purpose in mind, and that is to advocate for the veteran. And it is the person who sits in the corporate office to the person who cleans and empties the wastebaskets at night. That is the only, only thought that they should ever have.

Mr. COOK. Doctor, that concept of the ombudsman, or for lack of a better term, somebody that is ultimately responsible or somebody that is that advocate for that person in trouble——

Dr. SOMERS. And we agree that there needs to be an ombudsman. We know about the Navigator program and that is a great program. We know that they are doing a much better job of that out in San Diego. But it is not only the ombudsman, it is not only the Navigator, it is every single person——

Mr. COOK. But it should be an SOP, totally——

Dr. SOMERS [continuing]. Totally, totally, totally——

Mr. COOK. Standard operating procedure for every hospital. I yield back.

The CHAIRMAN. Thank you, Colonel. Ms. Brown for five minutes.

Ms. BROWN. Thank you, Mr. Chairman. First of all, let me thank each and every one of you. Let me just tell you recently I did some work with the Marines and they would just be very proud of you, your sons. So thank you very much for your service.

You know, I have to say that we are talking about the VA, but this is not just the VA. It is DoD. And this hearing should be VA/DoD. Because it is DoD that sends people over and over and over again to combat, and there is no transition as far as when they come back. So it is a bigger problem. And to sit here and just say, well it is the VA. That is just not true. It is just not true. And we need to deal with the problem.

The fact is we have been fighting a War with the reservists and we have sent them over and over again, and they did not have the support that they need. I have gone out when they are deployed and they just, they do not have all of the other resources that the other military branches have. So we are not doing the Wars the way that we need to, and the system is fragmented. And so as we develop a comprehensive system, let us get everybody in the room. Let us deal with the system the way we need to deal with it.

Now you mentioned the formulary. Now the VA and DoD, we insist that they negotiate the prices of the drugs to keep the costs down. Now what is wrong with the way we are doing that? Because in the regular market it is illegal for the Secretary to negotiate the price of the drugs, which I think is dumb.

Dr. SOMERS. Well there is no problem negotiating the price of the drugs. The problem is the drugs are not the same. So that for example Lexapro, which is, you would definitely want the DoD formulary as opposed to the VA formulary.

Ms. BROWN. Mm-hmm.

Dr. SOMERS. No doubt about it. And I know firsthand that you can basically get anything you need with relatively little hassle through——

Ms. BROWN. But I thought the VA was the one that was doing a lot of the research, not the DoD——

Dr. SOMERS. The research has nothing to do with anything. The only thing that has to do with it is the actual drug that you are being prescribed by your provider. You can do research, and actually that was one of Daniel's issues, is that there is a problem doing research because of the fear of the FDA and the DEA and Schedule 1 medications and things like that. So that is a totally different issue. The problem is the formularies are not the same. And as I said, you have got patients, not only veterans who are being discharged, but you have retired military who are being seen at a DoD hospital and at a VA medical center, and they are eligible to seen at both.

Ms. BROWN. Mm-hmm.

Dr. SOMERS. And they are under medication restrictions because the formularies are different. So that is the big issue. We need to make it a single formulary, bottom line.

Ms. BROWN. Okay——

Mrs. SOMERS. Excuse me, and just in addition to that——

Ms. BROWN. Mm-hmm.

Mrs. SOMERS [continuing]. It is like if a person is doing really, really well on a drug, they should be able to stay on that drug.

Ms. BROWN. And the doctor can override that.

Mrs. SOMERS. Just because you can get it for ten cents cheaper, and it can have major effects on their body.

Ms. BROWN. Absolutely. But the doctor can override that.

Mrs. SOMERS. Right, and——

Dr. SOMERS. Ma'am, not, no but what Jean is saying is different. It is still a generic, but as I said before it is a different formulation of the generic.

Ms. BROWN. Right, but——

Dr. SOMERS. So and especially as was said, I mean that is what is so important to have these groups of the multispecialty groups that are, the interdisciplinary committees, or whatever they are, that are going to community amongst themselves.

Ms. BROWN. Well I definitely think that is something we could work on. Ms. Portwine, I think you made a very important point. Your son you realized was having serious problems, and yet he was redeployed.

Ms. PORTWINE. yes.

Ms. BROWN. And he was not given the medication. I mean, it should have been a time out at that point.

Ms. PORTWINE. Well even on the form you can see it said no go, that was crossed through, and somebody stamped, the coordinator that sends the people, I forget what they call them, put go.

Ms. BROWN. Well, now that is DoD.

Ms. PORTWINE. So that tells me they had hesitation in sending him to begin with.

Ms. BROWN. That was DoD.

Ms. PORTWINE. That was DoD.

Ms. BROWN. Yes, ma'am. Well thank you very much.

Ms. PORTWINE. You are welcome.

Ms. BROWN. And what I am saying is it is a lot of work that needs to go on, and it is not just VA. Thank you again for your service.

The CHAIRMAN. Thank you very much. Ms. Walorski for five minutes.

Mrs. WALORSKI. Thank you, Mr. Chairman. And thank you to the panel for being here. I can assure you that this is how things change in this country, it is when brave men and women step forward and say to a concerned body like this of Republicans and Democrats, sitting here listening to your story, I cannot even imagine, I cannot pretend to imagine how tough it is to sit here and relive this. And I think I can, I think I can safely say that we are committed to bringing right to all of this wrong. And every one of you have hit the nail on the head by saying, every one of you have said the story is about the individual veteran. And you know, I have only been on this committee for 18 months but the last three months the chairman and the ranking member have led an intense investigation into what the heck happened to the VA. From the day that it started to the mission today. And every layer of this onion that we have peeled back comes down to the same core issue: nobody is advocating for the veteran. And the culture itself, and when we talk about systemic problems and the culture itself and we, and the Secretary is removed, and a bunch of people are removed, and we are sitting here trying to be able to help America reset a button.

Because Americans believe in our veterans. They sent us here to fight for our veterans. And I want to just applaud your effort.

You have made such a huge difference here today. This is how laws change. This is how policy becomes correct, and this is how we move forward in this country. We do it together. Unfortunately sometimes it takes the disaster that we have had in a bureaucratic system of the VA. But you know, the frustrating thing for me is I have 54,000 veterans in my district and every time I describe my veterans I talk about I have 54,000 veterans and their families in my district. And I want to applaud your effort on two huge issues that I think that we can address in this Congress and we can help move forward on this issue of mental health. The one is the support network. I cannot even tell you, and I know you know, how many constituents have called our office in Indiana, and the wife or the husband is in tears, and they are begging and they are advocating for the spouse that the VA says HIPAA prohibits me from allowing you to get involved in this. I have gotten personally involved in some of these mental health cases in my district, calling the directors and regional directors, and trying to advocate for my constituent on behalf of a spouse. And the answer is still no, HIPAA overrides. And I even asked the question, do you have a different law of HIPAA? Do you subscribe to a different definition than we do? And the answer was no. HIPAA overrides. And so just having a support network. To be able to come in and be that bridge between somebody who is dying and the system. And I applaud that effort. And I think, I mean, I am going to make sure that we do everything we can to get that part of the law changed. Because we can bring advocates into the lives of these struggling men and women. And for the spouses that are trying to hold the families together, we can do that, too.

And I want to just thank you for your commitment as well on the issue of keeping this focus where it belongs. And, you know, I think someday, I do not think this is a quick turnaround. But I think you have brought light, transparency, and accountability to another layer of what America needed to hear. And while you are sitting here today talking to us, and while we are trying to relate and share your brief, and we are trying to find solutions to move forward, you have had an opportunity to talk to the American people today. And I guarantee you that every single person that you are an influence to, that has followed your story in the states that you are from, I am going to hear from my constituents today and say I am just, I relate to that mom and I relate to that father and I relate to my fellow serviceman. And I just think it is a tribute today. This is how government works. And we have a commitment to make sure we restore not your sons, but certainly the America that they have been fighting for. Certainly our trust and their trust in us as a government who asks them to go fight for freedom and fight for liberty, our finest heroes in this nation, and to be able to reinstitute to them by continuing to root out the bad actors and the bad policy in the VA, and together set a reset button.

So I just want to applaud your efforts and thank you so very much for helping us reset an organization that started out as a great noble effort and really has run into a bureaucracy that has just run amok. But you have our commitment today and my com-

mitment certainly that none of what you have experienced will be in vain. So thank you so much for being here. I appreciate it. I yield back my time. The Chairman Thank you. Mr. Walz, for five minutes. Mr. Walz I would like to yield the first minute to my colleague Mr. Peters, who represents the Somers.

The CHAIRMAN. One minute to Mr. Peters.

Mr. PETERS. Thank you very much. Thank you, Mr. Walz. I want to start by thanking the chairman and the committee for allowing me to be a guest. We are not members of this committee, Ms. Sinema and I, but I do not think there is anyplace we would rather be this morning.

It takes a lot of courage to do what you are doing, and I just want to say thank you for that. And also to let you know beyond the power of your stories it is the education you provide that only you can provide. These are insights that only you have and so it has been very valuable to us. And while we are new here I can tell you that from time to time you see testimony that is going to make a difference, and that is certainly what has happened today. I think you can feel very confident that those brothers that you talked about, and sisters, will be heavily affected and helped by the time you put in and the effort you put in today.

And I also just wanted to thank in particular Howard and Jean Somers for your leadership, for the time you put in on behalf of Daniel, and for the education you have given me. I look forward to continuing to work with you to make these issues, to resolve these issues and to make things right with the veterans that the VA sees. Thank you.

Mrs. SOMERS. Thank you.

Mr. PETERS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Walz.

Mr. WALZ. Thank you, Chairman. And again, thank you all for being here. I am sorry I never got the chance to know Daniel or Brian. I did have the privilege and the honor to know Clay, and not only know him, to work with him on veterans issues. And the profound loss is felt by everyone who came in contact with him. And it shook me to the core because of someone so strong and to your point on we do not, you are not going to notice it, you are not going to see it. And these are very special individuals. And Josh, you and I have become friends over the years. We were in St. Paul a few weeks ago working with the Wounded Warrior Project. So I do, too, applaud you. It is, you hear it from the colleagues. And this is a committee of heartfelt folks that want to get this right.

I would just mention, and I think all of you get this, at this point, and I think the frustration we all feel, solutions and results are all that matter. I am done with it as you all are. I am done with the talk. I am done with the pilot programs, if you will. I understand we need to do some of that, but there are suggestions that are concrete that can be put into this. But I want to read you something.

I came here on the 3rd of January of '07, the honor of being elected to Congress. On the 9th of January I started working on a bill. And one of our colleagues, a Vietnam Veteran pilot Leonard Boswell put in, it was the Joshua Omvig Suicide Prevention Act. And here is a couple of things that it said. The Secretary of Veterans

Affairs should develop and carry out a comprehensive program designed to reduce the incidences of suicide among veterans. The program shall incorporate the components shown below. Staff educations for compassion amongst and recognizing risk factors, proper protocols for responding to crisis situations, best practices, screening of veterans receiving medical care, tracking of veterans in a timely manner, counseling and treatment of veterans, and designation of suicide prevention counselors throughout that, and on, and on, and on.

They did not do it. It was in law. We passed it. We gave the speeches. We had the signing ceremonies. And we went back home and said, gee, we made a difference. And it is the very same things. And here you sit, just like Joshua Omvig's parents sat, come up from Iowa to testify on this.

So I guess the thing I would ask of all of you is that this is the second, the VA is the second largest government agency, behind DoD. Yet we have one of the smallest committees. We have committees that I do not even know what they do, they have got like 80 staff on them, and they do it. So we can give lip services or we can get serious about how we are going to do it. We can have this. Or we can allow, if this crisis passes, and the American public's attention focuses elsewhere, or whatever. Our veterans will be coming back. There is veterans sitting behind you from Vietnam and others. They have seen this movie. They have seen it before.

Here is what I think is different. I think there is no doubt in my mind, the American public wants to get this right. And they are entrusting us as their representatives to get this right. And the commitment I have seen from this chairman and ranking member as a member of this committee, this is different. It is different than the seven years that I have been here. It is different in how we are focusing. It is different amongst the advocacy, and we cannot let this pass.

So what I would tell you, Ms. Portwine and some of you asked on this, you mentioned, and thank you for this, Chairman Miller and Representative Duckworth and myself, along with IAVA, Paul, VFW, a bunch of folks, are going to be out there this afternoon. We are going to introduce Act 2182. And here is what I would say is different. And this was a well-intentioned bill and well-written, except look to your right, these are the folks that helped write the bill. So Susan was in the office and making the suggestions. Look to your left, Josh was there. The Somers' suggestions are incorporated into this. And we are going out because what we have got here is, and this is I guess the silver lining. And you get tired of hearing that. There is no silver lining when your son is not coming home. But what you have done is ask for a solution. I would ask each of you as Act 2182 starts to move and Senator Walsh does it in the Senate, let us together make sure it does not end up as the Joshua Omvig Act. The Secretary had all this authority. He had it. The American people through us said do this, and they did not do it.

So I would only just state to each of you, as my colleague Mr. O'Rourke said, this is how democracy can work best. This is how we can incorporate people in it. And this idea of wringing our

hands at who could have anticipated this, really? This bill was started in 2007. It was anticipated before and here we sit in 2014.

So keep the faith, we have to. But again, I would say this. The cameras, the TV, the stuff that is there, whatever, none of it means a damn thing. If we do not get results this time then shame on us. Because here is the thing. I am not going to get to meet Daniel. I am not going to get to meet Brian. I am not going to see Clay again. But I dang sure want to see Josh. I want to see him here and forward. I want to see the rest of them. That is our calling.

So you have got the right guys up here. You have go the right commitment from the public. You have got the right folks sitting behind you writing good legislation. Now it is going to be can we do it? With that, I yield back.

The CHAIRMAN. Thank you. Dr. Benishek, five minutes. Dr. Benishek Thank you, Mr. Chairman. Well, I too would like to thank you for your courage to be here today. And please know that your efforts today will make a difference at the VA. I just really want to thank you.

Mr. and Mrs. Somers, I want to thank you too for that 15-page primer there. That had some really good ideas. And I really appreciate you all taking the effort to put together a document like that.

Mr. and Mrs. Selke, you mentioned, and I was disturbed by the comments that you found that the environment of the Houston VA was stressful. So could you elaborate on that? What specifically led to that conclusion? Have you been there since? Has it changed? Can you tell me a little bit more about that, when you described——

Mrs. SELKE. I went by myself that day and have not been back there since. For whatever reason I just compelled to go and quickly get his medical records. And I wanted to see them. And it was just, again, for ten weeks worth of care there, so there were not a lot.

You drive up to the facility. It is huge, as they all are huge. There were so many people milling around out front, big crowds, lots of people that I do not know if they were there waiting for appointments or if they, you know, just do not have anywhere else to go and hang out there. You go inside and it is, I likened it to an airport terminal, in a way. You go in and it is just a hub. Very busy, lots of people milling around, lines, the cashier lines look like in an airport where you would line up to get your tickets or something. Just, it was very stressful for me. And of course I was in a grief mode but not a Post Traumatic Stress mode. I just could not imagine. I could visualize Clay going in and I could understand why when he left that day and he called and he said, "I cannot go back there."

No one was at the information desk. You walk in the front door and they were on a break or something. But no one was there. And I looked around and finally found somebody that could direct me to where the medical records are and went and retrieved those. Before I left I just remember standing there for a few minutes and just imagining——

Dr. BENISHEK. Right.

Mrs. SELKE [continuing]. If I were a veteran, if this were Clay, how——

Dr. BENISHEK. How do you negotiate this? You mentioned another thing and that was your son had voiced concerns about the care he was receiving. Was there specific concerns that he raised?

Mrs. SELKE. I am not sure I am remembering what you are referring to.

Dr. BENISHEK. All right. Okay. Well let me ask Sergeant Renschler a question. You wrote that the combat veterans in particular often approach mental health care as hesitantly or distrustfully. How would you suggest that we change the dynamic to ensure that veterans who need mental health care feel more comfortable accessing the care?

Sergeant RENSCHLER. Yes, sir. Thank you. It kind of starts with what she was just sharing. Even at our facility we have two, Seattle, and then we also have American Lakes. Seattle is a large hospital building, not laid out very user friendly. And myself, I have a Traumatic Brain Injury that I have overcome fairly well but I get lost and confused in that place real bad and there is not a lot of friendly people there to direct me. I get better customer service at Best Buy, quite frankly. A little bit of care training would go a long way within the VA medical centers.

My other medical center closest to me is a campus with many, many buildings. And the building numbers do not even make sense, so I will be in 81 and I am told to go to Building 3, which is right next door, and Building 61 is across the campus. And the numbers make so sense, and the facility is confusing, overwhelmingly packed in and not a lot of people to help guide and navigate a very confusing situation. So for one, just recognizing who the audience of a veteran is and making an environment that is conducive to healing would be a start.

Another one would be as I discussed earlier and I keep bringing back to that interdisciplinary team, it takes rapport. It takes developing a relationship and rapport with the veteran to get him to go beyond surface level issues with a physician. I am going to go and I am going to triage myself. On active duty, especially in the infantry culture, sick call was very discouraged. And if we went to sick call you were a wuss, and you pretty much got crap for it for the rest of the day. And so we do not go to sick call unless something is debilitating in nature. And that just kind of sticks with you for the rest of your life. And so as I am muscling through ridiculous pain my wife will eventually stop and say when are you going to go see a chiropractor or get some help? And it is just that mentality of just suck it up and drive on. And that is what these guys are doing with mental health issues. And that is why when they get there it is a crisis and needs to be treated as such. And so there is a two-fold answer here. Number one, the VA needs to recognize that there is going to be a lot of crises and come back in three months is not acceptable, or come back in 14 days to intake so that you can intake in another 14 days to get treated in three months. Still not acceptable. But instead to have a team to say, hey, welcome here. This is your place. This is your team. These are the people caring for you. This is what we are going to do for you, and provide better customer service for one. But for two, develop a relationship with trust and rapport so that I can know that I can con-

fide in these people to provide the quality care that I know that they should.

Dr. BENISHEK. Thank you.

Sergeant RENSCHLER. I hope that answers it, sir.

Dr. BENISHEK. Thank you very much. I am out of time.

The CHAIRMAN. Thank you. Ms. Titus you are recognized for five minutes.

Ms. TITUS. Thank you, Mr. Chairman. Thank you all for being here. Your stories are just tragic and heart wrenching. But I hope you can take some comfort in knowing what powerful advocates you are. I mean, you have told your stories so eloquently, so orderly, so thoroughly, that it really, it will help us to move forward.

I have just been noting down some things that we need to address. And I think we are at a point where we really can make a difference. So in addition to the things that you have suggested I want this committee and the people in the room, and I ask you for your help on this, for us to address some other things that I think are also related to the problem.

First, you are obviously very loving families. You were there for your children. But many of your veterans do not have families like that. There are many homeless veterans, they are sleeping on the streets, they do not know where to go. They do not have somebody they can turn to. And so we need to figure out a way how we can address the problem for those veterans as well as for those like your children. So I want us to not overlook that.

A second thing is the VSOs are there to provide services to veterans and when they do not have that ability to bond like they do while they are in the military the VSO is there. They cannot be there 24/7 like your band of brothers and sisters can, but they are there. And maybe we need to look at some ways that we can help them to do more outreach and better fill that gap for when people come out.

Also we have heard some horror stories about the medicine and all the different drugs. I think we begin to hear that medical marijuana is a possible way to address PTSD. Let us do not leave that off the table as we move forward.

Even something as simple as the notion of companion dogs. That is something that you hear, too, that many vets, if they have a pet that helps them get through some of these troubled times. So let us keep that on the agenda. And you mentioned about being a firefighter. Let us also remember that when veterans come back they do not just need health care, both mental and physical, but they need to be able to transition into civilian life with easy access to education so some of their training counts towards college credits or employment to retrain and have jobs so they have something to look forward to that takes a little of that burden off.

So those are all things we need to look at the big picture. And I just thank you very much for committing to continue to go down this path with us. And I would ask you, too, do not leave anything off the table. Anything you can think of, no matter what it might be, now is the time for us to address it. So I do not know if you want to comment. I do not want to put you through more questions but I want you to know that that door is open.

Ms. PORTWINE. I have one more comment. I know that the VA has the emergency crisis line, 1–800–273–TALK. But I work for an insurance company and we have what we call Nurse Line. And anytime a member can call 24/7, 365 days a year. Why do we have to wait until it is a crisis for anybody to talk? When they are starting to feel depressed would be a great time for a nurse to be able to assess and triage what care this person needs. Do they need to go immediately now? Can it wait until tomorrow? Can it wait the routine three days? What do they need? I think by waiting until it is a crisis line, you are more down that slippery slope.

Mrs. SOMERS. And if I might add, we are fairly new at this whole political thing. But I came across something called the independent budget, which if I am interpreting correctly the VSOs actually put together for Congress. And I would ask that next time that comes to you, that you really look at that really, really closely. Because these are your veterans talking to you. Thank you.

Mrs. SELKE. I would like to just add quickly one of the things that Clay said over the years that sticks with me, and it just is wrong. He would say over and over, "I have to grovel for my benefits." And I just think we need to wake up as a country. Our veterans should not have to grovel for anything. And it just should not be so difficult to get the care they need, at all.

Ms. TITUS. Thank you very much. I yield back.

The CHAIRMAN. Dr. Wenstrup you are recognized for five minutes.

Dr. WENSTRUP Thank you, Mr. Chairman. And I cannot thank you enough for being here today, and the sacrifices that you have made. And I pray that the sacrifices that you and your entire family have made will make us a better nation at the end of the day. I think most that sign up to serve have that intention, that they will make this a better nation at the end of the day.

I am a physician and also a Reservist, and I served in Iraq for a year. That has led me to want to be here today. And one of the things that I know as a doctor, and I am sure Dr. Somers you can relate, that when you have patients with, and regardless of their problems, there is a level of anxiety because they have something wrong. Whether it is musculoskeletal or mental, it does not really matter. Something is wrong and there is anxiety. And it makes it even more difficult and it heightens the anxiety when you have all these administrative problems. And I know you started to deal with that in private practice, more so maybe than when you first started, where you, the prescription you think is best they are not allowed to have, those types of things just increase the patient problem and actually trying to take care of the patient. And we really are here, I will say on this committee, not just to complain but to come up with solutions. And so your input today is extremely valuable.

And one of the things I see is if a doctor is credentialed at one VA, he should be credentialed at every VA. That allows him to go from one VA to the other if there is a deficit sometime. And if your prescription is good at one VA it should be good at another VA. You can do that if your patient is out of town. You can call another state and get the prescription filled. And when you cannot, think

of the anxiety that comes with that. These are things that we can fix, and these are things we have got to fix.

And I will also contend that it is a big difference, too, being in uniform and out of uniform as far as care. As a Reservist, you know, I can just remember, you know, being with that family for 15 months. And then all of a sudden I am the last one left at the airport and going home. And when I get home they say, well, you have got 90 days to go back to work. Well, I said, that is not going to work. I am going back in two weeks. You know, I am getting my house in order and go back to work because you have to have something to go to. And so when you are just wallowing out there, and I think we need to engage, now this is the DoD side, engage on what you are doing when you go home. And have the VA be part of that as well. And we have got to blend these two systems together. We have to engage in the post-deployment activity. And so when I have been in uniform I have had the opportunity to serve in preventative medicine, and particular suicide prevention. And you know, we learn a lot, and we get a lot of training, I think, in uniform of what to look for, and have that battle buddy, and the types of symptoms you are looking for. And sometimes when the decision is made that you are going to take your life that there is a calmness. And you look for somebody giving away their stamp collection or coin collection because they have made up their mind. And they spend more time with family because they have made this decision that their problems are going away.

Those are the types of things we get. We get those in uniform but we do not get them afterwards. And for Guard and Reserve in particular, you just go home. And I did see, I have seen at Fort Lewis, for example, families being engaged with programs but that does not happen the same way with Guard and Reserve, and it is a different animal.

But I guess more than anything else what I want to do, when you want to talk about solutions, we can all be trained to look for symptoms and look for signs, but how do we go about preventing the very ideation of taking one's life? What are we doing that creates a situation where someone comes up with that ideation, that this is the best way to go? And that is the type of input we need. And that to me is really preventative medicine more than anything else. And I hope that through this we find our way. Because our suicide rate is going up in our civilian population as well. So we have a national problem here, not just a military problem.

Again, I applaud all your input. It is extremely helpful to us. And as you have seen, this is a determined group here that wants to make a difference in the history of our nation as we move forward. And we are glad to have you as a part of it. So your input is always welcome, and thank you for commitment. And I yield back.

The CHAIRMAN. Thank you, doctor. Ms. Sinema you are recognized for five minutes. Check your microphone, there you go.

Ms. SINEMA. Thank you, Mr. Miller and Mr. Michaud, for allowing me to participate in today's hearing. And a special thanks to my colleague from Arizona, Ms. Kirkpatrick, who represents our state's veterans so well on this committee.

I want to thank all of today's panelists for joining us. In particular, thank you to Daniel's parents, Howard and Jean for being

here. We worked together quite closely since learning of Daniel's suicide and it is an honor and a privilege to be here with you again today.

Unfortunately Daniel's story and the story of the other young men who committed suicide is just all too familiar in our country, and 22 veterans a day are still committing suicide even after we have heard the tragedies of the young men who lost their lives here, and their brothers all across this country. And as we heard from Mr. Walz, Congress has addressed this issue before, has passed legislation before, has said they were going to fix it before. And yet the problem has not only not gotten better, it has gotten worse.

I have heard a lot of testimony today about ideas to actually reform the system and make it better. The HIPAA issue I think is one that the committee would agree needs to be addressed. I am particularly interested in the pilot program that Sergeant Renschler participated in. And my question to Dr. and Jean Somers would be about Daniel. Daniel's experience at the Phoenix VA, like many, many veterans' experience at the Phoenix VA, was one of lack of concern, lack of care, lack of follow through, and a discombobulated system that did not allow veterans to get the care they needed. In particular one of the struggles Daniel faced was as an individual who had served in classified service, he was unable to participate in group therapy because he was not able to share the experiences he experienced while in service. And yet at the Phoenix VA he was unceremoniously put into group therapy. And when requested private therapy was not able to get that care. And of course, as we know, he took his own life as a result of being unable to get that care.

The medical home model I believe in the private community has provided an opportunity to create patient centered care and allow civilians to get the care they need in one home, easily, that is centered directly on their needs. While the pilot program in Washington was ended because of, well I do not understand why. They said they did not have enough money for it, which I think is outrageous and a horrible, horrible reason to stop providing care that we know is effective and appropriate. My question for Dr. and Jean Somers is whether you believe a medical home model would work or could be helpful to veterans like Daniel? We know that many of our Post-9/11 veterans face co-occurring disorders, PTS, TBI, anxiety, depression, physical maladies. Would a medical home model have been a model that may have worked better for Daniel than what he faced?

Mrs. SOMERS. Absolutely. As Daniel's irritable bowel syndrome worsened, he did not feel he could physically leave the house. I cannot imagine that embarrassment. And then as Howard mentioned at the time Phoenix has the speed traps set up on the major highway to get from his home to the Phoenix VA so he actually had to find a way to get off of the highway so that the flashing lights would not affect him. So absolutely. I can see that it would have been very helpful to him just to have the privacy capability.

Dr. SOMERS. I completely agree. I think not only the medical home model but what we talked about, the ability within the facility for the different people. Because of his IBS and his TBI and his

PTSD, you are being treated, as we learned here, the term being in silos. And what you have to do is you have to get out of the silos and you have to combine resources, combine knowledge. And we have heard of programs such as was mentioned that are very successful where people can have problems and for whatever reason have an optometrist or an ophthalmologist in there. And they say, well, you know, it sounds like it is not this, but it is this, and something that you might not have thought of. So the medical home model, the ability to create these panels of care, I think anything like that would be overwhelmingly positive.

Ms. SINEMA. Thank you. And Mr. Chair, while Dr. Benishek has already left I do want to take a moment just to thank him for cosponsoring legislation that we drafted with the Somers specifically to address the issue of servicemembers who served in classified settings and who need appropriate care when they return to the VA. And I want to thank the subcommittee and the committee for supporting just a part of the solution to this issue. Thank you. I yield back my time.

The CHAIRMAN. Thank you very much. Mr. Bilirakis, you are recognized for five minutes.

Mr. BILIRAKIS. Thank you, Mr. Chairman. I really appreciate it. And I appreciate the panel testifying, and I appreciate your courage.

I want to ask about alternatives to medication and I want to ask the entire panel. Which alternatives do you believe the VA could consider in addressing the mental health issue? I realize that you have to have some medication in most cases prescribed, but I am familiar with the recreational therapy. The chairman and myself participated in a field hearing not too long ago on recreational therapy, the equine therapy. In my district they have Quantum Leap Farms, I know they are all over, they travel from all over the country to go to Quantum Leaps. The service dogs do wonders, I understand, from talking to veterans, just to name a few. But can you maybe elaborate a little bit, whoever would like to, with regard to the alternatives to the medication for mental health therapy, PTSD, TBI, what have you? Please, thank you.

Ms. PORTWINE. Yes. Brian had a brother that came back and he had PTSD and he had a friend that was doing some gardening. So he started just working in gardening with him. Pretty soon they realized they really liked it and their garden was pretty good, so they decided to make it bigger. Then they thought, well let us take these vegetables and take it to market and see if we can sell them. And so now they have this huge area and they do this. I have also heard of veterans going on farms, because there is not loud noises and flashing lights and the, you know, the sound issues that they have with PTSD. So those are two others.

Mr. BILIRAKIS. Thank you. Anyone else, please?

Sergeant RENSCHLER. We, I mean, we could just put together an extensive list of what veterans use to cope with these things outside of medications. Motorcycle riding, bike riding, equine therapy, service animals. I mean, it just, the list could go on and one. And that is, I would rather stress the importance of the fact that there is no one solution. And until the VA can get to implementing best practices systemwide and tailor fitting to each individual veteran's

needs, and using these known best practices that exist out there, until they can do that we are not going to be able to fix anything. I mean, we can put policy in place saying that you have to provide access to these individual treatments that exist. But it is the implementation of that policy that is the major issue here. And yes, I mean there is, the list is extensive.

Mr. BILIRAKIS. Thank you very much. And definitely, one size does not fit all. Anyone else?

Mrs. SOMERS. I would like to weigh in on that. That we hear a lot, a lot of the excuses that we heard at Phoenix was it has to be evidenced-based treatment. And how do you get innovative therapy if everything has to be evidence-based before they will use it? I think they need to open up their minds a little bit and think outside the box. As you have heard, not every therapy works for every person. Everything does have to be individualized. And you know, I have heard of gardening before, too. You know, as being very therapeutic for people. I think it just, they need to get out of the mentality that this is all we can do, we have these blinders on.

Mr. BILIRAKIS. Thank you very much. The bottom line is, we need to listen to the vets, just like you said. Anyone else, please?

Mr. SELKE. I think it is, again to use the word holistic, it is a community, it is a lifestyle sort of approach. I mean, the VA needs to do what the VA needs to do the best way the VA can do it, but the VA cannot do everything. So there is a lot of, I mean, Clay kind of put together his own kind of therapy program. He got involved in service. That was helping him. He got involved with IAVA, you know, Storming the Hill, and their community. He got involved with Team Rubicon doing disaster relief programs. He got involved with Ride to Recovery riding bikes, and that was great for him to be able to heal but it was also great for him to be there to help his brothers and sisters heal. The problem, you know, for whatever reason when a person decides to take their life, they have given up hope. So what do you do about that? And Clay could do everything. He could go on these, you know, on these missions, and he could do one-week bike rides. But what got him was being alone, in his apartment, by himself, hopeless. And there is questions and matters of faith there, but it is a community approach. People need to come to government and volunteer organizations. Partner. No one organization, not even the government, can do it all. And everybody needs to realize that and come together and take care of these folks.

Mr. BILIRAKIS. Thank you so very much. I yield back, Mr. Chairman.

The CHAIRMAN. Mr. Jolly, you are recognized for five minutes.

Mr. JOLLY. Thank you, Mr. Chairman. I want to associate myself with the comments of Mr. Bilirakis and Ms. Titus about alternative therapies. I think we know they work. Clearly they do. And Mrs. Somers, I appreciate your comment about evidence-based. I am not a doctor but I have seen evidence that non-drug therapies work. And to me that is good enough, and if it is good enough for the veteran, it should be good enough for the VA.

I want to talk a little bit about the VA acknowledgment of non-drug therapies and your experience with that, understanding every case is going to be different. I hosted a VA intake day recently. We

had about 300 people come through my congressional office in the district. One man brought a backpack that he turned upside down on my desk and he dumped out surplus medications, dozens and dozens and dozens of bottles of them. Sergeant, you referred to your cocktail going from 11 drugs to 14. Mrs. Selke, I think you expressed some concerns about Ambien. The Somers have expressed concerns about the use of generics and otherwise. Just on its face, do you lack confidence in the way that VA administers pharmaceuticals? Not on the merits of pharmaceuticals, but in the experience of pharmaceutical use as administered and directed by the VA?

Mrs. SELKE. I mean, I will speak to that. I spoke earlier about the difficulty of Clay getting a prescription refilled. But what has been said before, in the private world if I go to a doctor and they determine I need Synthroid for my low thyroid issue, I got and I get Synthroid and I stay on Synthroid as long as I am retested and that is shown to be effective. I do not understand why the DoD and the VA have two different pharmaceutical programs and the veteran has to suffer the consequences when you separate from the service and move to VA, especially on mental health drugs. You cannot swap them out and stop cold and all of that. Or even on anything physical. It makes no sense to me. I do not understand why one system would not work for both. Why not whatever works for DoD as far as pharmaceutical medications or anything, why does the VA have to be different? It sounds to me like it is a cost factor.

Mr. JOLLY. And I——

Mrs. SELKE. We have to shift to the cheaper route. Well we have people dying everyday because we have switched to the cheaper route.

Mr. JOLLY. And I ask, and I realize very much this is just a matter of personal impression and not clinical. But my concern having heard each of your stories is that simply because of the volume of patients, that million-plus volume of mental health patients, the 21,000 employees, you have raised concern about personalized care. And it would seem to me there is, that is clearly lacking. I do not know what your impressions would be? If you could speak to that? And also, simply whether or not alternative therapies have ever, did your sons have that discussed perhaps? Or Sergeant, in your counseling the ability to get alternative therapy? And I say that based on a personal experience as well. At VA intake day I had a man in my office who said, "Equine therapy works." Well that was good enough for me. But it was not good enough for the VA. So can you speak to any discussions about alternative therapies, availability of, your opinions to that?

Sergeant RENSCHLER. Yes, sir. So again within the VA medical center they had at one point in time available to polytrauma patients or those who suffered from comorbid conditions, we were able to access recreational therapy and I was put on a six-month waiting list. And when the six months came up they lost the recreational therapist, so that was my only experience there. I never had a chance to engage in that because I was downgraded from polytrauma care when the VA determined that my Traumatic Brain Injury had reached a plateau of recovery and it probably

would get better. That is a completely separate hearing day. But as far as the efficacy of alternative therapies, I mean we could, again, it is, it really helps. And the VA currently——

Mr. JOLLY. The availability?

Sergeant RENSCHLER. The availability is not there through VA channels. It is private community, is where you have to go.

Mr. JOLLY. All right. Dr. and Mrs. Somers., do you——

Mrs. SOMERS. Yes, I would agree with that, that it is. Daniel himself was a musician so it was easy for him. He got a piano and a guitar and that was his therapy. But I would totally agree with that. At the San Diego VA I know they have pottery classes, which we were thrilled to hear about, and a guitar program.

Dr. SOMERS. And when you talk about evidence-based it is certainly not just medications. I mean, there are these psychological treatments that are out there but they are only using two of them at this time when there are so many other potentials out there. And the other thing that we had mentioned was the MDMA ecstasy and LSD for pain, the MDMA for PTSD and LSD for pain. And because of our national phobias against these particular chemicals, we are making it very difficult to do trials with these potential, potential benefits.

Mr. JOLLY. All right. Thank you very much. Thank you to each of you. Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much, members. We thank the witnesses for participating. Whether or not you know it, you have been at that table for three hours. And we are very thankful that you have been willing to share your stories with us. So with that, thank you very much, and you are excused.

Members, what we have done is we have asked the second and third panels to combine together. So we will have them appear at the witness table together instead of having a second and third separate panel. So I would like to invite the witnesses to please come forward.

Joining us at the table will be from VA Dr. Maureen McCarthy, Deputy Chief Patient Care Service Officer. She will have Dr. David Carroll, the Acting Deputy Chief Consultant for Specialty Mental Health with her at the table. Our third panel includes Alex Nicholson, the Legislative Director for the Iraq and Afghanistan Veterans of America; Lieutenant General Martin Steele, the Associate Vice President for the Veterans Research, the Executive Director of Military Partnerships and the Co-Chair of the Veterans Reintegration Steering Committee for the University of South Florida; also Warren Goldstein, the Assistant Director for TBI and PTSD programs for the American Legion's National Veterans Affairs and Rehabilitation Commission; and Dr. Jonathan Sherin, the Chief Executive Officer and Executive Vice President for Military Communities for Volunteers of America. Thank you all for being here. And Dr. McCarthy, you are recognized for your opening statement.

STATEMENT OF DR. MAUREEN MCCARTHY

Dr. MCCARTHY. Thank you. Good morning, Chairman Miller, Ranking Member Michaud, and members of the committee. I appreciate the opportunity to discuss the Department of Veterans Af-

fairs mental health care and services for our nation's veterans. I am accompanied today by Dr. David Carroll, Acting Deputy Chief Consultant, as you mentioned; and Dr. Harold Kudler, our Acting Chief Consultant for Mental Health; and Mr. Michael Fisher, from the Readjustment Counseling Services have joined us as well.

Let me begin by expressing my sorrow and regret to the families of Daniel, Clay and Brian. I want to thank you for coming forward and telling your story and their stories. We truly believe that one death by suicide is one too many. Thank you, Joshua, as well for sharing your experiences. Veterans who reach out for help deserve to receive that help. A veteran in emotional distress deserves to find there are no wrong doors in seeking help. In VA we must ensure those doors are swiftly opened, calls are returned, messages are responded to promptly, efficiently, and compassionately.

Over one million veterans, servicemembers, and their family members have called our crisis line and received help. Suicide rates among those who are VA users who have a mental health diagnosis have decreased. The rates of suicide following a suicide attempt have likewise decreased. We invite veterans to entrust their care to us and we want to ensure them that we can provide them the care they need or connect them with someone else who can.

Tragically it is true that about 22 veterans per day die of suicide. But another tragedy is five of those 22 veterans are veterans who have been in our care. We acknowledge that we have more work to do and we are fully committed to fixing the problems we face in order to better serve veterans.

Our actions include the deployment of mobile Vet Centers with locations with the greatest challenges in providing timely mental health care. Examples include El Paso and Phoenix. We have begun a program to ensure veterans waiting more than 30 days for care may receive mental health care in the community from providers who are not VA employees. We have removed access measures but not expectations about access and are focusing on veteran satisfaction with the timeliness of care they have received. We have initiated Operation SAVE, a training program for suicide prevention delivered by our suicide prevention coordinators to VHA and VBA staff. We have provided suicide risk management training to clinicians. This is a VA-mandated training for all VA clinical staff which teaches about assessment, warning signs, risks, means restriction, and safety plans. And we have developed a web based training for clinicians specifically focusing on women veterans who are struggling with suicidal thoughts about how to recognize their distress and bring them into treatment.

Our actions taken to meet the increasing demands for mental health care include the addition of over 2,400 mental health professionals and 915 peer support providers since March of 2012. We have expanded the Veteran Crisis Line services, renamed it from a suicide line to a crisis line to reach out specifically to those in crisis or not quite yet in crisis, and offer both text messaging and an online chat service in addition to receiving phone calls. We have partnered with the Vet Center Combat Call Center to respond to veterans in distress. We have greatly expanded opportunities to access mental health, including in rural areas, by telemedicine. We have developed mobile apps to assist veterans with their symp-

toms. We have developed an addition focus on improving and coordinating with care in the community for those who may not seek our help. We have trained community providers on military culture and partnered in community engagement. We have partnered with the Department of Defense in developing clinical practice guidelines for suicide risk assessments and intervention, and for the care of PTSD, depression, and substance abuse. We also reach out to Guard and Reserves at demobilization events to bridge the gaps in understanding about benefits and services. We have greatly expanded the provision of evidence-based treatments, including psychotherapies for mental health conditions. VA is committed to working with families and friends of veterans.

We know mental health outcomes improve when families are involved in care. We now have a family services continuum that includes family education, consultation, psychoeducation and marriage and family counseling, and research remains underway to address improvement of mental health care and prevention of suicide. To maximize what we can provide, we have developed measures of provider productivity, integrated mental health care into primary care settings and initiated several campaigns to break down any barriers or stigmas that may be associated with seeking help.

We have developed a program on college campuses where student veterans may receive needed mental health care without leaving the campus.

Mr. Chairman, we are fully committed to ensuring accessible mental health care of the highest quality for our servicemembers and veterans who have sacrificed so much on our behalf. We are committed in our efforts to decrease suicide by decreasing risks we can identify and focusing meanwhile on improving the quality of life for these veterans. VA will continue to provide care in a veteran-centered manner, expanding access and breaking down barriers associated with seeking help. We are compassionately committed to serve who have served making it easier for them to ask for and receive the help they need.

Mr. Chairman, this concludes my testimony. My colleagues and I are prepared to answer your questions as the panel proceeds.

[THE PREPARED STATEMENT OF DR. MAUREEN MCCARTHY APPEARS IN THE APPENDIX]

The CHAIRMAN. Mr. Nicholson, you are recognized.

STATEMENT OF ALEX NICHOLSON

Mr. NICHOLSON. Thank you, Mr. Chairman, Ranking Member Michaud, and Members of the Committee. On behalf of the Iraq and Afghanistan Veterans of America, we really appreciate the opportunity to share with you our views and recommendations recommending mental health access at the VA and suicide prevention efforts.

Combatting veteran suicide is IAVA's top priority for 2014 and it is a critically important issue that affects the lives of tens of thousands of servicemembers and veterans, especially of the wars of Iraq and Afghanistan. In IAVA's 2014 member survey, our members listed suicide prevention and mental health care as the number one issue facing our generation of veterans. In that same sur-

vey that was just conducted in February and March of this year, 47 percent of respondents reported that they knew an Iraq or Afghanistan veteran who had attempted suicide and over 40 percent knew and Iraq and Afghanistan veteran who had died by suicide. We have over 270,000 members. Forty percent of them know someone who is a fellow veteran of Iraq and Afghanistan who has died already by suicide.

In response to the overwhelming need for action, IAVA launched the campaign to combat suicide this year which includes a call to pass comprehensive legislation that can serve as a cornerstone for additional efforts across government and across the country. In addition to legislation, IAVA is calling on President Obama to issue an Executive Order to address additional aspects of suicide prevention efforts and IAVA is working to connect more than one million veterans this year with mental health services across the country.

The need to examine mental health services and suicide prevention efforts provided to veterans is even more critical in light of the recent VA scheduling crisis. In addition to the general delayed access to care that veterans are experiencing, as I am sure all of you know, investigations have also uncovered cases of significantly delayed access specifically to mental health care. While no veteran should have to wait months for a medical appointment of any kind, veterans utilizing mental health care services and especially those who are in crisis should never had to wait an unreasonable amount of time to be seen by a mental health care provider. Providing timely and efficient mental health care must be a much greater priority for the VA moving forward.

Increasing the accessibility of mental health services must also be coupled with increasing access to care for vulnerable populations of veterans currently excluded from VA care. Between 2001 and 2011, an estimated 30,000 servicemembers may have received a downgraded discharge characterization due to a misdiagnosis of personality disorder. Even more troubling, an unknown number of servicemembers were punitively discharged for disciplinary actions that may have been connected to an undiagnosed mental health injury. It is imperative that the thousands of individuals with such experiences are identified and their records are properly re-evaluated and rectified in order to provide access to earned VA mental health services and benefits.

Examining access to care should also include a review of the current five-year special combat eligibility for VA health care provided to recently transitioned veterans. The five-year time period may not be enough time for veterans who present with mental health injuries symptoms later or who might delay care due to concerns with stigma of seeking care. Extending special combat eligibility, though it may be costly, will provide access to care for veterans when they are ready to seek it. It is important to recognize the efforts the VA has put into mental health services and suicide prevention programs in recent years, and especially, as has been mentioned already, the Veterans Crisis Line has been an enormous resource for our community and the VA has done a terrific job of promoting that and we have been happy to partner with them in helping them promote that, disseminate that, and we refer veterans in crisis to the Veterans Crisis Line through our Rapid Response Re-

ferral Program every single day. It has been a fantastic resource, but more, of course, needs to be done. Increasing access to care, meeting the demand of that care, and providing high-quality care with continuity and responding to veterans in crisis requires a comprehensive approach, and while there is no illusion that veteran suicide will be completely eradicated, implementing better approaches to mental health care and suicide prevention can and does save lives.

Again, we appreciate the opportunity to share our views on this topic and we look forward to continuing to work with each of you and your staff and the Committee to improve the lives of veterans and their families. Thank you.

[THE PREPARED STATEMENT OF ALEX NICHOLSON APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, Mr. Nicholson.

Now, General Steele, who is the co-chair of the Veterans Reintegration Steering Committee at the University of South Florida, you are now recognized for five minutes.

STATEMENT OF GENERAL MARTIN R. STEELE

Lieutenant General STEELE. Thank you, sir.

Chairman Miller, Ranking Member Michaud, distinguished Members of the Committee, on behalf of the University of South Florida, thank you for holding today's oversight hearing. By way of a brief background, the University of South Florida is a global research university with over 47,000 students, including over 2,200 veterans and their families. Military Times EDGE magazine recently ranked USF the fifth best college for being veteran-friendly in the United States out of 4,000 colleges and universities.

Under the leadership of our president, Dr. Judy Genshaft and our Senior Vice President for Research and Innovation, Dr. Paul Sandberg, numerous USF researchers are currently involved in funded studies related to such topics as: suicide prevention, traumatic brain injury, post-traumatic stress, robotics and prosthetics, speech pathology and audiology, gait and balance, and age-related disorders. We have numerous research and health care partnerships through affiliation agreements to include the James A. Haley Veterans Hospital, the largest polytrauma center in the VA system, along with the C.W. Bill Young VA Medical Center, number four in the system, located in St. Petersburg. We have memorandums of understanding with United States Central Command, U.S. Special Operations Command, and work closely with MacDill Air Force Base and the Pentagon.

Our Veterans Research Reintegration Steering Committee consists of scientists from throughout USF's faculty, staff, and students who work with veterans, along with representatives from the Veterans Administration, the Care Coalition of Special Operations Command and Draper Laboratories. We have a holistic approach in regards to education to provide services to our veterans and their families.

In order to address the mental health needs of our veterans and our diverse population of at-risk students, we have embarked on a Collaborative Suicide Prevention Project. This is a three-year ini-

tiative funded by a $306,000 grant from the Substance Abuse and Mental Health Services Administration, SAMHSA. Some of the goals and measurable objectives of this project are to increase the number of persons involved in suicide-prevention efforts, reduce the stigma associated with it and the barriers, and increase family involvement in suicide prevention.

As you are aware, the Blue Ribbon Panel of the VA Mecical School Affiliations was established in 2006 to look at quote, "A comprehensive philosophical framework to enhance VA's partnerships with medical schools and affiliated institutions," unquote. The panel believed that the crisis in the U.S. Health Care System offered a unique opportunity to explore fundamentally new and better models of patient care, education and research. As the panel revealed, currently available mechanisms for meaningful dialogue between the VA and academic community were inadequate. Some of the major challenges include credentialing, as was mentioned earlier, which requires considerable time, along with the research approval process, which is cumbersome, very time-consuming for both parties. The process takes months, and in some cases can take over a year just for approval.

There are also many barriers to innovation. One of our professors, has an innovative approach for the treatment of post-traumatic stress and is highly unlikely, we believe, to receive approval by the VA health care facility. The protocol known as Accelerated Resolution Therapy, or ART for post-traumatic stress, has been shown to be effective in published research from the University of South Florida, yet the VA has not accepted invitations to collaborate on a pilot study for patients diagnosed with PTS. We do work with the Department of Defense. I have been at Fort Belvoir in Virginia and Fort Benning in Georgia and also Special Operations Command in Tampa to work with this protocol which has been proven very successful.

We recommend streamlining the credential process and creating fast track approvals for collaborative pilot studies between VA and University research studies that involve minimal risk to the patients, but could provide significant benefits to treatment of mental disorders. We also are recommending developing agreements between the VA system at the national level and academic communities throughout the country. We also believe the very definition of academic affiliates needs to be re-examined to move beyond the limited focus on health care to a much more encompassing venue which would include employment, education, business development, enhanced use/lease relationships, and increased researched funding.

In 2012, a VA research scientist from USF, along with a research scientist from the medical research service at James Haley, conducted a pre-clinical animal research linking post-traumatic stress, mild TBI, and the potential for suicides in the military. We believe their research needs to be extended to learn more about how the brain is affected by physical and emotional trauma. More importantly, we believe this type of animal research will lead to more effective treatments for post-traumatic stress and TBI, which will potentially reduce the risk of suicide in our military and veteran population and could be influential in alternative drug protocols.

The 2006 blue ribbon panel also noted, with concern, the aging VA's research infrastructure. The panel recommended that VA enhance its research facilities by fully exploiting opportunities to share core resources with its academic affiliates. To that end, the University of South Florida recommends strong consideration of the development of a singular, unique, one-of-a-kind research and clinical outpatient treatment facility. This initiative is intended to be a collaborative venture between the Department of Defense, the Veterans Administration and USF in order to meet the health and welfare needs of our veterans and their families.

USF remains committed to providing the nexus to foster research collaborations in pursuit of excellence in the rehabilitation, adjustment, resilience, and reintegration of wounded warriors and their families into civilian life. Our nation's dedicated heroes, from all wars, deserve to have the benefit of the best research and services available in order to return to productive lives and members of our society with jobs and homes for the sacrifices that they and their families have made for our country.

Thank you, again, for holding this hearing and the opportunity that I have to submit this testimony, sir.

[THE PREPARED STATEMENT OF GENERAL MARTIN R. STEELE APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you, General.

Mr. Goldstein, you are recognized for five minutes.

STATEMENT OF WARREN GOLDSTEIN

Mr. GOLDSTEIN. Thank you, Mr. Chairman.

Every day in America 82 people take their own life. That is one every 17 and a half minutes. Since this hearing began over three hours ago, statistically, 12 people have chosen to end their life with suicide. One in four suicides is a veteran. Twenty-six percent of suicides are veterans and veterans only make up seven percent of the population.

The stakes could not be higher. We must find a solution to this problem. Chairman Miller, Ranking Member Michaud, and Members of the Committee, on behalf of our National Commander, Dan Dellinger, and the 2.4 million members of The American Legion, I thank you for taking one of the most serious challenges facing America's veterans: finding solutions for this mental health crisis.

The mental health of veterans is something that The American Legion takes very seriously. The American Legion established a committee on TBI and PTSD in 2010 because of growing concerns of the unprecedented numbers of veterans returning home with what has come to be called the signature wounds of the war on terror. Since then, Legion staff, alone with senior leadership has met regularly with academia, medical consultants, experts in the field of mental health and brain science. We published the findings of our comprehensive three-year study of veterans, their treatments and therapies, in a report called The War Within, which is also available on our American Legion website.

Following up on that report, we recently conducted an on line survey to evaluate the efficacy and availability of treatments and what we found was somewhat disturbing. The result of the survey,

conducted in coordination with the Data Recognition Corporation, showed that nearly a third of veterans surveyed had terminated their treatment plans before completion and that almost 60 percent of veterans reported no improvement or feeling worse after having undergone treatment.

Clearly, there are problems with the current practice in place. The American Legion convened a symposium last month to discuss these findings and highlight other areas where complimentary and alternative treatments could prove helpful. We listened and saw firsthand the encouraging results for veterans who had benefitted from animal therapies with service dogs, art therapies, acupuncture, and a host of other non-traditional treatments. The American Legion believes that by exploring options such as these, we can all work together to help veterans get the effective treatments they need.

It is devastating when a veteran cannot get timely appointments, but 60 percent of veterans reporting no change or worsening symptoms after treatment means that what care they are getting is just as important as whether or not they can access the care in the first place. This is not to say that access does not matter. Indeed, over the past several months. The difficulties veterans face, access to care, have been front page news and have been a major focus for this committee.

For The American Legion, it wasn't enough to sit and watch idly as veterans struggled to get help; we had to go do something about it. That is why The American Legion developed Veterans Crisis Command Centers that have been deployed across the country, and specifically where it had been reported that veterans were being stonewalled while trying to seek care. By utilizing American Legion posts already located in every community in America, The American Legion has combined town hall meetings and coordination of care for veterans so they can get the immediate counseling and medical help they have earned and desperately need without getting in the way of VA's on-going efforts.

We are there to assist VA's efforts and to be a force multiplier. So far, Phoenix, Arizona; El Paso, Texas; and Fayetteville, North Carolina, we have been able to reach nearly 2,000 veterans and next week we will expand operations to two new locations in St. Louis, Missouri and Fort Collins, Colorado, with more locations to follow as we try to get help to veterans.

Yes, there are things VA should be doing to ensure veterans in crisis get the help they need, but we now see that our veterans can't just depend on VA to fix the problem, that is why The American Legion has full-time staff and a leadership committee dedicated to studying the challenges of mental health treatments to ensure the way America treats veterans is a way that will bring real improvements to their lives. And that is why legionnaires, veterans, VA, and local businesses across the country are supporting our Veterans Crisis Command Centers and donating their time and efforts to link the veterans with the resources they need.

By the time this panel finishes our opening remarks, America will have lost another person to suicide. That is a terrible tragedy. We all have to work together to ensure that this rate cannot and will not continue. Thank you.

[THE PREPARED STATEMENT OF WARREN GOLDSTEIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you.

Dr. Sherin, you are recognized.

STATEMENT OF DR. JONATHAN SHERIN

Dr. SHERIN. Thank you. Thank you Chairman Miller, thank you Mr. Michaud, and Committee for convening today and for inviting me to today.

My name is John Sherin. I am a psychiatrist and neurobiologist by trade and currently serve as the executive vice president for military communities and chief medical officer at Volunteers of America. While I am not a veteran, my life's calling has been to serve veterans. Having worked for a decade at VA as a psychiatrist and chief of mental health prior to joining VOA, I have been able to observe the VA from both the inside and out. This experience has given me a unique perspective as to the nature of access problems facing veterans and possible solutions.

In general, I contend that the most immediate solutions reside in growing capacity through more robust partnerships between VA and local communities. Working alongside VA last year, VOA supported and housed more than 10,000 homeless veterans, a number that will increase this year. Though significant, the opportunity for impact in partnership with VA is much larger and can include helping veterans at risk of watching their unmet needs become urgent problems that evolve into health crises due to inadequate access. The VA has a golden opportunity to lead this effort right now by leveraging organizations like VOA to grow capacity and improve access.

In contemplating partnership strategies, it is important to recognize that access barriers go way beyond wait times. Red flags in isolation and inadequate knowledge of available resources and unwillingness to engage in the help-seeking process, difficulty navigating complex systems and lack of care coordination all impact access. Recognizing this array of access barriers, VOA has developed the Battle-Buddy-Bridge program, a program rooted in trust and designed to mitigate access barriers through real time, peer-to-peer engagement and local resource navigation.

Peer approaches, which are used by other organizations, including the Augusta Warrior Project, Team Red, White & Blue, IAVA, The Mission Continues, Team Rubicon, and others, transform the access dynamic in many cases. As such, it is my first recommendation that community-based peer-engagement and navigation programs be brought to scale with federal support as part of all out assault on access barriers at the VA and beyond. Leveraging this model further, my second recommendation is for the VA and the private sector to set up rally points in communities, as well as on VA campuses that are endowed with trained peers, vehicles, resource maps, and tightly linked to VA's Suicide Prevention Program, the national crisis hotline, 2–1–1 exchanges, tech-based veteran community portals such as POS REP, and any other referral sources of relevance. Rally point networks could have a profound impact on access in any geography.

As a final point, I want to highlight a major partnership success story, the Supportive Services for Veteran Families Program of the VA. This program administered by VA's National Center for Homelessness Among Veterans has fostered relationships between VA and communities that are unprecedented. In the opinion of many experts in both the community and the VA, the streamlined structure of SSVF offers the best means for managing partnerships going forward.

As such, my third and final recommendation for resolving mental health access issues and improving suicide prevention going forward is for the VA to adopt an SSVF-like mechanism as the basic template for VA to use in developing more robust relationships. By using this mechanism, VA can most effectively leverage partners to create community-driven programs that improve access to the vast array of resources which address mental health conditions.

To close, more robust partnership between the VA and community will not only help veterans enrolled in VA to get better access, it may also help veterans—it may also help provide access to veterans who refuse to enroll in the VA, as well as veterans who are located in remote areas. Let's all take advantage of recent findings at VA and recognize that while inadequate access to care in the veteran population reflects the shortcomings of a federal agency, it also reflects the fundamental failure of the American community and process.

It is time to roll out a new era of public, private partnership that grows capacity and ensures veterans have access to the resources they need for successful community reintegration.

[THE PREPARED STATEMENT OF DR. JONATHAN SHERIN APPEARS IN THE APPENDIX]

The CHAIRMAN. Thank you very much, Doctor.

Dr. MCCARTHY., On Tuesday evening this committee heard from a whistleblower that was a former chief of psychiatry at the St. Louis VA Medical Center. Are you aware of his testimony?

Dr. MCCARTHY. I am aware of it, yes, sir.

The CHAIRMAN. Okay. He stated he could not identify, within his clinic, the average number of patients that are seen by provider per day or the time a provider spends on direct patient care per day. When he asked other psychiatry chiefs to estimate similar data at their facilities, he received answers that ranged from 8 to 16 veterans per psychiatrist per day.

When he worked with a VA database administrator and his outpatient psychiatry director, he said he was shocked to find that outpatient psychiatrists at the St. Louis VA were only seeing on average six veterans within eight hours for 30 minute appointments. There were only three 60 minute appointments of those each week and he could only account for three and one half hours of work during an eight-hour day.

So, as we have already heard people talk about a nationwide shortage of mental health providers, do you feel that the utilization of staff at VA is appropriate?

Dr. MCCARTHY. Sir, that is why we have what is called the SPARQ tool. This is something that has been developed as part of our physician productivity model. We can look at psychiatrists——

The CHAIRMAN. I am sorry, my question is: Do you think that utilization of staff at this level is appropriate?

Dr. MCCARTHY. I do not believe that what you said is an appropriate way to use staff; however, I have data that supports that that may not be the full story.

The CHAIRMAN. Do you know what the mental health staffing is and productivity requirements throughout the system?

Dr. MCCARTHY. I know the model, which is in terms of the number of psychiatrists and given population of veterans——

The CHAIRMAN. Whose model?

Dr. MCCARTHY. It is our model, sir.

The CHAIRMAN. VA's model?

Dr. MCCARTHY. Yes, sir.

The CHAIRMAN. Should we be using what VA wants now or should we be looking outside of VA?

Dr. MCCARTHY. It seems like there may not be a right answer to your question, but I can tell you why the model developed. It is a team-based model of care——

The CHAIRMAN. From VA?

Dr. MCCARTHY. Yes, sir.

The CHAIRMAN. Okay.

Dr. MCCARTHY. And——

The CHAIRMAN. Do you know what the health staffing and productivity requirements are throughout the system?

Dr. MCCARTHY. We have a quadrant-type model which looks at productivity and other measures to determine if we are staffing appropriately.

The CHAIRMAN. Do you know what the standard is?

Dr. MCCARTHY. Okay. Help me understand.

Are you asking how many work RVUs per physician, per day—is that the kind of question that you would like me to answer?

The CHAIRMAN. I guess that is good enough.

Dr. MCCARTHY. Okay.

The CHAIRMAN. Do you?

Dr. MCCARTHY. I don't have the exact expectations of the——

The CHAIRMAN. The other question is: Is VA meeting the standards?

Dr. MCCARTHY. Sir, I can answer that question. If we look at our work value units compared to the national average for physicians who are psychiatrists, as well as psychologists, we are meeting the national average for productivity according to that standard.

The CHAIRMAN. According to whose numbers? Are those numbers that VA establishes or——

Dr. MCCARTHY. No, they are external.

The CHAIRMAN. No, no, I am talking about internal numbers.

Dr. MCCARTHY. Okay.

The CHAIRMAN. Are your folks reporting the truthful number?

Dr. MCCARTHY. Sir, what that model is based on is the actual encounters that occur.

The CHAIRMAN. No, no. Are your folks telling the truth?

Dr. MCCARTHY. Yes, sir.

The CHAIRMAN. Everywhere?

Dr. MCCARTHY. I can't answer a question like that, sir. But about the model, I can tell you that the numbers are driven from a system that couldn't be manipulated.

The CHAIRMAN. Based on what we have seen over the past three or four months, do you trust the numbers that people are giving?

Dr. MCCARTHY. If you ask me about access numbers, I don't, and I think there has been evidence before this committee that shows that access numbers are not reliable.

The CHAIRMAN. And so—but you think the other numbers are reliable?

Dr. MCCARTHY. There are some numbers that are reliable, yes, sir. I have been looking for numbers that we can try and understand measures of our access and timeliness of care and we have, for instance, numbers of consults that——

The CHAIRMAN. Let me ask you a better question: Would you bet your life that the numbers that people give you are truthful?

Dr. MCCARTHY. I am sorry, sir. Are you talking about numbers related to productivity?

The CHAIRMAN. I don't care what the number is. Would you bet your life on any number that somebody gives you as a truthful number because we just had a panel of witnesses who have lost their children. They lost their lives.

Now I am asking you: Would you bet your life that the information that people are telling you is truthful?

Dr. MCCARTHY. Sir, I would not. I would not bet my life——

The CHAIRMAN. That is all I need to hear.

Dr. MCCARTHY. [continuing]. That the access numbers that you received are truthful.

The CHAIRMAN. That is all I need to hear. Thank you very much.

Mr. Michaud.

Mr. MICHAUD. Thank you very much, Mr. Chairman.

Dr. MCCARTHY., we heard an earlier panel issue dealing with HIPAA. My question as it relates to HIPAA is in the department and I actually did find the OIG report and I heard that the Veterans Health Administration and the Veterans Benefit Administration could not exchange information because of HIPAA problems. I mean they both work for the same department, so I am not sure why there would be any HIPAA problems with VHA talking to VBA.

My question is—is the recommendation from the OIG back in 2011 was that the VA medical center directors and VBA directors will meet monthly; they meet monthly and they will discuss this issue—had that issue about any HIPAA problems been resolved between VHA and VBA, do you know what would the outcome of that is; if not, could you get back to the Committee?

Dr. MCCARTHY. I would be happy to take that one for the record, sir. I can give you an example.

For instance, if I were to do a C&P (compensation & pension) exam on a patient, that is considered—it is not considered a VHA document; it is concerned owned by the veteran or by the VBA, so that is not something that VHA releases. There are some separations that are aimed at protecting veterans.

Mr. MICHAUD. But if both VBA and VHA works for the Department of Veterans Affairs——

Dr. MCCARTHY. Yes, sir?

Mr. MICHAUD [continuing]. So I am not sure why there would be any HIPAA problems between VBA and VHA. So, yeah, if you could get back on that, I would appreciate it.

Dr. SHERIN. I agree with you that VA can't do it alone. What has been your experience with trying to partner with the VA to provide the service to, you know, in the communities, and have there been different, you know, outcomes depending on what region VOA has been around the country—involved in?

Dr. SHERIN. That is a great question. I do believe there is variability, and getting back to my final point, I think that it is important that we look to the VA to develop a consistent mechanism that is responsive and that program that I have described, which I am sure you are familiar with, SSVF, is one that is very responsive and very effective.

The bigger question, as I see it: What is VHA's mission? Is VHA's mission to deal with all reintegration problems? And I would say probably not, because so much is trying to stream through VHA to deal with reintegration issues outside of health care, it has created a strain on the system and has diluted its primary mission of providing outstanding health care, including mental health services.

Mr. MICHAUD. Thank you.

Getting back to the VA, as you—I noted in your opening remarks that VA's spending on mental health is approaching $7 billion dollars, double the amount in 2007. What is the VA's—what is VA using as a measure of success of this investment in mental health services?

Mr. CARROLL. Thank you, Congressman.

There is no single measure that we point to that is going to satisfactorily answer that question and certainly what we have heard today, what we have heard over the past few weeks points to the fact that VA has a lot more to do. At the end of the day, what matters most is whether or not we have met the needs to the individual veteran who presented himself or herself for VA mental health care, whether we have addressed those needs at the time they came in today and whether they left better off or with a clear plan of things that they could do to move forward. That is the ultimate outcome of our care and it has to be addressed and assessed for each individual at each time of care.

I think we can point to some things in our system. We know that over the last seven years, there have been 37,000 rescues or saves that have been facilitated through the Veterans Crisis Line. On the one hand, that is a remarkable number and on the other hand, it is not enough and we know that. We can look to veterans with serious mental illness and we can look to our Mental Health Intensive Case Management Program and we know that they are able to live in the community of their choice, to find employment, and to stay out of the hospital. We know that when veterans drop out of care with serious mental illness, we can successfully re-engage them in care. There are multiple other examples, but I think at the end of the day, it is the individual veteran and whether or not we have addressed their needs today is the ultimate test.

Mr. MICHAUD. Thank you. I yield.

The CHAIRMAN. Dr. Roe.

Dr. ROE. Thank you, Mr. Chairman, and thank the panel for being here. I want to go ahead and continue along the line for just a moment the chairman did.

Dr. Matthews, in the St. Louis VA, six percent of the veterans did not return for care and then we hear in other testimony today that a third of other veterans dropped out of care and 60 percent showed no improvement. This is difficult to treat and I understand that. It is a very difficult issue and it is very individualized with each patient that you see. But how can you explain that kind of drop out when these people are lost to follow-up and you don't know what happens to them? Those are the folks that may be needing a hotline or the ones that are committing suicide at this astounding rate. When you have more veterans committing suicide that are diagnose in combat we have a true crisis, so is it—and we have added several thousand more providers to the VA during the last, I guess, couple of three years.

Dr. MCCARTHY. Yes, sir.

Dr. ROE. So how, exactly, in the metric that he was talking about, productivity, I don't really agree with that, that it is meeting the same metric because what we found out with these oversight and investigation hearings is that time after time after time, the VA's self-analysis is not true. It turns out that when it is investigated by an outside party—what we have been hearing now—now, let me tell you how frustrating that is for me to sit up here.

I expect people, when they come to that dais up there, whether they are sworn in or not, to tell the truth, not just to make themselves look good, and that is what we have done. And let me know what VA has done, and as a surgeon, you have to have a lot of trust to have a patient lie down and let you open them up and operate on them. The VA has lost a tremendous amount of credibility and trust and it is going to be very difficult to put that humpty dumpty back together again.

So how can you—what can we do now? That is all in the rear-view mirror. How do we go forward, that is what I am asking.

Dr. MCCARTHY. We do have a lot of work to re-build that trust. We absolutely do, and our department is focused on that. Our acting secretary has laid out clear expectations about ways to restore that trust. What we can tell you are things like for the veterans who seek our care and who have entrusted their mental health care to us, for those veterans who are receiving our services, the suicide rate is actually going down. For all veterans who seek VA care and are enrolled in our care, for all of them, not just the mental health veterans, their rate of suicide is going down.

We do have some successes and I guess what I want to do is not discourage the veterans from reaching out to us who need us.

Dr. ROE. We don't want to do that at all.

Dr. MCCARTHY. We want to get——

Dr. ROE. I don't mean to cut you off, but my time is limited.

Dr. Sherin, a couple of things that have interested me is that there are a lot of programs around, both outside, Not Alone and others you have heard of in what you do, how do you make—how does the VA help coordinate, because you are right, some veterans don't want to go through and see this—go through this big maze of things at the VA, walk into this big building and wind their way

around and follow a dotted line to some place. How do you coordinate all of that?

Dr. SHERIN. That is a great question. There are a number of efforts around the country. One where I live in LA, the Los Angeles Veterans Collaborative, which actually brings together roughly 250 organizations per month, including the VA, with the aim of developing coordinated systems.

The idea that I share with you, recommendation number two, to create rally points, is to get proactive by creating navigation—a navigation network that is operated by veterans who can function as a surrogate family. We heard the families that were here in the first panel talk about the need for a support system, that special relationship between the brothers and sisters in the military community. We need to leverage that. That is a way to get information from people that are suffering. It is a way to introduce a process and content expertise into communities with navigators who engage and then advocate.

Dr. ROE. One of the things that is in my local community that my wife is involved in is The Humane Society. We are finding out that veterans sometimes won't go to the hospital because they leave their animal, their dog at home, and they don't have anyone to take care of them because they are alone. And so The Humane Society are now taking care of those animals so the veterans can go to the VA. It is something that I never thought of. I had no idea that that was even going on, that people would not get care because their companion, which is their animal, didn't have anyone to care for them if they went in to seek care. So that is another thing that I think one of the great challenges—and I applaud your effort for doing that—is that there are a lot of people trying to help and there is no question about that, and you will see a renewed effort here—is how do we coordinate that?

And with that, Mr. Chairman, I yield back.

The CHAIRMAN. Ms. Brownley, you are recognized for five minutes.

Ms. BROWNLEY. Thank you, Mr. Chairman.

So, Dr. McCarthy, I wanted to follow up on I think Dr. Roe's line of questioning and you were talking about some of the successes that you feel improvements that have been made, and, Dr. Roe was talking a lot about trust. I think, you know, one of the issues I think for me and the rest of us here is of what data are you working—you know, when you state these successes, what data are you looking at and is it, you know, we have heard a lot about bad information and people not telling the truth and so it is hard to believe that there are successes, if there are, because I don't know—I am not feeling good about the data of which you would make those conclusions.

Dr. MCCARTHY. Thank you for asking that.

We have, in the last few years, been able to obtain data from the states, some with the help of the members of this committee. We now have suicide data from 48 states that is not VA data that we are using to analyze rates of suicide for veterans, including veterans who may not be seeking our care, and so the data that we are using include the data that we are getting from the states about actual suicides. We often did not hear about veterans even

in our care who completed suicides, and so now we have data about them, but also other veterans. That data doesn't go back to 2001, but if you start kind of counting in 2001 after 9/11, then that is the data that we are following the trends for, ma'am.

Ms. BROWNLEY. So do you believe that there is a crisis going on in the VA and certainly in terms of access to mental health care?

Dr. MCCARTHY. Absolutely.

Ms. BROWNLEY. And so what are some of your—what are your top three things that you are planning on doing to resolve this crisis?

Dr. MCCARTHY. Among them are extending hours, partnering with care in the community. There has been an increase in funding for what we call fee-basis care and our vet center partners have expanded their services and their hours to also provide for care. Those are the three major crisis kind of interventions and some of that extra hour care has included partnership with The American Legion and we are grateful for that.

Ms. BROWNLEY. So with partnerships, public/private partnerships, I mean I hear over and over and over again that it is very difficult to work with the VA and establish those partnerships with the community to expand services to our veterans in their communities. So what are you doing to alleviate some of those barriers to make it easier to create those partnerships?

Dr. MCCARTHY. Last year we started these community summits which included partnerships with various—they were run locally and in the various medical centers. We have reached out to all kinds of people of goodwill in the community, people that would like to partner with us and they are site-specific.

Ms. BROWNLEY. Well, reaching out, we have done that in my district where I represent and that is a good first step because quite frankly in my area, the VA didn't even know about all of the services that the communities are providing for our veterans. I think now they do, but how are we going to eliminate the barriers, if you will, and just in terms of contracts and so forth to actually create good public/private partnerships to increase services to veterans?

Dr. MCCARTHY. So after the summits, there are a series of action plans that we have engaged in to address some of the barriers that were identified. As far as the access to fee-basis care, we are using models of payment for fee-basis care that are traditional models, but we are also expanding kind of contracting services that would be available. El Paso, for example, has reached out and formed a relationship with the practice that provides their inpatient mental health care to provide more outpatient mental health care, and that is just one example nationwide.

Ms. BROWNLEY. And what about alternative therapies? We talked about that earlier today. Are you looking at partnerships with alternative therapies? Equine therapy, I have a great program in my district, Reins of Hope, that is a very successful program. Veterans are coming from all over the region to utilize this program. It would be great if the VA could partner with programs like that.

Dr. MCCARTHY. And there are programs like that that VA has research partnerships in and there are others where there are com-

munity partnerships and the veterans are engaged as part as the goodwill of the community involved in helping them.

Are you asking if every VA should have equine therapy?

Ms. BROWNLEY. Well, I want to know how we can increase these partnerships. I will just use my own exactly—I am really watching the clock here; my time has just run out, but I will follow up with you on my question.

The CHAIRMAN. I am glad that you saw that red light.

Ms. BROWNLEY. I am learning, Mr. Chairman.

The CHAIRMAN. Mr. Huelskamp, you are recognized.

Dr. HUELSKAMP. Thank you, Mr. Chairman.

A question for Dr. McCarthy, following up closely on a few others: What are the waiting times for access to mental health care?

Dr. MCCARTHY. It is hard to give an actual number, given that both the members of this committee and I have said that we are not sure that we trust the actual numbers. What we now have, though, right on the VA Web site, very transparently, information about access. I printed and brought some of that information, but what is posted is for every VA medical center, what the new patient mental health average wait time is, the established mental health wait time, and then a running average over the last month for what that particular wait time has been.

When we look over the last month, certainly for those, there are significant improvements over what they had been before, but——

Dr. HUELSKAMP. Ma'am, are those reliable data?

Dr. MCCARTHY. I believe these are reliable. I would not stake my life on it, as Chairman Miller has said, but to my knowledge——

Dr. HUELSKAMP. Have they ever been audited by independent entities outside the VA?

Dr. MCCARTHY. I do not know the answer to that question. I would be happy to take that for the record.

Dr. HUELSKAMP. Well, yeah, I would appreciate that because we have heard testimony, the Office of Inspector General on June 9th, clearly, data has been manipulated and data has been falsified and actually, I think on June 23rd, the VA admitted that their data was not reliable and a few minutes later they talked about their data and what they could draw from that.

I agree with most of my colleagues that we don't know what the data is. I mean the epistemological question is: What do we know that we know? And right now it is clear, especially the investigations, you know, 70 investigations going on—going after or investigating retaliation against folks that are saying that this data is falsified. In particular, I had just one whistleblower in one hospital and I had asked the VA what is the range of the workload for doctors across the nation and the total range—the bottom range, I found out, according to one whistleblower in only one hospital was lower than supposed the national range. And so one independent source verified that all the data was inaccurate there.

So can you tell me what the VA is doing to actually assess and verify and authenticate the data so folks on this committee and the 341,000 employees at the VA can actually say, this is where we are heading; this is where we have been; this is how we have improved the system. Give me a sense of how the VA is going to actually an-

swer that basic question of how we are going to independently assess the data.

Dr. MCCARTHY. Our Acting Secretary has talked about not looking at the same kinds of access measures, but instead, looking at patient satisfaction with the timeliness of the care that they have received as a measure of access and timeliness. As far as these——

Dr. HUELSKAMP. And that will all be done—internally handled by the VA? I mean who is coming in independently and saying—ma'am, I don't trust the data. You apparently don't trust your own data unless it serves the purpose and I am looking at an IG report for 2012 and said the average of 50 days—the average is 50 days to receive a full mental health evaluation.

I would say today that the Office of Inspector General probably says, well, we don't know; we use the data from the VA, and now they are telling us today that it is all made up and it could be falsified. And all we are going—and I am like many here, you are hearing from constituents is saying well, what you are being told, and I heard from a whistleblower who called my office yesterday, just wanted to say that what you are being told by the VA is whitewashing the situation in this particular vision because they are falsifying the data and punishing those that make that point.

So, again, quickly, if you could tell me how you are going to prove to me and members of the Committee and the American public that this is our data and this is how we can prove that we are improving our performance to meet the needs of our veterans?

Dr. MCCARTHY. Sir, I believe that there are audits planned, I am just not personally familiar with those particular audits, but I do invite you or anyone to go to the VA Web site and look at the data because you can see it and it is part of our effort at increased transparency. I think that looking at how long it took people in the last month to get care is——

Dr. HUELSKAMP. I can't believe the data.

Dr. MCCARTHY. Okay. I——

Dr. HUELSKAMP. Because it is not independently verified. It is not authenticated. There is no one on the outside. I mean my district is in four different VIZNs and some reports have come out in the last couple days of how they double checked. Everything is going fine, but I don't think that they talked to a single veteran, and it is not matching up with what the whistleblowers are saying. So every time someone from the VA comes to our committee and says, Hey, we have got data—it might not be good data, but we have got data, I mean it is the old GIGO, garbage in/garbage out, and that is what is happening here and we can't trust that.

I would suggest that you look at independent authentication, get an outside assessment of what is going on at the VA. I know that the chairman has been pushing that. I believe that is what needs to happen to re-establish trust, and more importantly, to re-establish to make certain that we are getting the care that we claim that we are giving to our veterans.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Kirkpatrick you are recognized for five minutes

Ms. KIRKPATRICK. Thank you, Mr. Chairman.

I recently attended a veterans stand down in Phoenix which is a one-stop shop for services that our veterans need and they had all kinds of things going on—thousands of people there—and off to a side was a room and I looked in and there were veterans sitting there with needles in their ears and maybe in the back of their neck and they were receiving acupuncture. So I was curious about it. The person delivering the acupuncture is actually a constituent in my district who is volunteering her time to be there.

And to a person, every veteran that I talked to said that they benefitted from acupuncture. It helped relieve stress, anxiety, and asked me to advocate that it be an approved treatment in the VA system, so I am doing that. But my question—and I didn't ask them if they had a PTS diagnosis, but clearly some of them in the room did—every one of them benefitting from this treatment.

So my first question for every panelist is simply this: Do you think that acupuncture should be an option within the VA for medical treatment for every veteran, starting with Dr. Sherin?

Dr. SHERIN. Yeah, I believe strongly in alternative approaches for mental health issues and pain and substance abuse. I think that acupuncture is a very powerful technique, so is meditation, so are many other, you know, well-established treatments. The question, though, that I go back to is: Is that something that you build into the VA or is it something that the VA supports in the community where there are already functioning systems?

Ms. KIRKPATRICK. And my question is simply: Does the VA cover it? Offer it as a treatment? And because I want to hear from everyone, I need to hear quickly.

Dr. SHERIN. Yeah.

Ms. KIRKPATRICK. Should it be a regularly offered treatment to veterans regardless of where it is provided?

Dr. SHERIN. I would say absolutely.

Ms. KIRKPATRICK. Thank you.

Mr. Goldstein.

Mr. GOLDSTEIN. Congresswoman, yes, The American Legion believes that all treatments should be made available. If it is helping veterans, then yes it should be made available for treatment. Thank you.

Ms. KIRKPATRICK. Lieutenant General.

Lieutenant General STEELE. I fully support it, also. I think alternative treatments need to be investigated. It is part of the cultural shift that we have been talking about and what this panel is all about. We have to get to alternative treatments. If they work for one person, just as you experienced, Congresswoman, hyperbaric chamber is the only thing that works for them. It is the same thing. It is not evidence-based. It is not approved right now. We have to fix this by bringing the opportunities in to get alternative therapies to take care of this population.

I would just like to make one amplifying comment. I am a Vietnam era vet. I have people who are contemporaries of mine, just like the congressman earlier today, who are just now coming forward with their issues about post-traumatic stress 47 years ago. We don't believe that this population is really going to come forward until the year 2030, so that is why I am talking about re-

search here to be able to get this fixed so we don't have the same thing that has happened to the Vietnam-era population.

I am going to say one other thing. Personally, again, not USF, my father is a prisoner of war of World War II. He suffered his entire life from post-traumatic stress—never recovered from it. He was an alcoholic. It is all part of what are we doing here to be able to include all of these things together, all of these opportunities that we have to be able to bring it together to make it better to take care of the patient? To take care of the veteran? Thank you.

Ms. KIRKPATRICK. Thank you.

Mr. NICHOLSON. IAVA has been a big proponent and advocate for alternative and complementary medicine, so absolutely. Especially for the younger generation of vets who are perhaps more open to alternative forms of treatment, it absolutely would be beneficial. They are already doing it. A lot of them are already doing it and covering the costs out of pocket. Having help with that would definitely be a big deal to them, especially since some of them, especially the younger vets are still transitioning, you know, they have lower incomes as they are in area earlier career trajectories, so definitely.

Ms. KIRKPATRICK. Dr. McCarthy.

Dr. MCCARTHY. Yes, it is part of our clinical practice guideline the joint DoD/VA clinical practice guideline for the treatment of PTSD that we have been rolling out. So we are hoping to have——

Ms. KIRKPATRICK. Does the VA pay for it? That is my question.

Dr. MCCARTHY. The VA is providing it at some medical centers, but——

Ms. KIRKPATRICK. But not across the board?

Dr. MCCARTHY. Not yet.

Ms. KIRKPATRICK. So my follow-up question is—quickly—what would it take for the VA to have this be part of the standard treatment offered to our veterans?

Mr. CARROLL. We need to ensure that there are credentialed providers available either on staff in the VA or in the community that we could partner with.

Ms. KIRKPATRICK. And just very quickly, would they be credentialed by the VA? Do you have a process for that?

Mr. CARROLL. If they were working for the VA, they would need to be credentialed for providing that service within VA, otherwise we would need to recognize that expertise in the community.

Ms. KIRKPATRICK. Thank you. My time is out, but I would like to explore at some point in a little more detail.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you, Ms. Kirkpatrick.

Dr. Wenstrup.

Dr. WENSTRUP. Thank you, Mr. Chairman.

Dr. MCCARTHY., when you talked about RVUs, relative value units, as a measure of productivity, would it be correct that those RVUs are based predominately on time spent with a patient in mental health?

Dr. MCCARTHY. Primarily.

Dr. WENSTRUP. Okay. And do you feel that that is a good measure of productivity?

Dr. MCCARTHY. We use the WRVUs and take out the part of the RVU that covers malpractice and overhead costs, so it is a part of the RVU that we call the WRVU, and it is not ideal, but it is the best we have.

Dr. WENSTRUP. Okay. But it is the measure of productivity that you are using?

Dr. MCCARTHY. For mental health.

Dr. WENSTRUP. Do you go and check to see if those RVUs match up with the number of patients seen? In other words, if somebody has RVUs that would add up to what would equal eight hours of patient care, are you checking to see if they really match that? In other words, if they have only seen three patients but they have RVUs that match an eight-hour day, eight hours of patient interaction, are you checking that?

Dr. MCCARTHY. I can't say that I personally am. I can say that I would hope that folks are matching that up.

Dr. WENSTRUP. So formally, that is not being done at this point?

Dr. MCCARTHY. It's a relatively new model for us and it has been rolled out since 2011, increasing the numbers of specialties per year. Mental health has just been added, so we just have the data, but we certainly have to refine it and make sure that it is validated.

Mr. WENSTRUP. Because that would authenticate things pretty well, which isn't being done.

And the other thing that we found that is not really being done is, what is the cost per RVU within the VA system—not just in mental health, but in anything—what are we actually spending per every RVU that we put out in care? And that is a key number as far as productivity and efficiency, and I think that we really have to go that way.

The next question is: Do our doctors in mental health claim responsibility for their patients? In other words, do you look back and say, well, Dr. X had 10 patients that attempted suicide and he had six that actually committed suicide.

Do you look at those numbers? Do doctors actually have patients that are their responsibility?

Dr. MCCARTHY. Absolutely. We have a very active peer-review program where cases are reviewed and typically all suicides are reviewed in that particular format. In addition, we go through what we call psychological autopsies and root cause analyses when those kinds of events occur, so a very thoughtful approach to each one so no death was in vain.

Dr. WENSTRUP. What happens if one provide had an abnormally high number? I mean is it bad luck or are you actually looking and saying, what are you doing as far as the type of care that you are administering or how much attention to detail are you paying to this patient?

Dr. MCCARTHY. So a typical peer-review committee would take looking at the chart that the doctor—that the documentation and all the other factors around the patient actually projecting up on a screen, the peer-review committee reviews all of the components of the care, looks at the follow-up, looks at what appointments were scheduled and so forth and then an assessment of did the doctor do the right thing.

Dr. WENSTRUP. And then action is taken, that part you didn't mention.

Dr. MCCARTHY. Oh, let me keep going then. People are rated on a peer-review scale of one, two, or three. Three is if the case should have been handled differently. Two if it might have been handled differently. One if people felt like it was—the standard of care.

If a provider has a level three, the provider is counseled about that and if there is more than one level three, certainly there is an intervention program followed and there is an FPPE often put in place.

Dr. WENSTRUP. Any firings ever? You ever let a provider go?

Dr. MCCARTHY. I can't say that I have personal experience with the letting of a provider who had issues with mental health suicides go, because I can say that there are situations in which we have let people go.

Dr. WENSTRUP. Just performance in general was my question.

Dr. MCCARTHY. Yes, sir.

Mr. WENSTRUP. Thank you very much.

You know, Dr. Sherin, when I deployed, I was also concerned about those who received no mail during an entire year, and I always tried to encourage people at home to send this soldier something and I wondered what happened to them when they went home. You know, which leads me to—I just want your opinion real quick on the idea of when you are getting a garden reserve go home, you know, active duty, go back to a base or post, an opportunity for consultation for the garden reserve of what are you doing when you go home? What activity are you engaging?

Because to me, the worst week was the first week home when I did nothing and then I went back and saw patients against. And so do you think that would be beneficial because you are not coming home to parades and there is not a lot of jobs?

Dr. SHERIN. Yeah. I think I may have missed the question.

What we try to do in the community is actually to try to generate lots of opportunities and one of the key features of opportunities involves, you know, kinship, support relationships, community. We look at individuals in terms of their well-being, and in order to have well-being, yeah, you need to have emotional health; you need physical health; you need intellectual health; need family; need a community and you need spiritual health. Those are the targets that we look at, at Volunteers of America and one of the things that we are actually trying to push out is a lot more recreational-occupational activities that bring people together and help them knit that community fabric together for the reasons that you are pointing out.

Dr. WENSTRUP. That answers my question. I really just was questioning if you see the great value in that, and I appreciate that. I yield back.

The CHAIRMAN. Thank you very much.

Mr. O'Rourke, you are recognized for five minutes

Mr. O'ROURKE. Thank you, Mr. Chairman. I would also like to thank all the panelists for their testimony today and their service to our veterans throughout the country and as I represent the veterans in El Paso, I would also like to thank Mr. Goldstein.

The American Legion worked with the local commander, Mr. Briton, to set up a command center to connect veterans there with health services like the ones that we are talking about today, as well as benefits, and by every measure, most importantly, in talking directly with veterans, it was very successful, so I want to thank you.

I want to thank Dr. McCarthy. She mentioned the mobile vet center and other resources that are being directed to El Paso, all of which should tell us that we had a problem in El Paso that we are now belatedly trying to correct and to fix. And during that time when, especially access to mental health care was so problematic, I had an opportunity to meet a young veteran named Nick D'Amico and his mom Bonnie, who came to a town hall meeting of mine and Nick was having a hard time accessing mental health care services at the El Paso VA and shared that with me and my team, but was also there to hear veterans who served as far back as Korea and Vietnam and the Gulf War share frustration with not being able to get into the VA.

As he was driving home with his mom Bonnie from our town hall that night in September, he said, you know, I am having a hard time getting in and I am a young, new veteran. Some of these guys have been trying for years and can't get in and for our five days later, Nick D'Amico killed himself, and I have got to connect the lack of access, the delay in care, which turns into denial of care into Nick D'Amico's death. It is at least partially responsible.

And yet in that time, the El Paso VHA and the national VHA was telling me that things were under control, and as recently as May 9th of this year, the director of VHA told me that there was zero days wait time on average for a veteran seeking mental health care access in El Paso, and what I take that to mean is that no veteran waited no more than 14 days to do that.

The discrepancies between what we are hearing from people like Mr. D'Amico and the VA were so great that, as I have told this committee before, we initiated our own survey of mental health care wait times and found that the average wait time was 71 days. Found at that like, Dr. Matthews told us earlier this week, more than 40 percent of veterans stopped trying to seek mental health care because it was too frustrating and fully 36 percent, one-third, could not get an appointment at all.

And so I want to ask you, if you had known that the average wait time was 71 days, or as your own VHA audit found last month, 60 days, but certainly much longer than 14 days, if you knew that as we know now, we are—we have the worst wait times in the country for access to mental health care for veterans, the worst as of June, what would you have done differently? You said in your opening testimony that we are fully committed to providing accessible care. You obviously did not have that in El Paso. If you had known all this, what would you have done differently?

Dr. MCCARTHY. Congressman O'Rourke, I had the opportunity to visit El Paso. I had a visit there in June, the 16th and 17th, and I know that at some point we are going to talk to you about that visit. What has happened in El Paso is tragic. There were five psychiatrists that left all at once. That left a huge hole in the ability for them to continue to provide mental health care.

Mr. O'ROURKE. Here is what I am trying to ask, because I have limited time: What the VA was telling me and perhaps you and the veterans in El Paso was one thing which turned out to be untrue and was very different from what reality was, which was that there was terrible, terrible access to care for veterans who could get it and one-third could not get into mental health care at all. So if you had known that in September of 2013, what would you have done differently?

Dr. MCCARTHY. I would have assisted you with a huge infiltration of kind of resources, but also telemental health services. I continue to provide care, even while I work at VA's central office, by telemedicine, and that is the kind of thing that we can help for places that are having a hard time recruiting. So deploying a system of being able to help——

Mr. O'ROURKE. You would have expanded capacity. We would have had greater access.

Dr. MCCARTHY. Yes.

Mr. O'ROURKE. People like Nick would have been able to get in to see somebody.

So given the fact that we were not told what the real conditions were and certainly the VA in El Paso and the VA in Washington, D.C., director of VHA reported different numbers to me to the veterans in our community, who is accountable for that and what are the consequences? Who is responsible?

Dr. MCCARTHY. I am not prepared to answer that question. I am sorry. I would be happy to take that one for the record.

Mr. O'ROURKE. That is my case in point. You can't tell me who is accountable. There are no consequences for veterans dying. Nothing is going to change as long as we still have the same mentality and culture at the VA, which you exemplify today in your testimony. The fact that you cannot tell me who is accountable for this, that there are no consequences, that you agree that if you had known the truth, you would have done something different and arguably people would have survived who are now dead, and yet there are no consequences.

I appreciate the surge in resources, the additional providers, your flight to El Paso in mid-June, but unless we change the culture at VA, this is going to be a temporary fix that will not last.

And, Mr. Chairman, I yield back.

The CHAIRMAN. Thank you very much.

Mr. Jolly, you are recognized for five minutes.

Mr. JOLLY. Thank you, Mr. Chairman, and General Steele, thank you for being here today.

Why are you pessimistic about the VA embracing art as a——

Lieutenant General STEELE. That is a great question.

Mr. JOLLY. It was your statement, not mine, by the way.

Lieutenant General STEELE. That was a great question that you asked me.

I just think from the experiences, sir, that we have had in regards to trying to bring it in as an alternative therapy, along with these other issues that we are talking about, alternative therapies, I believe, because I am an eternal optimist, that the pessimism that I have about the VA, they will be pulled into it because of what is happening here and what we are being able to be success-

ful with in the Department of Defense and the military right now because they are clamoring for art therapy because it works, particularly in the early stages of the Special Operations Command, those warriors who are having multiple deployments that are going back, they have come, they have sought art therapy and it has been very successful, returns them to the fight for Admiral McRaven and the special operators, and I believe that whole mechanism within DoD will result and it eventually being main streamed into VA if we pull all of these together, alternative therapies. So that is the reasons for that.

Mr. JOLLY. Thank you.

Dr. McCarthy, is there something that stands in the way—you know, you have a major research university partner ready to collaborate with a peer-review alternative therapy, what stands in the way of the VA from embracing that generally? I mean is it bureaucracy? Is it procedure? Is it regulation? Is it funding? Is it institutional bias? Is it not admitted here?

Dr. MCCARTHY. I am sorry, I don't have an exact answer to that. I would really be happy to review the program and understand it and then understand what the barriers might be in order to make those particular—make the implementation. I personally don't know.

Mr. JOLLY. Sure. And I guess I am just asking the general conceptual. We hear about all of these alternative therapies that are available, these non-pharmaceutical therapies that are available that work. In my previous profession, I tried to work with the VA research department on a regenerative proposal that was discovered at a non-VA center and I came up against a bias of extramural research not wanting to be, you know, be too tied to extramural research and therapies.

I am just asking an assessment, not why not art, but is there an institutional bias against extramural research and solutions?

Dr. MCCARTHY. I would not say that there is an institutional bias. What I can say is that VA funds in particular intramural research and some of our providers are certainly funded externally, but we don't tend to fund extramural research. The way to fund that is to partner with someone in the VA and then it would become intramural and that would be what would allow the funding.

Mr. JOLLY. On non-drug therapies, are there any pertinent regulations that control how a VA physician counsels a patient on pharmaceutical therapies versus non-pharmaceutical therapies? Are those dictated by other medical standards or are there VA regulations that address that.

Mr. CARROLL. Congressman, that is an important question. I think the standard within mental health care for VA treatment is to provide the care that makes sense for the veteran at the veteran's point in life. We offer a recovery model which would include a range of evidence-based psychotherapies, evidence-based psychopharmacologies, certainly supported by complementary and alternative medicine approaches, but it is to be an integrated package of care that makes sense for the veteran at that particular point in their life. So it doesn't bias against anyone one of those or towards any one of those.

Mr. JOLLY. Then I have a capacity question, which is when it does come to some of the pharmaceuticals, the first 30 or 60 days—again, I am not a doctor, but I know it is kind of critical when you begin a regiment or frankly the testimony we heard earlier when you switch medications because DoD to VA, is there more precise oversight or care provided to the patient or is there a different follow-up with patients in those first 30 days or 60 days that they begin a pharmaceutical regiment?

Dr. MCCARTHY. I can speak to this. It is clearly the expectation that people are monitored more carefully as you are making changes, either initiating a therapy or making increases in doses, yes.

Mr. JOLLY. Okay, thank you.

One last question: Dr. Steele, quickly, you have a distinguished DoD career and now working within VA, are there areas where DoD/VA, the transition, all of this together, given your career of experience and now with the research university, one or two things, quickly, that you would say could be game changers?

Lieutenant General STEELE. The first is that accountability and acceptance of responsibility are the game changers, that the separation from active duty to the VA system is such that it needs to have all this cohesiveness to be able to ensure that everything is transferred over—all the HIPAA discussions we have had—it is all transferred over. If we could get legislation that does that and to ensure that there is transparency and openness, I think that we have got a great chance to be able to have a major game change in all of this.

Mr. JOLLY. All right. Thank you very much.

Mr. Chairman, I yield back.

The CHAIRMAN. Thank you.

Mr. Walz, you are recognized.

Mr. WALZ. Well, thank you, Chairman for holding the hearing and to each of you.

And I was going to say, Dr. McCarthy I was thinking, and I was going to say that it is not personal, but then I got to thinking that that is not true; there is nothing more personal than this. We had Daniel and Brian and Clay and this is pretty personal stuff.

And so I guess the thing I am most amazed about is that I am amazed at the lack of anticipating what is going to be asked of you when you come here, and it shows me that it is a lack of self-reflection on this. I could have anticipated the question that the chairman was going to ask where you didn't have an answer. I could have anticipated what Mr. O'Rourke was going to say. You probably could anticipate maybe what I am going to ask because I ask it to every one of you who sits here and yet it might be symptomatic of that why would we go to that trouble—why would we look?

And my answer to you is, is because we are reflecting what the public is telling us. We are a reflection—if this place is working correctly, we should be mirroring and channeling that, and so I guess that is most disillusioned.

Again, General Steele, I am, along with you, the eternal optimist, because on the matter of now—what the point now is nothing matters but results. Nothing matters that we get this fixed, right? The

American public is fully behind getting this right and we just have to figure out how to do that.

Again, here is what I caution all of you is that people have sat there and offered up good suggestions. We even got so far as getting things into play, so Dr. Carroll You get to answer a few questions now. Here's what the law said that was required of you. In carrying out the comprehensive program, the secretary shall provide for research on best practices and prevention. Research shall be conducted under this subsection in consultation with the heads of the following entities: The Department of Health and Human Services—what have you done with them?

Mr. CARROLL. Sir, we are in partnership with Department of Health and Human Services and DoD regarding—and through The National Action Alliance on Suicide Prevention.

Mr. WALZ. What has come out of that in concrete results and implementation that went forward?

Mr. CARROLL. We have—education of the suicide prevention coordinators provide at every VA medical center. They provide at the veterans service organizations to veterans groups, to veteran providers, as well as all VA and VHA and VBA——

Mr. WALZ. How do you measure that, because I am going to go to this—you are responsible for doing this: In carrying out the plan, the secretary shall provide for outreach to and education of veterans and families for veterans with special emphasis on providing information to veterans of Operation Iraqi Freedom and Enduring Freedom of these veterans. Educate to promote mental health shall include the following: removing the stigma associated with, encouraging veterans to seek treatment, promote skills for coping with mental illness, help families with veterans understanding issues arising, identifying signs, and encouraging veterans.

You just saw a family here that said they didn't hear a damn thing from you. Would that not be the measure?

Mr. CARROLL. We have failed these families, sir. There is no question about that. Our suicide prevention campaign last year was called Stand By Them. It was specifically aimed towards veterans and people aimed in the community to stand by veterans and to reach out and to support them to look for the signs of suicide and to encourage to get them into care.

Our suicide prevention coordinators at every VA medical center do at least five outreach events to community organizations, veterans service organizations every month.

Mr. WALZ. What does the peer-support counseling program look like? How much training are you doing and how much encouraging—are you encouraging outside people to come in and peer support?

Mr. CARROLL. Absolutely. Peer support is one of the most transformative things that we have done in VA mental health care. We have hired 915 peer support providers over the last year. They are veterans. They are veterans who are in recovery from a situation in their own lives. We have them either trained or certified as peer-support providers or we will pay for that training. They are deployed across VA medical centers. We need more of them. We want them to be in primary care, as well as in mental health programs. They are a very transformative force in our organization, sir.

Mr. WALZ. So we have some things out there, and I bring these up because we are going to have to see how this implements moving forward as we start to do things. I fall into this camp, and I think it was Dr. Sherin who made the case, we certainly aren't going to do it all alone. There are 40,000 non-profits out there to help veterans; they simply aren't very well coordinated.

So, Dr. Sherin, I would ask you, what level of confidence do you have in this time we will get there? Because—just a quick anecdote from me is I am a provider in the community who was fee-based. He mostly treats Vietnam veterans. This guy is a local legend and beloved in that group there, and so in the midst of all of this, of course, with perfect—ear, he cancelled his contract in the middle of this after 30 years from the VA on this. And so now I have got 24 Vietnam veterans who are like, why the heck did you cancel this, this one was working? Now I got to go up to the VA and start again.

So, Dr. Sherin, what do you think, is there a chance that this new model, in which you are advocating, which I think most of us intuitively know is the right way to go?

Dr. SHERIN. I think there is. I think there is. The VA has led the way in the effort, but the VA is doing this internally, so this is happening within the walls of the VA and the concepts that we are pushing are actually to go beyond the walls. If we want to promote recovery and reintegration, we need veterans working with each other in the community.

Mr. WALZ. So some of the things that I read out of the Josh Omvig Act that the VA is doing, those could be applied the same way and already are?

Dr. SHERIN. Absolutely. That is right.

Mr. WALZ. Well, I yield back. Thank you, Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Very quickly, and thank you Members for being here.

Under threat of subpoena we finally got from VA the 2013 mental health employee survey, and if I can, I want to read just a few excerpts and ask if you will comment.

Leadership is disrespectful, autocratic and uncaring. They are clear that getting bonuses is the top priority if we want to keep our jobs. This is the worst leadership from Senator Richter on down that I have ever heard of.

The next one, poor leadership and administrative skills causing more confusion and disorganization at times when my superior does not fully find out all aspects of the issues before issuing a decree.

And the third one, no effective leadership in mental health for psych nurses, abusive management practices such as control, self-selecting, choosing staff, performance roles, no transparency.

Comments? I mean it took a long time for this committee to get this information.

Dr. MCCARTHY. And I apologize for that delay. I don't know what held it up.

The CHAIRMAN. Oh, I do. Continue.

Dr. MCCARTHY. I have had a chance to review some of the aggregated data from that particular——

The CHAIRMAN. You have not had a chance to review it?

Dr. MCCARTHY. I have, sorry.

The CHAIRMAN. Okay.

Dr. MCCARTHY. And that survey consisted of items that could be rated, as well as the free text comments, and what you shared were some of the free text comments, but the other side of it is there are some aggregated results that are significant from 2012 to 2013. As we hired more individuals to be part of the team, people did focus on a real sense of teamwork and be able to provide for the veterans.

Could I also add that—I would just like to respond to Mr. O'Rourke that I would like to restate my answer to your question about accountability and who is responsible. I think we at VA are all responsible and that includes me, and I apologize for not saying that beforehand, but when you reframed that question to me, it became clear that I answered that wrong and I am sorry.

The CHAIRMAN. And one other—Dr. Carroll, you made this comment just a second ago talking about peer support was one of the greatest things that you did. Did VA support that?

Mr. CARROLL. Support it financially, sir?

The CHAIRMAN. No, the concept.

Mr. CARROLL. Yes.

The CHAIRMAN. You did?

Mr. CARROLL. Yes, we had——

The CHAIRMAN. You fought it every step of the way. You fought it every step of the way. This committee and other people said you need to bring these folks who have experienced this in their own lives forward and VA fought tooth and nail against it.

Mr. CARROLL. I regret that, sir. Since I have been part of the central office team since 2007, we have been looking for ways to move this forward.

The CHAIRMAN. I don't believe—if you ask any member who has been sitting here for an extended period of time, they will tell you that VA has, in fact, fought bringing them in because they claim they didn't have the right credentials, they were not specific to the treatment, and, in fact, you just highlighted it as one of your best successes.

Dr. MCCARTHY. So thank you for your partnership in that.

The CHAIRMAN. With that, if there are no further comments or questions, we thank everybody. We thank the witnesses for being here today.

I would ask unanimous consent that all members would have five legislative days with which to revise and extend and add extraneous material.

Without objection, so ordered.

Once again, thanks to the witnesses and thanks to the members. This hearing is adjourned.

[Whereupon, at 1:38 p.m. the committee was adjourned.]

APPENDIX

Prepared Statement of Jeff Miller, Chairman

Welcome to today's Full Committee oversight hearing entitled, "Service should not lead to Suicide: Access to VA's Mental Health Care."

Following a Committee investigation which uncovered widespread data manipulation and accompanying patient harm at the Department of Veterans Affairs (VA) medical facilities nationwide, this Committee has held a series of Full Committee oversight hearings over the last several weeks to evaluate the systemic access and integrity failures that have consumed the VA health care system.

Perhaps none of these hearings have presented the all-too-human face of VA's failures so much as today's hearing will—a hearing that I believe will show the horrible human cost of VA's dysfunction and, dare I say, corruption.

At its heart, access to care is not about numbers; it's about people.

Recently, the Committee heard from a veteran who had attempted to receive mental health care at a VA Community Based Outpatient Clinic in Pennsylvania.

This veteran was told repeatedly by the VA employee he spoke with that he would be unable to get an appointment for six months.

However, when that employee left, another VA employee leaned in to tell this veteran that if he just told her that he was thinking of killing himself, she would be able to get him an appointment much sooner—in just three months instead of six.

Fortunately, that veteran was not considering suicide.

But what about those veterans who are?

How many of the tens of thousands of veterans that VA has now admitted have been left waiting weeks, months, and even years for care were seeking mental health care appointments?

How many are suicidal or are edging towards suicide as a result of the inability to get the care they have earned?

Despite significant increases in VA's mental health and suicide prevention budget, programs, and staffing in recent years, the suicide rate among veteran patients has remained more or less stable since 1999, with approximately twenty-two veteran suicide deaths per day.

However, the most recent VA data has shown that over the last three years, rates of suicide have increased by nearly forty percent among male veterans under thirty who use VA health care services and by more than seventy percent among male veterans between the ages of eighteen and twenty-four years of age who use VA health care services.

This morning, we will hear testimony from three families—the Somers, the Selkes [SELL–KEYS], and the Portwines—who will tell us about their sons—Daniel, Clay, and Brian—three Operation Enduring Freedom/Operation Iraqi Freedom veterans who sought VA mental health care following combat.

Each of these young men faced barrier after barrier in their struggle to get help.

Each of these young men eventually succumbed to suicide.

In a note he left behind, Daniel Somers wrote that he felt his government had "abandoned" him and referenced coming home to face a "system of dehumanization, neglect, and indifference."

VA owed Daniel—and Clay and Brian—so much more than that.

Prepared Statement of Michael H. Michaud, Ranking Minority Member

Good morning, and thank you Mr. Chairman for holding this hearing today.

We have had many discussions and debates about how to deliver the best health care services to our Nation's veterans, and how to ensure accountability within the leadership ranks of the VA.

Over the course of these recent hearings and discussions, we have touched on a number of important issues. But one that we haven't zeroed in on too much yet has been access to mental health care and suicide prevention services for our veterans. That's why this hearing today is so important.

I'd like to thank all of our panelists for joining us today, but in particular I want to thank the family members joining us who have lost loved ones—Howard and Jean Somers, Susan Selke and Peggy Portwine.

I know that speaking about the loss of a loved one—particularly a child—can be an incredibly difficult and exhausting experience. But, in this case, I believe we can and must honor the memories of the children of Howard and Jean, Susan, and Peggy.

We can listen to their stories, identify what went wrong, and we can take action to ensure those failures aren't repeated. So thank you very, very much for joining us today and sharing your stories.

Eighteen to 22 veterans commit suicide each day. In my opinion, that is 18 to 22 brave men and women each day who our system has let down in some capacity. It is a totally unacceptable figure.

When a veteran is experiencing depression or other early warning signs that may indicate mental health issues or even suicide, that must be treated like an immediate medical crisis, because that is exactly what it is. Veterans in that position should never be forced to wait months on end for a medical consult because quite frankly, that is time they may not have.

We have taken steps to help put in place programs and initiatives aimed at early detection, and we have significantly increased our funding. VA spending on mental health has doubled since 2007. But it's not working as well as we would hope, and we have to figure out why—and how we can correct these problems.

Our veterans are the ones paying the price for this dysfunction. A 2012 IG report found that VHA's data on whether it was providing timely access to mental health services is totally unreliable.

And a GAO report from that year not only confirmed that disturbing finding, but also said that inconsistent implementation of VHA's scheduling policies made it difficult—if not near impossible—to get patients the help they need when they need it. That is a problem we have seen repeatedly as we dig into the VA's dysfunctions, and enough is enough.

Our veterans and their families deserve a VA that delivers timely mental health services that cover a spectrum of needs, from PTSD, to counseling for family members of veterans, to urgent, round-the-clock responses to a veteran in need. A recent VA OIG report found that in one facility patients waited up to 432 days—well over a year—for care.

So once again, we are finding that our veterans deserve much better than the care they are receiving.

And of all the areas we must address, I would argue that fixing mental health services is among the most urgent. I look forward to a productive discussion that we will only begin today, but certainly continue over the coming days, weeks and months.

Thank you Mr. Chairman, I yield back.

Prepared Statement of Hon. Corrine Brown

Thank you, Mr. Chairman and Ranking Member, for calling this hearing today.

A veteran's mental health has been called many names through too many wars. From "soldier's heart" in the Civil War, to "shell shock" in World War I and "combat" or "battle fatigue" in World War II and now Post Traumatic Stress Disorder.

Other terms used to describe military-related mood disturbances include "nostalgia", "not yet diagnosed nervous", "irritable heart", "effort syndrome", "war neurosis", and "operational exhaustion."

Yet the name is not important for the disease, but how those affected are treated.

The men and women in our military are risking their lives to defend the freedom of this country and for them to be discarded after their operational usefulness has ended is inhuman and un-American.

I cannot think of anything more important to the returning members of the wars in Iraq and Afghanistan than knowing their health, and especially their mental health, is uppermost in our minds. It has been said that TBI is the signature injury of these wars. It is our responsibility to make sure they are treated properly when they get back.

Suicide is epidemic among our active duty servicemembers and the veterans who have served this country in the past.

More reservists and national guardsmen are serving in active duty now than in any other war. These men and women don't necessarily live near a military base to get the proper and timely treatment they need.

I do not think that VA and veterans mental health should be contracted out to the lowest bidder in an effort to rush any kind of care to our veterans. The VA has shown time and time again that they are the worldwide experts in treating PTSD and other mental illnesses, and that other mental health professionals, no matter how knowledgeable, cannot know the full range of PTSD symptoms unless they work regularly with veterans.

I am reminded of the words of the first President of the United States, George Washington, whose words are worth repeating at this time:

"The willingness with which our young people are likely to serve in any war, no matter how justified, shall be directly proportional as to how they perceive the veterans of earlier wars were treated and appreciated by their country."

I look forward to hearing the testimony of those panelists here today and learn how to best help those who have bravely served our nation in war.

Prepared Statement of Hon. Scott Peters

I want to thank Chairman Miller, Ranking Member Michaud, and the Committee for tackling an issue that touches entirely too many veterans and their families in my district, and districts throughout the country.

Improving access to mental health services in the VA is something I have a deep and committed interest in and while I am not a member of this Committee there is no place I'd rather be this morning.

I also want to thank the panelists for agreeing to be here today to share their experiences and expertise—it takes a lot of courage to do what you're doing and I want to thank you for that.

Beyond the power of your stories, you are providing us an invaluable education. These are insights that only you have and I know we are all thankful to have the opportunity to learn from you, and to use the knowledge we gain to work toward eliminating the barriers our veterans face in receiving the care they need.

I especially want to thank you, Howard and Jean Somers—not only for your participation today, but for your continued leadership and advocacy on behalf of Daniel, the education you've given me, and for fighting for our nation's veterans and their families. Your work in the face of such a tragedy is an inspiration to all of us. As the father of a 20-year-old son, I can't even imagine such as loss.

Sadly, the report you have shared with us today highlights the struggles faced by not only your son, but the struggle faced by veterans and their families throughout the country. The number of

veterans who found themselves in a position similar to Daniel's is unacceptably high.

Like many, Daniel returned from his service with invisible wounds including Post-Traumatic Stress and Traumatic Brain Injury. He was also afflicted with Gulf War Syndrome.

Like many, he suffered in silence because his attempts to reach out for help through the Department of Veterans Affairs were met with roadblocks and inefficiencies that left him with the feeling that no one cared.

Like many, Daniel tragically took his life rather than continue to struggle with his wounds, his constant pain, and the burdens of his service.

The truth is Daniel wasn't and isn't alone. Every day, 22 veterans find themselves with the same horrible choices and make the same decision he did.

As a country, we have failed these men and women who sacrificed so much to serve. The Somers' experience is evidence that there were steps that should have been taken and highlights systemic problems with the way the VA delivers care.

The House and the Senate have taken the initial steps toward fixing these problems. We will continue to work toward achieving much-needed reforms. However, these reforms will take time, and our veterans who are suffering from the very real pain of post-war mental anguish, shouldn't have to wait.

While Congress acts, and the VA implements reforms, our veterans and their families should take advantage of the many community resources available to them.

There are an estimated 44,000 volunteer organizations dedicated to helping servicemembers and their families: providing resources, information, and outlets for those who have kept us safe.

Too often, servicemembers and their families are not aware of the services available to them. That is why the Somers initiated Operation Engage America. With greater visibility, the programs offered by extraordinary Americans can reach veterans and their families in time to make a difference.

I had the opportunity to attend the inaugural event at American Legion Post 731 in June of this year.

I have never met a family more dedicated to sharing their story, raising awareness for the invisible wounds our servicemembers suffer, and committed to making a major impact on the way we care for our veterans.

Your determination and resolve in the face of sacrifice and severe adversity is truly inspiring. I thank you, Howard and Jean, for everything you have done, and everything you will continue to do to ensure that we in Congress remain committed to fixing the flaws in the way we treat our veterans.

From time to time in Congress, you see testimony that you know is going to right away make a difference and that is certainly what's happened today. You can feel very confident that our nation's heroes will be helped by the time and effort you've put in today.

I look forward to continuing to work with you to resolve these issues and to make things right with the veterans the VA treats.

Prepared Statement of Howard and Jean Somers

Thank you Chairman Miller, Ranking Member Michaud, and Committee members.

We are grateful for the opportunity to testify today, and it is especially good to see Representative Kirkpatrick, who has been a great ally to us in our effort to advance reforms of the VA based on the experience of our son, Daniel Somers.

As many of you know, our journey started on June 10, 2013, when Daniel took his own life following his return from a second deployment in Iraq. At that time, he suffered from Post-Traumatic Stress Disorder, Traumatic Brain Injury and Gulf War Syndrome. Daniel spent nearly six futile and tragic years trying to access the VA health and benefit systems before finally collapsing under the weight of his own despair. We have attached "The Story of Daniel Somers" to our testimony, which provides the details of his efforts, and we hope you will read it if you have not already done so.

Today, it is our hope that we can begin the process which will ultimately provide hope and care to the 22 veterans a day who are presently ending their lives.

Four days after Daniel's death, we sat with Daniel's wife, who has a Bachelor of Science in Nursing, and his mother-in-law, who is a psychiatrist, and prepared a 19 page report that we titled Systemic Issues at the VA. We have shared that document with several of you over the last year, and it is also attached to our testimony.

The purpose of this report remains the same as when we wrote it: to improve access to first-rate health care at the VA, to make the VA accountable to veterans it was created to serve and to make every VA employee an advocate for each veteran. (VHA)

A1. At the start, Daniel was turned away from the VA due to his National Guard Inactive Ready Reserve status.

A2. Upon initially accessing the VA system, he was, essentially, denied therapy.

A3. He had innumerable problems with VA staff being uncaring, insensitive and adversarial. Literally no one at the facility advocated for him.

A4. Administrators frequently cited HIPAA as the reason for not involving family members and for not being able to use modern technology.

B1. The VA's appointment system known as VISTA is at best inadequate. It impedes access and lacks basic documentation.

B2. The VA information technology infrastructure is antiquated and prevents related agencies from sharing critical information. There is a desperate need for compatibility between computer systems within the Veterans Health Administration, the Veterans Benefits Administration, and the DoD.

B3. Continuity of care was not a priority. There was no succession planning, no procedures in place for "warm handoffs"; no contracts in place for locum tenems; and a fierce refusal to outsource anyone or anything.

B4. At the time Daniel was at the Phoenix VA, there was no pain management clinic to help him with his chronic and acute fibromyalgia pain.

B5. There were few coordinated inter-Agency goals, policies and procedures. The fact that the formularies of the DoD and VA are separate and different makes no sense since many DoD patients who are stabilized on a particular medication regimen must re-justify their needs when they transfer to the VA.

B6. There were inadequate facilities and an inefficient charting process. (VBA)

There was no way for Daniel to ascertain the status of his benefits claim.

There was no VHA/VBA appointment system interfacing, nor prioritized, proactive procedures.

There was no communication between Disability Determination and Vocational Rehabilitation.

This report is offered in the spirit of a call to action and reflects the experiences of Daniel with VA program services beginning in the fall of 2007 until his death last June as seen through our eyes.

Our concern then was that the impediments and deficiencies which Daniel encountered were symptomatic of deeper and broader issues in the VA—potentially affecting the experiences of a much broader population of servicemembers and veterans. Unfortunately, this has been proven true as dramatically evidenced by recent revelations.

Many of the reforms outlined in our report will require additional funding for the VA. But with that new funding should come greater scrutiny and a demand for better, measurable results.

There is, however, an alternative to attempting to repair the existing, broken system. We believe Congress should seriously consider fundamentally revamping the mission of the VA health system. In the new model we envision, the VA would transition into a Center of Excellence specifically for war-related injuries, while the more routine care provided by the rest of the VA health care system would be opened to private-sector service providers—much like Tricare. That approach would compel the current model to self-improve and compete for veterans' business. This would ultimately allow all veterans to seek the best care available, while allowing the VA to focus its resources and expertise on the treatment of complex injuries suffered in modern warfare.

We thank you for your time, and would be happy to further discuss our recommendations and suggestions. We sincerely hope that the systemic issues raised here will provide a platform to bring the new VA Administration together with lawmakers, veterans and private sector medical professionals and administrators for a comprehensive review and reform of the entire VA system. And if the VA, Committee or Congress as a whole make the decision to involve other stakeholders in a more formal reform process, we would be honored to be among those chosen to represent the views of affected families.

Prepared Statement of Susan Selke

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the Committee.

Thank you for the opportunity to speak with you today about this critically important topic of mental health care access at the VA, suicide among veterans, and especially about the story and experience of our son, Clay.

My name is Susan Selke and I'm accompanied here by my husband, Richard. I'm here today as the mother of Clay Hunt, a Marine Corps combat veteran who died by suicide in March 2011 at the age of 28.

Clay enlisted in the Marine Corps in May 2005 and served in the infantry. In January of 2007, Clay deployed to Iraq's Anbar Province, close to Fallujah. Shortly after arriving in Iraq, Clay was shot through the wrist by a sniper's bullet that barely missed his head. After he returned to Twenty Nine Palms in California to recuperate, Clay began experiencing many symptoms of post-traumatic stress, including panic attacks, and was diagnosed with PTS later that year.

Following the recuperation from his gunshot wound, Clay attended and graduated from the Marine Corps Scout Sniper School in March of 2008. A few weeks after graduation, Clay deployed again, this time to southern Afghanistan. Much like his experience during his deployment to Iraq, Clay witnessed and experienced the loss of several fellow Marines during his second deployment.

Clay returned home from Afghanistan in October of 2008, and was then honorably discharged from the Marine Corps in April of 2009. He earned numerous awards during his service in the Marine Corps, including the Purple Heart for the injuries he sustained in Iraq.

Clay received a 30 percent disability rating from the VA for his PTS along with two smaller ratings for other health issues after separating from the military. After discovering his that PTS prevented him from maintaining a steady job, Clay appealed the 30 percent rating only to be met with significant bureaucratic barriers, including the VA losing his files.

The lapse in time during this appeals process left Clay worried about his professional and financial future. Eighteen months later, and five weeks after his death, Clay's appeal finally went through and the VA rated Clay's PTS 100 percent. The stresses and delays Clay experienced with his claim and appeal processes were also mirrored in his experience accessing and using VA medical care and educational benefits.

Clay exclusively used the VA for his medical care after separating from the Marine Corps. Immediately after his separation Clay lived in the Los Angeles area and received care at the VA medical center there in LA. Clay constantly voiced concerns about the care he was receiving, both in terms of the challenges he faced with scheduling appointments as well as the treatment he received for his PTSD, which consisted solely of medication. He received counseling only as far as a brief discussion regarding whether the medication he was prescribed was working or not. If it was not, he would be given a new medication. Clay used to say, "I'm a guinea

pig for drugs. They'll put me on one thing, I'll have side effects, and then they put me on something else."

At the same time, Clay also expressed frustration with delayed GI Bill benefit payments. This only aggravated his PTS symptoms and inhibited his ability to heal and move on with his life.

In late 2010, Clay moved briefly to Grand Junction, Colorado, where he also used the VA there, and then finally home to Houston to be closer to our family. The Houston VA would not refill prescriptions Clay had received from the Grand Junction VA because they said that prescriptions were not transferable and a new assessment would have to be done before his medications could be re-prescribed.

Clay only had two appointments in January and February of 2011, and neither was with a psychiatrist. It wasn't until March 15th that Clay was finally able to see a psychiatrist at the Houston VA medical center. But after the appointment, Clay called me on his way home and said, "Mom, I can't go back there. The VA is way too stressful and not a place I can go. I'll have to find a Vet Center or something."

After Clay's death, I personally went to the Houston VA medical center to retrieve his medical records, and I encountered an environment that was highly stressful. There were large crowds, no one was at the information desk and I had to flag down a nurse to ask directions to the medical records area. I cannot imagine how anyone dealing with mental health injuries like PTS could successfully access care in such a stressful setting without exacerbating their symptoms.

Just two weeks after his appointment with a psychiatrist at the Houston VA medical center, Clay took his own life. The date was March 31, 2011. The cause of death—a self-inflicted gunshot wound to his head.

Clay was consistently open about having PTS and survivor's guilt, and he tried to help others coping with similar issues. He worked hard to move forward and found healing by helping people, including participating in humanitarian work in Haiti and Chile after devastating earthquakes.

He also starred in a public service advertising campaign aimed at easing the transition for his fellow veterans, and he helped wounded warriors in long distance road biking events. Clay fought for veterans in the halls of Congress and participated in Iraq and Afghanistan Veterans of America's annual Storm the Hill campaign to advocate for legislation to improve the lives of veterans and their families.

Clay's story details the urgency needed in addressing this issue. Despite his proactive and open approach to seeking care to address his injuries, the VA system did not adequately address his needs. Even today, we continue to hear about both individual and systemic failures by the VA to provide adequate care and address the needs of veterans.

Not one more veteran should have to go through what Clay went through with the VA after returning home from war. Not one more parent should have to testify before a congressional committee to compel the VA to fulfill its responsibilities to those who served and sacrificed.

You all, especially here in the House of Representatives, have been aggressive, courageous, and vigilant in holding the VA accountable and trying to equip it with the resources it needs to care for veterans. But given the magnitude and extent of the problems at the VA, more is needed.

Mr. Chairman, I understand that today you are introducing the Suicide Prevention for America's Veterans Act. The reforms, evaluations, and programs directed by this legislation will be critical to helping the VA better serve and treat veterans suffering from mental injuries from war. Had the VA been doing these things all along, it very well may have saved Clay's life.

Mr. Chairman, Richard and I again appreciate the opportunity to share Clay's story and our recommendations for how we can help ensure the VA will uphold its responsibility to properly care for America's veterans.

Thank you.

Prepared Statement of Peg Portwine

I am here before you to tell the testimony of my son Spc. Brian Portwine. Brian was an infantryman and serve in Operation Iraqi Freedom in 2006–2008 and in Operation Enduring Freedom in 2010.

During his first tour he was deployed to Baghdad and his job was to patrol Haifa street, which was a very dangerous area. This was before the surge of troops. During this tour, Brian lost 8 brothers.

While in Iraq in 2006 Brian was in a Bradley tank that was struck by a RPG. The tank was immediately engulfed in flames and the driver was knocked unconscious. Due to the driver being able to hydraulically let down the ramp the 5 soldiers had to scramble thru the fire to manually lower the ramp and miraculously they were able to get out, all with injuries. Brian suffered a blast concussion and had lacerations to his face and legs from shrapnel. This was Brian's first episode of Traumatic Brain Injury.

During another mission Brian and his 1st Sgt were on patrol in a Humvee and had switched seats so Brian was now in the passenger seat. Twenty minutes later an IED hit the Humvee and his 1st Sgt was killed and Brian was thrown from the Humvee and injured his back. Besides these 2 incidents Brian was involved in 5 other IEDs during his 15 month deployment.

After coming home after his 1st deployment Brian had trouble with short term memory. When his friends were going somewhere he would often say "where are we going again, you know I have scrambled brains" To help cope with this he would post everything he had to do on his calendar or computer.

In 2010 Brian was recalled to the Army and deploying from Fort Shelby, Miss. During this deployment Brian did not email or call home or to his friends. Little did we know how he was struggling with PTSD and TBI. He had panic attacks being on the same roads he had traveled on the 1st tour where IEDs went off often. He had nightmares 3 x a week and would wake up his unit and someone would have to wake him up. He suffered with anxiety, depression,

insomnia, poor concentration, and hypervigilance. But he was never sent home.

After returning from his 2nd deployment in Dec. 2010 to Daytona Beach he did not want to return to school. We did not know he had applied for disability due to his PTSD/TBI. He knew the stigma of saying you had PTSD so he kept it to himself.

During out processing from Fort Shelby in 2010 Brain was diagnosed with PTSD, TBI, depression, and anxiety. During one assessment the counselor stated "Pt cannot remember questions asked". He had guilt, anxiety, hypervigilance, poor concentration, rage and anger but the VA/DoD told him to follow-up with the local VA outpatient.

I am horrified by this. All his symptoms are classic symptoms of PTSD and TBI. He should have been sent to the National Intrepid Center for excellence at Fort Hood, TX where they have a 3–4 week program for those with TBI and PTSD.

Brian deteriorated quickly from Dec, 2010 to May 2011. He could not stand how he acted but had no coping methods or treatment. It took a toll on his relationships with friends.

If the DoD and VA assessed Brian at high risk for suicide it is their duty to treat him. But he got nothing.

Brian's unit has lost 3 others to suicide, one just June 21st, 2014. It is a very slippery slope from PTSD and TBI and the VA should realize this.

Our soldiers never hesitated in their missions to protect, serve, and sacrifice for our country.

Now it is time for the VA to prove their commitment to our solders.

I never knew of Brian's PTSD and TBI or high suicide risk. I would think a life threatening event like this should be told to the emergency contact person.

The VA needs to work the service organizations and include the families in the plan of care.

I beg this Committee to pass act 2182, the Suicide Prevention for Americans Act

As a mother I have lost my only miracle child to suicide. It is devastating!

I would like to close by saying a quote from Rose Kennedy. It says, "time heals all wounds."

I disagree. The wounds remain. In time the mind to protect its sanity covers them with scar tissue and the pain lessen. But it is never gone. Thank you.

Prepared Statement of Josh Renschler

Chairman Miller, Ranking Member Michaud, and Members of the Committee:

I am honored to have the opportunity to speak to you today regarding VA mental health care.

I proudly served as a United States Army Infantryman for 5½ years, and was medically retired due to severe injuries from a mortar blast in Iraq. Working now with a non-profit in Washington state, I assist servicemembers, veterans and their families who are

struggling due to deployment-related trauma. I have a great deal of experience with VA medical facilities and VA mental health care—not just as a patient, but as an advocate for many other warriors I've mentored, and through dialogue with veteran leaders from across the country. Recently VA leadership invited me to participate in an online learning session through VA's eHealth University to share my perspective as a veteran accessing VA care, so VA clinicians and staff could have the opportunity to learn from my experience.

That experience with the VA health care system began in 2008. As I explained in testifying before the Subcommittee on Health last year, that experience began badly. At the time I was being treated for anxiety, sleep problems, migraines, pain, and seizures, and it had taken Army doctors 3 years to determine the right medications and dosages to treat those conditions. Because several of those 8 different medications were not on the VA formulary, my primary care provider at the American Lake VA Medical Center substituted different medications, despite the urging of my wife due to the failure of these medications in the past. The side effects caused me so much difficulty that I began to backslide in my recovery. I was soon on 13 medications (some to simply counter the effects of others); and soon all my conditions worsened and I had a severe panic attack at work.

Since then, with my multiple medical and surgical issues and my work with other warriors, I've had extensive experience with VA care. As to VA mental health care in particular, I've benefitted from excellent care at a VA medical center that for a period of time made that care a priority and staffed it accordingly. The facility provided easy one-stop access to OEF/OIF/OND veterans through a "Deployment Health Team" that brought together in one spot medical, mental health, pharmacy and social work providers. Unfortunately, medical center leadership concluded that providing this excellent, well-staffed interdisciplinary care was too costly. With budget considerations trumping patient-centered care considerations, the team's providers were reassigned. (While the facility still has a unit called the "deployment health team" it now provides only primary care and social work services. Having only a skeleton staff, the team manages a huge caseload and, as a result, has long wait times and shorter appointments.) Instead of seeing an interdisciplinary team, GWOT veterans now go through an impersonal intake/assessment process. From there they are channeled into a conventional system where providers do not work as a team, and where veterans have to navigate their way to the different services scattered across the sprawling, complex campus to get the care they need. For many of the warriors with whom I've worked, just navigating around the many buildings housing different treatment services in this complex facility is anxiety-provoking.

Interdisciplinary, Team-Based Care: Key to Mental Health Care and Suicide Prevention

I cite my and other veterans' very positive experience with this interdisciplinary, team-based-care approach (and the effective demise of that program) because it highlights some very important points. First, veterans with mental health issues are seldom going

to open up to a clinician they've never met and begin discussing painful, private issues. They're more likely to skirt those deeper issues and simply report that they're experiencing difficulty sleeping, having headaches, or some more general problem, with the hope that there's medication to provide relief. It takes time to build trust to open up to deeper problems or even to recognize them. And not every clinician is necessarily skilled at eliciting that trust or insightful enough to gauge from a veteran's demeanor that there are deeper issues, and to ask the probing questions that might begin to identify them. Working with a team increases the likelihood that one or more will see things that others missed.

Interdisciplinary care has profound implications for suicide-prevention. Veterans will rarely volunteer to clinicians that they're contemplating suicide, and there aren't obvious signs by which a mental health provider can reliably identify a veteran as a suicide risk. And we certainly won't prevent suicides by having physicians go down a mandatory checklist and mechanically asking a veteran-patient a series of questions like "have you thought recently about harming yourself?" While people who commit suicide often have a mental health condition, that alone is seldom an explanation for a suicidal act. Life events and problems are often important catalysts.[1] But in a treatment system, where, for example, I'm sent to Building 3 to see the neurologist for severe back pain, to Building 61 to see a psychiatrist for medication to help with sleep problems, and to Building 81 to see my social worker for serious relationship problems, no one is getting a full picture and no one can see and put together the red-flag signs that may point to the fact that my life is spinning out of control. This isn't just a problem in VA. But as an integrated health care provider, VA can provide the kind of care I got from the interdisciplinary deployment health team in the past. There, the team members shared observations, and could see potential problems as they had begun to develop and question veterans about issues before they became explosive. In my view, therefore, it is much less fruitful to press VA to establish or re-design "suicide prevention programs" than to improve VA health and mental health care delivery.

"Access" Is Only Half the Equation

When we discuss mental health care, it's not enough to talk about "access." One has to get to the question, "access to what?" Access to a system in which I go to three different buildings to see three different providers for health issues which are all related to my mental health—pain, lack of sleep, and relationship issues—is a real problem when those providers aren't working as a team, and aren't even given the needed time to coordinate their observations and treatment approaches with one another. In other words, access to mental health care isn't enough unless that mental health care is also effective.

This is particularly important as it relates to combat veterans; having been trained to tough it out and soldier through pain, they often come into treatment hesitantly and even distrustfully. A provider needs to understand that warrior mentality, and often must

[1] Keith Hawton, "Suicide prevention: a complex global challenge," 1(1) The Lancet (June 2014), 2.

work hard to win that veteran's trust. A clinician who doesn't understand that warrior culture or isn't permitted the time needed to develop that relationship of trust is unlikely to have success in helping that warrior overcome his or her demons. In my experience, veterans have a greater likelihood in the VA of working with a clinician who has some understanding of that warrior experience and of working with combat-related mental health problems than they would "outside." But a veteran who has to work with a provider who lacks cultural awareness or whose patient care load doesn't allow time will inevitably become frustrated (whether in the VA or outside) and often drop out of treatment. Similarly, many veterans who aren't ready for an often very traumatic exposure-based therapy have dropped out of these intense multi-week treatment programs, even though they are hailed as an "evidence-based therapy." I question the wisdom of evaluating facilities, as VA does, based on the percentage of veterans with PTSD who complete these evidence-based therapies. While the underlying intent has merit, there are many reasons that veterans don't complete those programs: for some, they're just too intense, for others, it's too difficult to come in for treatment that often. The bottom line is that this performance requirement, like others, can not only be "gamed," it fails to take the patient's preferences into account. VA has often cited the importance of a veteran-centered approach to mental health care. But if care is to be veteran-centered, as it must be, it's critical to recognize each veteran's unique situation, and their individual treatment preferences, and build systems to meet their needs and preferences, not the other way around. That seems to me, to be essential to providing effective care, whether in the VA or elsewhere.

The warriors I'm describing—and I've worked with many of them—very often don't come into treatment for PTSD or anxiety or depression when the textbooks say they should, at an early stage when the problems can be most easily dealt with. They finally come into treatment when things have gotten really bad. Sometimes that's when their spouse is threatening to leave. In some cases, it's when they've gotten into trouble with law enforcement, often involving substance abuse. Or it might be when the veteran has experienced a panic attack or overwhelming thoughts of self-harm, to cite some common examples. Timeliness is obviously critical in those kinds of instances, and they're not at all isolated occurrences among OEF/OIF veterans. Clearly a veteran in distress who finally asks for help for a combat-incurred mental health condition needs to get into treatment. VA policy did establish the expectation that veterans were to be afforded initial appointments for mental health care within 14 days. But—just as with the challenges many VA facilities faced in meeting that requirement for primary care appointments, limitations in mental health staffing at many facilities have made provision of timely mental health care either very challenging or impossible to meet. What I saw facilities do was to reconfigure their staffing to meet the technical requirement of the 14-day rule. At these facilities, warriors with mental health issues were assessed within the 14-day window; in that way they were "seen," even though facility staffing wouldn't permit an initial treatment appointment itself until many weeks later. Understand-

ably, warriors who are at the end of their rope and finally seek help at a VA medical facility often experience deep frustration and even despair if they are told to wait six weeks or longer to begin therapy. Deferred treatment can set the stage for potentially tragic outcomes.

I do believe that there are VA facilities that are providing veterans timely access to effective, patient-centered mental health care. But that's certainly not the case systemwide. Unfortunately there are no measures in place to assess patient outcomes. (In that regard, I would suggest that the Committee look into the rates at which OEF/OIF veterans drop out of PTSD treatment programs, surely one relevant indicator). But with what appear to be widespread disparities in the timeliness of VA care (but not necessarily the same focus on care-effectiveness), I understand that some have called for expanding veterans' access to care from non-VA providers.

Purchased Care: No Silver Bullet

It seems doubtful that that step by itself can be the "silver bullet" solution for veterans' mental health care. For one thing, it assumes first that the private sector holds a key to meeting VA's mental health workforce "supply" problem. But a 2013 report to Congress warns of "an already thinly stretched [behavioral health] workforce."[2] The report points to longstanding concerns about a national shortage of behavioral health workers, cited in previous publications, including the following:

- A 2009 Study that found that 77 percent of counties had a severe shortage of mental health workers, both prescribers and non-prescribers and 96 percent of counties had some unmet need for mental health prescribers;
- A 2012 Government report that found there were 3669 areas of the country with shortages of mental health professionals;
- A 2007 Report that 55% of U.S. counties, all rural, had no practicing psychiatrists, psychologists or social workers; and
- A 2010 Government report finding that more than two-thirds of primary care physicians who tried to obtain outpatient mental health services for their patients reported they were unsuccessful due in part to shortages in mental health care providers.[3]

Not only is there a real issue in terms of a national mental health workforce shortage, but there are real quality of care issues to contend with. According to the 2003 report of a presidential commission on mental health care in this country, "not only is there a shortage of [mental health providers, but those providers who are available are not trained in evidence-based and other innovative practices. This lack of education, training, or supervision leads to a workforce that is ill-equipped to use the latest breakthroughs in

[2] Hyde, P., "Report to Congress on the Nation's Substance Abuse and Mental Health Workforce Issues," Substance Abuse and Mental Health Services Administration (Jan. 24, 2013), 5. Accessed at *http://store.samhsa.gov/shin/content/PEP13-RTC-BHWORK/PEP13-RTC-BHWORK.pdf*

[3] Id., 10.

modern medicine."[4] The Commission found that "too few benefit from available treatment" because "state-of-the-art treatments vital for quality care and recovery . . . are not being used."[5] A later report by the Institute of Medicine that focused on improving the quality of behavioral health care cited "numerous studies [that] document the discrepancy between the [mental health and substance use] care that is known to be effective and the care that is actually delivered."[6]

A Better Purchased-Care Model

Years ago, Washington State's Department of Veterans Affairs, recognized the unique needs of Wartime Veterans and their families and established a PTSD Counseling Program to provide access to best practices of care for those who otherwise couldn't get that care through VA because of service-unavailability or distance. Under the Department's program, 30 licensed practitioners across the state provide counseling services at State expense; importantly each has a minimum of 24 years of experience and all providers are veterans or are trained to be military and veteran culturally competent. Veterans need only contact the program director who will determine the best practitioner for the individual situation and connect the Veteran with that office. Given the counselor's experience and backgrounds, the veterans I've referred to the program have found it very helpful. (For the same reasons, veterans with whom I've worked and whom I've met around the country have similarly positive experiences with VA's Vet Centers.) But in the most recent instance, the veteran I referred to the Washington State program was informed that all the providers in his area had full case loads and were not taking new clients.

I don't want to suggest that VA could not benefit from greater use of purchasing care, where that care is available and where it offers promise of being effective. But it would not be particularly helpful simply for veterans to be "seen" outside the VA by a provider who is not equipped to provide effective care—for lack of training in treating combat- or MST-related PTSD, for lack of "cultural competence," or any other shortcomings. In short, it is pretty clear that providing an avenue to mental health care, even if there is a source, does not assure that veterans will get effective care.

Improving VA Mental Health Care

So what's the answer? It's important to appreciate that the VA health care facilities do have caring, dedicated providers. I know, for example, that some of my own health care providers are coming in on weekends and staying late at night to keep up with their work. I don't believe the answer to improving VA mental health care is to demand more of those clinicians.

But I think we have to demand that VA mental health care—especially for veterans with service-incurred mental health conditions—become a top priority. VA leaders have, of course, repeatedly

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[4] "Achieving the Promise: Transforming Mental Health Care in America," The President's New Freedom Commission on Mental Health (July 2003), 70. Accessed at *http://store.samhsa.gov/shin/content//SMA03-3831/SMA03-3831.pdf*.

[5] Id., 68.

[6] Institute of Medicine, "Improving the Quality of Health Care for Mental Health and Substance-Use Conditions," National Academies Press, 2006, 35.

stated that it is. But if that were so, why would my VA medical center in Washington State have effectively eliminated—for reasons of cost—the one program through which OEF/OIF veterans got excellent mental health care? Why, given strong policies on PTSD care would there be variability on PTSD management from facility to facility, and why would it be "unclear whether VA leaders adhere to [VA PTSD] policies," as a recent Institute of Medicine study reported.[7] And why would veterans in facilities across the country be having problems getting timely and effective VA mental health care?

From this veteran's perspective—with staggering numbers who have come back from war with psychic wounds and PTSD—the starting point for improving VA mental health care lies with VA leadership at all levels embracing the principle that providing timely, effective mental health care for those with service-incurred mental health conditions—whether due to combat, military sexual trauma, or otherwise—MUST be a top priority! These are not just words. We've seen with the example of VA's efforts to combat veteran homelessness, that this Department can have a real impact when the direction and priority are clear, when artificial performance requirements don't create distortions, and when clinicians have latitude to provide good care. Improving mental health care may be as or more complex a challenge, but it surely requires a comprehensive approach. I don't think legislation is necessarily the path through which to meet the challenge, although there are important steps Congress can take. These might include:

- Providing incentives to help increase the mental health workforce;
- Funding training programs for non-VA mental health providers on treating service-incurred PTSD and on military culture to improve clinicians' expertise and cultural competence in working with military and veteran populations; and
- Increasing VA funding for research to find better treatments for PTSD.

But I believe that there is much that VA should, and with the right leadership, can do itself. First, I would reiterate the point I made above about instituting interdisciplinary, team-based treatment. While VA's PACT program employs that approach in the primary care arena, it shouldn't end there. There is also much to be learned from the Vet Center program, and why veterans—who have to feel safe and trust their provider if they are to engage in mental health care—are comfortable in that setting. Vet Center counsellors are typically veterans, and often combat veterans. Having a connection with peers is critical. And Vet Centers engage family members as well. I believe VA medical centers and clinics would have far greater success in treating veterans for PTSD and other mental health conditions—and keeping them in treatment—if they routinely engaged the family at the same time.

Many of the problems with which this Committee has wrestled in overseeing VA seem to relate to management practices. Perhaps it's time for VA to change course and rely more on the dedicated

[7] Institute of Medicine, "PTSD in Military and Veteran Populations," National Academies Press, 2014, 6.

clinicians in this health care system, and less on arbitrary performance requirements and metrics. As the ones who are closest to the patients, the clinicians are probably best able to develop veteran-centered programs—like the Deployment Health Team I described earlier.

Finally I would draw on my own experience working with other warriors as a peer-mentor. As a former infantryman who was badly injured and experienced psychic wounds too, I can say things to other warriors that a clinician can't and I can assure those warriors from my own experience that mental health treatment can work. To its credit, VA has hired and provided for the training of more than 800 peer-specialists, to work as members of VA mental health treatment teams. That is a great concept, but with the numbers of veterans coming to VA for mental health care, I would recommend that that number be greatly expanded.

I hope my experiences, observations, and recommendations are of some help, and would be pleased to answer your questions.

Prepared Statement of Maureen McCarthy

Good morning, Chairman Miller, Ranking Member Michaud and Members of the Committee. Thank you for the opportunity to discuss the provision of mental health care to Veterans, particularly those who are at risk for suicide. I am accompanied today by Dr. David Carroll, National Mental Health Program Director for Program Integration, Dr. Harold Kudler, Acting Chief Consultant for Mental Health Services and Mr. Michael Fisher, Operation Enduring Freedom/Operation Iraqi Freedom Specialist. My written statement will provide a brief overview of VA's mental health care system and programs for suicide prevention.

Mental Health Care Overview

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require optimal support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health system. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in Fiscal Year (FY) 2006 to more than 1.4 million in FY 2013. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, posttraumatic stress disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma (MST). In addition, VA has partnered with the Department of Defense (DoD) to develop the VA/DoD Integrated Mental Health Strategy to advance a coordinated public-health model to improve access, quality, effectiveness, and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families.

VA has many entry points for VHA mental health care, through 150 medical centers, 820 Community-Based Outpatient Clinics

(CBOCs), 300 Vet Centers that provide readjustment counseling, the Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services. Since March 2012, VA has added 2,444 mental health full-time equivalent employees and hired 915 peer specialists and apprentices. As of January 2014, VHA has 21,128 Mental Health full-time equivalent employees providing direct inpatient and outpatient mental health care. VA has expanded access to mental health services with longer clinic hours, telemental heath capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. Starting in FY 2012, site visits have been conducted to the mental health programs in each VA facility. All facilities were visited in the initial round, and subsequently one third are being visited each year by a survey team from VHA's Office of Mental Health Operations. The site visits are informed by ratings on performance measures; findings from the visits are used to develop action plans; and improvements are evaluated by following performance measures as well as the milestones and deliverables included in the plans. In an effort to increase access to mental health care and reduce any stigma associated with seeking such care, VA has integrated mental health into primary care settings. From the beginning of FY 2008 to March 2014, VA has provided more than 3.6 million Primary Care-Mental Health Integration (PC–MHI) clinic visits to more than 942,000 unique Veterans. This improves access by bringing care closer to where the Veteran can most easily receive these services, and quality of care by increasing the coordination of all aspects of care, both physical and mental. Among primary-care patients with positive screens for depression, those who receive same-day PC–MHI services are more than twice as likely to receive depression treatment as those who did not.

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, such as PTSD, substance use disorders, and suicidality. While VA is primarily focused on evidence-based treatments, we are also assessing complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD. VA has trained over 5,900 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, as indicated in the VA/DoD Clinical Practice Guideline for PTSD [1] VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioners (including primary care practitioners and Home-

[1] *http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg-PTSD-FULL-201011612.pdf.*

less Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, over 500 VA practitioners have utilized this service.

We know that there have been Veterans with complaints about access. We take those concerns seriously and continue to work to address them. Receiving direct feedback from Veterans concerning their care is vitally important. During the fourth quarter of FY 2013, a survey of 26 questions was mailed to over 40,000 Veterans who were receiving mental health care. This survey shows VHA's effort to seek direct input from Veterans in understanding their perceptions regarding access to care. We recognize that this is data only from those who chose to respond. We will bear those responses in mind as we strive to improve the timeliness of appointments; reminders for appointments; accessibility, engagement, and responsiveness of clinicians; availability and agreement with clinician on desired treatment frequency; helpfulness of mental health treatment; and treatment with respect and dignity.

Programs and Resources for Suicide Prevention

Overall, Veterans are at higher risk for suicide than the general U.S. population, notably Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. VA recognizes that even one Veteran suicide is too many. We are committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing Veterans' access to high quality mental health care and programs specifically designed to help prevent Veteran suicide.

In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line/Military Crisis Line (VCL/MCL) connects Veterans and Servicemembers in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline that offers 24/7 emergency assistance. August will mark seven years since the establishment of the initial program, which was later rebranded to show its direct support for Servicemembers. It has expanded to include a chat service and texting option. As of March 2014, the VCL/MCL has rescued 37,000 actively suicidal Veterans. As of March 2014, VCL/MCL has received over 1,150,000 calls, over 160,000 chat connections, and over 21,000 texts; it has also made over 200,000 referrals to Suicide Prevention Coordinators (SPCs). In accordance with the President's August 31, 2012, Executive Order titled, "Improving Access to Mental Health Services for Veterans, Servicemembers and Military Families," VA completed hiring and training of additional staff to increase the capacity of the VCL/MCL by 50 percent.

VA has a network of over 300 SPCs located at every VA medical center and the largest CBOCs throughout the country. Overall, SPCs facilitate implementation of suicide prevention strategies within their respective medical centers to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran population, particularly Veterans identified to be at high risk for suicidal behavior. SPCs receive follow-up consults from the VCL/MCL call responders after immediate needs are addressed and any needed rescue actions are made. SPCs are required to follow

up on consults received from the VCL/MCL within one business day to ensure timely access to care for Veterans callers who need additional support, treatment, or other services, including enrollment into VA's health care system. SPCs also plan, develop, implement, and evaluate their facility's Suicide Prevention Program to ensure continual quality improvement and excellence in customer service. SPCs are responsible for implementing VA's Operation S.A.V.E (Signs of suicidal thinking, Ask the questions, Verify the experience with the Veteran, and Expedite or Escort to Help). This is a one-to-two hour in-person training program provided by VA SPCs to Veterans and those who serve Veterans to help prevent suicide. Suicide prevention training is provided for every new VHA employee during Employee Orientation.

SPCs participate in outreach activities, which remain critically important to VA's goals of reducing stigma for mental health issues and improving access to service for all Veterans. Examples include community suicide prevention training and other educational programs, exhibits, and material distribution; meetings with state and local suicide prevention groups; and suicide prevention work with Active Duty/National Guard and Reserve units as well as college campuses. To date, each SPC is required to complete five or more outreach activities in their local community each month.

Veterans may be at high risk for suicide for various reasons. Determination of suicide risk is always a clinical judgment made after an evaluation of risk factors (e.g., history of past suicide attempts, recent discharge from an inpatient mental health unit), protective factors, and the presence or absence of warning signs. VHA Handbook 1160.01, "Uniform Mental Health Services in VA Medical Centers and Clinics," requires inpatient care be available to all Veterans with acute mental health needs (including imminent danger of self harm), either in a VA medical center or at a nearby facility through a contract, sharing agreement.

To ensure that high-risk Veterans are being monitored appropriately, SPCs manage a Category I Patient Record Flag (PRF) with a corresponding High-Risk List. The primary purpose of the High Risk for Suicide PRF is to communicate to VA staff that a Veteran is at high risk for suicide, and the presence of a flag should be considered when making treatment decisions. Once a Veteran is identified as high-risk, the SPC ensures that weekly contact is made with the Veteran for at least the first month, and that continued follow-up is made, as clinically appropriate. The SPC works with the treatment team to ensure that patients identified as being at high risk for suicide receive follow up for any missed mental health and substance abuse appointments at VA. Clinicians are required to initiate at least three attempts to contact Veterans on the High-Risk List who fail to appear for mental health appointments and ensure appropriate documentation. If attempts to contact the Veteran are unsuccessful, the SPC collaborates with the Veteran's treatment team to decide what further action is appropriate involving a range of options from continued outreach efforts to the Veteran and/or family members up to requesting local law enforcement perform a welfare check in-person.

SPCs ensure that all Veterans identified as high risk for suicide have completed a safety plan that is documented in their medical

record, and that the Veteran is provided a copy of his or her safety plan.

National suicide prevention outreach efforts continue to expand and include targeted efforts for Veterans, Servicemembers, families, and friends. VA has sponsored public service announcements, rebranded and optimized the VCL/MCL Web site for mobile access and viewing, and developed social and traditional media advertisements designed to inform Veterans and their families of VA's VCL/MCL resources including phone, online chat, and text services.

In addition, VA has established an online Community Provider Toolkit[2] for individuals outside of VA who provide care to Veterans. This Web site features key tools to support the mental health services provided to Veterans including information on connecting with VA, understanding military culture and experience, and working with patients with a variety of mental health conditions. There is also a comprehensive Suicide Prevention Mini-Clinic which provides clinicians with easy access to useful Veteran-focused treatment tools, including assessment, training, and educational handouts.[3]

In 2010, DoD and VA approved plans for a Joint Suicide Data Repository (SDR) as a shared resource for improving our understanding of patterns and characteristics of suicide among Veterans and Servicemembers. The combined DoD and VA search of data available in the National Death Index represents the single largest mortality search of a population with a history of military service on record. The DoD/VA Joint SDR is overseen by the Defense Suicide Prevention Office and VA's Suicide Prevention Program.

On February 1, 2013, VA released a report on Veteran suicides, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. With assistance from state partners providing real-time data, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA in identifying where at-risk Veterans may be located and improving the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. These data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary care, in order to replicate effective programs in other areas. VA continues to receive state data which is being included in the SDR. VA plans to update the suicide data report later this year.

In 2011, the most recent year for which national data are available, the age-adjusted rate of suicide in the U.S. general population was 12.32 per 100,000 persons per year. At just over 12 for every 100,000 U.S. residents, the 2011 rate of suicide has increased by approximately 15 percent since 2001. Rates of suicide in the United States are higher among males, middle-age adults, residents in rural areas, and those with mental health conditions.

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[2] *http://www.mentalhealth.va.gov/communityproviders.*
[3] *http://www.mentalhealth.va.gov/communityproviders/clinic-suicideprevention.asp.*

The most recent available data shows that suicide rates are generally lower among Veterans who use VHA services than among Veterans who do not use VHA services. In 2011, the rate of suicide among those who use VHA services was 35.5 per 100,000 persons per year; a decrease of approximately 6 percent since 2001. Rates of suicide among those who use VHA services have remained relatively stable; ranging from 36.5 to 37.5 per 100,000 persons per year over the past 4 years. Despite evidence of increased risk among middle-aged adults (35–64 years) in the U.S. general population, rates of suicide among middle-aged adults who use VHA services have decreased by more than 16 percent between the years 1999–2010. For males without a history of using VHA services, the rate increased by more than 60 percent, whereas for males with a history of using VHA services, the rate decreased by more than 30 percent. Decreases in suicide rates and improvements in outcomes were also observed for some other high-risk groups. Between 2001 and 2010, rates of suicide decreased by more than 28 percent among VHA users with a mental health or substance abuse diagnosis, and the proportion of VHA users who die from suicide within 12 months of a survived suicide attempt has decreased by approximately 45 percent during the same time period.[4]

Comparisons of rates of suicide among those with use of VHA services and the U.S. general population are ongoing. However, in 2010, rates of suicide were 31 percent higher among males who used VHA services when compared to rates of suicide among males in the U.S. general population. During that same year, women who used VHA services were more than twice as likely to die from suicide when compared to women in the U.S. adult population. Increases in rates of suicide have also been identified for younger males who use VHA services. Over the last three years, rates of suicide have increased by nearly 44 percent among males under 30 years of age who use VHA services and by more than 70 percent among males who use VHA services between 18 and 24 years of age.

In response to these findings, VA has been focusing on public health and community programming. This includes increased and targeted outreach efforts throughout the country to Veterans and their family members with significant emphasis on safety. We encourage Veterans and their families to learn more about mental illness and to take precautions particularly during times of stress (e.g., properly storing weapons and medications). Being alert to items in the environment that offer potential means of suicidal behavior can make a life-saving difference during a crisis. Messaging and interventions are geared toward those who are most at risk for suicide, including our younger male Veterans, women Veterans, Veterans with mental health conditions, and established patients who are known to be at high risk for suicide. Strategies include specialized training for VHA staff to enhance their recognition and treatment of those at risk, and offering Veterans skills-building and other preventive strategies to address major stressors in their lives. Furthermore, VA is engaged in ongoing research to determine the most effective mental health treatments and suicide prevention

[4] *www.mentalhealth.va.gov/docs/Suicide-Data-Report-Update-2014.pdf.*

strategies. Finally, VA has established the Mental Health Innovations Task Force, which is working to identify and implement early intervention strategies for specific high-risk groups including Veterans with PTSD, pain, sleep disorders; depression, and substance use disorders. Through early intervention, VA hopes to reduce the risk of suicide for Veterans in these high-risk groups.

Readjustment Counseling Service (RCS)

VA's RCS provides a wide range of readjustment counseling services to eligible Veterans and active duty Servicemembers who have served in combat zones and their families. RCS also provides comprehensive readjustment counseling for those who experienced military sexual trauma, as well as offering bereavement counseling to immediate family members of Servicemembers who died while on active duty. These services are provided in a safe and confidential environment through a national network of 300 community-based Vet Centers located in all 50 states (as well as the District of Columbia, American Samoa, Guam, and Puerto Rico), 70 Mobile Vet Centers, and the Vet Center Combat Call Center (877–WAR–VETS or 877–927–8387). In FY 2013, Vet Centers provided over 1.5 million visits to Veterans, active duty Servicemembers, and their families. The Vet Center program has provided services to over 30 percent of OEF/OIF/Operation New Dawn Veterans who have left active duty.

Closing Statement

Mr. Chairman, VA is committed to providing timely, high quality of care that our Veterans have earned and deserve, and we continue to take every available action and create new opportunities to improve suicide prevention services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

IRAQ AND AFGHANISTAN
VETERANS OF AMERICA

Alex Nicholson

Statement of Iraq & Afghanistan Veterans Of America
before the
House Committee on Veterans' Affairs
for the hearing on
Mental Health and Suicide Prevention

July 10, 2014

Chairman Miller, Ranking Member Michaud, and Distinguished Members of the Committee:

On behalf of Iraq and Afghanistan Veterans of America (IAVA), thank you for the opportunity to share with you our views and recommendations regarding mental health care services and suicide prevention efforts at the Department of Veterans Affairs (VA). Combatting veteran suicide is IAVA's top priority for 2014, and it's a critically important issue that affects the lives of tens of thousands of service members and veterans.

As the nation's first and largest nonprofit, nonpartisan organization for veterans of the wars in Iraq and Afghanistan, IAVA's mission is critically important but simple – to improve the lives of Iraq and Afghanistan veterans and their families. With a steadily growing base of nearly 270,000 members and supporters, we aim to help create a society that honors and supports veterans of all generations.

In partnership with other military and veteran service organizations, IAVA has worked tirelessly to see that veterans' and service members' health concerns, including mental health care, are comprehensively addressed by the VA. IAVA understands the necessity of integrated, effective, world-class healthcare for service members and veterans, and we will continue to advocate for the development of increased awareness, recognition and treatment of service-

connected health concerns.

In IAVA's 2014 membership survey, our members listed suicide prevention and mental health care as the number one concern facing this generation of veterans. In that same survey, 47 percent of respondents reported they knew an Iraq or Afghanistan veteran who had attempted suicide. Over 40 percent also knew an Iraq or Afghanistan veteran who had died by suicide[1].

But this is an issue that is affecting more than just new veterans. The VA's 2012 Suicide Data Report showed that at least 22 veterans die by suicide every day[2]. These numbers are staggering, and they are a clear indication that a multi-faceted, comprehensive approach to addressing this issue is desperately needed.

In response to the overwhelming need for action, IAVA launched the "Campaign to Combat Suicide" this year, which includes a call to pass a comprehensive legislative package that can serve as the cornerstone for additional efforts across the government and the nation. In addition to legislation, IAVA is calling on President Obama to issue an executive order to address additional aspects of suicide prevention efforts, and IAVA is working to connect one million veterans with mental health services across the country this year.

The need to examine mental health services and suicide prevention efforts provided to veterans is even more critical in light of the recent VA scheduling crisis. In addition to the general delayed access to care veterans are experiencing, investigations have also uncovered cases of significantly delayed access to mental health care services. In a recent audit of scheduling wait times at the VA, none of the 141 medical facilities audited provided an appointment for mental health care within 14 days. In fact, the average wait time at 30 facilities for mental health care was more than 40 days[3]. While no veteran should have to wait months for a medical appointment, veterans utilizing mental health care services should never have to wait an unreasonable amount of time to be seen by a mental health care provider. Providing timely and efficient mental health care must be a priority of the VA moving forward.

Increasing access to care is a critical aspect of addressing the mental health care needs of veterans. If a veteran is ready to seek mental health support and

services, the VA must be available to meet that need. There are far too many stories of veterans who have reached out to the VA seeking mental health care only to be met with long wait times and bureaucratic obstacles. Removing burdensome obstacles and implementing veteran-centric, high-touch and high-technology scheduling practices is the first step towards building a system that veterans can trust and more effectively utilize.

Increasing the accessibility of mental health care services must also be coupled with increasing access to care for vulnerable populations of veterans currently excluded from VA care. It is well known that combat veterans have five years of eligibility for VA health care if they separated from the military under other than dishonorable conditions. However, some veterans who were separated from the military under less than honorable conditions may have been unjustly given that discharge characterization due to misdiagnosed or undiagnosed mental health injuries.

Between 2001-2011, an estimated 30,000 service members may have received a downgraded discharge due to a misdiagnosis of "personality disorder"[4]. Even more troubling, an unknown number of service members were punitively discharged for disciplinary actions that may have been connected to undiagnosed mental health injuries. It is imperative that the thousands of individuals with such experiences are identified, and their records properly reevaluated appropriately and rectified in order to provide access to earned VA mental health services and benefits.

Examining access to care issues should also include a review of the current five year special combat eligibility for VA health care provided to recently transitioned veterans. This five years time period may not be enough time for veterans who present mental health injury symptoms later, or who might delay care due to concerns with the stigma of seeking care. Studies suggest that about 25 percent of post-traumatic stress disorder (PTSD) cases experience delayed onset[5]. And, when looking at Vietnam era veterans, research suggests that diagnosis may be delayed by 7 to 12 years[6]. Extending the special combat eligibility will provide access to care for veterans when they are ready to seek care.

Increasing access to mental health care services must also be combined with stringent standards of high-quality, veteran-centric care that increases the

likelihood an individual at risk of suicide can be identified and provided appropriate care and support. There have been many efforts in recent years to implement processes with such goals, but these efforts need to be examined using evidenced-based research to determine if these efforts are working. The VA's 2012 Suicide Data Report showed that between 74-80 percent of service members and veterans sought care from a provider within four weeks of attempting suicide[7]. This data illustrates the need to continue examining the best practices of identifying individuals at risk of suicide, and directing such individuals to the services and support needed. Utilizing evidence-based analysis of the current processes to improve the care provided to veterans will help ensure the best processes are put in place.

The responsibility for providing mental health care does not rest solely with the VA. The Department of Defense (DoD) is a critical partner in providing a smooth transition of care to the VA. The DoD and the VA have made efforts to provide such continuity of care, but there is much work to be done still. Mental health care services in particular need a comprehensive care plan, and this requires the VA and DoD have things such as uniform medical record keeping practices, common formularies, and interoperable health records. These aspects of continuity of care are particularly important to veterans seeking mental health care, and both the DoD and VA should continue to prioritize efforts to increase continuity.

While it is easy to point out the aspects of VA care that need improvement, the successful initiatives at the VA in mental health care and suicide prevention efforts should also be noted. The best example of a program that is working well is the Veterans Crisis Line (VCL). The VCL connects veterans in crisis, and their families and friends, to confidential VA responders trained in assisting veterans in all circumstances. The VCL can be reached by online chats, text messages, and phone calls, which makes their services easy to access for all generations. According to the VCL website, there have been over 1.1 million calls placed to the VCL and 37,000 lifesaving rescues since its launch in 2007[8]. There are also many different resources listed throughout the website for veterans and their families and friends to reference. The VCL has also done a remarkable job of connecting with veteran service organizations (VSOs), including IAVA, which allows for greater transparency and smooth transitions when veterans reach out to VSOs in crisis. The lifesaving services provided by the VCL should serve as an example of the possibilities that can be achieved through high-quality, high-

tech services and close collaboration with VSO partners.

It is important to recognize the effort the VA has put into mental health care services and suicide prevention programs in recent years, but there is still a considerable amount of work to be done. Increasing access to care, meeting the demand of that care, providing high quality care with continuity, and responding to veterans in crisis requires a comprehensive and evidence-based approach. And while there is no illusion that veteran suicide will be completely eradicated, implementing better approaches to mental health care and suicide prevention can save lives.

Again, we appreciate the opportunity to offer our views on this important topic, and we look forward to continuing to work with each of you, your staff, and this Committee to improve the lives of veterans and their families.

Thank you for your time and attention.

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[1] IAVA 2014 Member Policy Survey Preliminary Findings, pending publication
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Testimony for the Record Submitted to the
U.S. House of Representatives Committee on Veterans Affairs
For an Oversight Hearing on the Provision of Mental Health Care to Veterans
July 10, 2014

University of South Florida

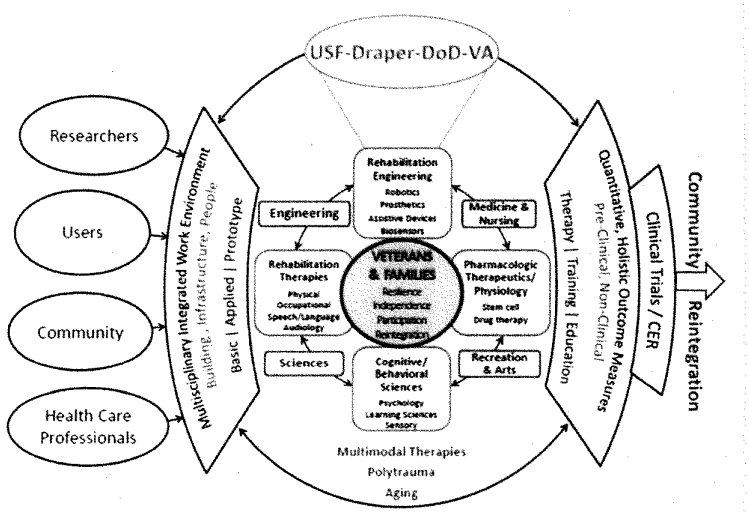
Chairman Miller, Ranking Member Michaud, on behalf of the University of South Florida, thank you for holding today's oversight hearing on the provision of mental health care to veteran patients – particularly those who are at-risk of suicide – through the Department of Veterans Affairs (VA) health care system. By way of background, the University of South Florida (USF) is a high-impact, global research university dedicated to student success. Over 2,200 veterans and their families are enrolled as students at USF. Military Times Edge Magazine recently ranked USF the 5th best college for being Veteran Friendly in the U.S. out of 4,000 colleges and universities. USF is the 8th largest university in the U.S., serves over 47,000 students and employs over 1,645 full-time instructional faculty and 6,840 full-time staff across three branches. USF is home to medical clinics and hospitals, a major mental health research institute, and two public broadcasting stations. The USF System has an annual budget of $1.5 billion and an annual economic impact of $4.4 billion. Under the leadership of our President, Dr. Judy Genshaft, and our Senior Vice President for Research & Innovation and the Executive Director, Center of Excellence for Aging & Brain Repair, Dr. Paul Sanberg, numerous USF researchers are currently involved in funded studies related to such topics as suicide prevention, traumatic brain injury, post-traumatic stress disorder (PTSD), robotics and prosthetics, speech and audiology, gait and balance, and aging-related disorders.

Relationships

In addition to USF's designation as one of the nation's top public research universities, it is one of only 40 public research universities nationwide with very high research activity that is designated as community engaged by the Carnegie Foundation for the Advancement of Teaching. USF has numerous research and health-care partnerships through affiliation agreements with hospitals and not-for-profit organizations in the metropolitan Tampa Bay area. The James A. Haley Veterans Hospital, located within walking distance of USF Health's Morsani College of Medicine, provides research and training experiences for faculty, staff, and students. USF Health is also closely affiliated with Tampa General Hospital and the Lakeland Regional Medical Center, which provides training for residents and medical students. The USF Health Byrd Alzheimer's Institute, Shriner's Children's Hospital (on the Tampa Campus), and Florida Hospital (also within walking distance), as well as All Children's Hospital, Bayfront Medical Center, and the C.W. Bill Young VA Medical Center (all located in St. Petersburg), provide additional research and training grounds for USF faculty and students.

These affiliation agreements with organizations provide for collaboration through shared facilities, faculty and equipment, as well as support for graduate students and internship programs. These types of agreements enable the institutions to pool such resources as laboratory space and enable compliance committees to stimulate an exchange of ideas. USF has standing Memorandums of Understanding with US Central Command (CENTCOM), US Special Operations Command (SOCOM), and works closely with MacDill Air Force Base in Tampa, Florida. Our Veterans Reintegration Steering Committee consists of research scientists from throughout USF faculty, staff, and students who work with veterans, representatives from the VA, the Care Coalition of SOCOM, and Draper Laboratories.

USF Tampa brings a multidisciplinary understanding of the enabling–disabling process and with the University's newly authorized PhD degree in rehabilitation science will integrate the work currently conducted within a variety of health professional, basic and social science, and engineering disciplines across campus and the Tampa Bay region. Our holistic approach to caring for veterans and their families is reflected in the diagram below:



In order to address the mental health needs of our veterans and diverse population of at risk students, the University of South Florida has embarked on a Collaborative Suicide Prevention Project. This is a three year initiative funded by a $306,000 grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). (See Appendix A). We intend to build upon university and state level resources and programs to enhance the existing university infrastructure and capacity, through improved collaborative partnerships across departments, student-led organizations, and community agencies, to develop a comprehensive suicide prevention approach to identify at-risk students through gatekeeper trainings, refer and link students to services through the Students of Concern Assistance Team, and train mental health professionals who, as a result of a professional training program, are able to assess and manage suicidal risk in students.

The goals/measurable objectives of this campus project are to (a) increase the number of persons involved in suicide prevention efforts; (b) increase the number of memorandums of understanding across departments and offices and with the community; (c) enhance the existing campus suicide prevention crisis plan and resource directory; (d) reduce barriers and improve attitudes toward suicide prevention amongst campus leaders across departments, administrative offices, and student-led organizations/groups; (e) develop a campus-wide suicide prevention marketing plan; (f) increase the quantity/quality of culturally competent prevention trainers; (g) increase distribution of suicide prevention materials; (h) increase family involvement in suicide prevention; (i) increase the number of students identified by prevention activities; (j) improve the quantity/quality of professional assessments of students; and, (k) increase the number of referrals and successful, sustainable treatment linkages.

To achieve these goals, this project is strategically engaging and working with various departments and centers such as Psychology, Social Work, Health, Wellness Centers, and the Joint Military Leadership Center as well as with non-profit community mental health agencies in Year 1. In Year 2, efforts will focus on preparing the campus for the identification of at-risk students by putting protocols and systems in place to effectively respond to at-risk students. The campus crisis response plan will be disseminated, professionals (24) on campus who receive referrals of at-risk students will be trained using the online QPR-T program and a supplemental role play training developed by the Florida GLS grantees, campus and family outreach efforts to increase awareness of the suicide prevention program, NSPL, and existing crisis support services will be started (6000 incoming students and families), and 6 trainers will be trained to deliver the Year 3 gatekeeper training program and mental health and substance abuse seminars. In Year 3, gatekeeper training will be deployed to identify at-risk students (24 trainings, 575 people trained) and an appropriate resource network will have been established to respond to referrals.

Ultimately such infrastructure enhances awareness among students and staff of risk factors and warning signs, reduces stigma, increases help-seeking behavior, and facilitates referrals and

access to services. USF is committed to allocating the majority of grant funds for the development of infrastructure and mental health promotion and training activities.

Complex systems comprised of many stakeholders who share goals but work under different systems with limited resources (e.g., community agencies, different departments and student service organizations) can present a major barrier due to lack of coordination (lack of adequate infrastructure, training, technical support, buy-in, and leadership). Additional barriers concern the integrity of implementation of proposed programs across organizations. The present project acknowledges and will address these potential barriers by doing a comprehensive needs analysis among key stakeholders, students and staff facilitated through the active building of partnerships within the university and the surrounding community. Identified stakeholders will be linked together to establish points of contact for training and ultimately, referral within the community. Training to increase awareness and knowledge of risk indicators and referral sources among staff and students will address associated barriers to utilization. Needs analysis with students will serve to establish targets for outreach and potential social marketing messages to address stigma and facilitate help-seeking.

Blue Ribbon Panel of VA-Medical School Affiliations

A Blue Ribbon Panel of VA-Medical School Affiliations (Panel) was established in 2006 to advise the Secretary of Department of Veterans Affairs (VA) on a "comprehensive philosophical framework to enhance VA's partnerships with medical schools and affiliated institutions".

The Panel believed that the crisis in the U.S. healthcare system offered a unique opportunity to explore fundamentally new and better models of patient care, education and research. Given its enduring partnership with the academic community, its past and present investments in academic infrastructure and its particular expertise in clinical system redesign, the Panel believed VA was uniquely well-positioned to take a leadership role in educating the future healthcare workforce, advancing medical science and helping to transform the healthcare system for the 21st century.

The panel reaffirmed the vital importance of academic affiliations and recommended that VA's partnership with the academic community be strengthened in order to further enhance health care for Veterans and lead the transformation of the U.S. healthcare system. Capitalizing on synergies between VA and its academic partners will assure the continued development and maintenance of an effective and diverse healthcare workforce, both for VA and the Nation. To do so, however, will require significant changes in the organization and governance of the partnership.

As the Panel revealed, currently available mechanisms for meaningful dialogue between VA and the academic community were inadequate. Relationships could be greatly improved by having more effective forums for discussion, strategic planning and decision making. To realize the full potential of the partnership, the Panel recommended that VA and its academic affiliates establish more effective national, regional and local management structures.

Barriers

There are a number of issues about which the House Committee on Veterans' Affairs should be aware and consider for further action. Discussions with fellow academic researchers and clinicians have revealed several common experiences in attempts to conduct applied, translational research with Veterans Affairs systems that could benefit veterans with mental health problems including PTSD, suicide risk, substance use disorders, military sexual trauma, and other issues that seem to affect the OEF/OIF veterans who are experiencing these problems at a higher rate than previous cohorts.

Academic researchers interested in conducting studies involving the VA system must anticipate long periods of time and considerable effort in order to become eligible to collaborate with the VA. As a result academic researchers avoid working directly with the VA healthcare system for funding or research opportunities that require a rapid response, and instead, seek other, less efficient ways to recruit veterans outside of the VA system, such as newspaper ads or contacting private organizations that work with veterans and their families.
Using the example of a university professor who wants to collaborate with the VA on mental health research, here are major challenges reported by a number of researchers across the U.S.:

1. Credentialing Requires Considerable Time: The professor must go through a lengthy approval process and training leading to "Without Compensation Status" (or WOC) to be included on any study involving VA patients. Even so, the professor cannot be considered as the lead investigator by the VA (see next item).

2. Lead Investigator Confusion: VA regulations require that for any research study involving VA patients, the principal investigator of the study (or P.I.) must be at least a $5/8^{ths}$ VA employee. For example, the university professor submitting a research grant as P.I. to the National Institute of Mental Health (NIMH) to improve treatment of PTSD must find an employee of the VA to be P.I. for the VA system's records even if that VA employee does not really implement the study.

3. Research Approval Process: Both the VA and the university require researchers to be trained and certified in protection of human research subjects. The process may differ somewhat at each VA facility, but often the professor would not only be required to

undergo training on the university's Institutional Review Board (or "IRB") processes and protection of human subjects, but also undergo the VA's similar training requirements.

4. Lack of Coordination of VA and University IRB processes: Assuming the professor is credentialed by the VA as WOC, the professor's study first must be reviewed and approved by the local VA facility's Research and Development (R&D) committee. This committee may meet only once a month. If modifications are requested by that committee, it has to wait until the next month before next review. Once approved by the VA R&D, the proposal then goes to the University's IRB for review. If a full IRB committee review is required, that could take at least another month. Often, changes requested by the university IRB lead to starting the process all over again. In some cases studies have been delayed by a year due to this back and forth process.

5. Approvals are Local to Each VA. A study that requires multiple VA sites often requires each VA facility's R&D committee to approve the study. Research would be more efficient if a "central" or national VA committee would credential university researchers for such studies.

6. Sharing Data – VA healthcare data are valuable for examining the nature and extent of mental disorders, costs, and treatment effectiveness. To protect veterans privacy and the confidentiality of their healthcare data, a professor would use de-identified data, referring to records that are stripped of all names, ID numbers, any other personal information by the VA system before any researcher would be able to use the information. However, data sharing agreements are treated much the same as other research studies and require the same lengthy process. We would recommend that the VA find a way to create a data repository that academics could access and analyze for research purposes. There are many successful models for this such as data systems provided by the CDC, SAMHSA (Substance Abuse & Mental Health Services Administration) where researchers access data from Medicare, Medicaid, hospital admissions and procedures, mental health and substance abuse treatment admissions, etc.

7. Barriers to Innovation – A professor who has an innovative approach to treatment of PTSD is highly unlikely to receive approval by a VA healthcare facility. The VA promotes two evidence-based practices: (4 to 5 sessions) of cognitive-based therapy (CBT) or prolonged exposure therapy (typically even longer in duration). One of their measures of quality of care is to ensure that a minimum number of sessions have been provided. Shorter-duration (1 or 2) sessions of innovative Accelerated Resolution Therapy for PTSD has been shown to be effective in published research from the University of South Florida, yet the VA has not accepted invitations to collaborate on a pilot study of patients diagnosed with PTSD.

8. Veterans Are a Challenging Research Population – Outside of research conducted within VA hospitals, nursing home units, outpatient centers, and other VA health facilities, recruiting veterans from the community can be a difficult task. Professors who wish to implement evidence-based, mental health treatment must go to great lengths and cost to recruit veterans from the community. As a result, treatment studies suffer from small numbers of participants, or long recruitment times, despite the fact that the VA system indicates there are waiting lists for veterans needing mental health care.

General Recommendations

- Consider methods for academic researchers to be approved to serve as lead investigators of studies on VA patients provided that they meet both VA and university ethical standards for credentialing as principal investigators and are limited to access to patients according to their profession and/or licensure. This may encourage or facilitate multi-site, VA/Academic partnerships.
- Develop or encourage the VA to create "fast-track" approvals of collaborative, pilot studies between VA and university research studies that involve minimal risk to patients, but could provide significant benefit to treatment of mental disorders. Such studies would be required to have scientific evidence that shows (1) the treatment is based on effectiveness studies conducted using rigorous scientific methods, and (2) minimal or no risks to the veterans' wellbeing.
- Develop agreements between the VA system at the national level and academic communities such that de-identified healthcare data would be made available to researchers outside of the VA system for research studies examining VA treatment effectiveness, cost, and long term benefits.
- Without having to go through VA credentialing and research committee approval, permit university researchers to distribute flyers or other general information in waiting rooms. The information would be limited to studies that: (1) are approved by the university IRB; (2) are only being conducted on the university's property; and (3) do not involve any data or personal information collected by the VA facility.
- Currently, such efforts are not permitted without having an internal ($5/8^{ths}$) VA employee as a P.I. and the lengthy VA and university committee approval processes mentioned earlier.

Our assessment of the Blue Ribbon report mandates reconsideration of their recommendations and their applicability to today's environment. The very definition of academic affiliates needs to be reexamined to move beyond a limited focus on healthcare to a much more encompassing

venue which would include employment, business development, enhanced use lease relationships, and increased research funding.

In 2012, a VA Research Scientist from USF, along with a Research Scientist from the Medical Research Service at James A. Haley VA Medical center, conducted pre-clinical animal research linking PTSD, MTBI and potential suicides in the military. A summary of their report is found at Appendix B. We believe their research needs to be extended to learn more about how the brain is affected by physical and emotional trauma. More importantly, we believe this type of animal research will lead to more effective treatments for PTSD and TBI which will potentially reduce the risk of suicide in our military and veteran population.

Unfortunately, the available funding budget for this research has not changed in 20 years and currently 80% of the VA research applicants are being turned down primarily for a lack of funding. The 2012 study was funded by the Roskamp Institute in Sarasota, Florida.

In 2012, the VA Inspector General's report on the review of Veterans' Access to Mental Health Care, indicated that during the informal survey of frontline mental health professionals, 71 percent reported that, in their opinion, their facilities did not have adequate mental health staff to meet current demand for care.

Furthermore, the 2006 Blue Ribbon Panel noted with concern the aging of VA's research infrastructure, which significantly limits its ability to conduct an efficient and effective biomedical research program. The Panel recommended that VA enhance its research facilities through new construction and renovation of existing research space and by fully exploiting opportunities to share core resources with its academic affiliates.

To that end, the University of South Florida recommends strong consideration of the development of a singularly unique, one of a kind, research and outpatient treatment facility, as outlined in Appendix C. This initiative is intended to be a collaborative venture between DOD, VA, and USF in order to meet the health and welfare needs of our veterans and their families.

The USF initiative project is committed to providing the nexus to foster research collaborations in pursuit of excellence in the rehabilitation adjustment, resilience, and reintegration of wounded warriors and their families into civilian life. Our nation's dedicated heroes from all wars deserve to have the benefit of the best research and services available in order to return to their lives with jobs and homes for the sacrifices they and their families have made for our country.

Thank you for holding this hearing and for the opportunity to submit testimony.

Contact: Lieutenant General Martin R. Steele, U.S. Marine Corps (Retired), Associate Vice President for Veterans Research, Executive Director, Military Partnerships, USF Research & Innovation, University of South Florida, 3702 Spectrum Blvd., Suite 165, Tampa, Florida 33612-9445. Office: 813-974-2343, Mobile: 347-672-8609, Email: martinsteele@usf.edu, www.research.usf.edu (See Appendix D).

STATEMENT OF
WARREN GOLDSTEIN, ASSISTANT DIRECTOR
FOR TBI AND PTSD PROGRAMS
NATIONAL VETERANS AFFAIRS AND REHABILITATION DIVISION
THE AMERICAN LEGION
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES
ON
"SERVICE SHOULD NOT LEAD TO SUICIDE: ACCESS TO VA'S MENTAL HEALTH CARE"

JULY 10, 2014

One suicide is too many.

Every day in America 22 veterans commit suicide[1].

Two troubling numbers stood out in a recent survey[2] conducted by The American Legion to evaluate the effectiveness of treatments provided by VA when treating veterans suffering from Posttraumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) – 59 percent and 30 percent. 59 percent of veterans surveyed reported "no improvement" or that they were "feeling worse" after having undergone TBI and PTSD treatment. Nearly a third of veterans, 30 percent, stated they had terminated their treatment plan before it reached conclusion. More than 3,100 veterans completed the online survey in February of this year.

On behalf of National Commander Daniel Dellinger and The American Legion; the country's largest patriotic wartime service organization for veterans, comprising 2.4 million members and serving *every* man and woman who has worn the uniform for this country; The American Legion is deeply committed to tackling the mental health needs of America's veterans. Earlier this year, Commander Dellinger reaffirmed our commitment to veterans trying to access care amidst a hiring boom for VA that sought to bring on an additional 1,600 mental health care providers in addition to over 1,400 positions that had languished unfilled. Prior to that Commander Dellinger expressed concern that priorities to see new patients were causing problems with meeting appointments for veterans with ongoing serious mental health conditions.

As this year has progressed, revelations from the Department of Veterans Affairs (VA) Office of the Inspector General (VAOIG) have made it clear that there have been serious lapses in the ability to provide care. Appointment concerns veterans have noted for years – that they are having problems getting appointments and care from VA – are now well documented. What VA had previously denied based on their own internal data was now shown to be true. Veterans struggling to be treated by VA for mental health condition are tired of being told their problems are in their heads.

[1] http://www.va.gov/opa/docs/suicide-data-report-2012-final.pdf
[2] http://www.legion.org/documents/legion/ppt/PTSD-TBI-Study-2014.ppt

 1608 K Street N.W. ♦ Washington, D.C. 20006 ♦ www.Legion.org ♦ (202) 861-2700

Veterans groups, as well as members of this committee have faced these same challenges in their districts. In El Paso veterans told Congressman O'Rourke they couldn't access mental health care despite VA telling him that veterans were waiting no longer than 7-14 days for appointments. He decided to stop listening to the self reporting from VA and go directly to the veterans, contracting a survey of the veterans in his district. What he found confirmed that the veterans in his district had a right to be frustrated. While El Paso VA reported "85-100 percent of new patients to the system seeking mental health appointments saw a provider within 14 days" the survey results showed "on average it takes a veteran 71 days to see a mental health provider and more than 36 percent of veterans attempting to make an appointment were unable to see a mental health provider at all[3]."

America's veterans deserve better. The stakes are not just suicide, which is the highest cost to veterans and families struggling with mental illness, but for veterans who do not take their own lives, the toll of struggling with mental illness without assistance or relief can be agonizing and result in related physical illnesses as well.

The American Legion will not sit idly by while veterans struggle with their mental illness, and have taken two major actions by:

1. Aggressively addressing the immediate care and needs of veterans with the Legion's Veterans Crisis Command Centers (VCCCs), and

2. Evaluating the needs of veterans through our Committee on TBI and PTSD.

Veterans Crisis Command Centers

As the veterans' healthcare crisis scandal spread nationwide this year, The American Legion quickly realized the real impact of the scheduling problems – veterans across America were suffering, and dying due to delayed access to healthcare. In response to this crisis The American Legion quickly organized VCCCs in critically affected areas throughout the country in conjunction with local American Legion Posts, and local resources, to address the needs of veterans.

To date, The American Legion has run VCCCs in three cities, with two more scheduled next week, and half a dozen more to follow over the next three months. Simultaneously, we conducted a System Worth Saving (SWS) Task Force meeting and veterans town hall in Indianapolis Indiana, followed by a visit to the Roudebush VA Medical Center. During the SWS town hall, The American Legion worked with nearly 100 veterans. While the purpose of the VCCCs is to provide a broad variety of support to meet the complex needs of the veterans in these communities, mental health remains a critical component. VCCCs have been able to put veterans and their families in touch with grief counselors when loved ones have been lost due to delays in care, as well as Vet Center counselors to deal with mental health problems such as PTSD and depression.

[3] http://orourke.house.gov/sites/orourke.house.gov/files/VAFinal6-3-2014.pdf

The American Legion has been able to reach nearly 2,000 veterans in Phoenix, AZ; Fayetteville, NC; and El Paso, TX. American Legion national staff has worked in conjunction with personnel from the National Veterans Legal Service Program (NVLSP), VA personnel, and staff from both sides of the House Committee on Veterans' Affairs (HVAC), and other local services to provide help with claims, VA enrollment, health evaluation, and counseling. Local American Legion Posts provide the backdrop for Town Hall meetings upon arrival in the new locations, providing veterans with an opportunity to communicate directly with our staff and VA officials in the area. VA is then able to communicate back to the veterans regarding how they are addressing the concerns and rectify the mistakes that have been made.

Survey and Symposium – The American Legion TBI and PTSD Committee:

The American Legion established its TBI and PTSD Committee in 2010 because of our concern with the unprecedented number of veterans returning from Iraq and Afghanistan with traumatic brain injury and post-traumatic stress disorder, also known as the "signature wounds" of the conflicts. The Committee is comprised of American Legion Past National Commanders, the Veterans Affairs and Rehabilitation Commission Chairman, medical consultants from academia, and national staff. Although the committee focuses on investigating existing science and procedures, it is also investigating alternative methods for treating TBI and PTSD that are currently employed by DOD and VA for the purpose of determining if such alternative treatments are practical and efficacious.

During a recent three year study, the committee met with leading authorities in DOD, VA, academia, the private sector, and with wounded veterans and their caregivers about treatments and therapies veterans had received or currently are receiving for their TBI and PTSD symptoms. The committee released its findings and recommendations in a report entitled "The War Within[4]." This report highlights these treatments and therapies, provides findings, and makes recommendations to the DOD and VA.

Following up on that report, The American Legion conducted an online survey in February 2014 of over 3,100 veterans to evaluate the efficacy of their PTSD and TBI treatments. The survey was conducted in partnership with the Data Recognition Corporation (DRC) of Washington, DC to determine if veterans were benefiting from current evidence-based therapies and treatments as well as Complementary and Alternative treatments because The American Legion strongly believes in promoting evidence based therapies for PTSD and TBI, as well as increasing research into those therapies and exploring the efficacy of Complementary and Alternative treatments[5].

The data from the February survey was recently released at the TBI and PTSD symposium "Advancing the Care and Treatments for Veterans" conducted by The American Legion. This survey, "The American Legion Survey of Healthcare Experiences of Veterans with Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury" was used to gather data from veterans that have been diagnosed with PTSD and TBI and their health care experiences. The survey broke veterans down by gender, era of service, number of deployments, diagnoses, access to care, access to treatments, therapies and medications, and included an examination of potential

[4] http://legion.org/documents/legion/pdf/american-legion-war-within.pdf

[5] Resolution No. 285: *"Traumatic Brain Injury and Post Traumatic Stress Disorder Programs"* – AUG 2012

side effects. The American Legion will use this data as a tool to further advise the Administration, VA, DOD, Congress, and the veterans' community, in order to improve TBI and PTSD programs.

Some of the key findings of the survey included:

- 59 percent of the respondents reported either feeling no improvement or worse after undergoing treatments for their TBI and PTSD symptoms
- 30 percent of respondents said they had terminated treatments prior to completion of the treatment cycle;
    - Termination factors included lack of improvement, side effects, dissatisfaction with provider, frustration at the lack of progress, belief that they can effectively treat themselves, time burden required for treatment, distance to treatments, and stigma of receiving mental health treatments.
- A sizeable proportion of the respondents reported prescriptions of up to 10 medications for their TBI and PTSD across their treatment experiences.

One of the more important takeaways from this data is that it reflects problems even for veterans who are getting care. The expediency with which a veteran receives care – or access to care – is important, but we cannot forget that an equally important factor is how effective the treatments are. Speed of access to care is only one of the metrics for how we are serving veterans' mental health needs – the quality of that care will ultimately determine how effective the care is. There must be metrics for efficacy of care or veterans will walk away from treatment unsatisfied, and possibly in a worse state than before, because they will have requested help but the treatment provided by VA did not alleviate their problems. This can place an even greater weight on these already at risk veterans.

It is devastating for veterans in Durham, North Carolina to have to wait 104 days for a mental health care appointment[6] and every day spent waiting only serves to increase frustrations and doubts. It is just as devastating to struggle through treatments that don't alleviate your symptoms, or to suffer under the burdens of overmedication, or ineffective therapies. The American Legion believes all health care possibilities should be explored and considered in an attempt to find the appropriate treatments, therapies, and cures for TBI and PTSD based on individual veteran needs, to include alternative treatments and therapies. These treatments need to be accessible to all veterans and if alternative treatments and therapies are deemed effective they should be made available and integrated into the veterans' current health care continuum of care.

On September 12, 2013, The American Legion launched a new Suicide Prevention Web Center to provide veterans and their families with life-saving resources and programs during their time of transition and need. The American Legion's online Suicide Prevention Web Center builds on several suicide-prevention initiatives launched in recent years by the Department of Defense

[6] http://www.va.gov/HEALTH/docs/VAMC_Patient_Access_Data_20140619.pdf

(DOD) and the VA. The center houses specific suicide-prevention data, statistics, programs and resources organized for veterans, families and the community.

The American Legion is not a medical treatment facility and the Suicide Prevention Center is for informational purposes only. This information does not constitute medical advice, and should not serve as the basis for any medical decision by anyone. The American Legion is simply working to put veterans in touch with the professional resources they need to cope with their mental health care concerns. In addition, we encourage any veteran in crisis to contact the Veterans Crisis Line at 1-800-273- 8255 (TALK)

In addition to the survey, symposium, and VCCC efforts put forth this year to address veterans with mental health concerns, The American Legion's System Worth Saving Task Force continues its mission to evaluate the overall VA healthcare system, of which mental health care is a critical component. The American Legion created the System Worth Saving program in 2003[7] to assess the quality and timeliness of veterans health care within the VA healthcare system. The American Legion remains committed to assuring that the VA healthcare system continues to perform as a premiere role model for the health care industry.

During the past two years, some of the concerns raised during System Worth Saving Task Force site visits included:

- During our Veterans Town Hall Meeting on November 4, 2013 in Pittsburgh, PA, veterans expressed their concerns with access to mental health care.

- During our SWS Site Visit to El Paso from November 18-19, 2013, we found that El Paso was challenged with the lack of psychiatrists working for the medical center, and veterans at the Town Hall Meeting expressed dissatisfaction with the 20-minute mental health appointments. Due to the VA's vacancy rate for psychiatrists, veterans are frustrated due to the length of time it takes to get an appointment which creates long waiting lists. During the visit, we recommended further reliance on local Vet Centers. Vet Centers provide a broad range of counseling, outreach, and referral services to eligible veterans in order to help them make a satisfying post-war readjustment to civilian life. All Vet Centers maintain non-traditional appointment schedules, after normal business hours, to accommodate the schedules of veterans and their family members.

- On January 28, 2014, the SWS Task Force visited the Atlanta VA Medical Center (VAMC) in response to the two VAOIG reports that identified serious instances of mismanagement at the Atlanta VAMC that led to the drug-overdose death of one patient and the suicides of two others. The VAOIG linked three patient deaths in 2011 and 2012 to mismanagement and lengthy waiting times for mental health care.

- The American Legion found that between 2009 and April 2013, the Atlanta Medical Center had referred out a total of 4,912 veterans to the community for contract mental health care. During that time, the Medical Center lacked a reliable process for

[7] Resolution No. 206: *"Annual State of VA Medical Facilities Report" – AUG 2004*

determining the treatment status of its referred veterans. Atlanta VAMC's ultimate goal is to provide more, if not all, veterans mental health care in house, and the Community Service Board (CSB) contracts were the medical center's way of ensuring that veterans were receiving mental health care in a timely manner. The Atlanta VA strengthened its monitoring and management of its contract mental health program. The facility has reduced the number of contracts it has with mental health organizations (from 26 to 6) and strengthened and added quality assurance monitors to the contracts. The Atlanta VAMC currently has 11 licensed clinical social workers/case workers embedded in the CSB sites to coordinate care for veterans, and there are improved mechanisms to track clinical and financial data for every referral. The average number of individuals assigned to each VA case worker is 180. An experienced supervisory social worker manages the embedded case worker program. In order to reduce the number of veterans on CSB contract, the medical center needs space and staff in order to treat more, if not all, veterans in house. In 2015, the medical center plans to activate a new 86,000 square foot outpatient annex and a 15,000 square foot clinical addition that will provide space for additional mental health services. The VAMC is awaiting final congressional approval for its replacement clinic in Cobb County that will increase the clinic's size from 8,000 square feet to 60,000 square feet. With the inability of Congress to resolve the Congressional Budget Office scoring issue, more veterans are being treated outside the VA system.

The American Legion thanks this committee again for their diligence in oversight of veterans' health care. The commitment of all parties to ensuring veterans receive quality healthcare in a safe environment is a sacred duty. This country's obligation to its Armed Forces and its veterans includes a responsibility for their care and treatment from wounds inflicted upon them while serving their country. The challenges posed by TBI, PTSD, and other mental health illnesses demands a dedicated, well-coordinated and flexible response that adapts care and treatment to an individual's needs -- not the other way around.

Questions concerning this testimony can be directed to The American Legion Legislative Division (202) 861-2700, or ideplanque@legion.org

PREPARED STATEMENT OF JONATHAN SHERIN

Greeting

Thank you Mr. Chairman, ranking member and committee for convening today's hearing on the critical issues of mental health access and suicide prevention challenges in the Veteran community. I am deeply honored to testify on these topics. Aside from being core drivers of my mission in life they represent national imperatives of the highest order.

Preface

Let me preface my testimony by stating that to manage serious mental health issues and to prevent suicide in any population requires not only identifying those who are suffering and dismantling any barriers that may be interfering with their access to treatment, but also creating enriched and cohesive communities in which all comers belong, in which opportunities to live purposefully are cultivated, in which wellbeing is nourished broadly and in which human flourishing is an articulated, promoted and attainable goal; in other words, we need proactive systems set up to disrupt suicidal thinking on the front end.

My Expedience, Current Role and Perspective

After completing my graduate work in medicine and neurobiology I was fortunate to be selected by UCLA as a psychiatry trainee. On the first day of residency orientation I drove myself to the majestic and hallowed grounds of the WLA VA campus, a primary clinical venue affiliated with UCLA's training program, and parked myself at the golf course where I watched Veterans come and go for hours. This experience changed me as it became clear in this one afternoon that my life's work would revolve around caring for our nation's Veterans. Four years later, the VA hired me straight out of training and my dream became a reality. Over the course of the next decade I served as a clinician, teacher, researcher and administrative leader at VA with my last stop as Chief of Mental Health for the Miami VAHS.

Since leaving the VA 2 ‡ years ago to join Volunteers of America (VOA) as Executive Vice President for Military Communities and Chief Medical Officer, this mission has continued. VOA is a large direct human service provider whose legacy of work with Veterans dates back to the post-Civil War era. We currently employ over 16,000 staff working in over 400 communities around the country and provide a broad array of programs to the Veteran community including services to well over 10,000 homeless Veterans through VA grants and contracts alone. It is VOA's national priority to do anything and everything we can for the Veterans of our Nation which we do not only through programs funded specifically for Veterans, but through any resources we can bring to bear for the mission. One of these programs, the Battle-Buddy-Bridge (B3), which leverages Veterans as peers in service to one another, is particularly relevant to solving access problems that are under review today (see B3 Concept Proposal, attached).

My experience working on this mission from inside the VA and now outside the VA gives me a great deal of perspective as to the nature of the problems facing Veterans and some possible solu-

tions. It is my contention that a great deal can be done to improve access to the resources that will help improve mental health outcomes and decrease suicides by aligning VA and community in a manner that mutually leverages existing infrastructure and expertise to increase the depth, breadth and efficacy of our efforts.

The Access Problem

One of the primary challenges facing VA as well as the health and human service sector in general, is dealing with broken systems of access to services. Access barriers are present in essentially every community today and affect vulnerable individuals as a rule, but they are particularly problematic for Veterans in need who can be hard to reach for any number of reasons: some are unaware of available services and opportunities; many are reluctant to seek help as a consequence of military culture and/or mistrust of the system; others are too sick to advocate for themselves or have been rebuffed or delayed in seeking assistance; and too many have fallen through the cracks as a consequence of poorly coordinated and overly complex bureaucratic systems. Though not unique to the Veteran community, a massive amount of unnecessary suffering is endured, lives are broken, and in some cases lives are taken as a result of suboptimal access. Access problems simply cannot continue to plague our Veteran population.

A Holistic Approach

The ultimate goal of our work with Veterans facing emotional challenges involves accessing not only mental health treatment but also interventions targeting other factors that mitigate mental distress and thereby protect against mental illness and suicide. For example, it is possible to improve mental status by providing access to resources such as peer navigation, case management, housing, education, training, employment, legal services, benefits assistance and family support when indicated.

Given the vulnerabilities conferred on any number of these factors by the military experience, Veterans in particular must receive care in a holistic manner that extends well beyond mental health treatment. Along these lines, the familial relations found in peer-peer programs, the community experience provided by a respectable job and the spiritual benefits obtained by engaging in mission-oriented endeavors are salves for disruptions in life that can occur during enlistment, service and separation.

The Need

As the offerings needed in the Veteran community are myriad, the resources limited, and the processes for accessing them frustrating to navigate, urgent problems sometimes go unaddressed, worsening mental states evolve and devastating life circumstances such as homelessness or life-threatening emergencies such as suicidal behavior emerge. Keeping in mind the principles of overcoming access barriers and broadly targeting needs to mitigate mental distress as well as suicide, Veterans with urgent problems (such as worsening family dynamics, spiraling substance-abuse, housing instability, health crises, progressing financial problems, acute legal challenges or loss of employment) need real time access to re-

sources that can keep them on a road toward community reintegration.

For these reasons, a caring advocate such as a fellow Veteran functioning as a battle buddy in the community who is trained, equipped, deployed and supported to provide expert hands-on engagement and local resource navigation can make all of the difference. We must immediately scale this type of solution as part of a full frontal assault on the barriers to access that face our nation's Veterans.

The Current Situation

Access to mental health services is suboptimal. In light of recent findings from investigations of scheduling practices at VA as well as a plethora of testimonials regarding wait times and inadequate service availability, there is clearly a need to develop strategies for improving real-time responsiveness to Veterans reaching out for help.

Suicide rates are unacceptably high, especially in the younger and older Veteran populations. Though discrepancies exist regarding the rates of suicide in different subpopulations, rates have climbed in the Veteran community and require the highest level of attention that our nation can muster to improve access.

The VA reaches less than half of the Veteran population. While it is clear that receiving care at VA benefits Veterans and mitigates suicidal behavior, many Veterans at risk never connect with these programs. Though many Veterans never connect with these programs because of outreach limitations, many others refuse to use the VA system.

Receiving care at the VA can be difficult due to time and distance constraints. Many of those who are reached by the VA find travel and wait times problematic which deters their interest in ongoing treatment, especially in the face of rapidly developing crises.

Community providers are woefully under leveraged as resources to support mental health and mitigate suicide risk. Due in part to the VA's noble tradition of trying to serve all the needs of all Veteran and in part to the constraints that complicate public-private-partnership, communities have not been fully engaged to assist in getting services to Veterans.

Recommendations for VA

The VA alone cannot provide all services to all Veterans in all geographies and must partner vigorously with appropriate providers to improve access to services as has been done to house homelessness Veterans by partnering with and embracing the community.

1. Promote pubic-private partnerships (PPP) across all sectors to increase agency reach and expand access opportunities for Veterans.

2. Use grant mechanisms straight out of VACO (such as NCHAV's SSVF) to avoid layers of bureaucracy and improve overall efficiency.

3. Identify partnerships to push out services as below that strategically supplement, complement and create synergy with VA operations to increase access through outreach, engagement and resource navigation according to a B3-like program model.

a. Place Veteran Peer Specialists (VPS) in the community to function as "battle buddies".

b. Connect Veterans in need to VPS thru suicide prevention coordinators, crisis line, 211.

c. Retrofit VA campuses with, and transform service centers into, reintegration centers that host VPS, a modicum of services and a map of all available community resources.

d. Leverage technology to amplify access to VPS (for example, PosRep).

Requests of Congress

Assistance from Congressional leadership in moving forward is critical.

1. Visit the trenches of your local VA and community providers to better understand the opportunities available through partnership between VA and other organizations.

2. Review the structure of VA and its strategy for facilitating Veteran reintegration in partnership with the community with special focus on considering the SSVF grant mechanism as a gold standard for how to manage organizational relationships.

3. Lobby for and support demonstration projects that employ Veterans to work as peer specialists who can expand outreach, facilitate engagement and lead navigation efforts for Veterans with acute needs.

4. Push reform where possible and develop new legislation where necessary to facilitate partnerships with the community.

Closing

Time is a conspiring enemy in what is becoming a domestic war. The resolve and urgency that our country mounts to win foreign wars must be employed to achieve victory at home. With the help of Congressional leaders, bureaucratic barriers must be torn down aggressively so that solutions can be erected. Most importantly, facile mechanisms that foster relationships across all sectors of the American collective must be developed with unprecedented efficiency to implement a shared process for promoting the wellbeing of our noble military community.

Statement For The Record

For the Record
General Steele

Neurocognitive Perspectives on PTSD, mTBI and Suicide in the Military

David Diamond, Ph.D.[1,3] and Fiona Crawford, Ph.D.[2,3]

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Summary of Report:

- It is well-established that either traumatic psychological stress or mild traumatic brain injury (mTBI), alone, can produce long-lasting adverse effects on brain functioning
- The emotional and physical toll of PTSD can interact with mTBI to exacerbate brain pathology which may contribute to increased suicidal tendencies in traumatized veterans
- We have described a novel research program which is based on the integration of a rodent model of PTSD with brain trauma
- Our preliminary findings provide evidence of a greater extent of brain injury and memory deficits in mice exposed to psychosocial stress in conjunction with physical trauma
- Our animal model of mTBI-PTSD interactions is an important strategy for developing pharmacological treatments which can rapidly ameliorate the pathological effects of physical and emotional trauma on the brain

Introduction: The Story of a Fallen Warrior

The issue of how psychological stress interacts with mild traumatic brain injury (mTBI) to increase risk for suicide has been discussed extensively in stories on how our veterans have been affected by wartime combat. All too often combat-related trauma experienced by our warriors has resulted in difficulty for them to adjust to civilian life. An illustration of how military service resulted in personal tragedy is described in a 2012 New York Times article written by Nicholas Kristof[1] based on a publication in the medical journal ***Neurosurgical Focus***. The subject was a 27-year-old former Marine who was struggling to adjust to civilian life after two tours in Iraq.

During his first deployment this man witnessed marines killed and wounded when a vehicle in his patrol was blown up. In another incident, he witnessed a school bus full of Iraqi citizens, many of whom were children, blown up by an IED. In addition to the psychological trauma of combat, he was also exposed to repeated mortar blasts and improvised explosive device (IED) blasts less than 50 yards away from him. Following his second deployment he developed a progressive history of cognitive impairment, impaired memory, mood disorders and alcohol abuse. Once an A student, he found himself unable to remember conversations, dates and routine bits of daily life. He became irritable, snapped at his children and withdrew from his family. He was diagnosed with a form of PTSD that included hyperarousal (irritability and insomnia) and emotional numbing. In 2011 he committed suicide by hanging himself with a belt, approximately 8 months after his honorable discharge from the USMC.

An autopsy of this man's brain revealed evidence of degenerative effects that may shed light on why there is an epidemic of suicides and emotional struggles among soldiers following combat. In a landmark study published in ***Neurosurgical Focus***, lead author Bennet Omalu, M.D., reported that this man's brain developed a disease called chronic traumatic encephalopathy (CTE). Normally, CTE is diagnosed as a degenerative condition typically affecting athletes who experience repeated blows to the head, such as boxers and football players. In this case, the subject had experienced intense emotional stress in conjunction with physical trauma to his brain, which produced his emotional instability and cognitive impairments. Dr. Omalu's assessment of this subject emphasized that this was a sentinel case which should stimulate new lines of thought and research in how PTSD interacts with mTBI to produce physical degeneration of the brain.[2]

Scope of the Problem

Since 2001, over 2,000,000 Americans have served in the Iraq/Afghanistan war.[3] There is a growing awareness of the adverse consequences of combat in this vast population of veterans, including a doubling in the rate of suicides by military personnel since 2001. The Department of Veterans Affairs has diagnosed at least 200,000 of these war veterans with PTSD. A study by the RAND Corp., which was confirmed by the VA's National Center for PTSD, suggested that at least 14 percent of all veterans in the past decade suffer from the headaches, sleeplessness, irritability, depression, rage and other symptoms of PTSD.[3] mTBI is caused by external impact to the head or by a pressurized wave blast injury, resulting in a rapid rotational acceleration/deceleration of the brain in the closed skull of restrained occupants. Conservative

estimates indicate 18% of returning veterans have been diagnosed with mTBI, primarily due to exposures to combat related blast injuries from improvised explosive devices (Hoge et al., 2008).

Veterans of combat with mTBI can develop neurological symptoms such as chronic headaches, dizziness, vertigo, memory-executive dysfunction and impaired concentration. Neuropsychological symptoms can also arise due to the trauma surrounding the injury and involve insomnia, depression, irritability, impulsiveness, anxiety, apathy and aggression, resembling a cluster of PTSD-like symptoms. The most concerning of these features of mTBI is PTSD, which has been shown to be the strongest risk factor associated with persistent post-mTBI/concussion symptoms. Hoge et al, (2008) found that 44% of Iraq war returnees who experienced a loss of consciousness as a result of brain trauma also met the criteria for PTSD 3-4 months after deployment, compared to 9% with no injury. Combat related mTBI has been demonstrated to approximately double the risk for PTSD (Bazarian et al., 2013).

Finally, in the most extensive study of veteran suicides ever conducted, a recent report by the VA examined suicide data from 1999 to 2010.[4,5] This study revealed that almost once per hour a military veteran commits suicide, for an average of 22 veteran suicides per day. This sobering statistic includes a substantial number of young veterans who were in the prime of their life. Two retired Army generals, Peter W. Chiarelli and Dennis J. Reimer, have spoken out about the urgency of reversing the trend of increasing rates of suicide among veterans. "One of the things we learned during our careers," they wrote in The Washington Post, "is that stress, guns and alcohol constitute a dangerous mixture. In the wrong proportions, they tend to blow out the lamp of the mind and cause irrational acts." [4]

Neurobiological Perspective on mTBI, PTSD and Suicide

Researchers over the last few decades have documented the types of brain damage associated with mTBI and PTSD. The mechanisms implicated in mTBI largely involve white matter (axonal/cytoskeletal) damage primarily to frontal and temporal lobe structures, and is also associated with neuroinflammation and blood brain barrier (BBB) dysfunction. The neurobiological background of PTSD is more complex, involving an aberrant regulation of the sympathetic nervous system and the hypothalamus-pituitary-adrenal (HPA) axis, low grade inflammation and excessive activation of the amygdala (Zoladz and Diamond, 2013).

It is a challenge to understand mTBI and PTSD, alone and in conjunction. To further understand how these neuropathological triggers can lead to suicides is a great challenge to neuropsychiatric research. There is evidence that the activity of three neurobiological systems has a role in the pathophysiology of suicidal behavior. This includes hyperactivity of the hypothalamic-pituitary-adrenal axis, dysfunction of the serotonergic system, and excessive activity of the noradrenergic system. While the first and the last system appear to be involved in the response to stressful events, dysfunction of the serotonergic system is thought to be trait-dependent and associated with disturbances in the regulation of anxiety, impulsivity, and aggression. It can be hypothesized that neurobiological dysfunctions mediate the occurrence of suicidal behavior through the disturbed modulation of basic neuropsychological functions.

Taken together, to understand mTBI, PTSD and suicidal behavior, we need to focus on neurochemical abnormalities, such as abnormal hormonal levels produced by intense stress, as well as increased brain inflammatory processes, which underlie brain pathology. In theory, the impairment of inhibition over behaviors which are common in mTBI and PTSD include a range of behaviors such as alcohol and drug abuse, as well as acting on suicidal thoughts. One of the most important of all brain structures is the ventrolateral prefrontal cortex. Functional imaging studies have demonstrated abnormal neurochemistry in this brain region of patients who attempted suicide, particularly in violent attempters.

Animal Research on the Neurobiology of mTBI-Stress Interactions

The complexity of pathological outcomes of mTBI and PTSD, individually and in conjunction, illustrates the importance of developing rapid and effective treatment strategies for brain trauma. Optimal strategies for attaining this goal requires the strategic benefits of animal research, with its efficient testing of novel candidate compounds and improved understanding of the pathophysiological mechanisms involved in mTBI and PTSD. Finally, animal research provides effective models for assessing how stress interacts with physical injury to exacerbate the development of brain pathology.

In a research program on PTSD-mTBI interactions, we have developed a mouse model of concussive injury, which has been extensively characterized from 24 hours to 24 months post injury (Mouzon et al., 2014;Ojo et al., 2013). Mice exposed to concussion show evidence of memory dysfunction with repetitive mTBI, axonal injury, demyelination, white matter (corpus callosum) thinning and glial activation. In our recent work this concussive injury model was combined with a novel PTSD paradigm involving predator odor exposure (fox urine) with the mice under restraint, in conjunction with a conditioned footshock stimulus which was paired with mTBI. We found distinct and overlapping outcomes in neurobehavioral, neuropathological and biochemical changes (in brain and plasma) in this newly developed model of mTBI-PTSD Specifically, we have reported a powerful increase in brain measures of inflammation which were present in greater magnitude in the mice that experienced both PTSD and mTBI (Ojo et al., 2014).

In cognitive testing our research has revealed an important aspect of memory which may be highly relevant to abnormal cognitive processing in soldiers that experience emotional trauma in conjunction with mTBI. Under control conditions, mice are administered a fear-provoking stimulus (pawshock) in a unique place (a fear conditioning chamber). In addition, training involves a cue (a tone) which is delivered in the shock chamber. Under normal conditions, when the mouse is returned to the chamber it exhibits fear (freezing) in response to the chamber, as well as to the sound of the tone. This type of training can help to identify the functioning of different brain memory systems. Specifically, memory for the place in which shock occurred is dependent on the hippocampus and memory for the sound associated with the shock is dependent on the amygdala. It is therefore highly relevant to human stress-mTBI interactions that we found impaired hippocampal memory for the context in which the shock occurred in the combined PTSD-mTBI group, but their memory of the specific cue present

during trauma remained intact. This finding is consistent with the disturbing "fragmented" and abnormal memories of trauma routinely reported in soldiers with PTSD in which impaired processing of the hippocampus appears to contribute to abnormal memories in people who experience physical and emotional trauma.

The significance of a relevant rodent model is that the consequences of mTBI, stress exposure, and their interactions, can be evaluated at the molecular level to fully understand the brain's response at a level that is not possible in human subjects. Our animal research includes analyses of brain neurochemistry using state-of-the-art biotechnology to reveal proteins and lipids that are disrupted in response to mTBI and stress, which can then reveal specific targets for therapeutic intervention. Moreover, these molecular level processes can be examined over the time course of development of brain damage, enabling creation of a temporal profile of pathology, from the acute aftermath of trauma exposure to chronic time points. Ultimately, animal research provides the opportunity to maximize intervention strategies for developing therapeutic approaches in translational studies from rodents to human applications.

In summary, there is great value in a rodent model of trauma-stress interactions. The fundamental neurochemical and physiological processes which are disturbed with stress and physical trauma are quite similar in humans and rodents. Our approach, therefore, can identify how emotional trauma interacts with physical trauma to exacerbate brain damage and to produce cognitive abnormalities with relevance to clinical outcomes. The approach, as well, will enable us to identify rapid treatment approaches which will improve the outcomes of combat-related trauma.

Relevant links:

1. http://www.nytimes.com/2012/04/26/opinion/kristof-veterans-and-brain-disease.html?_r=0

2. http://www.stripes.com/news/doctors-study-link-between-combat-and-brain-disease-1.98394

3 - http://www.rand.org/multi/military/veterans.html

4 - http://www.military.com/daily-news/2013/01/14/2012-military-suicides-hit-record-high-of-349.html

5 - http://www.va.gov/opa/speeches/2012/06_20_2012.asp

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AMERICAN FOUNDATION FOR
Suicide Prevention

Statement

Of

John H. Madigan, Jr.

Vice President of Public Policy
American Foundation for Suicide Prevention

submitted to

House Committee on Veterans' Affairs

July 10, 2014

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Chairman Miller, Ranking Member Michaud, and members of the Committee. Thank you for inviting the American Foundation for Suicide Prevention (AFSP) to provide a written statement on the issue of mental health care provided to veteran patients – particularly those who are at high-risk of suicide – through the Department of Veterans Affairs (VA) health care system. My name is John Madigan and I am AFSP's Vice President of Public Policy.

AFSP is the nation's leading organization bringing together people across communities and backgrounds to understand and prevent suicide, and to help heal the pain it causes. Individuals, families, and communities who have been personally touched by suicide are the moving force behind everything we do. You can learn more by visiting www.afsp.org.

- We strive for a world that is free of suicide.
- We support research, because understanding the causes of suicide is vital to saving lives.
- We educate others in order to foster understanding and inspire action.
- We offer a caring community to those who have lost someone they love to suicide, or who are struggling with thoughts of suicide themselves.
- We advocate to ensure that federal, state, and local governments do all they can to prevent suicide, and to support and care for those at risk.

Most, if not all suicide deaths are preventable. Suicide in America today, especially among our nation's veterans, is major public health concern. It is estimated that approximately 22% of the 39,518 deaths by suicide in 2011 (latest available data) were completed by veterans; and, according to the 2012 VA Suicide Data Report, an average of 22 veterans die by suicide each day.

While AFSP appreciates the efforts of VA to better meet the mental health needs of veterans, particularly OEF/OIF veterans, and applaud the delivery of world class health care in many instances, we believe that VA must take further steps to ensure that veterans have timely access to the care that they have earned and deserve. Simply stated, many of our veterans are being put in greater risk of suicide while enduring unacceptably long wait times for appointments with VA mental health services.

Suicide is the result of unrecognized and untreated mental illness. In more than 120 studies of a series of completed suicides, at least 90% of the individuals involved were suffering from a mental illness at the time of their deaths. Suicide prevention requires a proactive approach to identify veterans who may need immediate help by understanding the risk factors and warning signs of suicide and by knowing what immediate and short term protective actions one should take.

Suicide risk factors for veterans mirror those for society in general. Often, undiagnosed mental illness such as depression or bipolar disorder and alcohol and drug dependence are major risk factors for suicide. Post-Traumatic Stress (PTS) and Traumatic Brain Injury (TBI) may compound underlying risk factors along with environmental stressors such as transition from military life, job loss, relationship issues and financial or legal problems. Other risk factors may also include the history of a past suicide attempt and a family history of suicide or suicide attempts.

Suicide risk tends to be highest when multiple factors are present in an individual with a mental illness and the most important interventions are recognizing and treating these disorders.

If a veteran has one or more of the risk factors highlighted above, the key to preventing suicide is recognizing the warning signs of suicide such as:

- Talking or writing about death or a wish to be dead;
- Expressing hopelessness, feeling humiliated, trapped or desperate;
- Losing interest in regular activities or losing the ability to experience pleasure;
- Experiencing insomnia, intense anxiety or panic attacks;
- Being in a state of extreme agitation or intoxication;
- Becoming socially isolated and withdrawing from loved ones; and,
- Looking for a way to hurt or kill oneself such as hoarding medicine, purchasing a new firearm, or searching online for suicide methods.

Whether a veteran is in immediate crisis or is just looking for help, immediate protective actions should be taken that include:

- Not leaving the veteran alone and removing any lethal means for suicide (firearms, sharp objects, prescription drugs, and over-the-counter medicines);
- Encouraging an open conversation about symptoms and problems with a physician or mental health provider;
- Finding and delivering effective clinical care for mental and physical health, and seek treatment for problems with alcohol or drugs; and,
- Providing support through the recovery process, especially during the initial period when medications and treatment plans may need fine-tuning to work.

In medicine, acute care for a critical event is standardized and delivered urgently, centered on the patient. Thus a patient with an acute cardiac event, a stroke, or involved in a serious accident, all receive immediate care, typically following a protocol derived from scientific studies and best practices. These same principles must also be applied to mental health care delivery for our nation's veterans.

If a veteran exhibits the warning signs and have risk factors of suicide, they need to be given immediate care. If a veteran comes forward with the strength showing they are ready to receive care, they need to be able to access mental health services in a timely manner.

The need is evidenced in the 2012 VA Suicide Data Report. Figure 12 shows that among those at risk, the first four weeks following service require intensive monitoring and case management.

> *Figure 12 clearly demonstrates that the majority (80%) of non-fatal events occur within four weeks of receiving VHA services. An additional 10% of events occur in the second month following last VHA service visit. These findings have important implications for treatment and prevention efforts as the majority of those with report of a suicide event are active, recent VHA users. (pg. 32)*

The report also showed data that showed primary care should be an integral part of suicide prevention programs.

> *Furthermore, nearly 50% of the individuals with a VHA service visit in the year preceding the suicide event were last seen in the outpatient primary care setting (Figure 13). This implies that primary care should be an integral component of VHA suicide prevention programs and primary care clinicians should continue to receive support and training on the identification and management of those experiencing distress.*
>
> *Another 40% of those with report of one or more 33 suicide events were last seen for mental health services indicating a need for continued assessment and risk management following use of VHA services among those with known risk factors (i.e. mental health diagnosis). (pgs. 32-33)*

AFSP asks Congress to consider legislative and policy proposals that will further the VA's current efforts to prevent suicide among our nation's veterans:

- Funding the VA at the highest levels possible to ensure the delivery of timely, high-quality mental health care and crisis services including the Veterans Crisis Line;
- Supporting efforts of an interoperable medical record between DoD and VA. The lack of coordinated care impairs the VA's ability to identify and respond to individuals who were high risk of suicide in the service while in the Service; and,
- Addressing the critical shortage of mental health providers within the VA by recruiting and retaining mental health providers through bonuses, incentives and student loan reimbursement programs that would pay a portion of a provider's loan debt for every year of service.

Chairman Miller and Ranking Member Michaud, the bottom line is delayed appointments for those seeking mental health treatment carry greater risk for suicide. If a veteran is in immediate crisis they must be referred to and receive help immediately, and, if they request an appointment for mental health services they should be seen as soon as possible and certainly within the 14-day window currently required by the VA.

The American Foundation for Suicide Prevention thanks you again for the opportunity to provide this written statement for the record and looks forward to working with the Committee and the VA to prevent suicide among our nation's veterans.

George C. Carpenter and Henry T. Harbin, MD

July 10, 2014

Chairman Jeff Miller, Ranking Member Michael Michaud, and distinguished members of the House Committee on Veterans' Affairs:

We are honored to present this Statement for the Record to the hearing on July 10, 2014. I'm Henry T. Harbin, a Psychiatrist with over 30 years of experience in the behavioral health field. I've run two national behavioral healthcare companies covering 70 million Americans, headed the public mental health system in Maryland for ten years, and served on the President's New Freedom Commission. I'm George C. Carpenter, and I serve as Chief Executive Officer of CNS Response, a technology company working with the U.S. military to improve medication outcomes in mental health.

Today, you will hear from the veterans and families most affected by the state of mental health care in this country. Their stories should move you to action. Our story may provide insight into what positive actions this Committee can take.

Recent IOM Findings

The Institute of Medicine (IOM) report released in June 2014[1] was a catalyst for a system-wide review of treatment practices across both the Veterans Health Administration and the Department of Defense. The findings are relevant to this Committee's mission because despite a significant increase in spending, this four-year study of PTSD research and treatments came to a striking conclusion – we have no way to judge whether any of these programs work, because there's no collection of outcome data. To some extent, we're flying blind.[2] The Institute of Medicine recommended systematic collection of patient outcomes to support benchmarking, continuous improvement, and provider accountability across both departments.

We have a different story to share with the Committee, about a technology currently being piloted at Walter Reed NMMC which is doing ALL of these. Thanks to military leaders like Dr. Terry Rauch in Defense Health and the Behavioral Health leadership at Walter Reed National Military Medical Center, we may have **simple, powerful tools today that can improve medication outcomes, improve access to care, and reduce suicide risk for veterans.** It's good news. We ask that the Committee take notice of research in this area and encourage the VA and DOD to collaborate on rapid advancement and deployment of this type of research.

PEER Background

PEER is an outcome registry that helps double the effectiveness of medications by providing doctors with objective information. This quality assurance information helps physicians to reduce trial & error prescribing, and thereby reduce patient exposure to ineffective medications.[3]

Physicians developed PEER to address a fundamental gap in mental health: while medications currently represent the dominant treatment for mental disorders, historically there has been no way to personalize therapy to an individual's unique physiology. Unlike most other specialties, where there is, for example, an x-ray or a blood test on which to base treatment, there has been no physiological test in Psychiatry to guide treatment. As a result, the most common treatment modality for mental disorders is trial and error pharmacotherapy. Which is exactly what it sounds like: your doctor will try one or more medications for up to six weeks to learn whether you respond and/or have intolerable side-effects, before proceeding to a different medication.

Even though it is the standard of care for most VA/DOD treatment, patients aren't often informed of the limitations of trial and error:

> *For veterans to make such informed treatment decisions, they need to be educated about what treatment options are available and the risks, benefits, and possible outcomes associated with each option, including no treatment (VA/DoD, 2010).*[4]

We see in the IOM Report and from testimony before this Committee that real world clinical results for trial and error are not very good, and the evidence is not as strong as once thought. As a result, multiple studies have confirmed that 50% of patients will never seek treatment, 50% will dropout after a single visit, and 50% will not respond to prescribed medications.[5] Accordingly, SAMHSA has reported that only 12.7% of Americans get "minimally adequate" mental health treatment.[6] The IOM Report found that 33% of PTSD patients received "minimally adequate" treatment, but persistent trends in terms of stigma, dropout rates, and response rates have continued[7]. This is how military physicians have summarized the unmet need:

> *"Despite the magnitude of the problem, treatment of mental illness is unsophisticated at best and unsatisfactory at worst. Current psychopharmacotherapy practices are clinician-dependent, inductive and assume that certain behavioral symptoms respond to a specific medication class. This selection process is highly subjective. Further, there has been no objective method to select which of the numbers psychoactive medications will be effective in any particular patient. Additionally, a large pharmacoeconomic benefit could be seen if medications for patients could be based on an objective tool to inform the choice of medication by responsiveness or decreased adverse events."*[8]

PEER Technology

PEER* is a crowdsourced registry of patient outcomes that is used to compare responsiveness or non-responsiveness to particular medications according to a common test of brain function, the Electroencephalogram (EEG). The process is simple: a patient receives a 20-minute EEG (a painless, non-invasive procedure) which is uploaded to the cloud, and within an hour their physician receives a 2-page report on medication sensitivity to his/her computer or iPad. Physicians enter outcomes at each visit which are then fed back into the database to improve its predictiveness for future releases.

Evidence for this approach is consistently strong. Over 84 prior clinical trials[9] representing over 3,500 subjects using PEER, its predecessor technology rEEG, and other quantitative EEG tools have demonstrated success in predicting medication response. These trials have consistently shown **a doubling in medication effectiveness, and more recent trials have shown substantial reductions in medication risk, improvement in adherence to treatment, and improved physician efficiency.** In a randomized, prospective controlled multisite trial including Harvard, Stanford, and the University of California, Irvine, in 2011, DeBattista et al reported:

* PEER: Psychiatric Electroencephalography Evaluation Registry

> *"...rEEG-guided pharmacotherapy [PEER] would represent an easy, relatively inexpensive, predictive, objective office procedure that builds upon clinical judgment to guide antidepressant medication choice."*[10]

Similarly, a 2012 retrospective study of 435 patients for a commercial healthcare payer identified significant potential to reduce medication risk, **including a statistically significant 87% reduction in suicidality:**

> *This chart review demonstrated significant improvement on the global assessment scales Clinical Global Impression – Improvement and Quality of Life Enjoyment and Satisfaction – Short Form as well as time to maximum medical improvement and decreased suicidality occurrences. The review also showed that 54.5% of previous medications causing a severe adverse event would have been raised as a caution had the PEER Report been available at the time the drug was prescribed."*[11]

Because PEER captures outcomes, provides physicians with objective data, and has machine-learning algorithms which foster continuous improvement, this technology addresses the major requirements established in the IOM report.

Walter Reed PEER Interactive Trial

The PEER Interactive Trial at Walter Reed National Military Medical center was initiated in January 2013, and has so far enrolled approximately 10% of its planned 1,922 service members. The trial is designed as a "real-world evidence" trial in which subjects are randomized to a treatment group (physician receives PEER Report) or a control group (no PEER Report provided), and physicians are permitted to either follow or not follow PEER recommendations.[12] Interim results have been peer reviewed by a leading neuropsychiatric journal.[13]

Potential Impacts for Veterans

By repurposing existing technologies (like EEG) with the scalability of cloud computing, we believe tools like PEER offer the potential to rapidly meet each of the key IOM requirements:[14]

IOM Recommendation: physiological markers for treatment

"Developing markers — biological, physiological, and psychosocial — to identify better approaches for PTSD prevention, diagnosis, and treatment."[14]

- Over 84 clinical trials have confirmed the efficacy of physiological markers for medication response based on Quantitative EEG

IOM Recommendation: continuous improvement based on outcome data

"Given that DOD and VA are responsible for serving millions of service members, families and veterans, the committee found it surprising that no PTSD outcome measures of any type are consistently used or tracked in the short or long term..."[15]

- Automated collection of outcomes on each patient is the core of the PEER approach

- With over 37,000 clinical endpoints for 9,800 unique patients, PEER represents the largest brain-based biomarker registry for effective mental health treatments based on patient physiology.[16]

IOM Recommendation: provider accountability and transparency
"In its phase 1 report, the committee recommended that DOD and VA mental health providers follow their own guideline."[17]

- "Studies indicate that many veterans do not receive evidence-based treatments in the recommended manner."[18]
- "There are few data, however, to indicate that the five performance measures for mental health in the 2011-2015 plan are being met 4 years into the plan."[19]

PEER automates tracking of treatment selection and has the potential to improve provider adherence to guidelines, resulting in:

- Up to 40% improvement in physician efficiency, with potential to dramatically reduce patient waiting lists
- 2-3x improvement in medication effectiveness
- Significantly reduced medication risk, reduced suicidality
- Increased patient adherence to treatment

Conclusion

Given these findings, we strongly believe that the Committee should take notice of research in this area and encourage the VA and DOD to work toward rapid advancement and deployment of this type of research.

We recognize that advances in medicine often are delayed not by science, but by failures in financing, technology and leadership. We believe the IOM recommendation in this regard is applicable to all mental health treatments:

> *"A high-performing PTSD management system should expedite the translation of positive research findings into practice. Optimally, the translation would take advantage of proven methods for the delivery of clinical services in a way that breaks down barriers to care. The best evidence-based treatments will have little value without a model for promoting their effective and widespread delivery."*[20]

This Committee has found veterans waiting 30 days to three months for health care at the VA. That is unacceptable. It should be no more acceptable for veterans to wait years for doctors to begin using a technology that we know can help them today. 84 studies say PEER can improve outcomes, improve access to care, and reduce suicide risk for veterans. On behalf of everyone who could benefit from better, more evidence-based mental health care, we thank you for your commitment to improving veterans health care.

Henry T. Harbin, MD
George C. Carpenter IV

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2. New York Times, 2/13/11

> *Virtually all of the evaluations of both departments have found the lack of data on which to make quantitative assessments of the programs' effectiveness to be a major shortcoming. The most recent evaluation of DOD mental health programs prepared by DCOE is unavailable. The VA collects more programmatic information than does the DOD, but outcome data are still scarce.*

> *The response of modern psychiatry to modern warfare has not always been perfect… "These decisions about medication are difficult enough in civilian psychiatry, but unfortunately in this very-high-stress population, there is almost no data to guide you," said Dr. Ranga R. Krishnan, a psychiatrist at Duke University. "The psychiatrist is trying everything and to some extent is flying blind."*

3. Hoffman DA, DeBattista C, Valuck RJ, Iosifescu DV. Measuring severe adverse events and medication selection using a "PEER Report" for nonpsychotic patients: a retrospective chart review. Neuropsychiatr Dis Treat. 2012;8:277–284.
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5. Thomas R. Insel, MD in CantonRep.com, 5/13/14
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8. Statement of Work, A study to evaluate the efficacy of using PEER Interactive to inform the psychopharmacological treatment of patients with a primary diagnosis of Depression with or without comorbid disorders, grant application 4/13.
9. www.cnsresponse.com/evidence.html
10. DeBattista C, Kinrys G, Hoffman D, et al. The use of referenced-EEG (rEEG) in assisting medication selection for the treatment of depression. J Psychiatr Res. 2011;45(1):64-75.
11. Hoffman DA, DeBattista C, Valuck RJ, Iosifescu DV. Measuring severe adverse events and medication selection using a "PEER Report" for nonpsychotic patients: a retrospective chart review. Neuropsychiatr Dis Treat. 2012;8:277–284.

12. Walter Reed National Military Medical Center, PEER Interactive Clinical Investigation Protocol 378604 v7.3, "A prospective, double blind, randomized, multicenter study to evaluate the utility, safety, and efficacy of using PEER Interactive to inform the prescription of medications to patients with a primary diagnosis of a depressive disorder and comorbidity of non-psychotic behavioral disorders versus treatment as usual."

13. dovepress.com

14. IOM p 228

15. IOM p 220

16. www.cnsresponse.com/evidence.html

17. IOM p 130

18. IOM p 144

19. IOM p 217

20. IOM p 193

CNS Response Disclosure of Federal Grants

Grantor:	Dept. of the Army
Subagency:	USAMRAA United States Army Medical Research Acquisition Activity
Grant/contract amount:	$1,782,211.00
Paid to date:	$54,000.00
Performance Period:	07/01/2013 to 09/30/2015
Indirect cost limitations or CAP limitations:	
Grant number:	1217707
Grant/contract award notice provided as part of proposal:	Yes
Cooperative Research and Development Agreement(CRADA) with Walter Reed National Military Medical Center (WRNMMC)	378604-12
ClinicalTrials.gov identifier:	NCT01794559

THE WALL STREET JOURNAL.

U.S. Military Tests Predictive Analytics to Better Treat Depression in War Veterans

Joel Schectman
Reporter

The military is testing whether a cloud-based predictive analytics tool can help doctors do a better job treating depression in military personnel.

The effort to find a more objective basis for treatment comes as the U.S. military hospital system faces the dual strains of continued long-term care of veterans of the wars in Afghanistan and Iraq, and severe cuts from the sequestration. "People would like us to find more cost-effective treatment models," said Col. Brett A. Schneider, a psychiatrist running the study at Walter Reed National Military Medical Center, where sequestration has forced thousands of planned worker furloughs. Dr. Schneider hopes the new self-learning software, built on a cloud-based Salesforce.com Inc. platform, will allow the military to more precisely treat wounded veterans, who often must spend years trying different medications before they identify an effective treatment for depression symptoms. "Wounded warriors are the population that has the highest risk for multiple medications," Dr. Schneider said. "Multiple medications can have side effects and if we could avoid that by getting it right on the first try, that would be the way to go."

The 2,300-patient study at Walter Reed National Military Medical Center and Fort Belvoir Community Hospital, which began last April, aims to assess whether a self-learning software can make better recommendations for medications to treat depression in military personnel—many of them wounded veterans—compared with doctors prescribing treatments based solely on their own judgment.

The study is using PEER Interactive software, from Aliso Viejo, Calif.-based vendor CNS Response Inc., which crunches mental health data from 8,402 patients who have already been treated using its database recommendations, and provides practitioners with recommendations for psychiatric medication and a calculation of the probability the treatment will work.

Rather than basing its recommendation solely on patient responses to questions, the software tool compares a measurement of the patient's brain waves — the squiggly line printout known as an EEG—with those of thousands of past patients, and how those patients responded to drug regimens.

Past studies have found a correlation between EEG measurement and various forms of mental illness. The software is designed to sharpen those correlations by continually updating its recommendations based on how well patients with particular, distinct, EEG patterns respond to different medication regimens. The software will not adjust its recommendations during the study based on new patient data, but the military hopes its patients will benefit from the analysis already done on thousands of treated patients, whose data was gathered over the course of more than a decade.

Other areas of medicine have already made strides in using self-learning tools to improve treatment. For example, at Vanderbilt University Medical Center, a database compares patient genetic attributions with treatment results from various blood thinners drugs, and continuously improves treatment recommendations based on results, said Dr. Blackford Middleton, chief informatics officer at the hospital. Dr. Middleton says the method allows the hospital to continue to improve results instead of relying solely on periodic, costly studies. "Otherwise we won't be able to afford progress in the field," said Dr. Middleton. "Learning from the data that exists is a very attractive alternative."

But self-learning software in psychiatry is a greater challenge. Treating mental health conditions has traditionally relied more on observation than on cold, easily comparable indicators like blood tests, making it harder to create the empirical results needed for self-learning.

"Currently we have to go with clinical wisdom rather than more objective tests," said Dr. Schneider who hopes recommendations from the system helps patients "get better sooner with less trial and error and fewer side effects. If we can get the right medication the first time that's just good for the patient."

Brief Bio for Henry Harbin MD

Dr Harbin is a Psychiatrist with over 30 years of experience in the behavioral health field. He has held a number of senior positions in both public and private health care organizations. He worked for 10 years in the public mental health system in Maryland serving as Director of the state mental health authority for 3 of those years.

He has been CEO of two national behavioral healthcare companies – Greenspring Health Services and Magellan Health Services. At the time he was CEO of Magellan it was the largest managed behavioral healthcare company managing the mental health and substance abuse benefits of approximately 70 million Americans including persons who were insured by private employers, Medicaid and Medicare.

In 2002 and 2003 he served on the President's New Freedom Commission on Mental Health. As a part of the Commission he was chair of the subcommittee for the Interface between Mental Health and General Medicine. In 2005 he served as co-chair of the National Business Group on Health's work group that produced the Employer's Guide to Behavioral Health Services in Dec 2005. Since 2004 Dr Harbin has been providing health care consulting services to a number of private and public organizations.

BACKGROUND

PRESIDENT & CEO
CNS Response Inc. (CNSO:OB)

CHAIRMAN & CEO
WorkWell Systems Inc.

CHAIRMAN & CEO
CORE Inc. (Nasdaq: CORE)

VICE PRESIDENT, OPERATIONS
Baxter International Inc.

AWARDS

Innovation in Healthcare Award, ABL, 2004

Ernst & Young Entrepreneur of the Year Finalist, OC, 1998

PUBLICATIONS

Journal of Managed Care Medicine, Vol 9, No. 1, 2006

The Shape of Things: The Rising Impact of Obesity
LRP Publications, 2006

BOARDS

Remedy Interactive Inc.,
Sausalito, CA

WEBSITE

www.cnsresponse.com

2013

George C. Carpenter IV
CEO, CNS Response Inc.

http://youtu.be/qdlsj2WnEkw

A results-oriented biomedical executive with a passion for leading high growth and turn-around companies, George's focus is bringing new technology and business processes to underserved markets.

As CEO of CNS Response, Inc., (CNSO:OB) George is leading the commercialization of the company's patented PEER INTERACTIVE® technology for psychotropic medication management. CNS Response is the first biomarker solution for providers, in behavioral medicine.

Prior to CNS Response Inc., George ran WorkWell Systems, a national physical medicine firm managing occupational health testing programs for Fortune 500 employers. From 1990 to 2001, George served as Chairman and CEO of CORE, Inc., (Nasdaq: CORE) after leading the management buyout of this division of Baxter Healthcare. CORE was a pioneer in workforce health care management and analytics, establishing a record for clinical software innovation and talent development that, in the words of one Wall Street analyst, "created an industry". CORE was acquired in 2001 by Assurant Inc.

Prior to founding CORE, George was a Vice President of Operations with Baxter Healthcare, served as a Director of Business Development and as strategic planner for Baxter's alternate site businesses. His career began at Inland Steel in manufacturing process control and Sales.

George serves on a variety of biomedical advisory and fiduciary boards, and is a frequent speaker and writer on healthcare technology and financing issues.

He earned his MBA in Finance from the University of Chicago and a BA with Distinction in International Policy & Law from Dartmouth College. George and his family live in Laguna Niguel, CA.

CBS MarketWatch

THE ULTIMATE FALLOUT:

SUICIDE PREVENTION CARE DENIED TO AT-RISK VETERANS DUE TO MISCONDUCT IN SERVICE

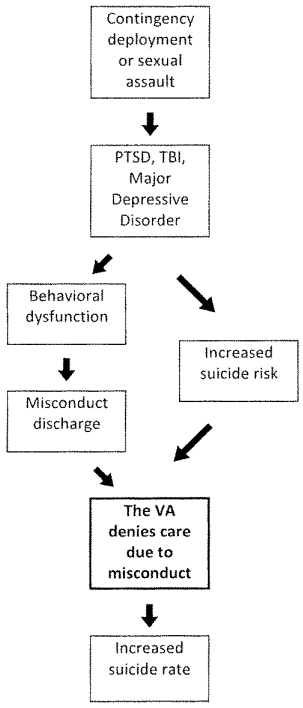
Written testimony by Swords to Plowshares
for
House Veterans Affairs Committee
"Service should not lead to suicide: Access to VA's Mental Health Care"
July 10, 2014

VA regulations prohibit the Agency from providing timely access to care and services to some former servicemembers who are most at risk of suicide. This arises when servicemembers acquired behavioral dysfunctions as a symptom of PTSD, TBI, or deployment stress, and where the military characterized such behavioral dysfunction as misconduct. Many of these are servicemembers that the public would expect to receive care and support, including servicemembers who deployed to contingency operations or survived trauma. The VA routinely denies care to these servicemembers because of their conduct in service.

This testimony describes the nexus between in-service misconduct and suicide risk, the delay and denial of VA care to this at-risk group, and the solutions available to Congress.

The Suicide Pipeline

25% of active-duty suicide victims have a record of misconduct, but the VA denies eligibility to 80% of veterans discharged for misconduct.



See text for citations to research

The Human Toll

The VA knows the names of hundreds of people that were denied care due to misconduct and who later committed suicide.[1] *This can be avoided for veterans like these:*

T. H.[2]
He deployed with the 82nd Airborne for the first Gulf War, where he earned the CIB for clearing bunkers and did vehicle and casualty recovery on the "Highway of Death." After his return he started experiencing PTSD. He attempted suicide once during service. He felt that he was unable to receive care, and was denied permission to take leave to be cared for by his family. He left anyway, and when he voluntarily returned he was given an OTH discharge. He has attempted suicide twice since separation. Still denied VA care.

Kash Alvaro [3]
A soldier deployed to Afghanistan who acquired PTSD and TBI so severe that it triggered seizures and heart palpitations. He was given an OTH discharge while waiting for a medical separation. His unit had not provided transportation to his medical appointments, had written that his seizures were faked, and had not approved his request to be assigned to a Warrior Transition Unit. He was discharged after he had isolated himself in his apartment for two weeks. Granted VA care only after media attention.

T.W.
He volunteered for the Marines and deployed to Vietnam twice. He earned two purple hearts and was hospitalized for "nervous shock" on his first tour. On his second, he had a breakdown and started a fight with MPs. He was given an OTH discharge. Without psychiatric care, he started illegal drug use, became homeless, and attempted suicide once. Still denied VA care.

Competency of Swords to Plowshares to testify on this issue:

Swords to Plowshares has been assisting veterans with access to VA health care and related services for four decades. This gives us a detailed, on-the-ground knowledge of how the VA's administrative procedures operate.

Swords to Plowshares is a veterans service organization in San Francisco.[4] Swords to Plowshares has been serving the veteran population since 1974. From its inception it has served veterans marginalized by society and rejected by the VA: it served Vietnam veterans with PTSD before the VA recognized this as a condition; it has provided housing and assistance to homeless veterans since the 1980s; and it is one of the few organizations that have provided representation to veterans with so-called "bad paper", discharges that are less than honorable and can interfere with access to VA benefits and civilian employment. Swords to Plowshares currently operates emergency and permanent supportive housing to over 300 veterans a year; assists over 400 veterans obtain other housing each year; has employment and training services; case management services; and provides legal services to over 400 veterans a year.[5]

Swords to Plowshares has worked extensively with veterans seeking access to VA health care. For homeless veterans, access to VA health care is the most important benefit that the VA offers. Our legal staff helps veterans obtain access to VA health care through direct advocacy with VA hospitals, through VBA claims, and through petitioning the DOD for a review of discharge characterization. This gives us a close understanding of the law around both VA eligibility and discharge review, as well experience with how they affect veterans in practice.

TESTIMONY

The rate of suicide for veterans outside of VA care is increasing. In 2010, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.[6] Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide. The VA is failing in its mission to prevent suicide among veterans by denying life-saving care to a high-risk group of servicemembers.

Section I explains why veterans at risk of suicide are at high risk of receiving a misconduct discharge. Section II explains how the VA excludes the large majority of veterans in this situation. Section III explains who this increases suicide risk. Section IV proposes solutions to this problem, including suggested legislative text on page 11.

I. Why servicemembers at risk of suicide are likely to receive misconduct discharges

Congress has given the VA responsibility for deciding which servicemembers should be granted "veteran" status and therefore be eligible for health care when they have been discharged for misconduct. The number of servicemembers separated with discharges that put them at risk of VA delays varies between 9% in 2002 and 4% in 2011. It also varies by service: in 2011 the Marine Corps discharged 8% in this way while the Air Force discharged less than 1% in this way. The largest number of affected discharges are those characterized as "Other Than Honorable" (OTH). From 2001 to 2011, 115,000 servicemembers received OTH discharges.[7]

Not all misconduct discharges are justly awarded. There are many cases of servicemembers with mental health disabilities acquired in service, some exhibiting suicidal risk, whose service does not necessarily protect them from receiving misconduct discharges characterized as "Other Than Honorable." These servicemembers, at high risk of suicide, are likely to be denied VA care.

Mental health disabilities acquired in service may lead to misconduct discharges

The misconduct that leads to an OTH discharge is often behavior symptomatic of acquired mental health disorders such as Post-Traumatic Stress or Traumatic Brain Injury. For example, Marines with PTSD from combat exposure are 11 times as likely to be separated with a misconduct discharge.[8] This section explains how that happens.

PTSD, TBI, and Major Depression produce behavioral dysfunction through an exaggerated startle response, inability to control reflexive behavior, irritability, or attraction to high-risk behavior.[9] Some of the medicines used to treat the conditions may induce fatigue or

lethargy that also interferes with basic functioning. In fact, interference with social and occupational functioning is a primary measure of the severity of these conditions.[10]

For servicemembers on active duty, these behavioral disorders may result in infractions of unit discipline. This may include non-prescription drug use as a form of self-medication, aggression towards co-workers or family members, or impairment as side effects of prescription drug use. Any of this conduct may be a basis for misconduct discharges characterized as "Other Than Honorable" (OTH) or "Bad Conduct" (BCD).

These behavioral disorders are not always recognized by the services as symptoms of acquired mental health disorders. The servicemember may not yet be diagnosed, or the command may not believe that the conduct is due to in-service trauma. If the military service is in the process of separating the servicemember for a disability, the services may suspend the medical separation process and give an immediate misconduct discharge if any misconduct occurs and the servicemember volunteers to be separated rather than be court-martialed.[11] A 2012 Army study found that the commander of Warrior Transition Units at Ft. Bliss showed a "primary attitude" that was "punitive, like a correctional facility."[12]

These same mental health disabilities increase suicide risk

The same mental health disabilities that may lead to misconduct discharges are associated with increased suicide risk.[13] PTSD in veterans is associated with elevated suicide risk both for those with PTSD diagnoses[14] and those with PTSD symptoms that fall below the threshold for a PTSD diagnosis.[15] Veterans with TBI are 55% more likely to die by suicide.[16] Service members with prior deployments are more likely to attempt suicide, even when controlling for the existence of other mental health disorders.[17, 18] Other predictors of suicide risk also involve behavioral dysfunction, such as Major Depressive Disorder, Substance Abuse, and Intermittent Explosive Disorder.[19]

Direct evidence linking misconduct discharges to suicide risk

Self-harm is often the culmination of a progression that starts with disciplinary infractions and proceeds to more major misconduct. This has been acknowledged by some of the services[20] and has been shown in data: 25% of suicide victims have some record of in-service misconduct.[21] When that misconduct occurred during service, they may have received discharges that interfere with their access to timely VA care.

Both anecdotal evidence and official policy show that the military services have discharged servicemembers for misconduct when they should have been retained. According to a 2010 report on suicide in the Army, one of its strategies for deterring suicidal behavior is aggressive citation and investigation of behavioral disorder that results in misconduct, and separation from the service when it arises.[22] In other words, it is the Army's policy to give

misconduct discharges to the servicemembers most at risk of suicide. They then become the VA's responsibility.

II. How the VA denies and delays care to servicemembers with misconduct discharges

Denial of care under VA standards

Not all those who served are recognized by the VA as veterans. A servicemember is only a veteran in the eyes of the VA if they were discharged "under conditions other than dishonorable."[23] This does not refer to a Dishonorable Discharge provided by the service. It refers to an overall judgment of the quality of service to be made by the VA after separation from the military. Congress has never defined for the VA what service should be treated as "dishonorable"[24], leaving it to the VA to define this term through regulation and adjudication.

Under current standards, the VA has very broad discretion to determine whether service was "under conditions other than dishonorable" if the servicemember's discharge was "Other Than Honorable" or "Bad Conduct."[25] According to its current regulations, the VA decides that service was dishonorable if misconduct was "willful and persistent" or if it involved "moral turpitude."[26] The standard is very low. Misconduct can be "willful and persistent" if it involved only two incidents of misconduct or if it was a single episode of unauthorized absence.

The VA is not required to consider whether in-service misconduct was due to deployment or mental health disabilities. The VA may overlook "minor" misconduct if service was "otherwise faithful, honest and meritorious."[27] However, deployment to a contingency operation, or several deployments, is not considered "meritorious" service by the VA because this was merely the servicemember's assigned duty.[28] The VA only considers deployment to be "meritorious" if there were documents acts of exceptional conduct. There are no other provisions in VA regulation or policy that require it to consider mitigating circumstances when deciding if misconduct was "dishonorable."[29]

In practice, the VA finds that most service that ends in an OTH discharge was dishonorable: 80% of its decisions deny "veteran" status.[30]

Delay of care under VA procedures

For servicemembers given OTH or BCD discharges, the VA presumes that they are not veterans until shown otherwise. When a servicemember appears at a VHA facility requesting services, his or her status is "non-veteran" and the initial response of VHA staff to servicemembers with OTH or BCD discharges is denial. We have heard directly and second-hand from clients that VA staff respond to requests for services by saying "you are not a veteran" and "you are dishonorable." This is premature, as the VA has not yet determined whether their

service was dishonorable. It also discourages servicemembers, particularly those at risk of suicide, from further pursuing eligibility for care.

The VA is required to evaluate service whenever a potentially ineligible servicemember seeks benefits; however, VHA personnel routinely violate this policy. VHA policy instructs Eligibility and Enrollment staff to initiate a request to the VBA to evaluate the service of people with OTH or BCD discharges.[31] However, VHA staff at the San Francisco VAMC have told us directly that they do not do so. Instead, they advise the servicemember to seek a discharge upgrade from the military service; they do not even inform servicemembers of the VA's duty to evaluate their service. When our staff have specifically requested that they initiate this process for servicemembers, VHA staff have refused to do so and have proceeded only after the involvement of an attorney. For servicemembers that do not seek the help of an advocate, VHA staff are effectively denying all eligibility, denying even the possibility of recognition as a "veteran."

If a servicemember insists on having his eligibility reviewed, that request will be handled in the slowest adjudication track. The task of determining "veteran" status is considered an "Administrative Adjudication" by the VBA. These issues are handled by "non-rating" teams. The VBA has shifted staff onto "rating" teams in response to the claims backlog, leaving "non-rating" teams understaffed. Currently, issues in the "non-rating" team are taking twice as long as "rating" issues.[32] Therefore VA compensation claims, as slow as they are, are handled twice as fast as the question of whether a servicemember is even a "veteran." At the Oakland Regional Office, these issues take an average of about two and a half years to complete.

The VA does not provide medical care while it performs an evaluation of service.[33] The VHA has discretion to provide care on a "humanitarian basis" if the servicemember signs a contract agreeing to pay for the services if required;[34] however, the VHA does not routinely offer this while the VA is evaluating character of discharge.[35] For urgent services, such as emergency psychiatric care and emergency homeless services, this delay amounts to a denial of the service sought.

III. Why the VA's practice increases the risk of veteran suicide

The data above shows the correlation between suicide risk, in-service misconduct, and denial of access to VA care: deployment increases risk of PTSD, TBI and substance abuse; all of those conditions increase the risk of receiving a misconduct discharge; and those conditions also increase risk of suicide. Therefore for the VA's denial and delay of care for veterans with misconduct disproportionately affects servicemember at risk of suicide.

Exclusion from VA care further increases risk of suicide. The VA's successful suicide prevention efforts have lowered the rate of suicide among veterans enrolled in VA care.[36] However, the rate of suicide for veterans outside of VA care is increasing. In 2010, the latest

data available, veterans outside of VA care were committing suicide 30% more frequently than those enrolled in VA care.[37] Excluding a servicemember from the VA increases the chance that this servicemember will commit suicide.

The VA knows these people by name. The VA has a list of servicemembers who have committed suicide, based on state death reports. Some of them at some time asked the VA to evaluate their service and grant them VA care. The VA rejected them 85% of the time.[38] That means the VA turned away at least 448 servicemembers who went on to commit suicide. The actual number is certainly higher, because the VA list does not collect deaths from all states, and because it doesn't include people who sought care at VA hospitals and where the staff turned them away without filing an eligibility request.

IV. Solutions

Providing timely care to suicidal veterans with misconduct discharges requires four solutions. These do not require large changes to VA obligations and would align VA practice with public expectations.

1. Issue: The VA denies most requests for assistance regardless of whether their condition was related to in-service mental health conditions and regardless of whether the servicemember had significant deployment service.

   Solution: The VA should enact presumptions to give the benefit of the doubt to certain categories of servicemembers most at need of care: those who mental health disabilities acquired in service and those who were deployed to contingency operations. ***See below for suggested text.*** The VA should presume that they served under conditions other than dishonorable unless evidence clearly shows otherwise. Effectively, this requires the VA to consider whether the misconduct that led to the discharge was the result of a mental health disorder, and it requires the VA to give credit for the inherently laudable service of a contingency deployment. Creating this clear rule would also accelerate the decision-making process by reducing the amount of investigation required of VA raters and provide immediate care to those most at risk of suicide.

2. Issue: The VA does not provide care prior to deciding whether service was "under conditions other than dishonorable."

   Solution: The VA should be instructed to provide health care and housing assistance to servicemembers pending original determination of "veteran"

status. ***See below for suggested text.*** Anyone who enlisted and served deserves the benefit of the doubt, and they should not be denied health care for years waiting for the VA to decide whether they are veterans. This will allow the VA to provide essential care immediately, without delaying care while it evaluates character of discharge, ensuring that no servicemembers at risk of suicide are turned away or left on the street merely because of a bureaucratic delay.

3. Issue: The VHA routinely fails to initiate a decision.

   Solution: The VHA should automatically start a request for a "Character of Service" determination when a servicemember with an OTH or BCD discharge requests health care. While this is already official VHA policy, this is routinely ignored. It is more likely that this will be followed if the VA enacts the provision recommended above.

4. Issue: The VBA places those decision it its slowest decision-making lane.

   Solution: The decision of whether someone is even a veteran should be a priority for the VA. Whether a servicemember is even a "veteran" is a fundamental question that deserves to be prioritized. The VA should create a "Flash" for claims with this issue and move them into expedited lanes.

These solutions would not require a major change to current VA obligations. There is a relatively small number of servicemembers who receive discharges that make the presumptively ineligible for VA care: from 2001 to present, about 6% of servicemembers received OTH or BCD discharges. The eligibility changes proposed above would create presumptions of eligibility for the subset of these who were deployed to contingency operations or who have a mental health condition acquired in service. This is not a significant increase in the number of people under VA care, but it will disproportionately target the servicemembers at risk of suicide.

The solutions would align VA practice with public expectations. In our experience, the public is unaware that servicemembers who deployed to combat or who have severe disabilities might not be eligible for VA support.

V. Conclusion

Our current wars have created tens of thousands of people injured by the conditions of their service. Often this results in behavioral disorders that may appear as "misconduct" to their chains of command. There is a pipeline from in-service mental health trauma to behavioral dysfunction to misconduct discharge, and it ends with veterans at risk of suicide denied access to

VA support. The VA's administrative processes deny immediate care to these servicemembers, and creates bureaucratic barriers to critical care that can save lives. Certain behavior may be incompatible with continued military service, but we also recognize that those servicemembers who once served honorably deserve and need our support after they separate. Congress gave the VA the duty to extend services to those servicemembers. Their slow bureaucratic process and their refusal to follow their own rules effectively deny care and dignity to those servicemembers. They deserve better.

SUGGESTED LEGISLATIVE TEXT

SEC. __. EVALUATION OF VA ELIGIBILTY FOR SERVICEMEMBERS WITH MENTAL HEALTH DISABILITIES OR WITH SERVICE IN CONTINGENCY OPERATIONS.

(a) Section 5303B is added: "Evaluation of conditions of discharge –

(1) Servicemembers who acquired mental health disabilities during service shall be presumed to have served under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(2) Servicemembers who were deployed to a contingency operation shall be presumed to have been discharged under conditions other than dishonorable in the absence of clear and convincing evidence to the contrary.

(3) The presumptions in this section do not overcome the prohibitions in 38 USC 5303(a).

(b) Tentative eligibility for essential care – The VA shall extend benefits under Chapter 17 and Chapter 20 to former servicemembers pending the outcome of character of discharge determinations. No overpayments will be assessed for services provided during this period.

[1] Conversation with VHA Analyst, June 27 2014, reporting that a list of veteran suicide deaths compiled by states includes 448 who had received misconduct discharges and had asked the VA to review their service, and for whom the VA had denied eligibility.
[2] Swords to Plowshares client.
[3] Profiled in "Other Than Honorable", Colorado Springs Gazette http://cdn.csgazette.biz/soldiers/day1.html.
[4] www.swords-to-plowshares.org
[5] http://www.swords-to-plowshares.org/wp-content/uploads/Swords-2013-Infographic.pdf
[6] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[7] "Administrative Separations" at http://www.dod.mil/pubs/foi/recent.html
[8] Highfill-McRoy et al. "Psychiatric diagnoses and punishment for misconduct: the effects of PTSD in combat-deployed Marines", BMC Psychiatry 2010, 10:88.
[9] James et al. (2014), "Risk-Taking Behaviors and Impulsivity Among Veterans With and Without PTSD and Mild TBI", Military Medicine, 179, 4:357; Elbogen et al. (2014). Violent behavior and post-traumatic stress disorder in US Iraq and Afghanistan Veterans. The British Journal of Psychiatry, Advance online publication. doi: 10.1192/bjp.bp.113.134627; Tateno et al., "Clinical Correlates of Aggressive Behavior After Traumatic Brain Injury", The Journal of Neuropsychiatry and Clinical Neurosciences 2003;15:155-160. doi:10.1176/appi.neuropsych.15.2.155.
[10] See "General Ratings Formula for Mental Disorders" 38 CFR 4.150 (2009).
[11] For example, AR 600-235 Ch. 10.
[12] Quoted in "Other Than Honorable", Colorado Springs Gazette http://cdn.csgazette.biz/soldiers/day2.html.
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[20] See U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report" July 28, 2010.
[21] U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, page 43
[22] U.S. Army "Health Promotion, Risk Reduction and Suicide Prevention Report." July 28, 2010, passim. and page 70 ("Recommended actions: Enforce separation actions for high risk behavior.")
[23] 38 USC 101(2)
[24] Congress has required the VA to deny benefits to certain veterans based in part on their conduct in service, e.g. 38 USC 5303(a), 38 USC 5303(d), 38 USC 5303A. However these do not define "dishonorable" service. They are additional eligibility requirements that apply even if a servicemember is found to have service under other than dishonorable conditions.
[25] Congress has not defined the term "dishonorable" in statute. The Court of Appeals for Veterans Claims characterized the VA's regulations that attempt to define the term as "very broad" in Manuel v Shinseki, 10-1858 (Vet. App. 2012).

[26] 38 CFR 3.12(d)
[27] 38 CFR 3.12(d)(4)
[28] Title Redacted by Agency, 03-09 368, Bd. Vet. App. (June 19, 2009).
[29] See "Benefits Adjudication", VA Manual M21-1MR, *passim*.
[30] The Veterans' Disability Benefits Commission, Honoring the Call to Duty: Veterans' Disability Benefits in the 21st Century (2007), page 97.
[31] See "Note" in "Eligibility Determination", VHA Handbook 1601A.02, page 5 (Nov. 5, 2009).
[32] *See* "Non-rating activity days pending" in *ASPIRE Benefits Dashboard* at http://www.dod.mil/pubs/foi/recent.html.
[33] 38 CFR 17.34 (establishing a narrow provision for "tentative eligibility determinations" that do not apply where the character of discharge is in question).
[34] 38 CFR 17.102(a)
[35] The VHA eligibility determination manual does not include an instruction to make this available. See "Eligibility Determination", VHA Handbook 1601A.02, page 4-5 (Nov. 5, 2009).
[36] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[37] "Suicide Rates in VHA Patients through 2011 with Comparisons with Other Americans and other Veterans through 2010", Veteran's Health Administration, January 2014.
[38] Data provided by VA Analyst, June 2014.

Statement for the Record
of
Vietnam Veterans of America

Prepared by

Thomas J. Berger, Ph.D

Executive Director, Veterans Health Council of VVA

For The

House Veterans Affairs Committee

REGARDING

"Service Should Not Lead To Suicide: Access To VA's Mental Health Care"

July 10, 2014

Good morning, Chairman Miller, Ranking Member Michaud and members of the House Veterans Affairs Committee. On behalf of VVA National President John Rowan and all of our officers and members we thank you for the opportunity for Vietnam Veterans of America (VVA) to share our statement for the record regarding "Service Should Not Lead To Suicide: Access To VA's Mental Health".

VVA is very concerned about two related mental health issues: suicides, especially among America's older veterans' cohort and timely access to VA mental health clinical facilities and programs, especially for our rural veterans.

VVA understands that it is very challenging to determine the exact number of veteran suicides. Some troops who return from deployment become stronger from having survived their experiences. Too many others are wracked by memories of what they have experienced. This translates into extreme issues and risk-taking behaviors when they return home, which is one of the reasons why veteran suicides have attracted so much attention in the media. Many times, suicides are not reported, and it can be very difficult to determine whether or not a particular individual's death was intentional. For a suicide to be recognized, examiners must be able to say that the deceased meant to die. Other factors that contribute to the difficulty are differences among states as to who is mandated to report a death, as well as changes over time in the coding of mortality data. In fact, previously published data on veterans who died by suicide were only available for those who had sought VA health care services. But for the first time, a February 1, 2013 VA report includes some limited state data for veterans who had not received health care services from VA, and the report paints a shocking portrait of what's happening among our older vets (see chart below).

Percentage of suicides by age and veteran status among males

Age group	Non-veteran	Veteran
29 and younger	24.4%	5.8%
30-39	20.0	8.9
40-49	23.5	15.0
50-59	16.9	20.0
60-69	7.4	16.8
70-79	4.2	19.0
80 and older	3.6	14.5

Over two-thirds of veterans who commit suicide are age 50 or older.

Among the report's other findings:

• The average age of veterans who die of suicide is just short of 60; for nonveterans, it's 43.

• Female veterans who commit suicide generally do so at younger ages than males. Two-thirds of women who killed themselves were under 50 years of age; one-third were under 40 and 13 percent were under 30. For men, the comparable figures were 30 percent, 15 percent and 6 percent.

• About 15 percent of veterans who attempt suicide, but don't succeed, try again within 12 months.

VVA strongly suggests that until VA mental health services develops a nationwide strategy to address the problem of suicides among our older veterans – **particularly Vietnam-era veterans** -- it should immediately adopt and implement the appropriate suicide risk and prevention factors for veterans found in the "National Strategy for Suicide Prevention 2012: Goals and Objectives for Action: A Report of the U.S. Surgeon General and of the National Action Alliance for Suicide Prevention" that's available on-line at the web sites for both the Surgeon General's Office and SAMHSA.

In addition, according to the American Foundation for Suicide Prevention, in more than 120 studies of a series of completed suicides, at least 90 percent of the individuals involved were suffering from a mental illness at the time of their death. The most important interventions are recognizing and treating these underlying illnesses, such as depression, alcohol and substance abuse, post-traumatic stress

and traumatic brain injury. Many veterans (and active duty military) resist seeking help because of the stigma associated with mental illness, or they are unaware of the warning signs and treatment options. These barriers must be identified and overcome.

However, VVA has long believed in a link between PTSD and suicide, and in fact, studies suggest that suicide risk is higher in persons with PTSD. For example, research has found that trauma survivors with PTSD have a significantly higher risk of suicide than trauma survivors diagnosed with other psychiatric illness or with no mental pathology (1). There is also strong evidence that among veterans who experienced combat trauma, the highest relative suicide risk is observed in those who were wounded multiple times and/or hospitalized for a wound (2). This suggests that the intensity of the combat trauma, and the number of times it occurred, may indeed influence suicide risk in veterans, although this study assessed only combat trauma, not a diagnosis of PTSD, as a factor in the suicidal behavior.

Considerable debate exists about the reason for the heightened risk of suicide in trauma survivors. Whereas some studies suggest that suicide risk is higher due to the symptoms of PTSD (3,4,5), others claim that suicide risk is higher in these individuals because of related psychiatric conditions (6,7). However, a study analyzing data from the National Co-morbidity Survey, a nationally representative sample, showed that PTSD alone out of six anxiety diagnoses was significantly associated with suicidal ideation or attempts (8). While the study also found an association between suicidal behaviors and both mood disorders and antisocial personality disorder, the findings pointed to a robust relationship between PTSD and suicide after controlling for co-morbid disorders. A later study using the Canadian Community Health Survey data also found that respondents with PTSD were at higher risk for suicide attempts after controlling for physical illness and other mental disorders (9).

Some studies that point to PTSD as the cause of suicide suggest that high levels of intrusive memories can predict the relative risk of suicide (3). Anger and impulsivity have also been shown to predict suicide risk in those with PTSD (10). Further, some cognitive styles of coping such as using suppression to deal with stress may be additionally predictive of suicide risk in individuals with PTSD (3).

Other research looking specifically at combat-related PTSD suggests that the most significant predictor of both suicide attempts and preoccupation with suicide is combat-related guilt, especially amongst Vietnam veterans (11). Many veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war, and these thoughts can often overpower the emotional coping capacities of veterans.

Researchers have also examined exposure to suicide as a traumatic event. Studies show that trauma from exposure to suicide can contribute to PTSD. In particular, adults and adolescents are more likely to develop PTSD as a result of exposure to suicide if one or more of the following conditions are true: if they witness the suicide, if they are very connected with the person who dies, or if they have a history of psychiatric illness (12,13,14). Studies also show that traumatic grief is more likely to arise after exposure to traumatic death such as suicide (15,16). Traumatic grief refers to a syndrome in which individuals experience functional impairment, a decline in physical health, and suicidal ideation. These symptoms occur independent of other conditions such as depression and anxiety.

All of this brings us full circle to what VVA has been saying for years – if **both DoD and VA** were to use the PTSD assessment protocols and guidelines as strongly suggested by the Institutes of Medicine back in 2006 (http://iom.edu/Reports/2006/Posttraumatic-Stress-Disorder-Diagnosis-and-Assessment.aspx), our veteran warriors would receive the accurate mental health diagnoses needed to assess their suicide risk status.

Once again, on behalf of VVA National President John Rowan and our National Officers and Board, I thank you for your leadership in holding this important hearing on this topic that is literally of vital interest to so many veterans, and should be of keen interest to all who care about our nation's veterans.

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Dr. Tom Berger

Dr. Tom Berger is a Life Member of Vietnam Veterans of America (VVA) and founding member of VVA Chapter 317 in Kansas City, Missouri. Dr. Berger served as a Navy Corpsman with the 3rd Marine Corps Division in Vietnam during 1966-68. Following his military service and upon the subsequent completion of his postdoctoral studies, he's held faculty, research and administrative appointments at the University of Kansas in Lawrence, the State University System of Florida in Tallahassee, and the University of Missouri-Columbia, as well as program administrator positions with the Illinois Easter Seal Society and United Cerebral Palsy.

After serving as chair of VVA's national PTSD and Substance Abuse Committee for almost a decade, he joined the staff of the VVA national office as "Senior Policy Analyst for Veterans' Benefits & Mental Health Issues" in 2008. Then in June 2009, he was appointed as "Executive Director of the VVA Veterans Health Council", whose primary mission is to improve the healthcare of America's veterans through education and information.

Dr. Berger has been involved in veterans' advocacy for over thirty years, and he is a member of VVA's national Health Care, Government Affairs, Agent Orange and Toxic Substances, and Women Veterans committees. In addition, he is a member (and the former Chair) of the Veterans Administration's (VA) Consumer Liaison Council for the Committee on Care of Veterans with Serious Mental Illness (SMI Committee) in Washington, D.C.; he is also a member of the VA's Mental Health Quality Enhancement Research Initiative Executive Committee (MHQUERI) based in Little Rock, Arkansas and the South Central Mental Illness Research and Education Clinical Center (SC MIRECC) based in Houston, Texas. Dr. Berger holds the distinction of being the first representative of a national veterans' service organization to hold membership on the VA's Executive Committee of the Substance Use Disorder Quality Enhancement Research Initiative (SUDQUERI) in Palo Alto, CA and serves as a committee member on the National Association of Alcohol and Drug Abuse Counselors (NAADAC) veterans' work group. He has also served as a member of the National Leadership Forum on Behavioral Health-Criminal Justice Services with the CMHS-funded national GAINS Center and as a reviewer of proposals for the Department of Defense (DoD) "Congressionally Directed Medical Research Programs", He is a current member of the Education Advisory Committee for the National Center for PTSD in White River Junction, Vermont, as well as a member of the Executive Committee of the National Action

Alliance for Suicide Prevention in Washington, D.C., and a member of the Advisory Board for the National Crisis Center in New York and serves on both the Scientific Committee and the Veterans Advisory Council for Suicide Prevention Initiatives in New York City.

Dr. Berger's varied academic interests have included peer-reviewed research, published books and articles in the biological sciences, wildlife regulatory law, adolescent risk behaviors, domestic violence, substance abuse, suicide, and post-traumatic stress disorder. He currently resides in Silver Spring, Maryland.

VIETNAM VETERANS OF AMERICA

Funding Statement

July 10, 2014

The national organization Vietnam Veterans of America (VVA) is a non-profit veterans' membership organization registered as a 501(c) (19) with the Internal Revenue Service. VVA is also appropriately registered with the Secretary of the Senate and the Clerk of the House of Representatives in compliance with the Lobbying Disclosure Act of 1995.

VVA is not currently in receipt of any federal grant or contract, other than the routine allocation of office space and associated resources in VA Regional Offices for outreach and direct services through its Veterans Benefits Program (Service Representatives). This is also true of the previous two fiscal years.

For Further Information, Contact:

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A REVIEW OF HOW PRESCRIBED PSYCHIATRIC MEDICATIONS COULD BE DRIVING MEMBERS OF THE ARMED FORCES AND VETS TO ACTS OF VIOLENCE & SUICIDE

A Report by
Citizens Commission on Human Rights International
July 2014

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INTRODUCTION

The recent tragedies at Fort Hood and the Washington, D.C. Navy Yard are deeply concerning because of the increasing reports of military and veteran violence and suicide in our Armed Forces. Though there can be many reasons for killing oneself or others, the possible role of psychiatric drugs in these tragedies has not been effectively explored. It would be a serious mistake to ignore this factor.

Researchers have identified 25 psychiatric medications disproportionately associated with violence, including physical assault and homicide.[1]

There are 22 international drug-regulatory agency warnings about these medications causing violent behavior, mania, psychosis and homicidal ideation.

There are almost 50 international drug-regulatory agency warnings about psychiatric drugs causing suicidal ideation.

Antidepressants carry an FDA "black-box" warning of "suicidality" for those younger than 25. They also have documented side effects of hostility, anxiety and unusual behavior changes for any age group.

One in six American service members were taking at least one psychiatric medication in 2010.[2] More than 110,000 Army personnel were given antidepressants, narcotics, sedatives, antipsychotics and anti-anxiety drugs while on duty in 2011.[3]

The majority (55 percent) of service members who died by suicide during 2008-2010 had never deployed and 84 percent had no documented combat experiences.[4] In the 2012 DoD Suicide Event report on suicide, 52.2 percent of completed suicides had not been deployed in the recent wars and 56.5 percent of suicide attempts had no reported history of deployment.[5]

Between 2005 and 2011 the military increased its prescriptions of psychoactive drugs (antipsychotics, sedatives, stimulants and mood stabilizers) by almost 700 percent, according to *The New York Times*.[6]

Prescriptions written for antipsychotic drugs for active-duty troops increased 1,083 percent from 2005 to 2011, while the number of antipsychotic drug prescriptions in the civilian population increased just 22 percent.[7]

The Department of Defense Suicide Event Reports (DoDSERs) for 2012 reported that the Armed Forces Medical Examiner System (AFMES) found that as of 31 March 2013, there were 319 suicides among Active Component Service members and 203 among Reserve Component Service members. 92.8 percent of the Service Members were male, with 39.6 percent aged between 17 and 24.

DoDSERs were only included in this report if they were submitted by April 1, 2013 and thus there are discrepancies between the figures reported by the AFMES and the number of DoDSERs included in the DoDSER 2012 report. In addition, there were some DoDSERs that were submitted for events that were still pending a final determination as a suicide.

A total of 841 Service Members had one or more attempted suicides reported in the DoDSER program for CY 2012.

Some 134 suicide DoDSERs (42.1 percent) and 452 suicide attempt DoDSERs (52 percent) indicated a history of a behavioral disorder.
The reports also indicated that "93 decedents (29.2 percent) were reported to have ever taken psychotropic[1] medications. A total of 63 decedents (19.8 percent) were known to have used psychotropic medications within 90 days prior to suicide." However, this is likely to be much higher as almost 21 percent of both the "Ever Taken Psychotropic Medication" and the "Use of Psychotropic Medication last 90 days" questions were answered with "Data Unavailable." Potentially up to 50 percent of those committing suicide had at some point taken psychiatric drugs and up to nearly 41 percent had taken them within 90 days.[8]

The suicide rate increased by more than 150 percent in the Army and more than 50 percent in the Marine Corps between 2001 and 2009.[9] From 2008 to 2010, military suicides were nearly double the number of suicides for the general U.S. population, with the military averaging 20.49 suicides per 100,000 people, compared to a general rate of 12.07 suicides per 100,000 people.[10]

There are hundreds of "sudden deaths" among veterans that have been prescribed massive cocktails of psychotropic[1] drugs, which a leading neurologist says are "probable sudden cardiac deaths." Yet the practice of prescribing seven or more drugs documented to cause cardiac problems, stroke, violent behavior and suicide (to name but a few of the adverse effects) is still prevalent.

PSYCHOTROPIC MEDICATIONS: ACTS OF VIOLENCE

FORT HOOD GUNMAN IVAN LOPEZ, 34, was taking Ambien, a sleep agent, and other psychiatric drugs for depression and anxiety when he shot dead three colleagues and injured 16 others before killing himself on April 2, 2014.[11]

WASHINGTON NAVY YARD SHOOTER AARON ALEXIS, 34, had been prescribed Trazodone killed 12 people and wounded 8 before being killed by police on Sept. 16, 2013.[12]

SOLDIER PFC. DAVID LAWRENCE, 20, and MARINE LANCE CPL. DELANO HOLMES were both taking Trazodone and other psychiatric medications when they killed a Taliban commander in his prison cell and an Iraqi soldier respectively.[13]

RECOMMENDATIONS

We call for:

1. An inquiry into the potential violence- and suicide-inducing effects of prescribed psychiatric drugs.

2. An investigation into the sudden deaths of vets prescribed cocktails of antipsychotics and other mental health medications with accountability for the deaths and the standard of care given these vets.

3. Full transparency and accountability for the efficacy and results of existing mental health programs for the Armed Forces and veterans.

4. Improved informed consent laws with full searching medical examinations performed before a member of the Armed Forces or veteran can be diagnosed with a mental disorder.

PSYCHOTROPIC MEDICATIONS: VIOLENCE RISKS

It is important to understand that the mental health system for our Armed Forces and veterans often involves the use of psychotropic and neuroleptic[2] drugs. Between 2001 and 2009, orders for psychiatric drugs for the military increased seven fold.[14] In 2010, the *Army Times* reported that one in six service members were taking some form of psychiatric drug.[15]

A National Institutes of Health website warns consumers to report if while taking Trazodone—one of the drugs prescribed the Navy Yard shooter—they are "thinking about harming or killing yourself," experience "extreme worry; agitation; panic attacks...aggressive behavior; irritability; acting without thinking; severe restlessness; and frenzied abnormal excitement...."[16]

Psychologists have blamed the surge in random acts of violence among U.S. military on the heavy use of prescribed drugs. "We have never medicated our troops to the extent we are doing now ...And I don't believe the current increase in suicides and homicides in the military is a coincidence," states Bart Billings, a former military psychologist and combat stress expert.[17]

The Food and Drug Administration (FDA) MedWatch system that collects adverse drug reports revealed that between 2004 and 2012, there were 14,773 reports of psychiatric drugs causing violent side effects including: 1,531 (10.4 percent) reports of homicidal ideation/homicide, 3,287 (22.3 percent) reports of mania and 8,219 (55.6 percent) reports of aggression.

Dr. David Healy, a psychiatrist and a former secretary of the British Association for Psychopharmacology, estimates that 90 percent of school shooters were users of antidepressants.[18] These same medications are prescribed to at least 6 percent of our servicemen and women.[19]

Scientific American recently reported on a study of the antidepressants paroxetine (Paxil) and fluoxetine (Prozac) involving more than 25,000 subjects, which showed that one out of every 250 were involved in "a violent episode," including 31 assaults and one homicide.[20]

Scientific American also reported the results of a study of more than 9,000 subjects taking paroxetine for depression and other disorders, which found that subjects experienced more than twice as many "hostility events" as subjects taking a placebo.[21]

PSYCHOTROPIC MEDICATIONS: SUICIDE

Between 2005 and 2011, orders for psychiatric drugs for the military increased seven fold.[22]

Antidepressants carry an FDA "black-box" warning of "suicidality" for those younger than 25. They also have documented side effects of hostility, anxiety and unusual behavior changes for any age group.[23]

The age range of 41 percent of deployed American soldiers is 18-24 and some are prescribed antidepressants despite the Black Box warning.

There were 1,304 active and reserve components of the military aged 24 and younger that committed suicide between 1998 and 2011, representing 43.6 percent of 2,990 suicides in this group.[24] The 2012 DoD Suicide Event report found 39.6 percent of the Service Members committing suicide were aged 17-24.[25]

During 1998-2011 (with the numbers increasing sharply since 2005), 2,990 service members died by suicide while on active duty. Numbers and rates of suicide were highest among service members who were male, in the Army, in their 20s and of white race/ethnicity.[26]

There was an eightfold increase in martial psychotropic drug use since 2005, with nearly 8 percent of servicemen and women on sedatives and 6 percent on antidepressants.[27]

In March 2013, the Pentagon reported more soldiers were dying overseas by committing suicide than from combat wounds —about one a day. Returning vets were committing suicide at a rate of 22 each day in 2010—one every 65 minutes.[28]

In 2012, there was one suicide every 17 hours among all active-duty, reserve and National Guard members, according to figures gathered from each branch.[29]

The suicide rate increased by more than 150 percent in the Army and more than 50 percent in the Marine Corps between 2001 and 2009.[30]

The majority (55 percent) of Service Members who died by suicide during 2008-2010 had never deployed and 84 percent had no documented combat experiences.[31] In the 2012 DoD Suicide Event report on suicide, 52.5 percent of completed suicides had not been deployed in recent wars and 56.5 percent of suicide attempts had no reported history of deployment.[32]

In a report that Health and Human Services and Centers for Medicare and Medicaid Services published in August 2013, it stated, "Antidepressant medications have been shown to increase the risk of suicidal thinking and behavior. In a pooled-analysis of short-term, placebo-controlled trials of nine antidepressant medications, patients taking an antidepressant had twice the risk of suicidality in the first few months of treatment than those taking placebo. The long-term risk is unknown."[33]

Harvard Medical School psychiatrist, Dr. Joseph Glenmullen, author of *Prozac Backlash*, says antidepressants could explain the mass-suicides over the last decade. People who take antidepressants, he said, could "become very distraught....They feel like jumping out of their skin. The irritability and impulsivity can make people suicidal or homicidal."[34]

Dr. David Healy also determined from a review of published SSRI antidepressant clinical trials that the drugs increase the risk of suicide.[35]

In February 2005, a study published in the *British Medical Journal* determined that adults taking SSRI antidepressants were more than twice as likely to attempt suicide as patients given placebo.[36]

SUDDEN DEATHS OF SOLDIERS & VETERANS:

The antipsychotic medication Seroquel, referred by vets as "Serokill," is implicated in hundreds of cardiac arrests and sudden deaths of combat veterans.[37]

In September 2011, the *European Heart Journal* published a study titled, "Psychotropic medications and the risk of sudden cardiac death during an acute coronary event." The researchers concluded: The use of psychotropic drugs, especially combined use of antipsychotic and antidepressant drugs, strongly associated with an increased risk of SCD [sudden cardiac death] at the time of an acute coronary event.[38]

Dr. Audrey Uy-Evanado reported at the annual meeting of the Heart Rhythm Society in 2013, that both the second-generation and first-generation antipsychotic drugs proved independently associated with greater than threefold increased risks of sudden cardiac deaths.[39]

California neurologist Dr. Fred Baughman Jr. collected a list of 395 questionable soldier and veteran deaths. He wrote of Andrew White, Eric Layne, Nicholas Endicott and Derek Johnson—all in their twenties, who were West Virginia veterans that died in their sleep in early 2008. "All had been diagnosed 'PTSD'—a psychological diagnosis, not a disease (physical abnormality) of the brain. All were on the same prescribed drug cocktail, Seroquel (antipsychotic), Paxil (antidepressant) and Klonopin (benzodiazepine) and all appeared 'normal' when they went to sleep...the deaths of the 'Charleston Four' were probable sudden cardiac deaths, a sudden, pulseless condition leading to brain death in 4-5 minutes, a survival rate or 3-4 percent, and not allowing time for transfer to a hospital."[40]

Sicouri and Antzelevitch (2008) concluded: (1) *"A number of antipsychotic and antidepressant drugs can increase the risk of ventricular arrhythmias and sudden cardiac death," (2)"Antipsychotics can increase cardiac risk even at low doses whereas antidepressants do it generally at high doses or in the setting of drug combinations."*[41]

The landmark U.S. Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, showed treatment with many atypical antipsychotics is associated with metabolic side effects such as overweight/obesity and diabetes. Failure to properly monitor and manage these effects can lead to increased risk of mortality due to diabetic ketoacidosis [life-threatening problem when the body cannot use sugar as a fuel source because of insufficient or no insulin] and cardiovascular disease.[42]

Marine Corporal Andrew White, 20, and Senior Airman Anthony Mena, 23, were prescribed a total of 54 drugs between them, including Seroquel, Effexor, Paxil, Prozac, Remeron, Wellbutrin, Xanax, Zoloft, Ativan, Celexa, Cymbalta, Depakote, Haldol, Klonopin, Lexapro, Lithium, Lunesta, Compazine, Desyrel, Trileptal, and Valium, before they died suddenly in their sleep in February 2008 and July of 2009, respectively. The *New York Times* reported, "What killed Airman Mena was not an overdose of any one drug, but the interaction of many."[43]

No one is held accountable for prescribing potentially lethal combinations of psychiatric medications to veterans, revealing a discrepancy in the law. Outside the military, doctors have been convicted of manslaughter and culpable negligence for prescribing addictive or dangerous cocktails of medicines. For example, Dr. James Graves' "chemical straightjacket" caused the death of four patients. Florida's Assistant State Attorney Russ Edgar said Graves should have reasonably known his prescriptions were "likely to cause death or great bodily injury."[44] He was sentenced to nearly 63 years in prison.[45]

A Florida psychiatrist Dr. George Kubski was jailed for one year, given 10-years' probation and ordered to provide $150,000 for a trust fund for the 11-year-old daughter of Jamie Lea Massey, who went to Kubski for pain management and died of drug toxicity. Kubski had prescribed more than 20,000 pills in three months to Mr. Massey.[46]

As stated in the Introduction, prescriptions written for antipsychotic drugs for active-duty troops increased 1,083 percent from 2005 to 2011, while the number of antipsychotic drug prescriptions in the civilian population increased just 22 percent.

Dr. Baughman Jr. points out, "The fact of the matter is that psychotropic drug polypharmacy is never safe, scientific, or medically justifiable."

Further, he called upon "the military for an immediate embargo of all antipsychotics and antidepressants until there has been a complete, wholly public, clarification of the extent and causes of this epidemic of probable sudden cardiac deaths."[47]

POST-TRAUMATIC STRESS DISORDER (PTSD)

The problems for members of the Armed Forces facing war include anguish, fear in battle, sleep deprivation, extreme environmental conditions, chemical warfare and vaccines, adding stresses to an already life-threatening environment. Members of the Armed Forces and vets can experience debilitating flashbacks, nightmares and anxiousness.

But to diagnose this as PTSD and imply it is a *physical disease* or *abnormality* is misleading. There is no medical test—no blood or urine test, x-ray or brain scan—that can confirm PTSD is a disease.

The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which lists the symptoms of PTSD has been criticized as unscientific and "clinically risky" which results in the "mislabeling of mental illness in people who will do better without a psychiatric diagnosis," and potentially harmful treatment with psychiatric medication.

Leading U.S. National Institute of Mental Health-funded researchers of schizophrenia in a 2012 study stated: "The validity of psychiatric diagnosis and the DSM process is the focus of criticism because we have not identified the lesions, the diagnostic process depends upon 'soft' subjective phenomena...."[48]

A 2013 study in the *Journal of Law, Medicine and Ethics* reported: "It is of no coincidence that this manual (DSM5) relies on a biological disease model of mental illness that is not well supported by the evidence but that does promote the commercial agenda of drug firms...."[49]

The chairman of the DSM5 Task Force, professor of psychiatry David Kupfer conceded last year that "biological and genetic markers that provide precise [mental health] diagnoses that can be delivered with complete reliability and validity" are still "disappointingly distant."[50]

A chemical imbalance in the brain has been marketed as a "possible" cause of PTSD. Yet even the American Psychiatric Association said that this was a theory that was "probably drug industry derived."[51] It was developed to market antidepressants.

A study published in 2005 in *PloS Medicine* found that the SSRI antidepressants ads "largely revolved around the claim that SSRIs correct a chemical imbalance caused by a lack of serotonin." Yet, "there is no such thing as a scientifically correct 'balance' of serotonin." Further, "not a single peer-reviewed article ... support[s] claims of serotonin deficiency in any mental disorder," they said.[52]

In 2013, James Davies, a Senior university Lecturer in Social Anthropology and Psychotherapy said, "despite nearly 50 years of investigation into the theory that chemical imbalances are the cause of psychiatric problems, studies in respected journals have concluded that there is not one piece of convincing evidence the theory is actually correct."[53]

Yet in 2011, a VA study found that 80 percent of veterans diagnosed with PTSD received psychiatric drugs. Of these, 89 percent were treated with antidepressants, and 34 percent were prescribed antipsychotic drugs.[54]

Members of the Armed Forces and veterans that are told that PTSD is caused by a chemical imbalance in the brain should be informed to require the medical tests to support the diagnosis, otherwise it violates their informed consent rights. One wouldn't undergo chemotherapy without first having the cancer confirmed with tests.

PSYCHOTROPIC DRUG USE & COSTS

A 2010 PBS Frontline documentary, *The Wounded Platoon* showed that American soldiers in *combat zones* did not take psychotropic medications prior to the Iraq War, but by the time of the 2007 surge more than 20,000 deployed troops were taking them.[55]

Veteran Affairs and the Department of Defense (DoD) spent more than $850 million on Seroquel between 2001 and 2011. The antipsychotic is prescribed to soldiers to treat "insomnia" for which it is not FDA approved.[56] 1.4 percent of soldiers and 0.7 percent of Marines on active duty in 2010—about 11,000 troops—had received prescriptions for Seroquel.[57]

Some 54,581 prescriptions for Seroquel were written for active duty service members in 2011 alone—the vast majority as a sleep aid, a condition for which is it not FDA approved to treat.[58]

Responding to the controversy over Seroquel, in 2012 the DoD conceded that antipsychotics are not an effective treatment for PTSD – a conclusion that an American Medical Association study had reached a year before—and removed Seroquel from its approved formulary list.[59]

Yet in 2013, the Army announced it was conducting studies on hundreds of vets and service members to evaluate Seroquel and antidepressants to see how the drugs fit into the treatment of traumatized veterans.[60]

Since 2001, the VA and DoD spent over $790 million on another antipsychotic risperidone.[61] Yet in 2011, the VA reported that Risperdal (risperidone) was no more effective in treating combat stress treatment than a placebo.[62]

The VA and DoD have spent almost $2 billion to treat mental disorders, which has done nothing to reduce the rate of hospitalization of active troops for these conditions.[63]

Use of anti-anxiety drugs and sleeping pills such as Valium and Ambien increased 170 percent while spending nearly tripled, from $6 million in 2001 to about $17 million in 2009. Between October 2001 and March 2012, the DoD spent a total of $44.1 million just on benzodiazepines, one class of anti-anxiety drugs.[64]

The VA and DoD spent $2 billion on antipsychotics and anti-anxiety drugs combined from 2001-2011.

The DoD also spent at least $2.7 billion on antidepressants from 2001-2011.[65]

In 2012, it was reported the military had spent more than $507 million on Ambien and its generic equivalents.[66] The drug may cause bizarre behavior, hallucinations, abnormal emotions, amnesia and neuropsychiatric consequences.[67]

In 2012, the Army Medical Command warned that the use of benzodiazepines such as Xanax and Valium could intensify combat stress symptoms and lead to addiction.[68] The Army Surgeon General's office also warned regional medical commanders against using anti-anxiety meds such as Klonopin, Ativan and Valium to treat PTSD.[69]

LEGAL JUDGMENTS REGARDING PSYCHIATRIC DRUGS & VIOLENCE

December 2011: Winnipeg, Canada judge Justice Robert Heinrichs ruled that a 15-year-old boy murdered his friend due to the effects of Prozac, stating: "He had become irritable, restless, agitated, aggressive and unclear in his thinking. It was while in this state he overreacted in an impulsive, explosive and violent way. Now that his body and mind are free and clear of any effects of Prozac, he is simply not the same youth in behavior and character."[70]

June 2001: A Wyoming jury awarded $8 million to the relatives of a man, Donald Schell, who went on a shooting rampage after taking Paxil and killing his wife, daughter and his granddaughter. Harvard psychiatrist John Maltsberger testified that SSRI manufacturers should warn that antidepressants could cause some patients to experience akathisia and mania, which can induce violent behavior and suicide.[71]

May 25, 2001: An Australian judge blamed the antidepressant Zoloft for turning a peaceful, law-abiding man, David Hawkins, into a violent killer. Judge Barry O'Keefe said that had Mr. Hawkins not taken the antidepressant, "it is overwhelmingly probable that Mrs. Hawkins would not have been killed...."[72] Further, "The killing was totally out of character" and "inconsistent with the loving, caring relationship which existed between him and his wife and with their happy marriage of 50 years."[73]

January 1999: University of North Dakota student Ryan Ehlis, 27, shot and killed his five-week-old daughter and wounded himself after taking the stimulant Adderall for several weeks. Shire Richwood, the manufacturer of Adderall, issued a statement to the court that psychosis is a side effect of this class of stimulants. Charges were dismissed against Ehlis after various doctors testified that he suffered from "Amphetamine-Induced Psychotic Disorder."[74]

INFORMED CONSENT RIGHTS

According to Dr. Baughman, Jr., "In no edition of the DSM are psychiatric diagnoses actual physical abnormalities of the body or brain, making them diseases, disorders, or syndromes in a medical sense." All such statements are false, he adds, stating that therefore, "no such patient has been accorded his or her right on informed consent."

A study of Direct-to-Consumer Advertising of psychotropic drugs pointed out that "None of the advertisements include detailed information on talk therapy or exercise, which have both been proven to help ease the stress of mental conditions—In fact, advertisements often go as far as to claim that 'only your doctor can diagnose depression,' when this simply is not true." This then directs the person to a doctor's office where they're most likely to receive a prescription.

The study cited one ad for the antidepressant Prozac, which stated that "talk therapy cannot control the medical causes of depression."[76]

Alternative approaches to helping the mental health needs of the Armed Forces and veterans can be disregarded in the face of a "quick fix pill," thereby violating informed consent rights. Dr. Hyla Cass, psychiatrist, reported that many drugs, such as the stimulants Ritalin and Adderall can reduce appetite. This, in turn, decreases the intake of beneficial nutrients. Some antidepressants also tend to have this appetite-reducing effect. Many of the neuroleptics (antipsychotic drugs) and some antidepressants cause insulin resistance or metabolic syndrome, with resulting blood sugar swings.[77]

Lt. Col. Charles Ruby, who retired from the Air Force launched Operation Speak Up to help establish group settings for veterans to talk about their combat stress, based on the Alcoholics Anonymous model. "Our view is that psychiatric drugs do nothing but sedate people. We believe that speaking out is a much better way to treat these people and to find a way to integrate back into their communities."[78]

A cost-benefit analysis must be done on existing mental health programs and the impact of these programs on the mental health of the nation, at the exclusion of alternative methods of help. Informed consent requires that all patients be informed of the subjective nature of a psychiatric diagnosis, the right to refuse to consent to psychiatric medication and the right to know about alternatives available.

CASE EXAMPLES

SGT. VINCINTE JACKSON, 40, stabbed to death Spc. Brandy Fonteneaux, 28, on January 8, 2012. He was convicted of and sentenced to life in prison for the unpremeditated murder and said he was "horrified" by the crime and takes full responsibility for his actions. But he doesn't know why he did it. A defense attorney, Capt. Jeremy Horn, said that a combination of heavy drinking and a prescription antidepressant, Celexa, left Jackson unable to control his own actions or form any kind of plan to commit murder.[79]

MARINE LANCE CPL. DELANO HOLMES, 22, fatally stabbed an Iraqi soldier to death in 2007 after being prescribed Trazodone, Ambien and Valium.[80] He was convicted of negligent homicide and received a bad conduct discharge from the Marines.[81]

FORMER U.S. ARMY SPECIALIST KYLE WESOLOWSKI returned from Iraq in December 2010 following a brutal yearlong deployment. Psychiatrists at Fort Hood gave him "a cocktail of seven different drugs" for war-related mental health issues. More than three years later, Wesolowski came to the uncomfortable conclusion that the prescribed drugs made him homicidal. He contemplated murdering a young woman he met in a bar near the base. "I began to fantasize about killing her," he said. Wesolowski, who is now off of most of the drugs he formerly took, is using his GI Bill benefits to attend college in Thailand.[82]

SPC. ANDREW TROTTO, a 24-year-old Army gunner, was prescribed as many as 20 psychiatric medications, starting while in combat in Iraq when he had difficulty falling asleep. He was prescribed the antipsychotic Seroquel. His body adapted to it and he was soon taking a dose meant for psychotics. "They had no clue what the hell they were doing," Trotto says of the doctors at the battalion aid station who prescribed the pills. "They just throw you on a drug, and if it doesn't work, they throw you on something else. 'Try this. Try this. Try this.'" In addition to Seroquel, he was taking the antidepressant Zoloft and Vicodin to

relieve pain from ruptured disks he sustained falling nine feet off a tank. "Let me remind you," he says, "I was a gunner, completely whacked out of my mind. There were quite a few of us on Seroquel and antidepressants." While in a warrior-recovery unit in Kuwait, he locked himself in an outside toilet with a loaded M16 in his mouth, but he managed to hold out long enough to seek help. "I told them, 'You need to do something, or I am going to take other people out with me.'" His mother, Gina, says: "This was the all-American kid. He never had psychiatric problems or problems with suicide. They took a young man who was reacting normally to an abnormal situation – which is war – and they shoved him on an antipsychotic. I watched him become a completely different person. My son ended up gaining 40 pounds from all these medications... I was watching my son slowly die."[83]

RONALD BRUCE WEDDERMAN, 55, a National Guard staff sergeant who fought in Iraq in 2005, returned home and VA doctors prescribed him the antidepressant Trazadone for sleep and Prozac. He says the combination was nearly lethal. "At one point I had two pistols raised to my head on the beach. Somebody called the police. They found me yelling and screaming at people and waving my guns." Wedderman has not taken Trazodone again, and he hasn't tried to kill himself, either.[84]

JOHN KEITH, 35, was put on Seroquel and the antidepressants Trazodone and Zoloft by a VA doctor in a single visit. "I called my doctor up and said, 'I just threw my friend's furniture off a third-story balcony.' [The doctor] said, 'Well, just cut the new pills in half'...At first they give you one or two or three, and you try those for a couple of weeks....But they keep giving you more and more, and by the end of it, you're on 17 medications." Since getting off the drugs and forming an organization to help vets manage their paperwork, Keith has processed more than a thousand veterans' disability claims. He says, "I have never seen a veteran who is or was on less than five medications."[85]

KELLI GRESE, former Navy corpsman, 37, on Veterans Day 2010 swallowed an unknown quantity of the antipsychotic Seroquel — her fourth suicide attempt in eight months using the same drug. Her death was the subject of a $5 million

lawsuit filed against the VA in December 2012.[86] The government ultimately settled the lawsuit, although it admitted no liability.[87] Between 1991 and 1997, Kelli and her sister, Darla, served in the U.S. Navy. In 1995, while serving in Naples, Italy, they were the victims of a home invasion by three men. Although they were physically unharmed, they were diagnosed with PTSD. Kelli continued to be a highly functioning, exceptional sailor: Her evaluations were superb; she was nominated for Junior Sailor of the Quarter at the end of her career; she managed and participated on the command color guard team. However, she was discharged from the Navy due to the PTSD and migraine headaches. There followed years of being prescribed up to 20 different psychotropic drugs as well as painkillers. In 1999, according to Darla, who kept meticulous records of Kelli's medication, 5,370 Klonopin, an anti-anxiety drug, were prescribed. Kelli worsened. In 2002, the VA began her on a "trial" of Seroquel in addition to other drugs, including Zoloft and Geodon. She attempted suicide. And still, her medication list ballooned until on November 12, 2010, she killed herself.[88]

CPL. CHAD OLIGSCHLAEGER, 21: For seven months in 2006, the marine patrolled a war-torn city in Iraq. When he returned to his home base he drank heavily, panicked at the sound of a car backfire, swerved around potholes as if they were roadside bombs and had visions of dead friends. He was diagnosed with PTSD and recommended him for a substance abuse clinic in San Diego. Instead, he was sent to a month of live-fire training in a mock Iraqi village in the High Desert in preparation for another deployment. Although the second deployment was less violent, his return to Iraq plunged him into the memories of his first tour. He was recommended psychoactive drugs, starting with Prozac. Over the next two months, Oligschlaeger's symptoms worsened, but his prescriptions increased and by mid-May, he had at least seven active prescriptions, totaling 18 pills a day. He was found dead on the floor of his barracks room on May 20, 2008. All signs pointed to suicide. But an autopsy revealed he had taken the pills that military doctors gave him, dying of accidental "multiple drug toxicity." The Marine's blood held a mix of two antidepressants, an antipsychotic, two kinds of benzodiazepines, and propranolol, a beta blocker sometimes used to subdue fears. A seventh drug was

a small amount of methamphetamine, which may have been from illegal drug use or it could be a false positive from over-the-counter medication. None of these drugs had been taken in deadly dosage, but together they had proven fatal.[89]

THE CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL

The Citizens Commission on Human Rights (CCHR) is a non-profit, non-political and non-religious mental health watchdog established in 1969 by the Church of Scientology and the late Dr. Thomas Szasz, professor of psychiatry, Syracuse University of New York Health Science Center. It works to enact protections for and increase consumer rights especially informed consent rights, and raises public awareness about psychiatric abuses.

It has assisted many thousands of individuals who have been adversely treated in the U.S. mental health system and around the world. It is the only group that has obtained more than 160 consumer/mental health patient-protection laws in the world, receiving recognition from the Special Rapporteur to the United Nations Human Rights Commission for being "responsible for many great reforms."

Several Congressional recognitions of our work includes a Resolution by Congresswoman Diane Watson, which "highly commends CCHR for securing numerous reforms around the world, safeguarding others from abuses in the mental health system and ensuring legal protections are afforded them."

Its board of advisors, called Commissioners, includes doctors, psychologists, attorneys, educators, artists, businessmen, and civil and human rights representatives.

CCHR's work aligns with the UN Universal Declaration of Human Rights, in particular the following precepts: Article 3: Everyone has the right to life, liberty and security of person and Article 5: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

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Questions For The Record

LETTER AND QUESTION FROM: HVAC, TO: VA

July 17, 2014

The Honorable Sloan Gibson
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

Committee practice permits the hearing record to remain open to permit Members to submit additional questions to the witnesses. In reference to our Full Committee hearing entitled, "Service Should Not Lead to Suicide: Access to VA's Mental Health Care" that took place on July 10, 2014, I would appreciate if you could answer the enclosed hearing questions by the close of business on August 29, 2014.

In preparing your responses to these questions, please provide your answers consecutively and single-spaced and include the full text of the question you are addressing in bold font. To facilitate the printing of the hearing record, please email your response in a Word document, to Carol Murray at *Carol.Murray@mail.house.gov* by the close of business on August 29, 2014. If you have any questions please contact her at 202–225–9756.

Sincerely,
MICHAEL H. MICHAUD
Ranking Member

Questions Submitted by Ranking Member Michaud:

Ranking Member Michaud

1. How is a call from a veteran in crisis handled by the phone system or personnel of VA facilities during working hours?

2. Is a veteran in crisis currently able to be transferred directly to the VA crisis hotline by automated system during off hours when he or she calls any VA facility, that is, without having to hang up and dial another number?

3. Has the VA analyzed what resources would be needed to provide an automated system that would allow a veteran in crisis to be directly transferred to the crisis hotline if he or she calls any VA facility?

4. Has the VA analyzed what resources would be needed to provide a "warm handoff" to the crisis hotline to a veteran in crisis calling a VA facility during non-working hours?

REP. BROWN

1. There are 22 veterans who commit suicide every day. The treatment most accessible to veterans is psychiatric drugs and the most commonly prescribed are the SSRI anti-depressants. *The FDA placed a black box warning on these drugs noting the particularly high risk of suicide in those 24 years old and younger taking them. Are the veterans who are prescribed SSRI anti-depressants told the drug may greatly increase their risk of suicide? What is the VA*

doing to ensure veterans are receiving full informed consent (which includes all information about risks and alternative treatments)?

A study in the Journal of Clinical Psychiatry titled, "Pharmacotherapy of PTSD in the U.S. Department of Veterans Affairs: diagnostic- and symptom-guided drug selection," found that 80% of veterans diagnosed with PTSD received psychotropic medication, with 89% prescribed anti-depressants, 61% anxiolytics/sedative-hypnotics, and 34% antipsychotics.

According to Department of Defense Instruction, Number 6000.14, September 26, 2011, entitled, "DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS)," military personnel are entitled to informed consent for any treatment and to refuse to receive treatment. That regulation states, in part, under the section, "PATIENT RIGHTS":

"f. Informed Consent

"Patients have the right to any and all necessary information in non-clinical terms to make knowledgeable decisions on consent or refusal for treatments, or participation in clinical trials or other research investigations as applicable. Such information is to include any and all complications, risks, benefits, ethical issues, and alternative treatments as may be available."

2. A UCSF professor once explained: "The mechanism of action of SSRI anti-depressants is to block the normal re-absorption of Serotonin, which leaves it firing at the receptor site over and over, artificially creating the effect of elevated Serotonin in the brain. It is possible to have an initial positive response to the drug, but shortly thereafter the brain recognizes the unnatural excess firing of Serotonin at the receptor sites. As a result, the brain adapts and tries to regain its equilibrium by shutting down production of Serotonin. If the SSRI anti-depressant continues to be taken, the brain will then move to shut down some of the receptor sites in a bid to regain normal. This mechanism of action is why the drugs stop working and why people have a hard time coming off them and why people get depressed when they come off the drug. The SSRI altered the normal brain chemistry and created a chemical imbalance. This is evidence-based. The use of SSRIs leads to chronic depression."

a. This is creating more need for treatment and overburdening the system. Has the VA done any outcome studies? What percentage of patients treated with SSRIs recover and are able to successfully discontinue the drug? Where is the evidence of SSRI effectiveness?

3. The VA is relying heavily on psychotropic drug treatments. Adverse reactions of psychotropic drugs include a long list of medical symptoms and conditions including weight gain, diabetes, metabolic syndrome, liver damage. Has the VA done any studies on iatrogenic illnesses caused by psychotropic drugs?

POST-HEARING QUESTIONS FOR THE RECORD SUBMITTED BY THE U.S. HOUSE COMMITTEE ON VETERANS' AFFAIRS "SERVICE SHOULD NOT LEAD TO SUICIDE: ACCESS TO VA'S MENTAL HEALTH CARE" JULY 10, 2014

Questions Submitted by Ranking Member Michaud

Question 1. How is a call from a veteran in crisis handled by the phone system or personnel of VA facilities during working hours?

VA Response: A Veteran who calls a Department of Veterans Affairs (VA) medical center will hear the facility's standardized telephone greeting message that 1) directs those who are having a medical or mental health emergency to hang up and dial 911, and 2) directs those who are having thoughts of hurting themselves or want to talk to a Mental Health professional to hang up, dial 1-800-273-8255, and then press 1 to reach the Veterans Crisis Line.

VA telephone operators who receive calls from Veterans in crisis may transfer Veterans to the Veterans Crisis Line (VCL) by "warm handoff," i.e., maintaining the caller on the telephone while directly contacting the VCL, and then providing the Veteran's name and telephone number to the VCL, before completing the call transfer. This process allows the VCL to have the Veteran's telephone number at the beginning of the call in case there are any difficulties with the telephone connection.

VA phone operators may also transfer calls to Veterans Mental Health or a health provider during working hours, as determined by local procedures.

Question 2. Is a veteran in crisis currently able to be transferred directly to the VA crisis hotline by automated system during off hours when he or she calls any VA facility, that is, without having to hang up and dial another number?

VA Response: No, infrastructure and configuration limitations exist with the ability of some legacy telephone systems to maintain the Veteran's phone number as part of an automated transfer of the call to the VCL; having the Veteran's phone number – and not the phone number of the facility from which the call is being transferred – is necessary for the VCL to conduct its crisis intervention services and send rescues as needed. Veterans would be at further risk if the automated transfer did not go through or the call was disconnected, and the call were lost without the VCL's having a telephone number to re-contact the Veteran. Efforts are in progress to bridge functionality gaps with VA's legacy voice systems.

Question 3. Has the VA analyzed what resources would be needed to provide an automated system that would allow a veteran in crisis to be directly transferred to the crisis hotline if he or she calls any VA facility?

VA Response: The Veterans Health Administration (VHA) and the Office of Information and Technology (OIT) are working collaboratively to develop a comprehensive plan to analyze the resources necessary to facilitate automated transfers. VA recognizes the need to leverage technical solutions at an enterprise level to improve business processes, such as transferring telephone calls from VA facilities to the VCL. Standardizing disparate telephone systems across VA will further allow this type of functionality to occur through automated methods. This standardization is a significant goal of the VA Enterprise Voice System (EVS) project, which is currently under pilot. Gaps in the supporting functionality for some locations are also addressed through ongoing life cycle sustainment investments in existing systems running parallel to the EVS project.

Question 4. Has the VA analyzed what resources would be needed to provide a "warm handoff" to the crisis hotline to a veteran in crisis calling a VA facility during non-working hours?

VA Response: The process to provide a "warm handoff" (e.g., a VA employee maintaining a caller on the phone while transferring the caller to the VCL contact center representative without the caller being placed in a queue, etc.) leverages the same technical solutions described in the response to Question 3 above.

<u>Questions Submitted by Congressman Brown</u>

Question 1. There are 22 veterans who commit suicide every day. The treatment most accessible to veterans is psychiatric drugs and the most commonly prescribed are the SSRI anti-depressants. *The FDA placed a black box warning on these drugs noting the particularly high risk of suicide in those 24 years old and younger taking them. Are the veterans who are prescribed SSRI anti-depressants told the drug may greatly increase their risk of suicide? What is the VA doing to ensure veterans are receiving full informed consent (which includes all information about risks and alternative treatments)?**

***A study in the Journal of Clinical Psychiatry titled, "Pharmacotherapy of PTSD in the U.S. Department of Veterans Affairs: diagnostic- and symptom-guided drug selection," found that 80% of veterans diagnosed with PTSD received psychotropic medication, with 89% prescribed antidepressants, 61% anxiolytics/sedative-hypnotics, and 34% antipsychotics.**

****According to Department of Defense Instruction, Number 6000.14, September 26, 2011, entitled, "DoD Patient Bill of Rights and Responsibilities in the Military**

Health System (MHS)," military personnel are entitled to informed consent for any treatment and to refuse to receive treatment. That regulation states, in part, under the section, "PATIENT RIGHTS":

"f. Informed Consent. Patients have the right to any and all necessary information in non-clinical terms to make knowledgeable decisions on consent or refusal for treatments, or participation in clinical trials or other research investigations as applicable. Such information is to include any and all complications, risks, benefits, ethical issues, and alternative treatments as may be available."

VA Response: We disagree with the assertion that selective serotonin reuptake inhibitors (SSRIs) "greatly increase their risk of suicide." According to the FDA, the analysis that led to the boxed warning considered data from all antidepressant trials up to that time. Although the boxed warning is brief, there is more detail in Section 5.1 (first item under "Warnings and Precautions") of every antidepressant label. It is worth noting that no suicides occurred in any of the pediatric studies. There were suicides in the adult studies, but the number was not sufficient to reach any conclusion about antidepressant drug effect on suicide. The warning is specific to suicidality (thoughts and behaviors, e.g. cutting), not to actual suicide. The table below is taken directly from the current warning language, and may help to clarify the extent of risk observed in these studies. Again, "suicidality" and "suicide" are not synonymous.

Table 1: Drug-Placebo Difference in Number of Cases of Suicidality per 1000 Patients Treated

Age Range	
	Increases Compared to Placebo
<18	14 additional cases
18-24	5 additional cases
	Decreases Compared to Placebo
25-64	1 fewer case
≥65	6 fewer cases

In a large study examining the relationship between specific antidepressant agents and suicide death in Veterans (Valenstein et al., "Antidepressant Agents and Suicide Death Among U.S. Department of Veterans Affairs Patients in Depression Treatment," Journal of Clinical Psychopharmacology, June 2012; 32(3): 346-53), the authors concluded that selective serotonin reuptake inhibitors (SSRI) had no significantly greater correlation with suicide than other antidepressants and determined this conclusion to be consistent with previously published findings:

"Most antidepressants did not differ in their risk for suicide death. However, across several analytic approaches, although not instrumental variable analyses, fluoxetine and sertraline had lower risks of suicide death than paroxetine. These findings are congruent with the Food and Drug Administration meta-analysis of randomized

controlled trials reporting lower risks for "suicidality" for sertraline and a trend toward lower risks with fluoxetine than for other antidepressants." It also should be noted that the meta-analysis did not reveal increased suicides in any population, and that suicidality was not increased or was decreased in patients over 24 years of age. Furthermore, SSRIs are considered to be an effective treatment for Veterans with Posttraumatic Stress Disorder (PTSD). The VA/DoD Clinical Practice Guidelines state:

"Antidepressants, particularly serotonergic reuptake inhibitors (SSRIs), have proven to be effective in treating PTSD and are recommended as first-line agents in treatment guidelines (Davidson et al., 2001; Brady et al., 2000; Foa et al., 2000; Foa et al., 1999). Over 3000 patients have participated in studies of paroxetine, sertraline, and fluoxetine. Sertraline and paroxetine have FDA approval for PTSD. SSRIs have a broad spectrum of action, effectively reducing all three core symptoms of PTSD. As a class, they are generally well tolerated." (Pages 151-152)

With regard to concerns expressed about informed consent, the regulation referenced in the question for the record is from the Department of Defense and not VA. However, VA employs several current mechanisms to ensure effective informed consent.

Regulation 38 C.F.R. § 17.32 – "Protection of Patient Rights, Informed consent and advance care planning" does the following:

- Defines informed consent as "the freely given consent that follows a careful explanation by the practitioner to the patient or the patient's surrogate of the proposed diagnostic or therapeutic procedure or course of treatment."
- Establishes that all treatments and procedures in VA (including psychotropic medications) require informed consent from the patient (as defined above), or if the patient lacks decision-making capacity, the patient's authorized surrogate.
- Requires that the practitioner "must explain in language understandable to the patient or surrogate the nature of a proposed procedure or treatment; the expected benefits; reasonably foreseeable associated risks, complications or side effects; reasonable and available alternatives; and anticipated results if nothing is done."
- Requires that "[t]he patient or surrogate must be given the opportunity to ask questions, to indicate comprehension of the information provided, and to grant permission freely without coercion."
- Establishes that the patient or surrogate "may withhold or revoke his or her consent at any time."
- Requires that the informed consent discussion be "appropriately documented in the health record."
- Requires that, for any unusual or extremely hazardous treatment or procedure, signature consent must also be obtained (see discussion/examples below).
- Establishes very specific safeguards for administration of psychotropic medication to an involuntarily committed patient against the patient's will.

VHA Handbook 1004.01, Informed Consent for Clinical Treatments and Procedures, implements 38 C.F.R. § 17.32 and contains additional requirements to ensure that patients are fully informed participants in decision making. For example, the Handbook includes the following requirement:

"The practitioner must promote the patient's voluntary decision-making during the informed consent process. The practitioner must not unduly pressure or coerce the patient into consenting to a particular treatment or procedure, but must instead convey that the patient is free to choose among any recommended treatments and procedures, including no treatment, or to revoke a prior consent without prejudice to the patient's access to future health care or other benefits."

The Handbook also defines the treatments and procedures that require the patient's signature consent based on clinical criteria. VA has processes in place for ongoing clinical review of drugs which include clinical updates based on a drug's risk profile in order to determine whether the drug meets the clinical criteria for informed consent that are specified in regulation. Currently, medications for which signature informed consent is required include but are not limited to the following:

- Sedating medications, other than those used for anxiolysis (level one sedation);
- Anesthetic agents, other than low risk local anesthesia (e.g. topical numbing agents);
- Clozapine;
- Methadone for narcotic dependence;
- Buprenorphine; and
- Antabuse

Question 2. A UCSF professor once explained: "The mechanism of action of SSRI anti-depressants is to block the normal re-absorption of Serotonin, which leaves it firing at the receptor site over and over, artificially creating the effect of elevated Serotonin in the brain. It is possible to have an initial positive response to the drug, but shortly thereafter the brain recognizes the unnatural excess firing of Serotonin at the receptor sites. As a result, the brain adapts and tries to regain its equilibrium by shutting down production of Serotonin. If the SSRI antidepressant continues to be taken, the brain will then move to shut down some of the receptor sites in a bid to regain normal. This mechanism of action is why the drugs stop working and why people have a hard time coming off them and why people get depressed when they come off the drug. The SSRI altered the normal brain chemistry and created a chemical imbalance. This is evidence based. The use of SSRIs leads to chronic depression."

This is creating more need for treatment and overburdening the system. Has the VA done any outcome studies? What percentages of patients treated with SSRIs recover and are able to successfully discontinue the drug? Where is the evidence of SSRI effectiveness?

VA Response: The Practice Guideline published by the American Psychiatric Association for the treatment of major depression (2010), reflecting the current accepted state of knowledge, states that "*A large body of literature supports the superiority of SSRIs compared with placebo in the treatment of major depressive disorder.*"

With regard to the assertion that SSRIs stop working and lead to chronic depression, we do not believe this to be true. Meta-analyses of maintenance effects of antidepressants including SSRIs for major depressive disorder provide evidence that these agents have sustained effectiveness (see Hansen et al., "Meta-analysis of major depressive disorder relapse and recurrence with second-generation antidepressants", Psychiatric Services, 2008 Oct; 59(10):1121-30, [1]

VA Researchers are also examining outcomes of antidepressant medications over time, as well as long-term effectiveness. A study currently being conducted at over 30 VA medical centers, VAST-D, is examining the effectiveness of augmenting antidepressant treatment versus switching antidepressants in Veterans with major depressive disorder that have not had satisfactory outcomes from their initial treatment. Important information to be obtained from this study will examine long-term effects, safety, suicidality, and quality of life.

Question 3. The VA is relying heavily on psychotropic drug treatments. Adverse reactions of psychotropic drugs include a long list of medical symptoms and conditions including weight gain, diabetes, metabolic syndrome, liver damage. Has the VA done any studies on iatrogenic illnesses caused by psychotropic drugs?

VA Response: VA provides mental health treatments in an interdisciplinary setting using a variety of modalities consistent with the veteran's preferences, clinical status and in accordance with clinical practice guidelines. These interventions are often non-pharmacologic and may include evidence-based psychotherapies and complementary and alternative treatments.

Treatment of mental disorders, like that of physical illness, entails the consideration, by both the clinician and the veteran, of the benefit: risk ratio for all available interventions. In choosing to prescribe psychotropic medications, VA clinicians judge that the potential therapeutic benefits outweigh possible adverse effects, and take steps to avoid or minimize side effects through selection of medications and dosages. For example, the question at hand lists adverse effects noted for some of the atypical antipsychotics; those particular drugs are generally avoided by VA clinicians treating patients at high risk for metabolic syndrome and related symptoms, and in any event require careful monitoring throughout treatment. Moreover, wherever available, medication treatment of mental disorders in the VA system is augmented with psychosocial interventions, including psychotherapy and case management.

[1] http://www.ncbi.nlm.nih.gov/pubmed/18832497#.

VA has conducted a variety of clinical studies evaluating the benefit of medications (not limited to psychotropics) in order to better understand medication benefits and side effects to determine potential effectiveness in a population. More recent research additionally focuses on determining the effect of genetic background on a disorder and how an individual would respond to a particular medication accordingly. Some examples of studies underway are those examining which treatments might work best for a patient population with schizophrenia, examining the basis for symptoms in psychotic disorders to identify potential medication targets, and looking at genetic information to determine if it is correlated with functional impairments to provide another way to identify the "best" treatment. Metabolic Syndrome is being studied in the context of medication treatment for psychotic disorders as well.

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