

MENTAL HEALTH AND SUICIDE AMONG VETERANS

HEARING

BEFORE THE

COMMITTEE ON VETERANS' AFFAIRS UNITED STATES SENATE

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MENTAL HEALTH AND SUICIDE AMONG VETERANS

WEDNESDAY, NOVEMBER 19, 2014

U.S. SENATE,
COMMITTEE ON VETERANS' AFFAIRS,
Washington, DC.

The Committee met, pursuant to notice, at 10:30 a.m., in room SR-418, Russell Senate Office Building, Hon. Bernard Sanders, Chairman of the Committee, presiding.

Present: Senators Sanders, Murray, Tester, Begich, Blumenthal, Hirono, Burr, Isakson, Johanns, Moran, Boozman, and Heller.

STATEMENT OF HON. BERNARD SANDERS, CHAIRMAN, U.S. SENATOR FROM VERMONT

Chairman SANDERS. OK, let us get to work. I want to thank the Members for being here, and all of our guests for being here, for what is not only a very important hearing, but is a hearing that discusses an issue of huge consequence in our country. This will no doubt be a very difficult hearing because of what we are going to be touching on today: what happens to the men and women who come home from war, who have served us with great courage, and what happens to them when they return to civilian life, what happens to them and to their families who experience unspeakable tragedies.

Today we have some wonderful panelists who are going to talk about what the VA is doing, what the VA should be doing, what other private, non-profits are doing. I especially want to thank two very, very brave women who are with us this morning. I cannot express to you my respect for their courage, because both of these women, Susan Selke and Valerie Pallotta, have experienced tragedies that are nightmarish.

But what they have chosen to do is to come forward and give us their best ideas in terms of how we can prevent the tragedies that they have experienced from happening to other families, and we so much appreciate their courage and their willingness to share their thoughts with us.

This is a difficult issue. We know that hundreds of thousands of men and women came home with PTSD and/or TBI. We will hear what the VA is trying to do to treat those men and women, what works, what does not work, and how we move forward.

We are also going to hear from Senator Walsh who has been very active in the whole issue of veterans' mental health and suicide in a moment. We thank him for being here. With that, I yield the mic to Senator Burr, the Ranking Member.

**STATEMENT OF HON. RICHARD BURR, RANKING MEMBER,
U.S. SENATOR FROM NORTH CAROLINA**

Senator BURR. Mr. Chairman, good morning and thank you for holding this hearing; and thank you to our witnesses today. Your insight into VA's mental health programs will be tremendously helpful to this Committee.

I would particularly like to welcome Susan Selke and Valerie Pallotta. Thank you for your willingness to be here, to share your sons' tragic experiences with this Committee. I know this is painful to recount, but it is absolutely crucial to our understanding of what our men and women go through.

I would also like to welcome Vincent and Joan Vanata. Thank you for sharing your story with the Committee, which I am sure is also difficult to tell. It is important to the Members of this Committee to hear firsthand from not only veterans, but from families and friends about their experiences accessing mental health treatment at the VA.

Before I turn to today's hearing, I would like to talk just a minute about a bill Senator McCain, Blumenthal, and I introduced this week, the Clay-Hunt Suicide Prevention for American Veterans of 2014, named for Sue Selke's son, which will direct VA to review its suicide prevention programs to determine which ones actually work, improve the transition from the battlefield to civilian life for the National Guard, provide incentives for psychiatrists to work at the VA, and direct VA to collaborate with non-profit organizations on suicide prevention efforts. While this bill will not fix everything, it is a big step in the right direction, I believe.

Now, turning to today's topic, this is my fifth hearing over the last 4 years providing oversight of VA's mental health programs. At those hearings, we have heard from veterans, their families, and their friends about the difficulties at accessing appropriate mental health care. While I find it disturbing—what I find so disturbing is what we will hear today is very similar to what we heard in 2011.

One problem I raised at previous hearings, which still applies today, is a misplaced focus on the process of providing treatment, for instance, whether VA is actually providing evidence-based treatments. As VA's written testimony states, VA has made deployment of evidence-based therapies a critical element of its approach to mental health care.

Yet, two studies say the VA does not consistently provide evidence-based treatments. More importantly, whether or not VA provides evidence-based treatments should not be the focus. The focus should be on improving mental health. According to a survey of 3,100 veterans by The American Legion, veterans do not believe their symptoms are improving. The Legion found that more than half of those surveyed felt that there was either no improvement or worsening of symptoms following psychotherapy or medication prescribed by the VA.

If more than half of our Nation's veterans do not think they are getting better, I believe the focus on whether evidence-based treatments is provided might be misguided. Where is the veteran in this? I am interested in hearing from VA how it tracks the improvement of veterans' mental health after receiving care, what

flexibility VA gives providers to make sure it is individualized, and how VA is working with outside providers and organizations to guarantee that if a veteran cannot get an appointment at a VA facility, they get the treatment they need and deserve somewhere in that community.

As I have said many times, Government cannot be the only solution. VA needs to bring other organizations and providers into the fold to help. It also does not take technology to help these veterans. It takes compassion and a passion to help. In the past, we have heard that veterans felt that VA providers did not care. I believe this needs repeating. It takes compassion and, as I have said in previous hearings, someone on the other end of the phone who sounds like they want to help.

Before I yield, Mr. Chairman, I would like to address very briefly the Veterans Access, Choice, and Accountability Act, which was signed into law in August. The Choice Act provided \$17 billion in funding to help veterans receive care from the provider of their choosing, and provides the largest reform in VA history.

While I appreciate the Department providing weekly updates to all of our staffs on the implementation of the Act, I believe that a \$17 billion bill deserves additional oversight from this Committee. So, I realize that time is running out in this calendar year and in this Congress, but I urge all those on the Committee next year to make sure that oversight of this reform package is number 1 on our list of priorities for the VA Committee.

I thank my colleagues, I thank the Chair, and I thank our witnesses.

Chairman SANDERS. Thank you, Senator Burr.
Now we are going to hear from Senator Walsh.

**STATEMENT OF HON. JOHN WALSH,
U.S. SENATOR FROM MONTANA**

Senator WALSH. Chairman Sanders, Ranking Member Burr, thank you for allowing me to speak today about an issue that is very important to me, our veterans' mental health. This is a sensitive topic that I am sure has touched every single person in this room. An oft-cited statistic is that 22 veterans die by suicide each and every day in this country. If that many men and women were dying on the battlefield, this country would be up in arms. It simply is unacceptable.

As the wars in Afghanistan and Iraq have wound down, many American families are welcoming back sons, daughters, husbands and wives who are changed people. These men and women were willing to sign their names on the dotted line. They were willing to give their full last measure of devotion, and we owe them the opportunity to heal, whether their wounds are seen or unseen.

So, I speak from my own humble experience. Combat changes you. When my own battalion returned from combat in Iraq, for some of my men the war did not end. I have known too many soldiers and airmen who have died by suicide. I think of them and their families every single day, and the impact that this war has had on our men and women across the country.

I am pleased to see the renewed attention this year to the crisis of veteran suicide from Congress and from the President. But I

want to focus your attention today on one immediate solution. Currently, veterans who serve in combat are eligible for prioritized care for 5 years after the end of their service. This 5-year period is inadequate. It has become increasingly clear that delayed onset PTSD is a serious phenomenon and the law today is out of date.

According to the National Comorbidity Survey, only 7 percent of people with PTSD seek treatment within 1 year of their initial trauma event. The average time it takes to seek treatment is well beyond the current 5-year combat eligibility period. Several major studies have also shown that between 16 and 20 percent of combat troops with mental illness suffered from delayed onset PTSD, the symptoms of which may not appear for several years.

Given this new research it is unacceptable that soldiers who have put themselves in harm's way for our country would have their eligibility for prioritized care revoked after only 5 years. These are soldiers who have walked roads booby-trapped with IEDs, experienced intense fire fights with an enemy that blended into the civilian population, and in too many cases, witnessed friends and comrades injured or killed by the enemy.

Extending the combat eligibility period for prioritized care at the VA is an immediate and affordable option that we should pass this Congress, and I emphasize this Congress. So, today I close by urging my colleagues to support this year extending combat eligibility to 10 years. We should not wait another day.

Mr. Chairman, thank you very much for the opportunity to speak.

Chairman SANDERS. Senator Walsh, thank you very much for your service, both in the Senate and in the military.

Let us hear now from Senator Tester.

**STATEMENT OF HON. JON TESTER,
U.S. SENATOR FROM MONTANA**

Senator TESTER. Thank you, Mr. Chairman. Of course, this is always timely, these hearings. I would just say this is something that comes with a fair share of challenges. Not only do we need all hands on deck, but the challenges of stigma that surround mental health is huge in our society. The challenges of not having enough mental health professionals—I do not care if it is in a rural area or an urban area—it is an incredibly important challenge.

I just talked to Secretary McDonald yesterday. He said even in some medical schools, 1 in 17 medical school students are taking up mental health or studying mental health issues. We have got to figure out a way to transcend those stats and get more people not only in the military, but quite frankly, in the private sector, too, where it is a huge problem also.

Then, the ability of the VA to use alternative treatment methods is critically important. I mean, different things work for different people and we need to give them flexibility. They need to have the flexibility to be able to treat these veterans who need help.

I would just say one other thing. We passed an important bill in July and it is a very good bill which needs to have oversight. Often-times, when the VA does not have a mental health professional, they cannot get it in the community either, meaning, we do not have enough folks. In the eastern two-thirds of Montana, east of

Billings, which is just about half the State, there is one mental health care professional. That is both VA and private sector.

So, we need to help not only our veterans, but the entire country deal with this issue as we move forward. I appreciate Senator Walsh's comments because I think he is spot-on. People do not want to admit they have a problem, and oftentimes it takes more than 5 years to get that admission. We need to reduce that stigma so they will admit to it earlier.

Thank you very much.

Chairman SANDERS. Thank you, Senator Tester.
Senator Isakson.

**STATEMENT OF HON. JOHNNY ISAKSON,
U.S. SENATOR FROM GEORGIA**

Senator ISAKSON. Well, thank you, Mr. Chairman, and I will not make a long statement at all out of respect for our witnesses, except to say that, Mrs. Pallotta, Mrs. Selke, you are in my thoughts and prayers not just today, but every day. The sacrifice of your sons for America is what keeps America strong, but the testimony about their tragedy is something I know is difficult. The VA and others will benefit from your willingness to share it and we are grateful to you for doing that.

To the VA members who will testify, I am anxious to hear what is happening. I know the testimony says there are 21,158 mental health professionals now in the VA full-time—equivalents or employees. I want to know, though, how much of that is contract community-based care and how much of it is in-house controlled care, and what has been done to make sure we do a better job of tracking veterans from the time they are diagnosed to the time they are treated. That is the most dangerous time of all.

Mr. Chairman, I will yield back after that.

Chairman SANDERS. Thank you, Senator Isakson.
Senator Hirono.

**STATEMENT OF HON. MAZIE HIRONO,
U.S. SENATOR FROM HAWAII**

Senator HIRONO. Thank you, Mr. Chairman. I thank the witnesses on this very important subject. Today, more than 1.4 million veterans receive mental health services from the VA, and I just want to mention briefly a person who came to testify at a Committee hearing that I held in Hawaii. Her name is Captain Elisa Smithers. She is one of these veterans. She is one of 120,000 veterans who live in Hawaii and she has testified at a field hearing in Hawaii about how she has suffered symptoms of traumatic brain injury and post-traumatic stress disorder after tours in Iraq and Kuwait.

She suffered from symptoms so severe that she nearly harmed one of her own children. While seeking treatment she experienced many obstacles in receiving VA care at her VA hospital. She eventually visited a civilian psychologist at a Vet Center who she credits with saving her life. Clearly, the mental health services that are provided through the VA should be accessible, and often the accessibility means that this care should be provided in a community health center setting, as Ms. Smithers experienced.

So, we know what the problems—many of the problems with the VA—and I agree with all my colleagues who stress the importance of collaboration and that we are all in this together and this is what we owe our veterans and their families.

Thank you very much.

Chairman SANDERS. Thank you, Senator Hirono.
Senator Moran.

**STATEMENT OF HON. JERRY MORAN,
U.S. SENATOR FROM KANSAS**

Senator MORAN. Mr. Chairman, thank you very much. Just this weekend I held a town hall meeting in Riley, KS, in which the first question was from a lady whose nephew had committed suicide. The question was, what are you doing about it, Senator? And while I indicated this hearing was taking place, the message to me was, having a hearing is not much comfort to anyone who just lost a family member.

In some ways, I found myself saying things that did not mean a lot to this person. So, the point I would make to my colleagues and to those who are here today is that this has got to be something much different than another hearing about this topic, although I am very grateful to you, Mr. Chairman, for having this hearing. We need to make sure that the follow-through occurs and that the families who have suffered so much and who continue to increase in number have something to take comfort, that their work will result in prevention.

So, I, too, join my colleagues in thanking these mothers, these family members for being here. I appreciate Senator Burr and the legislation, the Clay-Hunt Suicide Prevention Act. I have become a sponsor of that since learning about it this week. And I appreciate what Senator Tester had to say, the gentleman from Montana, our states are similar in many ways. Just the lack of health care professionals is so profound.

We have worked with the VA a decade trying to get them to utilize community mental health centers across our State, and I cannot see that there has been much success. So, I am anxious to hear that while the resources are short, are we utilizing the public sector resources within the VA that the VA is incapable of providing correctly.

Mr. Chairman, this is a serious topic, one of importance to us; and I look forward to finding solutions in the follow-through to make sure that suicide is prevented among our military men and women and their families.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Moran.
Senator Murray.

**STATEMENT OF HON. PATTY MURRAY,
U.S. SENATOR FROM WASHINGTON**

Senator MURRAY. Well, thank you very much, Mr. Chairman, for holding this really important hearing today. There really is no issue as pressing as providing quality, timely mental health care and suicide prevention programs to our Nation's heroes. The prob-

lem is familiar to everyone here, but as Senator Moran said, the solutions seem sort of elusive and we need to focus on that.

Senator Walsh just testified, as we all know, 22 veterans die per day because of suicide. I think it is important to note that rates have continued to increase among female veterans who use VA care, and among male veterans who are 18 to 24 who use the VA the rate has skyrocketed to 79 per 100,000. According to VA's access data, wait times for new mental health patients has been virtually unchanged. It is still 36 days over the 5 months that the VA has provided us the data.

So, I am very concerned about whether the VA and local communities are prepared with the resources and policy and training to help our veterans in serious crisis. We all know when our men and women in uniform have the courage to come forward and ask for help, the VA has to be there not only with high quality and timely care, but the right type of care to best meet the veterans' needs.

So, we have got to demand progress on all those areas. And as has been mentioned, we passed a new VA reform bill to help veterans get care just a few months ago. It included a temporary authority to improve access to community providers for veterans who are having trouble accessing VA care.

But a recent report by the RAND Corporation raises some serious concerns about whether private sector providers are ready to give high-quality care to our veterans and suggests we have to do a lot more to expand the use of evidence-based treatments and a lot more to help providers understand the unique needs and the culture of our servicemembers and our veterans.

The reform bill included some critically needed funds to build and strengthen the VA for the long term, but there are a lot more needs going forward. The VA has got to start planning and requesting the necessary resources now so it will be prepared to meet the growing demand for mental health care far into the future. So, there is a lot more work to be done. Just one suicide, just one veteran in crisis, or just one family struggling to make it through is just one too much.

I, too, want to thank you for this hearing and I want to thank Mrs. Selke, Mrs. Pallotta, and Mr. and Mrs. Vanata for being here today. It is incredibly difficult to talk about these issues, which we all really admire your courage and your strength for being willing to be here to share your stories with us today, because it is those stories and our understanding of them that will keep us focused on this, which I really appreciate.

Chairman SANDERS. Senator Murray, thank you very much.
Senator Johanns.

**STATEMENT OF HON. MIKE JOHANNS,
U.S. SENATOR FROM NEVADA**

Senator JOHANNS. Mr. Chairman and Ranking Member Burr, thank you again for holding this hearing. A very, very important topic. I also want to express to all the family members who are here how much we appreciate the difficult, difficult issue and what a difficult time of year. My hope is that the testimony will shed light on directions forward.

It was about 32 years ago that I was drawn to public service because I wanted to help people who had mental health issues and disabilities. It seemed the perfect way to do that was to run for Lancaster County Commissioner, and that was my first job in public service. It seems fitting that one of my last hearings, if not my last hearing, will be on the topic of mental health issues all these years later.

I have learned a lot over those years. When I was Governor of Nebraska, we did sweeping mental health reform because we could see that our services were concentrated in a given area, but not spread across the State. We wanted to do more with community-based services.

I only mention this because one of the lessons I learned over and over again through the years is that with appropriate services, mental health issues are treatable. People do get better. They return to lives that bring them happiness and joy. But without those services, very much the opposite happens.

Our job is to try to figure out how we deal with that puzzle, that very difficult issue of how to provide services to people who need it. But to anyone who might be listening in who is wondering if it is time to give up, it is not. I want to just implore those people to reach out to us. Our job is to try to figure out a way that we can help to provide the services they need to provide the stability which they can build a platform in their life to start putting things back together.

For any family who has been through this, it is—the pain of watching a family member deteriorate from a mental health standpoint is indescribable, and the difficulty of accessing a system that is confusing and complex and challenging, that also is indescribable. Somehow we have got to figure out a better way, because at the most important time in this person's life, when they are crying out for help, it should be a simple, straight-forward pathway to access that help instead of the complexity that family members and loved ones oftentimes face.

So, I will return where I started and just thank the family members. I understand the pain and agony, but I think you can educate us on ways forward to try to deal with the issues that we face.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Johanns.

Senator Blumenthal.

**STATEMENT OF HON. RICHARD BLUMENTHAL,
U.S. SENATOR FROM CONNECTICUT**

Senator BLUMENTHAL. Thanks, Mr. Chairman, and thank you and Ranking Member Burr for having this hearing, which I think is one of the most important that we have held on this Committee. I think we share that opinion. And I want to thank the family members who are here as well.

The experience each of us has had with these problems has been heart-breaking and riveting. Mine was most prominently with a young Marine, Justin Eldridge, from southeastern Connecticut who braved and survived combat in Afghanistan, mortar fire, sniper fire, and returned to his family, his children and his wife with post-traumatic stress and traumatic brain injury.

He was seeking mental health care at the Connecticut VA facility. He had already gone through a long battle for benefits, which I was helping him with, but there was a significant gap in the continuity of his care. Basically, he slipped between the cracks of care and slipped into suicide.

The gap that he leaves for his family and children is irreplaceable and the suicide that he suffered was unnecessary and avoidable. We will all live with our own feelings of obligation, not just regret, but feelings about what we could have done, each of us, to prevent it. I was a member of the Marine Corps League that he started in southeastern Connecticut. All of us knew that he was having that kind of difficulty, but none of us knew the black hole of despair and depression that he was suffering from.

So, this problem has real life implications, real consequences for all of us. VA recently released data that indicates a wide disparity of wait times for mental health appointments in Connecticut and the country. In Connecticut they range from 12 or 13 days in Willimantic and Waterbury to as long as 55 days at Home Instead.

For every veteran suffering from this despondency, despair, depression, every day is like a lifetime, and there is simply no excuse for even 12 or 19 days. But 55 days is exactly the root of the problem and the consequences are not only emotional, but practical. We need to do more to try to prevent those wait times, increase the quality of care, make sure that we keep faith with veterans who are suffering, as Senator Walsh said, from the unseen, invisible wounds of war that can be as devastating and life changing as even the most horrific physical and visible wounds of war.

So, again, I thank the families. I thank all of you, my colleagues, for feeling so deeply as you do about this issue.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Blumenthal.
Senator Heller.

**STATEMENT OF HON. DEAN HELLER,
U.S. SENATOR FROM NEVADA**

Senator HELLER. Thank you, Mr. Chairman. First I would like to take a moment to acknowledge our witnesses that are here today and some of the families, but in particular Ms. Selke and Ms. Pallotta. As a Committee, we truly do admire your bravery and your strength for coming here today to talk about your sons. We cannot begin to imagine your loss, but your sons served our country with valor.

In honoring that, we must take care of every veteran from here on out that comes home. They need to be taken care of. Chairman Sanders and Ranking Member Burr, I want to thank you for bringing this issue in front of our Committee, especially because of the impact it has on veterans throughout the State of Nevada and across this country.

It is easy to put this in perspective for me. Between 2008 and 2012, 593 veterans from Nevada were lost to suicide. Six months ago I may have looked at these numbers and asked why it was so high. What is missing within the VA are the mental health benefits that so many veterans across this country need to avoid resorting to suicide.

I think we know now that a big part of the problem is veterans' access to care at VA facilities. This is such a critical issue to get right at the VA because of the rippling effect that it has on veterans' well-being, whether it is medical care, mental health treatment, or support during transition to civilian life. Veterans being forced to wait for care from the VA can be very detrimental.

That is why I have asked the Las Vegas VA director to send me reports about wait times for primary care, specialty care, and the mental health treatment for southern Nevada veterans. Every 2 weeks, for both Las Vegas and Reno, I track these numbers for improvements. In the most recent data, patients already receiving mental health care from the VA facilities in Nevada wait a week or less for appointments.

Unfortunately, the average wait time for new patients seeking mental health treatment is 23 days in Reno and double that in Las Vegas. Even worse, a clinic in northwest Las Vegas has an average wait time of over 64 days for new patients. Veterans in need of mental health treatment absolutely cannot be waiting more than 2 months to be seen.

I have been pushing every one of these facilities to improve their wait times in the coming months and want to hear from the VA today about their resources, what resources it will be devoting to mental health treatment. We must also remember that scheduling an appointment is not the only barrier to receiving care. Veterans must also qualify for this care.

One of the best ways to ensure veterans qualify for mental health services is by reducing the VA's disability claims backlog. Veterans with Post Traumatic Stress who have PTSD-related claims approved will be able to access VA's mental health services and treatment. This claims backlog is an issue that I have brought up during every Committee hearing because I believe it should be a top priority of the VA and of this Committee itself.

It is why I sent a letter to the Chairman requesting that he reschedule a legislative hearing to consider my bipartisan bill to address the VA claims process. Nevada veterans have one of the longest wait times in the Nation at 248 days, on average, to complete a claim, and 240,000 veterans nationwide are still waiting longer than the VA's 125-day deadline.

Until this backlog is eliminated, veterans in Nevada and throughout this country will continue to face delays to access to the mental health treatment that they need and deserve. With 22 veteran suicides a day, nearly 600 veteran suicides in Nevada over the last 5 years, it is clear something must be done to improve the current state of mental health services at the VA. The VA facilities in my State know that I will use my oversight role in this Committee to continue holding them accountable for performances, timeliness, and the quality of care they provide to Nevada veterans.

I look forward to hearing from the witnesses today about the VA, about what the VA is doing to address this crisis, and how Congress can help in this effort.

Mr. Chairman, thank you.

Chairman SANDERS. Thank you, Senator Heller.
Senator Begich.

**STATEMENT OF HON. MARK BEGICH,
U.S. SENATOR FROM ALASKA**

Senator BEGICH. Mr. Chairman and Ranking Member, thank you very much for holding this hearing. Thank you for the work you have done. This may be one of my last hearings, but I think a very important hearing in many ways. You know, Alaska has 77,000 veterans. To the families that are here, I have talked to many families who have lost their loved ones through suicide in Alaska not only during my time here as Senator, but also my time when I was Mayor of Anchorage. I recognize the pain, the loss that you all feel. I am honored to have you here to help us better understand.

The work that has to be done is significant. And when I think about the hearings that I have participated in the last 6 years, you know—we have lots of hearings on these issues. The question is, what are we going to do? Having oversight hearings are important, but you have got to put resources with it.

Just assuming the private sector is going to absorb all this is not realistic. The private sector does not have enough mental health providers to provide for the current load of individuals who are not in the military or in the veteran system. That is just a fact. We have to do more to improve the system. That means also the VA has to recognize that you have to authorize not only psychiatrists that you have, but also many different types of mental health providers.

There are different levels of services that an individual may need that may not be to a full psychiatrist level opening those doors, but it does mean that we have to have some priorities. I may not be here to fight for those. I may be on the outside, you can rest assured, to all the members here, screaming about this issue as I have done for the last 6 years.

When we send \$500 million to fund rebels in ISIS with no funding source to pay for it, but when we debate veterans' bills, we can never find the money is outrageous. I am hopeful this hearing will shed some light on what we really need, which is more professionals in the arena to service these individuals, not only veterans but all across this country.

Mental health services has been secondary to health care. The Affordable Care Act finally made it parity. The Health Services Act finally made it a parity. But now we have to put resources to it. That does not mean just more speeches. It means actually in a budget that will be provided by the majority in May or April, that they actually put resources to this effort.

It means passing legislation that I have sponsored on ensuring that there is loan forgiveness for people who get into the field of mental health services. It means also changes in the way we do telemedicine. We did it with our active military. I was very happy to support an amendment that makes telemedicine available for active military anywhere in this country, to tap into telemedicine no matter where they live.

That doctor does not have to be certified in the State they live in. They just have to be certified in this country somewhere. That to me is what we need to do with the veterans' care. On top of that, the issue that veterans' care for mental health services no longer

require a co-payment; I was very honored to be able to work on that with the VA.

But it is, again, going to be about resources.

Training the next generation of mental health providers, not just psychiatrists, but counselors and group facilities and other activities. It means actually putting real money to it, because as hard as it is for these families, there are many other families that cannot get access even if they are a VA veteran. We have to do everything we can.

I am hopeful that this hearing will not only describe the issues that we face as a society when it comes to our veterans and the care that they deserve after serving our country, after we told them to go do certain things for us, but also bring the resources that are required.

I will say it again. You know, it will be billions we will be spending on what is going on in ISIS without any funding source for it. We will just spend the money. But I can guarantee you, it will be like *deja vu*. I will see it from a different viewpoint. Instead of in the chambers, I will be watching painfully C-SPAN. And in a positive way to C-SPAN people, but I will be watching.

What I am hoping for is that we do not debate the resources needed for our vets. You are for veterans or you are not. We put the money on the table they deserve for the service they have given us. And mental health services—suicide prevention is a critical need. I would just hope, as the next session occurs, that after these kind of hearings, that there actually is fundamental funding that makes a difference for these families, families that are still out there struggling that I hear from every day.

So, Mr. Chairman, I thank you and the Ranking Member for holding this hearing. It is crucial. I hope the ideas I have presented will be ideas that others will take up to ensure that we have better access for our veterans. But keep in mind, mental health services in this country, there is just not enough, veteran or non-veteran. We have to be realistic about that and be honest with the American people that we are going to do something to change this for the country.

Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Begich.
Senator Boozman.

**STATEMENT OF HON. JOHN BOOZMAN,
U.S. SENATOR FROM ARKANSAS**

Senator BOOZMAN. Thank you, Chairman Sanders and Ranking Member Burr for holding this hearing. Hopefully this is just one of many more in the future as we continue to delve into such an important subject, in fact, perhaps one of the most important subjects that we do face as a Committee.

I would also like to extend a warm welcome to the families that are here. There is simply no substitute for your presence, so we do appreciate you very, very much.

As has been stated, 22 veterans commit suicide every day in the United States. To say this is unacceptable would be a gross understatement. It is nothing short of a tragedy.

The Departments of Defense and Veterans Affairs must continue to aggressively address the problem. Much is being done to improve, expand, and increase access to mental health care, but we must do better. Significant resources have been directed toward medical care within the VA. Between fiscal year 2008 and fiscal year 2016, advanced appropriations requests, the funding has increased by \$24.5 billion, or 72 percent.

During the same period, mental health care programs have seen increased funding at \$1.8 billion, or 42 percent. Certainly we need to do much more. However, increasing the funding to these programs, while helpful and necessary will not solve the problem. The culture of the VA must change to become permissive and flexible.

The complaint that I hear from so many veterans is they feel the VA is a restrictive bureaucracy whose first instinct is to say no. I have heard many veterans characterize their experience within the VA as being hostile. For veterans who need health care, especially mental health care, this is totally unacceptable.

The response that these veterans should hear is, yes; let me figure out how to help you with that. A veteran who is having suicidal thoughts should never be turned away because of bureaucratic red tape.

I continue to be concerned about the VA's over-reliance on medication as a means of treatment within the VA. The use of opioids and psychotropic medicines certainly have a place in health care, but I believe that VA over-prescribes these medications and does not effectively monitor their use amongst veterans.

Unchecked, these medications can do more harm than good and are oftentimes a contributing factor to veteran suicide. A pill alone is not the answer. VA must embrace a holistic approach to providing mental health care and promoting wellness. The VA has made significant efforts to increase evidence-based treatment, but there is still room for improvement.

I look forward to hearing how the VA plans to improve this process and overcome existing barriers to providing evidence-based treatment. I also look forward to hearing about VA's efforts to increase its mental health workforce.

Thank you very much, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Boozman.

At this time, we welcome our first panel to this morning's hearing on Mental Health and Suicide Among Veterans. Representing the VA is Dr. Harold Kudler. Dr. Kudler, thanks for being with us. Dr. Kudler is VA's Chief Consultant for Mental Health Services. Dr. Kudler is accompanied by Caitlin Thompson, the Deputy Director of VA's Suicide Prevention Program, and Dr. Dean Krahn, the Deputy Director of VA's Office of Mental Health Operations.

We thank you all very much for being with us this morning. Dr. Kudler, you can begin.

STATEMENT OF HAROLD KUDLER, M.D., CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY CAITLIN THOMPSON, Ph.D., DEPUTY DIRECTOR, SUICIDE PREVENTION; AND DEAN D. KRAHN, M.D., DEPUTY DIRECTOR, OFFICE OF MENTAL HEALTH OPERATIONS

Dr. KUDLER. Thank you, and good morning, Chairman Sanders, Ranking Member Burr, and Members of the Committee. Thank you for this opportunity to discuss the provision of mental health care to veterans, and particularly those who are at risk for suicide. I am accompanied today by Dr. Dean Krahn, Acting Director of Mental Health Operations, and Dr. Caitlin Thompson, Deputy Director for VHA Suicide Prevention.

I want to say before I begin my formal remarks that I want to thank the families. I want to thank all the veterans, the veterans who are outside with flags when we came in today. We are here to support you and stand with you. We are here to learn from you. And, I hope that this meeting will help us do exactly that.

Long deployments and intense combat conditions require comprehensive support for the emotional and mental health needs of veterans and their families. Accordingly, VA continues to develop and expand its mental health system. The number of veterans receiving specialized mental health treatment from VA has risen each year from over 900,000 in fiscal year 2006 to more than 1.4 million in fiscal year 2013. During that same period, our mental health outpatient staff grew from 7,000 to over 13,000.

We believe this increase is partly attributable to our proactive screening which identifies veterans with symptoms of depression, Post Traumatic Stress Disorder, or substance abuse, as well as those who have experienced military sexual trauma. VA has partnered with the Department of Defense to develop the VA/DOD Integrated Mental Health Strategy to advance a coordinated public health model that improves access, quality effectiveness and efficiency of mental health services.

VA has many entry points for VHA mental health care, including 150 medical centers, 820 community-based outpatient clinics, 300 Vet Centers providing readjustment counseling, 70 mobile Vet Centers, a national veterans crisis line, VA staff on college and university campuses, and a variety of other outreach efforts.

Our OEF, OIF, OMD transition care management teams are located at every VA medical center and welcome returning veterans providing specialized care management services as those veterans transition from DOD to VA.

VA's mental health system is designed to address the changing needs of veterans as they age. While the term veteran often sums of images of young men and women, the Vietnam generation is now the largest veteran cohort. VA's highly-innovative community-based Vet Center system was created specifically for veterans of the Vietnam era and continues to track their evolving needs.

The Vet Center mission, though, has expanded over time to serve veterans of all combat eras at sites of care across the entire United States and its possessions. VA mental health is a leader in devel-

oping on-site coordinated mental health within primary care settings and within home-based care programs.

At VA, we insist that suicide prevention is everyone's business. Although we understand why some veterans may be at increased risk, we continue to investigate and act assertively with the ultimate goal of eliminating suicide among veterans. This quest has proven long and hard for veterans and for all Americans.

Between 1999 and 2010, the rate of suicide increased by 27 percent among all middle-aged Americans—American males. But it actually decreased by 16 percent among middle-aged males who used VA health care. In considering the veteran population alone, suicide rates during that same period increased by nearly two-thirds among middle-aged veterans who did not use VA services. But it actually decreased by one-third among middle-aged veterans who used VA care.

America's veterans represent many different subgroups and each have their own risk factors and each require unique interventions. We still have a good deal to learn about how to provide that. As part of that process, DOD and VA have built a joint Suicide Data Repository to improve our understanding of patterns of suicide among veterans and servicemembers.

With assistance from State partners, VA is now better able to assess the effectiveness of its suicide prevention programs and we can identify at risk veterans earlier and apply specific interventions tailored to their needs. These data will help VA replicate our most effective suicide prevention programs in different care settings, including rural settings, and test their applicability across generations, male, female, young, old, and across sites of care.

VA has over 700 full-time employees dedicated solely to suicide prevention. These include over 300 suicide prevention coordinators with boots on the ground at every VA medical center and at our largest CBOCs. They ensure that all appropriate measures are being taken to prevent suicide among veterans.

The Veterans Military Crisis Line connects veterans and servicemembers and their family and friends with qualified, caring VA responders through a confidential toll-free hotline offering 24/7 emergency assistance. Since we established it in 2007, there have been roughly 39,000 life-saving rescues alone. That is an average of 27 rescues every day.

As of June 2014, the crisis line received over 1.2 million calls, over 175,000 chat connections, over 24,000 text messages. The crisis line has also made over 220,000 referrals to VA suicide prevention coordinators.

Mr. Chairman, we know our work to deliver the mental health care which veterans deserve will never be entirely finished. We know that losing one veteran to suicide shatters an entire world. Veterans who reach out for help must receive that help when and where they need it in the terms that they value. Therefore, VA will act continuously to improve mental health and suicide prevention services.

We appreciate the opportunity to appear before you today and to discuss these vitally important issues and we thank you for your support. My colleagues and I are now prepared to respond to any questions you may have.

[The prepared statement of the Dr. Kudler follows:]

PREPARED STATEMENT OF DR. HAROLD KUDLER, CHIEF MENTAL HEALTH CONSULTANT, VETERANS HEALTH ADMINISTRATION (VHA), U.S. DEPARTMENT OF VETERANS AFFAIRS

Good morning, Chairman Sanders, Ranking Member Burr, and Members of the Committee. Thank you for the opportunity to discuss the provision of mental health care to Veterans, particularly those who are at risk for suicide. I am accompanied today by Dr. Dean Krahn, Deputy Director of Mental Health Operations and Dr. Caitlin Thompson, Deputy Director of VHA Suicide Prevention. My written statement will provide a brief overview of VA's mental health care system and programs for suicide prevention.

MENTAL HEALTH CARE OVERVIEW

Since September 11, 2001, more than two million Servicemembers have deployed to Iraq or Afghanistan. Long deployments and intense combat conditions require comprehensive support for the emotional and mental health of Veterans and their families. Accordingly, VA continues to develop and expand its mental health system. The number of Veterans receiving specialized mental health treatment from VA has risen each year, from 927,052 in Fiscal Year (FY) 2006 to more than 1.4 million in FY 2013. We anticipate that VA's requirements for providing mental health care will continue to grow for a decade or more after current operational missions have come to an end. VA believes this increase is partly attributable to proactive screening to identify Veterans who may have symptoms of depression, Post Traumatic Stress Disorder (PTSD), substance use disorder, or those who have experienced military sexual trauma. In addition, VA has partnered with the Department of Defense (DOD) to develop the VA/DOD Integrated Mental Health Strategy to advance a coordinated public health model to improve access, quality, effectiveness, and efficiency of mental health services for Servicemembers, National Guard and Reserve, Veterans, and their families. Among the President's 19 new executive actions to improve the mental health of Servicemembers, Veterans, and their families, announced on August 26 is a further enhancement of transition from DOD to VA and civilian health care by ensuring that all Servicemembers leaving the military who are receiving care for mental health conditions are automatically enrolled in the *inTransition* program. In this program, trained mental health professionals assist these Servicemembers through "warm handoffs" to new care teams in VA or in the community. Further, mental health medications prescribed by DOD clinicians will be carried over into VA care unless a specific safety or clinical reason to make a change is identified. Those Servicemembers with multiple, complex, severe conditions such as Traumatic Brain Injury, psychological trauma, or other cognitive, psychological, or emotional disorders will benefit by development of a single, joint comprehensive care plan between DOD and VA providers.

VA has many entry points for VHA mental health care. These entry points include 150 medical centers, 820 Community Based Outpatient Clinics (CBOCs), 300 Vet Centers providing readjustment counseling, a Veterans Crisis Line, VA staff on college and university campuses, and other outreach efforts. To serve the growing number of Veterans seeking mental health care, VA has deployed significant resources and increases in staff toward mental health services. Since March 2012, and with support from the President's Executive Order's focus on increasing mental health staffing, VA has added 2,444 mental health full-time equivalent employees and hired over 900 peer specialists and apprentices. Under the President's executive actions, VA will pilot the expansion of peer support beyond traditional mental health settings into primary care clinics in order to better connect with Veterans wherever they seek care.

As of April 2014, VHA has 21,158 Mental Health full-time equivalent employees providing direct inpatient and outpatient mental health care. VA has expanded access to mental health services with longer clinic hours, telemental health capability to deliver services, and standards that mandate immediate access to mental health services to Veterans in crisis. Starting in FY 2012, the Office of Mental Health Operations initiated site visits to every VHA healthcare system to review and facilitate compliance with VHA mental health policy. All healthcare systems were visited in FY 2012 and subsequently one third are being visited each year. Recommendations are made to address opportunities for improvement identified as part of the site visit process and progress is monitored by the Office of Mental Health Operations. In an effort to increase access to mental health care and reduce any stigma associated with seeking such care, VA has integrated mental health into primary care settings. From the beginning of FY 2008 through July 2014, VA has provided more

than 4 million Primary Care-Mental Health Integration (PC-MHI) clinic visits to more than 1,016,000 unique patients. This improves access by bringing care closer to where the Veteran can most easily receive these services, and improves quality of care by increasing the coordination of all aspects of care, both physical and mental. In addition, a second round of VA Community Mental Health Summits has recently been completed at virtually all major VA facilities across the Nation and analysis of feedback from VA and Community participants is underway. Based on 2013 Summit recommendations, Community Mental Health Points of Contact have been identified at every VA Medical Center and each 2014 Summit included featured presentations on best practices in support of military and Veteran families and in populating the National Resource Directory in order to enhance referral to VA and community resources across America for use by any Servicemember, Veteran, family member, referring clinician or other stakeholder.

VA has made deployment of evidence-based therapies a critical element of its approach to mental health care and offers a continuum of recovery-oriented, patient-centered services across outpatient, residential, and inpatient settings. State-of-the-art treatment, including both psychotherapies and biomedical treatments, are available for the full range of mental health problems, such as PTSD, substance use disorders, and suicidality. While VA is primarily focused on evidence-based treatments, we are also assessing complementary and alternative treatment methodologies that need further research, such as meditation and acupuncture in the care of PTSD. VA has trained over 6,100 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD, Cognitive Processing Therapy and Prolonged Exposure Therapy, as indicated in the VA/DOD Clinical Practice Guideline for PTSD¹. VA operates the National Center for PTSD, which guides a national PTSD mentoring program, working with every specialty PTSD program across the VA health care system. The Center has begun a PTSD consultation program for any VA practitioners (including primary care practitioners and Homeless Program coordinators) who request consultation regarding a Veteran in treatment with PTSD. So far, the consultation program has provided 1,818 consultations and triaged an additional 143 requests from the Suicide Risk Management Consultation Program.

We know that there have been issues with Veteran access. We take those concerns seriously and continue to work to address them. Receiving direct feedback from Veterans concerning their care is vitally important. During the fourth quarter of FY 2013, as part of VHA's effort to seek direct input from Veterans in understanding their perceptions regarding access to care, we conducted a survey of over 40,000 Veterans who were receiving mental health care. These results, and other outreach to Veterans, aid us as we strive to improve the timeliness of appointments; reminders for appointments; accessibility, engagement, and responsiveness of clinicians; availability and agreement with clinician on desired treatment frequency; helpfulness of mental health treatment; and treatment with respect and dignity.

PROGRAMS AND RESOURCES FOR SUICIDE PREVENTION

Overall, Veterans are at higher risk for suicide than the general U.S. population, notably Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. VA recognizes that even one Veteran suicide is too many. We are committed to ensuring the safety of our Veterans, especially when they are in crisis. Our suicide prevention program is based on enhancing Veterans' access to high-quality mental health care and programs specifically designed to help prevent Veteran suicide.

In partnership with the Substance Abuse and Mental Health Services Administration's National Suicide Prevention Lifeline, the Veterans Crisis Line/Military Crisis Line (VCL/MCL) connects Veterans and Servicemembers in crisis and their families and friends with qualified, caring VA responders through a confidential toll-free hotline (1-800-273-TALK (8255), then press 1) that offers 24/7 emergency assistance. This August marked seven years since the establishment of the initial program, which was later rebranded to show its direct support for Servicemembers. It has expanded to include a chat service and texting option. As of June 2014, the VCL/MCL has rescued 39,000 actively suicidal Veterans. As of June 2014, VCL/MCL has received over 1,250,000 calls, over 175,000 chat connections, and over 24,000 texts; it has also made over 220,000 referrals to Suicide Prevention Coordinators (SPC). In accordance with the President's August 31, 2012, Executive Order titled, "Improving Access to Mental Health Services for Veterans, Servicemembers and Military Fami-

¹ http://www.healthquality.va.gov/guidelines/MH/ptsd/cpg_PTSD-FULL-201011612.pdf

lies,” VA completed hiring and training of additional staff to increase the capacity of the VCL/MCL by 50 percent.

VA has a network of over 300 SPCs located at every VA medical center and the largest CBOCs throughout the country. Overall, SPCs facilitate implementation of suicide prevention strategies within their respective medical centers and clinics to help ensure that all appropriate measures are being taken to prevent suicide in the Veteran patient population, particularly Veterans identified as being at high risk for suicidal behavior, and the SPCs engage in outreach to other Veterans, family members, and community partners. SPCs receive follow-up consults from the VCL/MCL call responders after immediate needs are addressed and any needed rescue actions are made. SPCs are required to follow up on consults received from the VCL/MCL within one business day to ensure timely access to care for Veterans callers who need additional support, treatment, or other services, including enrollment into VA's health care system. SPCs also plan, develop, implement, and evaluate their facility's Suicide Prevention Program to ensure continual quality improvement and excellence in customer service. SPCs are responsible for implementing VA's Operation S.A.V.E (Signs of suicidal thinking, Ask the questions, Verify the experience with the Veteran, and Expedite or Escort to Help). This is a one-to-two hour in-person training program provided by VA SPCs to Veterans and those who serve Veterans to help prevent suicide. Suicide prevention training is provided for every new VHA employee during Employee Orientation. It has now been provided to staff within the Veterans Benefits Administration and, through the Presidents' new executive actions, training will be provided for volunteer tax preparers at over 200 tax assistance facilities through partnership between VA and the Treasury Department. Further, the President's new executive actions mandate that refresher courses and training updates be developed and delivered at regular intervals. Our goal is to increase mental health awareness wherever Veterans and their family members are present and to continuously enhance and expand our response to their needs.

SPCs participate in outreach activities, which remain critically important to VA's goals of reducing stigma for mental health issues and improving access to services for all Veterans. Examples include community suicide prevention training and other educational programs, exhibits, and material distribution; meetings with state and local suicide prevention groups; and suicide prevention work with Active Duty/National Guard and Reserve units as well as college campuses. To date, each SPC is required to complete five or more outreach activities in his or her local community each month.

Veterans may be at high risk for suicide for various reasons. Determination of suicide risk is always a clinical judgment made after an evaluation of risk factors (e.g., history of past suicide attempts, recent discharge from an inpatient mental health unit), protective factors, and the presence or absence of warning signs. VHA Handbook 1160.01, “Uniform Mental Health Services in VA medical centers and Clinics,” requires inpatient care be available to all Veterans with acute mental health needs (including imminent danger of self harm), either in a VA medical center or at a nearby facility through a contract or sharing agreement.

To ensure that high-risk Veterans are being monitored appropriately, SPCs manage a Category I Patient Record Flag (PRF) with a corresponding High-Risk List. The primary purpose of the High Risk for Suicide PRF is to communicate, consistent with appropriate privacy protections, to VA staff that a Veteran is at high risk for suicide, and the presence of a flag should be considered when making treatment decisions. Once a Veteran is identified as high risk, the SPC ensures that weekly contact is made with the Veteran for at least the first month, and that continued follow-up is made, as clinically appropriate. The SPC works with the treatment team to ensure that patients identified as being at high risk for suicide receive follow-up for any missed mental health and substance abuse appointments at VA. Clinicians are required to initiate at least three attempts to contact Veterans on the High-Risk List who fail to appear for mental health appointments and ensure appropriate documentation. If attempts to contact the Veteran are unsuccessful, the SPC collaborates with the Veteran's treatment team to decide what further action is appropriate involving a range of options from continued outreach efforts to the Veteran and/or family members up to requesting local law enforcement perform a welfare check in person.

SPCs ensure that all Veterans identified as high risk for suicide have completed a safety plan that is documented in their medical record, and that the Veteran is provided a copy of his or her safety plan.

National suicide prevention outreach efforts continue to expand and include targeted efforts for Veterans, Servicemembers, families, and friends. VA has sponsored public service announcements, rebranded and optimized the VCL/MCL Web site for mobile access and viewing, and developed social and traditional media advertise-

ments designed to inform Veterans and their families of VA's VCL/MCL resources including phone, online chat, and text services. September was National Suicide Prevention Month, and VA launched its new outreach campaign theme for this year, "The Power of 1," which emphasizes that just one person, one conversation, or one small act can make a big difference to a Veteran or Servicemember in crisis by offering hope and connections to confidential support and resources.

In addition, VA established an online Community Provider Toolkit² for individuals outside of VA who provide care to Veterans. This provides an important resource in the wake of the Veterans Access, Choice, and Accountability Act of 2014. This Web site features key tools to support the mental health services provided to Veterans including information on connecting with VA, understanding military culture and experience, and working with patients with a variety of mental health conditions. There is also a comprehensive Suicide Prevention Mini-Clinic that provides clinicians with easy access to useful Veteran-focused treatment tools, including assessment, training, and educational handouts.³

In 2010, DOD and VA approved plans for a Joint Suicide Data Repository (SDR) as a shared resource for improving our understanding of patterns and characteristics of suicide among Veterans and Servicemembers. The combined DOD and VA search of data available in the National Death Index represents the single largest mortality search of a population with a history of military service on record. The DOD/VA Joint SDR is overseen by the Defense Suicide Prevention Office and VA's Suicide Prevention Program.

On February 1, 2013, VA released a report on Veteran suicides including data from the SDR, a result of the most comprehensive review of Veteran suicide rates ever undertaken by VA. With assistance from state partners providing real-time data for SDR, VA is now better able to assess the effectiveness of its suicide prevention programs and identify specific populations that need targeted interventions. This new information will assist VA in identifying where at-risk Veterans may be located and improving the Department's ability to target specific suicide interventions and outreach activities in order to reach Veterans early and proactively. These data will also help VA continue to examine the effectiveness of suicide prevention programs being implemented in specific geographic locations (e.g., rural areas), as well as care settings, such as primary care, in order to replicate effective programs in other areas. VA continues to receive state data that are being included in the SDR. VA plans to update the suicide data report later this year.

In 2011, the most recent year for which national data are available, the age-adjusted rate of suicide in the U.S. general population was 12.32 per 100,000 persons per year. At just over 12 for every 100,000 U.S. residents, the 2011 rate of suicide has increased by approximately 15 percent since 2001. Rates of suicide in the United States are higher among males, middle-aged adults, residents in rural areas, and those with mental health conditions.

The most recent available data show that suicide rates are generally lower among Veterans who use VHA services than among Veterans who do not use VHA services. In 2011, the rate of suicide among those who use VHA services was 35.5 per 100,000 persons per year; a decrease of approximately 6 percent since 2001. Rates of suicide among those who use VHA services have remained relatively stable; ranging from 35.5 to 37.5 per 100,000 persons per year over the past 4 years. Despite evidence of increased risk among middle-aged adults (35–64 years) in the U.S. general population, rates of suicide among middle-aged adults who use VHA services have decreased by more than 16 percent between the years 1999–2010. For males without a history of using VHA services, the rate increased by more than 60 percent, whereas for males with a history of using VHA services, the rate decreased by more than 30 percent. Decreases in suicide rates and improvements in outcomes were also observed for some other high-risk groups. Between 2001 and 2010, rates of suicide decreased by more than 28 percent among VHA users with a mental health or substance abuse diagnosis, and the proportion of VHA users who die from suicide within 12 months of a survived suicide attempt has decreased by approximately 45 percent during the same time period.⁴

In response to these findings, VA has been focusing on public health and community programming. This includes increased and targeted outreach efforts throughout the country to Veterans and their family members with significant emphasis on safety. We encourage Veterans and their families to learn more about mental illness and to take precautions particularly during times of stress (e.g., properly storing weapons and medications). Being alert to items in the environment that offer poten-

² <http://www.mentalhealth.va.gov/communityproviders>

³ http://www.mentalhealth.va.gov/communityproviders/clinic_suicideprevention.asp

⁴ <http://www.blogs.va.gov/VAntage/11973/january-2014-va-suicide-data-update/>

tial means of suicidal behavior can make a life-saving difference during a crisis. Messaging and interventions are geared toward those who are most at risk for suicide, including our younger male Veterans, women Veterans, Veterans with mental health conditions, and established patients who are known to be at high risk for suicide. Strategies include specialized training for VHA staff to enhance their recognition and treatment of those at risk, and offering Veterans skills-building and other preventive strategies to address major stressors in their lives. Furthermore, VA is engaged in ongoing research to determine the most effective mental health treatments and suicide prevention strategies. Finally, VA has established the Mental Health Innovations Integrated Project Team that is working to implement early intervention strategies for specific high-risk groups including Veterans with PTSD, pain, sleep disorders, depression, and substance use disorders. Through early intervention, VA hopes to reduce the risk of suicide for Veterans in these high-risk groups.

READJUSTMENT COUNSELING SERVICE (RCS)

VA's RCS provides a wide range of readjustment counseling services to eligible Veterans and active duty Servicemembers who have served in combat zones and their families. RCS also provides comprehensive readjustment counseling for eligible Veterans and Servicemembers who experienced military sexual trauma, as well as offering bereavement counseling to immediate family members of Servicemembers who died while on active duty. These services are provided in a safe and confidential environment through a national network of 300 community-based Vet Centers located in all 50 states (as well as the District of Columbia, American Samoa, Guam, and Puerto Rico), 70 Mobile Vet Centers, and the Vet Center Combat Call Center (877-WAR-VETS or 877-927-8387). In FY 2013, Vet Centers provided over 1.5 million visits to Veterans, active duty Servicemembers, and their families. The Vet Center program has provided services to over 30 percent of Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn Veterans who have left active duty. A new executive action will promote awareness of Vet Centers for combat Veterans, Servicemembers, and their families through a new outreach campaign that partners VA with First Lady Michelle Obama and Dr. Jill Biden's Joining Forces initiative.

CLOSING STATEMENT

Mr. Chairman, VA is committed to providing timely, high quality care that our Veterans have earned and deserve, and we continue to take every available action and create new opportunities to improve suicide prevention services. We appreciate the opportunity to appear before you today, and my colleagues and I are prepared to respond to any questions you may have.

Chairman SANDERS. Dr. Kudler, thanks very much for being here and for your testimony. Dr. Kudler, this country, above and beyond the VA, faces a major crisis. We do not have enough doctors, we do not have enough nurses, we do not have enough psychiatrists, we do not have enough psychologists. Yet, we end up spending almost twice as much per person on health care than any other country. Why? That is always another discussion.

This Committee, which I am proud to have played an active role with all of the Members here, passed one of the most comprehensive pieces of veterans legislation in recent history, \$16.5 billion in additional funding for VA health care, and further, \$5 billion to give VA the ability to hire more doctors and mental health counselors.

Senator Tester started off by making the right point. There are parts of this country—Senator Moran in Kansas has the same issue—where we have virtually no mental health capabilities. In my office, and I think I speak for every Member up here, I get calls all of the time that I will never forget: the call from a woman who stated her brother is suicidal, homicidal. What can you do? We cannot find a place for him in the Burlington, VT, area. This goes on all over this country.

Question: we gave you \$5 billion to get more doctors and mental health providers. How are you doing on that? Are you going to significantly increase the number of mental health practitioners in VA?

Dr. KUDLER. First of all, Senator, thank you and thank your colleagues for the assistance. It makes a world of difference. \$5 billion, though, while it is an awful lot of money, is not earmarked for mental health. It is not under the control of us in mental health. We are hoping that money will be put where it is needed.

Chairman SANDERS. But it is there for mental health professionals, certainly.

Dr. KUDLER. It is there for mental health professionals, among others, and to build programs, among others. I believe this money is a great stop gap. We will be able to squeeze a little more juice from the lemon that exists, but as everyone here has pointed out, there is not enough juice in the lemon to cover all the capacity that is needed to meet the needs of veterans, and the Nation as a whole is in a mental health shortage crisis and is only awakening to that now.

I believe this will be a great help and we will use it to——

Chairman SANDERS. Is the VA aggressively going out trying to bring mental health professionals into the VA?

Dr. KUDLER. Yes, we are. We are——

Chairman SANDERS. Can you give us a progress report?

Dr. KUDLER. We have identified vacancies across the Nation and opportunities for expansion and we are filling those systematically. The Secretary himself is going from medical school to medical school reaching out to new graduates and the people to convince them to go into mental health and join us. We are helping to support those efforts.

We are partnering with SAMHSA and other organizations to identify folks interested in working with VA and with veterans, and to improve the coordination of care between different sites. We are working with the Association of American Medical Colleges.

Chairman SANDERS. Good. I was with the Secretary in Vermont at the University of Vermont and at Dartmouth. Several Members here raised a very important point. Ideally, no matter what the ailment, people should be able to get in to see a practitioner in a reasonable period of time. In mental health, it is even more important. When people are hurting, they do not want to hear that they have to wait 2 months to see a provider.

They do not want, as Senator Johanns correctly said, have to overcome a bureaucratic maze. When people are hurting, they should be able to get the help they need. I know that is hard and I know that VA is not the only bureaucratized institution in America.

But my two questions are, it is unsatisfactory to hear from my colleagues here about the long wait periods that folks struggling with mental health conditions have to overcome before they get in. What are we doing about that?

Dr. KUDLER. Dr. Krahn, could you speak to that, please?

Dr. KRAHN. Yes, thanks. Obviously, waiting even an extra day is too much when you are in crisis, and the VA is actually mandated to have both emergency and same-day care for veterans who need

that, and the Veterans Crisis Line, Military Crisis Line has 24/7—

Chairman SANDERS. Let me—I have a limited amount of time.

Dr. KRAHN. I am sorry.

Chairman SANDERS. I apologize. But you have heard from colleagues here—

Dr. KRAHN. Right.

Chairman SANDERS [continuing]. That some veterans have had to wait, in some cases, months. Say I am a veteran struggling with suicidal thoughts. I do not want to be waiting for months. What are we doing about that?

Dr. KRAHN. The best way we are able to reach out to people is by making more and more points of access that are available 24/7/365, whether that be by phone, by walking into an emergency room, or by walking into same-day walk-in clinics.

Chairman SANDERS. And are we making progress doing that?

Dr. KRAHN. Well, we are making progress in doing that. And the other thing we do is the integrated care.

Chairman SANDERS. Dr. Krahn, let me ask this. Is the goal that when somebody calls who is in trouble, that they will be able to get to see somebody that day?

Dr. KRAHN. That is the goal.

Chairman SANDERS. Last question. As one of my colleagues also mentioned, not every treatment works for everybody in the same way. We need a variety of treatments. Some if us are supportive of complementary and alternative medicine, which works well for some people. First, does VA have the flexibility that it needs.

I also want to go back to a point that Senator Johanns raised. Are we making any progress in breaking down this old bureaucracy where somebody walks in and they have got to fill out 18 forms and they go over here and they are on the phone and wait, get me three initials and fill out this additional form? And I know this is hard and I do not mean to be—it is true of bureaucracies all over the country, but especially with folks in mental health. Are we saying, come on in, sit down, we are with you? Are we trying to make progress on that?

Dr. KUDLER. We have created a number of paths into the VA that are human and involve warm hand-offs. I think of the Vet Centers and the 100, still called GWOT, Global War on Terrorism, outreach people who have themselves lived through Iraq and Afghanistan and now work there, 60 percent of the workforce of the Vet Centers are combat veterans. There are OEF, OIF, OMD case managers at every VA medical center. We have transition teams between DOD and VA.

Where these inlets exist, it is warm and personal. But they do not exist in enough places and not everybody knows the way into them. So, we have to build still bigger funnels. I want to add, in terms of listening and flexibility, I recently moved into my new office. My wife and I moved my analytic couch into that office, not because we are going to start practicing analysis in the VA full-time, but my point is, anyone who sees that office knows that I try to listen and that I want a model for all of us.

We need to listen to veterans and respond in their terms.

Chairman SANDERS. We need to know that they are hurting and they need to know that we are there for them.

Dr. KUDLER. And we feel that pain, yes.

Chairman SANDERS. OK. Thank you.

Senator Isakson.

Senator ISAKSON. Thank you, Chairman Sanders. I held a hearing in Atlanta a year-and-a-half ago over the tragic suicides that took place at the VA hospital on Clairmont Road. We had three in a short period of time, one in the hospital and two that took place between the time of diagnosis for being at risk for their life and the time they got to a community-based clinic appointment. They fell through the crack over a 6- to 8-day period of time.

Atlanta has done a good job of improving that system and we have had only one tragedy in the last 18 months since that time, and one is too many, but we have certainly made improvement. What is the VA doing systemwide to see to it that the hand-off from initial diagnosis to first treatment is seamless and that the veteran has a way to communicate back and forth with the professionals so they do not take their own life?

Dr. KUDLER. Every patient who is in mental health in VA is assigned a care manager, someone whose job is to integrate and oversee the plan. So, you do not have a bunch of different people doing a bunch of different things and no one integrating that care. And at the time, that person is identified and is part of the treatment plan, that they track what goes on to prevent exactly what you described.

Senator ISAKSON. In your testimony on page 3, the written testimony, you have a statement that says, VA has trained over 6,100 VA mental health professionals to provide two of the most effective evidence-based psychotherapies for PTSD. One is cognitive processing therapy and the other is prolonged exposure therapy. Can you describe those two for me?

Dr. KUDLER. Very briefly. These are two therapies that both work on the same basic principle, which is that what creates and maintains PTSD is the fact that every time you try to think about these things and solve the problems, untie the knots, you will begin to avoid. So, they both represent ways to overcome that avoidance. Cognitive processing: by working with the veteran to help realize how they have tied themselves in a knot then untie those knots. Every time you think of that, you think of yourself as a failure. Are you a failure? No, we are not totally a failure. Perhaps you begin to look at these things.

Prolonged exposure says, look, we are going to take you back there in a controlled way. I will go there with you and we will think about these things, and you will see that this is not more than you can stand. It is horrible, but not more than you can stand. Over time and in a very structured way, you begin to think, you know, I can be in my own life and I can begin to live my own life again.

I hope that is helpful, Senator.

Senator ISAKSON. Well, I may show my ignorance here. Hopefully I am going to show that I have got some intelligence. But I went to the VA hospital in Atlanta recently and saw two computer-based

carrels, if you will, that were simulating what exactly—is that what you are talking about?

Dr. KUDLER. Exactly. You are talking about Dr. Barbara Rothbaum's work with virtual reality, with the Atlanta VA being a world leader in developing that program. That is a particular way of using virtual reality to take that exposure therapy and make it even more real and vivid.

Senator ISAKSON. Mr. Chairman, the reason I bring this up is, we have a tremendous manpower shortage in terms of medicine and paraprofessionals and clinical people. But there are technologically-based therapies that can serve a lot more people than just one doctor could ever serve. And so, as we look to hire enough numbers to put in the box in terms of employees, we ought to be thinking outside the box on proven technologies where one doctor or one clinician can actually operate and supervise for a number of patients.

The day I was in the clinic watching, 24 different veteran patients came in. They had three operating carrels and two supervisors. That is a great ratio and the program has been very successful.

Last point. Again, this is on manpower. I think the VA basically is a 21st century problem operating in an 20th century environment. When I go to my doctor today in Atlanta, I get in a little small office where the nurse comes in, takes my temperature, takes my blood pressure, asks me what my prescriptions are, and I sit down and wait for the doctor to come in.

There are six separate offices just like that and six other patients waiting just like I am. The doctor comes in and goes, one, two, three, four, just goes through very quickly, which is the reason why VA doctors serve two-thirds of the number of people that private-sector doctors serve.

I do not think our facilities are modern enough in the way they are organized to support more capacity on the part of physicians. Do you agree with that?

Dr. KUDLER. Dr. Krahn, I do not know if you want to take that?

Dr. KRAHN. Well, I think the problem you are describing is a bigger problem in primary care, specialty medical, and surgical care.

Senator ISAKSON. Not in mental health.

Dr. KRAHN. Right. Actually, that is a big problem—space and to be efficient and support staff to be efficient is a very big problem in VA and, actually, much of the Veterans Access Choice and Accountability Act money is going in that direction as well as in direct hires of providers. In mental health, you should know that we can compare psychiatrists and psychologists fairly directly in work productivity with both academic and private practice providers.

Our psychiatrists are more productive than academic comparison groups, less productive than private. Our psychologists are just about at the academic to slightly above the academic level. So, we compare much more favorably with average work productivity than other parts of VA does.

Senator ISAKSON. Thank you very much for your testimony.

Chairman SANDERS. Thank you, Senator Isakson.

Senator Tester.

Senator TESTER. Thank you, Mr. Chairman. Do you have veterans staffing your hotline?

Ms. THOMPSON. We do, yes.

Senator TESTER. At what rate?

Ms. THOMPSON. At this point I would say it is about 20 to 30 percent are veterans and some are still in service. And then the majority of those are family members.

Senator TESTER. I think it is critically important. Do you guys monitor wait time on the hotline?

Ms. THOMPSON. We do.

Senator TESTER. Are people put on hold?

Ms. THOMPSON. People—do you want to take this, Dean?

Dr. KRAHN. People are actually rolled over to back-up hotlines when we are over—

Senator TESTER. The question is, if I am a veteran in crisis and I call that hotline, how long is it before I am talking to a real person?

Dr. KRAHN. I would have to get that exact number for you.

Senator TESTER. The fact is that you guys need to—you need to monitor that. That is pretty damn important moving forward.

Dr. KRAHN. It is. I just do not have that number with me.

[Responses were not received within the Committee's timeframe for publication.]

Senator TESTER. OK. If you could get that, that would be great. The Chairman brought up a question about the bill that we passed in July. What is the biggest health care challenge that you have in the VA right now, Dr. Kudler?

Dr. KUDLER. I think capacity, the number of mental health—

Senator TESTER. Overall capacity or capacity in mental health?

Dr. KUDLER. Actually I think capacity in mental health right now. Of course, that is my focus. That is what I am most concerned about.

Senator TESTER. I would hope you would say that. The signature injury coming out of Iraq and Afghanistan is PTSD.

Dr. KUDLER. PTSD and really in combination. I have spent my entire career trying to raise people's awareness and my own about PTSD. But PTSD rarely travels alone.

Senator TESTER. Right.

Dr. KUDLER. PTSD, substance abuse, depression, traumatic brain injury.

Senator TESTER. No argument at all. The question is, we have allocated \$16.5 billion, \$5 billion for recruitment—and I heard hesitancy in your voice that you did not have the resources because it was not earmarked for mental health—if that is true, we need to have the Secretary in here for a visit to discuss it, because the fact is the injuries coming out of these wars have a lot to do with unseen problems. Hopefully somebody is listening besides you in the VA and will deal with that.

You have got to have the resources. If you do not have the resources, mental health is not going to go away and everybody around this panel in their opening statement talked about the lack of professionals in that business.

Dr. KUDLER. I want to say I think this panel is extremely well informed and would love to have you around our conference tables

more often, actually. The fact is that our Secretary is entirely on our side. I feel totally supported and he gets it. He is out there looking for psychiatrists. I never thought that would happen.

Senator TESTER. I hear you. But, the fact is that there should be no hesitancy. \$5 billion is a lot of dough and you guys should be able to utilize that to take care of this mental health problem in the VA. By the way, I think that helps the whole country move forward.

I want to talk about mental health and the mobile Vet Centers. They are critically important. They are critically important in rural areas. Are they staffed with mental health professionals? So, if a veteran comes in, can you actually deal with it?

Dr. KUDLER. I think the Vet Center is one of the best things VA ever did and it is 21st century, and their staff includes a combination of people who are sort of peer support, people with life experience and mental health professionals, social workers, and psychologists.

Senator TESTER. That is good. So, they have that and it does not matter if you are in Montana, Alaska, or a more populated place?

Dr. KUDLER. They will come to you if, in fact, the need is in Montana or Alaska.

Senator TESTER. OK. Very good. Can I ask what the DOD is doing to help you? I get contacted not a lot, but by some veterans that say, "you know what? I have got some issues, but I am never going to admit to it because I will never be able to get a job." Is the DOD helping you to be able to determine who is at risk that need help so that you can do some outreach?

Dr. KUDLER. Colonel Ritchie, who is on the next panel, and I have worked together since at least 2002 when she was the Senior Behavioral Health Consultant to the Army Surgeon General, and we have built into each of the branches and into DOD all sorts of partnerships. We have in our office people who have joined VA and DOD activities. I think we are doing a tremendous job. This was not true before these wars, but it has been true over the years and it keeps building.

Senator TESTER. OK. As one of these guys talked about, over-medication—I think it was Senator Boozman, actually, who talked about over-medication—is this a problem? Is this a systemwide problem or does it happen rarely?

Dr. KUDLER. You know, there are several levels of the question so I will try to answer briefly. Reliance alone on medicine, which I heard stated, I think is a mistake. One has to listen, one has to talk, one has to be engaged. The therapeutic relationship is more powerful, I believe, than any medicine.

However, are we generally over-using medicine? No, I do not believe so. I think we fail to communicate.

Senator TESTER. That is all I needed to know.

Dr. KUDLER. Thank you, sir.

Senator TESTER. I am going to ask a question the Chairman asked you. I am going to ask it a little different way. Are you aggressively looking for alternative treatments for mental health?

Dr. KUDLER. Absolutely.

Senator TESTER. Can you give me some examples?

Dr. KUDLER. We are working, looking at alternative medicine and applying them wherever we can. We are looking at—the VA is actually one of the leaders in using ketamine, a drug that normally we would think of as a drug to abuse, but it may have a role both in depression and in PTSD. We have led the way in researching this.

Senator TESTER. What about things like—I will just lay it on the line—fishing, horses, mother nature?

Dr. KUDLER. Vet centers have been doing it forever and we have a lot of great community partners, we will hear from some today, who are for that. We are for it, too.

Senator TESTER. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Tester.

Senator Moran.

Senator MORAN. Mr. Chairman, thank you very much. Doctor, thank you for your presence here today. It seems like everybody is on a rush today to make sure we get our questions in and answers and I will be the same way. Two things that have occurred trying to bring services closer to home to veterans who live in rural America.

One was a pilot program called ARCH. A second one was the passage of the Choice Act in which if you live more than 40 miles from a facility, you are entitled to those services being attained at a place of your choice, presumably your home. In the case of ARCH, there is a pilot program in Kansas. The community mental health centers have attempted to be a participant in that program. I do not think it has been successful.

On that, they have not been successful in being allowed that opportunity. I worry about the same circumstance under the Choice Act. I am still waiting for an answer from the Department of Veterans Affairs in regards to how do you define a facility? Forty miles from a facility is different than 40 miles from a facility that provides the services that the veteran needs.

So, we may have a CBOC, an outpatient clinic someplace, but they do not provide mental health services. Is that going to be an impediment toward a veteran who lives within that 40 miles but cannot get the services he or she needs at that outpatient clinic?

I am interested in knowing whether that is a discussion that has been ongoing with you and others at the VA because how we define what a facility is is going to determine whether very many veterans are actually going to be able to access health care at home under the Choice Act.

In somewhat of a follow-up to the Senator from Montana, we have been pushing the VA for years to better include marriage and family therapists and licensed professional mental health counselors. We have not seen a lot of evidence and, in fact, I questioned the Secretary on this topic, the previous Secretary, back in September without much of an answer as to whether or not we are now going out beyond what we perhaps traditionally have thought of as mental health providers and bringing in the numbers that actually do exist, particularly in a State like mine.

There are marriage and family counselors. There are professional counselors, but they are not being integrated within the Depart-

ment of Veterans Affairs. Is any of that changing? Then I would capsule those two questions.

Tell me specifically, is the VA a different place today with a new Secretary? Can we expect a different outcome than what we have heard most members around this table describe about bureaucracy, culture? Is there a real change within the VA? Is life different for those who work there, but more importantly, does that translate into life being different for the veterans that the VA is intended to serve?

Dr. KUDLER. All right. Thank you. I will start with the last question. I believe the VA is significantly different with the new Secretary. There is an energy and there is a different way of approaching problems. There is the support and there is a willingness to be outgoing and engaging that is powerful. I believe it is spreading across our—

Senator MORAN. If you are an employee at the VA and you have a complaint about the way VA operates, is it different today in your ability to communicate that and find a result and feel comfortable that your job is secure, that you are doing something noble instead of something oppressive?

Dr. KUDLER. I can call that man's cell phone number and I can use a new electronic suggestion box, which I know gets results because I get pinged back when people make other suggestions.

Senator MORAN. Thank you.

Dr. KUDLER. Yes, sir. You brought up rural health. I have spent the last 5 years trying to develop rural health programs in North Carolina, Virginia, and West Virginia. You are absolutely right. Given that 40 percent of all veterans are from rural America and they tend to have a higher incidence of PTSD and they have less access to mental health, it is an essential question.

You also bring up marriage and family counselors, the whole idea of licensed professional counselors. In doing a lot of outreach in the community, I met a lot of these folks and I did not realize that in the past they were not allowed to be TRICARE providers independently. They had to be supervised and the VA also was not hiring these people.

These people are exactly who is out there in rural areas and they are accessible and they are part of the community. Yes, VA is engaging them. It is not as fast as any of us hope. We are working on increasing that across the country, but we are absolutely focused on doing that and we will achieve that.

Senator MORAN. The question I asked about those licensed professionals 6 months ago that got no answer from the VA, I will submit those questions again in writing. But you would tell me that today the answer would be things are changing and we are recruiting, encouraging, and hiring those licensed professionals?

Dr. KUDLER. We are doing that, and I will say to be absolutely clear that I am dedicated to doing that. Where we still have slow starts, I want to see that proceed.

Senator MORAN. Do you know, if you are a veteran that lives within 40 miles of a VA facility that does not provide mental health services, whether or not those services will be provided at home?

Dr. KUDLER. Thank you for bringing me back to that. My understanding—and if I am wrong about this I want to know from you

and from my colleagues—every community-based outpatient clinic of any size has got to have a mental health component. It is scaled to the size of that community and the size of that clinic. It is integrated between primary care and mental health. No longer VAs down the hall or several blocks away.

And if we do not have enough capacity at the moment to manage, we will have telehealth capacity to bring mental health directly into that area. Dr. Krahn, am I right?

Dr. KRAHN. That is certainly the goal at every site.

Senator MORAN. Which is a different answer: that is the goal.

Dr. KRAHN. That is—I cannot say that it happens at every place and I cannot say that they can deliver every type of care at every CBOC. So, I am trying to be very, very correct to you.

Senator MORAN. Thank you very much for the honesty. Mr. Chairman, I will conclude, but here is an important point for the VA. If there is a facility within 40 miles, it may not provide the services that the veteran needs and you cannot define, under the Choice Act, that that person is not entitled—is not capable of getting these services at home because there happens to be a facility despite not providing the needed services.

Finally, please give me the name of somebody that we can talk to about getting the Community Mental Health Centers of Kansas, which spread across our 105 counties—they are everywhere—somebody at the VA who will listen to them about how they can provide services to veterans at home. Thanks.

Dr. KUDLER. We will do that. Thank you, sir.

[Responses were not received within the Committee's timeframe for publication.]

Senator MORAN. Mr. Chairman, thank you.

Chairman SANDERS. Thank you, Senator Moran.

Senator Murray.

Senator MURRAY. Mr. Chairman, we are focused on the VA today, as we should be, on the issue of suicides, but I think Senator Tester's point about the DOD is extremely important, and if we are to start way back when someone is in service and embed mental health experts with our troops, I think that it will go a long way in making sure that they know what they need to do when they get home.

He also mentioned the fact that many of our veterans are not putting veteran on their resume when they seek a job, and that is because of this issue. We need the public to better understand this as well. So, this is a very broad topic.

I do want to ask about the VA today. This is a critical piece of this puzzle and I am really concerned that the VA is not making enough progress to bring down the wait times for mental health care. According to your own statistics, wait times for new mental health patients have remained unchanged since June 9, almost 36 days. Why have we not seen this come down?

Dr. KRAHN. I think that there is a difficulty in increasing—there are two issues to access. Right? How do we deliver care and how many people are there to deliver care? Getting more people on board does take time and that is a slow process.

The other aspect is sort of how we bring people into care. Many of those initial appointments, same day appointments, or actually

same day interactions, may or may not show up as first appointment, on the data. So, I am somewhat worried about whether or not those same-day emergency stops are counted or even if they should be counted. We could have a long debate about that.

But I believe people are getting in, in emergent situations, or can touch VA or be touched by VA in emergent situations.

Senator MURRAY. I think that is a point that we need to understand.

Dr. KRAHN. But, we need to do better, obviously.

Senator MURRAY. We cannot have someone call to get an appointment and be told that they can get one in 5 weeks when they have a problem.

Dr. KRAHN. Right.

Senator MURRAY. We have got to make sure, and I want to know that that's happening across the country. But it is also the quality of care once they get in, and I am very concerned about the new report by the RAND Corporation which looked at mental health providers' proficiency with the military culture and whether they are experienced with this.

Their findings raise a lot of concerns. According to the RAND analysis, only about 6 percent of civilian providers are ready to deliver mental health care that is evidence-based and culturally competent. I know you have put your provider toolkit online, but what are we going to do to make sure these community providers have the knowledge to do what they need to do?

Dr. KUDLER. Yes, that is a problem. Actually, that RAND study replicates something we did in the VA originally and found the same findings. I worked with Dr. Tanielian on the report a little bit, at least its release. There is a significant problem that most civilian providers do not even take military history, tell us they do not know much about military culture, tell us they do not know how to connect with VA.

There was a report published just this morning. I got the report for *Military Medicine*, this month's issue, showing something like 60 percent of community doctors felt that they really did not know how to work with VA when they had a veteran in their practice. How do we—

Senator MURRAY. But we just passed this bill saying anybody outside the 40 miles can go to a provider. If they are not competent and capable of dealing with this, we are creating another problem in the future. How do we address that?

Dr. KUDLER. Well, first of all, I still think the Choice Act was a move forward, but now, as you say, we have to make sure that there is community competence. The question is always, access to what? And what we are doing is using educational tools that already exist and finding ways to disseminate them.

We have a mental health community provider Web site in the VA with all kinds of tools and training to provide that crosswalk. We have created, through the IMHS process, the Mental Health Interagency Strategic Plan, an online training which has just been released on military cultural competence which is free, offers free education credit for doctors and psychologists, all the health professionals on military culture. We are building these crosswalks and we are reaching out through our VAs at all facilities. We have done

150 community mental health summits this year; we did them last year and we will do them next year.

Senator MURRAY. OK. My time is running out and I want to ask another critical question, yet I think this is something we need to have oversight on in the future; to really follow that this law has been implemented. So, we are seeing the suicide among middle-aged male veterans who use the VA decrease. You mentioned that. But female veterans who use the VA has increased by 31 percent. What is happening?

Ms. THOMPSON. Thank you so much for asking that, Senator. We are as concerned as you are and we are trying to better understand why that is, why those rates of suicides among women are increasing as is that youngest male population. One thing that I also want to say is that we also know that veterans use firearms more than non-veterans during—when they are feeling suicidal. And we know that women veterans are using firearms at an increased rate compared to non-veteran women.

We know that firearms—if you use a firearm when you are suicidal, there is a 90 percent chance that you will die. If you use medications, prescription medications, which is what most women non-veterans tend to use, there is a 3 to 4 percent chance that you will die because there is an opportunity to be reached before they die.

Senator MURRAY. I appreciate that response, but I think we also have to look at whether or not the VAs are meeting women's specific needs—

Ms. THOMPSON. Absolutely.

Senator MURRAY [continuing]. And why are they increasing dramatically? Are the programs not effective? Are they not feeling that they should ask about it? Is it something else? This is really concerning to me; it is something that I will be following very closely as well.

Ms. THOMPSON. Understandably. Thank you.

Chairman SANDERS. Thank you, Senator Murray.

Senator JOHANNIS.

Senator JOHANNIS. Thank you, Mr. Chairman. Sometimes it is a little difficult to even know where to begin. But let me offer a thought or two and this will lead to where I am trying to go. I disagree vehemently with the testimony I have heard about over-medication. I think over-medication and inconsistent medicating is a problem throughout the mental health system. It is with the VA, it is with private psychiatrists, and to downplay that, I think, ignores reality.

The second thing I would say is that even a medication that works, as you know, oftentimes has very severe side effects. So, you have this individual who has maybe spent years—part of the time in combat, part of the time in training—in very responsible positions, and all of a sudden things are falling apart for him back home.

They are put on this medication. They become lethargic, they start losing confidence in themselves, and family relationships start being strained and falling apart, and the world is just cascading downhill for them. That is the reality of medicating.

I am not saying there is not a place for it. Of course, there is a place for it, and I would argue, if it is medication that is part of

the solution, it should be utilized. But I think to ignore the impact of over-medicating and inconsistent medicating, again, is to ignore reality.

Another thing I want to mention, and this leads me to my question. I had an insight a year or so ago. The Chairman had a hearing much like this. We were questioning veterans and this one veteran explained something to me that I must admit I had missed. This veteran described their time in the military as very difficult.

He said, he was always surrounded by peer support, by people who were going through the same thing, going through the same difficult atmosphere in the absence of family and the absence of friends in a part of the world where it was very, very tough, but still surrounded by people. He said, things started falling apart when that disappeared. "I left the military, I went home, and they were not there anymore."

Here is my point. I love the fact that research is developing more medications that may help more people. I love the fact that there are smart people who can prescribe those medications. But I think we are missing a point here and that is, if we are not developing the peer support—you see, I have this concept that a veteran could walk into a VA center or hospital and ask, when does the next peer group meet? I need some help.

They say, they meet tonight. We hope you are there. And we do not need to have you fill out any forms. Just the fact that you are a veteran will get you to this support. Maybe there is somebody in that room who says, you know, I have been down this road and I found this doctor who prescribed something for me and it is working. But I also started doing some other things.

Why are we not doing more of that? Why are we not trying to support these men and women who come home with others who have had the same experience? Does that not just make sense? And you do not need multi-billions of dollars to get veterans to help veterans. It comes naturally. What am I missing here?

Dr. KUDLER. You are right on target and I wish you were teaching some of our medical students. The fact is that VA has really embraced peer support. I have mentioned the Vet Centers. They have been doing this since the 1970s, and in fact, you do not have to sign up even for VA care to use a Vet Center. That principle was there from the beginning. We have been following the President's Executive Order of 2012 and exceeded his demand that we hire 800 peer support specialists across America. We have well over 900 and we are growing rapidly.

Peer support is now being integrated, thanks to the most recent Presidential actions, into primary care settings as well for that kind of engagement. And I absolutely agree with you that that is one of the warm paths in. I also agree with you that if we are using medicine to push people away while trying to push their symptoms away, instead of engaging them as people and engaging their problems as part of our work.

As the core part of our work, we are all making a terrible mistake. What over-medication is for an individual I found over the years harder to decide because sometimes people need a lot of medicine. Once in a while you will find that a medicine is what makes psychotherapy possible when a patient cannot even be in the room

with you or their memories unless that medicine helps them have a longer fuse to then face the issues and work on them with you.

So, I absolutely agree with you also and I apologize if my remarks in any way trivialized this idea that there are many people on more medicine than they need and those medicines are used in ways that actually get in the way of the process you and I are both trying to describe here.

Senator JOHANNIS. My statement used up all my time, but, Mr. Chairman, I just hope we are not over-engineering something here. I worry about that because I agree with what you are saying about medications, et cetera. But, quite honestly, I think if you could bring people to bear who have been down this road, that could make a big difference. Thank you, Mr. Chairman.

Chairman SANDERS. Let me just say, I think Senator Johannis, what he is talking about, is community. People who served in the military have an extraordinarily strong community of people depending upon each other every day, then they come home and they lose that. I think, Senator, what you are talking about is rebuilding that community for people to support each other.

Senator Blumenthal.

Senator BLUMENTHAL. Thanks, Mr. Chairman. I want to pursue the line of questioning that Senator Johannis began because I think it is absolutely critical. I have held meetings around my State with veterans. Some of them have occurred at what are called Oasis, which are basically college- and school-based centers. They are not medical. They are just meeting rooms. They are literally a room where veterans can come together and call that place their own. They put up their posters. They have got a coffee machine, they have donuts, and they just come together "without medication."

I met with a group just a week or so ago and they talked to me, in very graphic, moving terms, about what it meant just to be with each other. I know that peer support specialists are part of this program. With all due respect to the peer support specialists, I would respectfully suggest that this kind of resource may not always require a trained specialist, but maybe just a veteran, and I have in mind the kind of veteran who got involved, in part, because I reached out to him at the suggestion of another veteran, just made a call to him out of the blue. And he came to one of these meetings.

I do not think it involves necessarily a doctor or a nurse or a medical person, but just a veteran who is empowered and enabled to perform this function. I do not want to use too much of my time with a statement about the importance of this topic, but I would like to know, and maybe you can provide this answer in writing, specifically what the current peer support program embodies and how it could be expanded to fund meeting rooms on State campuses, State schools—which already should be a part of this program—private colleges and universities. But then beyond the college or school setting, in communities, how that outreach function could be expanded. I know this is a topic that you are thinking about, so I would appreciate your expanding on the testimony that you have given already.

I do want to ask you about your testimony, because I think there are some very important questions about the age group that you

do not cover. You talk about middle-aged veterans, which as I understand it, are the 35-to-64-year-old group, and in that group rates of suicide have come down by 16 percent for those adults who use VHA services. In the population as a whole, the rates have remained stable. Correct?

Dr. KUDLER. They have actually gone up.

Senator BLUMENTHAL. Well, they have gone up. Exactly, they have gone up from 35.5 to 37.5 percent. Right? So, the rates are coming down for middle-aged adults who use VA services. They rates have gone up a little bit for the overall group, but they seem fairly stable at 35 to 37 percent.

Dr. KUDLER. Well, let us not take up time with the numbers.

Senator BLUMENTHAL. Well, here is where I am going. What that says to me is that among other age groups, suicide rates have risen dramatically for veterans who use your services, not just women, but men. Can you tell me how much they have risen? For example, for—and this is, so far as I can see, nowhere in your testimony—for the age group 18 to 25 or 20 to 29, for the younger population of veterans. Because after all, most of the veterans who are leaving the service right now are in that younger age group, right? So, what is the rate there?

Ms. THOMPSON. We are extremely concerned about this younger population.

Senator BLUMENTHAL. Well, I know you are concerned.

Ms. THOMPSON. No, I know, but I do not have the actual—I believe it is up to 70, and this is over time. So, the rates, I would have to find the exact number.

[Responses were not received within the Committee's timeframe for publication.]

Senator BLUMENTHAL. I think that is the elephant in the room.

Ms. THOMPSON. Is what—

Senator BLUMENTHAL. The elephant in this room. What is happening in that younger group?

Ms. THOMPSON. You are absolutely right.

Senator BLUMENTHAL. You are given middle-aged—

Ms. THOMPSON. No—

Senator BLUMENTHAL [continuing]. Friends who use your services.

Ms. THOMPSON. We certainly acknowledge that that rate is increasing, and so, what are we doing about this? We need to provide, and we are providing, very, very specific outreach to those youngest veterans that have come home.

Senator BLUMENTHAL. Well, we are talking about more than just outreach, with all due respect. We are talking about—and this is the really critical point here—we are talking about a group that uses your services.

Ms. THOMPSON. Absolutely.

Senator BLUMENTHAL. You have reached out to them.

Ms. THOMPSON. Yes.

Senator BLUMENTHAL. They are in your doors. They are using your services and they are committing suicide at a higher rate.

Ms. THOMPSON. Yes. So—yes. We are trying to understand why this is. We are at a loss as much as a lot of people are. We certainly—

Senator BLUMENTHAL. I mean, you know, this is, with all the publicity surrounding the wait times and people dying, are they dying because of the wait? Are they not? People are dying at a higher rate—

Ms. THOMPSON. Yes.

Senator BLUMENTHAL [continuing]. Who use your services.

Ms. THOMPSON. Yes, and this youngest group, absolutely. We are very, very focused on this.

Senator BLUMENTHAL. I do not know what more to say because my time has expired. I apologize, Mr. Chairman.

Ms. THOMPSON. We hear you.

Senator BLUMENTHAL. OK. Thank you.

Chairman SANDERS. Thank you, Senator Blumenthal.

Senator BOOZMAN.

Senator BOOZMAN. Thank you, Mr. Chairman. Following up on Senator Blumenthal, what is the average age of the veteran that decides to take their life? In the VA, what is the average age of veterans that are taking their lives?

Ms. THOMPSON. Who died by suicide? Well, I do not know the average age, but we do know that 70 percent of veterans who died by suicide are 50 years old and older. So, even though—

Senator BOOZMAN. Older group.

Ms. THOMPSON. Yeah.

Dr. KUDLER. And that is by far the largest group of veterans. That is one reason why we focused on that.

Senator BOOZMAN. And what percentage have been deployed?

Ms. THOMPSON. In terms of that 70 percent, it is difficult—

Senator BOOZMAN. Well, percentage of veterans that are taking their lives. What percentage of those have been deployed overseas?

Ms. THOMPSON. Well, what we know about those military members—and we are looking at the veteran numbers—but we know that those who have died who are servicemembers, fewer than half have ever been deployed. There is a perception that the number of deployments, the combat experience that people have is a primary reason that people are dying by suicide at these high rates. In fact, we are learning the opposite.

Senator BOOZMAN. I think the point that Senator Blumenthal tried to make, which I am trying to make, is that those two groups are very different.

Ms. THOMPSON. Absolutely, yes.

Senator BOOZMAN. And they need to be treated very differently, which I do not think we are doing right now. You know, we have a one-size-fits-all, which is a totally different thing. I am a little concerned or a little confused about the wait times. You know, you said it is mandated that it is the day. If a family practitioner sees a patient and, in the course of that examination, he is concerned that perhaps this individual is having problems and he writes down on the chart, you know, he needs a consult. How long does that take?

Dr. KRAHN. Well, actually, over 90 percent of facilities and over 90 percent of large CBOCs, there will be a co-located collaborative mental health person in the building and they should be able to walk that person over to the office and see them.

Senator BOOZMAN. Well, they should be able to. Where does the 33 days come in then? What is that?

Dr. KRAHN. That is a prospective. It is like if you make an appointment by, say, call in by phone and say, when is the next appointment? It is that far out. But if you come in—

Senator BOOZMAN. If you walk the person over, they see you, and then they say, well, you need to come back. Then it is 33 days?

Dr. KUDLER. And that is a very important point, Senator, because what often happens—

Senator BOOZMAN. Because that is not really—you know, I am just checking a box, but it is really not seeing the point.

Dr. KUDLER. Our standard is that they will be seen that day, but that does not get shown. That is not reflected in that longer wait time. That is to get the next official appointment. Quite frankly, they will often be seen back in other ways or other clinics earlier. They will be seen that day by a mental health professional if they need that help, and anyone can refer them and they can self-refer there.

Senator BOOZMAN. But if they—in follow-up appointments, it is probably 33 days?

Dr. KUDLER. Yes, I think that is right.

Senator BOOZMAN. So, they are actually not starting treatment for an extended period of time.

Dr. KUDLER. They do not get an official mental health appointment, though they may be seen in other ways. Unfortunately, our system does not capture all the ways we do it. For instance, we might have them come back to the emergency room and that will not be recorded as a mental health appointment. Nonetheless, they may have that mental health appointment, or a phone call which may not be registered as a mental health appointment. But, yes.

Senator BOOZMAN. Tell me about the over-medication. It is a problem not only in the VA, it is a problem throughout the entire country. The idea of saying that we are not over-medicating, to me, does not make any sense at all. Right now the United States uses more opioids than the entire rest of the world put together. It is the major problem as far as drug dependency now. It is replacing almost everything else.

So, I think it is a problem and I think it is something that we need to talk about and actually do something about. Now, I do not know if you have situations where after somebody does take their own life, if there is any follow-up to that where you look and see, you know, what they are on, what happened to them, you know, if they got seen or whatever.

But, I would suspect that those studies, in dealing with people that have had this problem, actually being out in the real world, talking to people at VSOs, talking to our veterans, talking to families that have gone through this, you know, anecdotally, there is a significant problem with many of the people that are in that situation.

Dr. KUDLER. And, Senator, I want to apologize if I misspoke or misrepresented. I do believe there is such a thing as over-medication. It is just hard to judge from a distance. Is this that or is that that? I also want to point out that we are doing education and re-

views at every level—computerized reviews, personal reviews, and ongoing education for our own staff.

And particularly about opioids, which we do not prescribe as a mental health medicine. I do not use opioids to treat any mental health illness.

Senator BOOZMAN. But that is all connected, too; and as a mental health provider, you should be able to look at the chart and see that this patient—

Dr. KUDLER. And I can.

Senator BOOZMAN [continuing]. Is on a bunch of opioids—

Dr. KUDLER. I can.

Senator BOOZMAN [continuing]. And you should be getting them off the opioids.

Dr. KUDLER. Yes. We, in fact, do that.

I wonder if Dr. Thompson would like to respond, also, to the question of what we do in follow-up with a suicide.

Ms. THOMPSON. Yes. We have established what we call a behavioral health autopsy program so that any veteran that we hear about who has died by suicide, whether they are in the VA or not, the Suicide Prevention Coordinator in that area will go through an extensive record review and then will reach out to a family member in order to talk with them about what the gaps are, what might have happened, were there over-medication concerns.

We have not put out any formal reports yet, but we plan to very soon.

Senator BOOZMAN. Thank you, Mr. Chair.

Chairman SANDERS. Thank you, Senator Boozman.

Senator Begich.

Senator BEGICH. Thank you very much. Let me follow-up on a couple of things you had noted, I think in response to one of the questions. It was to the Chairman on the amount of resources you have and I think your words were, it is a good stop gap. So, is your concern that that money will not continue? Is that a concern? I want to understand what you mean by stop gap, and then I have some very specific questions.

Dr. KUDLER. It is my understanding, I hope not a misunderstanding, that the funds in the—many of the funds in this bill, in this law, are time limited, and when they are out, they are out. We may not be able to sustain some of the activities we build. We can build great things, but can we keep them going?

Senator BEGICH. Right. That is what I thought you were pointing to, and I think your point, without you saying it, was if we pass laws like this, the Choice Act, and we put funding in it, we also have to have sustainable funding. Am I hearing that right?

Dr. KUDLER. Yes, sir.

Senator BEGICH. OK. I want to make sure that is clear again because I will not be here after January, but I want to make sure my colleagues hear exactly what you are saying, so a couple years from now, we do not hear complaints that, geez, why did you not do it? You will have the actual answer on the record, that you did not sustain the funding. So, I wanted to make sure that is on there.

Second, what is the ratio of actual—you may not know this right offhand, but—actual people who deliver the care, psychiatrists, to a veteran? You have told me the numbers were, I think, 900,000

up to now 1.4 million. What is your ratio? You did talk about 7,000 to 13,000 more people, but what is the ratio for a physician or a psychiatrist? Or does it make sense what I am asking you?

Dr. KRAHN. I can give you the ratio, first of all, for all FTE, provider FTE in outpatient services and it is 8.1 providers per 1,000 veteran mental health users in outpatient care. About one-seventh—

Senator BEGICH. Do you know what the private—

Dr. KRAHN. No, I actually do not have a comparison because it is very difficult to get that comparison and our populations are so—

Senator BEGICH. But I am assuming that a psychiatrist is not seeing 1,000 patients.

Dr. KRAHN. No. There would be about 1.2 psychiatrists on the average for every 6 other providers. So, it is about 1.2 out of 7, right in that range. With that team, the psychiatrists can work together to handle about 1,000.

Senator BEGICH. 1,000 people?

Dr. KRAHN. With 1.2—

Senator BEGICH. Psychiatrists.

Dr. KRAHN. But you may have another prescriber, like a nurse practitioner or pharmacist, a psychologist or two, social worker, et cetera.

Senator BEGICH. Let me jump to one thought which requires no answer. It is just something I hope you would work on. As you know, at DOD there are some issues with recognized educational requirements of certain colleges and certain degrees so DOD has actually waived that so they can tap into current mental health counselors and others. DOD has done that. I would hope that you would do the same thing. It is critical to get those different layers of services available.

It is not always psychiatrists—no disrespect to the VA doctor—but, you know, different counselor services are needed depending on the degree of the mental health issue. So, I ask this all the time. It seems like it is a struggle to just get movement on it, so just put that over here.

But I do want to say, since this is probably my last hearing so I will talk about Nuka.

Chairman SANDERS. Though not for too long.

Senator BEGICH. Not too long. Yet, here is why I want to talk about it, because when Senator Isakson talked about the doctor visit, that is actually an old model. That is a model that we are trying to get rid of, because what happens—tell me if I am wrong about this. When that patient comes in and they just come for the check-up, the physician shows up for 5 minutes, 10 minutes, the nurses check their pulse and their blood pressure and everything, and they leave. They never ask about mental health. They are not asking about hearing, eyes, and so forth.

The Nuka model, which my understanding is the VA is now contracting to try to implement this in certain regions throughout the country because it is a holistic approach, because you may have someone who comes in who has no issues in their mind about mental health services they need, but if they go through this model, the

odds are someone might realize this person needs some additional services. Is that a fair statement?

Dr. KUDLER. Sir, in fact, Nuka is a cultural model of delivering health care and it is exactly what the VA needs. This is my personal opinion.

Senator BEGICH. I want to have you say that again so the Chairman hears it. It is what the VA needs and that is why you are now contracting to try to implement this in certain regions, to test that model, because that old style of walking into a doc, get into your little box, and wait for him to show up for 10 minutes after the nurse checks your blood pressure, your temperature, your weight and your height; then the next thing you know, actually you might have a mental health issue that they never will detect.

Dr. KUDLER. Well, it speaks to what Senator Sanders said earlier in his comments. You know, it is military culture and the VA is all about military culture.

Senator BEGICH. Right.

Dr. KUDLER. And it is great that we are hiring all these people, but if we do not train our own people in military culture and then train all the people who might refer people about military culture, we are missing the critical element that pulls all this together and the actual meaning of the VA.

So, Nuka is one model for us to build that in, but we have to build it around that military model.

Senator BEGICH. That is right. Well, let me end on this, Mr. Chairman. You have a tough challenge; there is no question about it. The families that will be up next will tell us about the challenge. We have seen—I think the Chairman said it very clear—we hear it every day. You know, people call our offices or we run into them or their families.

How we approach this mental health system for the VA cannot be in isolation of the mental health system of this country. If we do that, we will fail. I think my worry is that when we passed the Choice Act—I think Senator Murray mentioned it—and that is where are the results?

Well, in isolation, you cannot get the results as quick as you want—26 months ago. To train someone in this mental health service area is months and years. But, if we now draw and extract from the private sector—the recruitment that you are doing—then we are going to now have this problem over here in the private sector which veterans also access without saying they are a veteran.

So, I hope you would, as you do this and this Committee looks at this holistically in mental health, because if we do not do this as a national model, you will not be as successful as we need you to be for the veterans of this country.

Dr. KUDLER. The truth is that only about one-third of all veterans use VA health services.

Senator BEGICH. Right.

Dr. KUDLER. Two-thirds are out there and—

Senator BEGICH. Already, without the Choice Act.

Dr. KUDLER. Without the Choice Act; and they are not recognized by their own clinicians as veterans. Something is broken.

Senator BEGICH. That is right. Thank you, Mr. Chairman.

Chairman SANDERS. With that, let me thank Dr. Kudler, Dr. Krahn, and Dr. Thompson very much. Thank you so much for being with us.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO DR. HAROLD KUDLER, VA CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Question 1. Dr. Harold Kudler, in your position and testimony as Chief Mental Health Officer for the VA, you mentioned the VA's Operation S.A.V.E. program, which denotes the V as "Verifying the experience." I am curious if you could go into further detail about how you verify the experiences, especially if there was no physical wound or decoration for bravery?

Response. *Operation S.A.V.E.* is a one to two-hour gatekeeper training program provided by VA suicide prevention coordinators to Veterans and those who serve Veterans. Optional role-playing exercises are included. Operation S.A.V.E. training consists of the following four components:

1. Brief overview of suicide in the Veteran population
2. Suicide myths and misinformation
3. Risk factors for suicide
4. Components of the S.A.V.E. model (Signs of suicide, Asking about suicide, Validating feelings, Encouraging help and Expediting treatment)

Operation S.A.V.E. was developed by the Education Core of the VISN 19 Mental Illness Research, Education and Clinical Center. It consists of a PowerPoint presentation, training script, instructors guide and toolkit, pre- and post-evaluation instructions, evaluation forms, tracking sheets, and Operation S.A.V.E. brochures.

Regarding the "V" for "Verifying the experience/Validating feelings" in the S.A.V.E. model, the "experience" discussed is the Veteran's experience of feeling suicidal. This experience is captured in the "A" component of the S.A.V.E. model during which a Veteran is asked if he/she is feeling suicidal. If a Veteran endorses feeling suicidal, the next step is to verify the suicidal thoughts and validate the feelings associated with the suicidal thoughts. By verifying the thoughts and validating the feelings, individuals are able to encourage the Veteran to receive help and expedite getting the Veteran the care that may be immediately needed.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. RICHARD BLUMENTHAL TO DR. HAROLD KUDLER, VA CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Suicide Prevention

Question 2. In a study cited by the New York Times of soldier suicides researching military suicide risk models, it was found that many factors contributed to risk levels of suicide. Some of these factors associated with higher risk were expected, such as previous suicide attempts, a history of weapon use and symptoms of severe traumatic brain injury, such as hearing loss. Others were less obvious, like a higher IQ and being older than 26 at enlistment. I would like to commend Dr. Kessler, whose team tested these factors—I urge the VA to incorporate this new prediction program to allow doctors to better track high-risk soldiers after discharge. We should consider how we can use these at-risk analytics and the factors identified to focus our provision of mental health care and take preventive measures where appropriate.

Dr. Kudler, you mentioned that the VA is pursuing a large number of research topics regarding suicide and mental health. Can the VA undertake a study of predictive indicators for risk of suicide using third party data or lifestyle indicators? <http://www.nytimes.com/2014/11/13/health/new-prediction-model-could-reduce-military-suicides-study-finds.html>

Response. VA has developed a model for predicting suicide risk among those who receive VHA services using data from electronic medical records. Results from this effort were recently reported in the American Journal of Public Health. <http://dx.doi.org/10.1176/appi.ps.201400031> VA is currently exploring opportunities for enhancing and refining models for predicting suicide risk; including the use of third party data and mechanisms for safe use of potentially sensitive information available from these resources.

Suicide Rates

Question 3. Dan Thurston, the Chairman of the Connecticut Veterans and Military Coalition, expressed that peer support is a positive step toward suicide preven-

tion and builds greater camaraderie for those transitioning back into civilian life. In prior wars, it was often easier for Veterans' to stay in contact with soldiers from their unit. Dr. Kudler, could you please provide the suicide rates of Veterans by era of service to determine any differentiation between suicide rates among Veterans of different wars?

Response. Information on rates of suicide by cohort is currently limited to Veterans from Operation Enduring Freedom, Operation Iraqi Freed and Operation New Dawn (OEF/OIF/OND) who use VHA health care services. In fiscal year 2011, the rate of suicide among OEF/OIF/OND Veterans who used VHA services was 42.1 per 100,000 . Data for other cohorts is being acquired through the VA/DOD Suicide Data Repository through collaboration between VA, DOD and the Centers for Disease Control and Prevention. Rates of suicide among Veterans from the Vietnam and Gulf War cohorts will be available as new information is obtained later this year.

Unemployment

Question 4. I have heard from constituents that one of the greatest stressors on returning Veterans is both unemployment and underemployment. Dr. Kudler, does the VA coordinate mental health services with assistances in veterans' employment? What support does the VA provide for veterans with post-traumatic stress who are seeking employment and do you assist employers with accommodating veterans suffering from post-traumatic stress?

Response. VA has created a Veterans Employment Toolkit (www.va.gov/vetsinworkplace). This is an important tool to help employers, managers and supervisors, human resource professionals, and employee assistance program (EAP) providers relate to and support their employees who are Veterans and members of the Reserve and National Guard. In this toolkit, users can learn about Veterans and the military, such as what Veterans bring to the workplace and what the military structure and culture is like. They can also learn how to support employees who are Veterans or members of the Reserve or National Guard in the workplace, through reading about common challenges and how to help, reviewing communication tips, reading a report about Veterans in the workplace, or by downloading handouts to use with EAP clients. Finally, Veterans and their family members can use this toolkit to find employment resources for Veterans.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. MAZIE K. HIRONO TO DR. HAROLD KUDLER, VA CHIEF CONSULTANT FOR MENTAL HEALTH SERVICES, U.S. DEPARTMENT OF VETERANS AFFAIRS

Military Families and Caretakers

Question 5. Many Veterans and their families in Hawaii have found that there is not enough support for military families and caretakers when servicemembers transition back to civilian life. Families and caretakers often feel overwhelmed and unprepared to help their loved ones. Please describe VA's efforts at improving mental health and suicide prevention programs available specifically for our military families and caretakers in Hawaii.

Response. Partnering with families is an essential component of VA mental health services. Consistent with a recovery philosophy, flexibility is a key principle when involving families in care. VA offers a continuum of family services to meet varying needs including family education/training, consultation, and marriage and family counseling. National training programs in several evidence-based practices for marital and family counseling are available for clinicians. VA also has an active monthly training program for clinicians on family issues and interventions of particular relevance to Veterans and has developed a family services Web site as a resource for VA providers.

Initiatives specific to VA-Pacific Islands include:

- VA Family Services training staff conducted a 3 day on-site clinical training in Behavioral Family Therapy for Serious Psychiatric Disorders and Veteran-Centered Brief Family Consultation family consultation for 20 VA clinicians;
- Five VA Hawaiian mental health clinicians have completed the VA four day training in Integrative Behavioral Couples Therapy for marital Distress (IBCT) including a mental health clinician from American Samoa;
- VA Family Services Trainings include guidance on suicide assessment and encourage family clinicians to collaborate with Suicide Prevention Coordinators; and
- VA family Services has established collaborative relationships with a prominent VA researcher, Dr. Julia Whealin, affiliated with the National Center for PTSD-Pacific Islands Division on the uses of telehealth to meet family needs in Hawaii

VA recognizes the crucial role that caregivers play in helping Veterans recover from injury and illness and in the daily care of Veterans in the community. VA values the sacrifices Caregivers make to help Veterans remain at home. Caregivers are partners in the care of Veterans and VA is dedicated to providing them with the support and services they need. The Caregivers and Veterans Omnibus Health Services Act of 2010, signed into law by President Obama on May 5, 2010, allows VA to provide unprecedented services and supports to Family Caregivers of Veterans. The Caregiver Law (P.L. 111–163, Title 1) establishes a comprehensive National Caregiver Support Program with a prevention and wellness focus that includes the use of evidence-based training and support services for Family Caregivers. Pub. L. 111–163 established additional support and services for Family Caregivers of eligible post-9/11 Veterans seriously injured in the line of duty under the Program of Comprehensive Assistance for Family Caregivers including education and training, a monthly stipend paid directly to the Family Caregiver, enrollment in VA’s Civilian Health and Medical Program (CHAMPVA) if the Family Caregiver is not already eligible under a health care plan, an expanded respite benefit, mental health services, and travel, lodging, and per diem to attend required training as well as to attend the Veteran’s medical appointments. As of [June 2015] VA has served 316 caregivers in Hawaii since inception of Comprehensive Assistance.

The Suicide Prevention Program at VA-Pacific Islands Health Care System (VAPIHCS) provides support to families of Veteran’s through Community Outreach activities at the State of Hawaii Suicide Prevention Task Force as well as the Department of Defense. Through Outreach activities, the family members are informed of the services available at VA Mental Health Service including family therapy, the Veteran’s Crisis Line, support groups and individual mental health treatments for Veterans. VAPIHCS recently presented information at a State Suicide Prevention Conference in April 2015 in which there was a “breakout session” for Veterans and their families. At times, VAPIHCS refers Veteran family members to community support services available through other providers who are members of the State of Hawaii Task Force. The Suicide Prevention Program also collaborates with the VA Caregiver Support Program. There have been occasions when a provider in the Caregiver Support Program identifies a caregiver in the program who needs additional Mental Health support. The Caregiver Support program contacts the Suicide Prevention Program to arrange for the caregiver to receive services.

The Suicide Prevention Program at VAPIHCS will be in a position to do more for family members in the future their two new hires have increased the staffing from one Suicide Prevention Coordinator and one Program Support Assistant to two full-time clinicians (one Suicide Prevention Coordinator and one Suicide Prevention Case Manager) as well as a Suicide Prevention Peer Support Specialist.

Female Veterans

Question 6. Female Veterans in Hawaii have told me that VA is not doing enough to assist female combat Veterans suffering from PTSD or TBI. What is VHA’s overall approach to helping female Veterans facing mental health issues? Please provide details on the type of treatments available to female Veterans in Hawaii who have experienced sexual assault or trauma? Specifically, what do you identify as VA’s shortcomings? What is VA’s plan to address these shortcomings; and what is the timeframe for these changes to be implemented?

Response. VA is enhancing facilities, training health care staff, and improving access to services to meet the current and future health care needs of women Veterans. More than 400,000 women Veterans are currently utilizing the VA health care system. Of these, over 40% use VHA mental health services.

VHA offers a full continuum of mental health services to women Veterans including: outpatient assessment, evaluation, psychiatry, individual, group and family therapy; specialty services for conditions such as PTSD and substance use disorders; and inpatient and residential treatment options.

VA has enacted universal screening programs for some of the most common mental health conditions, including those faced by women, such as depression, PTSD, alcohol use, and military sexual trauma (MST). These screening programs provide an opportunity to identify those individuals in need of mental health care and refer them to appropriate mental health services. Screening rates for depression, PTSD, and alcohol use are very high (96%–99%), exceed private sector rates, and do not significantly differ by gender.

Evidence suggests that women Veterans may differ from men in the prevalence and expression of certain mental health disorders, and responses to treatment. VA policy requires that mental health services be provided in a manner that recognizes that gender-related issues can be important components of care. For example, all VHA facilities must ensure that every outpatient and residential program has an

environment that can accommodate and support women with safety, privacy, dignity, and respect. Residential and inpatient programs must provide separate and secured sleeping and bathroom arrangements including, but not limited to, door locks and proximity to staff for women Veterans. All residential programs, including those in Hawaii, report compliance with these requirements.

Finally, VHA has strong clinical training initiatives in place to ensure that mental health providers have the knowledge and skills to meet the unique treatment needs of the growing population of women Veterans accessing VHA services. These include didactic teleconferences, expert case consultation and a web-based training curriculum on women's mental health needs across the reproductive lifespan (e.g., psychiatric disorders during and after pregnancy). In addition, the Women's Mental Health Section of VHA Mental Health Services is currently developing a women's mental health mini-residency curriculum. This 3-day intensive training event is designed to provide VA mental health providers (up to 200 attendees) with the clinical knowledge and skills to provide gender-sensitive care to women Veterans. Participants will help to disseminate best practices for women Veterans' mental health care to providers and leadership at their local facilities and at the VISN level.

Treatment available to female combat veterans in Hawaii suffering from PTSD or TBI

All Veterans, men and women, newly enrolled into the VA Pacific Islands Healthcare System (VAPIHCS); are confidentially screened for PTSD, Military Sexual Trauma (MST), and TBI consistent with national clinical reminder guidelines. For those presenting first to mental health (MH), the screening is performed by a MH provider and Veterans are referred for services accordingly. For Veterans presenting first to primary care (PC), they are screened by trained PC providers. If requesting to speak with a MH provider, warm hand-offs within Primary Care to the Integrated Care Team are prioritized; if a warm hand-off is not readily available, a consult is placed and the Veteran is contacted by an MH provider.

Female (and male) combat Veterans diagnosed with PTSD are offered outpatient evidence-based psychological treatments for PTSD through the Traumatic Stress recovery Program (TSRP), the outpatient PTSD team in VAPIHCS. Clinical services and groups offered include two primary evidence-based treatments: Prolonged Exposure Therapy (PE) and Cognitive Processing Therapy (CPT). Veterans are also given options for group-based treatments, including Unified Protocol for Transdiagnostic Treatment of Emotional Disorders, Dialectical Behavior Therapy, General Coping Skills, Anger Management, Cognitive Behavior Therapy for Insomnia, Mindfulness Drop-in Groups, and Seeking Safety. Additionally, Veterans are given the option of adjunctive pharmacological treatment (e.g., medication management), based on need and preference.

Veterans living on the outer islands have access to MH providers including psychiatrists, social workers, addiction therapists and psychologists (depending upon the location of the Community Based Outpatient Clinic (CBOC)). CBOCs without a provider trained in offering an evidence-based psychotherapy may refer the Veteran for Telemental Health for Evidence Based Practice (EBP) for PTSD.

Treatment available to female Veterans in Hawaii who have experienced sexual assault or trauma

Military sexual trauma (MST) is the term used by VA to refer to sexual assault or repeated, threatening sexual harassment experienced during military service. Not all MST survivors have long-term difficulties, but some experience chronic physical and mental health problems, including PTSD, depression, and substance use disorders. Recognizing that many survivors of sexual trauma do not disclose their experiences unless asked directly, it is VA policy that all Veterans seen for health care are screened for experiences of MST. In fiscal year (FY) 2014, 523 or 27.5% of female Veterans seen for health care at VAPIHCS had reported a history of MST when screened by a VA health care provider.

All VA treatment for physical and mental health conditions related to MST is provided free of charge. Service connection is not required, and Veterans may be able to receive free MST-related care even if they are not eligible for other VA services. VA offers a wide range of treatment services, and every VA health care system provides MST-related care. Additionally, VA has long recognized that gender-specific issues are an important component of providing care to Veterans who experienced MST. Creating a treatment environment that respects and accommodates MST survivors' gender-related concerns is a top priority. For example, national VA policy strongly encourages all VA health care facilities to offer Veterans the choice of a same-sex or opposite-sex provider for MST-related treatment whenever possible.

At VAPIHCS specifically, Veterans with PTSD secondary to sexual trauma are offered evidence-based psychological treatments for PTSD, including Prolonged Exposure Therapy and Cognitive Processing Therapy. These are the equivalent of what is offered for PTSD secondary to combat trauma, as they have been empirically validated in both populations. Veterans are also given options for group-based treatments, including Unified Protocol for Transdiagnostic Treatment of Emotional Disorders, Dialectical Behavior Therapy, General Coping Skills, Anger Management, Cognitive Behavior Therapy for Insomnia, Mindfulness Drop-in Groups, and Seeking Safety. Veterans are also given the option of pharmacological treatment (e.g., medication management), based on need and preference. If a female Veteran and the provider have attempted outpatient services and determined that a higher level of care is needed, a referral for residential PTSD treatment may be made. Veterans who have experienced sexual trauma but whose difficulties are other than PTSD (for example, primary difficulties of substance use, depression), are offered services within specialty clinics such as the Substance Abuse Treatment Program. Through these programs, Veterans are offered evidence-based individual and group psychotherapies and medication management, as desired. These services are not gender-specific. Like every VA health care system, PIHCS has a designated MST Coordinator who serves as the local point person for MST-related issues and can help Veterans access VA services and programs.

Among women Veterans who screen positive for MST in VA, rates of engagement in care and amount of care provided continue to increase every year. This is also true for women Veterans receiving care at VAPIHCS. In FY 2014, among women Veterans at VAPIHCS, 346 or 66.2% of women who screened positive for MST received outpatient care for either a mental or physical health condition related to MST. This is an increase of 25% from FY 2013, where 277 or 58.4% of women who screened positive for MST received MST-related outpatient care. These women Veterans had a total of 2,777 MST-related visits in FY 2014, which represents an increase of 31% (from 2,114 visits) from FY 2013.

Challenges related to providing services, and strategies to address those challenges

1) The waiting area in mental health may feel uncomfortable to some women Veterans because of the large majority of men present in this limited area of space.

What's being done: Providers have been encouraged to develop arrangements with women Veterans that they see to meet them in areas which made them feel safer. For example, if a woman Veteran has endorsed discomfort in waiting in the usual waiting area, they may plan with their provider to wait outside on the back lanai, in an unoccupied group room adjacent to the waiting room, or on the building's second floor landing.

The Traumatic Stress Recovery Program (TSRP) Orientation group now includes specific requests to male Veterans to behave courteously, whether in their language or behaviors, toward women in the waiting area—this applies to staff, Veterans, or family members. In addition, we are actively considering utilization of the Women's Health Clinic waiting room for use within mental health appointments.

2) Women Veterans, while growing in number, still represent a small minority of the Veterans who utilize the MH programs. This makes it difficult to plan for groups and other women Veterans' activities. Previous attempts to expand the number of groups offered specifically to women Veterans (with no males present) have either resulted in a lack of referrals and/or very low numbers of patients in the groups. The insufficient number of group members as well as their lack of consistency in attending regularly tends to detract from group cohesiveness and effectiveness of intended treatment.

What's being done: Currently, there is one weekly, ongoing group open for women referrals. This group utilizes a Unified Protocol (UP), which combines treatment elements from various Evidence-Based Therapy protocols. In addition, the Behavioral Health Interdisciplinary Program (BHIP) and MST teams jointly offer a Dialectical Behavior Therapy (DBT) group which is very useful for women Veterans with PTSD and other comorbid disorders. While open both to men and women Veterans, DBT provides assistance with emotional regulation and basic skill building needed in PTSD treatment. Women Veterans are eligible to participate in all other TSRP groups including both psychotherapeutic groups and psychoeducational groups, which provide instruction for specific problem areas commonly observed with PTSD, such as sleep hygiene, anger management, or couples.

Referrals for PTSD-related services for women tend to comprise three different subsets of women: 1) Combat-related PTSD; 2) MST-related PTSD; and 3) MST without PTSD. While group approaches are limited, women Veterans with combat related PTSD have ready access to individual therapy within the TSRP. Access to

PTSD care within TSRP does not differ for men or women Veterans except in one respect: rather than routinely referring new consults to the TSRP Orientation group, where they are likely to be outnumbered by men, women Veterans may be offered the choice of attending an individual TSRP Orientation. This additional option for women was implemented in an attempt to avoid potential discomfort of the women in their first contact with the treatment team. Women Veterans with PTSD secondary to MST are primarily seen within the MST program which is housed within the TSRP. A TSRP staff member and a psychology resident take primary responsibility for such referrals although other TSRP team members may serve as providers. EBTs are considered for women Veterans in either of these two situations, although other treatment approaches are also available if the women Veterans are either not interested or not able to participate in an EBT. Other women Veterans with a history of MST, yet who may not meet criteria for PTSD, may be seen within the MST program, or depending on their presenting concerns and treatment needs may be referred to other providers within the larger MH program. All MH programs will develop an individualized treatment plan with the Veteran which may include medication management and/or other therapeutic approaches.

3) Work, childcare or education limits availability for both group participation and individual therapy sessions

What's being done: Often, women Veterans are unable to attend treatment sessions with optimal frequency. Attempts to accommodate their availability for scheduling include offering of irregular appointment times—until 6:00 pm on Tuesdays, 7:30–11:00 am on Saturdays, and beginning at 7:00 am on weekdays.

Work is currently underway to initiate The Veterans Integration to Academic Leadership (VITAL) program, which will offer treatment services on college campuses. These additional VA sites of service are intended to increase convenience and ease of men and women Veterans in accessing care.

National Center for PTSD Pacific Islands Division

Question 7. Recently, my office was informed that the National Center for PTSD has decided to cut a significant number of staff at its Pacific Islands Division in Hawaii by January 2015, effectively shutting down its operations. Please provide background and an explanation of this decision and describe VA's plan going forward for the Pacific Islands Division?

Response. In response to a letter you sent to Secretary McDonald on November 26, 2014, asking for information about the status and future plans for the Pacific Islands Division of VA's National Center for PTSD, VA staff briefed two members of your staff by phone on December 19, 2014. Dr. Paula Schnurr, Executive Director of the National Center for PTSD (NCPTSD), led the briefing. She began the call by stating that the recent changes in staffing are voluntary separations and are not due to downsizing. The changes are expected to improve outcomes for Veterans with PTSD by allowing the Pacific Islands Division to recruit more qualified staff. She also stated that the changes would not affect clinical care in Hawaii or the region because NCPTSD is not a clinical program and does not deliver clinical services; also, the Center's clinical research programs have been retained despite the changes.

Dr. Schnurr then provided a brief overview of the National Center for PTSD and a mission description of the Pacific Islands Division. NCPTSD is a 7-part consortium that is a Center of Excellence devoted to research and education on PTSD. The primary mission of the Pacific Islands Division in Honolulu is PTSD research and education in the areas of ethnocultural issues and telehealth. The Division was founded in 1994 when the Pacific Center for PTSD was disbanded. The Honolulu VA Medical Center incorporated the Center's clinical program and NCPTSD was asked to incorporate the research and education programs, creating a new NCPTSD division. The Pacific Islands Division has struggled since its inception to achieve its mission or function comparably to other NCPTSD Divisions. There has been extreme difficulty in hiring a permanent Director or qualified staff. There have been few projects on ethnocultural topics and low productivity. For example, in the 20 years that the Division has been in existence, staff have obtained only one funded research grant focused on ethnocultural issues.

In order to help the Division, NCPTSD has enlisted the support of two experts on ethnocultural issues in PTSD, one through a telework agreement with the Minneapolis VA Medical Center and the other through an Interagency Personnel Agreement with the Department of Psychiatry at the University of Hawaii Medical School. Research on telehealth has been very successful, but the lead for that work has moved to the San Diego VA Medical Center. However, she is being retained on a part-time telework agreement to continue her telehealth research in the Division.

Dr. Schnurr then described current staffing and plans for rebuilding the Division, beginning with the recruitment of a new Director after the current Director retired. That date, originally scheduled for May 2015, was pushed back to June 2015. Preparatory work to begin the search has been conducted and we anticipate posting the position in Summer 2015. A new .5 Administrative Officer and a 1.0 Administrative Assistant have been hired. Dr. Schnurr and her staff meet with the staff of the Pacific Islands Division weekly and as needed to provide support and guidance.

Transition program

Question 8. As mentioned in Dr. Kudler's testimony, providing the necessary resources to servicemembers who are transitioning from active duty to civilian life is crucial, especially for those who suffer from TBI or PTSD. According to the VA an important component to this goal is the inTransition program. Please provide a comprehensive update on the program as implemented in Hawaii, including numbers on how many servicemembers were enrolled and information on how the comprehensive care plan is working between DOD/VA providers.

Response. VA provides comprehensive transition assistance and care management for wounded, ill and injured Servicemembers and Veterans who served in the military on or after September 11, 2001. Each VA Medical Center has a Transition and Care Management (TCM) team whose team members are highly experienced and specially trained in the needs of transitioning Servicemembers and new Veterans. These teams coordinate patient care activities and ensure that Servicemembers and Veterans are receiving patient-centered, integrated care and benefits.

The inTransition program is a DOD program that offers specialized coaching and assistance to Servicemembers receiving mental health care who are relocating to another assignment, returning from deployment, transitioning from active duty to reserve, reserve to active duty, or preparing to leave military service. These telephonic coaches initiate contact and assist servicemembers regardless of where they are located across the world by connecting them to their new mental health provider, monitoring their progress and empowering them 24/7 by phone or email. The VA TCM team works with the InTransition coaches to ensure transitioning Servicemembers and Veterans are connected to VA mental health care, if needed, and confirm this connection has been established.

The inTransition program is designed to enhance continuity of care for Servicemembers who are relocating within or across Departments and who are receiving on-going mental health care. The initiative is currently tracked as a key element of the VA/DOD Joint Strategic Plan. The inTransition program has opened 8,519 coaching cases since its inception in February 2010 through April 2015. The President's Veterans' Mental Health Executive Actions, announced in August 2014, mandate that DOD automatically enroll in that program all Servicemembers leaving the military who are receiving mental health care. Automatic enrollment went into effect in May 2015, and as a result the inTransition program opened 823 new coaching cases that month. DOD does not collect information by state or US territory, so we are not able to provide information about the number of servicemembers who have been enrolled in Hawaii.

A Memorandum of Understanding (MOU) between Department of Veterans Affairs and Department of Defense for "Interagency Complex Care Coordination Requirements for Servicemembers and Veterans" was signed in July 2014. The MOU is a foundational document that establishes joint processes for complex care coordination as directed by the Joint Executive Committee and implemented by the VA/DOD Interagency Care Coordination Committee. The MOU establishes a requirement to address complex care coordination needs of Servicemembers and Veterans when both the severity of the wound, illness, or injury is expected to result in a prolonged recovery time and/or extensive rehabilitation needs call for close interdisciplinary team coordination to achieve optimal recovery.

Research on Service Dogs

Question 9. What is the status of VA's research into the use of service dogs to treat Veterans with PTSD? What is the timeframe for its completion? In addition, if research shows the effectiveness of service dogs for persons with PTSD, will VA implement a service dog program for Veterans suffering from PTSD and TBI?

Response. The study is intended to determine the efficacy of providing to service dogs to veterans with PTSD Phase 1 was the initial attempt to conduct the study. This consisted of one study site, Tampa VAMC, with Veterans in the Tampa, Florida area. Of the original Phase 1 Veterans, those that have completed the study have chosen to keep their dogs, and VA has transferred ownership to them. Although the Phase 1 study is not enrolling new Veterans, a few who were far into the process when the Tampa/Phase 1 study was suspended, were paired with service

dogs once the Phase 2 multi-site study opened. The Tampa Phase I Veterans were at the threshold of pairing and had waited a long time. To do right by these Veterans, we made the pairings and those Veterans are completing the study protocol. Based upon lessons learned in the initial Phase 1 study, new safety features were added for both Veterans and dogs. These new safety features apply to all Veteran and dog pairings. Phase 2 will be conducted in Atlanta, Georgia, Iowa City, Iowa, and Portland, Oregon. Once completed, Veterans may choose to keep their assigned dog, free of charge, and VA will transfer ownership as indicated. If a Phase 2 Veteran elects not to keep an assigned dog or is unable to meet the responsibilities of dog ownership during or at the completion of the Phase 2 study, the specially trained dog will be placed with another patient or rehomed.

As of July 2014, three contracts were awarded to provide dogs for the study with the following vendors:

- Canine Companions for Independence,
- Armed Forces Foundation (K2 Solutions), and
- Auburn Research and Technical Foundation (iK9).

The results of the study will not be available until all Phase 1 and Phase 2 data have been collected and analyzed (see future timeline in Section D below). At that time, the results will be shared with the National Academy of Sciences for their report preparation, as required by paragraph (e)(2) of section 1077.

Estimated Timeline—This is a complex study and numerous scheduling uncertainties remain. Thus far, 49 Veterans have been consented into the Phase 2 study, 10 have been paired with a dog, and 35 are currently in the observation period prior to being paired.

At the present time, VA estimates:

- By September 2016—If monthly recruiting goals are met, all Veterans will be recruited into the study.
- By October 2018—If monthly recruiting goals are met, all Veterans would complete the study this month, and data collection would be complete. Thereafter, the study data would be compiled and prepared for peer review and publication in scientific journals.

Chairman SANDERS. Now we are going to hear from our second panel. Let me welcome our second panel, and apologize for the length of our first panel. The good news is that there is so much interest in this issue, virtually every Member of this Committee was here today, because they are concerned about the issue.

The bad news is that when every Member is here, it takes a long time to discuss and I apologize for keeping you waiting this long. So, let me introduce the panelists. First we will hear from two mothers who have personally experienced the grief of losing a child to combat, and we appreciate more than words can describe, your courage in coming here and your desire to prevent other families from experiencing the tragedies that you have experienced.

So, we thank Susan Selke, whose son, Clay Hunt, a Marine combat veteran, took his life after returning from Afghanistan. Then we will hear from Valerie Pallotta of Vermont. Valerie's son Joshua, a Vermont National Guard combat veteran, also served in Afghanistan and took his own life only a few months ago.

We will then hear from Master Sergeant Vincent Vanata, a participant in the Wounded Warrior Project's Combat Stress Recovery Program. We thank him very much for being here. We will then hear from Dr. Elspeth Ritchie, the Chief Clinical Officer of the District of Columbia's Department of Mental Health and a member of the Institute of Medicine's committee that produced the report, Treatment for Post-Traumatic Stress Disorder in Military and Veteran Populations. Dr. Ritchie, thank you for being here.

And then we will hear from the Executive Director of Team Red, White and Blue, Blayne Smith. I would ask the clerk to turn off the clock for Mrs. Selke and Mrs. Pallotta. Do not worry about the

time. You take as much time as you need to say whatever you want to say. We are extremely appreciative that you are here. Mrs. Selke, do you want to begin?

**STATEMENT OF SUSAN SELKE, MOTHER OF CLAY HUNT, A
DECEASED MARINE CORPS COMBAT VETERAN**

Mrs. SELKE. Thank you. Chairman Sanders, Ranking Member Burr, and distinguished Members of the Committee, thank you for the opportunity to speak with you today about this critically important topic of mental health care access at the VA, suicide among veterans, and especially about the story and experience of our son, Clay.

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

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

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

Clay received a 30 percent disability rating from the VA for his PTSD. After discovering that his condition prevented him from maintaining a steady job, Clay appealed the 30 percent rating only to be met with significant bureaucratic barriers, including the VA losing his files. Eighteen months later, and 5 weeks after his death, Clay's appeal finally went through and the VA rated Clay's PTSD 100 percent.

Clay exclusively used the VA for his medical care after separating from the Marine Corps. Immediately after his separation Clay lived in the Los Angeles area and received care at the VA medical center there in LA. Clay constantly voiced concerns about the care he was receiving, both in terms of the challenges he faced with scheduling appointments as well as the treatment he was receiving for PTSD, which consisted primarily of medication.

He received counseling only as far as brief discussions regarding whether the medication he was prescribed was working or not. If it was not, he would be given a new medication. Clay used to say, I am a guinea pig for drugs. They will put me on one thing, I will have side effects, and then they will put me on something else.

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

assessment would have to be done before his medications could be re-prescribed.

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

Just 2 weeks after his appointment with a psychiatrist at the Houston VA medical center, Clay took his own life.

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

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

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

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

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

I understand that Senator Burr and Senator McCain have just introduced an updated and improved version of the Suicide Prevention for American Veterans Act, or SAV Act, that is similar to the House version of the bill, and have also named the bill after our son, Clay, like the House. We thank them for stepping up to try to get something meaningful done to address this issue.

The reforms, evaluations, and programs directed by this legislation will be critical to helping the VA better serve and treat veterans suffering from mental injuries from war. Had the VA been doing these things all along, it very well may have saved Clay's life.

We know that time is short in this Congress, but we hope that Majority Leader Reid will prioritize getting this done for our veterans before you all leave for the holidays.

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

[The prepared statement of Mrs. Selke follows:]

PREPARED STATEMENT OF SUSAN SELKE, MOTHER OF VETERAN, CLAY SELKE

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

Thank you.

Chairman SANDERS. Thank you very much, Mrs. Selke.
Mrs. Pallotta.

STATEMENT OF VALERIE PALLOTTA, MOTHER OF JOSHUA PALLOTTA, A DECEASED VERMONT NATIONAL GUARD COMBAT VETERAN

Mrs. PALLOTTA. Good afternoon, Mr. Chairman, Committee Members. My name is Valerie Pallotta. If you could just bear with me, it has been only 6 weeks since my son ended his life. I felt it was very important to be here in front of you, so important—this is not in my testimony, but I do not fly and this is the third time I have flown in my life. That is how important I feel this is.

People say our son Joshua was a hero. His last words on Facebook were, "I see death in every thought. They taught me how to put this uniform on; I just cannot get it off." These are lyrics from "A Soldier's Memoir" by Mitch Rossell. Our son's last text to his father was a link to this song. He sent this song to all of his friends and his loved ones. He wanted everyone to have a better understanding of what he was going through. This song describes what PTSD was like for him. I encourage you to look it up online.

At 3:37 on the morning of September 23, 2014, my husband and I were awakened by a loud knocking at the door. As I looked out the window to see who was knocking at that hour, I saw two Burlington police officers. My heart started to race as I knew it had to have something to do with my son. He has been arrested, was my first thought. My head started pounding and my ears started ringing. I felt like I was going to pass out. I opened the door and one of them said, Valerie Pallotta? Yes, I heard myself say through the ringing of my ears.

Is your husband here? Yes. Gregory Pallotta? I vaguely heard my husband say yes. May we come in? May we come in? No, no, no, is what I wanted to say. I am very sorry to tell you that your son is deceased. No, this cannot be true. I thought he had been arrested. His PTSD was bound to get him arrested at some point. He had so much anger and so much pain. He is in jail. He is not dead. This cannot be.

I knew in my gut that my son had ended his life before I even asked them the question. Our son was pronounced dead from a self-inflicted wound at 2:17 a.m., September 23, 2014, at the age of 25. His death certificate should have stated the cause of death as PTSD or traumatic brain injury, not from a self-inflicted wound.

Joshua Rodney Pallotta left behind a childless mother and father, countless friends and loved ones and his brothers in arms, whom he had trusted his life. The sleepless nights, the headaches, the physical pain, the anger, not eating, the nightmares; these are all signs of PTSD.

Not only has PTSD taken the life of our son, but it has taken the life out of us. Our spirit left the day our son died. We lost our only child to something that should have been prevented. We used to have so much spirit. The light, that love, that spirit is gone and will be gone forever in us. We cry every single day.

We are wracked with guilt every single day. My son asked me to borrow money and I thought the tough love route would be the way to go and I told him no. I had not talked to my son for 9 months before he ended his life. It takes all that we have to get out of bed, after another night of not sleeping, because our minds race with thoughts of how we could have done things differently.

Driving and doing everyday tasks are a challenge. We struggle to get through a shower without breaking down. We force ourselves to eat and to go to work. We just go through the motions.

I forget which road I normally drive down. I have not cooked a meal since our son died. My husband went through a traffic light and did not know what color it was when he went through it. Just this past Saturday night, he was coming home and as he drove down our street it did not look familiar to him. He thought he was on the wrong street. He did not recognize it. We have been living on our street since 1998.

This is our life. Our minds are at the funeral home, crying over our son's body as it lays cold. We are kissing him and hugging him and trying to wake ourselves up from this awful, horrible nightmare. Our minds are at the veterans' cemetery in Randolph, VT, the place our son was laid to rest, a place we have not yet been able to visit.

Our minds are in Afghanistan wishing we could have been there to protect him, to shelter him from the pain he endured for 4 years. How can our son be dead from a self-inflicted wound, a wound caused by PTSD, invisible wounds nobody could ever heal, nobody could heal.

Our son was deployed to a combat outpost in Afghanistan, COP Herrera. We had not realized how dangerous a location it was until August 22, 2010. I received a call from our son that day. Mom, I cannot talk. I am OK, but I cannot talk. You will find out soon

enough. I just want you to know that I am OK. We are shutting down communications for now.

Then I received a call from one of my friends, another mom from my son's unit. Two soldiers had been killed in action, Staff Sergeant Steven Deluzio from Connecticut, and Sergeant Tristan Southworth from Hardwick, VT. I only just found out that our son was standing right next to Tristan when he was killed. His brothers had to pull him away because he was in shock. He could not move. Our son's life, the lives of his brothers in arms and the lives of our families have changed forever. They changed forever that day.

Our son was awarded the Army Commendation Medal with Valor that day for valorous achievement while assigned as a mortar assistant gunner for Third Platoon Alpha Company. His selfless service and dedication to duty were in keeping with the highest traditions of military service. Just 2 years later on August 22, 2012, our son posted the following on his Facebook page:

I do not know where to start. Southy and D were loved by all people that knew them. It did not matter what happened, those two would always have a smile on their face. When they walked into a room, they had the power to make everyone's day just a little better just with their presence.

They were truly the best people that I have ever known, and they paid the ultimate sacrifice for the freedom that so many people take for granted nowadays. Not a day goes by that I do not replay this horrible day in my head, always thinking what I could have done differently, always thinking about why I am here and these guys are not.

Why am I so special to make it home. They had a hell of a lot more going for them when they got back. Two years ago today, the world lost two amazing men that can never be replaced. Gone but never forgotten. Rest in peace, Staff Sergeant Steven Deluzio and Sergeant Tristan Southworth.

He then wrote, "Always wishing it was me instead of them." He lived with pain every single day, emotional, physical and spiritual. He saw their faces every single day. What our son and his brothers endured that year of deployment is something you would never wish on your worst enemy.

The things they saw on deployment are burned into their heads; visuals that are not going away. Suicide bombers, seeing their limbs, scalps and a head just lying on the ground with the eyes open. A young boy who was doing yard work hit a Russian land mine. He was missing his face, an arm, and some fingers on one hand. This boy choked to death on his blood in a medevac. One of my son's best friends was his escort. A little girl who came in for treatment. She came in because her father and uncle had burned her feet so badly that she almost lost them. These are the visuals that our young men and women are seeing and coming home with.

Our son was a casualty of war. Our son was a casualty of war just like Tristan and Steven. There were over 900 people at our son's funeral, 900 people. If you only knew. If that is the number of people affected by just one veteran's suicide, imagine the number

affected by—now the number is 23 veteran suicides a day. Multiply 23 by 900.

Our son lost his battle with PTSD and so did the rest of his family and friends. For the rest of our lives we will wonder if we could have done something different. Everyone always says, if there is anything you need, let me know. The only thing we need and wish for is to have our son back and we do not have the heart to tell them that that is not something they can give us.

What we ask for now is an end to the bureaucracy in giving our veterans the resources they need so no other mom, dad, husband, wife, child, or loved one has to go through this tragedy. Thank you very much for this opportunity to speak.

[The prepared statement of Mrs. Pallotta follows:]

PREPARED STATEMENT OF VALERIE J. PALLOTTA,
MOTHER OF VETERAN JOSHUA R. PALLOTTA

LYRICS FROM THE SONG “A SOLDIER’S MEMOIR” BY MUSICIAN MITCH ROSSELL

Been home about six months now	I can still taste the powder
But I still have my doubts	From the barrel of my gun
Well I’m not sure how I got here	I can hear my sergeant screaming
Or how I’m gonna get out	“Run, soldier, run”
My mama says I look the same	I can feel the backpack on my shoulders
As I did before I left	God it weighed a ton
But if she could see inside of me	And I see death in every single thought
It would scare her to death	They taught me how to put that
I can still taste the powder	uniform on
From the barrel of my gun	I just can’t get it off
I can hear my sergeant screaming	Yeah there’s no end in sight
“Run, soldier, run”	Cause even though I’m home now
I can feel the backpack on my shoulders	I’m still fighting for my life
God it weighed a ton	I can still taste the powder
And I see death in every single thought	From the barrel of my gun
They taught me how to put that	I can hear my sergeant screaming
uniform on	“Run, soldier, run”
I just can’t get it off	I can feel the backpack on my shoulders
Last Saturday they honored us	God it weighed a ton
In a small parade downtown	And I see death in every single thought
And when they shot off those fireworks	They taught me how to put that
I nearly hit the ground	uniform on
And while they smiled and cheered	I just can’t get it off
for us	Well the devil’s won some battles
All I could do was stare	And he may win some more
Cause part of me is here at home	But don’t he know the American soldier
And part of me is back there	Will always win the war

Good Morning Mr. Chairman, Ranking Member Burr and Members of the Committee. My name is Valerie Pallotta. It’s been only eight weeks since we lost our son.

The words above are lyrics to “A Soldier’s Memoir” by musician Mitch Rossell. Our son Joshua’s last text to his father was a link to this song. His last post on Facebook was “I see death in every thought. They taught me how to put this uniform on; I just can’t get it off.” He sent this song to all of his friends and his loved ones. He wanted everyone to have a better understanding of what he was going through; what PTSD was doing to him, had done to him.

25 years, five months and 20 days. That is the amount of time we had our son. In reality, it was 21 years, four months and one day because our son never really came home from Afghanistan.

At 3:37 on the morning of September 23, 2014, my husband and I were awakened by a loud knocking at the door. As I looked out the window to see who was knocking at that hour, I saw two Burlington Police officers. My heart started to race as I knew it had to have something to do with Josh. ‘He’s been arrested’ was my first thought. My head started pounding and my ears started ringing. I felt like I was going to pass out. I opened the door and one of them said: “Valerie Pallotta?”

“Yes.” I heard myself say through the ringing of my ears. I tried to stop my heart from pounding so hard. I tried to stop shaking.

“Is your husband here?”

“Yes.”

“Gregory Pallotta?”

“Yes,” I vaguely heard my husband answer.

“May we come in?” ‘NO, NO, NO’ I wanted to say. I was trying to stop the yelling in my head. ‘NO’.

“I’m very sorry to tell you that your son is deceased.”

‘NO! This can’t be true. I thought he had been arrested. His PTSD was bound to get him arrested at some point. He had so much anger. So much pain. He’s in jail. He’s not dead. This can’t be.’

“Did he kill himself?” I knew in my gut that our son had ended his life before I asked the question.

“I’m afraid so.”

‘NO, NO, NO! This isn’t happening. Please let me wake up from this nightmare and have everything be ok. Please.’

We are still waiting to wake up. We are still waiting for this to be some cruel joke.

Our son was pronounced dead from a self-inflicted wound at 2:17 AM, September 23, 2014, at the age of 25. His death certificate should have stated the cause of death as PTSD/TBI. Not from a self-inflicted wound.

Joshua Rodney Pallotta not only left a childless mother and father, he left his grandparents, uncles, aunts, great uncles, great aunts, cousins, countless friends, former classmates, teachers, co-workers, and neighbors and just as importantly his brothers-in-arms with whom he had trusted his life.

The sleepless nights, the headaches, the physical pain, the anger, not eating, nightmares; these are all signs of PTSD. Well, I’m sorry to say that these are also the effects of grief. Not only has PTSD taken the life of our son but it has taken the life out of us. Our spirit died the day our son died. We lost our only child that day to something that should have been prevented. We used to have so much spirit. The light, that love, that spirit is gone and will be gone forever in us. We hate this life; this life we have without our son. We cry Every.Single.Day. We are wracked with guilt Every.Single.Day. It takes all that we have to get out of bed, after another night of not sleeping, because our minds race with thoughts of how we could have done things differently. How we could have saved our son.

Driving and doing everyday tasks is a challenge. We struggle to get through a shower without breaking down. We force ourselves to eat and go to work. We forget which roads we normally drive down. I haven’t cooked a meal since our son died. My husband told me he went through a traffic light and didn’t know what color it was when he went through. Just this past Saturday night, he was coming home and as he drove down our street it didn’t look familiar. He thought he was on the wrong street. He didn’t recognize it. We have been living on the same street since 1998.

This is our life. This is our minds. Where are our minds? Our minds are at the funeral home less than two months ago; crying over our son’s body as it lays cold. We are kissing him and hugging him and trying to wake ourselves and him up from this awful, horrible nightmare. Our minds are at the Veterans’ cemetery in Randolph Vermont, the place our son was laid to rest by his brothers-in-arms; a place we haven’t yet been able to visit because it is too painful. Our minds are in Afghanistan wishing we could have been there to protect him; to shelter him from the pain he was about to endure for the rest of his short life. This can’t be true. I have been fighting for Veterans for almost 5 years now! How can this be OUR son lying there dead from a self-inflicted wound, a wound caused by PTSD, invisible wounds he couldn’t heal. We couldn’t heal.

I’ll never forget the day in 2009 when Josh came home and said: “Mom, I’m joining the National Guard and you can’t stop me.” After I picked my jaw up off the floor, I said: “You know you’re going to Afghanistan don’t you?” He said: “Mom, that’s why I’m joining. I want to protect my Country.” I had so many emotions that day; pride, fear, love and gratitude for this selfless act our son felt he needed to do. After he took the Armed Services Vocational Aptitude Battery (ASVAB), the test that measures your aptitude in eight areas, he was told he scored high enough to choose whatever branch of service through the Guard he wanted. He chose Infantry. My heart sank. He was going to the front lines; the most dangerous of all places in war.

I was filled with a rollercoaster of emotions. My baby, our only child was going off to war. I had to do something. I had to focus on what we could do to support our boys. How can we help him when he’s at war with some of the most evil people on the planet? He was 20 years old. I was overcome with an unlimited drive and

motivation to start something to give back, to support our boys, our men and women fighting for our Country. Somehow I guess I believed it was a way to still be there for him. If we could find a way to support our Troops and Veterans, indirectly we'd be supporting our Alpha Company boys, my boy. I did a lot of research early in 2009. When I came across Blue Star Mothers of America, I knew immediately that was the organization we needed to start in Vermont. The most intriguing aspect to me was that we could keep almost all of the money we raised in Vermont to support our Vermont Troops and Veterans. I brought the information to a Parent Network meeting, obtained the 5 signatures required to charter and was installed as Chapter President for the first Vermont Chapter of Blue Star Mothers of America.

In June 2010, while our son was deployed, my position at the University of Vermont was eliminated. My supervisor knew that my son was in Afghanistan serving our country. Didn't she know that this job kept my mind off what was happening over there? I threw myself into our Blue Star Mothers chapter's work and in addition to that I started volunteering for Family Programs at Camp Johnson in Colchester Vermont. I spent hours working with the Director and his staff, trying to support our Veterans but in particular our young, single Soldiers. I supported the Yellow Ribbon program for other Units who were deploying, family members of Soldiers who were already deployed and some who were coming home. I thought we had it figured out. We were going to make a difference. We were going to help our boys. Or so I thought.

We tried to send care packages to our boys. There were less than 100 of them at our son's combat out post, COP Herrera. They were in such a dangerous and remote location in Rowqian Afghanistan that Josh told me not to bother to send packages, by the time they got them they would be home. We hadn't realized how dangerous a location it was until August 22, 2010. That day, I received a call from my son. "Mom, I'm ok but I can't talk. You'll find out soon enough. I just want you to know that I'm ok. We're shutting down communications for now." Then I received the call from my friend, another Mom from my son's unit, two of the Soldiers who were with our boys had been killed; SSG Steven DeLuzio and SGT Tristan Southworth.

Our son was awarded the Army Commendation Medal with "Valor" that day, 22 August 2010; for valorous achievement while assigned as a mortar assistant gunner for 3rd Platoon, Alpha Company. "PFC Pallotta's actions against enemy combatants and ability as a mortar assistant gunner during combat operations contributed to the successful defeat of an enemy ambush. His selfless service and dedication to duty are in keeping with the highest traditions of military service and reflect distinct credit upon himself, 3rd Battalion, 172 Infantry (Mountain), Task Force Rakkasan and the United States Army."

The full narrative of the day that forever changed our son's life reads as follows:

"Private First Class Joshua R. Pallotta, United States Army, heroically distinguished himself by exceptionally valorous conduct in the face of enemy of the United States as a Mortarman, Company A, 3d Battalion, 172d Infantry Regiment (Mountain), COP Herrera, Paktya, Afghanistan on 22 August 2010, during Operation Enduring Freedom. At approximately 1145 hours on 22 August, PFC Pallotta's platoon was ambushed near Mullafatee village, Paktya Province, killing one U.S. Soldier, an Afghan Border Policeman and wounding two other ABP. The mortar team of PFC Pallotta and SPC Gubic, moved to cover the evacuation of the casualties. When the platoon began the evacuation of the casualties, they were attacked a second time and another U.S. Soldier was killed and one wounded. The platoon was taking fire from a river bed 300 meters away and a mountaintop roughly 500 meters away being engaged by at least three enemy machine gun teams and two rocket propelled grenade teams.

"PFC Pallotta, serving as the Assistant Gunner for the mortar team, engaged targets with his M4 rifle until he was told to move up into a position to engage the enemy with the 60MM mortar. With utter disregard for his own safety, PFC Pallotta moved into the open and loaded rounds into the tube for the mortar team gunner, SPC Gubic. PFC Pallotta continued to prep and load rounds into the tube so his gunner could engage targets, all the while taking enemy fire with rounds landing next to and in front of their position. PFC Pallotta called out targets for his gunner and assisted with ranging the targets and calling out the most dangerous threats. PFC Pallotta helped direct the mortar gunner in eliminating a machine gun team, an RPG team, and dispersing a squad sized element of dismounted troops in the river bed. The platoon was then able to break contact and move down the hill toward the Casualty Collection Point. PFC Pallotta pro-

ceeded to pull rear security taking cover behind a small berm, continuing to engage targets with his M4 while the element collected the casualties. As the casualties were being moved downhill, PFC Pallotta broke cover and ran to a litter and assisted with moving the casualty to a secure casualty collection site.

“The platoon came under fire again while moving the casualties from heavy machine gun fire and more RPG’s. PFC Pallotta again exposed himself to enemy fire in order to engage targets with his rifle. This directly allowed for the litter teams to move the casualties to the CCP. PFC Pallotta continued to provide covering fire as the rest of the element moved to the CCP, making himself one of the last to enter the safety of the building serving as the CCP. Once inside the CCP, PFC Pallotta moved to a position where he could provide security for the flank of the element.

“PFC Pallotta’s actions that day demonstrated bravery and ability to act under fire and he greatly helped this platoon break contact with the enemy to evacuate the wounded and killed. PFC Pallotta’s bravery and ability to act under fire is without a doubt inspiring and upholds the finest traditions of the Task Force Avalanche, 3rd Battalion, 172d Infantry (Mountain), Task Force Rakkasan, and the United States Army.”

Two years later to the day that our son’s life, the lives of his brothers-in-arms and the lives of our families changed forever, our son posted the following on his Facebook page:

“I don’t know where to start * * * Southy and D were loved by all people that knew them. It didn’t matter what happened, those two would always have a smile on their face. When they walked into a room, they had the power to make everyone’s day just a little better just with their presence. They were truly the best people that I have ever known, and they paid the ultimate sacrifice for the freedom that so many people take for granted nowadays. Not a day goes by that I don’t replay this horrible day in my head * * * always thinking what I could have done differently, always thinking about why I am here and these two guys aren’t. Why am I so special to make it home, they had a hell of a lot more going for them when they got back * * * 2 years ago today, the world lost two amazing men that can never be replaced. Gone but never forgotten. R.I.P SSG Steven DeLuzio and SGT Tristan Southworth, KIA August 22nd, 2010. Rowqian village, Paktya province, Afghanistan.

He then wrote: “Always wishing it was me instead of them.”

He lived with pain every single day; emotional, physical and spiritual pain. He saw their faces every day. What our son and his brothers endured that year of deployment is something you would never wish on your worst enemy. The things they saw on deployment are burned into their heads; visuals that aren’t going away. Suicide bombers, seeing their limbs, scalps and a head just lying on the ground with eyes open. A young boy who was doing yard work hit a Russian landmine and was missing his face, an arm, some fingers on the other hand * * * this boy choked to death on his blood in a med evac. One of our son’s best friends was his escort. An afghan worker who filled their fuel tanks went up in flames because of static electricity; a little girl came in for treatment because her father and uncle had burned her feet so badly that she almost lost them.

Our son was a casualty of war just like Tristan and Steven.

I asked our son’s brothers-in-arms to share their thoughts and frustrations so that I could share them in this testimony. One of them said he feels like heroine and opiate addiction takes priority, especially in Vermont. From his experiences with PTSD and TBI he feels like he’s slowly deteriorating. He sleeps three hours a night if lucky. He hasn’t slept in the same bed with his wife since returning home in 2010. He’s restless and has night terrors just about every night. He replays events from deployment and tries to figure out ways for them to save the men they lost. He’s easily distracted at work by loud noises and hammering which causes him to leave his work area to let his heart slow down. He goes through this every single day. He and our son talked things out many times and kept each other going. They agreed to fight this ongoing battle together. Josh’s unit had a pact, to fight this together. Our son’s buddy was going to end his life a little over two months ago because “I am just tired of the fight, the struggles, marriage issues, sleepless nights * * *” The only reason he said he is here today to share his feelings is because of his 4 year old German shepherd and peer counseling with our son. Our son lost his fight. Now that our son is gone, how will his friends keep fighting?

There is a strong feeling among Veterans that the counselors who work at the VA are only there to get a paycheck; they could care less about what is going on in the Veteran's mind or in their life. Many addressed the lack of compassionate counselors at the VA, counselors who spent time during their visits checking their watches. They are frustrated by lengthy intakes with no follow-up appointments and the over prescribing of medications. One said: "What we as Veterans need is someone to talk to who can share some of the same experiences from past deployments or a counselor who has been in the military before and doesn't just feed us medication to mask our depression, anxiety, PTSD or anything else." Another said the therapist had to look through her notes to remember his name. The counselors don't relate to their situations. They act like it is an inconvenience and waste of time talking to the Veterans. They act like our Veterans are crazy and give them medications to mask their problems and make them feel like zombies.

Some of the Veterans in our son's unit who admitted to having issues after deployment were sent to a Warrior Transition Unit (WTU) at Fort Drum, NY before coming home. They were isolated in the back of the barracks with no transportation and in the middle of nowhere. Why would you isolate a Veteran who admitted to struggling with PTSD or other issues? They lost cohesion. They lost unity. One Veteran told me he never heard from his Unit while at the WTU until they heard he was going to be discharged. He was then sent a letter with his next Drill dates. Our son told us he didn't admit to having issues when they were coming home because he just wanted to get home and see his family and friends.

The process for Soldier Readiness Checks (SRC) that happens during Drill weekends needs to change. Veterans told me if you admit on the questionnaire that you are having an issue you are pulled out of the line and moved into another area. They feel exiled; singled out. The questionnaires at SRC and the VA are not accurate tools of assessment. Some Veterans aren't truthful when answering the questionnaires so this data being collected is not accurate. This is a broken system. Instead of singling out those who need help, treat them all as if they need help.

I asked our son's brothers-in-arms how many have attempted or thought about suicide. 60% had attempted and 100% had thought about it. This is a problem. We're still talking about the same issues we've been talking about for years and nothing is getting better. It's getting worse.

Everybody always asked: "How's Josh?" It was the same answer from me. "Not good." It always ended there. Nobody asked: "What can we do to help?" Nobody followed up with him. His Outreach caseworker gave up on him. He told me he couldn't waste his time if Josh didn't want the help. Josh was not receptive to his visits so the caseworker gave up. His caseload was too high for him to keep spending time trying to help Josh if Josh wasn't receptive to him. He had other Veterans he needed to help, Veterans who wanted the help. Josh wanted the help; he just didn't know what he needed. Didn't his caseworker recognize this was the PTSD? Maybe he should have been assigned to another caseworker. Maybe his caseworker should have pushed our son more and not given up on him. He was a 21 year old male. The system is a broken system. There have to be checks and balances. There have to be more caseworkers in Veterans Outreach and Veteran Service Organizations. Josh fell through the cracks after being medically discharged. Nobody followed up with him. The signs were there. Our son's 4 year relationship with his girlfriend ended, he was in chronic pain and a job he finally found, that he liked, was ending due to the company closing. He felt like he was always taking one step forward and two steps back.

Many administrators say that the resources are out there but the Veterans have to come to us. Despite this, many of our Veterans are still afraid to ask for help because of their pride. They are afraid to talk about feelings. They are afraid of repercussions for seeking help. They are asking for Vet to Vet counseling. They need to be heard. Rather than letting Veterans who served our Nation become ticking time bombs, listen to them. Give them what they are asking for.

On February 9th, 2013, I attended via telephone, Senator Sanders Veterans' Advisory Council meeting. I raised the question of how our Soldiers, especially our single, younger Soldiers and Veterans would be supported. On March 20, 2013, this Senate Committee on Veterans' Affairs heard testimony regarding the same issues being addressed today. Instead of 22 Veterans committing suicide every day, that number has increased to 23 a day. Why are things getting worse as opposed to getting better? It's time for action. No more research. No more talking. Our Veterans deserve better. Our son deserved better.

It is not just our Veterans who are affected by PTSD and Veteran suicide. The families and our community at large are affected. There is an increase in illness as our grief manifests itself physically and mentally. We lose days at work or at school

as we grieve. We need to prevent this before another family goes through this tragedy.

If you want to know how mental health and Veterans suicide affects Veterans and their families? This is how: broken relationships, debt, self-medicating due to poor services and a Fallen Hero by his or her own hand, brokenhearted family members and loved ones who will live with the guilt for the rest of their lives, wondering if they could have done something different, if they could have said one thing different that would have made a difference.

We have lost our son forever. Our son lost his battle with PTSD and so did his family and friends. For the rest of our lives we will wonder if we could have done something different.

There were over 900 people at our son's funeral. This number does not take into account the number of loved ones who weren't able to attend his funeral. If roughly 900 is the number of people affected by just our son's suicide, can you imagine the number of people affected by 23 Veteran suicides a day?

As I close my testimony, I ask you, what would you do if you saw your loved ones struggling so much? What would you do if that was your child lying there * * * lifeless * * * because he or she could not take this fight any longer? Our son will never get married, never have children. We will never have grandchildren. Our only hope and prayer is that somehow, someday his death will be the catalyst to finally be the change to improve care for our Veterans.

Everyone always says, if there is anything you need, let me know. The only thing we need and wish for is to have our son back and we don't have the heart to tell them that is not something they can give us.

What we ask for now, is an end to the bureaucracy in getting our Veterans the benefits, resources and support they deserve so that our Veterans only focus can be on healing themselves and their families.

My husband and I thank you for this opportunity, Mr. Chairman.

Chairman SANDERS. Thank you very much, Mrs. Pallotta.
Sergeant Vanata.

STATEMENT OF VINCENT VANATA, MSGT, USMC (RET.), COMBAT STRESS RECOVERY PROGRAM, WOUNDED WARRIOR PROJECT

Mr. VANATA. Chairman Sanders, Ranking Member Burr, and Members of the Committee, thank you for the opportunity to speak to you today regarding mental health care and suicide prevention. I proudly served in the U.S. Marine Corps for 22 years, including 8 years overseas and a combat tour in Iraq.

My wife Jona also served in the Marines for 4 years and we both have assisted other veterans and their families who are struggling to receive effective mental health care in rural Wyoming. We understand deeply the challenges of reintegration for those with combat-related mental health issues, both as mentors for many other warriors and families, and from our own difficult journey.

In my written statement, I talked about the struggles we have had transitioning from active duty to civilian life and the challenges of accessing mental health care in rural Wyoming. But I want to focus my oral statement on a program through the Wounded Warrior Project's Combat Stress Recovery Program, called Project Odyssey.

Project Odyssey brings veterans together with other combat veterans on outdoor rehabilitative retreats that promote healing. For us, it worked. For many warriors, like Jona and I, such peer-connection is often the first step toward engagement in treatment. The experiences I gained from Project Odyssey helped me work through challenges related to my combat stress and PTSD and improved my mental attitudes and outlook while encouraging me to build new skills, connect with peers, and find support.

I have lost three fellow warriors, three friends, all to suicide this year. Two of these men survived combat without any physical wounds. One of them saved lives on the battlefield as a Navy corpsman, probably the bravest man that I have even known.

Still, no one knows why they took their own lives. There were no signals, no warnings. All three were receiving mental health treatment through the VA. As to whether it was satisfactory treatment, I am not sure and I am not placing blame on the mental health professionals or on the prescribed medications, nor am I placing any blame upon these warriors for taking their own lives. The fact remains they are dead and any one of their deaths may have been preventable.

When I returned home from Iraq, we were told to take some time off and decompress. We received no guidance or direction about what decompressing meant. In my case, I took some leave and traveled home to Cody to be with my family. I went from a combat zone to Cody, WY, in 3 days.

As I walked down Main Street the next day with my two children holding my hands, I heard gunshots. I put each child under my arm and I ran for cover with them. My daughter yelled, "It is OK, it is OK, Daddy. It is only the gunfighters." The gunfighters put on a show every day for the tourists in town. As I looked around, I saw people on the street looking at me as if I had done something wrong.

When I returned to Twenty Nine Palms of California and processed out of the Marine Corps, I received no counseling, no guidance, nothing to consider about the precautions of returning from combat and transitioning back to civilian life.

I had received the required transition assistance program, or TAP training as they call it, before my deployment. But it did not give me any critical information on returning to civilian life after a combat deployment. Within 24 hours I was back in Anytown, USA, just another retired Marine.

I struggled on my own for years until in 2012, I reached out to the Wounded Warrior Project at the urging of the mother of a soldier I know. She told me Wounded Warrior Project was in tune with post-9/11 veterans and I should give it a try. I contacted Wounded Warrior Project and seamlessly was brought aboard as an alumnus.

In the summer of 2012, I attended a Project Odyssey retreat in Telluride, CO. There, I was able to connect with 15 other warriors and, for the first time, realized I was not alone. Interacting with these warriors, who were experiencing the same feelings I was, was such a breath of relief—something that no medication could ever provide.

Since then I have been active with Wounded Warrior Project and have attended many different events. These events provided me with the opportunities to forge lifelong friendships with other veterans I would have never met otherwise. It is through these events and friendships that I have been able to regain a sense of honor and empowerment.

Me and my wife's experiences with Project Odyssey and as peer mentors illustrate how important peer support is in assisting veterans and their families. Whether we are engaging with a veteran

and helping them to see that he is not alone, or encouraging him to seek treatment, it is a proven method of assisting veterans and their family members in healing from the wounds of war.

Thank you again for the opportunity to speak with you today about mental health care and I am also happy to answer any questions that you might have.

[The prepared statement of Mr. Vanata follows:]

PREPARED STATEMENT OF VINCENT VANATA, MASTER SERGEANT USMC (RET.)
AND JONA VANATA

Chairman Sanders, Ranking Member Burr, and Members of the Committee: We are honored to have the opportunity to speak to you today regarding mental health care and suicide prevention.

I proudly served in the United States Marines for 22 years, including 8 years overseas and a combat tour in Iraq. My wife Jona also served in the Marines for 4 years and we both have participated in Wounded Warrior Project's (WWP) Project Odyssey program and work as peer mentors with the organization, assisting other veterans and their families who are struggling to receive effective mental health care in rural Wyoming. We understand deeply the challenges of reintegration for those with combat-related mental health issues, both as mentors for many other warriors and families, and from our own difficult journey. Project Odyssey, part of WWP's Combat Stress Recovery Program, brings warriors together with other combat veterans on outdoor rehabilitative retreats that promote healing. For many warriors, such peer-connection is often the first step toward engagement in treatment. The experiences I gained from Project Odyssey helped me work through challenges related to my combat stress and PTSD and improved my mental attitudes and outlook while encouraging me to build new skills, connect with peers, and find support.

A WARRIOR'S ROAD TO RECOVERY—
VINNY'S PERSPECTIVE

I've been retired from the Marine Corps for 11 years. When I retired, I had just returned from deployment. I spent 2 weeks "reintegrating" and then joined our family in rural Cody, Wyoming. The closest base to us is located 400 miles away in Cheyenne, Wyoming.

I look back upon my career as a great one. Each day, we Marines woke up and faced the reality that we could be going into harm's way. We viewed the world as an inherently dangerous place and our military was the first line of defense to preserve our way of life. We accepted the dangers associated with live fire training, operating aircraft, tanks, etc. We were able to mitigate those dangers with prudent safety practices, good training, and accepted risk management.

But when we went to combat the inherent dangers increased and the mitigation decreased. I believe that anyone who goes into harm's way and experiences combat comes back a different person. It is not like a video game. People are actually trying to kill you. You don't get to press the reset button. Yet, the unit I was with only lost one man throughout phases one and two of Operation Iraqi Freedom.

Flash forward to 2014, I've lost three fellow warriors to suicide. Two of these men survived combat without any physical wounds, one of them saved lives on the battlefield as a Navy corpsman. Still, no one knows why they took their own lives. There were no signals or warnings. All three were receiving mental health treatment through the VA. As to whether it was satisfactory treatment, I'm not sure. I am not placing blame on the mental health professionals or on the prescribed medications, nor am I placing any blame upon these warriors for taking their own lives. The fact remains they are dead and any one of their deaths may have been preventable.

When I returned to CONUS, we were told to take some time off and decompress. We received no guidance or direction about what decompressing meant. In my case, I took some leave and travelled home to Cody to be with my family. I went from a combat zone to Cody, Wyoming in three days. As I walked down Main Street the next day, with my two children holding my hands, I heard nearby gunshots. I put each child under my arms as I ran for cover. My daughter yelled, "It's OK, it's only the gunfighters" (the gunfighters are a group of actors who put on shows for tourists each day in the downtown area). As I looked around, I saw the people on the street looking at me as if I had done something wrong.

Shortly thereafter, I returned to 29 Palms, CA and processed out of the Marine Corps. I received no counseling, no guidance, nothing to consider about the pre-

cautions of returning from combat and transitioning back to civilian life. I had received the required transition assistance program training before my deployment. But even if I had the training after I returned, it still did not give me any critical information on returning to civilian life after a combat deployment. Within 24 hours I was back in Anytown, USA, a retired Marine.

I did what was expected and eventually found a job in law enforcement as a peace officer. When I took the required psychiatric evaluation for employment I was able to pass, but the doctor commented that I was “guarded.” He stated this was not atypical for a person who had recently been in combat. As time went on I was exposed to scenes in civilian law enforcement not very different from the military or combat. I witnessed traumatic car wrecks where people were maimed, saw dead bodies. The hypervigilance, distrust, and violence that surrounded me exacerbated all the feelings I had since returning from my deployment. In 2004, at the urging of my wife, I sought treatment from the Veterans Administration to explore the issues I was experiencing. Quite frankly, I thought I was fine—it was everyone else who had issues.

The nearest VA hospital to us is 120 miles away. However, there is a contracted civilian community based outpatient clinic (CBOC) 22 miles away. The social worker I met with at the CBOC told me that I was her first post-9/11 veteran and she was unsure how to proceed. The primary care provider I was assigned told me I probably had PTSD and prescribed anti-depressants, but they triggered nightmares and sleepless episodes. No formal intake or assessment was ever completed. After a while I stopped attending sessions and sought care from a private medical provider.

In 2007, I went through some very stressful experiences which led me back to the VA to seek treatment. I periodically attended counseling sessions until I reached a point where I felt I could cope again, then stopped. In 2011, I again went through a very stressful event, looking back, it was a crisis point. So, I sought out treatment and found the same social worker at the CBOC who I had seen years before. By that time, she had received training in PTSD and post-9/11 veterans. She referred me to a psychiatrist who I felt had a solid grasp on PTSD treatment. Both professionals were right on target with a course of treatment. Since then, I have attended regular weekly counseling sessions and periodic appointments with a psychiatrist in Sheridan, WY via teleconference, because that’s 120 miles away. When that doctor retired, I began teleconferencing sessions with a provider in Casper, WY (210 miles away). I’ve never met either doctor in person.

It seems as though the doctors at the CBOC have become more familiar with post-9/11 veterans and have worked with the VA to provide acceptable medical care. However, the VA care at the hospitals in Sheridan, WY and Cheyenne, WY has been disappointing. While considering inpatient treatment for PTSD in Sheridan, I visited the facility and was taken aback by the scene—akin to “One Flew over the Cuckoo’s Nest.” I refused to enter the treatment facility. I understand a new facility has been completed, but I haven’t yet been able to visit it.

At the VA, one has to advocate for oneself to receive treatment. There is a lack of patient management from the beginning of a consultation. For example, I had an adverse reaction to a medication and was unable to contact my doctor. I could not drive to the emergency room at the VA 120 miles away, and I was afraid of stopping the medication and going cold turkey. After reading about it online, I made the decision to stop the medication. When I was contacted five days later, the doctor’s nurse told me the doctor was going to prescribe a drug to counteract the negative side effects I was experiencing, but that medication interacted with something else I was taking. When I saw my doctor a month later he tried to prescribe the same medication which initially gave me the adverse reaction. He hadn’t even read my chart prior to seeing me. While I hold no ill will against the doctor, I wonder if an overburdened system is at fault for requiring the doctor to see too many patients, without enough time to carefully review individual cases.

In 2012, I reached out to WWP at the urging of the mother of a soldier I know. She told me WWP was in tune with post-9/11 veterans and I should give it a try. I contacted WWP, and seamlessly was brought aboard as an alumnus. In the summer of 2012, I attended a Project Odyssey retreat in Telluride, Colorado. There, I was able to connect with 15 other warriors, and for the first time, realized I was not alone. Interacting with these warriors, who were experiencing the same feelings as I was, was such a breath of relief—something which no drug could ever provide. Since then I have been active with WWP and have attended many different events. These events have provided me with opportunities to forge lifelong friendships with other veterans I would have never met otherwise. It’s through these events and friendships that I’ve been able to regain a sense of honor and empowerment.

Through this journey, my wife and I have felt we needed to give back to our community. We knew that there were other veterans in our community who would ben-

efit from the same interaction I had with my fellow brother and sister veterans. My wife and I became peer mentors through the training offered by WWP. Since then we have been able to touch the lives of veterans and spouses alike.

My wife and another spouse started a local support group called Wives of Warriors (WOW). My wife has also reached out to the spouses of Vietnam-era veterans and started another support group for those women. As for myself, I have been able to talk with many veterans individually. Having been in their shoes, I can help them by providing information about resources available to them, connecting them with local assistance, and most times, just listening.

Another milestone was the ability of my wife and me to attend a Couples Project Odyssey in Truckee, California. The interaction with other couples experiencing similar and unique circumstances opened our eyes to the problems we all were experiencing. We were also able to bond with some of those couples and continue our parallel journeys together. This year we were honored to have become couple peer mentors and attended our first Project Odyssey as couple peer mentors. Our experience was one of the most fulfilling opportunities we've had since becoming affiliated with WWP.

While working with veterans as a peer mentor I've observed and heard various stories regarding others' experiences. Some veterans feel a distrust toward the VA due to their past, negative experiences seeking care, conversations with others, and media reports. Some feel like they are lumped into a category, rather than being treated as an individual. Many veterans have indicated that some doctors are quick to push medications instead of exploring other options or alternative treatments. These veterans fear the long term or negative effects of medication, that the medications won't work, or that the VA providers won't treat them if they refuse to take the recommended medications.

Some veterans have had successes with the VA treatment. For example, a 26 year-old former Marine I know returned from Iraq and bounced from job to job. He became dependent on alcohol and pain medication, and was incarcerated in Montana and Wyoming numerous times. Finally, he was facing a felony charge. He progressed to a point where he felt his life was meaningless and began to ponder suicide. He formulated a plan to end his life. Had he not spoken to his father, a former Marine, he would have become a statistic and a memory to his friends and families. He was admitted into a VA hospital, treated for chemical dependency, PTSD, and later placed in a halfway home. After going to a community college, he now attends the University of Wyoming as an engineering student with a 4.0 GPA. His felony was expunged and he enjoys the freedoms he enlisted to defend. His story was a success only because he had the courage to admit he was contemplating suicide, after being turned away from treatment at the VA emergency room once before. I spoke with his father last week, who questioned why the VA had initially turned his son away. If this father was not there for his son, had he not pressed his son about what happened at the emergency room, he would not have taken him back to the VA hospital and encouraged him to tell the truth about what he was going to do to himself.

From my perspective, it seems the VA was not prepared to deal with the numbers of returning veterans. This, coupled with the unique nature of these wars and the advancements of battlefield medicine, brought so many veterans home in need of medical care, both physical and mental.

One of the biggest challenges facing the VA and many veterans' service organizations today is how to reach post-9/11 veterans in rural communities. Veterans living in rural areas face unique obstacles getting engaged with the VA. Distance is a huge factor for many veterans. Many times, driving to a VA involves driving long distances, sometimes in treacherous weather conditions. Often, those rural areas have no public transportation as an alternative. Just getting to a DAV van can be a hundred mile drive. An alternative to trying to get veterans to engage with the VA could be the VA trying to engage with the veteran. That might involve VA personnel or State Veteran Service Officers going out to meet with the veteran to speak with them about the services offered, such as the Caregiver Program does in our area. I realize the VA has mobile Vet Centers, but effectively getting the word out about their deployment in an area is challenging, at best.

Me and my wife's experiences as peer mentors and the profound impact it's had on our lives and on those with whom we've worked illustrate how important it is in assisting veterans and their families. Whether we're just engaging them and helping them see that they are not alone, or encouraging them to seek treatment, it's a proven method in assisting veterans and their family members in healing from the wounds of war.

THE TOLL OF COMBAT-RELATED MENTAL HEALTH CHALLENGES ON THE FAMILY—
JONA'S PERSPECTIVE

When Vinny returned from his deployment, we expected the same husband and father to walk in the door and resume where we left off. Right away we could tell that he was not the same, he seemed closed off, emotionless, and apathetic. He seemed as if he could not engage with us like he did prior to leaving. Though we were all making an effort to aid with the reintegration, it would take years before we made any strides in truly understanding the effect combat has on the entire family.

My children were 12 and 13 when their father returned from deployment. We were not prepared, in any way for what to expect. We had no tools to deal with the PTSD or the TBI from which he was suffering. We went to family counseling in our area, which turned out to be a disaster and only made things worse. The counselor did not recognize the effects of PTSD on a family and really didn't know how to assist us. The stress especially took a toll on our daughter, who we took to 6 different local counselors. We were even advised to have her institutionalized. She was finally diagnosed with secondary PTSD when she was 16. This came as a huge blow for us, but it also helped us begin to truly understand PTSD and the effect it has on family members. I was diagnosed a year later. Prior to my diagnosis, I was on 7 medications for anxiety, depression, sleeping issues—I felt like I had been in combat! Looking back, if we had still lived on a military base, not been so isolated, or had been surrounded by other military families, we likely would have been able to identify the symptoms more quickly and not have suffered so much pain. After the diagnosis we all began to learn tools to help each other heal.

Our family did not ask to be broken; we did not ask to suffer the pains of war that immersed us. In a rural setting it is difficult to find mental health professionals who know how to identify PTSD or secondary PTSD. There was no counseling available for families through the VA at that time. I am thankful for the child psychiatrist we found, who took the time to listen, but it took us several very challenging years to find a provider, and they were located 90 miles away and in another state.

For the first 6 years post-deployment, I was mourning the death of my husband. It seemed like the man who came back to us was not the man who had left us in January 2003. He was physically and emotionally changed and all my children and I desired was the husband and father we once knew. I learned the hard way, suffered in silence, and suffered alone in desperation.

I was a member of a support group, Families on the Frontline, that I helped form when my husband deployed. In the beginning, I was the only member who had a spouse deployed; the others were parents, grandparents, sisters, etc. of servicemembers. We supported those deployed and the families left behind. Over the years, during the meetings, I would ask other members, "How is your son/daughter doing?" The response was always, "Oh s/he's just fine, sleeping well, ready to go back, etc." I felt alone, like my veteran was the only one having issues. Their servicemembers were living in other states or had returned to their home base and were telling their families that everything was fine. I realize now that this is the survival attitude most veterans and family members take on. If we can just get through this hour, this day, this week maybe things will get better, maybe we will be able to handle these injuries. We are taught as military families to always adapt and overcome. However, a few years later, these other families finally began to reveal the issues their loved ones were experiencing.

Once our children graduated college and left home, my husband and I were alone in the house and still trying to overcome the physical and mental wounds of war and the challenges they presented. I have to be honest, in pure desperation, I have been—as we say in the military—in the dark places. I considered taking my own life. The emotional pain and the desperation that we would never find any help was overwhelming. The thought of never having a stable family or marriage again was daunting. I am a Marine, I know how to be tough and be a hard charger, never surrender. One of the main reasons I was able to carry on was the fact I had a constant stream of family members and veterans coming to us, seeking help. We were in so much pain ourselves, but what kept me going was that I was helping other veterans. This engagement, being needed, kept us moving forward.

We know several veterans in our area who have sought out mental health care and felt like the social worker providing the services just did not understand the military culture and the culture of war. For two of the veterans I am concerned about, it has been over 8 years since their first experience at the CBOC—they never returned for care. I know they are in pain, their families are suffering, and they are self-medicating with alcohol.

I have heard this often—from my family and from those with whom I work as a peer mentor—the long wait for a returned phone call from a doctor or nurse, the follow through with referrals, waiting for a prescription at a local pharmacy when the VA fails to mail a medication—these are all exacerbating the anxiety, the anguish, and the other symptoms of PTSD or mental health issue. When there are constant walls they run into, they feel like they are groveling for their benefits. After so many failures it's hard to encourage them to return for mental health care.

We have had it ingrained in us, “Hurry up and wait.” “Hurry up and wait” doesn't work when you have a fellow veteran who is suicidal, who shows up at the VA hospital, but due to pride, does not say the magic words: “I am suicidal.” Because those magic words aren't spoken, he is turned away, brought to a homeless shelter for some reason, but because there is no bed available, he is turned away again. Why does it have to be at a crisis point, why does it have to be at the point of the veteran being so close, so desperate that he no longer wants to suffer and only then will he be considered for care?

In all wars terrain is very important. If we are fighting in a jungle we train in jungle warfare, if we are fighting in the desert, we do the same. The battle that families face in rural areas continues on, we have very few weapons or resources, so we use what we have, survival instincts in an environment that does not have the resources needed for us to effectively heal. Unfortunately many veterans and their families have fallen and lost the battle, families are being by divorce and suicide.

I have engaged with hundreds of warriors through WWP events. I know for a fact that engagement and peer support has saved lives! I have met over 30 warriors who have confided in me that at one point they were at the point they were going to take their lives. One stopped because he was afraid his children were coming home from school and he didn't want them to find him. Another had a plan to take his life when his wife and daughter went to the commissary. He had a complete plan laid out, but then a fellow veteran called, engaged him, and assured him the VA would help. Another had the gun and was ready, but then his dog laid his head on his lap and he changed his mind.

We have found such healing, power, strength, and sense of acceptance from meeting with our fellow veterans and family members through WWP. We know what works, we have seen huge transformations and strides, not just with veterans but with the whole family. I know VA has adopted a peer support model in some places, but unfortunately I am not aware that it has been implemented in Wyoming. While I am encouraged VA is adapting their services to meet the mental health needs of this generation, for those of us in rural areas, we are still waiting for a comprehensive approach to engaging veterans and their families in mental health care. Every veteran is unique and mental health care has to engage them where they are, whether that is through traditional counseling, or through peer support, outdoor retreats, or other modalities.

Chairman SANDERS. Thank you very much, Sergeant Vanata.
Dr. Ritchie.

**STATEMENT OF ELSPETH CAMERON RITCHIE, M.D., COL, USA
(RET.), CHIEF CLINICAL OFFICER, DISTRICT OF COLUMBIA'S
DEPARTMENT OF MENTAL HEALTH**

Dr. RITCHIE. It is very hard to speak about a report after hearing the testimony from Mrs. Pallotta and Mrs. Selke. I will try, but I want to acknowledge your pain and suffering.

I would also like to say that I am an Army combat veteran myself and that is perhaps one of the most important credentials. I am here as a member of the Institute of Medicine report and I will talk to that report briefly. I also wanted to share some of the things that I think will make a difference that the VA can do that have not really been talked about before.

First of all, the brief version of the IOM report for the Veterans Affairs part of it—because there is a DOD part, too—is that there are a lot of very good people trying really hard to provide care and the results are mixed. Yet, we actually do not know the results because they are not well measured. We do not know who is getting

better and why. This is not a problem unique to the VA, but it is a major issue.

Now, we have briefed the VA on it and they have listened and I can go into more detail about the recommendations. You have them in the written testimony. Another big part of it that you all have heard a little bit about is the civilian providers are not familiar with military culture. The VA has begun to be. We really need to work on the civilian providers.

In my other capacity, actually in Washington, DC, we have a SAMHSA policy academy, DOD, VA, military family members group which is one of the things we are working on. So, that is a tremendous issue.

Let me come to some of the specific recommendations that I would like to make, not in my IOM capacity, but as a long-term Army psychiatrist and seeing them now through my other work.

First of all, the VA does not know enough about who is suiciding. You heard that here.

The military launched the Suicide Event Report shortly after 2001, got fielded really in 2005, and they know a lot about who suicides and why. I am pleased to hear about the Behavioral Health Autopsy. There needs to be more resources in the VA to learn who is suiciding.

Second, servicemembers need to be screened for what type of deployments they were on. Many of our soldiers and sailors and others went to, for example, detainee operations. Michael Little, who is in the back of this room, is one of the ones I have talked to quite a bit. He tells me that he has lost ten of his friends from suicide, and if you come from working at Abu Ghraib or Guantanamo Bay or the detainment facility in Bagram, you do not necessarily get a whole lot of pats on the back. And we need to recognize that kind of service as well.

Third, we need to recognize toxic exposures. It was Agent Orange from Vietnam, now there is a medication called Mefloquine or Lariam that causes psychiatric side effects in some people. We do not really know who, why, when. The VA needs to be screening for exposure to Lariam, Mefloquine, and other toxic agents. We have actually met with the VA and talked to them about that.

The subject of complementary and alternative medicines came up quite a bit here. I am a big proponent of that, either as a bridging therapy, because many people do not like medications, they do not like, "the evidence-based" psychotherapies. Unfortunately, we do not really know who they work on and why.

The VA has a great research portfolio. I would love to see them do more systematic research, areas like acupuncture, stellate ganglion block, which is an anesthetic technique that has been shown to help with post-traumatic stress disorder in some people—we do not know who and why—yoga. I am very involved with dogs, canine therapy, equine therapy. We need to have more research to see what works and who it works for.

I would like to close my remarks with a concept that has been alluded to here that we have not really heard too much about, which is the concept of moral injury. This concept has been around, actually, since Vietnam, but we are seeing it more and more. It is

related to post-traumatic stress disorder; it is not quite that. A lot of it has to do with survivor guilt.

Ma'am, when you were talking about the images that are burned in people's brain, people they have killed or they have seen killed, in some ways it is an existential anguish. I believe that that really is a contributor to suicide and we do not often enough recognize it.

I will close my remarks there. Thank you all very much for what it is that you are doing. This is just critically important.

[The prepared statement and recommendations of Dr. Ritchie follows:]

PREPARED STATEMENT OF ELSPETH CAMERON RITCHIE, MD, MPH, COLONEL, U.S. ARMY (RET.), DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH CLINICAL PROFESSOR OF PSYCHIATRY, GEORGETOWN UNIVERSITY AND MEMBER OF THE COMMITTEE ON THE ASSESSMENT OF ONGOING EFFORTS IN THE TREATMENT OF POSTTRAUMATIC STRESS DISORDER, INSTITUTE OF MEDICINE, THE NATIONAL ACADEMIES

Good morning Mr. Chairman, Ranking Member Burr, and Members of the Committee. Thanks to Senator Sanders, Senator Burr, and Members of the Committee on Veterans' Affairs, for your concern about veteran's health.

My name is Elspeth Cameron Ritchie. I am a long-time Army psychiatrist now serving as the chief clinical officer for the District of Columbia's Department of Mental Health. Before retiring from the Army in 2010, I spent the last five of my 24 years in uniform as the top advocate for mental health inside of the Office of the Army Surgeon General. Before that, I served in other leadership roles including the psychiatry consultant to the Army Surgeon General at the Department of Defense Health Affairs. I trained at Harvard, George Washington University, Walter Reed, and the Uniformed Services University of the Health Sciences. I am a professor of psychiatry at the Uniformed Services University of the Health Sciences—the U.S. military's medical school—in Bethesda, MD; I am also a clinical professor of psychiatry at Georgetown University. I am here before you today because of my experience as a volunteer serving on the Institute of Medicine (IOM)¹ Committee on the Assessment of Ongoing Efforts in the Treatment of Posttraumatic Stress Disorder. I will address the issues on Post Traumatic Stress Disorder as revealed by the IOM committee, however, any remarks I make regarding suicide will be my personal opinion as the Committee did not address issues of suicide in its study.

Posttraumatic stress disorder (PTSD) is one of the signature injuries of the U.S. conflicts in Afghanistan and Iraq, but it affects veterans of all eras. It is estimated that 7 to 20% of servicemembers and veterans who served in Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) may have the disorder. PTSD is characterized by a combination of mental health symptoms—re-experiencing of a traumatic event, avoidance of trauma-associated stimuli, adverse alterations in thoughts and mood, and hyperarousal—that last at least a month and impair functioning.

PTSD can be lifelong and pervade all aspects of a servicemember's or veteran's life, including mental and physical health, family and social relationships, and employment. It is often concurrent with other health problems, such as depression, Traumatic Brain Injury (TBI), chronic pain, substance abuse disorder, and intimate partner violence. The Department of Defense (DOD) and the Department of Veterans Affairs (VA) provide a spectrum of programs and services to screen, diagnose, treat, and rehabilitate servicemembers and veterans who have or are at risk for PTSD.

The 2010 National Defense Authorization Act tasked the IOM with assessing those PTSD programs and services. The IOM conducted the study in two phases; the Committee members directed the literature searches, requested data from the DOD and the VA, and visited nine military medical facilities and six VA medical facilities. I will discuss the Committee's findings.

¹The National Academy of Sciences, National Academy of Engineering, and the Institute of Medicine of The National Academies were chartered by Congress in 1863 to advise the government on matters of science and technology.

PTSD MANAGEMENT STRATEGIES

PTSD management in DOD appears to be local, ad hoc, incremental, and crisis-driven with little planning devoted to the development of a long-range, population-based approach for the disorder by either the Office of the Assistant Secretary of Defense for Health Affairs or any of the service branches. Each service branch has established its own prevention programs, trains its own mental health staff, and has its own programs and services for PTSD treatment.

VA has a more unified organizational structure than DOD and is able to ensure a more consistent approach to the management of PTSD in its medical facilities. However, there are few data to indicate that PTSD-related performance measures are being met, although improving mental health care is one of VA's major initiatives in its strategic plan.

Although the DOD and VA are coordinating strategic efforts such as the DOD/VA Integrated Mental Health Strategy and the National Research Action Plan for Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families, those activities have not proven to be sufficient to determine whether PTSD management is improving or whether a population-based approach is being used to reach and treat all servicemembers and veterans in need of care for PTSD. Furthermore, current DOD and VA strategic efforts do not necessarily encourage the use of best practices for preventing, screening for, diagnosing, and treating for PTSD and its comorbidities, and do not extend to ensuring continuity of care as servicemembers transition from active duty to veteran status.

LEADERSHIP AND COMMUNICATION

DOD leaders at all levels of the chain of command are not consistently held accountable for implementing policies and programs to manage PTSD effectively. In each service branch, there is no overarching authority to establish and enforce policies for the entire spectrum of PTSD management activities. A lack of communication among mental health leaders and clinicians in DOD can lead to the use of redundant, expensive, and perhaps ineffective programs and services while other programs, known to be effective, languish or disappear.

VA leadership engagement in PTSD management among sites varies resulting in different types and quality of PTSD programs and services. Although the VA central office has established policies on minimum care requirements and guidance on PTSD treatment, it is unclear whether VA leaders adhere to the policies or encourage staff to follow the guidance.

PERFORMANCE MEASUREMENT

DOD and VA do not collect data to identify best practices throughout the spectrum of their PTSD programs and services, although there are some initiatives to do so. Given that DOD and VA are responsible for serving millions of servicemembers, families, and veterans, it is surprising that no PTSD outcome measures of any type for psychotherapy or pharmacotherapy are consistently used or tracked in the short or long term (with the exception of the VA Specialized Intensive PTSD Programs). Without tracking outcomes neither department knows whether it is providing effective, appropriate, or adequate care for PTSD. Reliable and valid self-report measures are available and could be used to monitor progress, provide real-time response information to providers and patients, and guide modifications of individual treatment plans. VA is in the process of expanding its electronic health record to capture the types of psychotherapy that patients are receiving, but the revised record still will not include regularly administered outcome measures. Most veterans who have PTSD do not receive care in VA specialized PTSD programs, so their treatments and outcomes are unknown.

WORKFORCE AND ACCESS TO CARE

DOD and VA have substantially increased their mental health staffing—both direct care and purchased care. However, staffing increases do not appear to have kept pace with the demand for PTSD services. Staffing shortages can result in clinicians not having sufficient time to provide evidence-based psychotherapies readily and with fidelity. The lack of time to deliver psychotherapy with fidelity is reflected in the fact that in 2013 only 53% of OEF and OIF veterans who had a primary diagnosis of PTSD and sought care in the VA received the recommended eight sessions within 14 weeks. Provision of evidence-based treatments also implies refraining from providing services or programs that lack an evidence base or whose evidence base has been deemed ineffective by recent research. The size of the VA and DOD workforces will be influenced by how efficiently and effectively staff use their time

to deliver the most effective assessments and treatments in a patient-centered approach. Although expanding the number of staff to meet needs may be necessary, it may also be possible to achieve equal or better results with more efficient use of existing staff and by having existing staff use the most effective programs and services.

Neither department appears to have formal procedures for evaluating the qualifications of purchased providers, mechanisms to determine the best purchased care provider for an individual patient, or a requirement that those providers give referring providers updates on patients' progress. Having standards, procedures, and requirements for direct care and purchased care providers will help to ensure that they are trained in evidence-based treatments that are consistent with VA/DOD Clinical Practice Guideline for Management of Post-Traumatic Stress, understand military context and culture, measure the progress of patients in treatment on a continuing basis, and, in the case of purchased care providers, coordinate with patients' DOD or VA referring providers regularly. DOD and VA have expanded training in evidence-based psychotherapies for all mental health staff. However, the training is not required for purchased care providers in either department.

EVIDENCE-BASED TREATMENT

DOD and VA have expended considerable effort to develop, update, and disseminate the VA/DOD Clinical Practice Guideline for Management of Post-traumatic Stress. The guideline provides algorithms for choosing an evidence-based treatment for PTSD, addresses comorbidities, describes approaches for engaging patients in treatment, and discusses the evidence on first-line and other psychosocial therapies and pharmacotherapies.

However, mental health care providers in both departments do not consistently provide evidence-based treatment in spite of policies that require that all servicemembers and veterans who have PTSD receive first-line treatments, such as cognitive processing therapy and prolonged exposure therapy. It is unclear what PTSD therapies most servicemembers or veterans receive in any treatment setting and whether their symptoms improve as a result. DOD and VA are also integrating complementary and alternative therapies into some of their specialized PTSD programs, but the interventions need to be studied to establish their evidence base and to ensure that their use does not deter patients from receiving first-line, evidence-based treatments.

CENTRAL DATA BASE OF PROGRAMS AND SERVICES

DOD does not have a central database of PTSD programs and services that are available throughout the service branches. Without such a database, it is impossible to compare programs and services, to identify the ones that are effective and use best practices, and to recognize the ones that need improvement or should be eliminated. Most of the specialized PTSD programs in the service branches were developed and implemented locally. As a result, clinicians and other mental health care providers have no resource that provides information on programs (for example, type, location, admission criteria, and treatment modalities) to which they might refer servicemembers who need specialized PTSD care, or that might serve as models for new programs at their facility.

Although the VA prepares an annual report on its specialized PTSD programs, that report does not include all PTSD treatment settings, such as general mental health clinics and women's health clinics. Furthermore, the report does not contain any descriptive information on program elements and does not appear to be widely used.

All stakeholders, including families and direct and purchased care providers, would benefit from ready access to a routinely updated database in which programs are described and evaluated according to standardized measures. Existing resources, such as the National Center for PTSD, could be leveraged to develop more comprehensive information about VA-wide PTSD programs and services (not just specialized ones) and, in a collaborative effort, include those of DOD.

FAMILY INVOLVEMENT

DOD has a variety of resources to assist servicemembers and their families and others in learning about PTSD, its diagnosis and treatment, and its impact on family and friends. Many support services are available to servicemembers and their family members in military installations and personnel in those programs and services are trained to recognize early symptoms of PTSD, provide nonclinical supportive care, and refer servicemembers and their families to appropriate professional care.

VA also has resources for families of veterans who have PTSD, such as the National Center for PTSD. Some veterans have expressed their interest in and preference for having their partners involved in their PTSD treatment and the need for support groups for those partners. However, there is no formal VA-wide program for engaging family members in the veterans' treatments, for providing psychoeducation in a facility, or for establishing support groups for family members. In several VA mental health programs, veterans who have PTSD and their partners and children receive couple or family therapy from professional clinicians. VA, including Vet Centers, provides peer counselors and peer support groups that help to engage veterans in treatment, reduce stigma, and promote empathy, but data on the number of veterans who seek treatment as a result of peer counseling or who participate in support groups are not available. Vet Centers also provide counseling services for family members.

RESEARCH PRIORITIES

There can be substantial barriers to conducting PTSD research within and between the departments and in collaboration with academic, government organizations, and private partners. To date, there does not appear to have been a systematic effort by either department to identify those barriers and mechanisms to overcome them. Nevertheless, DOD and VA are funding broad PTSD research portfolios and are working collaboratively with the National Institutes of Health and other organizations to fill research gaps (for example, developing the joint National Research Action Plan for Improving Access to Mental Health Services for Veterans, Servicemembers, and Military Families for improving access to mental-health services), but much work remains to be done.

DOD and VA are spending substantial time, money, and effort on the management of PTSD in servicemembers and veterans. Those efforts have resulted in a variety of programs and services for the prevention and diagnosis of, treatment for, rehabilitation of, and research on PTSD and its comorbidities. Nevertheless, neither department knows with certainty whether those many programs and services are actually successful in reducing the prevalence of PTSD in servicemembers or veterans and in improving their lives.

SUICIDE

As previously mentioned, I am here today in several capacities: as a former IOM Committee member on PTSD, and as a retired career Army psychiatrist and subject matter expert on military suicide. This part of the testimony is from my professional experience in military and veteran mental health and suicide issues and does not reflect the collective opinion of the IOM.

The military has made a comprehensive effort to understand the dynamics of those who kill themselves while on active duty. That information is obtained in a variety of ways including suicide event reports, which help to inform suicide prevention efforts. The suicide numbers are still stubbornly hard to reduce, but the rate among active duty troops is beginning to flatten.

Far less is known about the reasons for suicide in reserve troops who kill themselves while not on active duty or on suicides in veterans. The numbers of Guard and reservists, including IAs or individual augmentees, who are killing themselves is still unacceptably high, and moreover we do not know why they are doing it.

For example, it's important that we also focus on the needs of our "Non Traditional Deployers." Members who deploy in support of missions like Detainee Operations have often been forgotten. This includes a large contingent of Navy Sailors who deployed to GITMO, Iraq Theater Internment Facilities and Afghanistan Internment Facilities. They received very little training in the jobs they were asked to perform, and came back to even less demobilization support.

Now would be the time to identify these members and study them, so we can identify what the training they went through was like, how they were treated in theater, and how they were received once they returned home. It would be good to compare these servicemembers with servicemembers who have been trained in the Military Correction Officer programs, and see how they favor during the same deployment environments.

The suicide rates among these sailors have continued to increase since 2010, and it is my thought that these rates may rise over the coming year with the IA's going away with the ending of the war. These sailors have been able to suppress their mental injuries by continuing to deploy and with that no longer being an option, it is likely that psychological symptoms will start to set in, and send most of them into a shock.

The numbers of veteran suicides are widely cited as 22 per day. However, as compared with suicides among active duty military, almost nothing is known about what precipitates self-injury among veterans. Anecdotally, I think that younger veterans are killing themselves in a pattern similar to that of active duty members, in other words over relationship and occupational difficulties. The pattern in older veterans appears to be more similar to the civilian population, with depression and substance abuse as key culprits.

To the best of my knowledge, the VA's suicide epidemiological office has two people. Thus the first of my recommendations is to better resource the efforts to understand who is killing themselves and why so that the risk of this tragedy can be reduced.

A second recommendation is to better screen veterans for exposures to a number of potentially toxic agents, including Mefloquine (an antimalarial), which has been associated with psychiatric symptoms and suicide. Fifty years after the beginning of the Vietnam War, and twenty-three years after the first Gulf War and the so-called Gulf War illness, the military has dramatically stepped up their screening as troops re-deploy home. But this is not yet uniformly done in the VA.

I turn now to the direction of research into PTSD treatment and suicide prevention. The VA has certainly been a leader in the former area. I would like to see them continue in that capacity, with a focus on expanding the evidence-base for the so-called cadre of complementary and alternative medicines (CAM) or integrative therapies. These CAM treatments include medical acupuncture, yoga, mindfulness, stellate ganglion block, and canine and equine therapy. For many of these CAM therapies, the evidence-base is promising but insufficient to guide changes in standard clinical treatment paradigms for PTSD. Given the well-documented low rate of effectiveness in existing evidence-base therapies (less than 30% overall) and the epidemic of PTSD in our military and veteran populations, it is an imperative that VA and DOD invest in research for new and innovative therapies with preliminary data showing favorable outcomes in PTSD symptom reduction.

It is important to keep in mind that many patients are already using these CAM strategies, some through established medical clinics and others through the internet or other non-traditional means. Based on preliminary published data as well as anecdotal patient testimonials, we know that some patients benefit greatly from these CAM therapies, but we do not yet know who which types of patients benefit most or why. DOD has begun doing some research on these innovative approaches, but it does not have the sophisticated ability to conduct clinical trials with the same capacity as VA does.

Finally, I would like to close with a concept that is important for all listening to understand: "moral injury." "Moral injury" is not a psychiatric disorder but a condition imposed by war, often related to the act of killing or of seeing others die. Servicemembers who have served in prisons, such as Guantanamo Bay and Abu Ghraib may be at highest risk. As a psychiatrist who has treated countless patients with PTSD, I believe that the related shame and guilt contribute to substance abuse, divorce, and suicide, but again there is not yet adequate research. I would encourage the VA—as well as the military and civilian community—to acknowledge and discuss these almost existential concepts with patients.

In closing, I would like to thank you for inviting me to testify before this Committee. I appreciate the work of the Senate Committee on Veterans Affairs. On behalf of the IOM PTSD committee members, I thank you for your trust in our ability to assist you with this important work for our Nation's veterans. I know from my service on the IOM committee that the Nation's scientists are happy to serve, and look to you for guidance on how we can be of most assistance to you and the VA and the DOD in addressing this difficult issue. I look forward to answering any questions you might have regarding the IOM's PTSD report. Attached to my testimony are the IOM committee's recommendations. Any questions you might have regarding suicide will be my opinion as the Committee did not address that issue as it was not part of their statement of task as outlined in the legislation.

ADDENDUM

TREATMENT FOR POSTTRAUMATIC STRESS DISORDERS IN MILITARY AND VETERAN POPULATIONS, FINAL ASSESSMENT (IOM, 2014)

RECOMMENDATIONS

PTSD MANAGEMENT STRATEGIES

Recommendation A: DOD and VA should develop an integrated, coordinated, and comprehensive PTSD management strategy that plans for the growing burden of PTSD for servicemembers, veterans, and their families, including female veterans and minority group members.

LEADERSHIP AND COMMUNICATION

DOD and VA leaders at the national and local levels set the priorities for PTSD care for their respective organizations. Authority, responsibility, and accountability for PTSD management needs to begin at the central office level—at the level of the assistant secretary of defense for health affairs and the VA under secretary for health—and extend down to facility leaders and unit leaders. Leadership accountability can help ensure that information on PTSD programs and services is collected and that their success is measured and reported. Effective leadership extends to supporting innovation in new processes and approaches for treatment for PTSD.

Recommendation B: DOD and VA leaders, who are accountable for the delivery of high-quality health care for their populations, should communicate a clear mandate through their chain of command that PTSD management, using best practices, has high priority.

PERFORMANCE MEASUREMENT

To better assess the success of their PTSD programs and services, DOD and VA should have a performance management system that includes:

- The use of standard metrics to screen for, measure, and track PTSD symptoms and outcomes throughout DOD and VA. The departments should work with the National Quality Forum to endorse consensus performance measures for both clinical measures and quality indicators.
- Health information technology that documents a patient's PTSD treatments and progress such that the data can be aggregated at the provider, program, facility, service, regional, and national levels.
- Performance measures to inform and improve the system via integrated feedback loops, which should be used by leaders at all levels to evaluate and improve PTSD management.

Recommendation C: DOD and VA should develop, coordinate, and implement a measurement-based PTSD management system that documents patients' progress over the course of treatment and long-term follow-up with standardized and validated instruments.

WORKFORCE AND ACCESS TO CARE

Recommendation D: DOD and VA should have available an adequate workforce of mental health care providers—both direct care and purchased care—and ancillary staff to meet the growing demand for PTSD services. DOD and VA should develop and implement clear training standards, referral procedures, and patient monitoring and reporting requirements for all their mental health care providers. Resources need to be available to facilitate access to mental health programs and services.

EVIDENCE-BASED TREATMENT

Recommendation E: Both DOD and VA should use evidence-based treatments as the treatment of choice for PTSD, and these treatments should be delivered with fidelity to their established protocols. As innovative programs and services are developed and piloted, they should include an evaluation process to establish the evidence base on their efficacy and effectiveness.

FAMILY INVOLVEMENT

Recommendation G: DOD and VA should increase engagement of family members in the PTSD management process for servicemembers and veterans.

RESEARCH PRIORITIES

The Committee identified the following as major foci of future PTSD-related research:

- Increasing knowledge of how to overcome barriers to implementation, dissemination, and use of evidence-based treatments to improve their accessibility, availability, and acceptability for patients and their families.
- Increasing understanding of basic biological, physiological, psychological, and psychosocial processes that lead to the development of more and better treatments for PTSD.
- Developing markers to identify better approaches for PTSD prevention, diagnosis, and treatment.
- Understanding the heterogeneity of PTSD presentations and predicting responses to treatment for them in different populations and at different times in the course of the disorder.
 - Preventing the development of PTSD before and after trauma exposure.
 - Developing and rigorously assessing new interventions and delivery methods (pharmacological, psychological, somatic, technological, and psychosocial) for both PTSD and comorbidities.
 - Identifying effective care models, establishing evidence-based practice competences, and developing methods to enhance effective training in and implementation and dissemination of them.

Recommendation H: PTSD research priorities in DOD and VA should reflect the current and future needs of servicemembers, veterans, and their families. Both departments should continue to develop and implement a comprehensive plan to promote a collaborative, prospective PTSD research agenda.

Chairman SANDERS. Thank you, Dr. Ritchie.
Mr. Smith.

**STATEMENT OF BLAYNE SMITH, EXECUTIVE DIRECTOR,
TEAM RED, WHITE AND BLUE**

Mr. SMITH. Chairman Sanders, Ranking Member Burr, distinguished Members of the Committee, and our distinguished guests here today, it is really my honor to be here to talk about this incredibly important topic and to represent our 55,000 members at Team Red, White and Blue. We are hoping that we can be a part of the solution.

Before we get into any solutions, I think it is worth taking some time to actually understand the challenge a bit better. We know that the physical, emotional, and psychological wounds of war affect a significant percentage of our veterans and they have to be addressed. Conditions like post-traumatic stress and traumatic brain injury have justifiably moved into the spotlight and are oft-cited as the culprits for many veteran challenges.

We acknowledge that, but we would like to submit that there are additional challenges that may play just as significant a role for many veterans, and that includes very common things like survivor's remorse, guilt and depression, and even just the loss of identity and purpose and comradeship that comes with taking off the uniform and transitioning to civilian life.

So, we want to craft solutions that address the full spectrum of the challenge and, whenever possible, proactively get at those challenges. We also think it is important to understand the people that are involved here. As has been stated many times this morning, every veteran is not the same.

Our organization, while we were building ourselves back in July 2012, conducted a representative survey and study of veterans in which we asked them what they wanted. We asked them what they needed and wanted in order to build an organization that could ad-

dress those wants and needs. And what they told us they wanted was connection to their community. They told us they wanted comradery, they wanted opportunities to continue serving, and they wanted meaningful relationships. So, that is what we have gone about trying to craft at Team Red, White and Blue.

The next thing I will state is that the solution requires empathy, not just sympathy. It really requires a deep understanding of our veterans and their families and their needs. So, we have to provide local, consistent, and inclusive opportunities for veterans and their families to interact with one another, but maybe more importantly, with members of their community who are not veterans.

One of the things we know is that stress and anxiety and depression and divorce and guilt, those are not veteran-centric issues. These are human issues that just happen to be experienced by veterans as well. So, if we can build meaningful connections between veterans and the members of their community, we can create understanding and we can create trust. Then we can move veterans toward the potentially life-saving treatments that they may need, because also what has been stated here this morning is that it does not matter what our capacity for acute care is if we cannot move veterans toward that care. That is a critically important step. The engagement and the outreach piece is absolutely critical.

So, at Team Red, White and Blue, our job is to build those connections in the community and we choose to do it primarily through physical social activities. We do that because we know that it works. So, why does it work so well? I think it is clear that physical exercise is great for your physical health. We all understand that.

It has also been well-documented in recent studies that physical activity, even moderate exercise, does great things for mood, reduction of anxiety, and reduction of stress. It is even cited in some cases that exercise can be as effective as some antidepressants or even counseling when combating depression.

But I will tell you that I think the most compelling argument for physical exercise is that in addition to improving physical health and mood, it is an extremely efficient vehicle for developing genuine relationships. We know that shared accomplishment and accountability, even shared hardship through exercise and challenges, builds a bond very rapidly and creates great understanding amongst people.

We have also found this team concept to be very, very attractive amongst veterans, especially of the younger generation. At Team Red, White and Blue we do not ask them to identify themselves as wounded or broken. We just offer them an opportunity to be a part of a new team, perhaps to help other veterans, and they really come out in droves. I think the results have been remarkable and we measure them.

Over the past 2 years, our membership has exploded by more than tenfold to now more than 55,000 members and we grow by about 700 members every week. We have gone from about ten local chapters to nearly 120 and those chapters host over 800 activities and generate almost 10,000 quality veteran interactions every single month.

Those outputs, I think, are interesting but the outcomes are actually more compelling. In a recent survey of about 4,400 of our members, we have learned that our programs are having a profound impact. Our members indicated that their health is improving, they have more meaningful relationships, and they have a stronger sense of purpose and identity.

For example, 94 percent of active Team Red, White and Blue members report feeling part of something bigger than themselves, and that is really important. Similarly, 61 percent of active Team Red, White and Blue members report feeling less down, depressed, and hopeless.

Additionally, veterans have more people they can turn to for emotional support, they are more involved in their local community, they have more programs they can turn to for resources, and they have a greater sense of brotherhood or sisterhood in their lives.

Last, I would say that our programs are effectively connecting veterans to their civilian counterparts. A majority of our veterans, nearly 75 percent, report sharing the challenges they face as a veteran with the civilian members of their community. I think that is remarkable. And of equal importance, 75 percent of our civilian members state that they have a better understanding of both the challenges veterans face and the strengths that veterans bring to their community, which is also very important.

So, while we are committed to measuring these outcomes, I think that ultimately our organization is about people. I would like to share a couple of quotes if I have time. I really believe that if Ian had been involved in this group, he would be alive today.

“Team Red, White and Blue helped me make friends when I moved to Virginia. It also allowed me to connect with the people I worked so hard to save. This is suicide prevention and life enrichment in its most simple and clear manner.”

And that comes from a very strong lady sitting behind me. Her name is Rebecca Morrison and her late husband tragically took his own life in 2012.

“PTSD and alcohol dependence were killing me, physically, mentally, and socially. My will to live was completely broken. Physically I was a wreck, mentally I was all over the place. Severe depression and anxiety ruled my life. Fast forward to April 2013 when I found Team Red, White and Blue. This is the point that my life definitely changed. I found what was missing since I left the Army. Genuine people and brotherhood and comradery, people who understand me.”

“Now I have lost 60 pounds and I reap the physical and mental benefits of consistent exercise. I have taken back my life and I have overcome the challenges the PTSD. I have regained self-esteem and confidence. I am now part of a wonderful group of friends and a very large extended family that genuinely care about me and I care about them, also.”

That comes from an Army veteran named Sean MacMillan. He lives in central Pennsylvania. He now leads our chapter there and is working every day to help hundreds of veterans like him.

Thanks for giving me this time. I look forward to answering any of your questions and helping in any way that I can.

[The prepared statement of Mr. Smith follows:]

PREPARED STATEMENT OF BLAYNE SMITH, EXECUTIVE DIRECTOR,
TEAM RED, WHITE AND BLUE

UNDERSTANDING THE CHALLENGE

The physical wounds of war are quite real and require dedicated attention and care. However, the invisible wounds of war affect a significant percentage of our Veteran population and must be addressed. Conditions such as post-traumatic stress and traumatic brain injury (TBI) have justifiably moved into the light and are oft cited as the culprits for Veteran challenges. While these conditions are serious, we submit that there are additional, perhaps overlooked, causes for the difficulty in transitioning from military-member to civilian. For many Veterans, survivors' remorse and guilt can be debilitating. For others, the loss of purpose, identity, and camaraderie can be devastating and greatly inhibit a smooth reintegration process.

UNDERSTANDING THE PEOPLE

It is critically important to understand Veterans' needs and preferences when creating support programs, rather than simply giving them what we think they need. That is why Team RWB conducted a representative study of Veterans in July 2012. The study was extremely informative and uncovered Veterans' true wants and needs: connection to community, physical activity, camaraderie, opportunities to serve, and meaningful relationships.

We also discovered that Veterans generally fall into one of three groups. We call them: Connection-seekers, Family-focused, and Driven. Interestingly, Connection-seekers and Driven have very complementary needs. While about 25% of Veterans are seeking connection, mentorship, and belonging (Connection-seekers); another 25% are actively looking for opportunities to lead, coach, mentor, and matter (Driven). The remaining 50% are generally getting along quite well and will join only if the experience adds value to their life (Family-focused). Armed with this knowledge and understanding, we went about creating a model that would actually give Veterans what they were asking for.

THE SOLUTION REQUIRES EMPATHY, NOT SYMPATHY

In order to provide Veterans with what they are seeking, we know that we need local, consistent, and inclusive programs that foster authentic interactions. We need to connect Veterans to other Veterans, and perhaps more importantly, non-Veterans within their communities. When people truly know each other, they build trust. Trust creates genuine, supportive relationships, and those relationships are the foundation upon which a healthy, happy, productive life can be built.

While post-traumatic stress, head injuries, depression, and anxiety can be challenges for Veterans, these are not "Veteran issues." These are human issues, experienced by many Americans. In most cases, Veterans and non-veterans have many more similarities than they do differences. This is easily discovered once we establish authentic relationships with one another. Our job at Team RWB is to create the conditions for these relationships.

WHY PHYSICAL ACTIVITY WORKS SO WELL

It is clear that exercise improves physical health. Servicemembers learn the benefits of maintaining a rigorous fitness regimen from the time they conduct initial training. However, we now know that physical activity, even moderate exercise, can also significantly improve mood, reduce stress, and limit anxiety. Some studies (Otto/Smits) show exercise to be as effective as common anti-depressants and counseling at combatting depression.

In addition to improving health and mood, physical activity is an extremely efficient vehicle for building authentic relationships. Shared accomplishment, accountability, and even shared hardship are powerful drivers of connection and friendship. This team concept is very attractive to Veterans because (unlike therapy) on a team, everybody contributes and everybody benefits. Team RWB members will generally tell you that they are participating in order to support their fellow Veteran, and

that is just fine. We do not require them to identify themselves as in-need or wounded or broken. At Team RWB, we don't rank-order suffering or injury. Put more positively, we don't rank-order "deserving." We simply provide Veterans an opportunity to be part of new team, to engage in positive activities, and to support their community.

REMARKABLE RESULTS

Team RWB's model of delivering local, consistent, and inclusive opportunities for positive involvement is clearly resonating with Veterans and community members alike. Over the past two years, total membership has increased almost tenfold (to over 55,000) and is continuing to grow at a rate of 700 signups per week. We have gone from 10 local chapters to nearly 120, hosting over 800 activities and facilitating more than 10,000 unique veteran interactions per month.

While these outputs tell part of the story, the outcomes are even more compelling. In a recent survey of 4,438 members, we learned that our programs are having a profound impact. A significant majority of members reported living richer lives since joining the organization. They indicated improved health (physical, mental, and emotional), more meaningful relationships, and a stronger sense of purpose and identity. Moreover, while outcomes were generally positive, those who are active in the organization consistently reported much higher levels of enrichment than those who identified themselves as less active.

For example, nearly half (45%) of "less active" TRWB Veterans felt part of something bigger than themselves, but the percentage jumped to 94% for those Team RWB Veterans who defined themselves as "active." Similarly, 61% of active Team RWB Veterans felt that they were "less down, depressed, or hopeless." While 57% of our "less active" members said they benefited from the opportunity to share their personal journeys, an astonishing 86% of "active" members found these experiences to be beneficial to them. Additionally, Veterans have more people they can turn to for emotional support (57%), they are more involved in the local community (60%), they have more programs they can turn to for resources (64%), and they feel an increased sense of brotherhood/sisterhood in their lives (66%).

Last, Team RWB programs are effectively connecting Veterans to their civilian counterparts. A majority of Veterans (73% among active members) reported sharing the challenges they face as a veteran with civilians, and 87% demonstrated the strengths they have as a Veteran to civilians. Of equal importance, 75% of civilian members stated that they better understand both the challenges and strengths of Veterans in their communities.

WE CAN SAVE LIVES

Suicide is most often the result of deep despair, a total loss of hope. We can proactively address this challenge by ensuring that Veterans are connected to a supportive community with programs that provide a sense of purpose, identity, and camaraderie. Once we've handled engagement and connection, we can more efficiently deliver the potentially life-saving resources that some Veterans need. I would like to close my testimony with short quotes from two of our members.

"I really believe that if Ian had been involved with this group that he would be alive today. Team Red, White, and Blue helped me make friends and feel connected when I moved to Virginia. It also allowed me to connect with the people I work so hard to save. This is suicide prevention and life enrichment in the most simple and clear manner."—*Rebecca Morrison, who's late husband Ian tragically committed suicide in 2012*

"PTSD and alcohol dependence were killing me physically, mentally, socially, and spiritually. My will to live was pretty much broken. Physically—I weighed over 230 pounds and could not run a mile without gasping for air. My blood pressure was through the roof, and my cholesterol was sky high. Mentally—I was all over the place. Severe depression and anxiety ruled my life.

Fast forward to April 2013 when I found Team RWB. This is the point that my life definitely changed. I found what I had been missing since I left the Army. Genuine people. The brotherhood. The camaraderie. People who understand me * * *. Now I am down to about 170 pounds. I reap the physical and mental benefits of consistent and challenging exercise. I have taken my life back, and overcome the challenges associated with PTSD. My mental health has never been better. I have regained my self-esteem and self-confidence. I now have a wonderful group of friends and a very large

extended family that genuinely cares about me (and I care about them as well).”—*Sean MacMillen, Army Veteran*

Team RWB is committed to enriching the lives of Veterans and their families. We are honored to be part of the discussion and welcome the opportunity to provide any additional insight or assistance on the very serious matter.

Chairman SANDERS. Mr. Smith, thank you very much for your testimony. Members of the panel, thank you all for your excellent testimony.

Let me start with Mrs. Selke and Mrs. Pallotta. Please answer this in any way that you want. Thinking back about the experiences that your sons went through, what recommendations would you make to the VA as to how they could have responded better to the needs of your sons? If the Secretary was sitting here right now, what should they have done that would have prevented the tragedy? Mrs. Selke, do you want to begin?

Mrs. SELKE. I think in Clay's case, I do not know that I can pinpoint any one particular thing, there was buildup; the difficulty in navigating the VA from the month that he left the service and started accessing VA care. That was summer of 2009 and that was just when the new G.I. Bill was going into effect. He was very delayed in getting his benefits to start school.

Chairman SANDERS. So, he had to deal with the bureaucracy and the delays of getting benefits which were important to him?

Mrs. SELKE. He did.

Chairman SANDERS. As I recall, he also had difficulty holding down a job because of—

Mrs. SELKE. Exactly. During that summer, he was working in a bike shop and because of his panic attacks, he would have to leave to go outside to collect himself often. He just had to be let go because it was interfering. So, that is when he realized he needed to make an appeal on his disability benefits as well. So, he was battling to get his education benefits in place as well as dealing with that.

In making that appeal for his disability benefits, that is when the VA lost his file and he had to re-create the medical records for the previous 2 years, since the time he had been diagnosed with post-traumatic stress in order to make that appeal. So, really from day one when he got out, he began experiencing the difficulty of just navigating through the system.

As far as the medical part of it, again, I said in my testimony, predominantly the medication was the way that he was dealt with. It was very difficult.

Chairman SANDERS. It sounds like he never received a warm hand that said, relax, we are with you, we are going to get you through this. We are going to get you through the benefits issue, we are going to get you through the mental health thing, we are here for you.

Mrs. SELKE. Right.

Chairman SANDERS. It sounds like he did not get that.

Mrs. SELKE. I look back and realize now how proactive Clay was, how determined he was that these were the benefits promised to him. He needed them and he was going to do what it took to get those. And it makes me realize how many others are out there that

may not have tried as hard. There are so many that just say, I give up, I am just not going to fool with it, I give up.

The medication was a real stumbling block for him. It was very frustrating to know that he needed help in some way. He knew he was not functioning the way that he should be. And yet, the place that he felt was his comfort zone, the place that he had been promised would take care of him as a veteran, there just did not seem to be very many options other than the medication route, and that just proved to be very difficult for him.

When he came back to Houston in those last really 10 weeks, before he saw the psychiatrist it just is uncanny how something can go wrong. It seems like something goes wrong so fast, but there is a buildup, and there is something that is the tipping point. For him I think it was his interaction with VA, with medication, he saw that psychiatrist.

I know they testified earlier about different health care professionals and mental health care professionals. He saw three or four people before he ever got to the psychiatrist. Well, he had been treated for PTSD for 3 years, so to start back over and have to go through all that intake, or whatever the term is, was very frustrating.

I did not tell this part in my testimony. When he saw the psychiatrist and he asked to be prescribed the medication that he had been on while he was active duty, which was Lexapro—because that had worked for him with the least amount of side effects—when he left active duty and went to VA, he was not given that drug. He was changed to a generic version of another drug, Celexa.

Those drugs are so specific. I mean, it takes a long time to find one that works and when you do, it is just incomprehensible to me that if it is documented, it is in your records that finally you found one that worked, and just because you transfer out and are under VA care, then you are told, well, we do not prescribe that right off the bat. We are going to do this.

So, when he came back and saw that psychiatrist, he said, I would like to be put back on that because it worked better for me, which he agreed and wrote the prescription. Then, Clay goes to the pharmacy at the VA and waits 2 hours. In addition, he had sleeping problems and he was given a prescription for Ambien.

So, he goes to the pharmacy and learns they do not stock Lexapro because at that time there was not a generic. He was told, we can get this for you, but we will have to send it to you by mail. It should reach you within 10 days. So, he left with a prescription for Ambien, nothing for anxiety, no antidepressant, being told it would come in the mail within 10 days.

He was so—in his voice when he called, which I said in my testimony that he called and said, I cannot go back there—he was just very dispirited. It was sort of like, I have fought for everything and now here I go with another battle, another hurdle to jump over. It seems unnecessary. Just looking back, some of that just seems unnecessary.

The medication for malaria that was brought up by someone, Clay's unit, he was part of 2-7 in the Marines, and one of his comrades called us a couple of—well, last week and he was just distraught. He said, we have lost—that combat in 2008 in Afghani-

stan, that 2-7 group, they lost 20 in combat and they have now recently lost their 20th to suicide.

He was just beside himself. He knew that Richard and I were involved in proactively trying to seek better help for them and they are struggling. They are worried about each other and I cannot even fathom those numbers. He brought up the malaria medication. He said, we are wondering, because they were all—they called it Malaria Monday. They would be given the pill on Mondays every week, and evidently there were side effects that were not fun.

But we have worried about Ambien. As we were meeting other families who had lost loved ones to suicide, veterans to suicide, it has been uncanny how many of them have been on Ambien. It just is worrisome.

Chairman SANDERS. My time has long expired, but I wanted to ask Mrs. Pallotta the same question. Thinking back.

Mrs. PALLOTTA. Thank you. I think Josh went through the same things that Clay did with the bureaucracy. Josh actually was only in the Guard for a few years. He joined in 2009 because he knew he was going to Afghanistan and he went right to basic training; then they went right to deployment.

When he was over there he got some back injuries along with the PTSD. So, for him to try to get treatment for his back, he had to drive an hour-and-a-half to White River Junction in his Jeep Wrangler and then an hour-and-a-half back, which he did not do because he could not deal with the pain.

He was on medications which, in fact, the VA has since sent us more automatic refills since he has been deceased.

I try to not—I try to go back and figure things out. What went wrong, what could we have changed? I know the fight for his disability was an extremely agonizing process and he was still only diagnosed at 65 percent.

He was medically discharged from the Guard in February, I believe, and I have since talked to buddies that he was deployed with, and every single one of them that I have talked to has said, we do not want the medications; we feel like zombies. We do not want counselors who are checking their watches while we are in our counseling session. We do not want a counselor to have to look through my file to find out what my name is.

Josh, fortunately, had a great counselor and he actually had started going back to counseling a few weeks before he ended his life. He was making headway. He had financial difficulties. He ended his 4-year long relationship with his girlfriend, which he described to his father as feeling like a weight had been lifted off of his shoulders. He had a job that he really liked. He was working in a deli in downtown Burlington, but they were closing. He felt like it was three steps forward and four steps back.

Going back, I do not know what one thing could have changed or what we could have done different. I think, as one of his buddies who was with him said, I think Josh just gave up the fight and I think it was a little too late. He had a veteran outreach worker who gave up on him. He did not want the help, so he said, I have got other veterans who want the help, so—yeah. Thank you.

Chairman SANDERS. Thank you very much. I have gone way, way over my time so you take as much time as you need, Senator Johanns.

Senator JOHANNNS. That is no problem because your comments are so incredibly compelling. Again, I thank you for being here. So, much of what you say is what we hear when we sit down with veterans, and all of us have had round table meetings with spouses and loved ones and family members and veterans themselves. They kind of walk us down through this same horrific challenge that they face.

But I must admit, I was very moved a year or so ago when a veteran described to me the experience of separating, separating from friends that had held them up on the worst day of their life and on and on, and then all of a sudden it is just not there.

Sergeant, you talked about going from combat and 3 days later walking down a street in Cody. And again, it is such a shock to put yourself in that position and think, oh, my Lord, how do you do that? Let me ask the two of you, if there would have been a support system of fellow veterans, do you think that would have been helpful?

If, literally, on the day of separation somebody would have said, you know, you are going back to wherever home is, here is a name and a phone number. You need to touch base because this is a group of people who have gone through what you have gone through and experienced what you have experienced. Would that have made any difference?

Mrs. PALLOTTA. I will speak personally for Josh's experience. Being in the National Guard is much more difficult, I think, and I am not saying this against anybody in the active military. Being in the National Guard, when they came home from their 2010 deployment they had 3 months off. Then, they came together at a Yellow Ribbon event. These were 20-year-old males who had not seen each other in 3 months. They went out and they got hammered. That was the way that they coped. This was the first time they had seen each other and been together in 3 months.

I believe that if the reintegration process was different where they were mandated to be together as part of drill or group therapy and if it happened immediately after they had come home from deployment, I think that it would have made a huge difference.

Because a lot of them in my son's unit, there was a huge leadership changeover after they came home and they lost that unity and they lost that cohesion and they lost that brotherhood—the guys who were next to them the whole time, who had watched their backs the whole time.

I mean, my son was aware of group therapy, but I think it needed to happen sooner, as opposed to being on an active duty military base where you have that atmosphere and that culture right there 24/7. The National Guard, they are trying to fit into their civilian life. I think they have tried some peer support groups at the Vet Centers and the VA, and my son contemplated it, but I think it was a little too late.

Senator JOHANNNS. Too late.

Mrs. PALLOTTA. I think it needed to happen when they came home from deployment.

Senator JOHANNNS. That is a good point.

Mrs. PALLOTTA. Thank you.

Mrs. SELKE. I would add that prior to leaving the service, if there is more of a, I do not know if you call it a debriefing or what. We do a great job of training up front to make wonderful, you know, wonderful soldiers and Marines out of all of these young men and women, and then when it is time to leave, time for getting out, our understanding is that it is a very brief process of getting out.

Something that developed actually as a result of Clay's death, at his funeral or at his memorial service, several of his fellow Marines were there and they realized that there were three from his unit that lived within 15 miles of Clay. He did not know that; they did not know that. None of them knew that the others lived that close to each other, and these were guys who literally served together.

So, on the plane on the way back to L.A., Clay's best friend, Jake Wood (who went on to found Team Rubicon), Jake and William McNulty came up with the idea of a mobile app for their phones. It is in place. It is called POS REP, P-O-S R-E-P, which stands for Position Reporting in the military.

How it works is, as a veteran, when you get out you choose to join this group which is a mobile application so that, say, while Clay was in Houston, had that app been available, he would have been able to register himself and log in to see that there were other veterans around him. Maybe not necessarily ones that he knew, but it seems that that would be just—I do not understand why the VA does not grasp that technology and offer that, because this generation, they live on their phones, you know, with the technology. It just would be so simple to do.

For Clay to come back to Houston, which is where he grew up, to feel so alone and, like you say, feel so isolated, things like that; there are things that we can do, that we can do better. I do not understand the pushback.

Senator JOHANNNS. I am out of time, too, but Sergeant, just because you talked about your experience, and there was a point at which you found others who were going through the same experience. You said, my goodness, I am not alone out here. What is your reaction to what I have been talking about and what these two mothers are talking about? If veterans could somehow be joined together, do you think that would make a difference here?

Mr. VANATA. I truly believe that bringing veterans together from similar experiences gives them a sense that they are not alone, that they have somebody they can talk to. They can talk about the things that have occurred in their life that they could never, ever say to a counselor or say to a psychiatrist. They can joke, they can laugh about things they have seen, things they have done that people on the outside might say is really inappropriate.

But, they both understand. And it is a way of rationalizing things and giving them an informal support system that they can always look to, to talk to each other. I have a good friend in Cody. He is retired Army, I am a retired Marine. We could not have less in common in that respect. Yet, we rely upon each other. It might be a quick text message, it might be a quick phone call, something along those lines. I know it helps me and I know it helps him.

I think it would be beneficial. And the dynamics of those who separate from the military after doing 4 years, 3 years, whatever it is, and those who retire from the military after doing 20-plus years, those dynamics are different. But having somebody within your peer group available, I think it would be beneficial.

Senator JOHANNIS. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Johanns.

Senator Moran.

Senator MORAN. Chairman, thank you. You know, I suppose the takeaway for me in listening to what has been said is that too often we hear the stories. Certainly I, as a member of Congress, have heard stories of the bureaucracy, the delays, the pushback, the lack of welcome and guidance that needs to take place in a department that is designed and created to take care of veterans.

We hear the stories of the bureaucracy and the culture there. The takeaway from what I hear you all saying is the idea that we just cannot write that off. You cannot say, well, that is just the VA. That is just the way the system works and we are going to have to figure out how to—I do not know how many times I hear about how we have to help, you know, somebody navigate the system.

The system ought not be something that requires navigation. It ought to be something that works. I would just tell you that I am quite certain that the testimony and your circumstances and being here, this cannot be anything that—I know you do not want to be here, you do not want to be in these circumstances, but there is a benefit to telling the story, because the reminder is that while we hear this stuff about the bureaucracy of VA, the consequences are something that we are not so readily aware of, as we heard from you today.

My point—I do not think I said it very well—but the point being that there can be no excuse. There can be no just kind of understanding that, well, that is the way the VA works; because if that is true, people's lives are lost. So, thank you for telling your stories, as difficult as that is.

Does anyone have the sense, any of our witnesses here, have the sense that anything is changing at the VA, that it is different than it was 6 months ago, different than it was in 2011? Or what you all are telling us is what a soldier returning today experiences in the process?

Sergeant.

Mr. VANATA. Sir, when I retired and had returned from Iraq in 2003, I went to see a counselor at the urging of my wife because she felt something was not right, and she was right on target. When I went to that counselor, she told me that I was the first veteran that she had spoken to from post-9/11 and she really did not know how to approach it.

Senator MORAN. This was a counselor at the VA?

Mr. VANATA. Well, it was through contracted care. It was at a CBOC. She referred me to a psychiatrist and a primary care physician. The primary care physician said, well, I think you have PTSD. He did not go through any kind of an assessment; zero. The psychiatrist said, well, yeah, I think the doctor, your primary care physician, is correct. You have got PTSD. And then they started throwing drugs at me.

Well, that lasted for about 3 months and then I turned them off for about 6 years. When I went back in 2011, it was very apparent that they had gone through a steep learning curve; that they now understand that there is a lot involved in this. I was directed to a doctor in Sheridan, WY, at the VA there through telehealth, and she was topnotch. I think she was on the leading edge of PTSD treatment.

Unfortunately, she has retired, but she really—she had it in hand. She knew what was going on and it was not through her experience with Vietnam veterans, but it was her experience with post-9/11 veterans and getting up-to-date on the latest and somewhat unconventional treatments.

Senator MORAN. Well, Sergeant, the question then becomes, is the problem that we do not know what to do or that we have not connected the veteran with the people who do know what to do?

Mr. VANATA. I think it is an issue of not connecting. Where I live, I live in a very rural part of the country. To the VA, to the hospital, it is 120 miles. If it is snowing, that 3 hours just converts into 5 hours since I have got to go around a mountain range. And you have a lot of guys returning back to the United States who are just not connecting because the VA is not near.

A lot of guys have this mind set: there is nothing wrong with me, it is the rest of the world that is screwed up. There is no outreach. So, from my perspective, the VA is not engaging with these returning veterans and letting them know what is available, whatever their situation may be, and how to overcome obstacles and challenges that they may be facing.

Senator MORAN. And that is where, in part, the technology that has been described here comes into play. It is where your organization comes into play. I think both the doctor and—

Dr. RITCHIE. We are both raring to jump in here. So, I think the short answer to your question is, it depends. When, as part of the IOM Committee, when we went out and looked at a number of different VAs, we found really highly-variable conditions. There were some terrific VAs who were doing on-the-edge treatment for post-traumatic stress disorder and traumatic brain injury, and then there were some others that were not.

Senator MORAN. What is the difference? What is the cause of that? Why is there such a difference between two different places?

Dr. RITCHIE. Some of them are where they are placed. So, for example, the Palo Alto VA right outside of San Francisco, you have got a lot of people who want to come to Palo Alto, who want to work there. You have got other VAs that are in more rural areas, have a tougher time. Part of it is the attitude of the staff, though.

I would like to say, just personally—again, I am a veteran, I am retired—I tried to get my comp and pen exam, compensation and disability exam. I am a retired colonel. I have good friends who work at the Washington VA. I work down the street from the Washington VA. Yet, it took me about 2 years to get my physical completed and done. And I know the system. Then, by the way, I could not get any disability because I have a job and make too much money. But that is fine; I do not need it.

So, if you are somebody who is struggling— people who are having more problems, they would not answer the phone. So, there are still a lot of roadblocks.

Senator MORAN. Well, that was an interesting thing for me to learn, is that we sometimes separate the benefits side from the health care side of the VA, and what I heard in the testimony of one of the moms is the consequences of the backlog had a terrible consequence on their son's life. It was one of those additional impediments of being stuck.

We segment oftentimes: this is a health care issue, this is a benefits issue. There is a consequence.

Mr. SMITH. So, I think there is another point to be made here which was pointed out earlier—that we need to get as far upstream of this as we possibly can. I served in Iraq and Afghanistan in very challenging conditions, lost friends, people that worked under my command, and I received mental health care from the VA in Tampa, FL, which is, I think, an exemplary facility. In fact, the Tampa director is now in Phoenix trying to work there.

They work very closely with our organization, they are very progressive, and so I think it is dependent upon the leadership and where you go geographically. And I think DOD has a role to play here. I do not want to gloss over this because I came back from Afghanistan in 2009 after a horrific deployment.

You must take a post-combat health assessment survey and I answered every one of the bad questions affirmatively. You know, did you kill people? Yes. Did you see people killed? Yes. Did you fear for your life? Yes. I answered all of those affirmatively and so did every guy in my detachment. Yet, we were not made to go see a mental health professional, which we should be because the stigma there is challenging, especially for barrel-chested, bearded Special Forces guys. They are not going to go see somebody. If we were all made to go, we would have.

The reference into VA from DOD could have been very critical there in both benefits and health care with regard to the backlog. So, I think it is incredibly important that we make those organizations work together.

Senator MORAN. Thank you. Thank you all.

Chairman SANDERS. Thank you, Senator Moran.

Senator BOOZMAN.

Senator BOOZMAN. Thank you, Mr. Chair. Again, I really do appreciate all of you being here testifying. As I said in my opening statement, you that have been directly involved, there is just simply no substitute for you being here. I know it is difficult to talk about these things, but we really do appreciate it.

The only thing I would like to know, having three daughters that are grown and just having three kids—Mrs. Selke and Mrs. Pallotta, you all were in difficult situations, you know, dealing with loved ones, with children that were struggling. Were you able to get some help as far as knowing how to deal with that situation? How did you personally cope in that regard—

Mrs. PALLOTTA. Well—

Senator BOOZMAN [continuing]. Because, you know, we have got a situation now that if a wounded warrior comes back and he has lost a leg or this or that and is in a dire situation there, then loved

ones could step in and we can direct them as to do this or that, provide training. But this is a different injury.

Mrs. PALLOTTA. It is different and what is ironic—that is not even the right word, but I actually was very instrumental in chartering the first Blue Star Mothers of Vermont chapter and I was a chapter president for 2 years. We were all moms from a parent network that started when our boys were getting ready to deploy. I say boys because it was infantry and there were no women in their unit.

We had active duty, all branches of the military. The work that we do for veterans is to support our veterans by giving them financial support, cook meals for veterans in transitional housing. We have two in Vermont that we support. And I do not know, because I should have. I saw the signs. I worked with veterans as part of this organization for over 3 years and I still could not save my own son.

So, I do not know the answer to that. I do know that what is frustrating as a parent is there are no support services for parents.

Senator BOOZMAN. That is really what I wanted to know.

Mrs. PALLOTTA. We have a Vet Center and they were very accommodating to me a few weeks before my son died, because I was really struggling with it. But because he was not currently being seen at the Vet Center, technically they could not see me. The VA would not see me. As a mother of a 20-something young male soldier, it is really difficult for us to provide support to them and get support for ourselves.

So, to answer that question, I do not know. I saw the signs. We saw the signs. And as an only child—but, you know, to use the term again, there is no rule book for it. There is no—I do not know. I mean, if I knew the answer to that, we probably would not be sitting here. I probably could have saved my son.

Mrs. SELKE. I do not know how it can be accomplished, but the lack of education about post-traumatic stress disorder or traumatic brain injury or what to expect when your veteran comes home. You talk about being discharged and leaving the military and all of a sudden you are back in a small town and a totally different culture.

As a parent, you have lived through two deployments. You have lived through your child, who is a 28-year-old scout sniper, survived two wars, and then they come home and they are—even if they are open about it, you do not know what to do as a parent other than encourage them to get help.

As a parent, I felt as well that the VA would be the source of that help for him because they know about war, they know what he had dealt with. As far as educating us, I never really thought about that until we started doing this kind of work, to think, Who could we have asked? Where could we have gone as a resource to say, our son has been diagnosed with this; is there anything we need to know to look out for?

I think as a parent, too, these are strong young men and women. The people they want to protect the most are their family. Clay did not want to worry us, and I think there were times when he would put on a good face as in, I am a tough Marine, I can handle this, I know what to do.

As a parent, maybe you are fooling yourself. What you want to believe is that they are going to be OK, that there are educated, qualified people taking care of whatever it is that they need medically. So, an education piece, as military folks are transitioning out, for families—I am not sure how that is accomplished—would be very helpful.

Senator BOOZMAN. Thank you very much. Thank you, Mr. Chairman.

Chairman SANDERS. Thank you, Senator Boozman. Well, this has been a very important hearing. I just want to thank all of the panelists for being here, and especially the moms for doing what we know has been very, very difficult. I think you are here to make sure other families do not experience what you have experienced, and I think you have helped us very much in doing that.

To everybody else, thank you for the great work that you all are doing. With that, the panel is concluded.

[Whereupon, at 1:34 p.m., the hearing was adjourned.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO
MRS. SUSAN SELKE, MOTHER OF CLAY HUNT, A DECEASED MARINE CORPS COMBAT
VETERAN

Question 1. Mrs. Selke, thank you for your deeply moving testimony. My question for you is when your son sought services from the VA, did he have to provide additional documentation to substantiate claims for exposure to situations that could be linked to PTSD?

Response. I appreciate the question from Senator Brown. Unfortunately, I don't know the answer. Clay was diagnosed with PTSD during active duty in 2007. He separated from the Marines in 2009 and began going to the VA in Los Angeles. I don't know if they asked for additional information or if they based his care on his active duty medical records.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO
MRS. VALERIE PALLOTTA, MOTHER OF VERMONT JOSHUA PALLOTTA

Question 1. Mrs. Pallotta, thank you for your deeply moving testimony. My question for you is when your son sought services from the VA, did he have to provide additional documentation to substantiate claims for exposure to situations that could be linked to PTSD?

Response. From my recollection Josh did have to provide additional documentation to substantiate his claim for PTSD. I know that he went through a series of disability tests.

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO
MSGT VANATA, USMC (RET.), COMBAT STRESS RECOVERY PROGRAM, WOUNDED
WARRIOR PROJECT

Question 1. In your testimony you mentioned that the doctor in Wyoming never even had the chance or the time to really review your chart when you sought services. I am curious, when you were filing for help, obtaining counselling, or anytime thereafter, were you required to submit additional information to corroborate your exposures to PTSD or TBI while serving in Iraq?

Response. [No response was received.]

RESPONSE TO POSTHEARING QUESTIONS SUBMITTED BY HON. SHERROD BROWN TO
COL ELSPETH CAMERON RITCHIE, USA (RET.), CHIEF CLINICAL OFFICER, DISTRICT
OF COLUMBIA'S DEPARTMENT OF MENTAL HEALTH

Question 1. Colonel Richie, in your study you mentioned that "most veterans who have PTSD are not receiving care in VA specialized PTSD programs." Given your experience in the Army, at the D.C. Department of Mental Health, and the Insti-

tutes of Medicine, do you believe the DOD is doing enough to sharing information about a servicemember's potential exposure to PTSD and TBI causal events with the VA and the transitioning servicemember? What more could be done by the DOD to share corroborative evidence with the VA?

Response. [No response was received.]

A P P E N D I X

REPORT OF CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL

A REVIEW OF HOW PSYCHIATRIC MEDICATIONS
COULD BE DRIVING MEMBERS OF THE ARMED
FORCES AND VETS TO SUICIDE AND
THE NECESSITY OF ENSURING INFORMED
CONSENT IS GRANTED TO MILITARY
PERSONNEL AS IT RELATES TO ANY
MENTAL HEALTH TREATMENT



A Report by
Citizens Commission on Human Rights International
November 2014

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PSYCHOTROPIC MEDICATIONS: SUICIDE

“We have never drugged our troops to this extent and the current increase in suicides is not a coincidence. Why hasn’t psychiatry in the military been relieved of command of Mental Health Services? In any other command position in the military, there would have been a change in leadership.”

**- Bart Billings, Ph.D., Retired Col.
and former military psychologist**

The life of a soldier is demanding.

They’re trained to be alert, decisive and focused—and in top physical and mental shape. It’s a necessity.

But soldiers operating under the influence of psychotropic^{*} drugs reflect just the opposite.

Nevertheless, military electronic records show that at least one in six service members has been on some form of psychotropic drug. This ratio is probably vastly understated, as prescription records are not kept on the front lines, where drugs are often informally passed out by medics or between fellow soldiers.

The risks of taking psychotropic drugs have long been known. With antidepressants, there are now nearly 100 drug regulatory agency warnings from ten countries and the European Union alerting prescribers and patients to the drugs’ adverse effects, including hostility, violent behavior and suicide.

Though none of this drugging truly serves the active-duty soldier or veteran, the U.S. Department of Defense (DoD) and the Veteran Affairs (VA) have spent almost \$2 billion since 2001 to treat mental disorders. This astonishing sum is not unique to the United States: Every year the Australian Department of Veteran Affairs spends \$160 million on mental health for its veterans.

Even so, considerable psychiatric expenditures like these in militaries throughout the world have done nothing to reduce the rate of hospitalization of active troops for mental health problems. On top of this, suicide rates continue to escalate.

^{*} *Psychotropic: A term coined in the late 1940s by Ralph Waldo Gerard, an American behavioral scientist and physiologist to medically describe medication capable of affecting the mind, emotions, and behavior—from the Greek, “mind-turning.”*

More British soldiers and veterans committed suicide in 2012 than were killed in battle. And more Australian Defense Force employees have died by suicide over the past decade than have died on the front line.

Between 2001 and 2009, there were 2,100 suicides in the U.S. military, triple the number of troops that died in Afghanistan and half of all American deaths in Iraq. During that same period, military orders for psychiatric drugs known to cause suicidal thoughts and acts increased 76%.

American vets have it even worse. One U.S. military veteran kills himself every 65 minutes—an astonishing 22 a day.

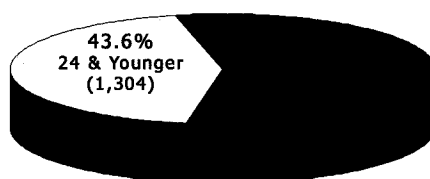
- Between 2005 and 2011, orders for psychiatric drugs for the military increased seven fold.¹
- Antidepressants carry an FDA “black-box” warning of “suicidality” for those younger than 25. They also have documented side effects of hostility, anxiety and unusual behavior changes for any age group.²
- The age range of 41 percent of deployed American soldiers is 18-24 and some are prescribed antidepressants despite the Black Box warning.
- There were 1,304 active and reserve components of the military aged 24 and younger that committed suicide between 1998 and 2011, representing 43.6 percent of 2,990 suicides in this group.³ The 2012 DoD Suicide Event report found 39.6 percent of the Service Members committing suicide were aged 17-24.⁴
- **A SOLDIER COMMITS SUICIDE NEARLY EVERY DAY (2013)**
- **AN ACTIVE-DUTY, RESERVE OR NATIONAL GUARD MEMBER COMMITS SUICIDE EVERY 17 HOURS (2012)**
- **THERE ARE 22 VET SUICIDES EVERY DAY (2010)**
- During 1998-2011 (with the numbers increasing sharply since 2005), 2,990 service members died by suicide while on active duty. Numbers and rates of suicide were highest among service members who were male, in the Army, in their 20s and of white race/ethnicity.⁵

- There was an eightfold increase in martial psychotropic drug use since 2005, with nearly 8 percent of servicemen and women on sedatives and 6 percent on antidepressants.⁶
- In March 2013, the Pentagon reported more soldiers were dying overseas by committing suicide than from combat wounds – about one a day. Returning vets were committing suicide at a rate of 22 each day in 2010—one every 65 minutes.⁷
- In 2012, there was one suicide every 17 hours among all active-duty, reserve and National Guard members, according to figures gathered from each branch.⁸
- The suicide rate increased by more than 150 percent in the Army and more than 50 percent in the Marine Corps between 2001 and 2009.⁹
- The majority (55 percent) of Service Members who died by suicide during 2008-2010 had never deployed and 84 percent had no documented combat experiences.¹⁰ In the 2012 DoD Suicide Event report on suicide, 52.5 percent of completed suicides had not been deployed in recent wars and 56.5 percent of suicide attempts had no reported history of deployment.¹¹

**PEOPLE WHO TAKE
ANTIDEPRESSANTS
"BECOME VERY
DISTRAUGHT... THE
IRRITABILITY AND
IMPULSIVITY CAN MAKE
PEOPLE SUICIDAL OR
HOMICIDAL."**

**-DR. JOSEPH GLENMULLEN
HARVARD PSYCHIATRIST**

Suicides of Active and Reserve Members



1998 - 2011: 1,304 active and reserve components of the military aged 24 years old and younger committed suicide.

-
- In a report that Health and Human Services and Centers for Medicare and Medicaid Services published in August 2013, it stated, "Antidepressant medications have been shown to increase the risk of suicidal thinking and behavior. In a pooled-analysis of short-term, placebo-controlled trials of nine antidepressant medications, patients taking an antidepressant had twice the risk of suicidality in the first few months of treatment than those taking placebo. The long-term risk is unknown."¹²
 - Harvard Medical School psychiatrist, Dr. Joseph Glenmullen, author of *Prozac Backlash*, says antidepressants could explain the mass-suicides over the last decade. People who take antidepressants, he said, could "become very distraught... They feel like jumping out of their skin. The irritability and impulsivity can make people suicidal or homicidal."¹³
 - Dr. David Healy also determined from a review of published SSRI antidepressant clinical trials that the drugs increase the risk of suicide.¹⁴
 - In February 2005, a study published in the *British Medical Journal* determined that adults taking SSRI antidepressants were more than twice as likely to attempt suicide as patients given placebo.¹⁵

INFORMED CONSENT RIGHTS

According to Dr. Fred Baughman, Jr., "In no edition of the DSM are psychiatric diagnoses actual physical abnormalities of the body or brain, making them diseases, disorders, or syndromes in a medical sense." All such statements are false, he adds, stating that therefore, "no such patient has been accorded his or her right on informed consent."

A study of Direct-to-Consumer Advertising of psychotropic drugs pointed out that "None of the advertisements include detailed information on talk therapy or exercise, which have both been proven to help ease the stress of mental conditions—In fact, advertisements often go as far as to claim that 'only your doctor can diagnose depression,' when this simply is not true." This then directs the person to a doctor's office where they're most likely to receive a prescription.

The study cited one ad for the antidepressant Prozac, which stated that "talk therapy cannot control the medical causes of depression."¹⁶

Alternative approaches to helping the mental health needs of the Armed Forces and veterans can be disregarded in the face of a "quick fix pill," thereby violating informed consent rights. Dr. Hyla Cass, psychiatrist, reported that many drugs, such as the stimulants Ritalin and Adderall can reduce appetite. This, in turn, decreases the intake of beneficial nutrients. Some antidepressants also tend to have this appetite-reducing effect. Many of the neuroleptics (antipsychotic drugs) and some antidepressants cause insulin resistance or metabolic syndrome, with resulting blood sugar swings.¹⁷

Lt. Col. Charles Ruby, who retired from the Air Force launched Operation Speak Up to help establish group settings for veterans to talk about their combat stress, based on the Alcoholics Anonymous model. "Our view is that psychiatric drugs do nothing but sedate people. We believe that speaking out is a much better way to treat these people and to find a way to integrate back into their communities."¹⁸

A cost-benefit analysis must be done on existing mental health programs and the impact of these programs on the mental health of the nation, at the exclusion of alternative methods of help.

Informed consent requires that all patients be informed of the subjective nature of a psychiatric diagnosis, the right to refuse to consent to psychiatric medication and the right to know about alternatives available.

THE RIGHTS OF MILITARY PERSONNEL REGARDING MENTAL HEALTH TREATMENT

There are certain rights for anyone regarding accepting or refusing any mental health treatment that has been suggested, prescribed, or ordered. Acceptance of mental health treatment, including drugs is nearly always voluntary. (In this document, CCHR is not providing any view regarding inoculations or vaccines given to active duty personnel, which may or may not be mandatory.)

Active duty military personnel have a right to informed consent before accepting treatment, as well as a right to refuse treatment if they disagree with such. The concept of “informed consent” means the right to:

**ACTIVE DUTY
MILITARY PERSONNEL
HAVE A RIGHT TO
INFORMED CONSENT
BEFORE ACCEPTING
TREATMENT, AS WELL
AS A RIGHT TO REFUSE
TREATMENT IF THEY
DISAGREE WITH SUCH.**

- Full and honest information on all the risks of any proposed psychiatric treatment (information about the adverse effects of psychotropic medications can be gotten at cchrint.org/psychiatrydangers);
- Full and honest information on all risks of all alternative treatments;
- Full and honest information on all risks and benefits of no treatment at all. Based on this information, military

personnel can then make an informed decision on what treatment is best.

Thus, they can take an informed decision on what treatment is best. And in case informed consent is refused, they have the right to seek the advice of an attorney. According to Department of Defense Instruction, Number 6000.14, September 26, 2011, entitled, “DoD Patient Bill of Rights and Responsibilities in the Military Health System (MHS),” military personnel are entitled to informed consent for any treatment and to refuse to receive treatment. That regulation states, in part, under the section, “PATIENT RIGHTS”:

“f. Informed Consent

“Patients have the right to any and all necessary information in non-clinical terms to make knowledgeable decisions on consent or refusal for treatments, or participation in clinical trials or other research investigations as applicable. Such information is to include any and all complications, risks, benefits, ethical issues, and alternative treatments as may be available.”

One should demand to be provided with easily understood information about all adverse reactions and side effects of psychotropic drugs, including the potential to alter behavior to such an extent as to cause violent or suicidal thoughts or behavior, and that withdrawal from such medication without medical supervision may exacerbate those thoughts and behavior. Enclosure 3 of the same regulation, under Procedures and MHS Compliance Guidelines states:

“d. Participation in Treatment Decisions. Each MTF/DTF [Medical/Dental Treatment Facility] shall ensure that MHS [Mental Health System] beneficiaries have the right and opportunity to participate fully in all decisions related to their healthcare, subject to readiness requirements for active duty Service members.

“(1) To the extent practical, MTF/DTF and TRICARE [Healthcare program of the United States Dept. of Defense Military Health System] Prime network healthcare professionals shall:

“(a) Provide patients with easily understood information and the opportunity to decide among treatment options consistent with the informed consent process.

“(b) Discuss all treatment options, including the option of no treatment at all with a patient in a culturally sensitive manner...”

“(e) Discuss all risks, benefits, and consequences to treatment or non-treatment.

“(f) Give competent patients the opportunity to refuse treatment and to express preference about future treatment.”

In an unusual case, the military doctor or commander may seek to override the active-duty soldier's refusal to consent to treatment, but it must be done through medical board proceedings which provide various due process rights to the soldier. Soldiers need to ensure they review these regulations with a chaplain (because a soldier may refuse mental health treatment for religious reasons), an attorney or other advocate so that they can take the correct action for their situation.

[Note: One should seek attorney advice about filing any complaint to the Medical Board to ensure his rights are fully protected.]

Army Command Policy—600-20 Rapid Action Revision (RAR) Issue, 20 September 2012, addresses a refusal of a soldier to submit to medical or mental treatment. It indicates that if the military doctor insists upon the treatment and the soldier refuses, the matter is sent to a Medical Board proceeding. There, the soldier may contest the treatment order and the matter will be heard and then decided upon. He should ensure he seeks attorney advice if requesting a Medical Board adjudication.

Should the soldier disagree with the Medical Board's recommendation, the soldier may appeal to the Surgeon General, and even if the Surgeon General agrees with the Medical Board, if the soldier continues to refuse, he or she may request or be subject to a court martial, including a full legal defense.

As noted above, treatment is nearly always voluntary. But military members should be aware of their rights so that they are not convinced by innuendo or suggestion that they may not refuse unwanted mental health treatment. And should they stand their ground and refuse such treatment in spite of orders from mental health practitioners, they must be aware of and granted the right of refusal mentioned above.

FOR VETERANS

For veterans of the armed services, there is no permissible enforced treatment. Some veterans are concerned about losing their benefits if they refused psychiatric treatments recommended to them from a VA hospital or VA clinic. The code is unclear whether this could happen, but it would be grossly inappropriate if it did. In such a case, you could bring the matter to the attention of an attorney or your Congressional representative.

Per 38 CFR 17.107, "VA response to disruptive behavior of patients," this section states:

"Although VA may restrict the time, place, and/or manner of care under this section, VA will continue to offer the full range of needed medical care to which a patient is eligible under Title 38 of the United States Code or Code of Federal Regulations. Patients have the right to accept or refuse treatment or procedures, and such refusal by a patient is not a basis for restricting the provision of care under this section."

You should obtain advice from the VA regarding this. If their advice is unsatisfactory to you, seek legal advice.

PSYCHOTROPIC MEDICATIONS: VIOLENCE RISKS

It is important to understand that the mental health system for our Armed Forces and veterans often involves the use of psychotropic and neuroleptic¹⁹ drugs. Between 2001 and 2009, orders for psychiatric drugs for the military increased seven fold.¹⁹ In 2010, the Army Times reported that one in six service members were taking some form of psychiatric drug.²⁰

A National Institutes of Health website warns consumers to report if while taking Trazodone—one of the drugs prescribed the Navy Yard shooter—they are “thinking about harming or killing yourself,” experience “extreme worry; agitation; panic attacks... aggressive behavior; irritability; acting without thinking; severe restlessness; and frenzied abnormal excitement...”²¹

Psychologists have blamed the surge in random acts of violence among U.S. military on the heavy use of prescribed drugs. “We have never medicated our troops to the extent we are doing now ...And I don’t believe the current increase in suicides and homicides in the military is a coincidence,” states Bart Billings, a former military psychologist and combat stress expert.²²

**“WE HAVE NEVER
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AND HOMICIDES IS A
COINCIDENCE.”**

The Food and Drug Administration (FDA) MedWatch system that collects adverse drug reports revealed that between 2004 and 2012, there were 14,773 reports of psychiatric drugs causing violent side effects including: 1,531 (10.4 percent) reports of homicidal ideation/homicide, 3,287 (22.3 percent) reports of mania and 8,219 (55.6 percent) reports of aggression.

**-DR. BART BILLINGS FMR. COL.
& MILITARY PSYCHOLOGIST**

Dr. David Healy, a psychiatrist and a former secretary of the British Association for Psychopharmacology, estimates that 90 percent of school shooters were users of antidepressants.²³ These same medications are prescribed to at least 6 percent of our servicemen and women.²⁴

Scientific American recently reported on a study of the antidepressants paroxetine (Paxil) and fluoxetine (Prozac) involving more than 25,000 subjects, which showed that one out of every 250

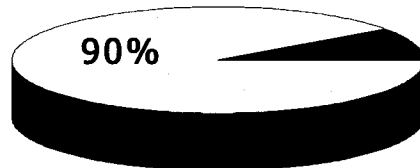
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¹⁹ *Neuroleptic*: A term coined in 1955 by French psychiatrists Pierre Deniker and Jean Delay to describe the “nerve seizing” effects of major tranquilizers (antipsychotics).

were involved in "a violent episode," including 31 assaults and one homicide.²⁵

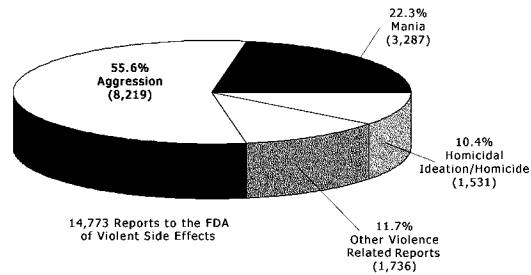
Scientific American also reported the results of a study of more than 9,000 subjects taking paroxetine for depression and other disorders, which found that subjects experienced more than twice as many "hostility events" as subjects taking a placebo.²⁶

School Shooters on Antidepressants



Dr. David Healy, psychiatrist, estimates that 90% of school shooters were users of antidepressants.

FDA Medwatch Adverse Psychiatric Drug Reports: 2004-2012



SUDDEN DEATHS OF SOLDIERS & VETERANS:

The antipsychotic medication Seroquel, referred by vets as "Serokill," is implicated in hundreds of cardiac arrests and sudden deaths of combat veterans.²⁷

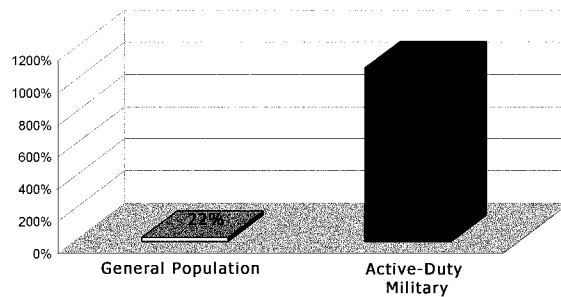
- In September 2011, the *European Heart Journal* published a study titled, "Psychotropic medications and the risk of sudden cardiac death during an acute coronary event." The researchers concluded: The use of psychotropic drugs, especially combined use of antipsychotic and antidepressant drugs, strongly associated with an increased risk of SCD [sudden cardiac death] at the time of an acute coronary event.²⁸

"THE DEATHS OF THE 'CHARLSTON FOUR' [VETS] WERE PROBABLE SUDDEN CARDIAC DEATHS." ALL "WERE ON THE SAME PRESCRIBED DRUG COCKTAIL, SEROQUEL, PAXIL AND KLONOPIN."

-DR. FRED BAUGHMAN, JR. NEUROLOGIST, HAS LIST OF 395 SUSPECT DEATHS OF SOLDIERS AND VETS.
- Dr. Audrey Uy-Evanado reported at the annual meeting of the Heart Rhythm Society in 2013, that both the second-generation and first-generation antipsychotic drugs proved independently associated with greater than threefold increased risks of sudden cardiac deaths.²⁹
- California neurologist Dr. Fred Baughman Jr. collected a list of 395 questionable soldier and veteran deaths. He wrote of Andrew White, Eric Layne, Nicholas Endicott and Derek Johnson—all in their twenties, who were West Virginia veterans that died in their sleep in early 2008. "All had been diagnosed 'PTSD'—a psychological diagnosis, not a disease (physical abnormality) of the brain. All were on the same prescribed drug cocktail, Seroquel (antipsychotic), Paxil (antidepressant) and Klonopin (benzodiazepine) and all appeared 'normal' when they went to sleep...the deaths of the 'Charleston Four' were probable sudden cardiac deaths, a sudden, pulseless condition leading to brain death in 4-5 minutes, a survival rate or 3-4 percent, and not allowing time for transfer to a hospital."³⁰

-
- Sicouri and Antzelevitch (2008) concluded: (1) "A number of antipsychotic and antidepressant drugs can increase the risk of ventricular arrhythmias and sudden cardiac death," (2) "Antipsychotics can increase cardiac risk even at low doses whereas antidepressants do it generally at high doses or in the setting of drug combinations."³¹
 - The landmark U.S. Clinical Antipsychotic Trials of Intervention Effectiveness (CATIE) study, showed treatment with many atypical antipsychotics is associated with metabolic side effects such as overweight/obesity and diabetes. Failure to properly monitor and manage these effects can lead to increased risk of mortality due to diabetic ketoacidosis [life-threatening problem when the body cannot use sugar as a fuel source because of insufficient or no insulin] and cardiovascular disease.³²

**Increase in Antipsychotic Drug Prescriptions
Military v.s. U.S. population
2005 - 2011.**



-
- Marine Corporal Andrew White, 20, and Senior Airman Anthony Mena, 23, were prescribed a total of 54 drugs between them, including Seroquel, Effexor, Paxil, Prozac, Remeron, Wellbutrin, Xanax, Zoloft, Ativan, Celexa, Cymbalta, Depakote, Haldol, Klonopin, Lexapro, Lithium, Lunesta, Compazine, Desyrel, Trileptal, and Valium, before they died suddenly in their sleep in February 2008 and July of 2009, respectively. The

New York Times reported, "What killed Airman Mena was not an overdose of any one drug, but the interaction of many."³³

- No one is held accountable for prescribing potentially lethal combinations of psychiatric medications to veterans, revealing a discrepancy in the law. Outside the military, doctors have been convicted of manslaughter and culpable negligence for prescribing addictive or dangerous cocktails of medicines. For example, Dr. James Graves' "chemical straightjacket" caused the death of four patients. Florida's Assistant State Attorney Russ Edgar said Graves should have reasonably known his prescriptions were "likely to cause death or great bodily injury."³⁴ He was sentenced to nearly 63 years in prison.³⁵

**ANTIPSYCHOTIC DRUGS
ARE ASSOCIATED WITH
GREATER THAN THREE-
FOLD INCREASED RISKS OF
SUDDEN CARDIAC DEATHS.**

**-DR. AUDREY UY-EVANDO
REPORT TO THE HEART
RHYTHM SOCIETY, 2013**

- A Florida psychiatrist Dr. George Kubski was jailed for one year, given 10-years' probation and ordered to provide \$150,000 for a trust fund for the 11-year-old daughter of Jamie Lea Massey, who went to Kubski for pain management and died of drug toxicity. Kubski had prescribed more than 20,000 pills in three months to Mr. Massey.³⁶

As stated in the Introduction, prescriptions written for antipsychotic drugs for active-duty troops increased 1,083 percent from 2005 to 2011, while the number of antipsychotic drug prescriptions in the civilian population increased just 22 percent.

Dr. Baughman Jr. points out, "The fact of the matter is that psychotropic drug polypharmacy is never safe, scientific, or medically justifiable."

Further, he called upon "the military for an immediate embargo of all antipsychotics and antidepressants until there has been a complete, wholly public, clarification of the extent and causes of this epidemic of probable sudden cardiac deaths."³⁷

POST-TRAUMATIC STRESS DISORDER (PTSD)

The problems for members of the Armed Forces facing war include anguish, fear in battle, sleep deprivation, extreme environmental conditions, chemical warfare and vaccines, adding stresses to an already life-threatening environment. Members of the Armed Forces and vets can experience debilitating flashbacks, nightmares and anxiousness.

But to diagnose this as PTSD and imply it is a *physical disease or abnormality* is misleading. There is no medical test—no blood or urine test, x-ray or brain scan—that can confirm PTSD is a disease.

- The American Psychiatric Association's *Diagnostic and Statistical Manual of Mental Disorders* (DSM) which lists the symptoms of PTSD has been criticized as unscientific and "clinically risky" which results in the "mislabeling of mental illness in people who will do better without a psychiatric diagnosis," and potentially harmful treatment with psychiatric medication.
- Leading U.S. National Institute of Mental Health-funded researchers of schizophrenia in a 2012 study stated: "The validity of psychiatric diagnosis and the DSM process is the focus of criticism because we have not identified the lesions, the diagnostic process depends upon 'soft' subjective phenomena...."³⁸
- A 2013 study in the *Journal of Law, Medicine and Ethics* reported: "It is of no coincidence that this manual (DSM5) relies on a biological disease model of mental illness that is not well supported by the evidence but that does promote the commercial agenda of drug firms...."³⁹
- The chairman of the DSM5 Task Force, professor of psychiatry David Kupfer conceded last year that "biological and genetic markers that provide precise [mental health] diagnoses that can be delivered with complete reliability and validity" are still "disappointingly distant."⁴⁰

A chemical imbalance in the brain has been marketed as a "possible" cause of PTSD. Yet even the American Psychiatric Association said that this was a theory that was "probably drug industry derived."⁴¹ It was developed to market antidepressants.

- A study published in 2005 in *PloS Medicine* found that the SSRI antidepressants ads “largely revolved around the claim that SSRIs correct a chemical imbalance caused by a lack of serotonin.” Yet, “there is no such thing as a scientifically correct ‘balance’ of serotonin.” Further, “not a single peer-reviewed article ... support[s] claims of serotonin deficiency in any mental disorder,” they said.⁴²
- In 2013, James Davies, a Senior university Lecturer in Social Anthropology and Psychotherapy said, “despite nearly 50 years of investigation into the theory that chemical imbalances are the cause of psychiatric problems, studies in respected journals have concluded that there is not one piece of convincing evidence the theory is actually correct.”⁴³
- Yet in 2011, a VA study found that 80 percent of veterans diagnosed with PTSD received psychiatric drugs. Of these, 89 percent were treated with antidepressants, and 34 percent were prescribed antipsychotic drugs.⁴⁴

**“THE VALIDITY OF
PSYCHIATRIC DIAGNOSIS
AND THE DSM PROCESS IS
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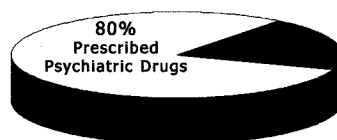
**- SCHIZOPHRENIA
BULLETIN, JANUARY 2012**

Members of the Armed Forces and veterans that are told that PTSD is caused by a chemical imbalance in the brain should be informed to require the medical tests to support the diagnosis, otherwise it violates their informed consent rights. One wouldn't undergo chemotherapy without first having the cancer confirmed with tests.

PSYCHOTROPIC DRUG USE & COSTS

A 2010 PBS Frontline documentary, *The Wounded Platoon* showed that American soldiers in *combat zones* did not take psychotropic medications prior to the Iraq War, but by the time of the 2007 surge more than 20,000 deployed troops were taking them.⁴⁵

Veterans Diagnosed with PTSD 2011

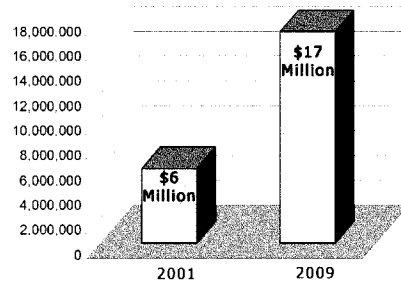


A VA study found 80% of vets diagnosed with PTSD were given psychiatric drugs. Of these, 89% were treated with antidepressants documented to cause suicidal ideation and aggression.

- Veteran Affairs and the Department of Defense (DoD) spent more than \$850 million on Seroquel between 2001 and 2011. The antipsychotic is prescribed to soldiers to treat “insomnia” for which it is not FDA approved.⁴⁶ 1.4 percent of soldiers and 0.7 percent of Marines on active duty in 2010—about 11,000 troops—had received prescriptions for Seroquel.⁴⁷
 - Some 54,581 prescriptions for Seroquel were written for active duty service members in 2011 alone—the vast majority as a sleep aid, a condition for which is it not FDA approved to treat.⁴⁸
 - Responding to the controversy over Seroquel, in 2012 the DoD conceded that antipsychotics are not an effective treatment for PTSD – a conclusion that an American Medical Association study had reached a year before—and removed Seroquel from its approved formulary list.⁴⁹
 - Yet in 2013, the Army announced it was conducting studies on hundreds of vets and service members to evaluate Seroquel and antidepressants to see how the drugs fit into the treatment of traumatized veterans.⁵⁰
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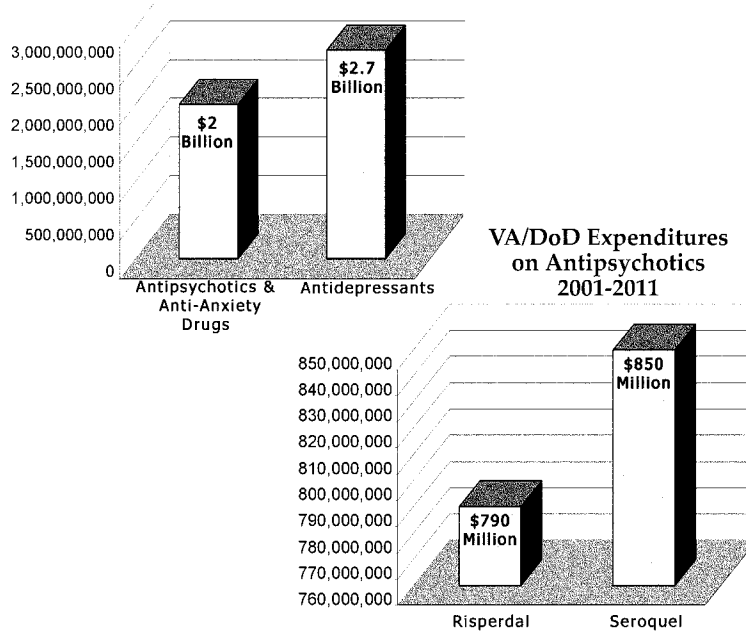
- Since 2001, the VA and DoD spent over \$790 million on another antipsychotic risperidone.⁵¹ Yet in 2011, the VA reported that Risperdal (risperidone) was no more effective in treating combat stress treatment than a placebo.⁵²
- The VA and DoD have spent almost \$2 billion to treat mental disorders, which has done nothing to reduce the rate of hospitalization of active troops for these conditions.⁵³
- Use of anti-anxiety drugs and sleeping pills such as Valium and Ambien increased 170 percent while spending nearly tripled, from \$6 million in 2001 to about \$17 million in 2009. Between October 2001 and March 2012, the DoD spent a total of \$44.1 million just on benzodiazepines, one class of anti-anxiety drugs.⁵⁴
- The VA and DoD spent \$2 billion on antipsychotics and anti-anxiety drugs combined from 2001-2011.
- The DoD also spent at least \$2.7 billion on antidepressants from 2001-2011.⁵⁵
- In 2012, it was reported the military had spent more than \$507 million on Ambien and its generic equivalents.⁵⁶ The drug may cause bizarre behavior, hallucinations, abnormal emotions, amnesia and neuropsychiatric consequences.⁵⁷

Anti-Anxiety & Sedative Military Spending in Millions



- In 2012, the Army Medical Command warned that the use of benzodiazepines such as Xanax and Valium could intensify combat stress symptoms and lead to addiction.³⁸ The Army Surgeon General's office also warned regional medical commanders against using anti-anxiety meds such as Klonopin, Ativan and Valium to treat PTSD.³⁹

U.S. Govt. Expenditure on Psychiatric Drugs for Military and Veterans 2001-2011



Although normally prescribed to treat psychotic disorders, anti-psychotics are largely being prescribed to treat insomnia in the military - for which they are not FDA approved.

RECOMMENDATIONS

We call for:

1. An inquiry into the potential violence- and suicide-inducing effects of prescribed psychiatric drugs.
2. An investigation into the sudden deaths of vets prescribed cocktails of antipsychotics and other mental health medications with accountability for the deaths and the standard of care given these vets.
3. Full transparency and accountability for the efficacy and results of existing mental health programs for the Armed Forces and veterans.
4. Improved informed consent laws with full searching medical examinations performed before a member of the Armed Forces or veteran can be diagnosed with a mental disorder.

CASE EXAMPLES

SGT. VINCINTE JACKSON, 40, stabbed to death Spc. Brandy Fonteneaux, 28, on January 8, 2012. He was convicted of and sentenced to life in prison for the unpremeditated murder and said he was “horrified” by the crime and takes full responsibility for his actions. But he doesn’t know why he did it. A defense attorney, Capt. Jeremy Horn, said that a combination of heavy drinking and a prescription antidepressant, Celexa, left Jackson unable to control his own actions or form any kind of plan to commit murder.⁶¹

MARINE LANCE CPL. DELANO HOLMES, 22, fatally stabbed an Iraqi soldier to death in 2007 after being prescribed Trazodone, Ambien and Valium.⁶¹ He was convicted of negligent homicide and received a bad conduct discharge from the Marines.⁶²

FORMER U.S. ARMY SPECIALIST KYLE WESOLOWSKI returned from Iraq in December 2010 following a brutal yearlong deployment. Psychiatrists at Fort Hood gave him “a cocktail of seven different drugs” for war-related mental health issues. More than three years later, Wesolowski came to the uncomfortable conclusion that the prescribed drugs made him homicidal. He contemplated murdering a young woman he met in a bar near the base. “I began to fantasize about killing her,” he said. Wesolowski, who is now off of most of the drugs he formerly took, is using his GI Bill benefits to attend college in Thailand.⁶³

SPC. ANDREW TROTTO, a 24-year-old Army gunner, was prescribed as many as 20 psychiatric medications, starting while in combat in Iraq when he had difficulty falling asleep. He was prescribed the antipsychotic Seroquel. His body adapted to it and he was soon taking a dose meant for psychotics. “They had no clue what the hell they were doing,” Trotto says of the doctors at the battalion aid station who prescribed the pills. “They just throw you on a drug, and if it doesn’t work, they throw you on something else. ‘Try this. Try this. Try this.’” In addition to Seroquel, he was taking the antidepressant Zoloft and Vicodin to relieve pain from ruptured disks he sustained falling nine feet off a tank. “Let me remind you,” he says, “I was a gunner, completely whacked out of my mind. There were quite a few of us on Seroquel and antidepressants.” While in a warrior-recovery unit in Kuwait, he locked himself in an outside toilet with a loaded M16 in his mouth, but he managed to hold out long enough to seek help. “I told them, ‘You need to do something, or I am going to take other people out with me.’” His mother, Gina, says: “This was the all-American kid. He never had psychiatric problems or problems with suicide. They took a young

man who was reacting normally to an abnormal situation – which is war – and they shoved him on an antipsychotic. I watched him become a completely different person. My son ended up gaining 40 pounds from all these medications... I was watching my son slowly die.”⁶⁴

RONALD BRUCE WEDDERMAN, 55, a National Guard staff sergeant who fought in Iraq in 2005, returned home and VA doctors prescribed him the antidepressant Trazadone for sleep and Prozac. He says the combination was nearly lethal. “At one point I had two pistols raised to my head on the beach. Somebody called the police. They found me yelling and screaming at people and waving my guns.” Wedderman has not taken Trazadone again, and he hasn’t tried to kill himself, either.⁶⁵

JOHN KEITH, 35, was put on Seroquel and the antidepressants Trazadone and Zoloft by a VA doctor in a single visit. “I called my doctor up and said, ‘I just threw my friend’s furniture off a third-story balcony.’ [The doctor] said, ‘Well, just cut the new pills in half’...At first they give you one or two or three, and you try those for a couple of weeks....But they keep giving you more and more, and by the end of it, you’re on 17 medications.” Since getting off the drugs and forming an organization to help vets manage their paperwork, Keith has processed more than a thousand veterans’ disability claims. He says, “I have never seen a veteran who is or was on less than five medications.”⁶⁶

KELLI GRESE, former Navy corpsman, 37, on Veterans Day 2010 swallowed an unknown quantity of the antipsychotic Seroquel – her fourth suicide attempt in eight months using the same drug. Her death was the subject of a \$5 million lawsuit filed against the VA in December 2012.⁶⁷ The government ultimately settled the lawsuit, although it admitted no liability.⁶⁸ Between 1991 and 1997, Kelli and her sister, Darla, served in the U.S. Navy. In 1995, while serving in Naples, Italy, they were the victims of a home invasion by three men. Although they were physically unharmed, they were diagnosed with PTSD. Kelli continued to be a highly functioning, exceptional sailor: Her evaluations were superb; she was nominated for Junior Sailor of the Quarter at the end of her career; she managed and participated on the command color guard team. However, she was discharged from the Navy due to the PTSD and migraine headaches. There followed years of being prescribed up to 20 different psychotropic drugs as well as painkillers. In 1999, according to Darla, who kept meticulous

records of Kelli's medication, 5,370 Klonopin, an anti-anxiety drug, were prescribed. Kelli worsened. In 2002, the VA began her on a "trial" of Seroquel in addition to other drugs, including Zoloft and Geodon. She attempted suicide. And still, her medication list ballooned until on November 12, 2010, she killed herself.⁶⁹

CPL. CHAD OLIGSCHLAEGER, 21: For seven months in 2006, the marine patrolled a war-torn city in Iraq. When he returned to his home base he drank heavily, panicked at the sound of a car backfire, swerved around potholes as if they were roadside bombs and had visions of dead friends. He was diagnosed with PTSD and recommended him for a substance abuse clinic in San Diego. Instead, he was sent to a month of live-fire training in a mock Iraqi village in the High Desert in preparation for another deployment. Although the second deployment was less violent, his return to Iraq plunged him into the memories of his first tour. He was recommended psychoactive drugs, starting with Prozac. Over the next two months, Oligschlaeger's symptoms worsened, but his prescriptions increased and by mid-May, he had at least seven active prescriptions, totaling 18 pills a day. He was found dead on the floor of his barracks room on May 20, 2008. All signs pointed to suicide. But an autopsy revealed he had taken the pills that military doctors gave him, dying of accidental "multiple drug toxicity." The Marine's blood held a mix of two antidepressants, an antipsychotic, two kinds of benzodiazepines, and propranolol, a beta blocker sometimes used to subdue fears. A seventh drug was a small amount of methamphetamine, which may have been from illegal drug use or it could be a false positive from over-the-counter medication. None of these drugs had been taken in deadly dosage, but together they had proven fatal.⁷⁰

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THE CITIZENS COMMISSION ON HUMAN RIGHTS INTERNATIONAL

The Citizens Commission on Human Rights (CCHR) is a non-profit, non-political and non-religious mental health watchdog established in 1969 by the Church of Scientology and the late Dr. Thomas Szasz, professor of psychiatry, Syracuse University of New York Health Science Center. It works to enact protections for and increase consumer rights especially informed consent rights, and raises public awareness about psychiatric abuses.

It has assisted many thousands of individuals who have been adversely treated in the U.S. mental health system and around the world. It is the only group that has obtained more than 160 consumer/mental health patient-protection laws in the world, receiving recognition from the Special Rapporteur to the United Nations Human Rights Commission for being "responsible for many great reforms."

Several Congressional recognitions of our work includes a Resolution by Congresswoman Diane Watson, which "highly commends CCHR for securing numerous reforms around the world, safeguarding others from abuses in the mental health system and ensuring legal protections are afforded them."

Its board of advisors, called Commissioners, includes doctors, psychologists, attorneys, educators, artists, businessmen, and civil and human rights representatives.

CCHR's work aligns with the UN Universal Declaration of Human Rights, in particular the following precepts: Article 3: Everyone has the right to life, liberty and security of person and Article 5: "No one shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment."

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