

**EXAMINING THE PROGRESS OF SUICIDE
PREVENTION OUTREACH EFFORTS AT THE
U.S. DEPARTMENT OF VETERANS AFFAIRS**

HEARING
BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND
INVESTIGATIONS
OF THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
ONE HUNDRED ELEVENTH CONGRESS
SECOND SESSION

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**EXAMINING THE PROGRESS OF SUICIDE
PREVENTION OUTREACH EFFORTS AT THE
U.S. DEPARTMENT OF VETERANS AFFAIRS**

WEDNESDAY, JULY 14, 2010

U.S. HOUSE OF REPRESENTATIVES,
COMMITTEE ON VETERANS' AFFAIRS,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
Washington, DC.

The Subcommittee met, pursuant to notice, at 10:00 a.m., in Room 334, Cannon House Office Building, Hon. Harry E. Mitchell [Chairman of the Subcommittee] presiding.

Present: Representatives Mitchell, Walz, Adler, Hall, and Roe.
Also present: Representative Holt.

OPENING STATEMENT OF CHAIRMAN MITCHELL

Mr. MITCHELL. Good morning and welcome to the hearing on Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs (VA) for July 14, 2010.

The Committee on Veterans' Affairs' Subcommittee on Oversight and Investigations will now come to order. I ask unanimous consent that all Members have 5 legislative days to revise and extend their remarks and that statements may be entered into the record. I also ask unanimous consent that the statements of Dr. Paula Clayton of the American Foundation for Suicide Prevention and Penny Coleman from New York be entered into the record. Hearing no objection, so ordered.

I appreciate everyone being here today and for your interest and concerns on the progress of suicide prevention outreach efforts.

Before we begin, I want to acknowledge a positive step that the VA has taken recently to help veterans suffering from post-traumatic stress disorder, or PTSD. The VA recently announced it is easing the evidentiary hurdle that veterans must clear to receive treatment for PTSD. This is a step in the right direction. I am glad they are doing it. However, to be truly effective in reaching all veterans who need help, not just those who are already showing up at the VA and asking for it, the VA also needs an effective outreach strategy.

We have 23 million veterans in this country, only 8 million of which are enrolled to receive care at the VA. The VA has an obligation to the 15 million who are not enrolled for care, not just the 8 million who are already enrolled. If these other veterans have PTSD or are at risk for suicide, the VA has an obligation to reach

out to them as well and let them know where they can turn for help.

Last year upwards of 30,000 people took their lives by suicide in the United States. Twenty percent of these deaths were veterans. Each day, an estimated 18 veterans commit suicide. By the time this hearing concludes between one and two veterans will have killed themselves. These statistics are startling.

As you know, many of our newest generation of veterans, as well as those who served previously, bear wounds that cannot be seen and are hard to diagnose. Proactively bringing the VA to them as opposed to waiting for veterans to find the VA is a critical part of delivering the care they have earned in exchange for their brave service. No veteran should ever feel that they are alone.

As Chairman of this Subcommittee, I have repeatedly called upon the VA to increase outreach to veterans who need mental health services and are at risk of suicide, and Members on both sides of the aisle have urged the same.

In 2008, the VA finally reversed its longstanding self-imposed ban on television advertising and launched a nationwide public awareness campaign to inform veterans and their families about where they can turn for help. As part of this campaign, the VA produced a public service announcement featuring Gary Sinise and distributed it to 222 stations around the country, aired it more than 17,000 times. The VA also placed printed ads on buses and subway trains.

According to the VA's own statistics, the effort proved successful. As of April 2010, the VA had reported nearly 7,000 rescues of actively suicidal veterans which were attributed to seeing ads, PSAs (public service announcements), or promotional products. Additionally, referrals to VA mental health services increased.

However, despite the success late last year, the public service announcements stopped airing. I don't understand this. If anything, it seems to me we need to be increasing outreach to veterans at risk for suicide, not stopping it. It is my understanding that VA is planning to produce a new public service announcement, which will be ready by the end of this year.

However, the question remains, why did the VA stop running the first public service announcements while they worked on the second one? How does this help veterans to go dark for more than a year?

While I commend the additional expansion in outreach that has grown in the way of brochures and other useful steps, I do not think the VA should suspend, even temporarily, outreach efforts like the public service announcements that have proven so successful. It is also imperative for the VA to utilize and adapt to technology, including the use of *Facebook* and *Twitter*, to reach the latest generation of veterans. Doing so I believe will help transform VA into a 21st Century organization and, most importantly, save lives.

Today, the Subcommittee is assessing the suicide prevention outreach program on national implementation and achievements. We have a wide range of testimony that will be presented today, and I look forward to hearing all that will be said on this vitally important issue. We appreciate our panelists' dedication to the formula-

tion of a more comprehensive and targeted suicide prevention outreach program. These struggling veterans deserve our help. We must continue to work on breaking the stigma associated with asking for help. We cannot wait for veterans to go to the VA. The VA needs to go to them. Additionally, we must work in a bipartisan way to ensure the VA delivers the resources our veterans have earned.

Before I recognize the Ranking Republican Member for his remarks, I would like to swear in our witnesses. I ask that all witnesses stand and raise their right hand, from all three panels.

[Witnesses sworn.]

Mr. MITCHELL. I now recognize Dr. Roe for opening remarks.

[The prepared statement of Chairman Mitchell appears on p. 50.]

OPENING STATEMENT OF HON. DAVID P. ROE

Mr. ROE. Thank you, Mr. Chairman. I appreciate your calling this hearing today to review what the VA has done in the area of outreach to veterans in our communities who are feeling vulnerable and uncertain of their future.

I cannot imagine what goes through the mind of someone seeking to end their life, but we must do anything we can to ease their pain and to help them through this crisis that they find themselves in so that they can move forward and heal the wounds from which they are suffering.

Public Law 110–110 was signed on November 5, 2007, by President Bush. This law, as part of the comprehensive program of suicide prevention among veterans, provided that the Secretary may develop a program for a toll-free hotline for veterans available and staffed by appropriately trained mental health personnel at all times and also designated that the Secretary would provide outreach programs for veterans and their families.

As part of this outreach, the VA contracted with the PlowShare Group, Inc., to distribute, promote, and monitor a public service announcement featuring actor Gary Sinise, who played Lieutenant Dan in the movie *Forrest Gump* and also performs with the Lieutenant Dan Band. This moving PSA, which can still be found on *YouTube*, encourages veterans to contact the toll-free national suicide hotline in an emotional crisis.

According to PlowShare, their work on this campaign was successful as they were able to generate nearly \$4 million in donated media and the suicide hotline saw an increase in activity during the campaign, as the Chairman mentioned.

The VA also piloted outreach advertising right here in the metro area of Washington, DC, driving around the city and on the metro bus system, and signs could be seen in various locations promoting the hotline to veterans.

What I look forward to learning in the hearing today is the following: Have we seen a reduction in the number of veteran suicides since the inception of PSAs, whether the plan is there to continue the PSAs now that the contract for the previous PSA has expired, and how has the national suicide hotline helped in the reduction of veteran suicides, and where do we go from here?

I am pleased that the witnesses from our veteran community are here today as well as the VA so that we can hear from everyone

how useful the previous PSAs were and what other kinds of outreach efforts need to be made to reach not just our older veteran population, but our new veterans coming out of Iraq and Afghanistan, and how the VA is using new media to get information out to our new set of veterans who may not be aware of all the services that the Department provides. We need to review and evaluate the successes of outreach efforts on an ongoing basis and see where they can be improved and enhanced as well as how frequently they are being broadcast to the general public.

And again, Mr. Chairman, I thank you for holding this hearing and I yield back my time.

[The prepared statement of Congressman Roe appears on p. 51.]
Mr. MITCHELL. Mr. Walz.

OPENING STATEMENT OF HON. TIMOTHY J. WALZ

Mr. WALZ. Well thank you, Chairman and Ranking Member Roe, and I appreciate your continued commitment to providing the oversight and responsibility that this Subcommittee has. I thank all of you for being here today. But I know no one in this room needs to be reminded, but I said here looking at the picture of Sergeant Coleman Bean and his mother who is going to speak to us in just a moment, this is the face of why we are here. There is no higher calling that we do here in the protection of these warriors that are willing to go and protect our freedoms, and I think that obligation and that responsibility is very apparent on everyone here that this is a zero sum game. One Coleman Bean is too many, and we need to get this right.

I am very encouraged to see we have in this room, and it is something many of you have heard me talk about often, we have U.S. Department of Defense (DoD) here, we have VA here, we have veterans service organizations (VSOs) here, we have the private sector here, we have the Congressional oversight here. We are starting to understand that this is a very complex project. It is going to have to be multidisciplinary across all these agencies, we have to get seamless transition right. We have to bring to bear on this problem all the resources this Nation can have. It is a moral responsibility, and it is a national security responsibility.

A mother lost this beautiful young man. We as a society lost one of our best and brightest. The world is weaker and worse for this, and we can do something about it.

So I am encouraged that we are here. I am, like many of you, searching for ways we can do this better, but the commitment amongst all of you here, I know, is unwavering. And I am personally very appreciative of it. And when we get to that zero sum, that has to be our goal. We may never get there, but we have an obligation to try. So thank you, Mr. Chairman, and I yield back I look forward to hearing from our witnesses.

Mr. MITCHELL. Thank you. Mr. Adler.

OPENING STATEMENT OF HON. JOHN H. ADLER

Mr. ADLER. Thank you, Mr. Chairman. I share your comments, those of Dr. Roe and Sergeant Walz. I want to particularly direct my attention with gratitude to Linda Bean of New Jersey, my State. It would have been enough just to let your son serve in the

military and serve two tours in Iraq, serve our country valiantly, heroically, and to have lost him is a loss you can't ever get back. You could then go away and not talk out, but instead, Ms. Bean, you choose to keep your son's memory alive by helping other people, by reaching out to other folks returning from Afghanistan, from Iraq and from missions around the world to keep us safe here at home, and that is an ongoing patriotism consistent with your love for your own son and his own patriotism. So I am grateful to you, to all the experts, the DoD, VSOs, private sectors, as Sergeant Walz said, but particularly Ms. Bean you take the time to share with us your own experience, Coleman's experience so that we can learn from it and avoid recurrences.

Thank you. I yield back.

Mr. MITCHELL. At this time I would like to welcome panel one to the witness table.

And joining us on our first panel is retired Warrant Officer Mel Citron, a Gulf War and Operation Iraqi Freedom (OIF) veteran from Woodbridge, Virginia, and Mrs. Linda Bean, a mother of an OIF veteran from Milltown, New Jersey. If both of you would please come and sit at the table.

I ask that all witnesses stay within 5 minutes of their opening remarks. Your complete statements will be made part of the public record.

Mr. Citron, you are recognized for 5 minutes.

STATEMENTS OF WARRANT OFFICER MELVIN CINTRON, USA (RET.), MANASSAS, VA (GULF WAR VETERAN AND OIF VETERAN); AND LINDA BEAN, MILLTOWN, NJ (MOTHER OF OIF VETERAN)

STATEMENT OF WARRANT OFFICER MELVIN CINTRON, USA (RET.)

Mr. CINTRON. Thank you. Mr. Chairman, distinguished Members of the Committee on Veterans' Affairs. My name is Melvin Citron. I was a flight medic conducting forward area medical evacuation in support of U.S. and enemy wounded personnel, civilian, military and enemy prisoners of war.

I am also a veteran of Iraq Freedom War on Terrorism. I am extremely proud of my service to our country. I have been submitted for Combat Air Medal in Desert Storm and the Army Bronze Star Medal, which I did receive for my services in this last tour as an aviation maintenance officer.

I have no regrets for answering the call and would proudly do so again, despite the fact that it came at a great cost to me and my family financially, physically, socially and mentally.

However, I am often ashamed to enter the VA for help, having seen so many of my fellow soldiers that have paid an even much higher price for their service. I am here today in hopes that my testimony will help improve the support for them.

I would like to make clear that I personally know that the VA has many caring and committed professionals. My testimony is reflective of the system, not of the dedicated and committed personnel of the Veterans Administration.

When I entered the VA medical center, I see a poster saying, it takes the courage of a warrior to ask for help. But the poster should read, it takes the courage of a warrior to ask for help from the VA.

There are numerous examples of failures our veterans encounter when seeking help from the VA. But this Committee is seeking specific input on the VA's suicide prevention efforts and hotline.

Make no mistake, I consider myself extremely blessed. I have the ability to provide for my loved ones, two arms to hug my children, full sight to see my family, two legs which led me here to testify, not for my own need, but as stated, in hopes that in some way I can contribute to providing better support for others who may not be as blessed.

Their need for timely help from the VA should never be compromised. I feel strongly that the VA suicide prevention efforts and hotline are not working since it is too much of a last alternative with little else in between before getting there.

Have you heard the recording when veterans call the VA? Either you don't have enough of a problem and you can wait, sometimes for weeks for an appointment, or you're suicidal.

Distinguished ladies and gentlemen, I believe that there is a large void that exists between the no problem type strategy and the suicidal stigma strategy. Not having that void filled with intermediate prevention tools and mitigation strategies will only continue to fuel the need for the forensic type strategy of concentrating only on the suicidal hotline. I could easily be wrong, but I believe that by the time a veteran is desperate enough to call the suicide hotline, it may already be too late.

In my 19 years since coming back from Desert Storm, and my 5 years coming back from Iraq, I have met many veterans who have broken down while talking to me about their experiences, experiences they held for a long time. I have asked them, why don't you go to the VA for help, knowing the answer. I have advised them to call the VA, but they don't, because they are not suicidal and do not want to risk that label for fear of the effect on their jobs, their family, or social circles.

I have interacted with the VA regularly for many years, and I am aware of the suicide prevention hotline. However, I do not know of a readily or easily accessible intermediate or nonsuicide hotline. I apologize for my ignorance if such a system does exist. But if it does, and so many don't know of it, then the system obviously needs better marketing, promotion, and outreach, or at least as much as is done with the suicide hotline.

Instead of just suicide hotline, we should provide support long before a veteran considers suicide. Veterans need and deserve a system of continuing support, a dignified program that addresses basic needs of a soldier to talk without the stigma or label of being considered a suicidal risk.

Please help our veterans ask for help in dignity, not in fear, apprehension or labeling. Thank you very much.

[The prepared statement of Warrant Officer Cintron appears on p. 51.]

Mr. MITCHELL. Thank you. At the time I would like to introduce Congressman Holt. You are recognized to introduce Ms. Bean.

OPENING STATEMENT OF RUSH D. HOLT

Mr. HOLT. Chairman Mitchell, Ranking Member Roe, and Members of the Subcommittee, thank you very much for holding this hearing and for allowing me the courtesy and giving me the honor of introducing my remarkable constituent, Linda Bean of East Brunswick, New Jersey. Linda and her husband Greg are accomplished communications professionals who have lived in central New Jersey for many years. For nearly 2 years now, Linda and Greg have waged a battle openly and courageously to prevent other military families from suffering the kind of loss that they endured when their son, Coleman, tragically took his own life in September 2008 after serving two grueling tours in Iraq. This is Linda's story to tell, and I ask you to give her your full attention.

I was astounded to learn that servicemembers who are in the Individual Ready Reserve (IRR), as Coleman was, do not receive the kind of suicide outreach protection they need and deserve. As the Bean family and I discovered, our current suicide prevention efforts simply do not encompass these reservists and a number of others.

I have sent a letter to Secretaries Gates and Shinseki asking that to the extent possible under law they implement the kind of Individual Ready Reserve suicide prevention program that I have advocated and which is included in the House version of the Fiscal Year 2011 National Defense Authorization Act. The very least we can do for the veterans of Iraq and Afghanistan who are still in the Reserve rolls but not in units is ensure that someone from the DoD or VA checks in with them periodically over the course of a year. If we can afford to send them to war, we can certainly afford a few regular phone calls to make sure that they are doing okay, that they are readjusting to civilian life and, if necessary, that they get the help quickly that they need when they need it, not after it is too late.

I ask for the Subcommittee's support in this effort and I now ask you to turn your attention to someone who can speak far more eloquently than I can about the need for action, Linda Bean.

Mr. MITCHELL. Thank you, Mr. Holt. Ms. Bean, you are recognized for 5 minutes.

STATEMENT OF LINDA BEAN

Ms. BEAN. Mr. Chairman and Members of the Subcommittee, thank you for allowing me to appear before you today. Representative Holt, thank you for all your support to my family and for me and for your leadership on this issue.

I testify today because my son, Sergeant Coleman Bean, 25, a veteran of two tours of duty in Iraq, shot and killed himself on September 6, 2008.

I am so grateful for this opportunity.

Coleman was an amazing man, and he was a proud soldier. I owe a duty to my son, and I owe a debt to the men with whom Coleman served.

It is my hope that the observations drawn from a shared experience of loss will be useful to you as you oversee the development and the implementation of suicide prevention strategies for the VA.

First, I would encourage you to accept some facts. Men and women come home from service to towns and cities and families

that are far removed from a VA hospital or a Vet Center. Many veterans who are at risk for suicide would never call themselves suicidal. And some veterans, as I think you well know, either will not or cannot use VA services.

I believe it is crucial for the VA to assume immediately, identify and publicize civilian counseling alternatives, including the Soldier's Project, GiveAnHour and the National Veterans Foundation; partner with civilian organizations to assure that all vets have the immediate access to the widest possible range of mental health care; and encourage media outlets in your district to publicize local information on mental health resources for veterans.

Second, I believe it is critical to implement a simple, straightforward public information campaign that is geared specifically to veterans' families and their friends. It may fall to a grandmother or a best friend or a favorite neighbor to seek out help for a veteran who is in trouble. Make information on available services easy to find, easy to understand, and publish that information broadly. The suicide hotline number, as you have already heard, is not enough.

Finally, I would encourage you to help veterans help each other. The VA is confronting PTSD and suicide with new programs and new research, and that is all good and important work. But that has not always been the case. And there are plenty of veterans who will tell you that they have had to scrap and fight for every service they have received from the VA.

In addition to the official patient advocacy complaint resolution program, please establish a separate body, one made up of your most feisty and tenacious veterans, to help ensure that no one gives up because it was too hard or because it took too long to get the service that they needed.

My son joined the Army when he was 18 on September 5, 2001. The terrifying tragedy of September 11 confirmed for my son the rightness of that commitment. When he came home on his first leave, he took a pair of socks, lovingly folded by his mother, and he unfolded them and refolded them to Army specifications. It was his intention, he said, to be a perfect soldier.

In the days following Coleman's death, our family had the humbling experience of meeting with the men with whom Coleman had served. They traveled from all over the country to be with us and to be with each other, and it was clear to us then that many of these men were carrying their own devastating burdens.

In the days after Coleman's service, I spent hours on the telephone trying to identify for some of these young men services that would assist them as well, and I reached out first to the VA hospitals in the States where those young men lived. I have to tell you my inquiries netted some mixed results.

A VA representative in Texas was horrified when I described for him my fear for our young veterans. And he said, Ms. Bean, just tell me where he is, I will get in my car, I will go there right now. Just tell me where he is and I will go to him.

By contrast, a man in Maryland told me, if they don't walk through the door, we can't help them.

Now, I know that is not correct. Of course we can help them. And it is our duty to figure out how, not theirs.

Thank you.

[The prepared statement of Ms. Bean appears on p. 53.]

Mr. MITCHELL. Thank you. Ms. Bean, I am very sorry for your loss.

Ms. BEAN. Thank you.

Mr. MITCHELL. And I want to thank you for your son's service.

Ms. BEAN. Thank you Mr. Chairman.

Mr. MITCHELL. In your testimony you described how you would like to see the VA identify and describe, identify and publicize civilian counseling alternatives.

How do you think the VA should go about this?

Ms. BEAN. There are a number of established organizations, most of them have developed since 2003, that use the services of civilian therapists in local communities to help augment whatever services the VA has available. The services are confidential, they are free of charge, they help veterans and they help the families, and I suspect if the VA posted a notice saying we would be interested in hearing what you do they would come to the VA. I am not sure the VA is going to have to look that hard to find community-based organizations that want to help soldiers.

In our own State of New Jersey, there is a hotline for veterans staffed by veterans that developed out of the events of September 11, a similar program, Cop to Cop. I know that there are vet to vet programs in a number of States and if somebody wanted to throw out the welcome mat and say tell us what you do, I know those people would come to you. But if you need a list of resources, Mr. Chairman, I have a list and I would be happy to provide that to your office.

Mr. MITCHELL. Thank you. Also from your testimony it is clear that you continue to be in contact with other veterans and their families as they try to navigate the government bureaucracy in search for help.

Can you tell the VA on how to make information easier and more accessible to veterans and their families?

Ms. BEAN. Veterans who are already in the system know how to navigate the VA Web site and they understand the jargon and they know how to get from point A to point B. But it isn't always the veteran who is going to be looking for the services. So somewhere within that dense content on both the DoD and the VA Web sites, there needs to be, and I think I said, a welcome mat. There needs to be a notice that says, if you know a veteran in trouble, if you have questions, if you think someone is suffering PTSD, click here, and make those resources easy to read and easy to understand.

It is daunting to go through the VA Web site in search of help.

Mr. MITCHELL. Mr. Cintron, in your testimony you say that the VA's suicide prevention hotline and suicide prevention efforts aren't working.

Can you please elaborate on why you think that?

Mr. CINTRON. Yes, sir. I believe, Mr. Chairman, that—and I am an aviation safety professional. I have a responsibility for safety. The things that we try to do is never go to an accident site but rather prevent the accident from happening. But the suicide hotline the way it is, and you are either don't have a problem serious enough to consider and you can wait and make an appointment 3, 4 weeks down the road, or you are suicidal. There is no interven-

tion in between. There is no prevention. There is no strategy there to say how do we keep our soldiers and our veterans from getting to that stage.

I am very glad that the hotline is there. Please don't misunderstand. I think it is needed. However, by not having something in the program that allows somebody to just talk or just keep them from going to the next level, because they don't have an outlet, that now they will get there, and by the time they reach the suicide hotline it is too late. We could have prevented them from even getting there.

The numbers that you stated today are stunning to me, both in the soldiers that we are losing, the veterans that we are losing, and in the good way, the ones that we are preventing. But I say we could prevent so many more if there was a prevention strategy of keeping them from getting to a suicide hotline.

One of the things that I would like to say, Mr. Chairman, is that programs such as are out there for our folks to interact with, are critical. But it also has to be part of the military's program. And I will share this example with you. When I came out of Iraq the second time around, we were in Fort Dix being outprocessed. As we are being given all our out briefings, a sergeant steps up and says who here needs to talk to somebody for anything you have seen or done? And nobody raised their hand. Nobody said here. He said okay, if you want to do it confidentially, we will have a board, a tablet that you can sign up on. The day before we left Fort Dix, same sergeant stood in an auditorium with that board and read those names and said, do you still need to talk to somebody?

I was one of those soldiers. I did not need to talk to somebody at that time.

So there has to be an interlacing, collaborative effort to also get the services involved in having peer-to-peer training in identifying, you know we have the buddy system, we have the life saver program for a soldier that doesn't have to be a trained medic to be able to provide that first aid lifesaving technique. They have that. We can have the same thing, but we are talking about saving a soldier's mind and saving their life.

Mr. MITCHELL. Thank you.

Dr. Roe.

Mr. ROE. Thank you all for being here, and Ms. Bean, especially you. I have a unique perspective being a veteran and being a physician to have worked with these types of issues during my medical career and I can't tell you how courageous it is and how much I appreciate you being here and sharing your testimony.

Ms. BEAN. Thank you.

Mr. ROE. I think you and actors like Gary Sinise who have stepped up and done an incredible job have more credibility than anyone, and I want you to comment certainly on some of the PSAs. It brings back to me breast cancer awareness, how we used public service announcements to raise awareness among women, and I think that has done a great deal in decreasing the incidence of breast cancer. And I think the VA, if we talked about suicide or talked about suicide ideation, that somehow we would increase the incidence. I think it does just the opposite.

And I wanted to hear your comments and both of you, Mr. Cintron also, on how you believe that just making people aware and then having some place to go, and I could not agree more with you, having that in between is very important because I as a physician had patients who said, you couldn't determine from even sitting down in a fairly long conversation whether they really were suicidal. And it is not easy. This is a very difficult diagnosis to make.

So I will be quiet. I want to hear what Ms. Bean has to say about that.

Ms. BEAN. I think that there are families like mine who have experienced the homecoming of a much loved child who is now out of harm's way and you are so grateful that they are back with you that you may overlook the fact that they are drinking too much or that they are irritated or that they insist on being isolated. And you are not empowered, as a mother or a sister or a wife, to go to the VA and say, my veteran is in trouble.

I don't even know that I would have known how to do that.

I think, in the way that Mr. Cintron described, we need to make sure that people understand there are places to go before you hit the suicide hotline. There are veterans who are not, who may in the end be alone in a room with a gun to their heads but the day before would not describe themselves to you as suicidal.

So I guess I would go back to my very strong feeling that as part of that, in addition to the messaging, we need to make sure that there are community-based programs that are easily accessible, and we need to make sure that the information that the VA has is geared to families and friends in a friendly and accessible way, made easily available so people can find it, and that the VA is willing to say, look, if you won't come here, that is okay, we will help you find help somewhere else.

Is that what you were looking for, the answer?

Mr. ROE. The public service announcements, I think you and the public service announcement in New Jersey would be an incredible statement for people.

Ms. BEAN. I guess if you are saying, are there other kinds of public service announcements that would be workable.

Mr. ROE. Yes.

Ms. BEAN. I think it would be the public service announcement that said, you know, you're home, you're drinking too much, you're fighting with your wife, you can't get along with your boss, you need help.

That is a message that resonates with people who are in that position. The message that says you are home and you are suicidal, not so much.

Mr. ROE. I agree. I agree.

Mr. Cintron.

Mr. CINTRON. Yes, sir. I agree. I think there has to be peer counseling both on the family side and on the soldier side. I once read in a magazine that had a copy, had a picture of a wall that was used as a firing squad wall, and in it, it said, you have never lived until you have almost died. For those who fight for it, life has a flavor to protect it we will never know. For the veterans, it also has a price for that flavor. They cannot just go to a family member and

talk about what that family member would never know. They cannot just go and talk to anyone.

So even that, in itself, is something that also needs to be addressed so that they feel that a mother is not nagging when they say, hey, I think you're drinking too much or a wife isn't nagging. So those are awareness things that also need to be out there.

I think there are so many good outreach programs that can be done. You have groups here that you must interact with and reach those folks that can be reached. The other thing that I would ask is that consider the unreached soldier, the person that doesn't go to the VA, the person that doesn't go to AVA, the person that doesn't think they need help. And all it takes is a simple outreach from someone saying, hey, let's talk about what you did.

Mr. ROE. I think your comment, Mr. Chairman, and then I will yield back, your comment about when you had the sergeant stand up is at least a move further than when I ETSed 36 years ago when nobody did and I am a Vietnam era veteran and served overseas, and we are doing better, and I think we have to do a lot better. But I know that then there was no outreach or anything, and that has steadily improved because of people like yourself being willing to stand up and saying something needs to be done. I thank you for doing that, and I yield back my time.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Thank you and, Ms. Bean, again I echo the comments of my colleagues and thank you again for being here, Mr. Cintron, and thank you both. You are making a difference and you are continuing your service. And I truly appreciate that.

I would also mention what Dr. Roe said, it may be a little bit of a move forward, but as a senior NCO myself I am just appalled by that. I think it goes to a deeper cultural issue. It is mental health parity in this Nation and how we view mental health issues. I think the good news is, and I would like to say a deep heartfelt thank you to my colleague from New York, Mr. Hall, on Monday when we got the notice from the VA on the issue of PTSD in trying to make this easier for folks, this is a huge step forward on the issue we are talking about today. I think we are starting to attack this from multiple perspectives. Monday was a very gratifying day for me because of that ruling coming down and I was in Hennepin County in Minneapolis where we established our State's first vets' court, which we all know is a way we start to see these things, a progression, exactly what you are all talking about is stop it before we get to that point, stop it before it escalates from driving on the wrong side of the road, drinking and driving, domestic violence down the road to these types of things. So I appreciate obviously because of your experience and unfortunately in your case, Ms. Bean, your personal experience. You are incredibly insightful on what needs to happen and I think we are starting to see that happen. I want to hit on one thing with you, Ms. Bean, and I know Mr. Holt just left but he mentioned and you explained a little of your concern with the IRR, and dropping back, I understand your son was on active service his first tour, then he was called back through the IRR on the second one. I am concerned with this as a former National Guardsman and coming from a State where we

have put a lot of time and thought in the beyond the yellow ribbon campaign on when these folks come back, of how we capture them in that seamless transition in that care. What did you see in your experience where there was a drop-off, both of you, as you see this, is it fair for me to say that it is, and Ms. Bean, you mentioned it about your view in Texas versus Maryland, those types of things. Do you think we are not capturing it as a whole and that it is spotty across the country as you come back on how that care is?

I would like each you to take a stab at that because we have talked about this, of nationalizing this beyond the yellow ribbon campaign, to make sure that no matter where you go into service or how you go in either active service or IRR, you are still going to have that support net. So if you have a comment on that of how that affected you.

Ms. BEAN. Coleman's first tour of duty was with the 173rd, and when they returned from Iraq to Vicenza, Italy, they had mental health musters on a regular basis. They were on a base. They were together. They had each other. They had shared the same sort of experiences, and they had that opportunity to talk things through.

He was home for I think almost 18 months, recalled to duty through the Individual Ready Reserve, and he was assigned to a unit of the Maryland National Guard. When they came back out of Iraq, the Maryland National Guard went home to Frederick, Maryland. Coleman came home to New Jersey. I know that they had regular musters in Frederick, mental health musters, health musters, weapons checks, all the kinds of things that you would do to keep a unit running. Mental health was a part of that. Coleman participated in none of that.

And I know that when the men from that National Guard unit came to Coleman's service and we talked later, they were heartbroken. They didn't know. And they didn't know how they could have known how to reach out. There wasn't, for them, for the leadership of that unit, there wasn't a way for that leadership to reach these men who served under their flag but lived in a different State.

And I would say to you, Mr. Walz, it is very, very hard to get numbers of soldiers in that circumstance. I don't think we have a clear number of how many IRR soldiers or how many individual augmentees may be at risk for suicide. But I think the numbers are big. And I think it is a shame that if a man from Wyoming serves with the National Guard from California, he should get the same help those boys get.

Mr. WALZ. You are absolutely right.

Mr. Chairman, I would suggest and I think Ms. Bean has hit on something that has troubled me for quite some time is how we disaggregate that data and find that out. We see this also with active forces coming back in ones and twos to our States. I have to be honest that I see that in Minnesota. You are far better off to go with a National Guard unit from Minnesota and be part of that community than you are not to. And I bet, I am willing to, anecdotal, but I bet if we disaggregate that I bet you we are seeing better prevention measures amongst that and that would be something that would be very interesting to know.

Mr. Cintron, before my time is up, any comments?

Mr. CINTRON. Yes, sir. I am your poster child also because I was in the IRR, and after 6 years of not being in uniform I got a letter in the mail saying that I have been called up. I served my country proudly. And I was put in with a National Guard unit from Maryland and New Hampshire and sent to Iraq as an IRR soldier.

When I came back, I didn't have any of that support that they had. Nobody reached out or said, hey, you are part of this unit, you did this, you did that, no, nobody did.

Mr. WALZ. Did you get a call from a first sergeant or anything?

Mr. CINTRON. No, I did not, sir. No, I did not, and so if you are part, at least my personal experience, being the IRR, having been called back, having served, you are done, we are done with you, you are not part of the unit. So you don't get this, you are not part of that unit.

I will even share you with an issue coming back, one of the programs was, which I think would have been an excellent program if it continued, was that when the soldiers came back you could actually go with your family to a retreat, to a retreat, you could go with your family. After 19 months and countless phone calls because I was not attached to a unit, and I could not get a first sergeant to approve this or a commander to approve that because I am not attached to a unit, my wife, who is extremely patient, we gave up after 19 months of the bureaucracy because we were not part of a unit.

Mr. WALZ. I know I have gone over my time but I want to hit on this. This is something I brought up back home often on this. They will not cut you travel orders, they will not pay for you to come back. These soldiers would come back if we were paying for them to come back, get them a hotel room, let them attend the 30, 60, 90, 120-day out processings on these retreats. This has been an ongoing problem.

I think it comes back to, and I will leave it at this, very frustrating on this. People like these two folks here and others have been talking about this for a long time. We know this is an issue and now we just need to address it. So I thank you both.

Mr. MITCHELL. Thank you.

Mr. Adler.

Mr. ADLER. Mr. Chairman, thank you. I want to follow up on what Mr. Walz was saying. I am very grateful for the two of you to make this so real for me. I think that the panelists and at least for me to give me some takeaways so that I can go do things starting today.

Mr. Cintron, you mentioned Fort Dix. I have the privilege of representing Fort Dix. I plan to call the base commander today, not to find out who the sergeant was a few years ago who was a little insensitive with respect to you and some other folks, but maybe to alert her so she can alert the various folks, people who are deploying and returning that show sensitivity for individual needs and on a discreet, confidential basis because folks aren't going to raise their hands in a big crowd and say I need help with something.

Ms. Bean, thank you for being a New Jersey person. We have fantastic yellow ribbon clubs throughout New Jersey, certainly at least in my area. Every soldier, sailor, Marine, Coast Guardsman, Navy person who returns from overseas from anywhere has a wel-

come home party. That is great. But maybe some of these organizations could also followup people afterwards 30 days, 60 days, 90 days, if somehow they are falling through the cracks governmentally, there are lots of very caring people who really want to celebrate the human being, not just somebody that wore a uniform and went overseas but the actual human being that did this mission for America. And I think some of those folks would be very willing to schedule followups so it is not just one parade and then forgotten but actually treating each person holistically, even episodically, the way Tim said first sergeants might want to call. There are volunteers who would be just as committed in terms of helping individuals.

So I thank you for at least giving me ideas of what I can do in New Jersey to help avoid Coleman Bean's situation for the next tier that comes back from overseas.

And I thank both of you.

Mr. MITCHELL. Mr. Hall?

Mr. HALL. Thank you, Chairman Mitchell and Ranking Member Roe, and thank you to our witnesses for graciously appearing and testifying before us today.

I will submit a statement for the record.

[No statement was submitted.]

But I would just like to ask Ms. Bean, first of all to thank you for your strength and clarity, appearing and speaking before us. I know how difficult that is but I think I can imagine how difficult that must be to speak about your son and I commend you for being willing to put that aside to help other veterans and their families. It has been obvious to many of us that when a person joins the military they should also be automatically enrolled in the VA and members of the Armed Forces and their families should have access to information or education about assimilating back into civilian life, into their families, into their communities before, during and after deployment.

One of the problems, as I see it, is that the Veterans' Affairs Committee has one piece of jurisdiction, the Armed Services Committee has another one, on the Executive side the DoD has one piece and then the VA has another piece, and there is not that overlap and that seamless transition that we have talked about in so many ways, not just medical records, but mental health followup.

So perhaps, Ms. Bean, you can start a little bit about what kind of information or resources were available to you and to your son before he took his life and what kind of outreach was there. And you have told us a little about what you would like to see available, but was there anything of substance?

Ms. BEAN. We have a strong VA system in New Jersey. When Coleman came home from his second tour of duty, VA services were certainly available to him. Mental health care is at a premium, and it is difficult to get an appointment in a timely fashion.

I don't know when or how Coleman called the VA to seek out mental health assistance, but it is something that we learned of only after Coleman had died.

I didn't know, and this is a gap in my own understanding as much as anything else, I didn't know what else was available. I

didn't go looking for something else to be available. And it wasn't until Coleman had died that I learned that there were many other programs that could have been available.

I keep going back to the idea that our local newspapers run Little League box scores, we run the Butterball Turkey hotline on Thanksgiving, we put out notices about bowling leagues. I think our local newspapers and radio stations could run a little box of resources; if you are a vet, if you are a soldier, if you are family, you can go to these places for help, and that list could include the VA hospitals and the Vet Centers, but it needs to go beyond that to include civilian resources, localized civilian resources.

And I am not sure I am answering your question.

Mr. HALL. That is helpful. Thank you.

Mr. Cintron, would you discuss the kinds of prevention that might help a veteran from reaching the point where they take their own life? We have heard about how Coleman and other veterans had not exhibited or used the word "suicide" and had not exhibited those tendencies until it is too late. And so what kind of outreach would you suggest could reach a veteran before they get to that point?

Mr. CINTRON. I think there are a few outreach efforts that can be done. But the first effort has to be to have the people to reach out to, and that can reach out to the folks, and they have to have some minimal training, not a lot. All it takes oftentimes, and like I said, I have encountered many veterans and for some reason they start talking to me and share their experience, and it is like, wow, you don't know that weight that was on me. And it just lingers with them and all they wanted to do was get it out at least once with someone that can understand, not to judge, but just to listen to them. That is what is needed.

Those outreaches, I think when you get with some of the groups that are available to us, if there is a combined effort with the groups, find the synergy with them and with the governmental organization, so that we all own part of the solution. It is not just the VA solution, it is not just the DoD solution, it is not just the solution of any individual program. It is a combined solution. We all own part of it.

So the outreach would be obviously training and identifying personnel who are willing to take a call at anybody. I give my phone to friends and to veterans that I meet and I say hey, if you ever have an issue give me a call, and I have actually received calls in the middle of the night. Man, I can't sleep tonight, I was just thinking about this, and we talked through, and we are done. But having that available, that outreach, the ability to call somebody, and it doesn't have to be somebody that they really know but somebody that knows what it is they are going through.

Mr. HALL. Thank you. I know I am over my time, but I would just mention that this Committee has—the full Veterans' Affairs Committee on the House side has voted to give funding not just for PSAs, as Ranking Member Roe mentioned, but for paid advertising and Iraq and Afghanistan Veterans of America (IAVA), who we will hear from shortly, partnered with the Ad Council in one effort to put together an ad that is more powerful than the average PSA. Public service announcements run in the middle of the night usu-

ally because that is when the time is cheapest and the TV station will give it up to do their public service, whereas what we really need I believe is advertising during the Super Bowl, during American Idol, during the highest rated shows during prime time where the half hour—I mean the 30-second spot or the 1-minute spot costs the most money. But we are willing to do that, to advertise be all that you can be or the few, the proud, the Marines, you know the lightning bolt coming down into the sword. So if we want to attract and recruit people to go into the armed services and go fight for our country we will spend the money for prime time advertising, but when it comes time to help them find the resources they need to stay healthy after they come home, we want to do it on the cheap and just do it at 3:00 in the morning on a PSA, and I think that needs to change to something we in Congress should fund so that the outreach is just as strong afterwards as it is before they were recruited.

I yield back.

Mr. MITCHELL. Thank you.

And again, Ms. Bean, I am very sorry for your loss and I want to thank you for your son's service and for you being here today.

Mr. Cintron, same with you, thank you for your service and I think you have both done a terrific job today to help further try to solve this big problem. So thank you very much.

Mr. CINTRON. Thank you, Mr. Chairman and Members of the Committee.

Mr. MITCHELL. At this time, I would like to welcome Panel two to the witness table.

For our second panel we will hear from Tim Embree, Legislative Associate for the Iraq and Afghanistan Veterans of America; Jacob Gadd, Deputy Director for Veterans Affairs and Rehabilitation Commission of the American Legion; and Dr. Thomas Berger, Executive Director of the Veterans Health Council for Vietnam Veterans of America (VVA).

And like the other panelists, I ask that you please keep your comments to 5 minutes. Your complete statement will be entered into the record.

I would first like to recognize Mr. Embree for 5 minutes.

STATEMENTS OF TIMOTHY S. EMBREE, LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA; JACOB B. GADD, DEPUTY DIRECTOR, VETERANS AFFAIRS AND REHABILITATION COMMISSION, AMERICAN LEGION; AND THOMAS J. BERGER, PH.D., EXECUTIVE DIRECTOR, VETERANS HEALTH COUNCIL, VIETNAM VETERANS OF AMERICA

STATEMENT OF TIMOTHY S. EMBREE

Mr. EMBREE. Thank you, sir.

Mr. Chairman, Ranking Member, and Members of the Subcommittee, on behalf of Iraq and Afghanistan Veterans of America's 180,000 members and supporters, I would like to thank you for inviting us to testify before your Subcommittee.

My name is Tim Embree. I am from St. Louis, Missouri, and I served two tours in Iraq with the United States Marine Corps Reserves. Veteran suicide is an issue that resonates with all of our

members, and we are grateful that you are holding this hearing today. This issue is of particular importance to me because I lost one of my Marines to suicide in 2005.

Last year, more U.S. servicemembers died by their own hands than in combat in Afghanistan. Most Iraq and Afghanistan Veterans of America, or veterans, know a fellow warfighter who has taken their own life since coming home.

As the suicide rate of our servicemembers and veterans continues to increase without any signs of abating, we must acknowledge that suicide is only one piece of the mental health epidemic plaguing our returning warfighters. Left untreated, mental health problems can and do lead to substance abuse, homelessness, and suicide.

For a veteran considering suicide, the act of reaching out to those close to them can often seem overwhelming. The act of a simple anonymous call to the VA's National Suicide Prevention Lifeline might be enough to save the life of a veteran who is struggling, feeling alone, and hopeless. IAVA proudly supported the Joshua Omvig Veteran Suicide Prevention Act, which established this important hotline, and we are encouraged to see some of the new programs the VA has implemented to help returning veterans.

The heavy stigma associated with mental health care stops many servicemembers and veterans from seeking treatment. More than half the soldiers and Marines in Iraq who tested positive for psychological injury reported concerns that they would be seen as weak by their fellow servicemembers.

To end the suicide epidemic and forever eliminate the stigma associated with combat stress, the VA and DoD must declare war on this problem and must launch a nationwide campaign to combat stigma and promote the use of DoD and VA services, such as the Vet Centers and the National Suicide Prevention Lifeline. This campaign must be well funded, research tested, and able to integrate key stakeholders such as veteran service organizations and community-based nonprofits.

Through our own historic public service announcement with the Ad Council and the help of some of the world's best advertising firms, IAVA has learned a lot about stigma busting and veteran outreach campaigns. Millions of Americans continue to see our uncomplicated, yet iconic PSAs, such as the one featuring two young veterans shaking hands on an empty New York street. These TV ads are just one component of this ground-breaking campaign. They are complemented by billboards, radio commercials, and Web ads, which have blanketed the country and touched countless Americans.

This cutting-edge campaign directs veterans to an exclusive online community, *communityofveterans.org*. This exclusive community shows our Nation's new veterans that we have your back.

Once inside a community of veterans, these vets are directed to a wide range of mental health, employment and educational resources operated by private, nonprofits, and the Department of Veterans Affairs. This campaign is an example of the innovation coming out of the VSO and nonprofit communities, which the VA should treat as an asset. Innovative, aggressive outreach programs like this should become part of the new VA culture and they can

fuel inject outreach efforts. IAVA is learning what works, and we want to share our knowledge.

Additionally, IAVA supports creative solutions for rural veterans. We support contracting at the local community mental health clinics and extending grants to groups that provide programs such as peer-to-peer counseling. Veterans must be able to receive mental health care near their personal support system, whether that system is in New York City or Peerless, Montana.

Our veterans are facing a mental health epidemic. Unless we address the overall issue of mental health stigma, we will never be able to stem the growing tide of suicides. The VA and DoD have created many programs that are extremely effective in helping servicemembers and veterans who are hurting, but great programs are worthless if servicemembers and veterans don't know they exist, cannot access them, or are ashamed to use them.

IAVA is proud to speak on behalf of the thousands of veterans coming home every day. We will continue to work tirelessly so veterans know we have their back. Thank you for your time today, and I look forward to answer any questions you may have.

[The prepared statement of Mr. Embree appears on p. 54.]

Mr. MITCHELL. Thank you.

Mr. Gadd.

STATEMENT OF JACOB B. GADD

Mr. GADD. Mr. Chairman and Members of the Subcommittee, thank you for this opportunity to submit the American Legion's views on the progress of suicide prevention efforts to the Subcommittee today.

Suicide among servicemembers and veterans has always been a concern. It is the position of the American Legion that one suicide is too many. The tragic and ultimate result of failing to take care of our Nation's veterans' mental health illnesses is suicide.

Turning first to VA's efforts in recent years with mental health care, the American Legion has consistently lobbied for budgetary increases and program improvements to VA's mental health programs. Despite the increased funding, the number of servicemembers and veterans with PTSD and traumatic brain injury (TBI) continues to grow. VA has seen more mental health patients with fewer resources and staff.

Of the 30,000 suicides reported among the general population every year, VA reports 20 percent of those suicides are veterans. In a recent AP article, it was cited that there have been more suicides than servicemembers killed in Afghanistan.

In regards to suicide prevention outreach efforts, VA founded the National Suicide Prevention Hotline where veterans are assisted by a dedicated call center in Canandaigua, New York. VA also hired local suicide prevention coordinators at all 153 VA medical centers. One of the primary responsibilities of the local suicide prevention coordinators is to track and monitor veterans who are placed on high risk of suicide. A safety plan for that individual veteran is created to ensure they are not allowed to fall through the cracks.

In 2009, VA also instituted an online chat center for veterans to further reach those veterans who utilize online communications. And as was mentioned earlier, VA has also targeted outreach cam-

paigns, which has included billboards, signage on buses, and PSAs to encourage veterans to contact VA for assistance.

The American Legion has been at the forefront of helping to prevent military and veteran suicides in the community. Last year during our national convention, we adopted Resolution 51, the American Legion's Policy on Suicide Prevention and Outreach. And Dr. Janet Kemp, who is with us today, also provided training to our VA and our commission members. And then after the training, American Legion State, district and post volunteers have established programs to refer veterans in distress with the suicide prevention hotline.

Also, in December, 2009, the American Legion took the lead in creating the Suicide Prevention Assistant Volunteer Coordinator position description under the auspices of VA's Voluntary Service Office.

Despite the recent suicide prevention efforts, more still needs to be done as the number of suicides continues to grow, and as we all know, the challenges still exist. The American Legion's System Worth Saving program conducts site visits to VA medical center facilities annually, including this year going to Canandaigua, New York to report firsthand on some of the progress that is being made.

One of the first problems we wanted to discuss was recruiting psychologists. The VA has a goal to recruit from their current level of 3,000 psychologists to 10,000 to meet the demands for mental health services.

Second, the budget. The American Legion applauded Congress for passing advanced appropriations, but delays still persist within VA itself in allocating budget funds from VA's Central Office to the Veteran Integrated Service Networks, and down, finally, to the VA medical center. So the American Legion continues to advocate for additional funding to meet the demand for mental health care and urges Congress to provide oversight that those mental health dollars are being used to their full intent.

Additionally, the issue of a lack of interoperable medical records between DoD and the VA, which is currently being addressed by the lifetime virtual electronic medical record, still exists. In addition, the American Legion recommends VA take the lead in developing a joint database with DoD, the National Center for Health Statistics, and the Centers for Disease Control to track suicide trends nationally, and have the numbers for the military as well as for veteran suicides.

The American Legion continues to be concerned about the delivery of health care to rural veterans. No matter where a veteran chooses to live, VA must continue to expand and bring needed medical services to the highly rural veteran population through telehealth, virtual reality exposure therapy, and online technologies.

The American Legion has seven recommendations to improve suicide prevention efforts: First, that Congress exercise oversight on VA and DoD programs to ensure maximum efficiency and compliance.

Second, Congress should appropriate additional funding for mental health research and a standardized DoD and VA screening diagnosis and treatment protocols.

Third, DoD and VA expedite development of a joint medical record to better track and flag veterans with mental health illnesses.

Four, that Congress allocate separate mental health funding for VA's recruitment and retention incentives for behavior health specialists.

The rest of my recommendations are included in the written testimony.

In conclusion, Mr. Chairman, VA has increased its efforts in support for suicide prevention but must continue to work with veteran service organizations, such as the American Legion, to improve outreach. The American Legion is committed to working with DoD and VA in providing assistance to increase involvement.

Thank you for allowing me to submit testimony today.

[The prepared statement of Mr. Gadd appears on p. 58.]

Mr. MITCHELL. Thank you.

Mr. Berger.

STATEMENT OF THOMAS J. BERGER, PH.D.

Dr. BERGER. Chairman Mitchell, Ranking Member Roe, and distinguished Members of the Subcommittee on Oversight and Investigations, Vietnam Veterans of America thanks you for the opportunity to present our views on examining the progress of suicide prevention outreach efforts at the VA. We also want to thank you for your overall concern about the mental health care of our troops and veterans.

Suicide is most often the result of unrecognized and untreated mental health injury, including depression, post-traumatic stress disorder, and traumatic brain injury. Those are three of the most common mental health injuries and conditions that can lead to suicide, and these three conditions in particular are medical conditions that can be life threatening.

In more than 120 studies of a series of completed suicides, according to our colleagues at the American Foundation for Suicide Prevention, 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 those underlying illnesses, such as depression, alcohol and substance abuse, post-traumatic stress, and traumatic brain injury.

Many veterans, and obviously active military people, 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.

But I think we need to also put this hearing or the call for this hearing in the proper historical context, and that is, in May 2008, then Secretary of the VA, General Peake, chartered the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population. Its function was to provide advice and consultation to him on various matters relating to research, education and programs, as well as improvements relevant to the prevention of suicide in the veteran population. Subsequently, on September 16, 2008, the House Veterans Subcommittee on Health held an oversight hearing on the VA's suicide hotline. As part of the press release for this hearing, VA announced that Secretary Peake had received recommendations

from this Blue Ribbon Panel, eight recommendations and findings, as well as a series of 14 other elements. While all those recommendations and findings are contained in my written report, I will just read to you panel finding number six:

“Efforts to improve accurate media coverage and disseminate universal messages to shift normative behaviors to reduce population suicide risk are not being fully pursued.”

Now, suicide prevention of course starts with leadership, but it has been almost 2 years now since the Blue Ribbon Work Group finished its work and we have yet to see any formal action plan that addresses each of the group’s findings and recommendations in a comprehensive, prioritized fashion. In fact, no one outside a select group of bureaucrats at the Veterans Health Administration (VHA) has probably ever seen this complete report, which of course was funded with taxpayer dollars.

This Committee must ensure that our veterans and their families are given access to the resources and programs necessary to stem the tide of suicide. We have heard of some attempts to do that. Where is the plan, the overall plan to do it? The first step in the process is knowing what has been recommended by the best medical scientists the VA could assemble to study the problem, and that is the report I referenced earlier. What is being done to implement those recommendations and address the findings of those experts?

Once again, on behalf of VVA, I thank you for your leadership in holding this hearing on this topic, and I also thank you for the opportunity speak to this issue directly. I will be glad to answer any questions later on.

[The prepared statement of Dr. Berger appears on p. 61.]

Mr. MITCHELL. Thank you, Dr. Berger.

Mr. Embree, I am very impressed by the PSA campaign that the IAVA ran with the Ad Council. You did this on a fraction of the budget that the VA has, and you clearly saw a vision and wanted to air it. Why do you think the VA has such a hard time recreating what the IAVA has done?

Mr. EMBREE. Sir, thank you for the question. I think one of the major problems is that we understand that vets help vets. Young vets coming back from Iraq and Afghanistan right now can speak to each other. If you are a first sergeant that served in Iraq, you can talk to a PFC that served in Iraq because you have a lot of the same experiences, you understand what is going on. Vets help vets, and we can talk to each other. And we understand that feeling, like in our first PSA, of that young soldier walking to the airport felt alone; in fact, that is the title of the commercial, it is called “Alone.” Because a lot of us vets have come back, we know that feeling, we remember that feeling very strongly, that first time when you are sitting there in a crowd and you feel like it is just you. We can speak to that. And we also understand what it is like when another veteran comes up and shakes your hand or just talks to you, how all of a sudden the world comes alive again, you feel part again, you feel part of something bigger.

I think the VA for too long has been dealing with issues that have affected past generations, and they haven’t recognized that

those issues are affecting this new generation of veterans just in different ways and we are dealing with them in different ways.

So I think that the VA is treating some of the old problems and not recognizing that those are the same problems just in different forms now. So I think the VA needs to reach out to the veteran service organizations, such as Afghanistan and Iraq Veterans of America, Student Veterans of America, and some of the other larger veterans service organizations to talk to the newer vets and to find out what is affecting us.

Because I remember when I saw the VA PSA, it was about 2:00 in the morning, I think it was actually one of those nights when I couldn't sleep because I came from a deployment and I had no idea what was going on. There was a bunch of World War II memorabilia around, and Lieutenant Dan from Vietnam with *Forrest Gump* was talking to me. That didn't speak to me, it didn't make any sense to me. But when I see two young veterans walking up to each other and shaking hands and the world coming back to life, that made sense to me, that hit me, I understood what was going on with those guys.

Mr. MITCHELL. The IAVA has secured \$50 million in donated media, reaching millions of veterans and their families. What lessons learned can the VA gain from your experiences in creating a new energy and new support? Maybe you just mentioned it.

Mr. EMBREE. Yes, sir. But also I think it means they need to work with a lot of these cutting-edge firms, some of these advertising firms that their job is to market products to people, to help you understand how to talk to the families, how to get mom to see a commercial or to see an ad at a bus stop or on *Facebook* and then go and talk to their son or daughter who may be dealing with these issues, or the wife or husband of a soldier or Marine or airman or sailor.

So I think it has to be more than just we put ads on a bus. I mean, if you have seen the VA ad on a bus, it is very hard to read; it is a lot of words, and unfortunately buses are mobile, so trying to read the small print is very hard to catch.

So I think that the need to listen to the private side and also the nonprofit world and find out what works, how do you get to your customers, how do you get to your members?

Mr. MITCHELL. And one last one to you, Mr. Embree: What actions can the DoD do to facilitate the VA's mission to prevent suicide?

Mr. EMBREE. Yes, sir. With the DoD, I think it is an even larger issue. I think they need to help with the stigma campaign, but I think they also need to implement training for your junior officers and your young noncommissioned officers. The way I like to explain it is, if you are a young Marine and you roll your ankle on a run, you come back to the squad bay, you don't just keep walking around on a swollen ankle, you go to the doc, you go to the corpsman and you say, hey, doc, something is wrong with my ankle, I need to figure out how to get better, how to get back in the fight. It needs to be the same thing with mental health injuries. We need to make sure that that platoon sergeant or that corporal as a squad leader or that platoon commander can recognize these injuries and say, hey, private so and so, it looks like something is going on with

you, we need to go get you treatment so you can get better and make our fighting force stronger, so you can come back in the fight, get back to the platoon.

So we need to teach our young leaders in the military how to recognize these injuries and treat them before they get too far.

Mr. MITCHELL. And one last question I have with what little time I have, Dr. Berger: What suggestions do you have on how the VA can best provide the outreach to at-risk veterans?

Dr. BERGER. Thank you, sir, it is a good question. Certainly the suggestions that have been made by everyone who has already been here at the table, but I do believe that any kind of comprehensive plan, as was hinted at by Representative Roe, is a plan. There has got to be parts that involve *Facebook*, the new communication technology. There has got to be parts of it that are messages on our transportation system. The list goes on. Let's see a plan so we don't have gaps in the message getting out there.

Furthermore, it has to be tailored to the various segments of our population. As you know, Vietnam veterans comprise the largest cohort of American veterans, and we still have, as I am sure Dr. Kemp can provide statistics, a significant number of Vietnam vets taking their own lives. We must not forget about them as well.

Thank you.

Mr. MITCHELL. Thank you very much.

Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman.

Just a couple of things. And then to all of you, for me, what I have had problems getting my hands—this is a huge problem when you are talking about thousands of people. As a doctor, you try to identify the person that would be at risk, and it is very hard in this situation to do. I have looked at it, and we have two issues, I think. We have active-duty veterans who are taking their lives and we have a much larger number of veterans who are taking their lives. So we have two separate issues. And when I started thinking about this, I read all this testimony, and it looks like we need to look at is there a trend here? How old is the veteran? Are they homeless? Do they have a job? Do they have family members? You can do that and get that information and look and see which one of those specific groups—and Dr. Berger, I know you are well aware of this—that you can identify. I thought about how many of them are unemployed? Are they Vietnam-era veterans? My personally, in the last few months, in my own district, in my own hometown, a patient of mine's husband committed suicide who is a Vietnam veteran. And there was an attempt by somebody I know extremely well just in the last 2 weeks, it was unsuccessful, thank goodness, and didn't commit suicide and now has a chance to get help and hopefully turn his or her life around.

Mr. Embree, your point was an incredible point you made. Both of those ads made a difference to me because I have the idea of looking at it both of not being welcomed home and of also being welcomed home. So I saw a different view of it than you did, and you can only see it through the experience you have had. But I can tell you that Dr. Berger will tell you in a Vietnam-era veteran, both of those ads hit home.

I want to know how we use, because I think the younger generation—I mean, how the Chairman and I *Twitter* is we shake hands, that is our *Twitter*. But *Facebook* and *Twitter* and the new media, how do you see that helping? I think it can be tremendous because you have access to someone in California or New York or around the world, a friend, with the new media. Could you comment on that?

Mr. EMBREE. Yes, sir. And thank you for asking about this. This is something that our organization, IAVA, takes very seriously because we recognize that our members are all over the country. One of the biggest successes of *communityofveterans.org* has been because a veteran in Tennessee can talk to a veteran in Florida securely, knowing they are both vets. They can talk about what is going on and what they are experiencing, and also those hundreds of miles go away and they help each other deal with these issues.

But I think one of the biggest problems is the VA is making steps, they are trying to use *Facebook*, they are trying to use *Twitter*, but they are using it as press releases, saying this is great, this is what we have done, and it is very regimented. But the vets want to hear more about what is going on. It needs to be a breathing organization they feel bought into. So when they are sending out tweets or *Facebook* updates, it needs to be stuff that is not just, hey, this new hospital has 20 new doctors because that doesn't make any sense to the vet, they are like, okay, that is great. But if one of the folks that runs the program tells a little bit about their life and about dealing with these programs and about their ideas and what they would like to do, it gives a face to the VA. I think that is what is so important. Folks want to know a little bit more; they don't just want press releases.

Mr. ROE. Let me give you an example of what one local sheriff in my district does, small county, mountain county, Unicoi County, Tennessee, Sheriff Harris has his officers call 130 people, elderly people who live alone every day to check on them and see how they are doing. Every single day they get a phone call. If they have a medical problem, they call the next morning and say, how are you getting along, did you have a good night? And they listen for that. I am wondering when our veterans—because we had a group, the 278s, just got home to Greenville, Tennessee, Friday night. I was out, they got home at 8:00 at night. And my question is, how hard would that be? It doesn't take, no offense, a Ph.D. to talk to someone, how are you getting along, are you having a tough day? I wonder if we can't do that, especially for our veterans that are in rural areas or anywhere. And I see this new media as being a real resource to do that, just pick this up right here and get on it, and it doesn't take you 30 seconds to do it. That may be a lifeline to somebody. If they are having a tough day, they can get pointed in the right direction if they know what direction to go in.

Dr. Berger, one other thing, and I want to know before my time runs out, this data that I mentioned here, has that been done with this Blue Ribbon Panel? Is there a way I can sit down and look at that and say, when I am talking to someone, and look at their experiences, are they 20 years old within a combat unit? Did they go through Fallujah? What experience did they have? Is that data out there?

Dr. BERGER. There are data contained in the final report—at least the copy of it that I have—and I would be glad to share that with you and you will have to look at it.

I would like to comment on what you said just a few minutes ago about looking at the veterans audience out there because what you said hinted at what suicide really is, and that is, suicide is a process where you lose hope. There are proximal events, whether it be a bad marriage, a drinking bout, some other kind of situation, losing a job, what have you, that may push the individual over the edge, but it is a process that 99 percent of the time people are thinking about as they lose hope. The point being that in the campaign, it needs to bring these elements in. It is not just taking your life, that is the ultimate, but what impact does losing your job when you can't get a mental health service, when your wife says, all right, go to the substance abuse clinic or I am taking the kids and leaving. It has to be thought out so that is addressed in the campaign.

Thank you, sir.

Mr. ROE. Thank you. I yield back.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Well, thank you. I thank all of you for your great advice. You have all been great partners and great resources to help us get this right.

I keep coming back to this, and I think our first panel made this very clear. We have to get to the front end of this instead of chasing our tails on the back end forever. I come at this from an education perspective. I am a teacher, and it just drives me nuts. We talk about closing the achievement gap. Every piece of research shows that by the time these kids get to be 18 it is virtually impossible to close the achievement gap. So we spend billions of dollars, tons of things, we don't get it done. We know that if we attack them between preschool, age two to five, our success rates are much greater.

This still comes back to the seamless transition. We are not going to get this right until it is all part of the same thing, until that culture changes, Tim, as you said amongst that, until we group all our veterans together and we understand that once they get in there.

My question to each of you is somewhat subjective, but I trust your opinions on this, you get this. Are we getting any closer? Is the virtual lifetime record moving us there? Are we getting any closer on seamless transition?

Tom, do you want to take it first and then we will just work our way down.

Dr. BERGER. Seamless transition. We need to change that to something that really better represents what we are trying to do.

I think there have been very good efforts made, but again, as you can hear, they are disjointed, the right hand doesn't necessarily know what the left hand is doing.

Mr. WALZ. It is not for lack of good intention.

Dr. BERGER. It is certainly great intentions, but let's get all the parties together and sit down and say, okay. And then ask, ask our veterans, the ones who are coming out, what do you need? What

I need is not the same thing that Tim needs or that Mr. Gadd needs. It has to be individualized as well, in my opinion. And certainly we heard earlier about the retreat kind of approach. Certainly that should be considered as well, where you can bring all these elements together in a nonthreatening kind of situation.

When my colonel walked in and said you are not going to commit suicide, that is a lot different than me sitting down with Tim and saying, you know, I have some things I need to talk about, buddy, can you help me?

Mr. GADD. Thank you for the question.

Does the American Legion believe it is moving fast enough? We do not. They have been talking about this for several years, we just want them to make it happen. The AHLTA system and the Vista system, the architecture is very complex, but they have teams working on it and it is just not moving quick enough. We are here today talking about suicide and veterans falling through the cracks, and that is a byproduct of the system not being designed too effectively, once that servicemember goes in the first day of active duty, tracking him until he comes back to his community and returns from the service.

But also, I just wanted to point out too, VA did make some strides with the TBI screening and how if you go in for a podiatry appointment, something completely unrelated, they will ask you about the TBI screening, they have that questionnaire. There is nothing of that sort for mental health, and there should be. They have integrated mental health into primary care in the hospitals and in the clinics, but the American Legion would like to see more tracking there.

Thank you.

Mr. EMBREE. Yes, sir. There are a lot of different programs going on. I think one thing that is extremely important is there must be more VA contact. There is actually a model already out there, and it is your average college university alumni association. Everyone knows when you are a freshman and you get that first intro to college, there is a rep from your alumni association to meet you, to tell you about all the events going on campus, and then they are going to contact you throughout your whole 4 years—or in some people's case, 5 or 6 years.

Mr. WALZ. And then the rest of your life for donations. They will be there.

Mr. EMBREE. Exactly, sir. And that is the thing, they make those touches, they make those touches while you are there so you become bought in, you become part of that alumni association. And in that way, throughout the rest of your life they stay in contact with you. The VA needs to be the DoD's alumni association. They need to make that contact when you come into the fleet, when you are that young lance corporal or PFC or young sailor or a young soldier or airman, they need to make that contact with you. And they need to keep making that contact with you and your family throughout your time in uniform. So when you leave, it is that actual simple transition into the VA because you already understand everything they do, you already understand the programs that are available.

Mr. WALZ. Well, thank you. And I couldn't agree more with all of you. I think that is absolutely the key to this. The systemic change to help us prevent suicides, that is what we are trying to get at. So I yield back.

Mr. MITCHELL. Thank you.

Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman.

Earlier this week, as Mr. Walz referred to, the VA announced a new rule change which went into effect yesterday morning which gives veterans who served in a combat zone, servicemen or women, a presumed service-connection for PTSD and removes the necessity of proving a particular incident that was the trigger of that trauma. This Committee, the full VA Committee, voted unanimously for legislation that basically did the same thing. It was on its way to the floor when the President and the Secretary, General Shinseki, moved in and did a rule change to basically accomplish that piece of it.

What impact do you see this as having on veterans being willing to come forward and seek treatment for possible mental injuries before they reach the point where they could harm themselves or others? And how best can the knowledge of this rule change be spread far and wide in the veterans community so that those who are afraid of rejection or afraid of stigma can have less of that fear and take advantage of this new opportunity?

Tim, do you want to start that?

Mr. EMBREE. Yes, sir. I think with the new rules for PTSD, what it does is it makes it easier for the veterans to get the care that they need. There are very good counselors within the VA system and there are very good doctors that have very effective treatment to help these folks, but unfortunately the process was so long before with the old rule, it was very hard. Say if you were a female veteran who had served in a forward operating base in al Anbar Province in Iraq and you got mortared on a regular basis, or you served as a machine gunner on multiple convoys, but you walked into a VA system that didn't understand that women are in combat and you had to sit there and prove these horrible things that happened to you and relive it every time you are trying to prove your case, that was awful. It was very unfair to the former servicemembers. Something now that the rules have changed and we are making it easier for folks to get to that care. That has been a major step forward and we are very pleased to see that. We think a lot more servicemembers and veterans are going to be able to get the care they need because they are not going to have to go through that 6-month, 9-month process to say, yes, I got blown up, or, yes, I was shot at, or, yes, I watched my buddy die right in front of me, be it man or woman in uniform. This eliminates one more barrier for those folks seeking treatment.

Mr. GADD. Yes, sir. The American Legion is supportive of any law that can be relaxed such as that to make the process simpler. Our veterans come home and have to fight another war to get their benefits. Our 1,400 accredited service officers help them with the claims, and this will make it a lot easier for the veteran. We hope to see more of them file for their benefits and use their 5 years of free care at the VA and knowing about this.

So thank you.

Dr. BERGER. Good question. VVA certainly agrees with that. And as you may remember, Congressman, we strongly supported the initiative. The one area where we have some difficulties is the VA's requirement that it only be a VA clinician, meaning a psychiatrist, psychologist or clinical social worker's diagnosis that is acceptable. We find that rather difficult. It does impose a burden on people who live far away from a VA facility. And let's suppose that there were no VA in Topeka, Kansas, you mean the VA is going to turn down the opinion of a psychiatrist from Menninger Clinic who has been practicing for 30 years? That is going to be a problem. That is going to be a problem. And it could create some backlogs in terms of complaints down the road. But overall, as has been indicated by my colleagues here, it certainly will ease the process.

Mr. HALL. I would agree with that. And I think in my written comments last fall to the VA on the proposed rule was that they include private psychiatrists and psychologists' diagnoses equal to VA docs. But at any rate, this is, nonetheless, I think a big step forward.

I wanted to ask, in your own experience, and as a matter of what you would suggest, how active duty or soldiers who are going through basic training who are entering the military could be prepared for this? The reason I ask is because West Point, which is in my district and where my nephew just graduated a few weeks ago, had a year and a half ago a spate, a rash of suicide attempts, half of them unsuccessful I am happy to say. But the stress and the manifestation of this caused a stand down and a teach-in and a buddy system all in an academy predeployment.

So the question is, should this not just be done in the military academies that are producing the officer corps, but also is it being done to any extent, and should it be done more as part of the basic training of all of our servicemen and women?

Dr. BERGER. Certainly, Congressman Hall. I am aware, it was announced in the press that the Army has instituted a resiliency program down at Fort Stewart. Now, what is the resiliency program? I don't know, I haven't been able to get a hold of the copy of the curriculum. I don't know who is teaching it, I don't know anything about it. And obviously there is no data on the outcomes. But if it is happening and it follows those standards, principles and practices that some of us in the clinical side know about resiliency, then that is a great step forward for our folks who are in basic training.

Mr. HALL. I am out of time, but Mr. Chairman, if you would like to allow the other two witnesses to answer if they wish.

Mr. GADD. I will go ahead. Sir, the American Legion, in our recommendations, had said training, education and outreach are all important components there.

I think having the suicide prevention coordinator on the DoD installation side is going to be helpful, too, like VA has them in all of 153 hospitals, something to that sort. And part of the testimony we talked about psychologists and the shortage, 3,000 moving to 10,000, there is still a shortage in DoD as well with psychologists, but just having that training component at the installation level will be helpful in helping this problem.

Mr. EMBREE. Yes, sir. Thank you for the question because I think one of the things that is very important, like I mentioned before, I do think that there needs to be a training for your corporals course, your sergeants course, your staff NCOs, your lieutenants and your captains because these are the folks that, for a young Marine or soldier just coming to the military world, these folks are like God to them. They tell them when to get up in the morning and when to go to sleep at night. They tell them when they are getting paid, they tell them when they are going to eat chow. So these folks need to be the ones that can recognize private—I am trying to refrain from using military terminology or Marine Corps terminology, at least—Private Smith, let's say, if Private Smith is acting funny, the platoon sergeant or the squad leader is going to be the first one to recognize this, and they are going to be the ones that say you need to go get treatment for your mental health because that way you make the fighting force stronger. Because we PT to make sure our legs are strong so we can run across the battlefield. We lift weights to make sure we can throw our buddy over our shoulder when we need to get him out of harm's way in a kill zone. We need to make sure that we are also exercising our minds and that we can recognize injuries. You can recognize when someone rolls an ankle or blows out a knee. You need to be able to recognize if they are having a mental health issue, be it depression, be it combat stress.

So I think we need to make sure that the folks that have the everyday interaction with our young soldiers, sailors, airmen and Marines, need to be the ones that—they don't have to be taught to be a clinician by any way, shape or form, they need to be taught just to recognize that someone needs to go get that mental health treatment.

Mr. HALL. Thank you, Mr. Chairman.

Mr. MITCHELL. Thank you very much.

I want to again thank you on behalf of all of us for the service that you have given to this country. Thank you.

I would now like to welcome Panel three to the witness table. For our third panel, we will hear from Colonel Robert Saum, Director of Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury, U.S. Department of Defense; and Dr. Robert Jesse, Principal Deputy Under Secretary for Health, U.S. Department of Veterans Affairs. Dr. Jesse is accompanied by Dr. Janet Kemp, the National Suicide Prevention Coordinator for the Department of Veterans Affairs.

Colonel Saum, you are recognized for 5 minutes.

STATEMENTS OF COLONEL ROBERT W. SAUM, USA, DIRECTOR, DEFENSE CENTERS OF EXCELLENCE FOR PSYCHOLOGICAL HEALTH AND TRAUMATIC BRAIN INJURY, U.S. DEPARTMENT OF DEFENSE; AND ROBERT JESSE, M.D., PH.D., PRINCIPAL DEPUTY UNDER SECRETARY FOR HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY JANET KEMP, RN, PH.D., NATIONAL SUICIDE PREVENTION COORDINATOR, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS

STATEMENT OF COLONEL ROBERT W. SAUM, USA

Colonel SAUM. Thank you, Chairman Mitchell, Ranking Member Roe, and the Subcommittee Members. Thank you for the invitation to talk about the Department of Defense suicide prevention programs and related outreach efforts.

I am not here only today as the Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, but also as the father of an Army sergeant who after two tours in Iraq, suffered a mild traumatic brain injury and post-traumatic stress. He has considered suicide. It wasn't until my family and I intervened that he sought care and recovery.

Our servicemembers, veterans and families have, and continue to display, strength and resilience. They have raised their hands and volunteered to serve their country and lay down their lives, if necessary, and we owe them the very best.

The largest barrier we face as a military and a society is preventing suicide and the stigma that is associated with it. Stigma prevents our warfighters, veterans and their loved ones from reaching out in the most troubling of times.

In May of 2009, DCoE launched the Real Warriors Campaign, a public education initiative specifically designed to combat stigma associated with seeking help. Realwarriors.net is accessible globally and has reached 72,000 unique warriors and visitors, with more than 110 visits and 781,000 pages viewed. The campaign partners with more than 100 organizations throughout the country to increase visibility and outreach.

Additionally, DCoE has partnered with the Department of Veterans Affairs to coordinate information and resources specifically designed for the military community when calling the National Suicide Prevention Hotline, 1-800-273-TALK. This number continues to be displayed on all Web sites and resources, such as Military OneSource, the go-to resource for servicemembers and their families. The Department of Defense and the Department of Veterans Affairs continually collaborate on suicide awareness, creating resources, coordinating with the services and other relevant organizations to send messages to the widest possible audiences.

Another important aspect of our suicide prevention efforts is to increase awareness and knowledge. The DCoE Outreach Center is staffed by health resource consultants who are available 24/7 by phone, by e-mail, by chat, and they are there to answer questions and refer callers to a wide range of resources on psychological health and traumatic brain injury.

The Reengineering System of Primary Care Treatment in the Military, RESPECT-MIL, is a collaborative effort and a care model that enables health care providers to screen patients for post traumatic stress disorder, depression in the primary care clinics. Since its inception in 2007, RESPECT-MIL has screened approximately 350,000 Army personnel at medical treatment facilities. They identified 2,528 soldiers with suicidal ideation and provided the appropriate intervention and care. The program will be implemented across the Services very shortly.

Another facet of DCoE's outreach is our partnership with the Congressionally mandated Yellow Ribbon Reintegration Program. This program proactively reaches out to our National Guard and Reserve members and their families, and since its inception in 2008, more than 2,000 events have been held for nearly 300,000 servicemembers, enabling them to successfully reintegrate back into their families and their communities of choice.

DCoE's collaboration with the Sesame Street Workshop launched the Sesame Street Family Connections Program. The Emmy-nominated program releases 700,000 bilingual dual DVD kits that provide videos featuring Elmo and his family working through the difficult issues, and includes materials for adults on how to discuss the sensitive issue with children of a lost parent from combat, illness, or suicide.

I want to thank you for the opportunity to highlight some of DCoE's and DoD's suicide prevention outreach efforts, and I look forward to your questions.

[The prepared statement of Colonel Saum appears on p. 64.]

Mr. MITCHELL. Thank you.

The Subcommittee has been trying to determine the VA's vision and its strategic plan on moving forward with their suicide prevention outreach program. So at this time we are going to show a short video display of some of that vision.

[Video shown.]

Mr. MITCHELL. Thank you.

Dr. Jesse.

STATEMENT OF ROBERT JESSE, M.D., PH.D.

Dr. JESSE. Chairman Mitchell, Ranking Member Roe, and Members of the Subcommittee, thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs efforts to reduce suicide amongst American veterans.

I am accompanied today by Dr. Janet Kemp, VA's National Suicide Prevention Coordinator. Before I begin, I would like to thank the Committee, and you, Chairman Mitchell, for your continued advocacy on this issue and your leadership in this area.

I would also like to thank the VSOs for their insight. But mostly I would like to thank Ms. Bean for being here today. I can't begin to comprehend her personal pain, but I would like to acknowledge that sharing that and opening that public dialogue I think really is, as Congressman Adler said, it is the PSA that is important, that we continue to discuss this in a public fashion.

I would also like to thank Dr. Kemp for being here. She truly is the brilliance and the spark behind the VA's suicide prevention initiatives and clearly leads the country in this area.

I don't think anybody in this room would deny how important this issue is to the VA. We have initiated several programs that have put the VA in the forefront of suicide prevention in the Nation, including the establishment of the National Suicide Hotline. The addition of a chat service I think has been an extremely important addition to that, the national advertising campaigns to promote that hotline and phone number to all veterans and their families. The placement of suicide prevention coordinators in all VA facilities, and expanding their role and interaction into the communities, expansion of mental health services, and to my mind most important, the integration of mental health services into primary care as a major effort to reduce the stigma of those seeking mental health care.

In response to the urgent need to reduce the incidence of veterans and servicemember suicides, the VA has been significantly expanding its suicide prevention program since 2005. We work in close collaboration with other Federal partners, including our colleagues at the Department of Defense, to discuss and facilitate ways that we can reduce the prevalence of suicide amongst veterans and servicemembers. Part of that collaboration includes the Defense Centers of Excellence and Veterans Integrated Services Network as a formal partner in the Real Warriors anti-stigma campaign. We also serve as a member of the DoD Suicide Prevention and Risk Reduction Committee to ensure that suicide prevention efforts are coordinated between the two Departments.

The VA Call Center for Suicide Prevention Hotline, since its creation in 2007, has now received just shy of 300,000 calls. And we just recently have led to more than 10,000 rescues, more than 35,000 referrals to the suicide prevention coordinators.

Since its inception, the VA call line has also helped more than 3,700 active-duty servicemembers. And during 2009, the hotline services were supplemented with the veterans Chat, which has been receiving more than 20 contacts a day, again, to engage the younger servicemembers and veterans who would prefer that rather than a phone call.

VA suicide prevention coordinators work hard to raise the awareness about warning signs associated with suicide and the availability of both treatment and support. In addition to these measures, VA has been aggressively advertising this information, improving outreach to veterans and family members.

In 2009, VA began an advertising campaign in Dallas, Los Angeles, Las Vegas, Miami, Phoenix, San Francisco, and Spokane. The metropolitan areas second campaign is displaying suicide prevention advertisements in the interior of transit public buses. This effort has reached more than 4.3 million daily riders in 124 markets and covering 42 States and 21,000 buses.

VA is reviewing the association between exposure to public health media messaging, knowledge of the hotline use, and self-reported likelihood of hotline use if needed. Preliminary data indicate an increase in the number of calls originating in the areas where these advertisements were deployed, and based on these promising efforts, VA is pursuing two contracts to further promote our suicide prevention efforts.

First, we are soliciting bids to contract to support an expanded presence on public buses and mass transit bid options. And secondly, we are pursuing a second generation of suicide prevention outreach that is based on a comprehensive strategy developed with social marketing experts, implemented through a newly created national outreach contract.

We are working towards suicide prevention coordinators to secure air time locally for new public service announcements, and our goal is to have these PSAs at more than 70 percent of the 153 local markets, particularly during the National Suicide Awareness Week in September.

Mr. Chairman, the VA has taken a number of steps to provide comprehensive suicide prevention services, and the data indicate our efforts are succeeding, though not complete. Our mission will not be fully achieved until every veteran contemplating suicide is able to secure services he or she needs.

I thank you for your support of our work in this area, and we are prepared to answer your questions.

[The prepared statement of Dr. Jesse appears on p. 67.]

Mr. MITCHELL. Thank you.

Dr. Jesse, who is in charge now of making sure the progress of moving forward on the momentum that was built in the pilot program that ended in the fall of 2009?

Dr. JESSE. Mr. Chairman, we see this as a team effort, that there are—

Mr. MITCHELL. Who is the captain of the team?

Dr. JESSE. Well, Dr. Kemp, I believe, is truly the captain of this team.

Mr. MITCHELL. So she is in charge of making sure that we move on from the momentum that was stopped after the pilot program ended in 2009?

Dr. JESSE. Well, yes, sir. But I am not sure if we would say that that pilot was stopped. That pilot is phasing into—

Mr. MITCHELL. Well, let me move on. Why did the responsibility for the pilot program move from Tammy Duckworth's office to the VHA?

Dr. JESSE. I don't mean to sound like I am dodging your question, but I just simply can't answer that. I can certainly get back to you on the record for it.

[The VA subsequently provided the following information.]

The responsibility for the pilot program never changed. Public Affairs are overseen by Assistant Secretary Duckworth's office but the program elements are the responsibility of the program office, specifically the Office of Mental Health Services. VHA programs that spend more than \$10,000 on marketing and advertising have their plans approved by Assistant Secretary Duckworth and this campaign falls into that category. We have included that policy in a directive that has just been released so everyone has a better understanding of responsibilities and oversight.

Mr. MITCHELL. Sure. I want to know why the VA stopped airing public service announcements late last year? Now, I understand the need for a thorough evaluation to determine the effectiveness of this outreach, and I applaud the VA's accountability. But your own testimony, in the written testimony, indicates that preliminary data indicates that the advertising had been successful and has resulted in an increase in calls to the suicide hotline. As of April,

2010, the VA reported nearly 7,000 rescues of actively suicidal veterans which are attributed to seeing the ads, PSAs, or promotional products, and referrals to VA's mental health services have increased.

Instead of suspending relatively low-cost outreach efforts like the public service announcement, which cost only \$200,000 to produce, why not keep it on air while you complete your more comprehensive evaluation of its overall effectiveness?

Dr. JESSE. I am going to ask Dr. Kemp to address that fundamentally, and I will come back on the back side if that is okay.

Mr. MITCHELL. All right.

Ms. KEMP. Thank you, sir.

First I want to stress that we did not stop airing the PSAs. The contract that we had was for distribution. They were distributed. Radio stations and TV stations across the country have them, and we continually make stations aware of the fact that they have them.

We track the number of airings that we see. They are still available to be aired, and we still are encouraging local stations to use them whenever they can.

One of the ways that we have found we were most effective in getting stations across the country to air the announcements was to have local people at their sites call them and encourage them to use them. So we have moved into a mode where the suicide prevention coordinators will continue to have the PSAs available, continue to make sure that they are there at their local stations, and will continue to—

Mr. MITCHELL. Let me just interrupt real quickly. On March 17th of this year, the VA was in this room testifying, and the question is, are the PSAs still airing? Their answer was, no, the PSAs are not airing. However, they are available, but they are not airing. And this was what the VA said on the 17th of March.

Ms. KEMP. Right. And we, at that point, asked our suicide prevention coordinators to contact their local stations, continue to ask them to show them, and they have been airing since that time.

Mr. MITCHELL. Can you give us a number later of how many airings they have had since April of last year?

Ms. KEMP. No, but I certainly can get that to you.

[The VA subsequently provided the following information.]

We asked the Nielsen Corporation to track the airings of the PSA over the past year. Since January of 2010 (through August, 2010) there have been 4,279 airings across the country and they are continuing to air. We have placed the PSA's on *Facebook* and during fiscal year 2010, the Gary Sinise video received approximately 4,800 hits and the Deborah Norville video over 1400 hits.

Mr. MITCHELL. And the next question I have for Dr. Jesse, we have approximately 23 million veterans in this country and only 8 million are enrolled in VA care. What about the remaining 15 million? Do you really think that stopping the airing of a PSA is the best way to serve them right now amidst the epidemic of veteran suicides?

Dr. JESSE. Well, I think Dr. Kemp addressed the issue of stopping the airing. I think part of that answer is, what is the most effective way to reach out to those veterans? So, for instance, two of the highest days' volumes to the call centers were, one, I think

when Ms. Duckworth was on CNN, and two, when Dr. Phil had a thing on suicide and we ran the number as a trailer underneath the dialogue. That taught us an important lesson, that, particularly the local suicide coordinators, because they know what is going on in the local markets, if those kind of discussions are going on or being aired on TV, that they can encourage the stations to run that number. That turns out to be hugely effective strategy. We are doing a lot of strategies like that.

Now, in terms of reaching out and bringing in the remainder of the veterans, as I am sure you are all aware, there has been a lot of discussion between the Secretary of the Veterans Administration and Congress about how we get the rest of those veterans to come into the system, including opening up—as you know, President Obama and Secretary Shinseki have committed to opening up to the remainder of the Category 8 veterans.

Mr. MITCHELL. Right. I just note that, as I said earlier, during the period of this testimony today, one or two veterans will have committed suicide. And even from your own VA, it was reported that there were 7,000 rescues of actively suicidal veterans that were attributed to the PSAs. So I think these were pretty good, and I would have kept them on. In any case, I have used up my time.

Dr. Roe.

Mr. ROE. Thank you, Mr. Chairman. Good points made.

Colonel, a couple of questions I have is, why are active-duty suicides increasing? Is it the multiple deployments? Is it military occupations speciality (MOS)? Is it a difference between Iraq and Afghanistan? Is it the length of service? Are there more Reservists than active duty? I mean, I don't have any of that information to know who to target. And let me just give you an example.

The question I have is, is training going on for the young officer corps and the NCOs to identify—because I read an article in the paper a week or 2 ago where apparently this is going, this training is going on, a young soldier's buddy recognized that he might be having problems, took the firing pin out of his weapon. And when he attempted to commit suicide, the weapon didn't fire.

And he later got help and is now doing fine.

And is that training going on now for the online on-duty soldiers? And the other information, is it available and why is it increasing? Why do you we think it is?

Colonel SAUM. Yes, sir, excellent question and a complicated answer. The training is ongoing, and General Casey has introduced a program called Comprehensive Soldier Fitness. And it addresses not only the physical fitness but the mental health fitness and resource availability to the NCOs and the officer corps so that training, you are correct, is going on and the buddy-buddy system of taking care of each other is one of the primary things that that program addresses.

The statistics you are looking for about what are the primary causes for increased suicide among soldiers, I would have to take that to record and get back to you. I believe there are data points that have been collected, but I have been sitting in this chair 14 days and I have not been exposed to it.

[The DoD subsequently provided the following information:]

While the data show an increase in suicide rates among active-duty servicemembers, the primary causes of these increases are not definitively known. The causes for suicide are multifactorial, interlinked, cumulative, often repetitive, and progressive over a period of time. Demographic risk factors include male, Caucasian, E-1 to E-4, younger than 25-years old, GED or less than high school education, divorced, and in the Regular Component (active-duty, including National Guard and Reserve). Other potential contributing factors can include real or perceived relationship, financial, and/or legal difficulties. Loss of protective factors may stem from having lowered social and family support during deployment.

The Department of Defense Suicide Event Report (DoDSER) is a monitoring tool designed to facilitate standardized data collection and reporting across DoD. Over 250 data points per suicide are captured including personal characteristics, historical factors, suicide event details, and clinical history. Over time, the DoDSER can help the DoD better identify potential risk factors for suicide events and help inform areas to focus prevention efforts.

Mr. ROE. I think the importance of it is that if your training doesn't do anything good, if there is not training to pick up the indicators of who might commit suicide; in other words, if somebody has been to Iraq four times are they much more likely, or whatever, if my MOS is combat or medic or whatever, it may be there are identifiers out there that you could look for.

Colonel SAUM. Absolutely, sir. And one of the things we are finding, and I will get that report to you, is that it is the first deployment we see the most suicides. It appears that repeat deployments, there is a decrease of suicide among redeployed individuals.

[The DoD subsequently provided the following information:]

A report, pending publication by the American Association of Suicidology*, analyzed suicide risk associated with deployments. Analysis of suicide risk associated with deployments was demonstrated by comparing Service suicide rates in 2005 when all Service's rates were within historic norms, with suicide rates in 2007, which were higher across the Services. The analysis indicates that among the Regular Component of the Army, risk of suicides, measured by an odds ratio, dropped from 1.60 for one deployment to 1.10 for two or more deployments in 2005 and the ratio dropped from 2.03 to 1.25 in 2007. The difference was not as dramatic for the other Services. However, it is important to keep in mind that the Army deployed the most and had more suicides compared to the other Services. The results of this analysis may illustrate the "healthy warrior effect," which refers to servicemembers who are more at risk of suicide being removed from the pool of servicemembers, because unfit servicemembers are not deployed. In 2007, for both the Air Force and Army, there was a much greater increase in deployment/no deployment suicide risk odds ratios compared to the Navy and Marines. A possible explanation may be the increasing lengths of deployment over that period of time for both the Air Force (4 to 6 months) and Army (12 to 15 months), while length of deployments for the Marine Corps and Navy did not change.

* July 2010—Manuscript submitted for publication, *The Journal of Suicide and Life-Threatening Behavior*. "A study of suicide incidence and risk in an Active Duty United States Department of Defense population." Hyman, J., Frost, L.Z., Ireland, R., Cottrell, L.

Mr. ROE. I think that is a very important right there; that is an incredibly important piece of information, I think.

And this is for Dr. Kemp and Dr. Jesse, and has the VA—and obviously most veterans don't commit suicide. Most veterans if you look at the vast majority of us, we don't. You have 23 million of us running around, we don't.

Have we done those same identifiers in the veteran population and are we screening for that so you can pick those folks out and not have to wait until you get to a hotline to make a call in the middle of the night?

Ms. KEMP. We are, sir. We know a lot about the veterans who do die by suicide in the VA. We know about their characteristics and have implemented several screening programs to help us identify those ahead of time. We do have what we call a high risk list that we place veterans on if they meet our high risk criteria, which ensures that they get what we call an enhanced level of care with safety plans that you heard about earlier and other sorts of treatment modalities.

The other news is that we do know that veteran suicide rates have decreased in the time period from 2001 to 2007 among those veterans who get care within the VA.

Mr. ROE. Is the suicide rate different in the 15 million of us that are not in the VA system versus 8 million who are?

Ms. KEMP. Yes. The suicide rate actually among veterans who get care within the VA is slightly higher, but we believe that is because of case mix and the high risk nature of veterans who do get care within the VA, especially in our older population groups. But we have been able to decrease that rate over the past 6 years.

Mr. ROE. I agree with you on that. It depends on who you are seeing. So the group at the VA, the rate is higher but you are right, it may be more indigent.

Ms. KEMP. People at risk in general.

Dr. JESSE. I would like to just tack on to that just as an example of the very high touch and close hold on this. In these patients that are on that high risk designation the suicide coordinators will literally put the hotline phone number into their cell phones so that they have it readily handy as part of their risk plan.

Mr. ROE. I think one of the most important people—and Tim hit on this just a minute ago when he was speaking—is the person most likely to observe your behavior is the person closest to you, the guy next to you, he is going to watch out for you the most and that is your buddy, your family, in this case for a veteran it may be the wife, the child, the worker at your job. So those are the folks that need to keep an eye on us. And I also think—and I am closing. My time is up, too—that the VSOs have a tremendous opportunity to help here. I think that the American Legion, Vietnam-era veterans, and Iraq, all of those organizations I think are doing a wonderful job at making veterans more aware that there is help out there and thank them for that.

Dr. JESSE. Absolutely. If I might I think also it is important to mention the chaplain services, I think both in the Department of Defense and VA, in their outreach programs into the community chaplaincies to teach them particularly for the Guard who are going home not with the benefit of going home as a unit what to look for, so that the chaplains know that there are particular issues with the veterans that they need to watch out for and they can counsel the families and intervene early on. I think this very comprehensive approach is extremely important.

Mr. MITCHELL. Thank you. Just excuse me just a minute, Mr. Walz. I have heard also that there has been an increase in the suicide rate among chaplains. And I don't know if you have looked at that at all but I have heard because they are seeing the same thing veterans are seeing and talking to them and there is real work that needs to be done with chaplains that should be done.

Dr. JESSE. Gosh, I am not aware of that, but I certainly will look into that and get back to you.

[The DoD subsequently provided the following information.]

There were four active-duty and one reserve chaplain suicides in the FY 2007–2010 time period. Data by year and by Service are below.

Chaplain population numbers are:

2,800 active-duty chaplains in FY 2007;
 2,900 active-duty chaplains in FY 2008;
 211 Naval Reserve chaplains in FY 2009;
 2,973 active-duty chaplains in FY 2009; and
 3,023 active-duty chaplains in FY 2010.

The chaplain suicide numbers are too small to perform a statistical test for trends.

FY 2003: Army 0; Navy 0; AF 0
 FY 2004: Army 0; Navy 0; AF 0
 FY 2005: Army 0; Navy 0; AF 0
 FY 2006: Army 0; Navy 0; AF 0
 FY 2007: Army 1; Navy 0; AF 0
 FY 2008: Army 2; Navy 0; AF 0
 FY 2009: Army 0; Navy 1 (Reserve, not on duty); AF 0
 FY 2010–Present: Army 0; Navy 0; AF 1.

Mr. MITCHELL. Thank you.

Mr. Walz.

Mr. WALZ. Thank you, Mr. Chairman, and thank you all for being here. You certainly could have chosen to do something else, go into the private sector. You did not, you chose to serve our Nation and our veterans, and for that I am incredibly grateful.

I think you hear from us, and I said it before, I am the staunchest advocate of our VA and the care of our veterans and because of that I also can be some of the harshest critics. I think that is how I am as a parent I guess, too, because we care so deeply to get this right. But I don't think we say it enough. Thank you for all you are doing.

I think it is a great step to have DoD and VA sitting at the same table. It is something around here we don't see that much and I will be honest with you I will get criticism for saying this but I am going to say it, but we have no one here from Armed Services Committee sitting with us. And I don't know why we can't do joint hearings. I don't know why we can't get together on this because we will ping pong it back and forth. And it is a very frustrating thing.

I don't want to send Tom off back there, but Tom, until you and I think of a better name the seamless transition will come back and I will ask on this.

Dr. Roe was hitting on a very important point here on data driven and I applaud him for that and I know that that is where all of you operate from, too. And we need to do better with that. We need to have that data.

I would just ask a question because I am curious about this, we were discussing the VA, active and all that, society as a whole because sometimes I think we need to be very careful with the VA. We had a hearing this week, very critical, and an error that shouldn't have happened down in St. Louis. It happens once in a while. But the one thing is I think we need to be clear is the VA reports medical errors, the private sector does not at the same level of scrutiny and things like that. So I am just wondering, obviously

with this risk factor, but I would think there are some comparative peer groups out there, police officers, firefighters in tough areas or anything if we are seeing that. Are we bringing in those lessons learned? Are we bringing in those best practices from those? And maybe Dr. Kemp, it may be, or Dr. Jesse start out coming on your side of things.

Dr. JESSE. That is actually very true and a very important statement and why I think that the dialogue about suicide needs to address vulnerable populations like those people who have post-traumatic stress disorder, if you will, which is not limited to veterans. It includes clergy and firefighters and the like, but very important that this become a national dialogue. It is not a dialogue about veterans, it is a dialogue about suicide and identifying people at risk, identifying the warning signs and, as was pointed out, it is knowing that the families, the people who are closest to those folks, the clergy are the first to see those signs and need to be both empowered and have access to the kind of help that they need to help prevent suicides.

Mr. WALZ. I think it is true. I think it is a true statement, and we will hear from Dr. Kemp, because I think the systemic issue here is mental health parity and society in general reaction to it. So I think that is a very important point that we need to broaden this because I think to a certain degree you may be swimming upstream as the VA, and we have that responsibility, and all those who have said it, until we get everyone right we won't rest, but we may get some help from the outside on that.

Ms. KEMP. One of the things we made a conscious decision about in the beginning of the inception of our suicide prevention program and hotline was that we did want to partner with the Nation in addressing this issue. So our hotline actually was founded through interagency agreement with the Substance Abuse and Mental Health Services Administration (SAMSHA) and we have decided that we all need to have the same number available to call for help, whether you are a veteran or a community member or a service person, I mean that there are some options on that one national number if you are an active-duty servicemember or a veteran.

But as a result of that, what we have been able to do is garner in all of the national resources, through SAMSHA, using national data, being able to look at best practices, be a part of the SAMSHA best practice registry and both the DoD and VA have partnered with them.

Mr. WALZ. That is smart and I know that no one is as frustrated as you if we are failing on certain areas. But I think it is a broader dialogue.

I want to end with just a quick question to Colonel Saum. First of all, your personal story is very powerful. And when you tell that story about your son that makes a huge difference and they have the right guy in the right job now and I feel good about that. The Yellow Ribbon Campaign is something that originated as a long-time member of the National Guard in Minnesota. I watched this from its inception, infancy to being implemented. How are we dropping the ball on IRR soldiers? How are we dropping the ball on our first panelists where they get the ball dropped on that? How does that happen, Colonel?

Colonel SAUM. Sir, I think that was very well addressed. It is a communication education, but most importantly, we are not giving them the skills when we demob. They do get the pamphlets. They do get the information about what the resources are. There is not a skill level of how to call, who to call or reaching the families of the IRR member. I think that is one of the key elements we need to focus on, who is getting that information. As Dr. Roe said, the buddy, and the buddy for the IRR is the family and the people in the community. And I think that is one of the things we have to focus on as we reorganize that ourselves and put that information out.

Mr. WALZ. Are you confident we can capture those, that we can get that safety net under those IRR soldiers, too?

Colonel SAUM. I believe we can do much better, sir.

Mr. WALZ. Thank you and I yield back.

Mr. MITCHELL. I would just like to ask Dr. Jesse another question. Dr. Berger on the last panel mentioned the Blue Ribbon Committee, titled the Blue Ribbon Work Group on Suicide Prevention in the Veteran Population. And then he goes on to say, however, it has been almost 2 years since the Blue Ribbon Work Group finished its work and we have yet to see any formal action plan that addresses each of the Group's findings and recommendations in a comprehensive prioritized fashion.

Are you aware of this Blue Ribbon Committee and its findings?

Dr. JESSE. I am aware of the Committee. It has been my understanding that those issues have been addressed, but I would like to refer the specifics of that to Dr. Kemp.

Ms. KEMP. We certainly formed a suicide prevention steering committee after the Blue Ribbon panel gave us their findings back. We do have a plan and have addressed each one of those recommendations. We have completed the major recommendations and most of the additional key findings. We continue to meet on a regular basis, and I will be glad to supply that plan and where we are on those recommendations to you.

Mr. MITCHELL. Not only myself but I think the VSOs ought to know this. People ought to know if we spend money on a Blue Ribbon Committee and no one believes that anything is done, this just reflects bad.

Ms. KEMP. Right. The past 2 years of my life have been spent completing those, so we would be glad to share that.

Mr. MITCHELL. I think you ought to share those with Dr. Berger.

Ms. KEMP. We will be happy to.

[The VA subsequently provided the following information.]

The Blue Ribbon Panel recommendations and outcomes are attached. These items are in the Suicide Prevention Strategic Plan which continues to guide the current the current Outreach program.

Attachment A—Blue Ribbon Work Group on Suicide Prevention—Recommendations

Key Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 12/00/09
1	VHA should establish an analysis and research plan in collaboration with other Federal agencies to resolve conflicting study results . . . to ensure . . . a consistent approach to describing the rates of suicide and suicide attempts in veterans.	An initial review of methods used in published and unpublished veteran suicide reports has been conducted. This document will be circulated shortly to the Federal Work Group. Planning is underway for a face-to-face meeting of the Work Group for late January/early February to review differences in calculating veteran suicide rates and definitions of suicide attempts. Methodology for a potential study of veteran suicide will also be developed and discussed at the in-person meeting.	Workgroup has been established and is making recommendations for joint use of both national and agency data. A common nomenclature system has been adopted by both the VA and the DoD and is in varying stages of implementation. See # 4 on Attachment B.
2	VA should revise and reevaluate the current policies regarding mandatory suicide screening assessments.	A VA work group completed a review of VA current practices as well as the evidence-base on screening and the evaluation of suicidality. It recommended continuation of VA's current policy requiring a clinical evaluation of suicidality for evaluation of patients who screen positive for conditions such as depression and PTSD. It further recommended use of a clinical reminder, currently available, with four standardized questions from VA's Suicide Prevention Pocket Care, to guide the clinical evaluations.	Recommendation is completed. Current policy continues, clinical reminder is built, implemented and being used on a daily basis.
3	Proceed with the planned implementation of the Category II flag with consideration given to pilot testing the flag in one or more regions before full national implementation.	Based on experience with 6 months of pilot use, the Category II flag has been implemented nationally, with use monitored by the National Suicide Prevention Coordinator. There have been no reports of unintended consequences related to privacy issues. There are still 9 sites that do not have any patients "flagged" as of December 1st. All of these sites indicate that they do have processes in place to being flagging as of some time in December. This program will require continued monitoring.	Category II flag is still in place and fully implemented. Flagging program is placed and tracked in 100 percent of facilities.
4	Ensure that suicides and suicide attempts that are reported from root cause analyses use definitions consistent with broader VHA surveillance efforts.	VA's National Center for Patient Safety and the National Suicide Prevention Coordinator have reached consensus on terminology and definitions, and are using them as a basis for coordination of their suicide prevention activities.	Common nomenclature terms have been implemented and all aggregate RCAs are now sent to the Office of Suicide Prevention, Single RCA's go to the NCPS and are tracked as part of the patient safety program, The Office of Mental Health and NCPS share information regularly.

Attachment A—Blue Ribbon Work Group on Suicide Prevention—Recommendations—Continued

Key Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 12/00/09
5	VHA should ensure that specific pharmacotherapy recommendations related to suicide or suicide behaviors are evidence-based.	Plans regarding a national "academic detailing" program are being reviewed as a component of the draft VHA Comprehensive Strategy for Suicide Prevention.	Program fully implemented and funded for FY 2011.
6	VA should continue to pursue opportunities for outreach to enrolled and eligible veterans and to disseminate messages to reduce risk behavior associated with suicidality.	Based on evidence for a positive impact of the Washington, DC pilot program, VA is expanding its public awareness advertising campaign to additional markets. In addition, VA has developed a released public service announcements that have been broadly used.	National public awareness plan put into place for FY09 and FY10 including multimedia and public transit systems. FY11 plan in development with the use of an outside public relations firm.
7	The issue of confidentiality of health records of Operation Enduring Freedom (OEF)/OIF servicemembers who receive care through the VHA should be clarified both for patient consent to care and for general dissemination to Reserve and Guard servicemembers contemplating utilizing VHA medical system services to which they are entitled.	VA policy on sharing of clinical information with DoD needs to be specified by senior leadership.	Discussions continue. This is an ongoing issue and we continue to work on policy to guide us.
8	In order to maximize the effectiveness of the Suicide Prevention Coordinators program, it is recommended that there be ongoing evaluation of the roles and workloads of the SPC positions.	The National Suicide Prevention Coordinator continues to monitor the work load and activities of the facility-based suicide prevention teams.	Ongoing and monthly reports and scorecards demonstrate ongoing work of the SPCs.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
1	Adopt a standard nomenclature/definition for suicide and suicide attempt that is consistent with other Federal organizations such as the CDC and the scientific community.	VA awaits action from CDC, the Federal lead on nomenclature, definitions, and standards for self-harm and suicide related events.	New nomenclature system adopted and implemented in VA with expectation of continued training and implementation.
2	Prepare a single document that details the comprehensive suicide prevention strategic plan outlined to the Work Group in different briefs and documents in order to facilitate more efficient review of suicide prevention progress.	The draft VHA Comprehensive Plan for Suicide Prevention, modified during the concurrence process, awaits review by senior leadership.	Suicide Strategic Plan in place.
3	The VHA framework for suicide prevention should consider a public health approach that goes beyond secondary and tertiary prevention.	See response to item 2.	See above.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan—Continued

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
4	Portfolio for suicide research across VHA should be expanded with suicide prevention prioritized as a research area.	<p>1. Specifically related to suicide prevention, HSR&D DHI 08–096: Outcomes and Correlates of Suicidal Ideation in OEF/OIF Veterans; Steven K. Dobscha MD; VA Medical Center, Portland; Portland OR; Funding Period: October 2008–September 2011.</p> <p>2. From the August 2008 HSR&D review, one additional study that specifically addresses suicide prevention is likely to be funded when the IRB approval is received.</p> <p>3. Of the 23 mental health related (substance abuse, depression, TBI, PTSD) HSR&D proposals in review this cycle (March 2009), one is specifically related to suicide prevention.</p>	Portfolio is growing and being monitored.
5	Consider establishing an Advisory Board of key VHA stakeholders involved in suicide prevention education treatment and research to monitor and evaluate suicide programs and policies on an ongoing basis, establish research priorities and provide advice to senior VHA leadership on existing and new initiatives.	The Advisory Board has been convened. It meets monthly by conference call. Agendas and minutes are posted on its SharePoint site at http://vaww.national.cmop.va.gov/MentalHealth/VHA%20Suicide%20Prevention%20Steering%20Committee/Forms/AllItems.aspx .	Advisory Board established and meets monthly.
6	The VA's efforts to reach out to community emergency departments to improve care for active service and veterans at risk for suicidal behavior are encouraged.	<p>Funding for the SAFE VET demonstration project for FY 09 has been sent to the COE at Canandaigua. Completion of the project will require approximately \$2 million in FY 2010 and in FY 2011.</p> <p>The protocol as submitted from the COE is attached below. In response to VACO input, the evaluation component has been revised to include information about the timeliness and processes for the transfer of care from community setting to VA.</p> <p>The SAFE VET team is working on developing the infrastructure for this project, which includes confirming the project sites and the recruitment of the Acute Service Coordinators at the VA hubs sites. The team is also planning for the training of the Acute Service Coordinators during early-mid February 09, and developing a common database for data collection to be housed on a secure server at the Canandaigua VA medical center.</p>	SAFE VET project on-going.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan—Continued

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
7	The VA should continue its efforts to promote training in implementing suicide prevention programs.	<p>Ongoing training for the Suicide Prevention Coordinators and their teams is continuing on an ongoing basis. The next formal, large scale training will be coordinated with the VA–DoD National Suicide Prevention Conference to be held in San Antonio during the week of 1–12–09.</p> <p>More detailed plans for continuation of training are included in the draft VHA Comprehensive Strategic Plan for Suicide Prevention that is currently being reviewed by Senior Leadership.</p>	Annual DoD/VA conferences established. January 2010 was held in Washington DC. March 2011 is arranged in Boston.
8	Promising followup interventions designed to prevent veterans identified as being at risk from “falling through the cracks” should be evaluated and, if deemed effective, implemented further.	A report on the Caring Letters program is included in the Facility Report Care attached to the update for Key Recommendation 8.	Caring letters continued. Safety planning as an intervention implemented and continues.
9	The VA should work collaboratively with other Federal agencies to understand and evaluate the implications of new technologies for suicide prevention (e.g., social networking, text messaging, etc).	<p>The general issue remains on the agenda for the Federal Partners Work Group on Suicide Prevention.</p> <p>The National Suicide Prevention Coordinator and the COE in Canandaigua have developed a Web Based Chat Room program that would connect veterans accessing a highly publicized, non-VA Suicide Prevention Web Site with professional responders at Canandaigua. The Chat Room would be anonymous and private. The primary goal would be to facilitate calls to the Hotline or help-seeking at VA facilities. Implementation of the Chat Room project is on-hold, awaiting permission to either load the needed software on VA computers, or for providing VA responders with authorization to use non-VA computers for this program.</p>	On-going. VA Chat Service implemented in July 2009 and continues to receive chats.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan—Continued

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
10	The VA should design and disseminate psycho-education material for families of veterans who are at risk for suicide, particularly, those hospitalized for suicide attempts.	<p>Dissemination of the Resource Guide for Family members is underway. Dr. Kemp has forwarded it to Suicide Prevention Coordinators and Dr. Karlin to Home Based Primary Care Mental Health Providers. The guide is also posted on the Veterans Integrated Services Network (VISN) 19 MIRECC Web site—http://www.mirecc.va.gov/vsn19/docs/Resource_Guide_Family_Members.pdf</p> <p>A product under development is a brief guide for parents to assist them in discussing family member suicide attempts with their children in a developmentally appropriate manner.</p>	Completed.
12	VA should review approaches for better integrating VA chaplaincy and pastoral care services and traditional mental health services. . . The Work Group further recommends that the VA collaborate with other public and private partners to reach out to faith-based communities that can assist veterans at risk.	This is included in the VHA Comprehensive Plan for Suicide Prevention that is currently under review by senior leadership.	See strategic plan—this is an on-going item.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan—Continued

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
13	Work Group recommends that the VA implement a gun safety program directed at veterans with children in the home, both as a child safety measure and as a suicide prevention efforts.	<p>Funding has been sent to the COE in Canandaigua New York to implement this program for FY 09.</p> <p>The draft of the Statement of Work document with the National Shooting Sports Foundation (NSSF) is awaiting final cost figures for the education materials and gun locks from the Foundation. The draft of the Sole Source Justification document utilizing the unique program operated by NSSF has been completed. It is anticipated that the contract will be awarded by the end of January 2009. Five hundred thousand gun locks will be delivered to the 153 VA Medical Centers within the first year of the 3 year program. Under the current timetable, gun locks should start to arrive at VA locations on May 1st, 2009. It is anticipated that gun locks will be available to veterans, their families and VA employees through collaboration with the VAMC Police Departments and other points of contact. Each VA facility will be responsible for development of a locally specific policy for distribution of the gun locks and educational materials. The Center of Excellence is currently developing the process for tracking distribution and collecting data.</p>	Currently in year 2 of a 3 year project. Several hundred thousand gun locks have been distributed.
11	For veterans who exhibit chronic suicidal behavior, and who do not respond to short term therapies, more intensive modalities should be considered. Additionally, the evaluation of intensive outpatient alternatives to hospitalization should be promoted.	Following his initial evidence summary suggesting that Dialectical Behavioral Therapy (DBT) may be effective in preventing suicidal behavior specifically in patients with Borderline Personality Disorder (BPD), Dr. Karlin evaluated rates of BPD diagnoses at all medical centers, and found several facilities with exceptionally high rates. One, Portland, was in a geographical area with high suicide rates. In evaluating services at this facility, he found a well-established DBT program. The next step in evaluating need and feasibility for enhancing DBT programs in VA will be a survey of other facilities to account for, quantify, and document where and to what extent DBT is currently available throughout the system, and to relate its availability to diagnoses of BPD.	DBT training programs being implemented and DBT treatment is being used throughout VA. Additional EBT programs established.

Attachment B—Blue Ribbon Work Group on Suicide Prevention—Strategic Plan—Continued

Other Recommendations	Summary Recommendation	Progress as 12/31/08	Status as of 10/00/2010
14	The Work Group recommends that VA analyze entitlement changes required to allow treatment of combat related conditions to reduce suicides in un-entitled veteran populations. Currently, VA treatment of mental health and substance use disorders in some combat veterans is not allowed because of the category of their discharge, such as dishonorable discharge. Congressional authorization to treat some combat conditions in this population may enhance their outcomes and reduce suicide.	As previously noted, implementation of this recommendation could only be accomplished through Congressional action.	Closed. New PTSD legislation has been helpful.

Program Office: Office of Mental Health

Mr. MITCHELL. I would like also to thank Colonel Saum for your service, your son's and your family's because your wife is as much of what we are doing here as you and your son. So I want to thank you for your service.

And I want to ask kind of a followup on Mr. Walz very quickly, when a person is in the Ready Reserve and not on active duty, are they under the, I guess they are under VA and not DoD, when they are called active duty they go under DoD. Is there a disconnect sometimes between when a person is in between deployments?

Colonel SAUM. I am sorry, sir, deployments or active duty to Reserve you mean? I believe that is what you mean.

Mr. MITCHELL. Right, I am sorry.

Colonel SAUM. No. It is a seamless transition as far as the benefits when you come from the Reserve Component National Guard to active duty because the pre-mob that they do at the Reserve Guard units gets the families enrolled and gets the individual enrolled. Where we are looking at—and we have a program called Transition for when they demob and they are leaving, say, Fort Sill, Oklahoma, and going to California, that transition program is in place and giving them the information during transition home for resources that they would have for resources within the DoD.

Mr. MITCHELL. So when that soldier goes back to California he is now under the VA system, not DoD?

Colonel SAUM. No. There is a transition system where he is still covered by us.

Mr. MITCHELL. Thank you. And again Dr. Roe.

Mr. ROE. Just very briefly, I am sitting here, I sat here today and heard a lot of compelling testimony and I am trying to get a take-away from this, and part of it is, I believe, and one of the things I am going to do is make sure that it is on my official House Web page, that that hotline number is on there; number two on my campaign Web page that I put it on there and veterans have access to it. So I would encourage all of our House Members to do those two things. You can cover a lot of people. We get a lot of hits on the Web site.

The other that I hadn't appreciated as much is how the Committees, our own Committees, haven't interacted, and it has been brought, Sergeant Major Walz brought it up, the Chairman brought it up, and Mr. Hall brought it up, about how the Armed Services Committee and this Committee haven't coordinated this at all, and so I don't really see as much coordination between DoD and VA as I think we need and I need a little better clarification on what the DoD is doing in training the buddies. I think that may be going on right now. I believe that General Casey said he is in the process of doing that. I think this Committee needs to know how that is going on and then how that information can be shared with the VA, so that we know that soldiers who have maybe been trained to look for things in their buddies that that is actually being done, because I believe that has as much to do with it on the active-duty side than the VA, the veterans side where I am, and where the sergeant major is, is a totally different issue and are we doing enough there. And I am not there yet that we are.

I really appreciate you being here, all the witnesses being here, and Colonel, so much, I look at your chest and you are a patriot and I appreciate you coming back on the service to help veterans and help active-duty soldiers.

Colonel SAUM. Thank you, sir.

Mr. MITCHELL. Again on behalf of this Committee and the Congress, we want to thank all of you for your service. I do want to let you know that there will be followup with these questions from our Committee staff. And with that this hearing is adjourned.

[Whereupon, at 12:25 p.m., the Subcommittee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Harry E. Mitchell, Chairman, Subcommittee on Oversight and Investigations

Good morning and welcome. I appreciate everyone being here today, and for your interests and concerns on the progress of suicide prevention outreach efforts. Before we begin, I want to acknowledge a positive step that the VA has taken recently to help veterans suffering from Post-Traumatic Stress Disorder, or “PTSD”. The VA recently announced that it is easing the evidentiary hurdle that veterans must clear to receive treatment for PTSD. This is a step in the right direction, and I am glad they’re doing it.

However, to be truly effective in reaching all the veterans who need help—not just those who are already showing up the VA and asking for it—the VA also needs an effective outreach strategy. We have 23 million veterans in this country—only 8 million of which are enrolled to receive care with the VA. The VA has an obligation to the 15 million who are not enrolled for care—not just the 8 million who are already enrolled. If these other veterans have PTSD—or are at risk for suicide—the VA has an obligation to reach out to them, as well—and let them know where they can turn for help. Last year, upwards of 30,000 people took their lives by suicide in the United States. Twenty percent of these deaths were veterans. Each day, an estimated 18 veterans commit suicide. By the time this hearing concludes—between one and two veterans will have killed themselves by suicide. These statistics are startling.

As you know, many of our newest generation of veterans, as well as those who served previously, bear wounds that cannot be seen and are hard to diagnose. Proactively bringing the VA to them, as opposed to waiting for veterans to find the VA, is a critical part of delivering the care they have earned in exchange for their brave service. No veteran should feel they are alone.

As Chairman of this Subcommittee, I have repeatedly called upon the VA to increase outreach to veterans who need mental health services and are at risk of suicide—and members on both sides of the aisle have urged the same. In 2008, the VA finally reversed its long-standing self-imposed ban on television advertising and launched a nationwide public awareness campaign to inform veterans and their families about where they can turn for help. As part of the campaign, the VA produced a public service announcement featuring Gary Sinise, and distributed it to 222 stations around the country that aired it more than 17,000 times. The VA also placed print ads on buses and subway trains. According to the VA’s own statistics, the effort proved successful. As of April 2010, the VA has reported nearly 7,000 rescues of actively suicidal veterans, which were attributed to seeing the ads, PSAs, or promotional products. Additionally, referrals to VA mental health services increased.

However, despite this success, late last year the public service announcement stopped airing. I don’t understand this. If anything, it seems to me we need to be increasing outreach to veterans at risk for suicide, not stopping it. It is my understanding the VA is planning to produce a new public service announcement, which will be ready by the end of this year.

However, the question remains—why did the VA stop running the first public service announcement while they work on the second one? How does it help veterans to go dark for more than a year?

While I commend the additional expansion in outreach that has grown in the way of brochures and other useful steps, I do not think the VA should suspend—even temporarily—outreach efforts like the public service announcement that have proven successful. It is also imperative for the VA to utilize and adapt to technology, including the use of *Facebook* and *Twitter* to reach the latest generation of veterans. Doing so, I believe will help transform VA into a 21st century organization and most importantly save lives.

Today, the Subcommittee is assessing the suicide prevention outreach program on national implementation and achievements. We have a wide range of testimony that will be presented today and I look forward to hearing all that will be said on this vitally important issue. We appreciate our panelists' dedication in the formulation of a more comprehensive and targeted suicide prevention outreach program. These struggling veteran's deserve our help, and we must work in a bipartisan way to ensure that the VA delivers it to them.

**Prepared Statement of Hon. David P. Roe, Ranking Republican Member,
Subcommittee on Oversight and Investigations**

Thank you Mr. Chairman.

I appreciate you calling this hearing today to review what the VA has done in the area of outreach to the veterans in our communities who are feeling vulnerable and uncertain of their future. I cannot imagine what goes through the mind of someone seeking to end their life, but we must do anything we can to ease their pain and help them through the crisis that they find themselves in, so that they can move forward and heal from the wounds from which they are suffering.

Public Law 110-110 was signed on November 5, 2007, by President Bush. This law, as part of the comprehensive program for suicide prevention among veterans provided that the Secretary may develop a program for a toll-free hotline for veterans available and staffed by appropriately trained mental health personnel at all times, and also designated that the Secretary would provide outreach programs for veterans and their families.

As part of this outreach, the VA contracted with the PlowShare Group, Inc. to distribute, promote and monitor a Public Service Announcement (PSA) featuring actor Gary Sinise, who played Lt. Dan in the movie "Forrest Gump," and also performs in the Lt. Dan Band. This moving PSA, which can still be found on *YouTube* (<http://www.youtube.com/watch?v=x1QXoVJQdDm>), encourages veterans to contact the toll-free national Suicide hotline number in an emotional crisis. According to PlowShare, their work on this campaign was successful, as they were able to generate nearly \$4 million in *donated* media, and the suicide hotline saw an increase in activity during the campaign.

The VA also piloted outreach advertising right here in the metro area of Washington, DC. Driving around the city and on the metro system buses and signs could be seen in various locations promoting the hotline to veterans.

What I look forward hearing today is the following: Have we seen a reduction in the number of veteran suicides since the inception of the PSAs; what plans are there to continue the PSAs now that the contract for the previous PSAs has expired; How has the National Suicide Hotline helped in the reduction of veteran suicides, and where do we go from here?

I am pleased that we have witnesses from our veteran community here today, as well as the VA, so that we can hear from everyone how useful the previous PSAs were, and what other kinds of outreach efforts need to be made to reach not just our older veteran population but our new veterans coming out of Iraq and Afghanistan. How is VA using new media to get information out to our new set of veterans who may not be aware of all the services the department provides?

We need to review and evaluate the success of these outreach efforts on an ongoing basis, and see where they can be improved, and enhanced, as well as how frequently they are being broadcast to the general public.

Again, thank you Mr. Chairman, and I yield back my time.

**Prepared Statement of Warrant Officer Melvin Cintron, USA (Ret.),
Manassas, VA (Gulf War Veteran and OIF Veteran)**

Distinguished Members of the Committee on Veteran Affairs, my name is Melvin Cintron. I am a veteran of both Desert Storm and the current war in Iraq. In Desert Storm I worked as a flight medic conducting forward area medical evacuation support of both U.S. and enemy injured and wounded personnel, both civilian and military with a large portion of those being children and a portion of those that died in transport in our aircrafts. Additionally, although I had been inactive for approximately 6 years, I also received notification of my reactivation into active duty beginning 2004 for a period of 18 months for the war in Iraq. While I could have chosen at that time to seek the avenue of many of those who were in my condition and

were activated I chose not to seek deferment or to make any attempt to shy away from my responsibility in responding to my country's call. I did this, as our oath requires, without purpose of evasion or mental reservation because I knew that if I did not go then some other father, mother, son or daughter would have to have the same painful conversation with their family that I had with my family when I received my letter, because someone else would have to go in my place because I didn't and that was not an acceptable option for me so I chose to answer this Nation's call and serve it proudly and honorably. In the first Gulf War I was submitted for a combat air medal for part of my efforts and the conduct of my duties in support of our units mission. In my second activation I was submitted and received the army's Bronze Star medal for my contributions and performance as the unit's aviation maintenance officer in the 1159th medical evacuation company. My and my team's combined efforts led to our unit having the following approximate statistics in our Medical Evacuation mission; over 2400 U.S. Military, over 700 U.S. civilian and Coalition and more then 150 EPW (Enemy Prisoners of War). Within these there where over 2100 Litter patients and over 1700 ambulatory

While I feel that I served honorably and at great cost to myself financially, physically and mentally and to my quality of life, and at a much higher cost to my family and my children and yet I have no regrets of having answered a call and would proudly do so again. And yet my sacrifice to me seems so small and I consider myself often ashamed to enter the VA to seek help when I have seen so many of my colleagues who have faced so much of a higher price than I and some who I've seen pay the ultimate price. I have never been nor will I ever be ashamed of the service that I have performed for my country nor will I ever cease to be proud of what I have seen my fellow soldiers do in answering their call to duty. This goes to a sharp and contrary contrast to the service provided by the VA to those men and women whom like me have served proudly and selflessly. When I walk into the VA medical center I see in the walls posters that say "it takes the courage of a warrior to ask for help", but I am here to tell you that it really should read not that "it takes the courage of a warrior to ask for help", but "it takes the courage of a warrior to ask for help from the VA". I can give countless examples of many of the failures encountered by our veterans daily in seeking help from the VA, but that is a different chapter. This Committee as I understand it is seeking input on the suicide prevention hotline and efforts of the VA. Make no mistake, I consider myself extremely blessed with all the blessings that God has and continues to bestow on me regardless of my deserving or not. But there are many who are not as blessed and their need for good timely help from the VA should never be compromised as I believe it is now. But I digress so I will state that I believe that the VA suicide prevention hotline and suicide prevention efforts in my singular opinion are not working. I often call the VA for medical appointments and there is a message that comes on and it says that if I or a loved one is at risk for committing suicide to call the suicide hotline. I'm here to tell you that while I have never considered suicide nor see that as an option in my life I have often desired someone to talk to or share with when I've had a bad day who would understand, however never would I consider calling a suicide hotline if it is not something that I see as an option in my life. I believe that there are many veterans whose faith might be different and for whom suicide is not as foreign a thing as I consider it to be in my life. However these veterans too seek no more than someone to talk to or help them get through a certain hour in their life. However the VA in my experience does not provide for that, what it provides for is suicide so a veteran would have to have reached the point of actually considering suicide to actually call the suicide hotline and I would submit that by then for some it could have prevented or that might have been prevented it would already have been too late. I am not an expert in these matters but I would think that providing for the mental well being of our returning soldiers in a manner that allows them to seek and get help without tying to them the stigma of "you are considering suicide so you need to call this number". In my 19 plus years since coming back from desert storm as well as in the last 5 years in coming back from Iraq this time I have met many veterans who have seen fit to talk to me about their experiences and who have broken down in the middle of telling these experiences to me. These have been things they've held in for a long time. I've asked them why they don't go to the VA for help already knowing the answer. I've also advised them of calling the VA and they too have shared with me that they are not suicidal nor would they want to risk such a label for fear within their job, their family or their social circles.

Much to my discomfort I interact with the VA on a regular basis and in all of the time that I interact with the VA I have been keenly aware of the suicide prevention and the posters suggesting that you call for help. What I have not readily and easily encountered is a system that puts strong emphasis, however if in all these

years of dealing with the VA I am ignorant of the easily accessible and readily available intermediate or non-suicidal hotline efforts going on then I apologize, however the fact that I don't know it means that that system needs help in its promotion, marketing and easy accessibility for our veterans to seek and receive help long before the point of resorting to a suicide hotline by which time I would consider we've missed the help opportunity.

As stated earlier, I am one who is blessed beyond anything I could ever earn. I have 2 arms to hug my children with, I have full sight to see my family and my blessings and 2 legs which easily led me here today to testify not for my need but in hopes that others who are not as blessed and who have need of better support from their government would hopefully receive it and if I can be a part of making their support easier then I am proud to have come and testified before this Committee. And I hope that instead of just suicide prevention that we also attack the problem at a point long before our system would lead another veteran to just a dire end. I am not aware of ongoing efforts but if not considered I would strongly recommend that those more learned than I would seek to establish a system of continuity support or life intervention type program that would address a basic need to our soldiers to talk without acquiring the stigma of, or being considered, a suicidal risk or at least without having the perception whether real or not that you need to talk a suicide hotline because you are now suicidal just because you wanted someone to talk to on any given day and in any given hour.

In addition to such a continuity support/life intervention program I also feel that a peer mentor program would be an effective approach to helping veterans before they reach the point of considering suicide. On a personal note, I just as many of my peers, was hesitant to make any formal approach to the VA or another medical facility to talk about any problems because of the stigmas I noted previously. However, if there are mentors or peers who had lived through the same experiences and with whom soldiers could express themselves as counterparts and receive guidance on how to deal with their emotions and move forward with their lives, this would have provided a much more approachable solution for their problems rather than a sterile doctor's office or an open forum. Only those who have lived through these experiences can truly listen and understand those who have.

However for such a program to be successful it must start not only at the VA but in our services. As an example, when returning from Iraq, as we out processed in Fort Dix, New Jersey, in an auditorium, a sergeant asked "Is there anybody here who feels they need to talk to someone about anything they saw or did?" Nobody raised their hand. He then stated, if you want to do it confidentially please sign the roster that will be in the adjoining room. On the day prior to our leaving the out processing center the sergeant again addressed the crowd of soldiers and with the pad in his hand he read out the names of those soldiers that had signed up confidentially for the offer made the previous day and asked do you still need to see somebody. Needless to say, nobody responded with a yes. I was one of those soldiers.

I further recommend that we have a program within each unit to help identify both formal and informal leaders within the groups that can be trained on a voluntary basis to be outreach mentors or peer confidants who could informally reach out as colleagues or fellow soldiers to talk to them as friends or as fellow soldiers who have been through similar situations and can equally share discussions outside of to structured a program although it could lean towards a more structured group help type program should it be needed down the road as they currently exist today (group therapy programs).

In a magazine I read many years ago there was a picture of a wall that was depicted as a wall where people were executed by firing squads it read "you have never lived till you've almost died, for those who fight for it, life has a flavor that the protected will never know" I would at that such a taste also has a price that no soldier should be left to pay alone.

I thank you for this opportunity and pray that my contribution may in some way help my fellow men and women of our armed forces and others who support our countries efforts in combat zones or in harm's way.

**Prepared Statement of Linda Bean, Milltown, NJ
(Mother of OIF Veteran)**

Mr. Chairman and Members of the Subcommittee.
Thank you for allowing me to appear before you. And thank you, Rep. Holt, for standing with me and my family.

I testify today because my son, U.S. Army Sgt. Coleman Bean, 25 and a veteran of two tours of duty in Iraq, shot and killed himself on Sept. 6, 2008. I am grateful for this opportunity; I have a duty to Coleman and I owe a debt to those with whom he served.

It is my hope that these observations, which are drawn from a shared experience of loss, will be useful to you as you oversee the continued development and implementation of suicide-prevention programs.

First, we need to accept these facts: Many veterans come home to families and towns that are a far remove from VA hospitals or Vet centers. Some veterans at risk for suicide would not describe themselves as suicidal and some veterans will not or cannot use VA mental-health services.

I believe it is crucial that the VA:

- Identify and publicize civilian counseling alternatives, including The Soldier's Project, GiveAnHour and The National Veterans Foundation.
- Partner with civilian organizations to assure that all vets have immediate access to a wide range of mental-health care, and
- Encourage media outlets to publish local information on mental-health resources for veterans.

Second, I believe it is critical to implement a simple, straightforward public information campaign geared specifically to veterans' family members and friends. It may fall to a grandmother, a best friend or a favorite neighbor to seek out help for a veteran who is suffering. Make information on available services easy to find and understand and publish it broadly. The suicide hotline number is not enough.

Help veterans help each other. The VA is confronting PTSD and suicide with new programs and new research, good and important work. But that hasn't always been the case and there are vets who will tell you that they have had to scrap and fight for every VA service they've received. In addition to the official patient-advocacy complaint resolution program, please establish a peer body—made up of the most feisty, tenacious veterans. They will help assure that no vet gives up because it just got too hard or took too long to navigate the VA system.

My son joined the Army when he was 18, enlisting on Sept. 5, 2001. The terrifying tragedy of Sept. 11 reaffirmed for Coleman the rightness of his commitment. Home on leave, he took a pair of socks that had been lovingly laundered by his mother and refolded them to comport with Army specifications. It was his intention, Coleman said, to be a perfect soldier.

In the days following Coleman's death, our family had the humbling opportunity to meet men with whom he had served; they traveled from around the country to be with us, and with each other. It was clear to us then that many of these men carried their own devastating burdens.

I spent hours on the telephone, trying to identify services for these young men, reaching out first to the VA facilities in the States where they lived. My inquiries netted mixed results.

A VA representative in Texas, horrified when I describe our fears for a young veteran there, said "just tell me where he is and I will go there. I'll get in my car right now."

By contrast, a man in Maryland was firm: "If they won't come here, we can't help them," he said.

That simply is not right. Of course we can help them and we can help their families. And it is our duty—not theirs—to figure out how.

**Prepared Statement of Timothy S. Embree, Legislative Associate,
Iraq and Afghanistan Veterans of America**

Mr. Chairman, Ranking Member, and Members of the Committee, on behalf of Iraq and Afghanistan Veterans of America's one hundred and eighty thousand members and supporters, thank you for the opportunity to testify before you today. My name is Tim Embree. I am from St. Louis, MO and I served two tours in Iraq with the United States Marine Corps Reserves. Veteran suicide is an issue that resonates with all of our members and we are grateful that you are holding this hearing. As an IAVA member recently told us:

"For most of the past year I thought about suicide almost every hour of every day, and I felt so ashamed for this. I wondered what was wrong with me, why I couldn't get rid of it."—IAVA Member

And this issue is of particular importance to me because I lost one of my Marines to suicide in 2005.

The Most Dangerous Part Of Going To War These Days Is Coming Home.

“Since my return, I have lost 2 close friends to suicide, 2... I said 2, from my platoon. That is the sick reality.”—IAVA Member

Last year, more U.S. servicemembers died by their own hands than in combat in Afghanistan.¹ Most Iraq and Afghanistan veterans know a fellow war fighter who has taken their own life since coming home. The numbers do not even include the veterans who commit suicide after their service is complete. They are out of the system and their deaths are often unknown and uncounted. Recently the Army Times reported “18 veterans commit suicide each day . . . an average of 950 suicide attempts each month [are] by veterans who are receiving some type of treatment from the Veterans Affairs Department”.² Worse yet, the Department of Defense (DoD) recently released numbers showing that we are on track to surpass last year’s 30-year-high suicide rate.

As the suicide rate of our servicemembers and veterans continues to increase, without any signs of abating, we must acknowledge that suicide is only one piece of the mental health epidemic plaguing our returning war fighters. Left untreated, mental health problems can and do lead to substance abuse, homelessness and suicide. A 2008 RAND study reported that almost 20 percent of Iraq and Afghanistan veterans screened positive for Post Traumatic Stress Disorder (PTSD) or major depression. A recent Stanford University study found that this number might actually be closer to 35 percent. Compounding the problem is the fact that fewer than half of those suffering from mental health injuries are receiving sufficient treatment.

Suicide Hotline is a Real Lifesaver.

The VA National Suicide Prevention Lifeline (800-273-TALK) is a 24-hour hotline for veterans in crisis, which fields nearly 10,000 calls a month. These calls have rescued more than 7,000 veterans wrestling with suicide.³ IAVA proudly supported the Joshua Omvig Veteran Suicide Prevention Act which established this important hotline. Our members continually inform us that they have used this valuable service for themselves and have referred it to their friends.

We know this because IAVA hosts an online community for Iraq and Afghanistan veterans to connect. Across the country, through *CommunityofVeterans.org*, they share their challenges and support one another as only they can. *CommunityofVeterans.org* also connects veterans with private and VA mental health support information—including the VA National Suicide Prevention Lifeline. Recently a veteran asked,

“How often do YOU think of suicide? It kinda creeps up on me every couple of days, I toss the idea in my head around a little bit, then tuck it away again till the next time. It mildly disturbs me because I don’t WANT (consciously) to kill myself, but sometimes it just seems easier.”—IAVA Member

One of the many veterans who reached out to this vet responded,

“Maybe you should call that National hotline, just to ask a couple more questions. I am pretty sure it’s a free service, and they’re there to listen a bit, and could tell you if it’s more serious or not.”—IAVA Member

For a veteran considering suicide, the act of reaching out to those close to them can often seem overwhelming. The act of a simple anonymous call to the VA’s National Suicide Prevention Lifeline might be enough to save the life of a veteran who is sitting alone, with a gun and a bottle of booze. Veterans in these desperate situations can’t wait for regular business hours to seek help. Thankfully, the National Suicide Prevention Lifeline is available 24 hours a day, 7 days a week.

The National Suicide Prevention Lifeline recently added a live chat feature which allows veterans to express their fears, anger, and sadness in a confidential manner, 24 hours a day, with a trained professional on-line. This on-line chat is a good way to reach suffering veterans not reachable through the hotline.

“When the online counselor said, ‘I hear you’ I knew I was going to be ok.”—IAVA Member

Outreach, Outreach, Outreach.

The Department of Veterans Affairs must develop a relationship with servicemembers while they are still in the service. Like many successful college alumni associations that greet students at orientation and put on student programs throughout their time in college, the VA must shed its passive persona and start

¹ In 2009, a record 334 servicemembers committed suicide.

² http://www.armytimes.com/news/2010/04/military_veterans_suicide_042210w/

³ http://www.armytimes.com/news/2010/04/military_veterans_suicide_042210w/.

recruiting veterans and their families more aggressively into VA programs. Once a veteran leaves the military, the VA should create a regular means of communicating with veterans about events, benefits, programs and opportunities. If a veteran received half as many letters and emails from the VA, as college grads do from their alumni association, we would be getting somewhere.

Moreover, the VA must aggressively promote all VA programs and reach out to veterans who have yet to access their VA benefits.

“The VA could be more aggressive in contacting OIF/OEF veterans and at least talking to them before the veteran has a mental health crisis. They need to be proactive instead of reactive.”—IAVA Member

To begin the shift from a passive to an active agency, IAVA believes the VA must prioritize outreach efforts and include a distinct line item for outreach within each VA appropriation account. This line item should fund successful outreach programs such as the OEF/OIF Outreach Coordinators, Mobile Vet Centers, and the VA’s new social media presence on *Facebook* and *Twitter*. In their current forms, these outreach programs are much too small to make a transformative difference. IAVA was disappointed that there were only a few brief mentions of outreach activities in the President’s VA budget submission. Regrettably, none of them were to a dedicated outreach campaign.

The VA’s current outreach campaign is disappointing. When the VA announced that it had placed ads on more than 21,000 buses nationally,⁴ to spread the word about the suicide prevention lifeline, we were initially enthusiastic; an image of the ad is below. When we saw the ad, it was clearly a failure. The ad has over 30 small print words; the average bus ad is limited to 5–10 words. In the short time in which a bus passes, a veteran would have to go by the bus repeatedly to even read the hotline number.

IAVA has run one of the largest non-governmental outreach campaigns in history, through a partnership with the Ad Council and some of the world’s best advertising firms. We have learned a lot about the best ways to communicate complex and serious issues through television and print. We are ready to work with the VA and share our expertise.



The World’s Best Mental Health Program Will Still Fail If No One Uses It.

The heavy stigma associated with mental health care stops many servicemembers and veterans from seeking treatment. More than half of soldiers and Marines in Iraq who tested positive for a psychological injury reported concerns that they will be seen as weak by their fellow servicemembers. One in three of these troops worried about the effect of a mental health diagnosis on their career. Even in an anonymous survey we conducted in December of last year, more than 10 percent of our members selected “prefer not to answer” in response to the question of whether they had sought care for a mental health injury. It is easy to conclude that those most in need of treatment may never seek it out.

“paradigm shift must occur. . . . ‘you’re a wimp if you see the wizard’ needs to go away and be replaced with ‘everyone needs someone’.”—IAVA Member

To end the suicide epidemic and forever eliminate the stigma associated with combat stress, the VA and DoD must declare war on this problem. They must launch

⁴<http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1707>.

a nationwide campaign to combat stigma and to promote the use of DoD and VA services such as Vet Centers and the National Suicide Prevention Lifeline.

This campaign must be well-funded, research-tested and able to integrate key stake-holders such as veteran service organizations and community-based non-profits. Furthermore, the VA must develop and aggressively deploy combat-stress injury training programs for civilian behavioral health professionals who treat veterans outside of the VA (e.g., college counselors, rural providers, behavioral health grad students, and professional associations).

The VA must allocate specific resources toward battling this dangerous stigma, or we will never see a critical mass of veterans coming in to seek help.

Department of Veterans Affairs, IAVA Has Your Back.

Through our own historic Public Service Announcement (PSA) campaign with the Ad Council, IAVA has learned a lot about stigma busting and veteran outreach campaigns. Millions of Americans continue to see our iconic PSAs, like the one featuring two young veterans shaking hands on an empty New York street.

“The *Iraq and Afghanistan Veterans of America* brilliantly portrayed this feeling of isolation in a 2008 ad where a soldier returning from the war walks through an empty airport. He continues through downtown Manhattan, which is also completely empty. No cars. No people. It isn’t until a young veteran approaches the soldier with a handshake, a smile and pat on the back saying, ‘Welcome home, man,’ that the street becomes populated.

I was a bit shaken the first time I saw it, as it immediately resonated with me. It hit an exposed nerve, and I knew that those guys at the IAVA ‘got it.’ They knew exactly where we were coming from.

The problem, of course, is that we, as veterans, live the rest of our young lives in the ‘civilian’ world and not on the battlefield. It took me several months to fully comprehend this. After realizing that my sense of isolation was alienating me from those I loved, I made the conscious decision to use my experiences in combat as a source of great strength, versus letting them become a weakness.”⁵

The TV ads are just one component of this groundbreaking campaign. They are complemented by billboards, radio commercials, and web ads which have blanketed the country and touched countless Americans. In just the first year of the campaign, IAVA secured \$50 million in donated media while reaching millions of veterans and their families.

This campaign is an example of the innovation coming out of the VSO and non-profit communities, which the VA should treat as an asset. This cutting-edge campaign directs veterans to an exclusive online community, mentioned above, that strongly shows our Nation’s new veterans that “We’ve Got Your Back”. It also directs them to a wide range of mental health, employment and educational resources—operated by both private non-profits and the Department of Veteran Affairs. Innovative, aggressive outreach programs like this should become part of the new VA culture and they can fuel-inject outreach efforts. IAVA is learning what works, and we want to share our knowledge.

“Eight Weeks To See A Counselor?”

“It took me over 6 months for a mental health appt through VA and this was after I told them I was having suicidal and homicidal ideations. I’m still waiting now for some appointments.”—IAVA Member

Convincing a veteran to overcome his fear of ostracism and choose to seek help is an uphill battle. We must ensure that when they do seek treatment, there is ready access to the necessary care. Regrettably, many of our veterans have complained about long wait times and inconvenient hours.

The VA must focus on dramatically increasing the number of mental health providers within the Department of Veteran Affairs. This increase will reduce wait times and improve overall quality of care.

“I went 80 miles to the local VA outpatient treatment facility, they did not have anyone on staff to talk to. They have group meetings, but again, its 80 miles roundtrip and I would have to be there by 4. I work till 5. That means that I would have to leave almost 2 hours early to drive 80 miles roundtrip just to talk to someone who had a similar experience. I can’t do that.”—IAVA member

⁵“Back from Iraq war, and alone.”, Mike Scotti, March 10, 2010; <http://www.cnn.com/2010/OPINION/03/10/scotti.war.veterans/index.html?iref=allsearch>.

“We need a ‘surge’ of mental health professionals! It is time the rest of the country steps up and begins to sacrifice as well.”—IAVA Member

Additionally, IAVA supports creative solutions for rural veterans. Many veterans live too far from local VA facilities to receive treatments at traditional brick and mortar VA facilities. We support contracting with local community mental health clinics and extending grants to groups that provide programs such as peer-to-peer counseling. Veterans must be able to receive mental health care near their personal support system, whether that system is in New York City or Peerless, Montana.

Our veterans are facing a mental health epidemic. Unless we address the overall issue of mental health stigma, we will never be able to stem the growing tide of suicides. The VA and DoD have created many programs that are extremely effective in helping servicemembers and veterans who are hurting. But great programs are worthless if servicemembers and veterans don’t know they exist, can’t access them, or are ashamed to use them.

IAVA is proud to speak on behalf of the thousands of veterans coming home every day. We work tirelessly so veterans know we have their back. Together, with this Congress and the Department of Veteran Affairs, every veteran must be confident that America has their back.

Thank you.

**Prepared Statement of Jacob B. Gadd, Deputy Director,
Veterans Affairs and Rehabilitation Commission, American Legion**

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to submit The American Legion’s views on progress of the Suicide Prevention efforts at the Department of Veterans Affairs (VA) to the Subcommittee today. The American Legion commends the Subcommittee for holding a hearing today to discuss this timely and important issue.

Suicide among servicemembers and veterans has always been a concern; it is the position of The American Legion that one suicide is one too many. However, since the war in Iraq and Afghanistan began, the numbers of servicemembers and veterans who have committed suicide have steadily increased. As our servicemembers are deployed across the world to protect and defend our freedoms, we as a Nation cannot allow them to not receive the care and treatment they need when they return home. The tragic and ultimate result of failing to take care of our Nation’s heroes’ mental health illnesses is suicide.

Turning first to VA’s efforts in recent years with Mental Health Care, The American Legion has consistently lobbied for budgetary increases and program improvements to VA’s Mental Health Programs. Despite recent unprecedented increases in the VA budget, demand for VA Mental Health services is still outpacing the resources and staff available as the number of servicemembers and veterans afflicted with Post Traumatic Stress (PTS) and Traumatic Brain Injury (TBI) continues to grow. This naturally leads to VA’s increase in mental health patients.

In 2008, RAND’s Center for Military Health Policy Research, an independent, nonprofit group, released a report on the psychological and cognitive needs of all servicemembers deployed in the past 6 years, titled, “Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery,” which estimated that more than 300,000 (20 percent of the 1.6 million) Iraq and Afghanistan veterans are suffering from PTS or major depression and about 320,000 may have experienced TBI during deployment.

The Centers for Disease Control and Prevention estimates 30,000–32,000 U.S. deaths from suicide per year among the population. VA’s Office of Patient Care and Mental Health Services reported in April 2010 that approximately 20 percent of national suicides are veterans. The National Violent Death Reporting System reports 18 deaths per day by veterans and VA’s Serious Mental Illness Treatment, Research and Evaluation Center reported about five deaths occur each day among VA patients. In a recent AP article, it was cited that there have been more suicides than servicemembers killed in Afghanistan.

The Veterans Health Administration (VHA) has made improvements in recent years for Mental Health and transition between DoD and VA such as the Federal Recovery Coordinators, Polytrauma Rehabilitation System of Care, Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) case management teams, integrating mental health care providers into primary care within VA Medical Center Facilities and Community Based Outpatient Clinics (CBOCs), VA Readjustment (Vet) Centers hiring of Global War on Terrorism (GWOT) Counselors, establishing

directives for TBI screening, clinical reminders and a new symptom and diagnostic code for TBI.

Regarding suicide prevention outreach efforts, VA founded the National Suicide Prevention Hotline, 1-800-273-TALK (8255) by collaborating with the National Suicide Prevention Lifeline where veterans are assisted by a dedicated call center at Canandaigua VA Medical Center in New York. The call center is staffed with trained VA crisis health care professionals to respond to calls on a 24/7 basis and facilitate appropriate treatment. VA reported in 2010 a total of 245,665 calls, 128,302 of which were identified as veterans. Of these veterans, 7,720 were rescues.

VA hired Local Suicide Prevention Coordinators at all of the 153 VA Medical Centers nationwide in an effort to provide local and immediate assistance during a crisis, compile local data for the national database and train hospital and local community on how to provide assistance. One of primary responsibilities of the Local Suicide Prevention Coordinators is to track and monitor veterans who are placed on high risk of suicide (H.R.S). A safety plan for that individual veteran is created to ensure they are not allowed to fall through the cracks.

In 2009, VA instituted an online chat center for veterans to further reach those veterans who utilize online communications. The total number of VeteransChat contacts reported since September 2009 was 3,859 with 1471 mentioning suicide. VA has also had targeted outreach campaigns which included billboards, signage on buses and PSA's with actor Gary Sinise to encourage veterans to contact VA for assistance.

The American Legion Suicide Prevention and Referral Programs

The American Legion has been at the forefront of helping to prevent military and veteran suicides in the community. The American Legion approved Resolution 51, *The American Legion Develop a Suicide Prevention and Outreach Referral Program*, at the 2009 National Convention. In addition, VA's National Suicide Prevention Coordinator Dr. Janet Kemp facilitated an Operation S.A.V.E. Training for our Veterans Affairs and Rehabilitation Commission members. VA&R Commission members and volunteers subsequently developed American Legion State, district and post training programs to provide referrals for veterans in distress with VA's National Suicide Prevention Hotline. The American Legion currently has over 60 posts with active Suicide Prevention and Referral Programs.

In December 2009, The American Legion took the lead in creating a Suicide Prevention Assistant Volunteer Coordinator position, under the auspices of VA's Voluntary Service Office. Each local suicide prevention office is encouraged to work with veteran service organizations and community organizations to connect veterans with VA's programs in their time of transition and need. The Suicide Prevention offices can increase their training of volunteers to distribute literature and facilitate training in order to further reach veterans in the community.

This year, The American Legion entered into a partnership with the Defense Centers of Excellence's Real Warrior Campaign to educate and encourage our members to help transitioning servicemembers and veterans receive the mental health treatment they need. Additionally, during our 2010 National Convention we will have a panel to discuss prevention, screening, diagnosis and treatment of TBI with representatives from DoD, VA and the private sector.

Challenges

Despite recent suicide prevention efforts, yet more needs to be done as the number of suicides continues to grow. The American Legion's System Worth Saving (SWS) program, which conducts site visits to VA Medical Center facilities annually, has found several challenges with the delivery of mental health care. VA has the goal to recruit psychologists from their current nationwide level of 3,000 to 10,000 to meet the demand for mental health services. However, VA Medical Center Facilities have expressed concerns with hiring and retaining quality mental health specialists and have had to rely on fee basis programs to manage their workload.

The American Legion applauds last year's action by Congress in passing Advance Appropriations for mandatory spending. However, problems exist in VA itself in allocating the funds from VA Central Office to the Veteran Integrated Service Networks (VISNs) and to the local facilities. This delay in funding creates challenges for the VA Medical Center Facility in receiving its budget to increase patient care services, hiring or to begin facility construction projects to expand mental health services. VA's 2011 budget provides approximately \$5.2 billion for mental health programs which is an 8.5 percent, or \$410 million, increase over FY 2010 budget authorization. The American Legion continues to be concerned about mental health funds being specifically used for their intent and that Congress continue to provide the additional funding needed to meet the growing demand for treatment.

Challenges in preventing suicide include maintaining confidentiality and overcoming the stigma attached to a servicemember or veteran receiving care. Additionally, the issue of a lack of interoperable medical records between DoD and VA, while being addressed by Virtual Lifetime Electronic Records (VLER), still exists. The American Legion has supported the VLER initiative and the timely and unfettered exchange of health records between DoD and VA. Unfortunately, DoD and VA still have not finalized both agencies AHLTA and VistA architecture systems since the project began in 2007, which limits DoD and VA's ability to track and monitor high risk suicide patients during their transition from military to civilian life. The American Legion recommends VA take the lead in developing a joint database with the DoD, the National Center for Health Statistics and the Centers for Disease Control and Prevention to track suicide national trends and statistics of military and veteran suicides.

The American Legion continues to be concerned about the delivery of health care to rural veterans. As mentioned, a nationwide shortage of behavioral health specialists, especially in remote areas where veterans have settled, reduces the effectiveness of VA's outreach. No matter where a veteran chooses to live, VA must continue to expand and bring needed medical services to the highly rural veteran population through telehealth and Virtual Reality Exposure Therapy (VRET). DoD and VA have piloted VRET at bases at Camp Pendleton, Camp Lejeune and the Iowa City VA Medical Center. VRET is an emerging treatment that exposes a patient to different computer simulations to help them overcome their phobias or stress. The younger generation of veterans identifies with computer technology and may be more apt to self-identify online rather than at a VA Medical Center or CBOC.

Both DoD and VA have acknowledged the lack of research on brain injuries and the difficulties diagnosing PTS and TBI because of the comorbidity of symptoms between the two. The Defense and Veterans Brain Injury Center (DVBIC) developed and continues to use a 4-question screening test for TBI today. At the same time, Mount Sinai School of Medicine in New York developed the Brain Injury Screening Questionnaire (BISQ), the only validated instrument by the Centers for Disease Control to assess the history of TBI, which has over 100 questions with 25 strong indicators for detecting TBI. Mount Sinai has published data that suggest some of the symptoms, particularly those categorized as "cognitive," when found in large numbers (i.e. 9 or greater), indicate the person is experiencing complaints similar to those of individuals with brain injuries. The American Legion wants to ensure that DoD and VA are working with the private sector to share best practices and improve on evidence-based research, screening, diagnosis and treatment protocols of the "signature wounds" of Iraq and Afghanistan.

Recommendations

The American Legion has seven recommendations to improve Mental Health and Suicide Prevention efforts for VA and DoD:

1. Congress should exercise oversight on VA and DoD programs to insure maximum efficiency and compliance with Congressional concerns for this important issue.
2. Congress should appropriate additional funding for mental health research and to standardize DoD and VA screening, diagnosis and treatment programs.
3. DoD and VA should expedite development of a Virtual Lifetime Medical Record for a single interoperable medical record to better track and flag veterans with mental health illnesses.
4. Congress should allocate separate Mental Health funding for VA's Recruitment and Retention incentives for behavioral health specialists.
5. Establish a Suicide Prevention Coordinator at each military installation and encourage DoD and VA to share best practices in research, screening and treatment protocols between agencies.
6. Congress should provide additional funding for telehealth and virtual behavior health programs and providers and ensure access to these services are available on VA's web pages for MyHealthyVet, Mental Health and Suicide Prevention as well as new technologies such as Skype, Apple i-Phone Applications, *Facebook* and *Twitter*.
7. DoD and VA should develop joint online suicide prevention servicemember and veteran training courses/modules on family, budget, pre, during and post deployment, financial, TBI, PTSD, Depression information.

In conclusion, Mr. Chairman, although VA has increased its efforts and support for suicide prevention programs, it must continue to reach into the community by working with Veteran Service Organizations such as The American Legion to improve outreach and increase awareness of these suicide prevention programs and

services for our Nation's veterans. The American Legion is committed to working with DoD and VA in providing assistance to those struggling with the wounds of war so that no more veterans need lose the fight and succumb to so tragic a self-inflicted end.

Mr. Chairman and Members of the Subcommittee, this concludes my testimony.

**Prepared Statement of Thomas J. Berger, Ph.D., Executive Director,
Veterans Health Council, Vietnam Veterans of America**

Chairman Mitchell, Ranking Member Roe, and Distinguished Members of the HVAC Subcommittee on Oversight and Investigations, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on "Examining the Progress of Suicide Prevention Outreach Efforts at the VA". We should also like to thank you for your overall concern about the mental health care of our troops and veterans.

The subject of suicide is extremely difficult to talk about and is a topic that most of us would prefer to avoid. Although statistics on suicide deaths are not as accurate as we would like because so many are not reported, as veterans of the Vietnam War and those who care for them, many of us have known someone who has committed suicide and others who have attempted it. But as uncomfortable as this subject may be to discuss, VVA believes it to be a very real public health concern that needs solutions now.

Suicide is most often the result of unrecognized and untreated mental health injuries. Depression, Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) are three of the most common mental health injuries and conditions that can lead to suicide. The three conditions in particular are medical conditions that can be life-threatening.

In more than 120 studies of a series of completed suicides, according to the American Foundation for Suicide Prevention, 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.

Consider the facts: earlier this spring, troubling data showed an average of 950 suicide attempts by veterans who are receiving some type of treatment from the VA. Seven percent of the attempts are successful, and 11 percent of those who don't succeed on the first attempt try again within 9 months. These numbers show about 18 veteran suicides a day and about five by vets receiving VA care. These numbers are simply unacceptable to both the veterans' community and the American public.

To be fair, since media reports of suicide deaths and suicide attempts began to surface back in 2003, the VA has claimed to have developed prevention strategies to reduce suicides and suicide behaviors that includes: the establishment of the Suicide Prevention Hotline in partnership with the Substance Abuse and Mental Health Administration; the institution of suicide prevention coordinator (SPCs) positions at all VA medical facilities whose duties include education, training, and clinical quality improvement for VHA staff members; increased screening and monitoring of individuals who have been identified as being at high risk for suicide; and research efforts utilizing cognitive-behavioral interventions that target suicidal ideation and behaviors. While these efforts are laudable, VVA continues to believe they have not gone far enough.

In May 2008, then-VA Secretary Peake chartered "The Blue Ribbon Work Group on Suicide Prevention in the Veteran Population". Its function was to provide advice and consultation to him on various matters relating to research, education, and program improvements relevant to the prevention of suicide in the veteran population. Although their report was not made public, the Work Group panel presented a series of findings and recommendations to improve relevant VA programs, with the primary objective of reducing the risk of suicide among veterans.

The panel's work was not made public because some in the VA claimed that even talking about suicide made it much more likely to occur among veterans and soldiers. VVA takes the view that transparency in government in general, and at the VA in particular, leads to better and more consistent application of the very evidence based medicine that is founded on peer reviewed science. It also would be in keeping with the proclaimed principles of the Administration of President Obama.

Perhaps most importantly, it will lead to much more accountability in government. It is past time for the VA to make the full report public.

The Work Group report discussed eight key findings and recommendations:

Panel Finding 1. Conflicting and inconsistent reporting of veteran suicide rates were observed across various studies.

Blue Ribbon Recommendation 1: VHA should establish an analysis and research plan in collaboration with other Federal agencies to resolve conflicting study results in order to ensure that there is a consistent approach to describing the rates of suicide and suicide attempts among veterans.

Panel Finding 2. Suicide screening processes being implemented in VHA primary care clinics go beyond the current evidence and may have unintended effects.

Blue Ribbon Recommendation 2: The VA should revise and reevaluate the current policies regarding mandatory suicide screening assessments.

Panel Finding 3. The VA is attempting to systematically provide coordinated, intensive, enhanced care to veterans identified as being at high risk for suicide. However, the criteria for being flagged as high risk are not clearly delineated; nor are criteria for being removed from the high risk list.

Blue Ribbon Recommendation 3: Proceed with the planned implementation of the Category H flag, with consideration given to pilot testing the flag in one or more regions before full national implementation.

Panel Finding 4. The root cause analyses presented to the Work Group did not distinguish between suicide deaths, suicide attempts, and self-harming behavior without intent to die.

Blue Ribbon Recommendation 4: Ensure that suicides and suicide attempts that are reported from root cause analyses use definitions consistent with broader VHA surveillance efforts.

Panel Finding 5. The emphasis by VHA leadership on the use of clozapine and lithium does not appear to be sufficiently evidence-based.

Blue Ribbon Recommendation 5: VHA should ensure that specific pharmacotherapy recommendations related to suicide or suicide behaviors are evidence-based.

Panel Finding 6. Efforts to improve accurate media coverage and disseminate universal messages to shift normative behaviors to reduce population suicide risk behavior are not being fully pursued.

Blue Ribbon Recommendation 6: The VA should continue to pursue opportunities for outreach to enrolled and eligible veterans, and to disseminate messages to reduce risk behavior associated with suicidality.

Panel Finding 7. Concerns about confidentiality for OIF/OEF servicemembers treated at VHA facilities may represent a barrier to mental health care.

Blue Ribbon Recommendation 7. The issue of confidentiality of health records of OIF/OEF servicemembers who receive care through the VHA should be clarified both for patient consent-to-care and for general dissemination to Reserve and Guard servicemembers contemplating utilizing VHA medical system services to which they are entitled.

Panel Finding 8. The introduction of Suicide Prevention Coordinators (SPCs) at each VA medical center is a major innovation that holds great promise for preventing suicide among veterans; however, there is insufficient information on optimal staffing levels of SPCs.

Blue Ribbon Recommendation 8. In order to maximize the effectiveness of the Suicide Prevention Coordinators program, it is recommended that there be ongoing evaluation of the roles and workloads of the SPC positions.

In addition to the above central findings and recommendations, the Work Group panel identified fourteen other areas for possible action, including:

- adopting a standard definition for suicide and suicide attempts;
- preparing a single document that details the comprehensive suicide prevention strategy;
- considering a public health approach as part of the VA framework for suicide prevention that goes beyond secondary and tertiary prevention;
- expanding the portfolio for suicide research across the VA, with suicide prevention prioritized as a research area;

- considering the establishment of an Advisory Board of key VA stakeholders involved in suicide prevention, education, treatment, and research;
- increasing VA efforts to reach out to community emergency departments to improve care for active duty servicemembers and veterans at risk for suicide;
- continuing efforts to promote training in implementing suicide prevention programs;
- developing and implementing followup interventions for veterans identified as being at risk;
- working collaboratively with other Federal agencies to understand the implications of new technologies for suicide prevention;
- designing and disseminating psycho-education materials for families of veterans at risk for suicide, particularly those hospitalized for suicide attempts;
- considering more intensive therapies for veterans who exhibit chronic suicidal behavior;
- more effectively integrating pastoral care services and traditional mental health services;
- implementing a gun safety program directed at veterans with children in the home; and
- analyzing entitlement changes required to allow treatment of combat-related conditions to reduce suicides in un-entitled veteran populations.

Suicide prevention, of course, starts with leadership. However it has been almost 2 years since the Blue Ribbon Work Group finished its work and we have yet to see any formal action plan that addresses each of the Group's findings and recommendations in a comprehensive, prioritized fashion. In fact, no one outside a select circle of bureaucrats at the Veterans Health Administration (VHA) has ever seen the complete report of this panel, which was of course, funded with taxpayer dollars.

Why not?

There are no valid reasons for keeping this report a secret. The Russians do not have spy networks out looking for copies of this report, so there is no valid national security reason not to make this report available to the Congress, to veterans advocates, to VA's own clinicians at the service delivery level, and to the public. The reason for the delay initially was to give the VHA time to design a good implementation plan to carry out all of the panel's recommendations, and to take steps to address concerns raised by the report, it seems to us at Vietnam Veterans of America (VVA) that 21 months is enough time to do that, even with the change in formal leadership as to the Undersecretary of Health. Dr. Petzel has now been on the job long enough to review any such plans, and be ready to implement the recommendations in a timely way.

This Subcommittee must ensure that our veterans and their families are given access to the resources and programs necessary to stem the tide of suicide. The first step in that process is knowing what has been recommended by the best medical scientists the VA could assemble to study the problem (the above referenced report), and what is being done to implement the recommendations and address the findings of those experts.

While we do not mean to distract from the basic thrust of this hearing, VVA points out that PTSD is a common condition among veterans that often leads to suicide attempts. We continue to be troubled that VHA has also not implemented, nor seemingly even tried to implement, the recommendations of the report commissioned by the VA and delivered by the Institute of Medicine (IOM) of the National Academies of Sciences (NAS) on June 16 of 2006 entitled "Posttraumatic Stress Disorder: Diagnosis and Assessment." (<http://iom.edu/Reports/2006/Posttraumatic-Stress-Disorder-Diagnosis-and-Assessment.aspx>) Even more troubling is that the Department of Defense has not tried to systematically implement these very important findings as to the best medical science can recommend as to proven techniques and procedures for accurately diagnosing and properly assessing Post traumatic Stress Disorder (PTSD). If you do not accurately diagnose and accurately assess a veterans' (or a returning war fighters') condition as PTSD which may be so acute that he or she is at risk of attempting to take their own life, then there is no way that you can effectively intervene or treat that American who has put their life on the line for our country. This is bad medicine, and it leaves our veterans at risk. VVA hopes that this distinguished Subcommittee will take a look at this issue, perhaps as a followup to this hearing.

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. I also thank you for the opportunity to speak to this issue on behalf of America's veterans.

I shall be glad to answer any questions you might have.

**Prepared Statement of Colonel Robert W. Saum, USA, Director,
Defense Centers of Excellence for Psychological Health and
Traumatic Brain Injury, U.S. Department of Defense**

Introduction

Chairman Mitchell, Congressman Roe, distinguished Members of the Committee; thank you for the opportunity to appear here today to talk to you about the Department of Defense's (DoD) suicide prevention programs and related outreach efforts.

On behalf of DoD, I want to take this opportunity to thank you for your continued support and demonstrated commitment to our servicemembers, veterans, and their families.

Over the last 9 years, a new era of combat emerged where our servicemembers are constantly challenged by the demands of a high operational tempo. Despite these challenges, they continue to meet the increasing demands placed upon them with resilience, dedication and remarkable ability.

However, the constant stress placed upon our servicemembers is taking its toll. The loss of even one life to suicide is unacceptable and of deep concern at all levels of DoD leadership. DoD has developed many resources and tools for servicemembers, veterans and families; however we realize utilization of these resources is dependent upon prevention education and communication about their existence. Therefore, continued outreach to servicemembers, veterans and families is an essential part of the Department's overall suicide prevention strategy. Today, I will share with the Committee our current suicide prevention outreach efforts.

Suicide has a multitude of causes, and no simple solution. Recognizing this, DoD is using a multi-pronged strategy involving comprehensive prevention education, research, and outreach. We believe in fostering a holistic approach to treatment, engaging the community, leveraging primary care for early recognition and intervention, and, when needed, providing innovative specialty care. This includes a proactive preventive approach addressing multiple stressors. Some of these stressors include relationship failures, legal/work/financial problems and substance misuse.

Outreach is only one part of DoD's overall strategy, but is an essential part. As we shift to a culture focused on building resilience and improving the well-being of the force, we need to educate our servicemembers, veterans and families on the available resources to achieve and sustain a healthy lifestyle. DoD conducts outreach through a variety of mechanisms to disseminate available resources, promote awareness and encourage servicemembers, veterans and families to seek help when they need it.

Collaborative Outreach Efforts

Continued collaboration and coordination with the Department of Veterans Affairs (VA) and other Federal, private, and academic organizations is the key to ensuring we reach our military community in the most meaningful way. We collaborate with the VA on many outreach initiatives to ensure that servicemembers, veterans and their families receive resources and access to services on a continued and consistent basis.

In November 2007, the DoD established the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) to offer a central coordinating point for activities related to psychological health concerns and traumatic brain injuries. DCoE focuses on the full continuum of care and prevention to enhance coordination among the Services, Federal agencies, and civilian organizations. DCoE works to identify best practices and disseminate practical resources to military communities.

DCoE works closely with the VA to coordinate information and resources with the National Suicide Prevention Lifeline (1-800-273-TALK). This partnership facilitated a modification to the introductory message on the Lifeline, by pressing the number 1, that enables veterans, servicemembers, or callers concerned about a veteran or servicemember to access a crisis counselor who is knowledgeable about the military and has access to resources designed specifically for this community.

The DCoE Outreach Center is staffed by health resource consultants (licensed mental health and traumatic brain injury clinicians) who are available to listen, answer questions, and refer callers, to a wide range of resources. These consultants include licensed nurses, social workers, and doctoral-level clinical psychologists. In

March 2010, the Outreach Center health resource consultants attended and completed the American Association of Suicidology (AAS) "Recognizing and Responding to Suicide Risk" 2-day training program. Since then, the Outreach Center utilized AAS' best practice methodologies and constructed a lethality assessment document as well as a safety plan document to further assess suicide risk and need for intervention. Since its launch in January 2009, the Outreach Center has been utilized by approximately 5,000 people.

DoD and VA collaborate to educate and train regional suicide prevention coordinators each year on innovative programs, best practices and new platforms for outreach.

DoD and VA are collaborating annually to promote suicide awareness week, creating common theme materials such as factsheets and coordinating with the Services and other relevant organizations to disseminate messages to the widest audience possible.

The Suicide Prevention and Risk Reduction Committee (SPARRC) has served and will continue to serve as the venue for inter-Service and interagency collaboration on suicide prevention activities. Members include Suicide Prevention Program Managers from the Services and representatives from the National Guard Bureau, Office of the Assistant Secretary of Defense for Reserve Affairs, VA, Office of Armed Forces Medical Examiner, National Center for Telehealth and Technology (T2), Substance Abuse Mental Health Services Administration (SAMHSA), and others. This Committee is the main forum for ensuring coordination and consistency in system-wide communication related to suicide, risk reduction policy initiatives, and suicide surveillance metrics across the military.

DoD Outreach Initiatives

Each of the Services has a variety of suicide prevention programs and outreach efforts tailored to their specific population. They utilize multiple communication avenues to increase awareness of available resources. In addition, DoD has many efforts currently in place to raise awareness and increase leadership involvement in promoting healthy choices. The initiatives listed below are not dedicated solely to suicide prevention, but they feature a variety of resources for psychological health, including suicide prevention, and offer the opportunity to increase outreach to servicemembers, veterans and families.

Real Warriors Campaign

Stigma is a toxic threat to our servicemembers, veterans and families receiving the care they need. We recognize that outreach is essential for combating stigma, encouraging help-seeking behaviors and promoting awareness of resources.

In May 2009, DCoE launched the Real Warriors Campaign, a multimedia public education initiative designed to combat the stigma associated with seeking psychological health care and encourage servicemembers to reach out for the care they may need. Under the theme "Real Warriors, Real Battles, Real Strengths," this effort provides concrete examples of servicemembers who sought care for psychological health concerns and are maintaining a successful military career.

While primarily focused on combating stigma, the Real Warriors Campaign addresses the issue of suicide in a number of ways:

- The Web site, *www.realwarriors.net*, prominently displays the National Suicide Prevention Lifeline on every page.
- Two video profiles of servicemembers involved in the campaign openly discuss their struggles with thoughts of suicide by demonstrating that they reached out for care, received it and that action has enabled them to continue to lead a fulfilling personal and professional life.
- The site allows servicemembers, veterans, families and health professionals to confidentially reach out to health consultants for assistance around the clock through the Real Warriors Live Chat feature or by calling the DCoE Outreach Center.

The Campaign's message boards include numerous posts from servicemembers who share their coping strategies for dealing with suicidal ideation. The site includes content that focuses on suicide prevention and substance abuse, which is a potential contributing factor to suicide. Short, documentary-style videos illustrate the resilience exhibited by servicemembers, their families and caregivers.

The Real Warriors campaign has reached thousands since the Campaign launched in May 2009. The Web site, *www.realwarriors.net*, which servicemembers can access globally, has reached 72,239 unique visitors, with more than 110,000 visits and 781,600 page views. The campaign is featured in the Army G-1 Suicide Prevention Program and the Air Force Surgeon General's Office used the campaign in a Suicide

Prevention Stand Down in May 2010. In addition, the campaign has partnered with more than 100 organizations to increase their visibility and reach among servicemembers, veterans and military families.

Military OneSource

Military OneSource, the “go-to” resource for servicemembers and families, prominently features the National Suicide Prevention Lifeline on its home page and provides suicide prevention information.

Yellow Ribbon Program

DCoE is an active contributor to the legislatively mandated Yellow Ribbon program and working group, which provides suicide prevention information, services, referrals and proactive outreach programs to servicemembers of the National Guard and Reserves and their families through all phases of the deployment cycle. The intent of the program is to proactively prevent suicide by reaching out to National Guard and Reserve members and their families to prepare them for deployment; sustaining their families during the deployment; and reintegrating the servicemembers with their families, communities and employers upon re-deployment or release from active duty. The Yellow Ribbon program also conducts outreach to help servicemembers and their families navigate through the numerous DoD, VA, and State systems to ensure they receive information and assistance regarding all the benefits and entitlements they have earned as a result of deployment. The working group is conducting a gap analysis of existing suicide prevention programs specific to the National Guard and Reserve populations.

Afterdeployment.org

DoD is leveraging technology to conduct outreach in real time and connect servicemembers, veterans and families to resources. Web-based resources such as *afterdeployment.org* provide a safe platform to better understand and increase awareness of substance misuse, depression and other mental health related issues. In August 2008, the National Center for Telehealth and Technology (T2) launched the Web site *afterdeployment.org* to support servicemembers, veterans and families with adjustment concerns that often occur after a deployment. The Web site provides interactive, self-paced solutions addressing post-traumatic stress, depression, relationship problems, substance abuse, and several other health issues including mild traumatic brain injury and spirituality concerns. Site features include quick health tips, self-assessments, e-libraries, self-paced workshops, warrior and family stories, community forum, RSS feeds, and daily topical quotes. Additionally, a Google map locator helps users find providers close to home. Visitors to the site can benefit from a sense of community by joining the *Facebook* group, receive *Twitter* messages, and download podcasts from *iTunes* or *Zune* depicting warrior stories. *Afterdeployment.org* surpassed the 100,000 visitor milestone in April 2010.

Telebehavioral Health

T2 is developing and testing multiple technologies that will provide ways to supply timely telebehavioral health services to enable a broad telehealth network for servicemembers and their families across the deployment cycle of support. Populations with access to care barriers such as geography, mobility, and stigma can benefit greatly from telebehavioral health services, which refer to the use of telecommunications and information technology for clinical and non-clinical behavioral health care. Leveraging these technologies enables DoD to reach out to a broad array of populations and provide servicemembers, veterans and their families access to patient-centric behavioral health care even in the most extreme and/or remote circumstances.

Caring Letters

An outreach effort that has shown significant promise to reduce suicides in the civilian sector is the Caring Letters Program. In a randomized clinical trial, sending brief letters of concern and reminders of treatment to patients hospitalized for suicide attempts, ideation or for a psychiatric condition was shown to dramatically reduce the risk of death by suicide following their hospitalization. In an effort to determine the applicability to military populations, T2 is piloting a program at Ft Lewis, Washington. Efforts are currently underway to plan a multi-site randomized control trial.

Way Forward

DoD has made much progress in suicide prevention outreach, but we recognize that there is still much to be done.

DoD and VA are currently developing a strategic action plan for the next 3 years. This plan will: create consistent communication of suicide data between DoD and VA; improve communication to servicemembers, veterans and families on available suicide prevention practices, programs and tools; continue resource and information sharing between VA and DoD; and coordinate training efforts to educate community members, suicide prevention coordinators and medical staff throughout both agencies.

Families play a vital role in preventing suicides among servicemembers and veterans. A current Suicide Prevention and Risk Reduction Committee (SPARRC) initiative is focused on identifying available resources for families and dissemination platforms used throughout DoD in order to increase outreach efforts targeted to families.

In addition to numerous existing DoD web-based resources, the SPARRC is developing a Web site to serve as the clearinghouse for suicide prevention information, contacts, innovative approaches, and tools. This Web site will be open to anyone looking for suicide prevention information specific to the military and will leverage existing resources. The Web site will provide a platform to increase awareness and streamline access to current suicide prevention initiatives and resources.

Conclusion

The Department of Defense is aggressively pursuing new ways to address suicide prevention in collaboration with our partners at the VA. Outreach is a crucial part of DoD's multi pronged suicide prevention strategy which emphasizes education, early recognition and intervention, and providing the best treatment possible.

On behalf of the DoD, thank you for the opportunity to address this vital issue. I look forward to your questions.

Prepared Statement of Robert Jesse, M.D., Ph.D., Principal Deputy Under Secretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs

Chairman Mitchell, Ranking Member Roe, and Members of the Subcommittee: Thank you for the opportunity to appear before you today to discuss the Department of Veterans Affairs' (VA) efforts to reduce suicide among America's Veterans. I am accompanied today by Dr. Janet Kemp, VA National Suicide Prevention Coordinator. My testimony today will cover four areas: first, data on suicidality in Veterans and VA's Suicide Prevention Program; second, VA's National Suicide Prevention Hotline and Veterans Chat (an online resource); third, VA's outreach and informational awareness efforts to reduce suicide among Veterans; and finally, VA's impact on reducing the risk of suicide among Veterans.

Let me begin by saying how very important this issue is to VA and all of us in the VA health community. We have initiated several programs that put VA in the forefront of suicide prevention for the Nation. Chief among these are:

- Establishment of a National Suicide Prevention Hotline, including a major advertising campaign to provide the hotline phone number to all Veterans and their families;
- Placement of Suicide Prevention Coordinators at all VA medical centers;
- Significant expansion of mental health services; and
- Integration of primary care and mental health services to help alleviate the stigma of seeking mental health assistance.

I will discuss these initiatives in detail later in my testimony.

VA's Suicide Prevention Program

A suicide by a Servicemember or Veteran is a tragedy for the individual, his or her friends and family, and the Nation. Data indicate that while civilian suicide rates have remained fairly static over the past 30 years, there has been a deeply concerning increase in the suicide rate among members of the Armed Forces over the last 5 years. Eighteen deaths per day among the Veteran population are attributable to suicide. Approximately 50 percent of suicides among VA health care users are among patients with a known mental health diagnosis.

These are staggering numbers, and the data fail to reveal the true cost of suicide among Veterans. In response to this urgent need, VA has been significantly expanding its suicide prevention program since 2005, when it initiated the Mental Health Strategic Plan and the Mental Health Initiative Funding. In 2006, VA supported two conferences on evidence-based interventions for suicide and provided funding to

begin integrating mental health care into primary care settings and expanding services at community-based outpatient clinics (CBOC) for treatment of mental health conditions such as post-traumatic stress disorder (PTSD), and substance use disorders (SUD). In 2007, VA began providing specific funding and training for each facility to have a designated Suicide Prevention Coordinator; it also held the first Annual Suicide Awareness and Prevention Day and opened the National Suicide Prevention Hotline in partnership with the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration (SAMHSA).

VA also established new access standards that require prompt evaluation of new patients (those who have not been seen in a mental health clinic in the last 24 months) with mental health concerns. New patients are contacted, within 24 hours of the referral being made, by a clinician competent to evaluate the urgency of the Veteran's mental health needs. If it is determined that the Veteran has an urgent care need, appropriate arrangements (e.g., an immediate admission), are to be made. If the need is not urgent, the patient must be seen for a full mental health diagnostic evaluation and development and initiation of an appropriate treatment plan within 14 days. Across the system, VA is meeting this standard 95 percent of the time. The same year, VA initiated system-wide suicide assessments for those Veterans screening positive for PTSD and depression in primary care, instituted training for Operation S.A.V.E. (which trains non-clinicians to recognize the SIGNS of suicidal thinking, to ASK Veterans questions about suicidal thoughts, to VALIDATE the Veteran's experience, and to ENCOURAGE the Veteran to seek treatment), and required Suicide Prevention Coordinators to begin tracking and reporting suicidal behavior. In addition, VA added more suicide prevention coordinators and suicide prevention case managers in its larger medical centers and community-based outpatient clinics, doubling the number of dedicated suicide prevention staff in the field.

By 2008, VA had re-established a monitor for mental health followup after patients were discharged from inpatient mental health units, developed an online clinical training program, and held a fourth regional conference on evidence-based interventions for suicide. In 2009, VA launched the Veterans Chat Program to create an online presence for the Suicide Prevention Hotline. VA also added a clinical reminder flag to patient records to notify physicians of patients at risk for suicide. This year, VA has already held a Suicide Prevention Coordinator conference and co-hosted a conference with the Department of Defense (DoD) to discuss ways VA and DoD can reduce the prevalence of suicide among Veterans and Servicemembers.

VA has adopted a broad strategy to reduce the incidence of suicide among Veterans. This strategy is focused on providing ready access to high quality mental health and other health care services to Veterans in need. This effort is complemented by helping individuals and families engage in care and addressing suicide prevention in high risk patients. VA cannot accomplish this mission alone; instead, it works in close collaboration with other local and Federal partners and brings together the diverse resources within VA, including individual facilities, a Center of Excellence in Canandaigua, New York; a Mental Illness Research and Education Clinical Center in Veterans Integrated Service Network (VISN) 19; VA's Office of Research and Development; and clinicians.

During fiscal year (FY) 2009, VA's Suicide Prevention Coordinators reported 10,923 suicide attempts among patients and non-patients, 673 of which were fatal (6.2 percent). There were 9,297 unique Veterans who attempted suicide and survived in FY 2009; 811 of these Veterans made repeated attempts, and 42 died from suicide after they survived an initial attempt during the year. Approximately 47 percent of those who attempted suicide in FY 2009 attempted it for the first time, and more than 31 percent of reported deaths from suicide involved cases where the individual had previously attempted suicide in 2009 or before.

It is not possible to determine if the reported cases are representative of suicidality in VA's patient population, but we do know that suicidality can be both an acute and a chronic condition. Those who survive attempts are at high risk for reattempting and dying from suicide within a year, so it is essential that we engage survivors in intensified treatment to prevent further suicides. It is precisely because of this concern that VA has initiated the post-discharge followup for patients leaving its inpatient mental health units. The data reported above include self-reporting of previous suicide attempts that have not been validated by VA, and all estimates are based on events reported in the Suicide Prevention Coordinator database and may not represent the complete number of suicide attempts among Veterans. Also, the records of suicide attempts for 136 Veterans were incomplete and omitted from this analysis.

This evidence clearly demonstrates that once a person has manifested suicidal behavior, he or she is more likely to try it again. As a result, VA has adopted a com-

prehensive treatment approach for high risk patients. This includes a flag in a patient's chart, necessary modifications to the patient's treatment plan, involvement of family and friends, close followup for missed appointments, and a written safety plan included in the Veteran's medical record. This plan is shared with the Veteran and includes six steps: (1) a description of warning signs; (2) an explanation of internal coping strategies; (3) a list of social contacts who may distract the Veteran from the crisis; (4) a list of family members or friends; (5) a list of professionals and agencies to contact for help; and (6) a plan for making the physical environment safe for the Veteran.

VA's Vet Centers also fulfill a critical role in reducing the risk of Veteran suicide. The Vet Centers screen all Veterans who visit them for potential harm to themselves or others; in FY 2009, this resulted in 174,700 assessments. Vet Centers intervened in 132 cases of potential suicide or homicide in the Center or in the community. There were no negative outcomes and their engagement potentially saved at least as many lives. All Vet Center staff members have been trained in the Gatekeeper suicide prevention model, based on the U.S. Air Force's similar approach. Vet Centers also participate in outreach and community education projects with local county, State, Federal and DoD components and can identify Veterans at risk during these events.

Suicide Prevention Hotline and Veterans Chat

Between its creation in 2007 and March 2010, the VA Call Center for the Suicide Prevention Hotline (1-800-273-TALK) has received more than 256,000 calls. Approximately a third of these calls are from non-Veterans. These calls have led to 8,183 rescues of those determined to be at imminent risk for suicide and 30,176 referrals to VA Suicide Prevention Coordinators at local facilities. The VA Call Center has received calls from 3,270 active duty Servicemembers, a little more than 1 percent of all calls. To address the needs of the active duty population, VA worked with SAMHSA to modify the introductory message for Lifeline (their well-established hotline that feeds calls to the VA Suicide Hotline) developed memoranda of understanding with DoD, and established processes for facilitating rescues, including collaborations with the U.S. Armed Services in Iraq. During 2009, the Hotline services were supplemented with Veterans Chat, which has been receiving more than 20 contacts a day.

The Hotline has 15 active phone lines, 1 warm transfer line, and 151 employees, consisting of 123 Hotline responders, 17 health technicians, 6 shift supervisors, 3 administrative staff, 1 clinical care coordinator and psychologist, and 1 supervising program specialist. There is also a director, a deputy director, and their program support assistant. After receiving a call from a Veteran, Servicemember or family member, the responder conducts a phone interview to assess the emotional, functional and psychological condition. The responder then determines the level of the call, namely whether it is emergent, urgent, routine or informational.

Emergent calls require emergency services to keep the caller (or the person about whom the caller is concerned) safe; urgent care requires same day services at a local VA facility; and routine calls require a consultation by the local Suicide Prevention Coordinator. Consults occur if a Veteran consents to a consultation or if emergency services are required. They are simply alerts to the Suicide Prevention Coordinator and do not mean the Veteran is suicidal. Even if the Veteran is already engaged in treatment, a consultation can be done to alert the Suicide Prevention Coordinator to changes in the Veteran's circumstances or to other needs he or she may have. VA analyzed data from the Hotline and identified the top 10 reasons for calls:

1. Mental Health Needs	59 percent
2. Substance Abuse	28 percent
3. Other	21 percent
4. Loss of Home/Job/Finances	15 percent
5. Physical Health Problems	15 percent
6. Relationship Issues	10 percent
7. Loneliness	7 percent
8. Sleep Problems	6 percent
9. Death of Friend/Family Member/Pet	5 percent
10. Questions about VA	4 percent

The warm transfer line referenced above is a special phone line that is staffed 24 hours a day, 7 days a week and accepts calls from sites or other call centers who want to transfer a caller to VA directly, without having to call the main 1-800 num-

ber. VA has pre-arranged agreements to do this with over 20 entities, as well as all other community crisis centers.

The online version of the Hotline, Veterans Chat, enables Veterans, family members and friends to chat anonymously with a trained VA counselor. If the counselor determines there is an emergent need, the counselor can take immediate steps to transfer the visitor to the Hotline, where further counseling and referral services can be provided and crisis intervention steps can be taken. Veterans Chat and the Hotline are intended to reach out to all Veterans, whether they are enrolled in VA health care or not. Since July 2009, when Veterans Chat was established, VA has learned many valuable lessons. First, it is clear that conversations are powerful and capable of saving lives. As a result, opening more avenues for communications by offering both an online and phone service is essential to further success. Second, training and constant monitoring is very important, and VA will continue pursuing both of these efforts aggressively.

The Lifeline and VA Call Center may be the most visible components of VA's suicide prevention programs, but the Suicide Prevention Coordinators are equally important. Both the VA Call Center and providers at their own facilities notify the Suicide Prevention Coordinators about Veterans at risk for suicide. The Coordinators then work to ensure the identified Veterans receive appropriate care, coordinate services designed specifically to respond to the needs of Veterans at high risk, provide education and training about suicide prevention to staff at their facilities, and conduct outreach and training in their communities. Other components of VA's programs include a panel to coordinate messaging to the public, as well as two Centers of Excellence charged with conducting research on suicide prevention: one, in Canandaigua, NY, focused on public health strategies, and one in Denver, CO, focused on clinical approaches. VA also has a Mental Health Center of Excellence in Little Rock, Arkansas, focused on health care services and systems research.

Outreach and Awareness of VA's Suicide Prevention Efforts

As discussed previously, VA's Suicide Prevention Coordinators do a tremendous amount of work to raise awareness about warning signs associated with suicide and the availability of treatment and support. For example, in February 2010, VA's Suicide Prevention Coordinators provided 614 informational and outreach programs in their local communities. As a result, VA added 1,511 Veterans to its High Risk List and 1,353 (90 percent) have completed safety plans. In addition to these measures, VA has been aggressively advertising this information and improving outreach to Veterans and family members alike. Perhaps the most notable examples of this outreach are the public service announcements (PSA) featuring actor Gary Sinise and broadcaster and journalist Deborah Norville. All told, these PSAs have been shown more than 17,000 times and represent a significant cost savings. The two PSAs cost approximately \$200,000 to produce, while the estimated value of the air time in which they were broadcast is \$3.8 million.

Another major effort in this regard is the advertising VA developed and placed on buses and Metro trains in the Washington, D.C. area, resulting in a significant increase in calls to the Hotline from the area. In 2009, VA began an advertising campaign in Dallas, Los Angeles, Las Vegas, Miami, Phoenix, San Francisco and Spokane metropolitan areas (all locations where the suicide rate among Veterans is greater than the national average). The table below contains specific information on the forms and extent of outreach VA pursued in these areas. These advertisements ran for 12-week, non-concurrent periods starting in late spring and ending in early fall 2009. "Units" refer to each specific location, so a bus displaying side, taillight and interior advertisements would count as three units. A second advertising campaign is being pursued through a contract with BluLine Media, Inc. and is producing and displaying suicide prevention advertisements in the interior of public transit buses. This effort has reached 4.3 million daily riders in 124 markets covering 42 States and 21,000 buses. The total cost for these two campaigns was approximately \$1.4 million.

City	Media Form	Number of Units
Dallas	Bus: Side, Taillight, and Interior Ads	275
Los Angeles	Bus: Taillight and Interior Ads	1,700
	Bus Shelter Ads	40

City	Media Form	Number of Units
	Rail Car Ads	105
Las Vegas	Bus: Side, Taillight and Interior Ads	1,112
	Bus Shelter Ads	150
Miami	Bus: Side, Taillight, and Interior Ads	310
	Rail Station Ads	22
	Rail Car: Interior Ads	136
Phoenix	Bus: Side, Taillight and Interior Ads	950
	Bus Shelter Ads	25
San Francisco	Bus: Taillight and Interior Ads	1,265
	Rail Car Ads	336
	Rail Station Ads	140
Spokane	Bus: Side, Taillight, and Interior Ads	348

VA is continuing to conduct assessments of these programs. The Center of Excellence at Canandaigua is reviewing the associations between exposure to public health media messaging, knowledge of Hotline use among those known to the participant, and self-reported likelihood of Hotline use if in need. The current evaluation strategy aims to collect data from three random samples of approximately 500 community members from each of the 2009 media campaign implementation sites. To identify any long-term associations between exposure to media messaging and likelihood of Hotline use, data are collected at baseline (the time the campaign was initiated), and 6 and 12 months following the start of the campaign. This study is not complete, but preliminary data indicate an increase in the number of calls originating in the areas where these advertisements were deployed. Phoenix, for example, saw a 234 percent increase in calls from the 602 area code within 30 days of the start of the media campaign. This change is all the more notable due to the contrast between it and the more modest change or even decrease among calls originating from other Arizona area codes during those same time periods. Based on these promising efforts, in FY 2011 VA will pursue a “next generation” of suicide prevention outreach based on a comprehensive strategy developed with “social marketing” experts and implemented through a newly created national outreach contract.

VA's Impact on Reducing Suicide

On the macro level, one way to evaluate the impact of VA mental health care and its suicide prevention program is to evaluate suicide rates. However, before addressing this issue, it is important to consider who accesses VA health care. For this, it is useful to refer to findings on those Veterans returning from Afghanistan and Iraq who participated in the Post-Deployment Health Re-Assessment (PDHRA) program administered by DoD. Between February 2008 and September 2009, approximately 119,000 returning Veterans completed PDHRA assessments using the most recent version of DoD's form. Of the more than 101,000 who screened negative for PTSD, 43,681 came to VA for health care services (43 percent). Among 17,853 who screened positive for PTSD, 12,674 came to VA for health care services (71 percent). These findings demonstrate that Veterans screening positive for PTSD were substantially more likely to come to VA for care. Findings about depression were similar. Both sets of findings support earlier evidence that those Veterans who come to VA are those who are more likely to need care and to be at higher risk for suicide. The increased risk factors for suicide among those who came to VA is often referred to as a case mix difference.

Working with the Centers for Disease Control and Prevention's National Violent Death Reporting System, VA recently calculated rates of suicide for all Veterans, including those using VA health care services and those who do not. This analysis included data from 16 States for individuals aged 18–29, 30–64, and 65 and older for the years 2005, 2006, and 2007 (during the period of VA's mental health en-

hancement process). The year 2005 marked the beginning of enhancement, while the year 2007 is the most recent one for which data are available.

Suicide rates for Veterans using VA health care services aged 30–64, and those 65 and above were higher than rates for non-users, and they remained higher from 2005 to 2007, probably a reflection of the case mix discussed above. However, findings for those aged 18–29 were quite different. In 2005, younger Veterans who came to VA for health care services were 16 percent more likely to die from suicide than those who did not. However, by 2006, those younger Veterans who came to VA were 27 percent less likely to die from suicide, and by 2007, they were 30 percent less likely. This difference appears to reflect a benefit of VA's enhancement of its mental health programs, specifically for those young Veterans who are most likely to have returned from deployment and to be new to the system.

Because the number of Veterans from the 16 States in this group is relatively low, the rates are, for statistical reasons, variable. Nevertheless, they demonstrate important effects. In 2005, 2006, and 2007, respectively, those who came to VA were 56, 73, and 67 percent less likely to die from suicide. Those who utilized VA services, to some extent, showed a lower rate of suicide with an effect that appeared to increase during the time of VA's mental health enhancements. More broadly, the rate of suicide among Veterans receiving health care from VA has declined steadily since FY 2001; specifically, the rate declined more than 12 percent during this time. From a public health perspective, the decline in rates is significant, corresponding to about 250 fewer lives lost as a result of suicide. A chart detailing the VHA suicide rate from FY 2001 through FY 2007 is attached.

Conclusion

Mr. Chairman, as my testimony demonstrates, VA has taken a number of steps to provide comprehensive suicide prevention services, and the data indicate our efforts are succeeding. But our mission will not be fully achieved until every Veteran contemplating suicide is able to secure the services he or she needs. I thank you again for your support of our work in this area, and for the opportunity to appear before you today. I will be happy to respond to any questions from you or other Members of the Subcommittee.

Statement of Paula Clayton, M.D., Medical Director, American Foundation for Suicide Prevention

Chairman Mitchell, and Ranking Member Stearns, 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 suicide and suicide prevention among our Nation's veterans. My name is Paula Clayton. I am a physician. I currently serve as AFSP's medical director. My responsibilities include overseeing and working closely with the AFSP's scientific council to develop and implement directions, policies and programs in suicide prevention, education and research. I also supervise staff assigned to the research and education departments within AFSP.

Prior to joining AFSP, I served as professor of psychiatry at the University of New Mexico School of Medicine in Albuquerque. I also currently serve as professor of psychiatry, Emeritus, for the University of Minnesota, where I was a professor and head of the psychiatry department for nearly 20 years. My research on bipolar disorder, major depression and bereavement allow me to understand some of the antecedents of suicide and to appreciate medical research and public/professional education programs aimed at preventing it.

AFSP is the leading national not-for-profit organization exclusively dedicated to understanding and preventing suicide through research, education and advocacy, and to reaching out to people with mental disorders and those impacted by suicide. You can see us at www.asfp.org.

To fully achieve our mission, AFSP engages in the following Five Core Strategies, (1) Funds scientific research, (2) Offers educational programs for professionals, (3) Educates the public about mood disorders and suicide prevention, (4) Promotes policies and legislation that impact suicide and prevention, (5) Provides programs and resources for survivors of suicide loss and people at risk, and involves them in the work of the Foundation.

I have provided the Committee staff with a Power Point presentation I delivered here in Washington, DC on March 8, 2010, entitled, "Suicide Prevention—Saving Lives One Community at a Time." I also included a copy of AFSP's 2010 Facts and Figures on Suicide. Both documents will provide Committee members and their staff

an overview on the issues associated with suicide in America today, along with some examples of programs and services to prevent this major public health problem.

Chairman Mitchell, Ranking Member Stearns, suicide in America today is a public health crisis. Consider the facts:

- More than 34,500 people die by suicide each year in the United States. Approximately 20 percent of those individuals—or one in five—are veterans.
- Suicide is the 4th leading cause of death in the United States for adults 18–65 years old and the third leading cause of death in teens and young adults from ages 15–24. Currently 67 percent of all Marines are between the ages of 17 and 25.
- Male veterans are twice as likely to die by suicide as male non-veterans. On average 18 veterans commit suicide each day.
- Men account for 80 percent of all completed suicides in America.
- A suicide occurs approximately every 15 minutes, totaling over 90 suicides a day.
- Suicide in the military is not just a mental health problem; it is a public health problem. The number of suicide attempts by Army personnel has increased six-fold since the wars in Afghanistan and Iraq began.
- Depression, Post Traumatic Stress Disorder and traumatic brain injury are real medical conditions.

We need to let our veterans know that seeking help for mental health and substance abuse problems is a sign of strength. The keys to improving these statistics are reducing the stigma associated with mental illness, encouraging help-seeking behavior, and being aware of warning signs and treatment options.

Suicide is the result of unrecognized and untreated mental disorders. 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 deaths. The most common is major depression, followed by alcohol abuse and drug abuse, but almost all of the psychiatric disorders have high suicide rates.

So the major risk factors for suicide are the presence of an untreated psychiatric disorder (depression, bipolar disorder, generalized anxiety and substance and alcohol abuse), the history of a past suicide attempt and a family history of suicide or suicide attempts. The most important interventions are recognizing and treating these disorders. Veterans have strong biases against doing that. These must be identified and overcome.

Whether a civilian or a veteran, there are signs that health care professionals look for, what we call risk factors. In addition to those above, they include:

- Difficulties in a personal relationship;
- A history of physical, sexual or emotional abuse as a child;
- Family discord;
- Recent loss of a loved one;
- A recent arrest;
- Sexual identity issues;
- Availability of firearms.

Protective factors or interventions that work, again in the general population and for veterans include:

- Regular consultation with a primary care physician;
- Effective clinical care for mental and physical health, substance abuse;
- Strong connections to family and community support;
- Restricted access to guns and other lethal means of suicide.

It is vitally important that we communicate effectively with our veterans that consulting a health care professional does not in and of itself preclude an individual from obtaining a security clearance. On May 7, 2010, Admiral Mike Mullen, stated concerning behavioral health issues, “If you feel as though you or a close family member needs help, please don’t wait. Tell someone. Asking for help may well be the bravest thing you can do.” Mr. Chairman, and Members of the Committee, we must make sure that Admiral Mullen continues to be heard loud and clear inside and outside the military and veteran community.

AFSP is pleased to report that help is available. The Department of Veterans Affairs (VA), Veterans Health Administration (VHA) founded a national suicide prevention hotline to ensure veterans in emotional crisis have free, 24/7 access to trained counselors. To operate the Veterans Hotline, the VA partnered with the Substance Abuse and Mental Health Services Administration (SAMSHA) and the National Suicide Prevention Lifeline. Veterans can call the Lifeline number, 1-800-273-TALK (8255), and be routed to the Veterans Suicide Prevention Hotline. This

Hotline is available 24 hours a day, 7 days a week. It is important to note that friends and family members of veterans in crisis are welcome to call the Veterans Hotline.

The VA has expanded an advertising campaign that debuted in Washington DC, and is now active in 124 cities with advertisements on local buses. The ads are designed to make veterans and their family members aware of the VA Suicide Prevention Lifeline. The VA has also been distributing brochures, wallet cards, bumper magnets and other educational items to veterans, their families and VA employees to promote awareness of the Lifeline number. These items serve to educate the public, veterans and family members about suicide risk factors and how to get help for those veterans that need it. They are all important building blocks in our efforts, both public and private, to get the word out regarding the services and programs available.

Another valuable service that veterans, their family members, and even friends can access, is a program called Veterans Chat through the National Suicide Prevention Lifeline Web site. Veterans Chat enables veterans, their families and friends to go online where they can anonymously chat with a trained VA counselor. If the chats are determined to be a crisis, the counselor can take immediate steps to transfer the individual to the VA Suicide Prevention Hotline, where further counseling and referral services are provided and crisis intervention steps can be taken.

Additionally, AFSP supports President Obama and the new VA policies that will make it easier for war zone veterans with PTSD to receive disability benefits by stripping the requirement to produce evidence that a specific incident triggered their stress disorder. This policy has kept those who served in non-combat roles in war zones from getting the care they need and the new policy changes will expand access to care for those veterans.

AFSP would like to commend the U.S. Department of Veteran Affairs, Dr. Antonette Zeiss and Dr. Jan Kemp for their leadership and vision in constructing and implementing this program designed to help our veterans contemplating suicide. We urge this Subcommittee, the full Committee and the entire Congress to fully support Dr. Zeiss and Dr. Kemp in their important efforts.

Chairman Mitchell, Ranking Member Stearns, suicide in Veterans is an absolute crisis. Depression can be fatal. Excessive drinking or drug use can be fatal. The fatality is mainly by suicide. Culturally sensitive but sustained efforts with multiple approaches offer our best hope to get veterans into treatments. We must reduce this fatal outcome. The American Foundation for Suicide Prevention is ready and willing to offer our expertise and advice to this Committee and to all Members of Congress as you make the important decisions on how to reduce suicide among our veterans.

**Statement of Penny Coleman, Rosendale, NY, Author,
*Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War***

Mr. Chairman, Ranking Member, and Members of the Subcommittee, I thank you for the opportunity to share my views and concerns on the very important issue of the VA's national suicide prevention outreach efforts, which are based on the reported success of a pilot program that encouraged veterans at-risk for suicide to call the VA suicide hotline.

I have several concerns about the current suicide prevention outreach efforts:

- a. that it is being called a success when there is little evidence of that,
- b. that it is a non-evidenced-based strategy, and
- c. that it intervenes with the problem of suicide at the moment of crisis rather than providing a more proactive and systematic approach.

I will first address each of these in turn. Following that, I will present a number of suggestions for alternative strategies:

1. Make VA enrollment automatic and universal
2. Integrate and coordinate DoD and VA their health care transition
3. Hire more mental health care providers
4. Give the VA a budget that will not require outsourcing of services
5. Reconstitute VA counseling for incarcerated veterans
6. Establish Veterans Programs in the Nation's prisons
7. Support Community Living projects like Valley Forge Village and most importantly,
8. Establish more Vet Centers

a. My first concern is that the stated purpose of these hearings is based on the assumption that the pilot suicide hotline program was a success.

In 2008, Lisette Mondello, Assistant Secretary for Public and Intergovernmental Affairs for the VA, reported to this Committee that the pilot program, a televised public service announcement and posters placed on area trains and buses encouraging veterans considering suicide to call the VA's suicide hotline, had produced a 50 to 100 percent increase in calls from the area where the advertising ran.¹

The 50 to 100 percent increase may sound substantial, but it actually refers to only eight more calls a week in the D.C. area, nine more in Northern Virginia, and 17 more in Maryland. And there is no indication that even those small numbers are indicative of success. For one thing, Assistant Secretary Mondello's statement fails to acknowledge that calls to the VA's hotline more than doubled in the first 6 months of 2008 nationwide, independent of the Washington metro ad campaign.² Second, rather than a measure of the pilot's success, that increase in calls can also be interpreted as a warning that failures of our military and veterans' mental health care systems were leaving increasing numbers of the men and women who so desperately need them on the brink of crisis. Thus, my first concern is whether this program should in fact be considered successful. In other words, is it working?

b. That there is no viable data to suggest that it is brings me to my second concern: that this is not an evidence-based strategy.

In the fall of 2008, the VA's blue ribbon panel of experts recommended that the VA "apply evidence-based research" in their intervention efforts. In January 2009, VA's Health Services Research and Development Service (HSR&D) published a pamphlet called "Strategies for Suicide Prevention in Veterans" in which the authors state categorically that they "found no studies that assessed the specific effectiveness of any hotlines."³ The peer review comments (Appendix D)⁴ specifically chide the VA for withholding data describing the impact of their national suicide prevention hotline.

In April 2010, Dr. Janet Kemp, the national suicide-prevention coordinator for the VA, proudly told the *American Forces Press Service* that the advertising campaign, now in 124 cities nationwide, had increased the hotline call volume to about 10,000 calls a month, or about 25 percent in 2 years.

But she offered no information about who is calling, what era and branch of service they represent, how many of those callers have attempted suicide in the past, what kind of followup procedures are in place, how many of the callers are already enrolled in the VA system, how many are re-routed to back-up call centers, and nothing to back up her claim that the calls to the hotline were responsible for stopping 7000 in-process suicides.

Instead of data, Dr. Kemp offered an anecdote about a veteran who was in the process of writing a suicide note when he happened to notice a poster with the hotline number on it and placed the call. "He's now alive and well and telling his story of success."⁵

This is not evidence-based intervention.

In June of 2010, doctors from the Los Angeles VA and the RAND Corp. did a systematic review of suicide prevention programs developed for military and veterans world wide. This program is not listed among them. The review found that all of the programs developed for the military reported declines in suicides and suicide attempts, but all were so badly designed, so inadequately documented and the data so poorly analyzed that "it was not possible to infer causality from the reported as-

¹House Committee on Veterans' Affairs, Subcommittee on Oversight and Investigations, Lisette M. Mondello, Assistant Secretary for Public and Intergovernmental Affairs, U.S. Department of Veterans Affairs, September 23, 2008. <http://veterans.house.gov/Media/File/110/7-15-08/Demvaqfrs.htm>

²"Calls To Veterans' Suicide Hot Line Double," Jul 28, 2008. <http://cbs3.com/national/veterans.affairs.suicide.2.781329.html>

³"Strategies for Suicide Prevention in Veterans." www.hsrd.research.va.gov/publications/.../Suicide-Prevention-2009.pdf

⁴"Strategies for Suicide Prevention in Veterans," Appendix D: The VA National Center for Suicide Prevention and the MIRECC in Denver may have at least some published data describing the impact of the recent VA national suicide prevention hotline. This would obviously be the most relevant information, yet there was no mention of this in the project synthesis. It would be helpful if the document states explicitly one way or another if there is any recent data to be factored from either of these VA suicide prevention centers, either in the literature, in press or otherwise. www.hsrd.research.va.gov/publications/.../Suicide-Prevention-2009.pdf

⁵Donna Miles. "VA officials strive to prevent veteran suicides" *American Forces Press Service*, 4/23/2010. <http://www.af.mil/news/story.asp?id=123201368>

sociations.” And they found *no* studies focusing on veterans. Their conclusion that “(t)here is an urgent need for continued research in this area” seems restrained.⁶

These hearings are evidence that the VA is still asking Congress to take this program seriously, yet in 2 years they have produced nothing to back up their claim that what they are doing is working. In fact, there is no way to distinguish between those callers who have been driven to their limits by service-related injuries and those who have been driven to their limits by the failure of the VA to deliver the care and support that are so desperately needed.

While there is a lack of convincing evidence that the hotline has been successful as an suicide intervention strategy, there is no lack of evidence that it has not. Military suicides have continued to rise across all branches of service: in 2009, the suicide rate in the Marine Corps was 24-per-100,000; it was 23 in the Army; 15.5 in the Air Force; and 13.3 in Navy, all, by the way, higher than in 2008⁷ and all significantly higher than the civilian suicide rate which has held steady at 11.1 for some years.⁸ The VA acknowledges that 18 veterans take their lives every day, the same number the VA accepted in 2007 when confronted with the CBS investigation.⁹ That is 6570 veteran suicides a year, or almost 60,000 in the 9 years since these wars began.¹⁰

- c. My final concern with the hotline program is its centrality to the VA’s suicide prevention efforts. I take no issue with a hotline, only with the suggestion that it is anything more than an 11th-hour prayer. Rather than waiting until veterans are at the edge of the precipice and relying on haphazard message to pull them back, the VA should be focusing their attention on evidence-based interventions, interventions with documented histories of success.

In 2008, when the pilot was announced, CBS News quoted David Rudd, a former army psychologist, warning that after the posters and the public service ads have directed veterans to turn to the VA for help, the VA had best be prepared to deliver. Specifically, they had best reduce delays and provide the services that will keep veterans in care. “Those are the things we know reduce death rates.”¹¹

A 2008 RAND Corporation report warned that fully a third of returning veterans were suffering from post-traumatic stress injuries.¹² In 2008, that was 300,000 troops. In 2010, over 2 million troops have been deployed in Iraq and Afghanistan, and a third is just shy of 700,000, a number that continues to grow.¹³ The magnitude of that crisis requires a response of commensurate magnitude. A hotline doesn’t belong at the top of the list.

In that vein, the following are offered as an incomplete list of suggestions for evidence-based interventions that prioritize prevention rather than crisis management, and avoid raising hopes and expectations that will not be met. Perhaps even more to the point, invest in programs that offer the hope of dignity and independence.

1. Make VA enrollment automatic and universal.

In 2008, Congressman Harry Mitchell, who has been instrumental in pushing the VA to improve its suicide outreach, told CBS News, “We can’t just wait for veterans to come to us, we need to bring the VA to our veterans.”¹⁴ The VA should take him at his word. When servicemembers are being processed out of the military, when they are cut loose and sent home, the VA should be sitting in the room signing them up, simply and automatically.

⁶ Steven C. Bagley, MD, MS, Brett Munjas, BA, and Paul Shekelle, MD, PhD. “A Systematic Review of Suicide Prevention Programs for Military or Veterans Suicide and Life-Threatening Behavior,” 40(3), June 2010, p. 263–4. www.hsrd.research.va.gov/publications/.../Suicide-Prevention-2009.pdf

⁷ Gregg Zoroya, “No Letup in Marine attempted Suicides,” *U.S.A Today*, June 8, 2010. http://www.usatoday.com/news/military/2010-06-07-marine-suicides_N.htm

⁸ Suicide Facts. <http://www.athealth.com/Consumer/issues/factsuicide.html>

⁹ Armen Keteyian. “VA Hid Suicide Risk, Internal E-Mails Show: Follow-Up Reporting On Exclusive Investigation Reveals Officials Hid Numbers, April 21, 2008. http://www.cbsnews.com/stories/2008/04/21/cbsnews_investigates/main4032921.shtml

¹⁰ <http://www.chron.com/displstory.mpl/nation/6428651.html>

¹¹ Pia Malbran, “VA To Test Suicide Public Service Ads,” July 14, 2008. http://www.cbsnews.com/stories/2008/07/14/cbsnews_investigates/main4260904.shtml

¹² Tanielian, T., and Jaycox, L.H. (2008). *Invisible Wounds of War Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*. Santa Monica, CA: Rand Corporation. Accessed July 1, 2008. <http://www.rand.org/pubs/monographs/MG720/>

¹³ VCS Fact Sheet: Consequences of Iraq and Afghanistan Wars. Updated March 13, 2010 using documents obtained from the Department of Veterans Affairs (VA) under the Freedom of Information Act (FOIA).

¹⁴ “Calls To Veterans’ Suicide Hot Line Double.” <http://cbs3.com/national/veterans.affairs.suicide.2.781329.html>

Post-traumatic stress injuries are unique among anxiety disorders in that they are significantly associated with suicide, suicidal ideation and attempts.¹⁵ If suicide prevention is the issue, it is surely counter productive to make access to support and services dauntingly complicated and selectively exclusive. Especially if betrayal of expectations and frustration with what are perceived to be gratuitously forbidding procedures are going to exacerbate their post-traumatic stress symptoms and make disaster more likely.

It is also well understood that the stigma associated with mental health issues prevents those who need it most from asking for help. Especially with new veterans, the VA should take advantage of the anonymity of universality. If everybody does it, nobody is exposed.

Contrary to popular belief, currently, only about 20 percent of all of America's veterans are enrolled in the VA and make use of their health care services. Far too many are excluded, far too many are daunted and overwhelmed, and far too many need help with the process. The VA has recently been pointing out that if there is any cause for optimism in the recent suicide data it is that it appears that veterans using VA health care seem increasingly less likely to take their own lives than those who did not.^{16,17}

So make it accessible. Make enrollment simple and automatic and universal. The new rules streamlining the process for filing disability claims is a long overdue improvement, but already the posturers are lining up wagging fingers and tongues about how veterans are gaming the system and taking advantage of easy hand-outs.¹⁸ There will be Fraud! There will be Malingering! There will be Chronic Dependency! And there will be Budget Deficits!

Shame on their selective memories. It has only been 5 years since the VA was directed to review the claims files of the 72,000 most fragile, most vulnerable (most expensive to maintain) veterans, those with 100 percent disability ratings for post-traumatic stress. After a review of a sample 2100 of those files, a review that was so stressful that one veteran was driven to suicide, the Inspector General's report found not a single case of fraud on the part of a veteran. What it did find was an administrative mess. Then-Secretary Nicholson called off the review and promised to improve VA employee claims handling and administrative oversight.¹⁹

When there is real fraud at the VA, it is almost always at the top and very expensive, not just in dollars, but in lives.²⁰ And though the VA declined to be the object of a lawsuit in 2007, it was not because they were innocent of the charges leveled against them, but because of a legal technicality that prevented the lawsuit from proceeding.²¹

And as to budget deficits, the RAND Corporation estimates the costs of the psychological and neurological injuries suffered by Iraq and Afghanistan veterans at between \$4 and \$6.2 billion, just in the first 2 years after combat. Providing proper evidence-based care for all of these veterans would lower that cost to society by about 27 percent.²²

2. Integrate and coordinate DoD and VA their health care transition.

There is no logical or moral justification for the chasm that is allowed to exist between the two agencies—only an apparently territorial one and the ubiquitous financial one. Both agencies are confronting the same terrible problem with suicide,

¹⁵The Relationship Between PTSD and Suicide—National Center for PTSD <http://www.ptsd.va.gov/professional/pages/ptsd-suicide.asp>.

¹⁶<http://www.cbsnews.com/stories/2010/01/11/national/main6083072.shtml>

¹⁷Interestingly, the number of veterans under VA care who took their own lives in 2007, five, is the same number cited by the VA in 2005.

¹⁸Allan Breed, "Tide of new PTSD cases raises fears of fraud: Some veterans have learned to game the system to get disability payments," May 2, 2010. http://www.msnbc.msn.com/id/36852985/ns/health-mental_health/page/2/Tide_of_new_PTSD_cases_raises_fears_of_fraud.

¹⁹No Across-the-Board Review of PTSD Cases—Secretary Nicholson, Public and Intergovernmental Affairs, November 10, 2005, <http://www1.va.gov/opa/pressrel/pressrelease.cfm?id=1042>

²⁰The scandal at Walter Reed (<http://www.washingtonpost.com/wp-dyn/content/article/2007/03/04/AR2007030401394.html>), was followed by stories of VA using veterans as guinea pigs in dangerous drug trials (<http://www.washingtontimes.com/news/2008/jun/17/va-testing-drugs-on-war-veterans/>), and then by the revelation that VA employees had taken \$24 million in bonuses (<http://www.veteranstoday.com/2009/08/21/va-24-million-bonus-scandal/>), to the multiple scandals that resulted in the "retirement" of the director of the Philadelphia VA (<http://www.vawatchdog.org/10/mf10/mffeb10/mf021710-6.htm>). Just Google VA scandal.

²¹*Veterans For Common Sense et al. v. Peake*, Case No. C 07 3758, U.S.D.C. (N.D. Cal. 2007) <http://www.veteransptsdclassaction.org/>

²²Terri Tanielian and Lisa H. Jaycox, Eds., "Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery," RAND, 2008: <http://www.rand.org/pubs/monographs/MG720/> p.17.

and their attempts at intervention have produced the same disappointing results. There will be fewer suicides, on whichever side of the tally sheet they are finally counted, if soldiers and veterans who are at-risk for suicide aren't allowed to get lost in the system—or worse, to it.

If the DoD wanted enlisted men and women to know about the programs that will be available to them after they leave the service, they have a captive audience. Veterans who left the service years ago and veterans who left months ago tell the same story: suicide awareness and intervention options are touched on in a single sentence, at the last minute, as a footnote in an overwhelmingly condensed out-processing ordeal.²³

One recently returned veteran compared the suicide awareness presentations given at out-processing to pharmaceutical ads on TV: don't pay any attention to this list of lethal side effects that we are reading through as fast as we can; just keep your eye on the seductive fantasy payoff: happiness, health, sanity, and especially home.

If suicide awareness and intervention options are important to both agencies, perhaps some thought should be given to how and when and with what degree of seriousness and urgency they are presented by the military and then what the VA can do to followup and reinforce the message.

Perhaps more to the point, after years of stalling, the VA and the DoD have yet to implement a fully interoperable electronic health record systems. It is those who are most at risk who most need continuity of care, and continuity of care is exactly what gets lost in the tug of war over whose software system is going to win.

3. Hire more mental health care providers.

The significant association of post-traumatic stress injuries with suicide²⁴ makes the availability of adequate numbers of trained providers key to any suicide intervention strategy. It is not enough to say that an additional 2000 or 4000 or 6000 have been hired, if at-risk veterans are not seen in a timely fashion and given care that lives up to best-practice standards.

If experienced therapists continue to leave both the military and the VA because they can get higher paying, less stressful jobs in the private sector, then the budget for mental health services must include higher salaries and incentives to induce them to stay.²⁵ If younger, less experienced providers are more easily available, then they must be hired immediately, as it will take time to train them in cultural competencies essential to establishing the trusting relationships with veterans that will keep them in care.

In fact, if a hotline generates 50,000 calls a day, 100,000, and the services and support advertised are not actually available, it can only add to a caller's despair, and may even make it more likely that he or she will give up.

4. Give the VA a budget that will not require outsourcing of services.

Contracting out the responsibilities of the VA may be an attractive short-term solution to a very real problem, but it is a solution that leaves the 3 million veterans who live in rural areas that are underserved by VA facilities particularly vulnerable.

In three short years, Project HERO, run by Humana, has expanded from an experimental pilot program specifically charged with providing health care to rural veterans into an entity providing a full range of services in metropolitan areas—in direct competition with established VA Medical Centers. The Business Section of the *Milwaukee Journal* referred to that phenomenon as “big business for Humana, Inc.”²⁶ The VA is dependent on Project HERO for 30 percent of their fee-based contracts nationwide,²⁷ and so far they have managed to keep providers “stepping up”

²³I have only heard variations on what is essentially the same story from veterans: “They try to fill your head at the last formation before the weekend, the last day before you get out. Everybody's trying to sit in the back of the room, just waiting for a smoke break, with shades on because we'd drunk too much the night before because we were going home and what were they going to do to us anyway? Give us an Article 15?” “VA eligibility, TRICARE, the GI Bill, and a million other things were covered. The suicide hotline got one sentence.” Did he still have all the handouts he got in his ACAP[23] folder? “I took what was important, the GI Bill and TRICARE stuff and tossed the rest without reading it.”

²⁴*The Relationship Between PTSD and Suicide—National Center for PTSD* <http://www.ptsd.va.gov/professional/pages/ptsd-suicide.asp>.

²⁵Paul Rieckhoff, “A Memo to Obama from America's Vets,” Military.com, November 06, 2008. <http://www.military.com/opinion/0,15202,178674,00.html>

²⁶Ed Green, New Veterans unit could be big business for Humana Inc.—June 1, 2007. <http://louisville.bizjournals.com/louisville/stories/2007/06/04/story6.html>

²⁷Dennis Douda, “Expanding Private Medical Care For Veterans,” (WCCO), Feb 19, 2009. <http://ucco.com/health/project.hero.veterans.2.939294>

and “doing the right thing,” but the more dependent the VA gets on Humana, the less leverage they will have over their service delivery and fees.

Humana was generously excused for their slow start, for the time it took to establish a network of providers, but it is still ostensibly on trial, and already it is “not living up to its contractual obligations for timely referrals and communication with FB (fee-based) providers” at the Orlando VMHC.²⁸ In June, the VA Inspector General found that veterans were waiting for referrals, for appointments, for test results, and for medical record updates for up to 3 months.

Furthermore, the new Web site of the Office of Management and Budget, PaymentAccuracy.gov, which showcases Federal “high-error” programs, included Project Hero in their June audit, identifying \$11.6 million in potentially erroneous payments.²⁹

Outsourcing VA services delays the construction of new VA facilities and the training and hiring of VA staff. Vet Centers will not be established, VA mental health teams will stop building travel to Community Based Clinics into their schedules, the burgeoning fleet of mobile VA clinics will be side-lined rather than expanded.

The wars in Iraq and Afghanistan have drawn heavily on recruits from rural areas, and the need for VA services will only continue to grow. The Reserve is also largely drawn from those same communities and already exceptionally at-risk for suicide. In 2009, Army Reserve suicides were up 26 percent.³⁰

For all its challenges and problems, the VA still manages to deliver the best medical care to the most people at the best price in the country. Humana never promised to be cheaper, only to give the VA a chance to catch up with the overwhelming needs of a rapidly expanding veteran population. Rural veterans at-risk for suicide need reliable, accessible mental health services. The VA should be funded at the levels required to put that system in place.

5. Reinstitute VA counseling for incarcerated veterans.

Current regulations restrict VA from providing counseling to incarcerated veterans because it is the duty of “another government agency,” in this case the criminal justice system, to provide that care. They don’t.

The most recent Bureau of Justice estimate of incarcerated veterans in 2007 was 228,700,³¹ many, perhaps most, as a result of their untreated, service-related psychic injuries. That is only an estimate though. No one actually knows because the Federal Government doesn’t require prison authorities to ask.³²

Prison is a terrible place for veterans suffering from post-traumatic injuries. Left untreated, PTSD predictably gets worse and becomes chronic, making one of two scenarios far more likely: recidivism or suicide. The suicide rate in jails is an astonishing 47 per 100,000. The Army’s is now 23 per 100,000, and everyone agrees that is a crisis.

And no one knows how many of the suicides in jails and prisons are veterans, but an article published last year in the *Journal of the American Academy of Psychiatry and Law*, points to the “absolute dearth of data,” and suggests that “defining the scope of this problem should be an absolute priority.”³³

To whatever extent PTSD and TBI and the other emotional, cognitive, and behavioral consequences of such injuries account for criminal behaviors, throwing this vulnerable population behind bars, where they will not get treatment, is compounding the risk that they will not survive. The probability that the produces an excess of

²⁸Healthcare Inspection Inadequate Coordination of Care Orlando VA Medical Center Orlando, Florida—Report Number 10–00219–180, 6/24/2010. <http://www4.va.gov/oig/54/reports/VAOIG-10-00219-180.pdf>

²⁹Alice Lipowitz, “Agencies Faulty Claims make OMB site hit list,” June 25, 2010, <http://washingtontechnology.com/Articles/2010/06/25/OMB-sets-up-new-Web-site-to-track-improper-payments-by-agencies.aspx?Page=2>

³⁰Danny Spatchek, “Chiarelli: suicides down, but not enough,” Jun 25, 2010. <http://www.army.mil/news/2010/06/25/41363-chiarelli-suicides-down-but-not-enough/>

³¹Christopher Mumola and Margaret E. Noonan, “Justice involved Veterans,” Bureau of Justice Statistics, Power Point presentation: The VHA National Veterans Justice Outreach Planning Conference, Dec. 2, 2008 Baltimore.

³²In 1994, a few concerned members of Congress managed to get a provision attached to the Violent Offender Incarceration and Truth in Sentencing Incentive which would have rewarded the operators of correctional facilities for adopting policies that would identify the veterans among their inmates. Those incentive grants were passed, but they were rescinded by the Gingrich Congress before they were ever implemented.

³³Hal S. Wortzel, MD, Ingrid A. Binswanger, MD, MPH, C. Alan Anderson, MD and Lawrence E. Adler, MD. “Suicide Among Incarcerated Veterans,” *J Am Acad Psychiatry Law* 37:1:82–91 (2009). <http://www.jaapl.org/cgi/content/full/37/1/82>

suicides should be reason enough for the VA to re-institute counseling for incarcerated veterans.

6. Establish Veterans Programs in the Nation's prisons.

The relatively new phenomenon of veterans' courts is a laudable attempt to intervene in an historical injustice. Veterans with service-connected mental injuries whose symptomatic behaviors get them in trouble with the law can opt into a treatment program rather than going to jail or prison. But those courts can't yet begin to deal with the numbers and only a few are willing to accept veterans whose crimes are considered violent.

In the meantime, veterans with felony convictions are more likely to be unemployed or homeless, both of which contribute to hopelessness and despair.

In 1993, New York State had Veterans' Programs in 19 of its facilities that offered VA substance abuse and PTSD counseling, and education and job training opportunities. They had a documented recidivism rate of 8.9 percent after 5 years for veterans who completed the program, compared to 51.6 percent for non-veterans.

Those programs have been eviscerated or killed, but the model exists and would be a valuable component of any suicide intervention strategy.

7. Support Community Living projects like Valley Forge Village

Valley Forge Village,³⁴ outside of the Twin Cities, is a 240-acre community for that will house 200 veterans coping with mental health conditions and cognitive impairments and their families. As conceived, it will be a place for veterans to go to heal and learn new skills. Organic farming and sustainable practices will be taught in a therapeutic setting. Residents can go to school in the surrounding area and business start-up skills and development training are an integral part of the program.

Valley Forge Village is one of a growing number of privately funded intentional communities that will serve as models for the future. The combination of therapy, and farming in a peaceful, therapeutic, predominately peer environment is one the VA might do well to watch. As a suicide intervention strategy, it holds great promise.

8. Establish more Vet Centers

For 25 years, Vet Centers have been the first line of defense against suicide. They are walk-in clinics, designed to be less intimidating than the large VA medical centers. They are largely staffed by veterans, and unlike the big medical centers, they offer counseling to veterans *regardless of discharge status* and to their family members as well.

It is family members who are most likely to notice behaviors or attitudes suggestive of suicidal ideation, and Vet Center counselors can help them decide how best to help. It is the families who are best positioned to encourage traumatized veterans, especially those who are in denial about or ashamed of their mental health issues, to get the help they need.

Vet Center counselors are specifically trained to deal with combat- and other service-related issues, and they are fluent in with necessary cultural competencies. They offer an array of social support services, employment and addiction counseling, sexual trauma and family counseling, as well as housing and legal support.

Vet Centers are not the answer to the homelessness and unemployment problems that so disproportionately affect the veteran community, and it is the co-occurrence of multiple issues that is most likely to leave a veteran feeling the despair and hopelessness that can lead to self-destructive behaviors.³⁵

Expanding this system of small, local, largely veteran staffed, walk-in clinics, as General Shinseki has proposed, is an evidence-based suicide intervention strategy that has an undeniable documented history of success.

Advertising the existence of the Vet Centers and the services they provide would help to prevent veterans from ever reaching the crisis state in which a call to a suicide hotline appears to be the only option.

³⁴ <http://www.valleyforgecenter.org/>

³⁵ Steven C. Bagley, MD, MS, Brett Munjas, BA, and Paul Shekelle, MD, PhD. "A Systematic Review of Suicide Prevention Programs for Military or Veterans Suicide and Life-Threatening Behavior," 40(3), June 2010, p. 263-4. www.hsrd.research.va.gov/publications/.../Suicide-Prevention-2009.pdf

Statement of Oregon Partnership, Portland, OR

Chairman Mitchell, Ranking Member Roe, and Members of the Committee, an alarming threat to the well-being of our active military and veterans is emerging.

In the past several years, members of the military, veterans and their families have placed an increasing number of calls to Oregon's statewide crisis lines, operated by the nonprofit Oregon Partnership (OP).

While calls to Oregon Partnership's 24-7 Suicide Interventionline have more than doubled since June of 2008 because of the economic downturn, we were surprised to learn of a corresponding increase in calls from the military. Since March 2009, OP's Crisis Lines have received over 1,600 calls from members of the military, veterans and their families.

These calls have run the gamut—from suicide and substance abuse to concerns about symptoms of post traumatic stress disorder, depression, and questions about jobs about health benefits.

As a result, this past spring Oregon Partnership established a Military Helpline to meet the tremendous and growing need for compassionate, confidential crisis intervention and referral. The line—one of five specifically targeted crisis lines at OP—is operated by highly trained and dedicated staff and volunteers who are on hand around the clock. Some possess a military background, bringing a strong understanding of the daunting challenges our citizen soldiers and their families face.

There is no question that America must do right by the men and women who have served and continue to serve our country.

After experiencing war, life back home can be overwhelming. Issues such as unemployment, family strife, the loss of a home, PTSD and other serious health care concerns descend as soldiers return from long—and often repeated—deployments. These challenges may stop them from seeking help at all.

What Oregon Partnership found was a huge gap in services—a gap that is serious and time-sensitive.

Soldiers, veterans and their families desperately need the immediate and confidential help that 24-hour crisis lines offer—crisis lines operated outside the military and the Veterans Administration.

There is a clear and present stigma in the military culture about seeking help for mental illness, emotional distress and contemplation of suicide. Recent efforts by the Department of Defense to diffuse this are to be applauded, but have decades of practice to overcome.

Many active duty soldiers or members of the reserves are hesitant to seek help within the military health care system because of fear that it would appear on their military record, jeopardize their security clearance and/or impact promotion opportunities.

So often, men and women separating from the military are reluctant to access the VA because of perceived agency dysfunction, claims denial, red tape, and frustration about the length of the process.

It is vital that veterans and active military can call a confidential line and speak anonymously if they so choose. It's all about reacting quickly, compassionately and effectively in time-sensitive situations, and providing for the safety of those suffering from invisible wounds.

Recently, a severely depressed and suicidal veteran called our helpline. Wheelchair-bound and without transportation to the VA to get his prescribed medication, he was ready to kill himself. We connected him with the Portland VA Medical Center's suicide prevention team and secured a quick resolution to his life-threatening situation. Without our helpline, he was tragically slipping through the cracks.

A confidential military helpline is a valuable tool for returning soldiers who struggle with PTSD. Early intervention and assessment is key. And Oregon Partnership's Military Helpline provides that, guiding individuals and families on a path to safety and healing.

In establishing the Military Helpline, Oregon Partnership has received unwavering support from the Oregon Military Department and the Oregon National Guard. They have been and will continue to be tremendous partners in this life-saving work.

The brave men and women who have served us so faithfully deserve our faithfulness in return. Oregon Partnership urges Congress to help robustly support these non-military lifelines.

MATERIAL SUBMITTED FOR THE RECORD

Committee on Veterans' Affairs
 Subcommittee on Oversight and Investigations
 Washington, DC.
July 28, 2010

Honorable Robert M. Gates
 Secretary of Defense
 U.S. Department of Defense
 1000 Defense Pentagon
 Washington, DC 20301

Dear Secretary Gates:

Thank you for the testimony of Colonel Robert W. Saum, USA, Director of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on July 14, 2010, entitled "Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs."

Please provide answers to the following questions by Friday, September 10, 2010, to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigation.

1. Can you give examples of how DoD has used multi-media to prevent suicide prevention within its own ranks? I know you have only been on the job for about a month, but what are your impressions so far on ways VA could improve outreach to at risk veterans and servicemembers contemplating suicide?
2. Can you explain how the DoD and VA coordinate to help activated guard and reserve members—and ensure that they have the resources they need to help prevent them from becoming suicidal?
3. During the July 15, 2008 hearing on Media Outreach, then Ranking Member Ginny Brown-Waite asked if there was a prohibition on using email addresses, or social media sites such as *Facebook* or *Twitter* to contact veterans regarding services available to them. At that time, Ms. Mondello, the Assistant Secretary of Public and Intergovernmental Affairs for VA stated that VA is working to enable Federal representation of citizen information on social media Web sites, and is planning an initial social media presence on four of the most popular networking Web sites: *Facebook*, *MySpace*, *YouTube*, and *Second Life*. What is the current status on the use of these types of Web sites by the Department of Defense, and how is the Department integrating its suicide prevention outreach into these social media?
4. According to a fact-sheet we received from the VA on suicide statistics, there are between 30,000 and 32,000 U.S. deaths from suicide per year among the population in the U.S. overall. Of these about 20 percent are veterans, about 18 deaths from suicide per day are veterans. Does your Department also keep statistics on active duty personnel, as well as Guard and Reservists with relation to the rate of suicides?
5. On June 8, 2010, there was an article in *Marine Times* about the rise in suicide attempts by Marines. In the report, it indicated that "recent improvements in tracking suicide attempts may have contributed to more reports." What is the Department of Defense currently doing to track suicide attempts amongst not only its active duty personnel, but also among the National Guard and Reserve units, and the Individual Ready Reserve?
6. What is the Department of Defense doing to combat the stigma, or the worry that they are possibly jeopardizing the military career if a servicemember calls a hotline, or sought other help when they have suicidal thoughts? What reassurances do servicemembers have that when they call for help, they will not be tagged as a weakling or someone not worthy of being in the military?
7. How does the Department of Defense reach out to servicemembers who may be at risk for suicidal ideation?
8. Would the Department of Defense be interested in working on a coordinated effort with the VA on working to prevent suicides amongst our Nation's servicemembers and veterans through outreach and media advertising?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Martin Herbert, Majority Staff Director for the Subcommittee on Oversight and Investigations at (202) 225-3569 or Arthur Wu, Minor-

ity Staff Director for the Subcommittee on Oversight and investigations at (202) 225-3527.

Sincerely,

Harry E. Mitchell
Chairman
 MH:tc

David P. Roe
Ranking Republican Member

Hearing Date: July 14, 2010
House Committee on Veterans' Affairs
Member: Congressman Mitchell
Witness: Colonel Saum

Question 1: Can you give examples of how DoD has used multi-media to prevent suicide prevention within its own ranks? I know you have only been on the job for about a month, but what are your impressions so far on ways VA could improve outreach to at risk veterans and servicemembers contemplating suicide?

Answer: The Department of Defense and the Military Services have designed and implemented multimedia programs to promote the processes of building resilience, facilitating recovery, and supporting reintegration for returning Servicemembers and their families. The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury's Real Warriors Campaign is a multimedia public education initiative that is designed to break down the barriers to care for the invisible wounds of war and to encourage Servicemembers to reach out for the care they may need. Visitors to www.realwarriors.net who are experiencing suicidal ideation—or who know someone who is—will find articles, video profiles, and message boards that focus on suicide prevention as well as combat-related stress, traumatic brain injury and other invisible wounds. The Web site also includes a live chat feature that makes it easy for visitors to confidentially connect to health consultants with expertise in psychological health and traumatic brain injury for information 24 hours a day/7 days a week/365 days a year. Many of our campaign materials were developed in collaboration with the VA, and all materials are in the public domain.

There are also multimedia initiatives within each of the Services to encourage Servicemembers to reach out for necessary care before they reach a moment of crisis. The Army Suicide Prevention Office's "Shoulder to Shoulder" program includes the video "I Will Never Quit on Life," which includes vignettes and testimonials of members of Army families who received help for psychological stress or who assisted individuals in need. The Navy Suicide Prevention Program includes posters and other materials, such as brochures and public service announcements to educate sailors about the signs and symptoms of combat-related stress and available treatment resources. The Air Force Suicide Prevention Program includes tools and resources for Airmen and their families, commanders, leaders, and health professionals, as well as videos addressing ways Airmen can help their fellow Servicemembers who are experiencing combat-related stress.

Question 2: Can you explain how the DoD and VA coordinate to help activated guard and reserve members—and ensure that they have the resources they need to help prevent them from becoming suicidal?

Answer: When Guard and Reserve members are activated, they are fully eligible for care through the Department's Mental Health System. In addition, there are numerous suicide prevention programs within the Department of Defense (DoD) to which activated Guard and Reserve members are exposed and have access to. The DoD and Department of Veterans Affairs (VA) coordinate their outreach and suicide prevention resources for activated Guard and Reserve members through: (1) the DoD/VA Integrated Mental Health Strategy, (2) the National Suicide Prevention Lifeline, and (3) National Suicide Prevention Week activities.

First, through DoD/VA Integrated Mental Health Strategy, the two Departments will be coordinating suicide surveillance standards, trainings and suicide prevention outreach efforts for Servicemembers, including activated Guard and Reserve members, and veterans. Second, the VA National Suicide Prevention Lifeline offers suicide prevention services with trained crisis counselors for Active Duty Servicemembers, including activated Guard and Reserve members, and veterans. There is also a process in development for warm transfers between DoD call centers and the VA Lifeline. The VA Lifeline serves as the primary crisis counseling resource for

DoD servicemembers and their families. Third, the DoD and VA are coordinating activities for National Suicide Prevention Week, which begins September 6, 2010. Both departments will be cross-promoting each other's activities and resources such as webinars and suicide prevention factsheets. In addition, the DoD and VA are working with the American Association of Suicidology so that veterans and activated Guard and Reserve members receive all relevant and appropriate resources.

Question 3: During the July 15, 2008 hearing on Media Outreach, then Ranking Member Ginny Brown-Waite asked if there was a prohibition on using email addresses, or social media sites such as *Facebook* or *Twitter* to contact veterans regarding services available to them. At that time, Ms. Mondello, the Assistant Secretary of Public and Intergovernmental Affairs for VA stated that VA is working to enable Federal representation of citizen information on social media Web sites, and is planning an initial social media presence on four of the most popular networking Web sites: *Facebook*, *MySpace*, *YouTube*, and *Second Life*. What is the current status on the use of these types of Web sites by the Department of Defense, and how is the Department integrating its suicide prevention outreach into these social media?

Answer: Social media are an integral part of Department of Defense (DoD) operations. The Services have social media platforms, including, but not limited to, *Facebook*, *Twitter*, *YouTube*, and *Flickr*. The DoD has created a special Web site designed to help the DoD community use social media and other Internet-based capabilities responsibly and effectively, both in official and unofficial capacities. Each of the Services uses social media to drive traffic to their respective suicide prevention Web sites and programs. The Service-specific social media outlets can be found online at <http://socialmedia.defense.gov/services/>.

The Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) also uses social media to guide those who may need help or information on suicide prevention and available psychological health resources; to promote psychological resilience; and to combat stigma. The DCoE social media team provides information on suicide prevention programs and access to a 24/7 call center through its pages on *Facebook*, *Twitter*, and the *DCoE* blog.

Question 4: According to a fact-sheet we received from the VA on suicide statistics, there are between 30,000 and 32,000 U.S. deaths from suicide per year among the population in the U.S. overall. Of these about 20 percent are veterans, about 18 deaths from suicide per day are veterans. Does your Department also keep statistics on active duty personnel, as well as Guard and Reservists with relation to the rate of suicides?

Answer: Yes. The DoD maintains suicide statistics on Active Duty, Guard, and Reserve personnel and calculates the rate on an annual basis. In calendar year (CY) 2008, the suicide rate among Active Duty personnel, including activated Guard and Reserves was 16.2 per 100,000 per year. In CY 2009, the suicide rate was 18.4 per 100,000 per year, for the same population. An annual report with suicide data, historical and civilian context, and summaries of DoD suicide prevention initiatives are submitted to the Secretary of Defense. The DoD also began tracking Inactive National Guard and Reserves suicide data starting in 2009.

Question 5: On June 8, 2010, there was an article in *Marine Times* about the rise in suicide attempts by Marines. In the report, it indicated that "recent improvements in tracking suicide attempts may have contributed to more reports." What is the Department of Defense currently doing to track suicide attempts amongst not only its active duty personnel, but also among the National Guard and Reserve units, and the Individual Ready Reserve?

Answer: The Department of Defense (DoD) uses a standardized surveillance system called DoD Suicide Event Report (DoDSER) to track suicide attempts among Active Duty personnel. The DoDSER captures data points such as personal characteristics, historical factors, event details, and clinical history for each suicide or suicide attempt. Some of the Services also collect this information on suicide attempts among the National Guard and Reserve units. At this time, the DoD does not track suicide attempts among the Individual Ready Reserve members.

Created to facilitate collaboration and synchronize suicide prevention surveillance across the Services, the DoDSER tool has been used to capture information on suicides since January 1, 2008. As of January 12, 2010, as directed by the Under Secretary of Defense for Personnel and Readiness, the DoDSER has been used by all the Services to track suicide attempts.

Question 6: What is the Department of Defense doing to combat the stigma, or the worry that they are possibly jeopardizing the military career if a servicemember calls a hotline, or sought other help when they have suicidal thoughts? What reassurances do servicemembers have that when they call for help, they will not be tagged as a weakling or someone not worthy of being in the military?

Answer: To successfully encourage at-risk veterans and Servicemembers who are experiencing suicidal ideation to reach out for help, we must prove to them that every warrior experiences some deployment stress; treatment and resources are readily available and they work; and reaching out is a sign of strength and not automatically a career-ender.

The warriors profiled on *www.realwarriors.net* are sharing their own stories of resilience, recovery, and reintegration because they want to encourage others to reach out for necessary care. They are proof that Servicemembers need to know that reaching out makes a difference for their mental health but not in their careers. Many of the Servicemembers profiled on the Web site have been promoted since seeking care for their invisible wounds. We hope that these real-life stories are inspiring others to reach out and access psychological health resources such as the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury's Outreach Center and "GiveAnHour," which can be accessed online and by telephone to provide confidential assistance.

As part of encouraging Servicemembers to reach out without fear of repercussion, in May 2008, Defense Secretary Robert M. Gates announced the change to Question 21 on the National Security Background Questionnaire (SF-86), which asks security clearance applicants to indicate whether they had ever received psychological health care. The question now excludes counseling related to service in combat.

Question 7: How does the Department of Defense reach out to servicemembers who may be at risk for suicidal ideation?

Answer: The Department of Defense (DoD) leverages a variety of approaches to reach out to Servicemembers, including education campaigns and interactive Web sites. There are practical challenges to identifying individuals who are at risk for suicidal ideation, therefore the DoD and the Services have designed and implemented broad outreach initiatives to encourage Servicemembers to seek help and to educate them on all the available resources.

The Defense Centers of Excellence (DCoE) for Psychological Health and Traumatic Brain Injury's Real Warriors Campaign is a multimedia public education initiative designed to break down the barriers to care, and to encourage Servicemembers to reach out for the care they may need. The Real Warriors Campaign provides real-life examples of Servicemembers and veterans who have had the strength to reach out for care for psychological health concerns, including suicidal ideation. They illustrate the importance of support from friends, families and units, and show examples of individuals who are now maintaining successful careers either in the military or as civilians. For example, our most recently featured Real Warrior speaks candidly about suicidal ideation after losing his leg as a result of an improvised explosive device. He had the strength to reach out for care and continues to serve the military community in a civilian career.

The Web site, *www.realwarriors.net*, also includes a live chat feature that enables visitors to confidentially connect to health consultants with expertise in psychological health and traumatic brain injury for information 24 hours a day, 7 days a week, 365 days a year.

The Caring Letters Project is an outreach program that involves sending brief letters of concern and reminders of treatment availability at regular intervals to individuals at high risk for suicide following psychiatric hospitalization. The Caring Letters Project has proven to be a successful intervention practice in the civilian sector. The DCoE's National Center for Telehealth and Technology is currently piloting a Caring Letters program at Madigan Army Medical Center.

In addition, DCoE's web-based platform *www.afterdeployment.org*, offers a safe and interactive platform to better understand and increase awareness of substance misuse, depression, and other mental health related issues. The site features include quick health tips, self-assessments, e-libraries, self-paced workshops, personal stories, and a community forum. There is also a Google map locator tool to help users find providers close to home.

Question 8: Would the Department of Defense be interested in working on a coordinated effort with the VA on working to prevent suicides amongst our Nation's servicemembers and veterans through outreach and media advertising?

Answer: The Department of Defense (DoD) is interested in expanding our collaboration with the Department of Veterans Affairs (VA) on outreach and media advertising efforts. Currently, the DoD is coordinating with the VA on outreach and media advertising for the National Suicide Prevention Lifeline, which is a crisis hotline. Promotional materials and public service announcements attempt to increase awareness of the crisis line as a resource for Active Duty Servicemembers as well as veterans and their families.

In addition, the DoD and VA are coordinating to prevent suicides among Servicemembers and veterans through outreach during National Suicide Prevention Week, which begins September 6, 2010. Both departments will be cross promoting each other's activities and resources such as webinars and suicide prevention factsheets. In addition, the DoD and VA are working with the American Association of Suicidology so that veterans and activated Guard and Reserve members receive all relevant and appropriate resources. Lastly, there are plans included in the DoD/VA Integrated Mental Health Strategy for increasing coordination on communication and outreach to families of Servicemembers and veterans in the area of suicide prevention.

Committee on Veterans' Affairs
Subcommittee on Oversight and Investigations
Washington, DC.
July 28, 2010

Honorable Eric K. Shinseki
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, D.C. 20420

Dear Secretary Shinseki:

Thank you for the testimony of Robert L. Jesse, M.D., Ph.D., Principal Deputy Undersecretary for Health, Veterans Health Administration, U.S. Department of Veterans Affairs, accompanied by Janet Kemp, R.N., Ph.D., National Suicide Prevention Coordinator, U.S. Department of Veterans Affairs at the U.S. House of Representatives Committee on Veterans' Affairs Subcommittee on Oversight and Investigations hearing that took place on July 14, 2010, entitled "Examining the Progress of Suicide Prevention Outreach Efforts at the U.S. Department of Veterans Affairs."

Please provide answers to the following questions by Friday, September 10, 2010, to Todd Chambers, Legislative Assistant to the Subcommittee on Oversight and Investigations.

1. What progress have you made in advancing the VA's use of multi-media in outreach efforts since the pilot program ended in the fall of 2009?
2. What lessons did the VA learn from the suicide prevention outreach pilot?
 - a. How is the VA planning on utilizing the lessons learned going forward?
3. In your testimony you state that in 2009, VA launched the Veterans Chat Program to create an online presence for the Suicide Prevention Hotline. Do you think this initiative is doing what it was designed to do, and how do you track whether this initiative is succeeding?
4. You stated in your testimony that all Vet Center staff members have been trained in the Gatekeeper suicide prevention model and that the Vet Centers participate in outreach and community education projects. Do you think there is a better way for VA to do this by using the power of multi-media? If so, in what ways?
5. How was the hand off of the success of the pilot program carried out in the transition of power from the last administration to the current one?
6. During the July 15, 2008 hearing on Media Outreach, then Ranking Member Ginny Brown-Waite asked if there was a prohibition on using email addresses, or social media sites such as *Facebook* or *Twitter* to contact veterans regarding services available to them. At that time, Ms. Mondello, the Assistant Secretary of Public and Intergovernmental Affairs for VA stated that VA is working to enable Federal representation of citizen information on social media Web sites, and is planning an initial social media presence on four of the most popular networking Web sites: *Facebook*, *MySpace*, *YouTube*, and *Second Life*. What is the current status on the use of these Web sites by VA, and how is VA integrating its suicide prevention outreach into these social media?

7. Members of your staff recently briefed the Senate and House staff on the progress being made by the Suicide Hotline in preventing suicides amongst veterans. Included in the discussion was an update on the calls to the hotline during times when VA made a concerted effort to advertise the hotline in major media outlets, including the Public Service Announcement (PSA) featuring actor Gary Sinise. These statistics showed that during peak advertising periods, the rate of calls to the hotline increased. What is your plan for your outreach and advertising campaign for 2011?
8. Is there a one-stop shop, so to speak for an individual to go to when they are feeling depressed, want someone to talk to, and need help regardless of whether they are a veteran, a servicemember, a guard or reservist, or even just a regular citizen on the street? What occurs when someone calls into your existing hotline who is not a member of the armed forces, or a veteran?
9. The New York Police Department has a partnership with an organization called POPPA, Police Organization Providing Peer Assistance, to help the NYPD officers deal with the stress of their jobs. This mainly serves as a 24-hour helpline staffed by other police officers who volunteer to act as suicide counselors. Officers often feel most comfortable talking anonymously to fellow members of the force. The POPPA helpline is credited with saving the lives of 80 NYPD officers in the last 14 years, and the rate of suicides within the department has fallen 40 percent. What efforts has the VA made to make peer-to-peer counseling available to veterans? Are there any plans to expand this, and has the VA considered partnering with other organizations that have developed such programs?

Thank you again for taking the time to answer these questions. The Committee looks forward to receiving your answers. If you have any questions concerning these questions, please contact Martin Herbert, Majority Staff Director for the Subcommittee on Oversight and Investigations at (202) 225-3569 or Arthur Wu, Minority Staff Director for the Subcommittee on Oversight and Investigations at (202) 225-3527.

Sincerely,

Harry E. Mitchell
Chairman
 MH:tc

David P. Roe
Ranking Republican Member

Questions for the Record
The Honorable Harry E. Mitchell, Chairman
The Honorable David P. Roe, Ranking Republican Member
Subcommittee on Oversight and Investigations
House Committee on Veterans' Affairs
"Examining the Progress of Suicide Prevention Outreach Efforts at the
U.S. Department of Veterans Affairs"
July 14, 2010

Question 1: What progress have you made in advancing the VA's use of multi-media in outreach efforts since the pilot program ended in the fall of 2009?

Response: Veterans Health Administration (VHA) social media outreach continues to expand. Suicide prevention themes remain a core message. VHA *Facebook* fans currently are about 35,000. *Twitter* followers are over 3,500. We monitor *Facebook* for Veterans who express suicidal thoughts and reach out and contact them directly and have been successful in getting these Veterans help when needed. In addition, the Veteran's Chat Service was implemented in 2009, since then over 7,000 "chatters" have worked with VA counselors on a one-on-one basis using the chat. We continue to work with our Substance Abuse and Mental Health Services Administration (SAMHSA) and Lifeline Partners to market the service and increase usage. We continue to do local outreach efforts including poster placement at various VA and Community sites, Suicide Prevention Coordinator training in the community, and regular "awareness" activities.

Question 2: What lessons did the VA learn from the suicide prevention outreach pilot?

Question 2(a): How is the VA planning on utilizing the lessons learned going forward?

Response: VA learned the following lessons as a result of the suicide prevention outreach pilot:

- A lesson learned early on from Veterans' focus groups was the need to prevent possible feelings of shame and stigma from being attached to a Veteran's possible "emotional problems." The lesson was that careful selection of slogans served both to reaffirm the Veteran's positive character traits, while simultaneously promoting the acceptability of calling the suicide prevention hotline when having symptoms of mental distress. This helped us to select the campaign's central message and slogan "*It takes the courage and strength of a warrior to ask for help*".
- Veterans' feedback noted it was important to deflect attention away from the Veteran as the *exclusive* target audience. Thus, rather than focusing solely on the Veteran as the one most likely to need help dealing with depression, the campaign message became "*If you or someone you know is in an emotional crisis, call . . .*" This allowed the Veteran the option to refer a military "buddy" to the suicide prevention hotline but did not rule out that he or she could also call the hotline for their own personal needs.
- We learned that an aggressive outreach to our target audiences "*wherever they are*" was needed. Accordingly, the Transit Authority Suicide Prevention Campaigns used thousands of Transit Authority vehicles of various kinds, metro and bus station dioramas, "street furniture" provided by the Transit Authorities for advertisements, metro rail cars, etc. Feedback from Veterans, however, included advice to use fewer words on these materials. This will be implemented in the future. We observed that television and radio were potent means for outreach to Veterans in their homes and cars.
- We also learned that the choice of a spokesperson for a Public Service Announcement (PSA) is important. The PSA featuring actor Gary Sinise may appeal to older Veterans, but younger Veterans from Iraq and Afghanistan have noted in testimony that they do not relate to this actor. Experts advise that many effective and memorable PSA's do not rely on "talking heads," and we have learned that it is important to work through experienced professional communications experts to develop our next campaign. We will seek to collaborate with organizations such as The Ad Council, which has been effective in developing and promoting PSA's directed at Iraq and Afghanistan Veterans. Our in-house pilot efforts resulted in 17,000 airings for the Gary Sinise PSA, but we know collaboration with communications experts will help us to obtain the hundreds of thousands of airings needed in an effective national effort.
- We also learned that early notification should be given to the Suicide Prevention Hotline responders regarding PSA airing schedules. The first time the PSA's were shown on local TV stations there were significant increases in the numbers of calls to the Hotline. This coordination will be implemented in the future campaigns.
- Finally, we learned that it is extremely important to do the analysis and planning for advertising to reach targeted audiences—both Veterans who may be at special risk as well as those who can influence and intervene on behalf of Veterans—so that we can, in turn, use professional industry analysis to evaluate the effectiveness of our efforts. Our initial research in the pilot activity does, in fact, show an encouraging relationship between our print and other communications and the number of calls to the Hotline. But there are many intervening variables that effect social behavior outside the realm of our pilot communications. We will ensure that our future efforts include expert formative research; careful, evidence-based logic models that show how our communications actually affect our specific target audiences; and model-based evaluative research that can show clearly our success. We will engage social marketing experts in our partnership with the Office of Public and Intergovernmental Affairs through a new National Outreach Contract. This will add considerably to our capabilities to document, evaluate and strengthen our delivery of effective health and wellness messages to priority audiences.

Question 3: In your testimony you state that in 2009, VA launched the Veterans Chat Program to create an online presence for the Suicide Prevention Hotline. Do you think this initiative is doing what it was designed to do, and how do you track whether this initiative is succeeding?

Response: The Chat Program has been hugely successful. It was designed to provide an alternative mechanism for Veterans to seek help in times of emotional need.

Since its inception in 2009, over 7,000 Veterans have opted to seek help over the Chat Service. We have been able to transfer almost 800 of these chatters to the Suicide Hotline for immediate services and we have provided on-line support for the other Veterans. The number of Veterans who use this service continue to grow and we feel the Veterans Chat Program is in a position to accept more and more “chatters” as younger Veterans need services. We will continue to expand this program as need dictates. Our on-line relationship with the Lifeline has also allowed us to market the Chat Service and the Hotline through non-VA social media sources which helps us reach groups of Veterans who are not already enrolled or looking for VA care. Most of our “chatters” are non-enrolled Veterans and we hope we are providing a new avenue for them to seek services.

Question 4: You stated in your testimony that all Vet Center staff members have been trained in the Gatekeeper suicide prevention model and the Vet Centers participate in outreach and community education projects. Do you think there is a better way for VA to do this by using the power of multi-media? If so, in what ways?

Response: It will take a combination of both personal outreach and the use of multi-media and social-media venues to reach everyone. There are still large numbers of people who respond best to personal interactions and there are people who respond better to media and non-personal approaches and marketing. We have to use all of our people and technological resources. VA employees at both the Medical Centers and the Vet Centers are being given access to social media venues and we are learning how to use them to reach out to people. We are using broadcast media to promote selected aspects of our services such as the Hotline. We will continue to explore new venues.

Question 5: How was the hand off of the success of the pilot program carried out in the transition of power from the last administration to the current one?

Response: The hand-off between the two administrations went smoothly. The Transit Authority Suicide Prevention campaign concept that was piloted in Washington, DC, between July and October of 2008, was expanded in the summer of 2009 to seven metropolitan markets including: Dallas, TX; Las Vegas, NV; Los Angeles, CA; Miami, FL; Phoenix, AZ; San Francisco/Oakland, CA; and Spokane, WA.

Further, we entered into a contract with BluLine Media to provide interior bus advertisement space on municipal buses in many markets around the country. VA Suicide prevention advertisements were displayed on 21,000 public transit buses in 124 cities in over 42 States across the country. The 3-month campaign started in the summer and extended into the fall of 2009.

In addition, the airings of our PSA's featuring actor Gary Sinise and TV personality Deborah Norville, which started airing at the end of 2008, continued and in fact greatly expanded (particularly the Sinise PSA) in 2009.

Question 6: During the July 15, 2008 hearing on Media Outreach, then Ranking Member Ginny Brown-Waite asked if there was a prohibition on using email addresses, or social media sites such as *Facebook* or *Twitter* to contact Veterans regarding services available to them. At that time, Ms. Mondello, the Assistant Secretary of Public and Intergovernmental Affairs for VA stated that VA is working to enable Federal representation of citizen information on social Web sites, and is planning an initial social media presence of four of the most popular networking Web sites: *Facebook*, *MySpace*, *YouTube* and *Second Life*. What is the current status on the use of these Web sites by VA, and how is VA integrating its suicide prevention outreach into these social media?

Response: VHA currently has an active and dynamic presence in the most popular social media sites, *Facebook*, *Twitter* and *YouTube*. Veterans Health Administration and nearly 25 medical centers use *Facebook* as a form of outreach, and, mindful of the audience of Veterans at risk, as well as family members, they have made suicide prevention one of the recurring messages. VA Medical Centers that use *Facebook* routinely monitor the comments from readers that have sometimes indicated an emotional crisis. The Suicide Prevention Hotline staff use *Facebook* and also monitor VHA *Facebook* pages to directly engage with Veterans and family members who may need help.

Twitter messages regarding suicide prevention resources are very widely read and shared with other *Twitter* readers. We also continue to have a presence on the virtual world of *Second Life*.

Question 7: Members of your staff recently briefed the Senate and House staff on the progress being made by the Suicide Hotline in preventing suicides amongst Veterans. Included in the discussion was an update on the calls to the hotline dur-

ing times when VA made a concerted effort to advertise the hotline in major media outlets, including the Public Service Announcement (PSA) featuring actor Gary Sinese. These statistics showed that during peak advertising periods, the rate of calls to the hotline increased. What is your plan for your outreach and advertising campaign for 2011?

Response: We are in the process of developing a contract with a public relations company that will assist us in interpreting the results from the media campaign evaluation, as well as various focus groups that we have conducted. We will use the input we have received about our current products to develop a plan for FY 2011 that will specifically help us address our identified target groups and reach as many people as we can. We know that what we have done so far has allowed us to reach many people but we do not know that it allowed us to reach as many Veterans as possible. We expect that contract to be in place very shortly and that the plan will be developed by the end of the calendar year. In the meantime we are re-distributing the Public Service Announcement and running a second mass transit campaign this fall to maintain the momentum. The contract for this campaign has been awarded and we anticipate the posters will be placed in buses in late September.

Question 8: Is there a one-stop shop, so to speak for an individual to go to when they are feeling depressed, want someone to talk to, and need help regardless of whether they are a Veteran, a Servicemember, a guard or reservist, or even just a regular citizen on the street? What occurs when someone calls into your existing hotline who is not a member of the armed forces, or a Veteran?

Response: The Hotline is available for anyone to call. We provide services to all who call or enter the chat service. Rescues are provided to everyone who is in imminent danger. Referrals are made to whoever can help the caller. For non-Veterans "Warm transfers" are made to community Lifeline crisis centers—who in turn send Veterans and Servicemembers to us if they did not directly call the VA Center. 1-800-273-TALK is indeed a national one-stop shop for American citizens and we are proud to be a critical part of this national program.

Question 9: The New York Police Department has a partnership with an organization called POPPA, Police Organization Providing Peer Assistance, to help the NYPD officers deal with stress of their jobs. This mainly serves as a 24-hour helpline staffed by other police officers who volunteer to act as suicide counselors. Officers often feel most comfortable talking anonymously to fellow members of the force. The POPPA helpline is credited with saving the lives of 80 NYPD officers in the last 14 years, and the rate of suicides within the department has fallen 40 percent. What efforts has the VA made to make peer-to-peer counseling available to Veterans? Are there any plans to expand this, and has the VA considered partnering with other organizations that have developed such programs?

Response: We work closely with community organizations such as POPPA. POPPA also has a Veterans line that routinely refers Veterans to the Hotline or the local VA for care. We will continue to work with these very critical community based agencies and support their efforts. Our Vet Centers also provide peer counseling services and we do refer Veterans to the Vet Center Call Center for help in non-crisis situations or their local VA Medical Centers if they want longer term peer-to-peer counseling services. Approximately 30 percent of our Hotline staff is Veterans and within the Hotline, calls are transferred to responders who may relate well with the caller. We agree that these are valuable services and we will continue to seek out partnerships and ways to work together.

