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CONGRESSIONAL TESTIMONY OF HEARING ON
VETERAN SUICIDE PREVENTION
BY PANEL OF EXPERTS FROM THE
U.S. DEPARTMENT OF VETERANS AFFAIRS
BEFORE THE
U.S. HOUSE VETERANS' AFFAIRS SUBCOMMITTEE ON HEALTH
DECEMBER 2. 2011

BUERKLE:
Good morning. And welcome to this morning's subcommittee on health hearing. Today, we meet to search for your answers to the most hunting of questions. What leads an individual who so honorably served their nation out of helplessness and homelessness to take their own life? And how do we prevent such a tragedy from happening to one who has bravely worn the uniform and defended our freedom?
Suicide is undoubtedly a complex issue but it is also preventable one. And I'm deeply troubled by its persistent prevalence in our military and in our veteran communities. The statistics are sobering. 18 veterans commit suicide each day with almost a third receiving care from the Department of Veteran Affairs at the time of their death.
Each month there are 950 veterans being treated by the VA who attempt suicide. The number of military suicides has increased since the start of operations Enduring Freedom and Iraqi Freedom, with data from the Department of Defense indicating service members took their lives at an approximate rate of one every 36 hours from 2005 to 2010.
We continue to hear tragic stories despite significant increases in recent years, in the number of programs and resources devoted to suicide prevention among our service men and our veterans. Today, we will hear from the VA that they are making strides in identifying at risk service members and veterans and providing treatment for mental health and other disorders that can lead to suicide.
Yet, no matter how great our programs are or services are, if they do not connect with those who are in need, they do no good at all. The VA and the DOD continue to struggle with persistent obstacles including data limitations, cultural stigma, access issues, a lack of partnerships with community providers and outreach that relies on the service member, veteran or loved one to initiate the treatment.
We must do more to reach out to our veterans inside and outside of the VA and the DOD healthcare systems to ensure that all those who need the help get it. They've earned it and they deserve it before time runs out on them. Until the family no longer must bare the pain of losing a loved one, we are failing. And not enough is being done.
I thank you all very much for joining us this morning. And now, it gives me pleasure to introduce and recognize the ranking member, Mr. Michaud.

MICHAUD:
Thanks very much, madam Chair. I too would like to thank everyone for attending today's hearing. It is a tragedy that our service members and veterans survived the battlefield abroad only to return home to suicide.
Since 2007, this committee has held five hearings regarding this issue of veteran suicide, and the figures continue to increase at an alarming rate, far greater than the comparable suicide rate among the general population. The center for a new American security in a recent publication studied entitled "Losing the battle, the challenge of military suicide" says that from 2005 to 2010, service members took their own lives at a rate of approximately one every 36 hours. This statistic is troubling. But it pales in comparison to the VAs estimate that one veterans die by suicide every 80 minutes. While I commend the VAs effort to reduce the suicide rate, particularly with the success of its veteran's crisis hotlines, challenges still remain.
Through this hearing, we will examine the steps, the VA is taking to strengthen data collection, to pinpoint veterans who maybe at risk and to offer effective intervention. In this process, we'll also seek to better understand the reasons

why more and more service members and veterans are taking their own lives and what VA and DOD are doing to put a stop to more suicides.
I would like to thank our panelists for appearing before us this morning. Particularly I'd like to commend Dr. Kemp for her leadership. Under her direction, the VA has made great strides in their suicide prevention efforts. Dr. Kemp's work is award winning. And she has been named Federal Employee of the Year in 2009.
I'd also like to thank Maine Army National Guard for submitting written testimony and for their effort to insure that every soldier has access to care that they need. The Maine Army National Guard already has a close working relationship with the suicide prevention staff at Togus VA Hospital.
This is a relationship that must be replicated at the national level through cooperation between the VA and the DOD. Unfortunately, as the Maine Army National Guard testimony points out, too many soldiers including those not eligible for VA benefits and those who do not have health insurance struggle to find care.
I look forward to the hearing from all the witnesses today to discuss how we can improve the access to treatment and prevention effort to best serve our nation's veterans. I want to thank you, Madam Chair, for having this very important hearing today. I look forward to work with you as we move forward to address these very important issues. I yield back the balance of my time.

BUERKLE:
Thank you very much. Before we begin, I would like to yield just a moment to Dr. Roe, who I understand has a special constituent in the audience if you would like to recognize.

ROE:
Thank you, Madam Chairman. And thank you for having, holding this hearing. Actually he's not a constituent, he is somebody I actually met on the phone at first. And then had a chance, the privilege to meet him in Memphis last fall. And this is -- and Ron, would you stand, please?
Madam Chairman, this is Ron Zalski. He's a veteran of the Marine Corps. And he walked across America barefooted to raise awareness for veteran suicides. And as he walked he wore a large sign that said -- you'll see displayed in this committee room -- stating that 18 vets a day commit suicide.
In order to bring attention to PTSD in the military, given today's hearing topic I want to make sure that we invited this veteran and recognize his tremendous efforts on the military suicide and PTSD. And I understand that Mr. Zalski has brought testimony with him today. And I asked unanimous consent that they've submitted before the congressional record?

BUERKLE:
Without objection.

ROE:
Thank you. And Ron (ph), just from another veteran, and a veteran that just returned from Afghanistan about six weeks ago. That the way that this is treated today, the way PTSD is acknowledged and treated today is totally different than the end of Vietnam when I got out of military. And I think we had a vacuum of 20 years of which we ignored our veterans and you being one of them, me being one of them.
That's not happening now, and it's not happening now thanks to people like yourself who took the time out to make this tremendous sacrifice for your fellow veterans. So I want to thank you. And I wanted this room to give Mr. Zalski a great round of applause.
I yield back.

BUERKLE:
Thank you, Dr. Roe. And thank you, Mr. Zalski for being here for your service to our nation, and for what you're doing to raise awareness on behalf of our veterans. Before I welcome our first panel I must, and would like to express my extreme disappointment that the National Institute of Mental Health declined to participate as a witness this morning in our second panel.
Although a formal letter of invitation to testify was sent on November 7th, the Committee staff was informed on November 23rd that bureaucratic obstacles in clearing a statement would prevent the agency for being a part of today's discussion. I find this unacceptable especially given NIMH's partnership with the Department of Army to administer the largest study on suicide and behavioral health in the military, the Army study to assess risk and resilience in service members; our military deserves better.
In addition, I would like to note that unfortunately our Department of Defense witness, Colonel Castro is unable to be with us this morning due to an illness. Today, we will begin this serious discussion and given its importance and the critical need for VA and DOD to work together in collaboration.
I expect and I fully expect to follow up with additional hearings and oversight that will include DOD as a partner in this new year. Now, we would like to invite our first panel to the witness table. It's always a pleasure to welcome the members of our veteran service organizations to share their expertise with us.
With us today are Commander Rene Campos, the Deputy Director of Government Relations for the Military Officers Association of America. Mr. Tom Tarantino, a senior legislative associate for the Iraq and Afghanistan Veterans of America. Dr. Thomas Berger, the Executive Director of the Veterans Health Council for the Vietnam Veterans of America. And Ms. Joy Ilem, the Deputy National Legislative Director for the Disabled American Veterans.
Thank you all very much for joining us this morning for this very important conversation. Commander Campos, we will start with you. Please, proceed.

CAMPOS:
Madam Chairman and distinguished members of the sub- committee, on behalf of the 370,000 members of the Military Officers Association of America, I am grateful for the opportunity to present testimony on MOAA's observations concerning the VA suicide prevention programs and efforts.
MOAA thanks the sub-committee for its interest and its extremely difficult issue, and for your commitment to the health and well being of our veterans and military families. In conducting my research for this hearing, we were really struck by the tremendous amount of work that has been done, the steadfast determination of the VA central office staff and Secretary Shinseki's personal involvement in synchronizing the agency's suicide prevention efforts is quite visionary.
The two most impressive initiatives are the VA suicide prevention campaign. And thanks to Dr. Kemp, the National Veterans crisis line. Despite the improvements, the VA concedes barriers still exist to advancing suicide prevention to the level needed.
Veterans and family members we talked to have seen great progress in improving policies and programs. But they've seen it at the national level. They don't know how we see these programs and policies implement it consistently across all VA medical facilities. Here are some of the experiences veterans and their families have told us.
One caregiver spouse of a veteran with PTSD said that it took the VA two months to schedule an appointment just to get a fee based referral for her husband who needed, who had some difficulty with sleeping. Now, the veteran must wait till May, 2012 for the VA to do a required sleep study.
The caregiver questions why it's taken almost a year for the VA to give her husband the care he needs. Especially since the VA knows that difficulty sleeping is a risk factor. And her husband has a history of suicide attempts. Another caregiver spouse of a veteran with PTSD and TBI told us, that when my husband attempted suicide in March, the VA doctor told me to go to the ER.
But the ER had no beds, and said he may have to wait 24 hours before one was available. They gave me no

alternatives. I was scared and no one in the VA did anything to help us or help me know what to do in a situation like that. Finally, one severely disabled veteran with TBI said that he was frustrated because his providers seldom talked to him or asked him how he's doing. He usually talked to the caregiver.

I just want them to know that I can contribute to my care. When they don't talk to me it makes me feel like they don't care about me. MOAA urges Congress to take immediate action on three recommendations where which will further enhance VA's suicide prevention efforts as well as address other systemic issues.

One, require VA and DOD to establish a single strategy and joint suicide prevention office that reports directly to the department secretaries through the senior oversight committee. Congress has been VAs and DODs greatest champion on promoting collaboration after Walter Reed. We need that level of oversight now.

Two, authorize funding to expand VHA Mental Health capacity and capability in order to improve access and delivery of quality and timely care and information. There needs to be research that includes a longitudinal study of the economic and societal costs of veterans suicide and its country.

And three, authorized additional funding to expand outreach and marketing efforts to encourage enrollment of all eligible veterans in VA healthcare with special emphasis on the Guard and Reserve, rural veterans and high risk populations. In other words there needs to be a long-term investment in outreach and marketing to improve VA's image and its brand if you're going to attract veterans to the system.

MOAA believes that there is a business case for addressing suicide that should consider the impact of National Security and the long-term cost of society of failing to do so. We have no doubt, with the will and the sense of urgency from Congress, the Administration, DOD and the military services and VA, we can win the war on suicide. After all, our veteran and military medical systems have eliminated some tremendous barriers with unprecedented results in saving lives on and off the battlefield. We owe these heroes and their families our full commitment and eliminate remaining barriers to mental healthcare so they can obtain the optimal quality of life.

MOAA is encouraged by the significant progress made by the VA. We thank the sub-committee for your leadership and your support in helping our nation's veterans and their families. Thank you.

BUERKLE:

Thank you, Commander Campos. Mr. Tarantino, you may proceed.

TARANTINO:

Thank you, Madam Chairwoman, ranking member Michaud, members of the committee. On behalf of Iraq and Afghanistan Veterans of America's 200,000 member of veterans and supporters, I want to thank you for inviting me to speak on this pressing issue facing veterans and their families. And that's the staggeringly high rate of suicide, not just amongst the veterans but service members as well.

My name is Tom Tarantino. And I'm the Senior Legislative Associate for IAVA. I proudly served the Army for 10 years, beginning my careers in enlisted reservist and ending as an active-duty cavlary officer.

Throughout these 10 years my single most important duty was to take care of other soldiers. In the military, they teach us to have each others back both on the battlefield and off. Although my uniform is now a suit and tie, I've been proud to work with Congress to continue to have the backs of America's veterans and service members.

And today's hearing on suicide really couldn't have come at a more critical time. The Defense Department recently reported that 468 active duty and reserve soldiers, sailors, airmen and marines committed suicide in 2010. Overall the DOD tracked 863 suicide attempts, and the rate for veterans is likely much higher.

Although we have this limited data about service members there remains a fundamental gap when it comes to understanding veteran suicide. One of the greatest challenges in understanding and preventing veteran suicide is this lack of full data. If we don't know the entirety of the problem, how could we ever hope to solve it.

Even in this age of information and technology, we have no way of tracking veterans unless they interact with some social service that happens to ask about their military service. Frankly, this is unacceptable. To address this problem,

we have to look a little bit outside the box.

IAVA recommends that we need to collect this data, and we should do it by expanding existing services like the Center for Disease Control and Prevention's National Violent Death Reporting System. Currently the CDC collects data on all manner of violent death including suicide in 16 states.

Veteran status can be reported to the CDC either through the death certificate or by information collected by the medical examiner. If we expand this data base to all 50 states and require medical examiners to report veteran status to the CDC then we can get a much clearer picture of the problem and know where can better target our limited resources.

Critical steps on understanding how we can stop veteran service member suicides is to understand that suicide itself is not the whole issue. Suicide is the tragic conclusion of the failure to address a spectrum of challenges that veterans face. These challenges are not just mental health injuries, they include challenges finding employment, reintegrating into family and community life, dealing with healthcare and benefits bureaucracies that frankly are almost as traumatic as the injuries themselves.

Fighting suicide is not just about preventing the act of suicide. It's about providing a soft and productive landing for veterans when they return home. The problems of the mental healthcare in the VA system have been pretty well documented. The VA reports that 18 veterans in their care commits suicide everyday. And wait times for mental health care as Commander Campos has mentioned are still unacceptably high.

And there's just not enough mental health care providers to meet the need. We also know that many veterans may not be seeking care because of the stigma attached to mental health injuries. Multiple studies confirm that veterans are concerned about seeking care because it could impact their career both in and out of the military.

To combat this, IAVA recommends that the VA and the DOD partner with experts in the private, the non-profit community to fund a robust, aggressive outreach campaign. This campaign needs to focus on directing veterans the services such as the veteran centers as well as local community based and state based services. It should be integrated into local campaigns such as San Francisco's new veterans 311 campaign for their city.

This campaign needs to be well funded and reflect the best practices and expertises in both the mental health and the advertising fields. It drives me nuts every time the VA asks me, how do you reach out the veterans. I told them to stop reaching out the veterans, reach out to people. And why are you asking me? Go ask the people who know how to sell toothpaste. They can put your campaign in front of 40 million eyeballs. Me, not so much.

Providing a smoother transition from the military to civilian world is critical in preventing veteran suicide. Insuring veterans actions, access to mental healthcare is connected to other issues that can contribute to a veteran's sense of stability throughout their transition home. We must tackle the other contributing factors such as employment and homelessness that can increase the risk of veterans who are vulnerable to suicide.

The responsibility of building a support network doesn't necessarily lie with the military and the veterans' families alone. Preventing veteran suicide is about easing the transition for military to civilian life. And it's our collective responsibility as a community. Our veterans are not just readjusting to their families or connecting with other veterans, they're coming back to jobs.

They're the GI Bill to go to school and study at local colleges, and they're seeking care and services from businesses and providers across the community, and outside of the veterans network. We must focus on extending this understanding not just to spouses but also to society at launched.

Teachers and professors should know what students of theirs are veterans or the children of veterans and service members. Businesses should invest in the leadership of returning veterans by hiring them. Healthcare providers must understand the injuries facing these incredible men and women.

By promoting awareness, we can ensure that our entire community is able to support veterans throughout their transition back to civilian life and help stem the tide of veteran suicide. By accurately measuring the problem, by improving access to mental healthcare and tackling the transition for military to civilian life, and creating a robust community of support, we may be able to significantly reduce the number of veterans that attempt to commit suicide

every year.
Veteran suicide does not have a silver bullet solution. No one bill is going to solve this problem. But better practices are out there and we don't want to have to ask ourselves if there is something more we could have done.
Thank you very much for your time and attention. I'll be glad to take your questions.

BUERKLE:
Thank you, Mr. Tarantino. Dr. Berger, you may proceed.

BERGER:
...Veterans Affairs sub-committee on health, Vietnam Veterans of America thanks you for the opportunity to present our views on understanding and preventing veteran suicide. We want to also thank you for your overall concern about the mental health, care and issues affecting America's troops and veterans.
When I got up this morning, I beg your indulgence. When I got up this morning to get ready to come down here I turned on my little Blackberry here. And I had a message from a colleague who lives in North Central states of the U.S.
My colleague is also the mayor of a small town in this state, and a member of VVA National Board. And this is the message I received this morning, Sergeant --, 31 years old from - will be buried in Arlington Cemetery. U.S. army, two tours in Iraq, one tour in Afghanistan, walked into the emergency room at -- in this particular city and the state. And stated to a nurse on duty that someone outside needed help. He went outside and shot himself in the chest. On his arm was a note. He had written his blood type, A-. And he had written, "Please, use my organs for someone more worthy than me." I'm a little bit upset this morning to come in obviously and talk about this issue after receiving this email this morning.
We've been here before, we're 10 years into the war, ladies and gentlemen, I appreciate the comments of my colleagues here. And I wont belabor the fact that there had been some excellent efforts made by Dr. Kemp and her division there, and I'll leave it at that. But I'll try and take the rest of my allotted time and talk about VVAs concern with suicide within the system.
It's very challenging as we've heard, to determine an exact number of suicides. Many times suicides are not reported. And it's very difficult to determine whether or not a particular individual's death was intentional. For suicide to be recognized obviously examiners must be able to say that the deceased meant to die. And other factors that contribute to the difficulty including differences amongst states as to who is mandated to report a death as well as changes over time in the coding of mortality rates.
But those aren't the problems. The problems, OK, and VVA has long believed in the links between PTSD and suicide. And in fact, there's plenty of research studies out there yp suggest that suicide risk is highest and persons with PTSD. Others claim that suicide risk is higher in individuals because of related psychiatric conditions.
But a study publishing or published by the national co-morbidity survey showed that PTSD alone out of six anxiety diagnoses was significantly associated with suicide ideation or attempts. Now, some studies point to PTSD as the cause of suicide, suggesting that high levels of intrusive memories can also predict the relative risk of suicide.
Anger and impulsivity are two more factors that are on the list as you all know are part of the symptomology for PTSD. Other research says that the most significant predictor of both suicide attempts and preoccupation with suicide is combat related guilt particularly amongst Vietnam vets.
All of this brings us full circle to what VVA has been saying for at least the last six years. If both DOD and VA were to use the PTSD assessment protocols and guidelines as strongly recommended by the institutes of medicine back in 2006 then our veteran warriors would receive the accurate mental health diagnoses needed to assess their suicide risk status.
Thank you. I'd be glad to answer any questions.

BUERKLE:
Thank you, Dr. Berger. Ms. Ilem, you may proceed.

ILEM:
Thank you, Madam Chair and members of the sub-committee. I'm pleased to present the DOD's views on suicide prevention efforts in the Department of Veterans Affairs. We appreciate the sub- committee's continued focus on this difficult issue and on the effectiveness of VA's mental health services.
Suicide is a complex phenomenon, and one which VA and DOD have struggled in finding preventative solutions and effective strategies in the shadow of wars. DAV observes that VA and DOD have made feasible and positive efforts to address the unique challenges in meeting the mental health needs of post-deployed active military personnel and newly returning veterans.
Both agencies are populated with dedicated practitioners and specialists, researchers, policy makers and other leaders who continue developing new approaches to address suicide and attend to the other serious emotional and behavioral consequences of war. However, despite this obvious efforts and notable progress they've registered, it's clear that more needs to be done.
All the experts tell us that effective suicide prevention must begin with strategies for routine mental health screening and early intervention for everyone accompanied by ready access to comprehensive primary care and especially treatments for suspected serious problems identified.
If not readily addressed or untreated problems of these types can easily compound and become chronic. Delay in treatment may lead to a host of personal and social problems including early discharge from the military or other job loss, family break up, homelessness, criminal incarceration and even suicidal thoughts and action.
In our opinion VA has made valid efforts for early identification and effective treatment of behavioral problems in returning war veterans. Likewise Congress provided VA significant increases in resources to institute system wide changes, expand mental health staffing, integrate mental health services into its primary care system, develop a specific suicide prevention program, expand programs for PTSD, substance use disorders and training on evidence based psychotherapies.
As we understand it that the goal of VA strategy is to promote healthy outcomes and strengthen family unity with the focus on recovery. In addition to the goal of recovery VA has adopted, now adopted a patient centered model of care. These are the changes veteran say they want, and we believe all of these efforts are moving VA in the right direction.
But over the past several years, a number of Congressional hearings have been held, studies conducted and informal surveys done related to the effectiveness of VA mental services including questions about how to alleviate the known access problems, stigma, gaps in services and other identified barriers to VA care.
The results help us frame the problem but they do not solve it. Based on the number of factors all of us are acutely aware of, it appears that real challenges still blocks VAs goals of meeting the most severe needs of the minority of new veterans who require intensive therapies and who consume significant blocks of time of VA practitioners.
In VA, these are the same professionals who must also meet the mental health needs of a large population of older veterans with chronic and severe mental illness, in a constrained resource environment. Growth in demand for mental health service impacts all of VAs providers and patients. Unfortunately, it appears that VA is still struggling to figure out the right balance to ensure and identifies those few crucial cases with a high risk of suicide while still meeting the needs of other veterans and the older chronically ill populations in a clinically appropriate way for all.
(inaudible) preventing suicides is the most pressing public issue. With even more troops returning home by the end of the year and many who will likely transition to veteran status is an extremely complex mandate to me. Yet, VA is attempting to do it and must succeed.
In closing, DAV believes VA is moving on an appropriate direction but must find a way to hear direction must find a way to hear directly from veterans trying to gain access to the system to better understand their unique needs and desires for treatment and services, and then tailor programs accordingly. We also believe that listening to veterans'

feedback and making necessary changes are going to be essential to recreating a VA mental health system that meets veterans where they are, that works for them and is effective in achieving the recoveries they all seek. Likewise, VA leadership must acknowledge and address the challenges its providers are bringing to light. We encourage VA leadership to build on that knowledge to come and to be more forth coming in dealing with the challenges it faces. But despite DAVs concerns as expressed here in my written statement we do recognize the lifelong dedication of the leaders of VAs office of mental health and VA practitioners in the field.
We appreciate their tireless commitment to improving the system for all veterans in need, old and new. Madam Chairman, this completes my statement. I'd be happy to answer any questions you may have.

BUERKLE:
Thank you very much. And thank you to all of our panelists. I will now yield myself five minutes for questions. Dr. Berger, you mentioned that for years your organization has advocated the use of the PTSD assessment protocols and guidelines. Could you discuss these standards and how you think that they would improve the situation and the quality of care for our veterans?

BERGER:
If I may, Madam Chair. A little bit of history, the VA itself commissioned a group of some of the most distinguished mental health experts in the country including some people who are on the staff of the VA itself, some years ago in the early 2000s, about 2005 or so, to take a look at and develop a series of guidelines and protocols to diagnose and assess PTSD. They did so.
And in my written testimony I have the link to that document. Subsequently there was no directive in any aspect or area of the VA to utilize this document. But they paid all this money for and utilize the time and service of these brilliant minds. Alright. We still have reports of people being assessed on the basis of a 30 minute interview where most of the time, the clinician is taking personal information.
Those are the kinds of things that the guidelines in our opinion, the protocols that were developed were meant to minimize, but they still exist. Granted since the IOM report was issued there are many more clinicians who are aware of the guide and protocol, but largely because of our efforts to educate them on this through our network of state council chapters and that sort of thing.
So that's where it stands at the present time. We just wish that it would utilized by both DOD and VA. And we feel that if the correct assessment and diagnosis is made then they can move on to the suicide risk assessment, and everything should just follow along.

BUERKLE:
Thank you, Dr. Berger. I'd like to think that there is no lack of will to get to the root of this problem and to get our veterans the services they need to avoid these suicides. And so I would ask each one of you, where do you see, what to you is the biggest gap, the biggest reason why we are not getting this problem solved? It's getting worse instead of better. What's the one thing we need to focus on?
I'd like to hear if you could just tailor your remarks so all four of you get the opportunity to respond. I would appreciate it. Thank you. Let's start with Commander Campos.

CAMPOS:
Yes, ma'am. I think that's a very valid question. I think admittedly in recent hearings and as early as yesterday, VA admits that and we found in our research is that there are definitely policies and programs in place. But the challenge to VA is the execution and the implementation of these policies.
It is a decentralized system. And I think what we are hearing is that there's so much focus now at the medical facility level of getting the numbers and getting people seen and so on that I think that has become more of an assembly line

process. And it's creating I think havoc in the system and then you have the pockets where there aren't enough resources and staffing, and facility infrastructure that the system is overwhelmed and the resources, and the staffing and all the other needs to support the system are not out there consistently.
So I think for VA to get to a system of being veteran centric, they're going to have to step away from focusing on investigation, looking at the numbers and start looking at the veterans themselves. And what their needs and letting them be part of the discussion.

BUERKLE:
Thank you. Mr. Tarantino?

TARANTINO:
I know this is going to kind of sound lame but outreach and awareness. I mean bottom line, the VA has good programs. It has the crisis line, it has the new making connections program which I think is pretty slick and pretty cool.
The problem is nobody knows what the VA does, nobody barely even knows that the VA exists. If you'd go outside and pull 100 people off the street and ask them what NASA does, I guarantee you you're going to get 90 of them and they're going to give you a pretty decent answer and NASA affects a fraction of a percent of the population directly in this country.
Six percent of the population will be directly affected by the VA and you'd be lucky if maybe 10 out of those 100 will be able to tell you what the VA does and what programs they have. It's because as a community we're so insular. We're insular to the veterans' community, the military community.
And as the veterans' population is dynamically shrinking we have to stop that and we have to change the way we think about outreach to veterans and we have reach out to families, to the community. Why? There's not that many of us in my generation of veterans and guess what I'm a soldier and I'm also kind of a knucklehead. I'm not the one who is going to go out and seek help. It's going to be my girlfriend, my mom, my best friend. Those are the people you have to reach out to and that's where we need to focus our efforts to stem the tide of this.

BUERKLE:
Thank you. My time is expired and I now yield to the ranking member Mr. Michaud.

MICHAUD:
Thanks very much Madam Chair.
Doctor Berger, you had mentioned the fact that the VA has gone full circle and talked about DoD and VA using the PTSD assessment protocol and guidelines. That was one of his recommendations.
And I'd like to have and I'd ask the other three individuals whether or not you agree with that assessment that that's a good place to start.
I'll start with the commander.

CAMPOS:
I don't think I have the expertise to really address that but I don't think we ever go wrong by including VA and DoD collectively and collaboratively in addressing this issue.

TARANTINO:
Yes.

ILEM:
I think what Dr. Berger indicated whether research indicates that direct link with higher risk of suicide for those with PTSD so certainly it's absolutely critical to make sure that people do get diagnosed, or at least addressing that there is a readjustment issue that needs to be dealt it to be able to get the proper treatment and to avoid and prevent any further, you know, suicide or other, you know, negative behaviors that can really impact them.

MICHAUD:
Thank you. My next question for all of you and we've heard the testimony of how the different VA facilities do things differently in terms of accountability, oversight, monitoring and evaluation of what the VA is doing to implement strategies across the system, so that our veterans are getting the proper health care needs, what would - is there that you think we should be doing specifically or advice you'd have for VA as far as the accountability and oversight monitoring?

ILEM:
I would Dr. Shohan (ph) has indicated that one of her goals in coming into the system and with the new development of sort of one focused on policy issues and the other focused on driving that, those policies out to the field and making sure implementation is critical.
So I would be interested to hear more from her on the second panel in terms of how they think that's going. I know they're trying to work on the standardization of the package that they've, you know, developed for mental health and kind of a robust package in place at all places and to decrease that variance but it's absolutely the critical piece is who is connecting with the field, listening to the feedback from providers and the directors and the leadership in the field where they are having the problem and doing that.
What's the problem, you know, is the lack of staff, lack of resources, just over a significant increase in veterans coming in so I think it can be unique in every location and some places have a problem and others don't, but having those connecting up is essential.

BERGER:
And I'd like to support my colleague in his earlier comments about outreach. The fact of the matter is that almost 70 percent of America's veterans do not use the VA for lots of different reasons.
So we're not getting the word out there and the word that is getting out there or the image that is projected because of the shortness in resources and variability and accessibility of program concerns, that's not coming in.
The VA has to do a better job in terms of its outreach program for the stuff that it does offer to get to the veterans and let's get away from this development of policies and all these other kinds of things that seem to get in the way of actually getting out there to our veterans and make sure that they get the message that this is the system that was developed and is in place for them.

CAMPOS:
I did have the opportunity to talk to a DOD mental health professional before the hearing and I know that there are folks out there who really want to work closer with VA. I know VA wants to work closer with DOD and either leadership issues.
And this mental health professional said, the best thing we can do especially when we know people that are at high risk when they leave the military service is to do that warm hand-off to the VA where that veteran will go to. They want to do it but again sometimes the barriers and bureaucracies get in the way and I think that there are people in the VA system who really - who are veterans themselves and I think they can - they can actually probably find some of the solutions that plague the VA bureaucracy.

BUERKLE:
Thank you.
And I now yield five minutes to the gentleman from Tennessee.

ROE:
Thanks, Chairwoman, for yielding. And I don't understand why NIH wouldn't be here and I think we need to have an explanation and it boggles my mind, but anyway one of the - Mr. Michaud and I, I guess, two and a half years ago went to Afghanistan and we went back to Afghanistan about six weeks ago to look at where the injuries occur at the point of the spear, follow those physical and psychological injuries to launch to - to the forward surgical hospital to Kabul or Leatherneck, to (inaudible).
And this Monday I was at Walter Reed Bethesda and then next week I'm meeting with Dr. Brown (ph) who is a psychiatrist at the VA in Mountain Home to try to close the loops so that I have made full circle.
What's happening now in Afghanistan and I assume in Iraq, the 101st Airborne Division really made a real effort in TBI and PTSD to get on top of that early. And what they've found by doing that and I won't go through all of the things we saw, but they actually got the fighter back in the war, back in the battle sooner by being proactive in treatment. So I think that that's being done.
And, Dr. Berger, I mean, that's heart-breaking what that email you just read. I know that didn't affect one person, that affects that family. That family will deal with that every Christmas for the rest of their lives, that family member will be.
Tom, you had mentioned about getting the information out. Yesterday, we had -- well, I don't know if you know Jim Young or not, but Google has -- you probably do. Google has two people assigned -- DOV assigned -- to help in their Google search engine to get information out which is how a lot of young people are treated in the theatre for instance.
Many of them are in isolated places and they use Tele-Health. And a lot of our younger soldiers -- not like me, I mean, I couldn't do that. But they enjoy or it's easier for them the cause of the stigma of PTSD. They much prefer that. And in some instances, that works very well. I think that would work here stateside very well where you have overly burdened VAs. So that's one thing. I know there's an organization we also went to this week, Not Alone, I'm sure you aware of them, too. They're in 20 something states now, who on their own outside the VA are another resource for veterans to reach to if they know that they are there.
So I think this new way to approach people with this idea anyway, I mean, everybody's got a cell phone now just about in this country. And that's one way we could communicate better.
I think, Tom, if you would, this -- I was intrigued by the 311 campaign. What are we doing there?

TARANTINO:
Well, as you know, many cities have a 311 campaign. The law should access all matter of city services. New York has one, I think Houston has one, you know, Chicago.
And in San Francisco, we were contacted by the former mayor. And as you know, we want -- we have a lot of veterans in San Francisco. We have a lot of veteran services, but we need a way to get our citizens to these services. And so we worked with them to develop a campaign where when you call 311, if you're a veteran, you press -- I can't remember what the exact number is -- one or two, and you get sent on a separate track, meaning you have a shorter queue. You get sent to a separate track of veteran services, you have unique access. And that works not just on the phone but it works online as well.
And coming from the Bay Area myself and from the State of California, they actually do this on all their -- with all their social services. If you're a vet, there's a separate line. There's a separate track that you go through and it's -- and the services are more tailored to you.
And the idea of integrating national and VA services with that is, look, the VA has the power to be omnipresent. They

have the power to set minimum standards for care and services. But it doesn't mean that we can't use the multiple touch points and interactions that are actually happening in communities that we don't know about because we're not tracking it.
And I'm not talking about contracting, we're just talking about partnerships for care. And I think by developing that type of model where, you know, city services and state services have some sort of integration or at least have some sort of cross talk and communication with VA services, then you can actually catch a lot more people before they get to that tragic conclusion of suicide.

ROE:
Commander Kemp, (Inaudible) we talked with Commander Evans at Bethesda on Monday. And she was of the opinion that a lot of times where I know you're looking at another layer. But I wonder if the resources aren't there now and instead of creating another bureaucracy just organize the resources that we have because that was one of the problems that they were dealing with.
There were so many ways -- I mean, the veterans dealing with, wounded warriors dealing with 7, 8, 9, 10 people. That's confusing for them. It would be confusing to me if there were eight different people making rounds on me everyday. Usually, when I make rounds in the hospital it was a nurse and myself would come by and you knew what's going on.
These veterans are facing multiple people that come in to see them. So I'd like to work with you on that. I think that's a great idea, but I wonder if we couldn't just organize what's already there.
Last thing -- and I know my time's expired. I'd be very quick. Do we know the incidence of suicide 5, 10 -- among veterans -- 5, 10, 15, 20, 30 years ago? And is what we're doing changing it, or are we collecting data better now than we used to. That's the thing that is hard for me to understand is, you know, before did we just not have the information. And now we're doing a better data collecting and making it looking higher.

TARANTINO:
I think there are more states, for example, that have responded to the call to report violent deaths that's been hinted at more accurately than were in my generation of veterans.
But the fact remains that it's still because it's in some corners of the country and some corners of the states. It's just simply not reported as a suicide. And until we can get some kind of way to address that, I don't know if we're going to...

ROE:
I'm saying was it apples to apples.
My time has expired. I yield back.

BUERKLE:
Thank you, Dr. Roe.
I now yield to the gentleman from Texas, Mr. Reyes.

REYES:
Thank you, Madam Chair, and thank you for calling this hearing.
And I had a question for my colleague, Dr. Roe. When you asked unanimous consent to enter into the record Ron's information, is that the letter to the Veterans' committee that...

ROE:
Yes, I think that's it.

REYES:
If it's not, then I would ask the same unanimous consent.

ROE:
Thank you.

REYES:
And the reason is because, Ron, thank you for much for -- I got the opportunity to talk to him yesterday. I have never met him before, but I've heard of him. And so I appreciate the work that you've done.
And in his letter to the Veterans' committee, there are a number of recommendations that he makes and that he identifies that track very well with what our panelists have said here this morning and in the interest of transparency I'm a life member of both the VVA and the DAV.
But I wanted to add being a Vietnam veteran, having come back during the tumultuous time when we were not received as well as -- thank God -- today's veterans are, one of the constant questions that is asked, at least in my district, by some of the same -- some of our same veterans groups is a question of, you know, with the kind of support that veteran -- outpouring of support that veterans are seeing today, it's incredible that we're still going through all of these issues.
But I try to explain to people, you know, we don't have all the information because as I too go to Afghanistan, Pakistan, Iraq, Kuwait, anecdotally, I get information from active duty personnel that they're still reluctant to come forward with concerns of PTSD and sometimes TBI because I think it's -- they want the military as a career and they think it's going to hurt their career.
I really do believe it's important and our ranking member here can attest to that. When we had the full committee hearing, one of the recommendations that I made to Chairman Miller is we have to bring in Secretary Shinseki and Secretary Panetta so that we can work on these many recommendations that all our veterans organizations have long recognized. We have to have a single effort, a single program of -- of working between the DOD and the -- and the V.A. especially today, when we're looking at tough budgets.
I asked that because one of -- one of the -- I've been on this committee since I've been in Congress. I had to take a leave of absence when I was chairman of the Intelligence Committee. But my -- my interest has always been there being a veteran and having, by the way, Dr. Berger, a brother that served also in Vietnam that absolutely refuses to go to the V.A.
And -- and his rationale -- and he suffers like many of us with that jungle rot that periodically comes up because of stress -- he refuses because he says, "Listen, I served my country not so that my country would take care of me for the rest of my life." So he's very independent that way and a number of veterans are.
In my -- in the 16th district of Texas, I have a fulltime staff member that is actually going out throughout the homeless population and the rescue mission and things like that to ask people if they're veterans so we can get that information to them.
But some of them just absolutely -- for many different reasons -- some of them because they're obviously suffering from PTSD and other types of mental illnesses need to be -- need to be brought in.
So I was -- I was curious -- I know my time is short and five minutes I -- with all the things that we've -- we have to deal with is very short -- but Dr. Berger, do you have any observations on that?

BERGER:
Well first of all, Congressman, thank you for your service and welcome home, brother.

REYES:
Thank you.

BERGER:
Secondly and to be quick about this, my colleague Tom Tarantino mentioned something that's -- that's quite understated. And you hinted at it also and that is the brotherhood and sisterhood that exist between veterans out there.
Veterans talk to one another and maybe we'll hear something about this a little bit later on. But in any case, one of the ways of getting the word out is veteran to veteran, OK? Despite all the signs on the buses and late night videos and all that sort thing, the fact of the matter is if Tom calls me, -- I know Tom -- and says, "I'm having some problems with this," or whatever, you know, I'll talk to him.
And maybe even suggest that he go -- find out where he lives -- and suggest he go -- and if I know a clinician there or whatever, say, you need to ask for, veteran to veteran, helps a lot.

REYES:
Right. Right.
And, Madam Chairman, if I can just have a second, in his letter to the Veterans Committee, Ron also makes mention of something that Tom did and that is the number of times as he walked across the country that mothers and wives and relatives turned around to commiserate with him, to hug him and cry with him about their loved one that -- that was suffering with PTSD or had suffered with PTSD.
All of these -- all of these issues are -- are so important, that's why I say let's -- if we don't do anything else in this Congress, let's get Secretary Shinseki and Secretary Panetta here before this committee so we can -- so we can start working towards one single understanding and probably a number of different single programs in all these different areas that are absolutely related.
It's not always about money because, you know, we funded that independent budget when we were in the majority every year. And the organizations were very grateful but it certainly has not brought us to a point where -- where we're any more successful today regrettably.
So thank you -- thank you again, Madam Chairman.

BUERKLE:
Thank you.
I now yield five minutes to the gentleman from Florida.

STEARNS (?):
Thank you, Madam Chair.
You know, a question when you look at the statistics of 18 deaths from suicides per day and then about five of the deaths from suicides per day among veterans receiving care, Dr. Berger, are, the care we give veterans who are actually participating in the program, is it working?
I mean, with 5 of the 18 deaths per day are coming from veterans actually receiving the care and then when you look at the statistics where about 11 percent of those who attempted suicide did not succeed or have made repeated attempts with an average of nine-month follow- up. So the question is, does the Veterans Administration have a program that's working.

BERGER:
At the present time, there is so much variability across the spectrum of mental health services, not only in the training of the clinicians and the programs that are available plus just general physical access. And I think all of that enters into it and so I would say there's room for lots of improvement.
(CROSSTALK)

STEARNS (?):
On a one to 10 scale...

BERGER:
Pardon, sir?

STEARNS (?):
On a one to 10 scale, how would you rate the veterans' success and preventing suicides?

BERGER:
Four.

STEARNS (?):
That's a fail.

BERGER:
Yes, sir.

STEARNS (?):
So what you're really doing this morning is indicting the Veteran Administration which I understand what you're saying and I'm sympathetic because when I read these statistics, that's alarming.

BERGER:
Yes, sir.

STEARNS:
To think that five people of the 18 actually are getting clinical care. So your rating at a four indicates the Veterans Administration is not providing the services even if we get the veterans there, even if we get the communication and the education that Tom has talked about, once they get there, they still were not successful.
And so -- and is it -- is it possible the reason is because there are so many programs that are not working together or is it possible that the actual procedures are not working or we just don't know enough about suicide?

BERGER:
That's correct. We don't know if they're working. I would point out again, the accessibility; I mean we heard on the Senate side the other day the difficulties that some veterans are suffering, getting in to the proper treatment program.
It may be days. It may be weeks. It can be months. And when you've got somebody who's been through trauma as the research suggest -- serious combat trauma, who needs help, you can't wait six weeks for your initial appoint.

STEARNS:
And in fact, if a person has to wait, it might contribute because he gets frustrated. He or she gets frustrated and to say, "There's no hope here. I'm going to have to sit around for weeks, possibly months." Is that possible?

BERGER:
Yes, Sir.

STEARNS (?):
What would be the longest wait that you -- you've experience or you're familiar with that a veteran who has a suicide tendency has had to wait to get treatment.

BERGER:
Eight months.

STEARNS (?):
Eight months. OK. Because I see here, it was talking about -- there is something about nine months in some of the fact sheet here. Well, let me ask you this. This is a more difficult question. Is the suicide rate from Iraq and Afghanistan worse than it was from Vietnam or Korea or just we don't have the data?

BERGER:
We don't have the data. As Congressman Roe pointed out.

STEARNS (?):
Right.

BERGER:
The information gathering or data collection 40 years ago, 35 years ago is a lot different than it is now. Although, the technologies have improved, reporting has improved. It's difficult to compare. One thing we do hear is that for a couple of years after the cessation of hostilities in Vietnam, there was an increase in suicides, that's more anecdotal than anything. But at the same time, we're sort of hearing that anecdote now beginning to arise.
And I have concerns professionally when all these folks come home, if they don't have access to what they need in terms of mental health services and that includes accurate, scientific based or evidence based treatment programs when they need them, we're going to have real problems, and we got, what, half a million coming home here in the next month. Right.

STEARNS (?):
Well, Madam Chair, it seems to me is that we can solve as members of Congress was money to the administration to get an educational component of the veteran coming home will know of its availability. We can actually probably convince a lot of veterans to perhaps take the test when they leave the DOD.
But what I'm worried about is once they get in the VA, you're telling me there's no accurate information to show that the program that they have implemented is working. There's no statistical information that it has been investigated to show how successful. And in two, in a larger sense, it's not working. It's failing.

BERGER:
Sir, if there is an outcome measurement being conducted, I'm not aware of it. And then we need to hear from the appropriate VA officials if indeed such information exists. And then I might be willing to revise my grading scale.

STEARNS (?):
OK. Well, I think, I think you got to be honest here. And I just want before I close, Madam Chair, to ask each one do they agree with Dr. Berger. You don't have to agree to his four rating. But in general, do you agree with what his assessment is? You can say or no.

BERGER:
Yes, sir.

(UNKNOWN)
Yes.

(UNKNOWN)
Yes, sir.

(UNKNOWN)
Yes.

STEARNS (?):
All right. Thank you. Thank you, Madam Chair.

BUERKLE:
Thank you. I now yield to the gentleman from Indiana, Mr. Donnelly.

DONNELLY:
Thank you, Madam Chair.
One of the points has been the issue of isolation and that we will work to put programs together but 70 percent of the vets don't want to have that initial contact. And Tom's point about media in reaching out and touching other family members about getting our other vets included. What are your -- and Dr. Berger, you talk about vet to vet, that that's the way or one of the ways to help get this.
For that 70 percent, what other ideas do you have, you know, to reach out to our vets, the vets who aren't going to join DAV or VFW or the American Legion who aren't connecting to the VA but who struggle every day?

TARANTINO:
Congressman, I can talk a little bit about some of the lessons we learn from IAVA is Ad Council campaign that was those very successful in reaching out to vets and their families who otherwise might not have paid attention.
You know, the commercials that we produced and the PSAs that we produced weren't done because Tom Tarantino or Paul Rieckhoff are smart guys and we know what we're doing. We do in our space but we're not innovators in the advertising space.
This was done because of Ad Council brought in professionals from BBDO and Saatchi & Saatchi, people who know how to communicate, the people who set the standards in this country for how we publicly communicate.
And we are able to over the course of a couple of years, boring in our knowledge base from the veterans community match it with their knowledge base from the advertising community and create an outreach campaign that spoke to virtually everyone who saw it whether you're a vet or a civilian.
And that's something that the government really doesn't do at all. And when they do it, they do it poorly, and it's not very well- researched. It's not focused. And I think a lot of times, we trade expedience for quality that you want to get this campaign. Oh, we got to get it on in six months, and that's the metric for success.
Well, a bad campaign out soon is just still a bad campaign. So, you know, why aren't we taking the time to focus? Why aren't we talking to industry leaders? Why aren't we going out into the technology community and thinking, you know, what can we do? You know, where are our people communicating online and why aren't we going there? Why aren't we buying targeted Facebook ads?
I mean, Facebook -- for a second about Facebook. It's the most -- it is the most advanced advertising platform known to man. They know absolutely everything about you and it's not an accident that all the ads that show up on the right side of your screen are all stuff that you're interested in.
You know, there's no reason why we can't be reaching out in ways like that using technology and using these best

practices to laser target into, you know, military communities, veteran's communities and military families. We just don't do that and I don't know why.

BERGER:
I would -- just only to add to Tom said, what he said earlier. This is a community effort as well. It's not just getting the ads put together or the outreach programs put together. You have to have the involvement of the community when you're dealing with that element, that demographic element that are almost 70 percent are not going to the VA. So, I mean you have to have people when you're community talking about this stuff and, you know, using the methodologies that are developed at the national level.

DONNELY:
Do you have -- in a way a lot of us have rural areas, too, and I think staff going out and trying to locate our vets. And in some of the rural areas, it's not always the easiest thing to do, you know, with the Facebook techniques that you talked about, and other techniques.
Do you know of any or have you heard of any specific targeted efforts in rural areas so our vets who may be almost they're off the grid in effect? How do we locate them?

BUERKLE:
VA did bring to our attention and gave us a demo just last week of their new, the connection, Making the Connection campaign. I think that will be worth asking the next panel about specifically.
It seemed in the roll out to be testimonials from veterans, from family members and other to certainly as a web based tool with lots of resources. It seems to be very, to be able to be manipulated, to be tailored to a specific person's interest. So I think that's one way that definitely could be available in rural communities.

DONNELY:
And Madam Chair, one of the great concerns is truly we will, we will do everything we can as a committee, as the VA, but when 70 percent of our veterans are living their lives and we're not touching them, we've got to figure out a much better way to touch them.

BUERKLE:
Thank you.

DONNELY:
I yield back.

BUERKLE:
Thank you very much. We have been called to vote. We have about two minutes left to vote. So the vote should take about an hour, and what we would like to do is recess this hearing and then reconvene at around 12:15. If you could all join us for our second panel to come back at 12:15 and we'll reconvene this hearing. Thank you.
(RECESS)

BUERKLE:
Excuse me. We are reconvening our hearing the Subcommittee on Health. If I could invite our second panel to come to the table. I thank you all very much for your patience for a little bit of disruption in this morning's hearing.
Joining us on our second panel is Dr. Margaret Harrell, Senior Fellow and Director of the Joining Forces Initiative Center for the Center Of, for a New American Security. Dr. Katherine Watkins, Senior Natural Scientist for The Rand Corporation; Dr. Janet Kemp, the National Suicide Prevention Coordinator For The Department Of Veteran Affairs

accompanied by Dr. Antoinette Zeiss, the Chief Consultant For Mental Health of the U.S. Department of Veterans Affairs; and Colonel Carl Castro, who as I mentioned earlier, is not able to be with us this morning.
Thank you all very much. I am very eager to begin our discussion. Dr. Harrell, if you could proceed.

HARRELL:
Madam Chairwoman, Ranking Member Michaud, and members of the Subcommittee, thank you for the privilege of testifying today. It is an honor to be here.
While the topic at hand is suicide prevention among veterans, I must underscore the importance of considering both veteran and service member suicide. We can only be sure that strides have been made when the frequency of suicide decreases amongst both of these populations.
There is for an example a possibility that a decrease in suicide among service members could represent an expeditious outprocessing of service members struggling with mental health wounds of war. Only the joint consideration of both service member and veteran outcomes will highlight reasons for increased concern or will identify success.
Addressing suicide among service members and veterans is vital to the health and sustainability of the all-volunteer force. It will take a collaborative effort by DOD, VA, federal and state legislatures, and communities to curb suicide amongst those who have served.
Our leaders in the DOD and VA deserve recognition for their actions to reduce these tragedies, and I'm confident that my co-panel members will articulate many of the excellent efforts taken in this regard. Despite their best efforts, however, challenges remain.
In my submitted testimony, I highlight multiple challenges and proposed recommendations. I focus upon four of those challenges here.
The first challenge is the lack of accurate accounting of veteran suicide and the reliance on incomplete and delayed data. We recommend Congress establish reasonable time requirements for states to provide their death data to the CDC, and that the Department of Health and Human Services ensure that the CDC is resourced sufficiently to expedite compilation of these data. Additionally, the DOD, the VA, and HHS should coordinate efforts to analyze the veteran suicide data annually.
A second challenge pertains to the national shortage of mental health care and behavioral healthcare professionals, a factor linked to higher rates of suicide. Congress should require the VA to establish deadlines by which all 23 VHA regions will be manned to the recommended level of care providers.
Additionally, and especially in the meantime, the VA should increase their use of existing public/private partnerships to provide care to the extent that such partnerships would expedite evidence based care to veterans.
A third challenge pertains to the geographic moves that are a feature of military life. Separating service members also often relocate their families as they leave the military. Because mental healthcare providers are licensed on a state by state basis, a move across state lines can preclude continued care from the same provider.
When a care provider and a patient develop a relationship and that relationship is severed by a move, individuals are often reluctant to begin treatment anew. Thus, we recommend Congress establish a federal preemption of state licensing such that mental healthcare could be provided across state lines for those instances in which veterans, service members, or military family members have an established preexisting care relationship.
The fourth challenge is the decentralized multitude of suicide prevention programs in the National Guard. The solution is inefficient and at risk of reduction or elimination, such is the case in Minnesota where there exist both the highest number of National Guard suicides this year and also dwindling resources to address their problem. We recommend the consideration of a system-wide centrally funded prevention approach.
In conclusion, my testimony is extracted from a CNAS policy brief entitled "Losing the Battle - The Challenge of Military Suicide." America is currently losing its battle against suicide by veterans and service members. As more troops return from deployment, the risk will only grow.

To honor those who have served and to protect the future health of the all-volunteer force, America must renew its commitment to its service members and veterans. The time has come to fight this threat more effectively and with greater urgency.
Thank you for addressing your attention to this critically important battle.

BUERKLE:
Thank you very much, Dr. Harrell.
Dr. Watkins?

WATKINS:
Thank you. Chairman Buerkle, Rep. Michaud, and distinguished members of the subcommittee, it's an honor and a pleasure to be here. I know that members frequently get calls from their constituents, from veterans about how to access VA services and increasing access to care is incredibly important. However, it's equally important to provide good care once the veteran does access care and it's about this that I'm going to talk to you today.
Preventing suicide is difficult. The best evidence we have about preventing suicide is to provide quality mental health care. In this testimony, I will summarize key results from a study conducted by RAND and the Altarum Institute on the quality of mental health care provided by the VA to veterans with mental illness and substance use disorders.
I will then propose specific steps which could be taken by the VA to improve the quality of mental health care, steps which, if taken, could help to reduce suicide risk among our nation's veterans. My written testimony provides more details on our specific findings and our additional recommendations.
In response to the question by Representative Stearns about the quality of VA care, our study actually found that the quality of mental health and substance abuse care provided by the VA is as good or better than the care provided by both the public and the private sector. However, there's still room for significant improvement.
Let me give you an example. Although our study found that veterans with mental illness are assessed for suicide ideation, and if they're found to have suicide ideation, are given appropriate care, providing good care for people who are already suicidal is not enough, it's important to provide them good care before they become suicidal, both because providing good care is important in its own right and because high quality care might prevent people from becoming suicidal in the first place. It is in this area that the VA could improve their performance.
My first recommendation that comes directly from the results of our study is to increase the proportion of veterans who have received the recommended length of pharmacotherapy. Taking psychiatric medications consistently and for the recommended length of time is important because for both depression and bipolar illness, taking psychiatric medication prevents suicide.
We found that more than half of study veterans who began medication treatment did not receive the recommended length of treatment and more than two-thirds of those on maintenance treatment did not take their medications consistently. This can be improved.
There are systematic methods for increasing adherence which the VA is not using. For example, the use of clinical registries which allow clinicians to track medication compliance could be incorporated into the VA's medical record system with relatively little effort.
A second recommendation is to implement uniform assessment and standardized written treatment plans. In the case of uniform assessment, we found that while the VA had high levels of assessment for suicide, in other areas performance was poor and more variable. For example, less than two-thirds of the mentally ill were assessed for problems with housing and unemployment and there were large differences between the best performing VISNs and the worse performing VISNs.
This is important because homelessness and unemployment are both risk factors for suicide. The VA's employment policies are vague. If you are a veteran with mental illness who has an employment problem, it's unclear where you should go to for help.

The VA needs to clarify what constitutes need for housing and employment services and clearly define the role of the Veterans Health Administration and the Veterans Benefit Administration with regard to work in housing.
We found that written treatment plans were incomplete and difficult to locate, and in some cases, do not appear to be present at all. This is a problem. Written treatment plans are essential for communication between providers because they tell providers in short succinct ways what problems a patient has and what's being done for those problems. Although we understand that VA Office of Mental Health Services has recently purchased treatment planning software, implementation of the software has been held up because of lack of computer personnel at the VA Office of Information Technology.
In conclusion, I would like to say that the VA had substantial capacity to deliver mental health and substance use treatment to veterans and it outperforms the private sector on most quality indicators.
This most likely demonstrates the significant advantage -- advantages that accrue from an organized nationwide system of care. Nonetheless, the VA is falling short of its own implicit expectations. Our study revealed ways in which the VA could build upon their current system with marginal effort to improve quality and potentially prevent suicide.
Thank you for the opportunity to testify today and to share the results of our research.

BUERKLE:
And I thank you, Dr. Watkins for your testimony.
Dr. Kemp, if you would like to proceed please? Thank you.

KEMP:
Chairwoman Buerkle, Ranking Member Michaud, and members of the subcommittee, thank you for the opportunity to appear before you today to discuss VA's efforts to reduce suicide among America's veterans. I'm accompanied today by Dr. Antoinette Zeiss, the chief consultant for mental health.
And at this point, honestly, I'm going to put down my prepared statement and talk to you a little bit from my heart. It's been a very moving hearing and I -- I think I have some important things to say.
First, I want to thank you all for the kind words about the suicide prevention program and in my personal efforts, and I think that speaks to the people up in Canandaigua, New York who work 24 hours a day, seven days a week answering that phone and making those connections; and the suicide prevention coordinators across the country who work tirelessly to connect people into care and to really make a difference.
And while I truly accept your kind words for them because they work really hard, I have to tell you it makes me feel a little bit like a fraud and a little bit humbled by what you said because veterans are still dying by suicide, which means we have more work to do.
And as long as one veteran any day of the year dies by suicide, who is receiving care in the VA, I haven't done my job well enough and I will continue to persevere to -- to get that job done.
That being said, we've had some exciting news this week. We have recently gotten the 2009 data and you've heard from the other witnesses how tragic that is, that it's almost three years old. But we did get the 2009 data very recently from the CDC and have looked at that data, bounced it up against veterans who get care within the VA system, and we are very encouraged by what we're seeing in 2009, which was a couple of years after we implemented the very beginnings of our suicide prevention program.
And it's encouraging to know that this perceived epidemic of veteran suicide rates that we keep hearing about truly is not happening for veterans who are getting care in their -- in the VA, that rates in certain age groups and population groups in fact are decreasing.
And when we look at our most "at risk" patients like you all have talked about, we're making a difference, those rates are going down. And in the group of patients who get mental health care in the VA, our suicide rates are decreasing. And we know that's because we're paying attention to them and we've got them involved in our enhanced package of care, and where they are being followed by suicide prevention coordinators, they are getting evidence-based

psychotherapies.
We know that treatment works and that's extremely helpful and is enough for us to keep going and to keep making these changes that we're headed towards and to know we're in the right direction and we've got a long way to go. I'm not going to sit here and tell you we think things are fine because we don't.
We've got high standards that we've set, and as you said, we're not meeting our own standards and we need to continue to strive to do that and then we'll set higher ones, and that's a promise.
It also points out that there's a group of veterans that, while their rates are staying stable, we haven't seen the decrease in, and those are our veterans who are not currently getting mental health services. And I think that that really makes what my - my good friends from the VVA and the IAVA talked about critically important and that's outreach.
And the things that we've put into place so far are having an effect but we've got to do more and we'll continue to do that and we'll work with them and get their input and their ideas.
And I don't think they actually know how valuable they've been up to this point. I think that the influence on Tom Tartano (ph) and Tom Berger (ph) have had on our current campaigns has been tremendous and we thank them for that and we ask them to keep hanging in there with us. We're getting it right and we're going to continue it to get it right.
And I am going to end my testimony with a story that maybe talks about how we do we get it right. And there are as many of these stories as there are stories of people where we honestly get it wrong. And somehow we've got to bridge that gap. And I promise to do that.
In August of this year, we heard from our benefits people that they got an email inquiry from a veteran who was currently living in Germany. And his question to them was, if I kill myself, will my wife and children still get their benefits? And this was an email question through our email IRIS helpline.
Having had the training and knowing that that was a warning sign, they notified the people in the crisis line that this veteran may be in trouble. The people in the crisis line called this veteran in Germany. They found him. They talked to him. They talked to his wife. Truly he was in a great deal of distress. He was having a lot of physical pain. He wasn't getting the care he needed. But he thanked us for calling him and moved on.
Something didn't sit right in the responder's mind after he hung up that call and he called him back. And truly the veteran had left his house and his wife said, "I don't know where he is and I can't find him."
We did track him down. We found him. In the meantime, we had contacted the Wounded Warrior Project people, people who also partner with us to provide services, who arranged for transportation from Germany to the United States for this veteran if we could get to agree -- if he would agree to come.
We contacted a suicide prevention coordinator in California who found him placement in a program. We called them back. Between us and his wife, we talked him into services. We got him on a plane. We got him into California. As of 80 hours later, he was in care, in treatment and is alive today.
You know, well, that's an extraordinary story. Again, it's only one of many, many that we could tell over the past three years. And we can't stop until those stories don't need to be said anymore. That people get the services way ahead of time. They get the care that they need and that dying by suicide is not an option for America's veterans. And that's our goal.
So, Madame Chairwoman, thank you for the opportunity to be here. Our services will continue. We greatly appreciate your support in this area. And Dr. Zeiss and I are prepared to answer your questions.

BUERKLE:
Thank you very much, Dr. Kemp. And thank you for speaking from the heart so often. The committee is frustrated by folks who stick to their scripts and it's almost irrelevant to the testimony that was heard before them. So, thank you very much and thank you for what you do.

Dr. Harrell, my question you is in your testimony you testified that we seem to know more about suicide among our military rather than our veterans. Can you just explain why that is or you think that is?

HARRELL:
Yes. Thank you. I'd be happy, too. As Dr. Kemp did note, we've recently received data for 2009 but the data that they received was for those veterans who do receive VA care. The estimate of 18 suicide deaths amongst our veterans everyday represents in large part extrapolations from the states' death data.
In other words, there are 16 states that note on their death certificate whether an individual who has died had served previously in our military. For the other 34 states, the estimate -- it's just that is an estimate. It's an extrapolation.
So, not only when we say 18 deaths a day is that extrapolated for the majority of states but it is three years delayed.
And so, that's why I assert we really don't know enough about our veterans that are dying by suicide. We do not for example know whether those deaths represent veterans of Iraq and Afghanistan or whether those are Vietnam veterans that are dying by suicide. We don't know who they are.

BUERKLE:
Thank you. Dr. Watkins, in your testimony you talked about one of the issues is adherence to a drug protocol and how important that is. And you mentioned that there are no clinical registries within the VA system and clinical registries are pretty basic with regards to tracking and their compliance with the program.
Can you just speak to that as well as speaking to the assessment and the treatment plans or the lack thereof?

WATKINS:
Yeah. Well, the VA does have registries. But they're not clinical registries. And what I mean by a clinical registry is something that an individual clinician can use or an individual administrator to pull up all their patients with a particular diagnosis.
So, for example, all their patients with depression and then they can easily see who's missed an appointment; who hasn't filled their medications? And then, you could go and do outreach and try to target that particular patient. That's what I mean by clinical registries. And I think that could be incorporated into their medical record fairly easily and could do -- go a long way to identifying people who are dropping out of treatment.
In terms of the assessment, when we did the study, there was no standardized packet of assessments. So we found a lot of variability about what people were getting.
For example, I told you about the housing and employment services. The differences between the best performing VISNs and the lowest performing VISNs was 26 points.
So, I think that there is something that the best performing VISNs are doing that is not being done by the worst performing VISNs.
And I believe that central -- you know, a central directive that says, "This is what an assessment should consist of. Every veteran needs to get this assessment. Here are some templates that are going to help you make sure you remember to do those assessments." could really benefit because, like I said, they do a great job. I think 95 percent of the veterans were assessed for suicide. That's really terrific.
And when they got -- when they found someone who is suicidal, they got good treatment. They got appropriate referral. But we have to go beyond. We have to figure out how to prevent people.
People don't all of a sudden become suicidal. It starts before then; usually with a mental illness.

BUERKLE:
Dr. Kemp, would you like the opportunity to perhaps speak about if there are any initiatives in the Veterans Administration with regards to those kinds of -- you know, this registry that would have a database of those who have indicated are suicidal and are on medication?

KEMP:
We currently have -- and then I'll let Dr. Zeiss explain from a broader mental health perspective what we're doing -- for patients who have expressed some degree of suicidal ideation, hopefully, before they become actually suicidal or have a plan, et cetera, we do include them in what we call our high-risk database.
And this high-risk designation allows us to put chart notifications on their chart so all providers are aware of their concerns. It pushes them into a different level of care, an enhanced package of care we call it. And we do monitor them for a period of time after this designation.
The gap as is pointed out is defining ways and figuring out ways to move these people into that level of care sooner. And to do that, we have developed treatment planning software that Dr. Zeiss will talk about the implementation of and other mechanisms within mental health to assess that and make that happen.
We're excited about our recent integration of mental health into our primary care teams with our patient-centered model. And we've done a considerable amount of training and will continue to train these teams of people so that perhaps we can catch people earlier in their whole healthcare process where they wouldn't need to be referred to mental health to get those kinds of services and those kinds of care, that it would happen in their primary care team.

BUERKLE:
Thank you. I am going to -- my time has expired. And I want to give my colleagues a chance to answer questions and then I'll come back. I am sure I'll have a second round of questions.
I know yield to the gentleman from Maine, Mr. Michaud.

MICHAUD:
Thank you very much, Madame Chair. This question is for the panelists, for all of you. You heard VVA earlier. What are your thoughts on their recommendations that both the VA and the DOD should use the PTSD protocol and guidelines suggested by the IOM? Any comments from the...?

HARRELL:
I'd like to defer evaluation of that tool to those with specific medical expertise. But I'd like to encourage the extent -- any extent possible that the DOD and the VA join forces on this effort.

WATKINS:
I can't speak to the validity of that tool. But I think it would be a mistake to focus all of your efforts on PTSD. I actually think the higher -- much higher rates in people with bipolar disorder, substance use and depression.
And so, it's really critical that you look at those as well.

KEMP:
I'm going to let Dr. Zeiss talk about the PTSD tool.

ZEISS:
Well, I am glad that Dr. Berger brought up that tool. It was to go up for the National Center for PTSD, that is part of VA, and there are two versions of it. One is clinical assessment tool and the other is for use in doing an interview in the context of the CNP diagnostic interview.
And I have really made it a priority to try to bring this tool into focus for our assessments. I think it's an excellent tool. And I appreciate, you know, the persistence that the BVA has shown in ensuring that it stays in focus. And since I have been chief consultant, the National Center for PTSD has a national mentoring program for PTSD to increase the consistency of care and utilization of best practices and they are doing training throughout the country in use of this clinical tool.

And we also have a study that has been completed looking at it in the context of C&P exams that was very positive in terms of its utility.
So, there is more for us to do, absolutely. But I think we're on that track. I also agree with what Dr. Watkins said that we can't just attend to PTSD. There are other disorders that need very significant attention.
But for those with PTSD, I do think consistent, reliable, valid assessment is very important.
So, the short answer to that question is yes.
But in addition to that, the DOD and the VA currently are developing clinical practice guidelines along those same lines specifically for suicide prevention. And we will jointly implement those as soon as they're done.

MICHAUD:
OK. My next question actually for Dr. Kemp is the 300 Vet Centers, they provide great service for our veterans as well as active duty. I'll talk without names. But with Vet Centers that active duty personnel come in on their furlough days to get help , mental health addressed, my concern being is all of the 300 Vet Centers, are you fully staffed in all those Vet Centers with the appropriate personnel?

KEMP:
We'd have to defer that to Dr. Batres from my Readjustment Counseling Service. But my experience is yes. They are incredibly awesome and responsive people. The Readjustment Counseling Service where the Vet Centers fall under have also developed an online peer support call center which we use at the crisis line to move callers back and forth from and we support each other.
Another huge attribute to the system are the soon-to-be 90 mobile Vet Centers that travel across the country providing care to people in remote and distant areas. I think that the pieces are in place. And if we can get them to the veterans and veterans to them, we are well on our way to making sure things happen.

MICHAUD:
All right. Well, the next question requires a simple yes or no answer. The Military Officers Association of America recommended that -- to require the VA and the DOD to establish a single strategy and a joint suicide prevention office that reports directly to the department secretaries through a senior oversight committee. Do you support that proposal?

KEMP:
Not the way it's written.

MICHAUD:
OK. Thank you, Madame Chair.

BUERKLE:
Thank you. I now yield five minutes to the gentleman from Texas for questioning.

REYES:
Thank you, Madame Chairman.
I was curious for your comments on what can be done to improve outreach to our servicemembers, particularly we've heard a number of comments just today in terms and in the context of younger veterans versus the older veterans and the lack of a tracking system.
So, can you -- do you have any thoughts about that recommendation?

KEMP:
Of course, I have thoughts. We've made huge drives in the past three years providing outreach in different access modes to younger veterans. We realize that they communicate differently and we have to go to them. We can't wait for them to come to us.
Then, we developed a veterans chat service. This is actually the first formal announcement that this month we opened a texting service so people can text the crisis line. It's having a remarkable response and going really well.
We have Facebook pages. We monitor those pages. We have Facebook monitors who look for people in difficulty.
We have partnered with and contracted with a nationally well- known advertising firm to help us develop some messages and new marketing strategies. We've re-branded the suicide prevention hotline into the veterans crisis line in order to better portray what we do and reach people. And the results of that have been tremendous.
And we've put some PSAs out there that have been well-received; some newer ones. You heard references to the Make the Connection campaign which is incredible actually. And we partnered with the entertainment council to make that happen and make that happen right. Dr. Sonja Batten is organizing that program and is doing an exceptional job. But it's the tip of the iceberg.
And I think what we need is to continue to listen and not only listen but get help and support from people like IIVA and Student Veterans of America and, as Tom said, from people. I mean, veterans are people. And we need to listen and get their input and find out how to get that message across. And I don't think we're going to have an answer tomorrow. But we've got to start putting what we know now into effect like we have been and just keep going and pushing and not stop putting the resources into that area.
I mean, it bothers me a great deal when I hear about veterans who don't know what the VA does. I mean, there is no reason for that in America today.

REYES:
What about the comment that Dr. Berger has made which I had found to be true as well in terms of veterans relating to veterans. How do we bridge that -- is this texting, is that intended to do that and...?

KEMP:
You know what? I think it helps. And I think other ways that we do it are very formal and then also very informal. And that we do have peer support processes set up in all of our facilities. We have our Vet Centers who provide that vet-to-vet communication.
We have veterans who work on our crisis line and in our facilities who provide that vet-to-vet sort of options for people.
Right now, we're working kind of behind-the-scenes to develop what I am calling some buddy programs. You know sometimes I think veterans don't need a peer counselor or want a peer counselor. But they might want a buddy. They might want a friend and they might want someone they can call in the middle of the night who will go bowling with them or take a walk with them or just tell them that things are OK. And I think we have to help those relationships form. So, I think we can work in arenas like that.
And the Veterans Service organizations like VVA have been very supportive in helping us think about those sorts of programs.
So, I think that's the direction we have to go.
And we have to really work with our communities. Veterans live in communities. There is a move in America right now I think to become involved and to make a difference. And it (inaudible) us now to help people do that.

REYES:
Thank you, Madame Chairman. Thank you.

BUERKLE:
Thank you. I am going to yield five minutes of questions. If you'll indulge us, we'll have a second round of questioning.
Dr. Watkins, I was really impressed and really struck by the fact that in your testimony you talked about veterans, not necessarily veterans, but those who had committed suicide have contact with either a primary care or mental health provider prior to the year that they committed suicide.
So, much of what we're talking about today is awareness among our veterans and our military that there are services. But now, these folks were in the system.
So, I'd like, if you would, to speak to that as to where there any reasons why it would occur that they're actually in the system, they're getting care and yet they still committed suicide?

WATKINS:
Yes. That study didn't look at what the quality of the care that they were getting. That was not our study. I am referring to another one there.
But I think what it points to is the opportunity that exists for intervention and the importance of providing good quality care once the person walks in the door. I think what we know and what Dr. Kemp and Dr. Zeiss said is that if they get to specialty mental healthcare, it seems that they're getting -- the rates of suicide are going down. It's in the primary care setting that that's not happening.
So, perhaps, we need to focus our efforts on providing good quality care in the primary care settings.

BUERKLE:
Based upon your research, what would you suggest? Say like how would you do that within the primary care?

WATKINS:
I think one of the most important things is registries. So, again, a way to allow the individual clinician easily not with the assistance of a computer programmer but in real time at their desk to be able to pull up their panel of patients and say, "Who missed their appointment?" Because probably it's those people who are missing appointments or who are not showing up or are missing their medication refills, those are probably the ones who are struggling the most. That's a hypothesis. But I think it makes sense.

(UNKNOWN)
I think that attention to infrastructure is critical. The VA has a wonderful medical record system but it could do more. And it's amazing to me that the bottleneck seems to be the computer programming. Like they have treatment planning software but it can't be incorporated because the computers programmers -- it is now? That's terrific.
So, it took several years. That seems unacceptable.

BUERKLE:
And this question is for Director Kemp. The VA has established mandatory screening for depression. We were just talking about it's not all PTSD. It's depression. It's substance abuse.
So, you have mandatory screening for depression. But does the VA conduct periodic reviews to assess and to see where those patients are at?

KEMP:
Those screens are done on a minimum on an annual basis. And if someone does screen positive for depression or PTSD, that requires at least a basic assessment for suicide and suicide ideation.

BUERKLE:
And, Dr. Watkins, would you registry take care of that if they've been assessed for depression, they've been diagnosed for depression? If there would be a registry in place, then, that would continue to monitor?

WATKINS:
Yes. (Inaudible) to the registry and someone could follow them. And that might be a person who you might want to (inaudible).

(UNKNOWN)
(Inaudible) include the clinician in so that every month in outreach, some kind of outreach call is done and the veteran or maybe they should up for their podiatrist appointment. And then, the podiatrist would know and might say, "OK. Let's check in with you and see how you're doing."
It's that kind of wrap-around services that a -- that's what I call a clinical registry -- would help.

BUERKLE:
Thank you. Dr. Kemp, just in my few seconds that I have left, section 304 of the Public Health Law The Caregivers and Veterans Omnibus Health Bill of 2010 provided that the VA establish a program to provide mental health services to members of the immediate family of OIF and OEF. And I think what we've heard this morning and this afternoon is that the family is such a big part of this in understanding symptoms and what to do with all of the information that they're receiving.
So, has this program been implemented?

KEMP:
Yes. We are able to provide services to include families in our care for veterans. As a matter of fact, all really high-risk veterans are required to provide us -- required is a loose term -- with family contacts that we then work with to help us and help them recognize signs of when they might be getting into trouble, when they are at higher risk.
We're also working very closely with our Department of Social Work who is working right now with SAMHSA to help identify modes of referral and to do community resources for families when we're not able to do that to assure that those services get done.

BUERKLE:
Thank you. Our information is a little bit contrary to that. That is has not been implemented for the families. So, if you could specifically -- and maybe you don't have the information on -- which VA Centers have you implemented the immediate family outreach?

KEMP:
Yeah. I'll take those questions if I could for the record and get that -- those responses back to you.

BUERKLE:
Thank you very much. I now yield to the gentleman from Maine, the Ranking Member.

MICHAUD:
Thank you very much. Yeah. I would be very interested also in seeing that information.
So, what you're saying is that you got the rules and regulations already adopted for that section and that it's underway?

KEMP:
It's underway.

MICHAUD:
Are the rules and regulations all adopted?

KEMP:
The policies and procedures are already in place that allows us to respond to that recommendation. And, again, I think you're going to see like you've heard before that there are varying degrees of implementation. I think there is variability among the system and we'll help figure where it's happening and where it's not.

MICHAUD:
Yeah. I'd be very interested in that because I am under the same understanding that it has not been implemented. So...
And, I guess, this one's for Dr. Watkins. We know that testimony from Lt. Col. Michael Pooler from the Maine Army National Guard -- at this point, DOD is not here today but I don't know if you've done any studies that was raised in his testimony where he talks about those who buy TRICARE have a very difficult time finding clinicians who will see them and many clinician that want to help soldiers find the process to become a TRICARE provider extremely cumbersome.
He goes on to state that someone other than the providers needs to maintain the TRICARE to ease the frustration soldiers find when they are looking for help.
Have you done any research on TRICARE and on the effects?

KEMP:
That's a great question. And I think that's research that needs to happen. We don't know the quality of care provided by TRICARE, the quality of mental healthcare provided by TRICARE or the DOD and that's a really important study that I think needs to be done.

MICHAUD:
Thank you. I guess, it's more of a comment, Madame Chair, is reflecting on when we did a code out a number of years ago I went to Iraq and Afghanistan and this is a concern that I had when you look at particularly in the Department of Defense. It is every trip that I've been on, I always ask the generals when they give us a briefing is what are they doing personally to help destigmatize the problem with PTSD and those that have traumatic brain injury?
And the second part of the question is whether or not they need any additional help. And the response I get over and over again is the same response we have here in D.C. is "Things are fine. We got the resources we need. We're taking care of them."
The problem being is right after that meeting someone with much lesser rank pulled aside and said, "We're getting the help that we need" And the suggestion was that I talk to the clergy. And for the rest of that trip and every other trip since then, I did talk to the clergy. And the interesting thing is in fact that more and more soldiers are going to them.
So, evidently, there is a disconnect between those that are in the decision-making mode to provide help for the soldiers. If they tell us that things are OK and really they're not and if you look at the statistics with the increased amount of suicides among our active military today, then, I think we have to look at doing things differently, in how can we provide those services for the active military personnel as well as our veterans.
And when I read the Lt. Col. Pooler's testimony with the problems that they are seeing within the TRICARE system, I

think we can do a much better job than what's currently being done. But if we do not have the folks in that decision-making process recognizing that, then, I think we have that extra hurdle we have to get over.
I noticed, Dr. Watkins, you're (inaudible)...

WATKINS:
I think you need data. I think you don't know. I mean, that's really what our VA study was. It was an independent evaluation from outside the VA looking in and I think that's what makes it so powerful. Because it's -- I think you don't know what's going on and you've got basically anecdotal evidence about what's going on with TRICARE and what's going on with the DOD.
And unless you do -- unless you get data, you really -- and I think it speaks to what Dr. Harrell said about suicides. You have to have data about what you really know what's going on.
And so, I would encourage you to think about getting data, about what's happening. The quality of mental healthcare provided by TRICARE and provided by the DOD because then you could go on and make a difference.

BUERKLE:
Thank you. I have one last question for all three of our panelist.
Part of what we heard this morning -- and I have heard this on several occasions on other hearings -- are that there is a lot of services but they are not well-coordinated and they're not collaborating their services.
And so, the veteran -- and Dr. Harrell mentioned it earlier -- is maybe visited by maybe 10 people at his bedside rather one point person. So, where is the balance in all of this? And I'd like to give all of you the opportunity to respond.

HARRELL:
Madame Chairwoman, I am not quite sure how to answer where the balance is in all of that. I would confirm your perception that there are many programs out there. I think in many cases a multitude of programs are a result of the recognition that this is a crisis before us. And as a result, we have programs running in parallel with one another, inefficiencies resulting and the risk of programs especially at the state level being cancelled due to competing resources.

WATKINS:
I think you need to ask a veteran what they want. Some veterans may want multiple -- they want 10 people coming in. Other people may want one.
I think what you don't want is duplication. And one of the things that we found in our study was that this common electronic medical record, if you move across a VISN -- right -- across a region. Like say you are a snow bird and you move from Minnesota to Florida, your VA provider in Florida has a great deal of difficulty accessing your records from Minnesota. That's not easy to do.
And so, that Florida provider has to redo all the assessments. They can't count on -- they can't learn from what's already been done before.
So, in terms of trying to prevent duplication, I think making a common portal or a common portal exists. But making it easier for clinicians to access the data across VISNs or, you know, within different medical centers within a VISN, I think would go a long way towards preventing duplication. And that would be a first step.

BUERKLE:
Dr. Kemp, before you have the opportunity to answer that question, why is it so difficult for the information to be transferred from VISN to VISN? If you know or if you could provide that information?

KEMP:
Yeah. Well, actually, I'm going to have to find out because I can travel from VISN to VISN and see anyone's record and I can see anyone's record from my office in Canada or Washington, D.C.
So -- and I know from working in the field in being the clinician, I never had difficulty finding information out about patients that were being seen somewhere else.
So, I suspect that we might have some provider education issues that we need to address if the providers, as Dr. Watkins talked to, were having trouble, we, perhaps, need to explain better how to do that. But the capability is there for that to happen.

ZEISS:
My understanding is that part of it has to do with how the patient is counted; who has -- who gets credit for the patient? And it has to do with having the appropriate authority to be able to access that common portal.
Anyway, we can...

(UNKNOWN)
(Inaudible).

(UNKNOWN)
It's a new problem.

BUERKLE:
If you could Dr. Kemp, we would really appreciate that information and your assessment of (inaudible).

KEMP:
Certainly.

BUERKLE:
Thank you.

KEMP:
Yeah.

BUERKLE:
And did you have any answer to the balance?

KEMP:
Of course. Actually, I think there is -- that's a tough question. And I think there is a fine line between multiple services and not coordinating those services and choices. And I think we sometimes lose the fact or attention to the fact that veterans do have choices. And they don't have to come to the VA. They don't have to get care from particular people. And we need to make sure they know about those choices.
We do need to coordinate care within systems while still protecting patients' privacies. And so, that's a fine line that we need to walk.
I think most importantly we need to know about all of the services that are available and the programs available so that we have a wide range of options to be able to provide people.

BUERKLE:
Thank you. And I would say we talked earlier someone mentioned mentoring, a system like AA has, having someone

stay with you. And I know that there is a relatively new program, Team Red, White and Blue, and that's what they believe. They believe that, that person coming out of the military that new veteran needs someone to be with them to monitor all of these different aspects of their life and to really mentor them and help them with their transition.
So, it seems to me, you know, there is appreciation of the needs out there. But one of the problems we have is coordinating it. And then, as Dr. Watkins mentioned, making sure it's what the veteran wants. And I'd be interested to know when your study, Dr. Watkins, that RAND Corporation did if there was -- if there were conversations with the veterans. Are they getting what they need? Did they identify areas where they'd like to see things a little different?

WATKINS:
That's so interesting. We did do a telephone survey of 7,000 veterans where we called them up and asked them about their experience with VA care. And what's interesting is that most veterans were really satisfied. We also asked about timeliness which has to do with how long did you have to wait for an appointment and did you get an appointment as soon as you wanted? And if it was an emergency, did you get an appointment as soon as you wanted?
And, again, over half -- most of them said they -- that their care was timely.
So, again, it's interesting what data versus -- because I think you will always have some people who don't get what they need. But when you have data, it allows you to put it in context.

BUERKLE:
And I think the sad part of that is that the folks who apparently need the services, who do commit suicide aren't getting what they needed.

WATKINS:
Yeah. Yeah. Exactly. It should be 100 percent.

BUERKLE:
(Inaudible) here today.
Before we adjourn our hearing this afternoon, I'd like to turn your attention to the monitors for an airing of the VA's latest public service announcement assisting and addressing suicide prevention.
(Video)

(UNKNOWN)
I have never been the type to ask for help. But I had enough.

(UNKNOWN)
Thank you for calling the Veterans Crisis Line. How can I help you?

(UNKNOWN)
Life still has its challenges. But my family and I can deal with them better now.
Veterans Crisis Line. It's your call.
(Video end)

BUERKLE:
And I think our message here today with our hearing is that to any servicemember, veteran or civilian loved one listening today, suicide is never the right answer. If you are hurting, hope and help are available to you at any time. Please call the VA crisis hotline number at 1800-273-TALK and press one if you are a veteran.
And with this, I ask unanimous consent that all of the members have five legislative days to revise and extend the

remarks and included any extraneous material. Without objections, so ordered.
I want to thank all of you again to our first panel and our second panel for being here today and for all of the members of the audience for joining today's conversation.
As I mentioned earlier, this is just the beginning of a very important conversation and we will work to get DOD and the National Institute of Mental Health in here along with -- it was suggested by some of my colleagues that we get Secretary Shinseki and Panetta in here for a hearing as well.
So, we will continue this conversation. It is of the outmost importance and our veterans deserve that.
Before we adjourn I would just like to always ask you to remember the men and women who serve our nation so valiantly and keep us safe. And to all of our veterans, this is a good opportunity to thank them for their service.
To any veteran in the room today, thank you very much for your service to this nation.
And with that, our hearing is adjourned.

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List of Panel Members and Witnesses PANEL MEMBERS:
REP. ANN MARIE BUERKLE, R-N.Y. CHAIRWOMAN
REP. CLIFF STEARNS, R-FLA.
REP. PHIL ROE, R-TENN.
REP. GUS BILIRAKIS, R-FLA.
REP. DAN BENISHEK, R-MICH.
REP. JEFF DENHAM, R-CALIF.
REP. JON RUNYAN, R-N.J.
REP. JEFF MILLER, R-FLA. EX OFFICIO
REP. MICHAEL H. MICHAUD, D-MAINE, RANKING MEMBER
REP. CORRINE BROWN, D-FLA.
REP. JOE DONNELLY, D-IND.
REP. RUSS CARNAHAN, D-MO.
REP. SILVESTRE REYES, D-TEXAS
REP. BOB FILNER, D-CALIF. EX OFFICIO
WITNESSES:
RETIRED NAVY CMDR. RENE CAMPOS, DEPUTY DIRECTOR FOR GOVERNMENT RELATIONS, MILITARY OFFICERS ASSOCIATION OF AMERICA
TOM TARANTINO, SENIOR LEGISLATIVE ASSOCIATE, IRAQ AND AFGHANISTAN VETERANS OF AMERICA
THOMAS BERGER, EXECUTIVE DIRECTOR, VETERANS HEALTH COUNCIL VIETNAM VETERANS OF AMERICA
JOY ILEM, DEPUTY NATIONAL LEGISLATIVE DIRECTOR, DISABLED AMERICAN VETERANS
MARGARET HARRELL, SENIOR FELLOW AND DIRECTOR, JOINING FORCES INITIATIVE CENTER FOR A NEW AMERICAN SECURITY
KATHERINE WATKINS, SENIOR NATURAL SCIENTIST, RAND CORPORATION
JANET KEMP, NATIONAL SUICIDE PREVENTION COORDINATOR, VETERANS HEALTH ADMINISTRATION
ANTOINETTE ZEISS, CHIEF CONSULTANT FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION
COL. CARL CASTRO, DIRECTOR, MILITARY OPERATIONAL MEDICINE RESEARCH PROGRAM RESEARCH AREA DIRECTORATE III, U.S. ARMY MEDICAL RESEARCH AND MATERIAL COMMAND