

**STOPPING SUICIDES:
MENTAL HEALTH CHALLENGES WITHIN
THE U.S. DEPARTMENT OF VETERANS AFFAIRS**

HEARING
BEFORE THE
COMMITTEE ON VETERANS' AFFAIRS
U.S. HOUSE OF REPRESENTATIVES
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**STOPPING SUICIDES:
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WEDNESDAY, DECEMBER 12, 2007

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

The Committee met, pursuant to notice, at 10:10 a.m., in Room 345, Cannon House Office Building, Hon. Bob Filner [Chairman of the Committee] presiding.

Present: Representatives Filner, Snyder, Michaud, Herseth Sandlin, Mitchell, Hall, Hare, Berkley, Rodriguez, McNerney, Space, Walz, Buyer, Stearns, Boozman, Brown-Waite, Bilirakis, and Buchanan.

Also Present: Representatives Boswell, Manzullo, and Kennedy.

OPENING STATEMENT OF CHAIRMAN FILNER

The CHAIRMAN. This meeting of the House Committee on Veterans' Affairs is called to order.

I appreciate your attendance, and I appreciate your interest in this very important issue of mental illness, particularly of the suicides that have occurred in our veterans' population, especially those involved in combat situations.

So this is going to be a very tough hearing, an emotional hearing. It is an issue the military, the U.S. Department of Veterans Affairs (VA) and the American public does not like to talk about. Yet, we owe it to our fighting men and women. We owe it to their families. We owe it to our future mental health as a Nation to explore this issue in as much depth as possible.

This year, as we try to deal with the influx of veterans who are coming from Iraq and Afghanistan, plus the needs of our older veterans, which continue, it has been a great challenge for this Committee and for this Congress and for this Nation.

Earlier in the year, and in a series of articles since, *The Washington Post* reporters dealt with the terrible scandal at Walter Reed which had the effect, as other local newspapers around the country did stories on their military and veterans' hospitals, of a wake-up call for all of America. Their veterans, their troops coming back from the current war were not getting the treatment, the care, the respect, the honor and the dignity that Americans thought they deserved.

Because of that awareness that really spread throughout America, this Congress was able to add almost \$13 billion of new money for healthcare for veterans, an unprecedented increase of 30 per-

cent or more, based on the public perception that we had to do more.

The injuries that come from this war are very great, both physically and mentally, and yet, America has not really come to grips with it.

One of the television networks, ABC, whose reporter Bob Woodruff had suffered a blast injury and traumatic brain injury (TBI) in Iraq, opened up that subject to millions of Americans. And we know more now about TBI and how to treat it.

Recently, the CBS network opened up again to millions of Americans the issue of suicides amongst our veterans. They had a great deal of difficulty getting information from the authorities or from the U.S. Department of Defense (DoD) or from the Department of Veterans Affairs. That is one of the issues we are going to explore today, the issue of information and the tracking of these issues. But they had to spend 5 or 6 months tracking down statistics in different States because nobody seemed to be interested in Washington, of understanding the statistics.

Their report of several weeks ago again opened the eyes of millions of Americans to statistics, which went way beyond what people had thought or imagined as to the number of suicides, not only amongst our returning vets but amongst veterans from previous wars. I think it is now recognized that as many Vietnam veterans have now committed suicide as had died in the original war. That is a terrible, terrible statistic and says we have to do more.

So what we are going to do today is try to open up this subject which is very difficult for the families involved and for our government. We want to talk about the statistics. Why doesn't the VA do more about trying to understand the nature of the issue? We leave it to citizens like Ilona Meagher, who will be testifying later, to keep a Website for tracking suicides, of which she is one person with limited resources. This is what our government should be doing.

We want to talk about the stigma of mental illness and how we try to deal with this as a Nation. We want to talk about the apparent inability of the military to look at mental illness and people's honest attempts to deal with it as something to be recognized, promoted, encouraged. It is denied. Anybody who admits mental illness is threatened with no promotions or no jobs in law enforcement when they leave the military.

It is an issue for all of us in America but particularly for those in the military, and we have to face it honestly and come to grips with it. That is what we hope to do today.

We have a brave mother and father who have decided that their son's suicide must be talked about and understood to help others, and other families, prevent that. We have citizens, authors who have dealt very directly with this issue and, of course, the professionals within the VA system and those in the veterans service organizations (VSOs) who try to help their members deal with these issues.

So we will have a very tough hearing, as I said earlier, but it is an important hearing. America must look at these issues. We have to decide that we have to deal with them in a far more open and dedicated manner, and that is our objective today.

I would yield for an opening statement of the Ranking Member, Mr. Buyer.

[The prepared statement of Chairman Filner appears on p. 66.]

OPENING STATEMENT OF HON. STEVE BUYER

Mr. BUYER. Thank you, Mr. Chairman.

Some in this room today, including several of our witnesses, have been personally devastated by the loss of a loved one who has chosen to take their own life. Before I begin, I want to personally thank you for testifying about your extremely personal and painful experiences. While I know nothing can compensate you for the loss of your loved ones, we can hopefully find ways to help deter another soldier from succumbing to such tragedy.

I hope that, as we delve into these sensitive matters, we do not lose sight of the fact that every case that we will discuss here today represents a human life, a veteran, a family, and a tragedy. Discussing the tragic circumstances surrounding a suicide of one who has worn the uniform should be done with great respect and in recognizing also their service to our country. We must search for answers and solutions to veteran suicide.

As most of our witnesses will attest this morning, tracking suicide rates nationwide is very difficult, and it is clear to me that the data we currently have does not give us a definitive understanding nor a scope of the problem. There seems to be significant variations among the data provided by *CBS News*, the VSOs, the DoD and the VA. These veterans' lives were important, and it would be a dishonor to them and to their service if information is not accurately portrayed. Accurate information is crucial to identifying risk factors, to providing better prevention and treatment protocols.

Therefore, it is imperative that the VA have a better method to systematically collect and to track suicides so we can get a true understanding and scope of our challenge. It is my understanding that the VA is beginning to work with the DoD to do this, and I applaud them. But, again, I cannot overstate the urgent need to do it quickly. When decision makers do not have accurate data, we must rely on anecdotal evidence. While this can raise awareness, it does not help us make informed decisions on how best to develop strategies to diminish the risk and to prevent the events of suicide.

Notwithstanding the tragic stories that surround this hearing, I believe we can point to the steps that the VA and the DoD have taken to help veterans and servicemembers deal with mental health challenges.

The VA has already formulated a comprehensive strategy for suicide prevention, focusing on the needs of both new veterans from Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) and on those of prior conflicts. The specific program for suicide prevention is based on public health and clinical models and activities both within the VA facilities and the civilian medical community.

The cornerstone of this program is the VA's new 24-hour veteran suicide prevention hotline, which opened its lines in July of 2007. Since its inception, the VA reports that they have made more than 1,300 referrals to suicide prevention coordinators and have rescued

317 veteran callers. Veterans experiencing thoughts of suicide can call 1-800-273-TALK for help.

We have seen clearly that early intervention and treatment has a significant and demonstrated impact and is crucial to preventing suicide. It is important to recognize the warning signs and to ensure that servicemembers receive the treatment they need right away.

This starts with DoD. I am very encouraged that a new training program called BattleMind, developed at the Walter Reed Army Institute of Research, is being developed and is working to help soldiers transition from the combat zone to the home front.

Mr. Chairman, I would sum this up with this. VA and DoD have made strides in the treatment of mental health disorders that can lead to suicide. However, until families like the Bowmans no longer bear such pain, not enough is being done. I welcome their testimony here today, and I hope this hearing can help us gain a better understanding of how to offer more effective and timely assistance for those troubled servicemembers to prevent them from turning to such a tragic option.

On a personal note, as I see the parents sitting in front of me, your quest for answers will never end, and probably on your last breath there will still be the thoughts of your son. At the age of 16, my best friend committed suicide. His baseball cap sits in my office. I think people walk in, and they think it is my baseball cap, but it is that of a very dear friend. I constantly search for answers because none of us knew, even as close as we were to him. And, of course, the parents would drill us all the time about the signs. What were they? And there were no signs. There were no risk factors. It was just one of these bizarre strikes of the mind that just—I do not have an answer. I just want you to know I carry the pain of suicide, and I am in constant search of answers. And I am haunted, haunted by suicide. Even among my colleagues—if you want to talk about something that is not discussed, in the 15 years I have been in Congress, it is the number of suicides of sons and daughters of Members of the Senate or of the House, and it is not discussed—or the attempts. It is that dark side.

So you know what? It is not just us, and it is not just those in the military. You can touch any sector of our society. So, as we delve into this issue, we have to also be very sensitive, because I recognize there are anti-war advocates who also want to say that these individuals who then commit suicide and who have worn the uniform are somehow victims, and that is not right either, as we are trying to find out actually how can we prevent and how can we be helpful to someone who thinks that suicide is some form of option that can help them.

So, on a personal note, I thank you for your bravery to come here and to talk about your son, and I know you are doing this because you absolutely believe that your testimony here today can help someone else.

Thank you. I yield back.

The CHAIRMAN. Thank you, Mr. Buyer.

Our first panel will be Mr. and Mrs. Mike Bowman, whose son, Tim, an Army specialist in the Illinois National Guard from Bravo Troop, 106th Cavalry, committed suicide.

Before that, if you will allow me, Mr. and Mrs. Bowman, to ask our colleague Mr. Boswell if he would just step forward for 2 minutes. He is the author of Public Law 110–110, the Joshua Omvig Veterans Suicide Prevention Act, named after a young man in his own district, whose parents have now become friends with the Bowmans.

The Bowmans are being introduced by our other colleague from Illinois, Mr. Manzullo.

Mr. Boswell, please.

OPENING STATEMENT OF HON. LEONARD L. BOSWELL

Mr. BOSWELL. Thank you, Mr. Chairman, Ranking Member Buyer and Members of the Committee. I appreciate your holding this hearing and your leadership on this issue.

To Mike and Kim, we extend our hand in friendship, our concern and sympathy for the loss of your son, Tim, and we pledge to do our best to stop this.

As we all know, suicide is sweeping through our veteran population, and the Committee has shown leadership in addressing the issues our veterans face today. I want to thank you again for allowing me to speak on this important issue.

Suicide is an epidemic which is encompassing much of our veteran population. For too long, suicide among veterans has been ignored, and now is the time to act. We can no longer be afraid to look at the facts, and the sad fact is we are missing adequate information on the number of veterans who commit suicide each year.

I was shocked, and I am sure all were, when we saw the *CBS Evening News* report focusing on veteran suicides. They found that in 2005, over 6,200 veterans committed suicide—120 per week. The report also found that veterans were twice as likely to commit suicide as nonveterans. These statistics are devastating.

As a result of this report, I immediately introduced H.R. 4204, the “Veterans Suicide Study Act,” which several Members of the Committee have co-sponsored. If time had permitted, there would be many, many more, because no one—no one—who I approached chose not to sign on.

This legislation will direct the VA to conduct a study to get the real facts on the rate of suicide among veterans. It is just one step that we must do to ensure that we have adequate information so we can treat our veterans as they return from combat.

I would also like to personally thank the Chairman and the Ranking Member of the full Committee for their action in support of the Joshua Omvig Veterans Suicide Prevention Act earlier this year. Now that this crucial piece of legislation has been signed into law, I am confident our veterans will begin to receive more of the vital care they need.

While the Joshua Omvig bill puts in place a comprehensive approach in treating high-risk veterans, we still need to know the facts. So I implore the Committee, and the Congress, to act swiftly on H.R. 4204 so we can ensure we have the data we need to treat our Nation’s heroes. Our veterans have dedicated their lives to keep our great Nation safe, and it is now our duty and our time to protect them.

So I want to thank you again for allowing me to share this time with you, Mr. Chairman, and I am sorry I have to go to a markup. Thank you very much.

The CHAIRMAN. Thank you, Mr. Boswell, for your leadership on this issue.

Mr. Manzullo, if you want to introduce your constituents. Thank you for being here with us.

OPENING STATEMENT OF HON. DONALD A. MANZULLO

Mr. MANZULLO. Thank you, Mr. Chairman. I have the honor today of introducing, three constituents who are testifying before the Committee today.

In inverse order, on the second panel is Ilona Meagher. Ilona's father was a Hungarian freedom fighter and also became a member of the United States Armed Forces, so he is a veteran of both the Hungarian and the American Armed Forces. Ilona is a tremendous campaigner, a seeker of truth, and she wrote this book, "*Moving a Nation to Care*," about the very subject of which we are discussing this morning.

The other two constituents really exemplify the people about whom Ilona Meagher is concerned, and they are the Bowmans from Forreston, Illinois. Kim and Mike live about 10 miles from my farm in the same county in northern Illinois. Their testimony is nothing less than startling and compelling. They would rather be anywhere in the world than here today to talk about what happened in their lives and to their precious son.

I encourage the Members of this Committee to continue their leadership, to draft legislation or whatever is necessary, in order to make sure that the Bowman's testimony is not in vain and that their son's life is not in vain and that the lives of other young men and women who have taken their lives, will be used in order to prevent those situations from occurring in the future.

The CHAIRMAN. Thank you, Mr. Manzullo.

Mr. and Mrs. Bowman, you are recognized for your testimony. I had a chance to talk to you yesterday and to understand a little bit more about Tim, about the incredible job he was doing overseas, about the soldier that he was, about the close relationship you had with him, about your patriotism and his. So, again, I cannot say I am looking forward to your testimony, but I just thank you for having the courage to be here and for making sure that Tim's life and death will be used to help other people.

Please, Mr. Bowman.

**STATEMENTS OF MIKE AND KIM BOWMAN, FORRESTON, IL
(PARENTS OF SPECIALIST TIM BOWMAN, U.S. ARMY, ILLINOIS NATIONAL GUARD, BRAVO TROOP, 106TH CAVALRY)**

Mr. BOWMAN. Mr. Chairman and Members of the Committee, my wife and I are honored to be speaking before you today, representing just one of the families who lost a veteran to suicide in 2005.

As my family was preparing for our 2005 Thanksgiving meal, our son Timothy was lying on the floor of my shop office, slowly bleeding to death from a self-inflicted gunshot wound. His war was now over; his demons were gone. Tim was laid to rest in a combination military-firefighter funeral that was a tribute to the man that he was.

Tim was a life-of-the-party, happy-go-lucky, young man who joined the National Guard in 2003 to earn money for college and to get a little structure in his life. On March 19th of 2005, when Specialist Timothy Noble Bowman got off the bus with the other National Guard soldiers of Foxtrot 202 who were returning from Iraq, he was a different man. He had a glaze in his eyes and a 1,000-yard stare, always looking for an insurgent.

Family members of F202 were given a 10-minute briefing on post traumatic stress disorder (PTSD) before the soldiers returned, and the soldiers were given even less. The commander of F202 had asked the Illinois Guard Command to change their demobilization practices to be more like the regular Army, only to have his questions rebuffed. He knew that our boys had been shot up, had been blown up by improvised explosive devices, had extinguished fires on soldiers so their parents would have something to bury, and had extinguished fires on their own to save their lives. They were hardened combat veterans now, but were being treated like they had been at an extended training mission.

You see, our National Guardsmen from the F202 were not filling sandbags. They departed in October of 2003 for 6 months of training at Fort Hood and Fort Polk. On Tim's 22nd birthday, March 4th of 2004, Foxtrot left for Iraq, where they were stationed at Camp Victory. Their tour took them directly into combat, including 4 months on the most dangerous road in the world, the highway from the airport to the Green Zone in Baghdad, where Tim was a top gunner in a Humvee. Tim, as well as many other soldiers at F202, earned their Purple Hearts on that stretch of road known as "Route Irish." We are still waiting for Tim's Purple Heart from various military paperwork shuffles.

My wife and I are not here today as anti-war protesters, and let me make that very clear. Our son truly believed that what his unit did in Iraq helped that country and helped many people that they dealt with on a daily basis. Because of his beliefs, I have to believe in the cause that he fought and died for. That does not mean I do not feel that we lost track of our overall mission in Iraq.

When *CBS News* broke the story about veterans suicides, the VA took the approach of criticizing the way the numbers were created instead of embracing it and using it to help increase mental healthcare within their system. Regardless of how perfectly accurate the numbers are, they obviously show a trend that desperately needs attention.

CBS News did what no Government agency would do. They tabulated the veterans suicide numbers to shed light on this hidden epidemic and to make the American people aware of this situation. The VA should have taken those numbers to Capitol Hill, asking for more people, funding and anything else they need to combat this epidemic. They should embrace this study, as it reveals the scope of a huge problem, rather than complain about its accuracy.

If all that is going to be done with the study is to argue about how the numbers were compiled, then an average of 120 veterans will die every week by their own hand until the VA recognizes this fact and does something about it. The VA mental health system is broken in function and understaffed in operation. There are many cases of soldiers coming to the VA for help and being turned away

or misdiagnosed for PTSD and then losing their battle with their demons.

Those soldiers, as well as our son Timothy, can never be brought back. No one can change that fact. But you can change the system so that this trend can be slowed down dramatically or even stopped.

Our son was just one of thousands of veterans that this country has lost to suicide. I see every day the pain and grief that our family and extended family go through in trying to deal with his loss. Every one of those at-risk veterans also has a family that will suffer if that soldier finds the only way to take battlefield pain away is by taking his or her own life.

Their ravished and broken spirits are then passed on to their families as they try to justify what has happened. I now suffer from the same mental illness that claimed my son's life—PTSD from the images and sounds of finding him and hearing his life fade away, and depression from a loss that I would not wish on anyone.

If the veterans suicide rate is not classified as an epidemic that needs immediate and drastic attention, then the American fighting soldier needs someone in Washington who thinks it is. I challenge you to do for the American soldier what that soldier did for each of you and for his country: take care of them and help preserve their American dream as they did yours. To quote President Calvin Coolidge, "The Nation which forgets its defenders will itself be forgotten."

Today, you are going to hear a lot of statistical information about suicides, veterans and the VA, but keep one thing in mind. Our son, Specialist Timothy Noble Bowman, was not counted in any VA statistic of any kind. Let me repeat that. Our son is not included in any VA count. Now, why, you ask? He had not made it into the VA system because of the stigma of reporting mental problems. He was National Guard, and he was not on a drill weekend when he took his life. Therefore, he was not counted as active duty. The only statistical study that he was counted in was the *CBS News* study. And there are many more just like him. We call them KBAs, killed because of action, the unknown fallen.

I challenge you to make the VA an organization to be proud of instead of the last place that a veteran wants to go for help. It is the obligation of each and every one of you and all Americans to channel the energies, the resources and the intelligence and wisdom of this Nation's best and brightest to create the most effective, efficient and meaningful healthcare system for our men and women who have served.

We must all remove the stigma that goes with the soldier's admitting that he or she has a mental issue. Let those soldiers know that admitting they have a problem with doing the most unnatural thing that a human being can do is all right. Mental health issues from combat are a natural part of the process of war and have been around for thousands of years, but we categorize that as a problem.

Take that soldier who admits a head and mental health injury from combat and embrace him as a model for others to look up to. Let the rank-and-file know by example that it is okay to work through your issues instead of burying them until it is too late. Grab that soldier and thank him for saying, "I am not okay," and promote him. A soldier who admits a mental injury should be the

first guy you want to have in your unit, because he may be the only one who really has a grasp on reality. But instead, he is punished and shunned, and by that example, he has become the model for PTSD and suicide.

While we are at it, why do we call it a disorder? That title, in itself, implies ramifications that last forever. It is an injury, a combat injury, just like getting shot. And with proper care and treatment, soldiers can heal from this injury and can be as productive and as healthy as before.

We, as a country, have the technology to create the most highly advanced military system in the world, but when these veterans come home, they find an understaffed, underfunded, underequipped VA mental health system that has so many challenges to get through it that many just give up trying. The result is the current suicide epidemic among our Nation's defenders, one of which was our son, Specialist Timothy Noble Bowman, a 23-year-old soldier and our hero. Our veterans should and must not be left behind in the ravished, horrific battlefields of their broken spirits and minds. Our veterans deserve better.

Thank you, Mr. Chairman.

[Applause.]

[The prepared statement of Mr. and Mrs. Bowman appears on p. 68.]

The CHAIRMAN. Mrs. Bowman, do you have anything to add? Thank you for being here with Mike. And, again, thank you for your courage in being here.

Mr. Michaud, you are recognized.

Mr. MICHAUD. Thank you very much, Mr. Chairman and Mr. Ranking Member, for having this very important and timely hearing today.

And it is going to be a tough day going through all of the testimonies, but I appreciate your remarks, Mr. Bowman.

Thank you, Mrs. Bowman, for coming.

Our soldiers, as you know, put their lives in harm's way to protect our country. Not all wounds are physical. The memories of the war do not disappear when they take off the uniform. A lot of us have seen the casualties of war. Maine recently lost one of its sons to suicide. Kyle Curtis, who served in Iraq, took his own life, like your son.

My question is: When your son came back, did he try to get some assistance from the VA? Did either one of you notice any changes in the way your son was acting? Did you try to see or to encourage him to get help?

Mr. BOWMAN. Timothy was a very smart kid, for one thing, and that gave him the ability to—as soon as he would start to open up in a situation where he thought his anger or his drinking problem or any sign that he was having trouble was going to be visible by us, he would immediately change the subject, or if we were sitting around our patio, he would go home. He would find a way to leave that situation that was putting him in that position, so that he could close that door in the back of his mind again and go on to something else.

He had shown us small signs but not enough to trigger anything, because we did not know what we were looking for. And we, as Na-

tional Guard families, are never educated on what to look for, because it is volunteer. You know, you show up at a readiness group meeting, and there is somebody there who gives us a 10-minute briefing. That was 2 months before the guys got home. Then you go through the process of the homecoming, and you realize that they are going to be changed when they come out of combat. That is fact. So then they hit your back door, and sure, there are some issues that you see, yet they think it is normal, and they portray it as being normal, and they tell you that it is normal. "This is just the way I am now."

Now, he showed us one little sign. He showed certain friends other little signs. If we had all gotten together, we would have seen a larger picture, and we would have known he was in more trouble. But he was so good at hiding that that nobody knew for sure.

And he was a model employee. He worked for me in the family business. We have an electrical contracting business. He would have been the third generation in 40 years. He was an absolute model employee. He went to work every morning regardless of what happened the night before or anything else. So, you know, you would discount any problem he was having at night because he did such a good job during the day.

So trying to read the picture was very, very tough for him, especially with our not being educated on what the signs should be.

Mr. MICHAUD. Not knowing where you live in relationship to the VA hospital, other than providing resources to the VA so they can hire staff to take care of the need that is out there, as well as to provide additional resources so if you live in a rural area, they could contract with providers in a rural area, do you think it would be helpful if the VA established a program for those individuals who might not want to go to the VA facility to have counseling online, on a computer?

With technology today, a lot of individuals, particularly our younger individuals, are on the computer all of the time. Do you think it would be helpful if the VA established a program where someone could actually access help from home, whether it is to a clinic or to the VA hospital?

Mr. BOWMAN. I would say, yes, definitely. As in the case with Tim and with a lot of his unit buddies, they are very well-computer-connected. They stay connected with us now via e-mail and by all kinds of ways through the computer.

I would think that would be an easy way, especially as long as they can enter it anonymously, because you have the stigma of, if you walk into a VA clinic, somehow that information is going to get back to your commanding officer. And until that stigma is removed, that you have just admitted to having a mental health issue, they have to be able to find help in some way so it is not going to come back to haunt them in their careers.

A lot of these guys who come home from Iraq, a lot of the guys in Tim's unit are 10-years-plus in the National Guard. They want to get to their 20 years. They do not want to get out. So they do not want to have a problem with their careers down the road, which means they also do not want to have a problem with promotions. And it is a known fact that if you voluntarily admit that

you have a mental health issue that your chance of progression in the military ranks at that point is pretty well shot.

So, with the computer, it is if you can make it anonymous and can make it helpful. By “helpful,” I mean it is peer-to-peer counseling.

We had a discussion this morning about this very issue. The Vet Centers were a wonderful idea, but then all of a sudden, the VA comes along and they decide they have to have a guy with a title and a suit as a counselor at the Vet Center. Now, what did that do? That took that soldier who was walking in with that issue and made him on the defensive right off the bat. He was not talking to his peer anymore. He was talking to somebody who was sitting at another level above him.

If you take a Vet Center and you make it a room with a couch and a pop machine and you put guys in there who are not in uniform and who are not in a suit or anything else and they just sit and talk, you will have veterans opening up. But if you take a guy with PTSD and you shove him in a room with a doctor in a suit, he is going to shut that door.

Mr. MICHAUD. Thank you very much. It has been very helpful.

Once again, I am sorry for the loss of your son, but I really appreciate both of you and your willingness to come forward to talk about your tragedy in order to help others who have not taken their lives. Hopefully, we will be able to move forward in a positive, productive manner.

So, once again, thank you very much for coming here today.

Mrs. BOWMAN. Thank you.

Mr. MICHAUD. Thank you, Mr. Chairman.

The CHAIRMAN. Ms. Brown-Waite, you are recognized.

Ms. BROWN-WAITE. Thank you very much, Mr. Chairman.

Mr. and Mrs. Bowman, all of us here who are parents can only imagine what it is like to lose a child. It is the toughest thing that a parent ever does.

One of the questions that I was just asking counsel was—I do not believe, in many of the Community-Based Outpatient Clinics (CBOCs) where they offer mental healthcare, that that information gets back to the commanding officer. And I think we need to look at that. I know the CBOCs in my district consider anyone who seeks mental health or any kind of care as a VA case, and it is not reported to the National Guard commanding officer or to the Reserves or even if the person is ready reserve call-up.

Tell me why you believe that—tell me why veterans who have served believe that the information gets back to the commanding officer.

Mr. BOWMAN. The 118 soldiers who were in F202 have basically all—they have all adopted us. We are their adoptive parents now, and they are all our adopted sons. I talk with these boys all the time, and they open up to me because they know that I will understand about their mental status. They ask me questions about Tim.

I have a list as long as my arm of soldiers in that unit who are all seeking counseling of some form or another privately, all away from the military, away from the VA, some as far as 100 miles away from home, to make sure that that information does not get back to their unit.

Now, you say that that information should be kept anonymously by the VA and should never make it back. If that is true, then you are not—I am sorry, not “you”—then they are not educating the rank-and-file soldiers to let them know that it is safe to go to the VA. You have to change that stigma.

And I know for a fact that I can call four or five guys right now who will tell you the same thing. They are all active-duty National Guard. They will not go to a VA center for this because they are going back. My son’s unit is going to Afghanistan in the spring, and they do not want to risk a redeployment opportunity by having a mental health issue all of a sudden show up on their records.

Ms. BROWN-WAITE. Please do not misunderstand me. I am not questioning it. I am just saying what I believe is the policy. I will certainly check on that, as to if someone goes to a VA hospital or to a CBOC, that that information is kept private. Certainly, under Health Insurance Portability and Accountability Act (HIPAA), for example, which covers the privacy of medical records, that would be absolutely prohibited unless the patient releases any information.

So what I am saying is, believe me, I do not think there is a person on this panel on either side of the aisle who would ever stand for, if that is the policy, its continuing. If it is not the policy, I agree with you, it needs to be out there loud and clear, absolutely loud and clear, to our military.

The last casualty in my district happened to have been someone who was active-duty who committed suicide. I do not believe that the people who are active-duty even are properly informed. In this case, the young man was crying, and one of his buddies came up to him and said, “Can I help you? Do you need to talk to someone?” He said, “Yes.” So the buddy left to go get the chaplain, and in the meantime, this young soldier committed suicide. What should have happened was, if it were just the two of them, he should have stayed there with him and should have gotten, called, you know, just perhaps gone outside the door and called for help. So there are certainly ways that we could do a better job at suicide prevention.

Again, thank you very much for coming and for sharing your story. And I will follow up on that issue.

Mrs. BOWMAN. Thank you.

Ms. BROWN-WAITE. Thank you.

The CHAIRMAN. Thank you, Ms. Brown-Waite.

By the way, I would not just concentrate on the official records, on whether they are sealed or not. It is the knowledge of when someone walks into a clinic. People talk; their buddies talk. The information is there even if the exact record may not be held. It is that information and that sense that seeking help is itself the problem for the military.

So, you know, when you are in a small community like this, everybody knows what everybody is doing. I would think that that is more of the sense than someone’s individual record being given.

Would you agree, Mr. Bowman?

Mr. BOWMAN. Yes, it very true, especially in a National Guard unit because, traditionally, those men are closer than a regular military unit because they all live in the same neighborhood also.

The CHAIRMAN. Mr. Hare, I know the Bowmans live near your district.

Mr. HARE. Thank you, Mr. Chairman.

I want to thank the Bowmans for their courage in coming today and for telling the story, the chilling story, about your son, Tim. I had the opportunity to sit with both of you this morning with my friend, Representative Manzullo. I cannot begin to express my sorrow for your loss. My son is about the age of your son.

I find it appalling that you have not received the Purple Heart for your son, and I want you to know, this morning, Representative Manzullo and I will work very hard, and we promise you that we will get this situation taken care of quickly. I cannot imagine that that is something that has not already been done, but we will work on that.

Your son was a brave young man. He served this country honorably. We talked a lot about some of the things, about Iraqi veterans and Afghanistan veterans coming back. One of the things that you talked about, Mr. Bowman, too, was about how on a Monday you are in Iraq and on a Thursday you are home. You may be playing soccer or watching your kid's soccer game or doing things, but it is a very different war, and it has put tremendous stress upon people.

I just want to ask a couple of things of both of you. We talked about this this morning, but I think, for the record, it is important.

You know, the Chairman has a wonderful idea, and that is to screen every person who comes back for PTSD. You know, Representative Murtha said if you are in combat for more than 6 months you are a prime candidate. For those particularly in the Guard and in the Reserves who have to come out and say, "Hey, I think I have a problem here," they are really setting themselves up, as you said, for a possible loss of employment, a possible loss of being redeployed again in their units. So I wonder if you think that makes sense, from a perspective of testing everybody.

But also, I was amazed when you said you only had a 10-minute briefing prior to your son's coming home. A lot of parents—I know Mrs. Bowman this morning was obviously very upset. You do not know what to look for. This is not just an individual problem. It seems to me, Mr. Chairman, this is a problem that affects the entire family. How do you know what to look for if you do not know what to look for or know what the signs are?

So it puts you at a handicap, and then the parents and the family end up feeling like somehow they could have intervened or should have intervened, but if you do not know what you are looking for, you are relying upon bits and pieces. Like you said, Mr. Bowman, different groups of people had to come up and say, hey, Tim said this or Tim said that.

So I don't know. If you would spend maybe just a couple of minutes talking about the need—and I thoroughly agree with the Chairman that every person coming back should be screened. I think we should look farther down the road, because it does not necessarily manifest itself within 30 days of coming home. It could be 4 or 5 years. We have seen this.

Then also, maybe, just how little knowledge you had or the families had before your sons and daughters were coming back from this war to know even what to look for.

Mr. BOWMAN. The redeployment process, basically reintegrating back into society—we were talking with Chairman Filner last night about the unboot camp, the reverse boot camp. It is something that we have lobbied with the Illinois National Guard for a long time. You cannot just educate the soldier; you have to educate the family.

Now, obviously, I am speaking from the standpoint of a National Guard parent, but Army Reserves and Marine Reserves would pretty well fall into the same category. I have a young Marine Reservist who lives right up the road from me who is going through the same type of scenario right now.

You cannot make it optional. Our education meeting from the State Family Readiness Group was optional. You did not have to be there as a family member. So, out of 118 families, we might have had half of them there, so there were 50 families who were there. The meeting was about an hour long.

We spent, I would say, about 10 minutes with a brochure on PTSD, and then the rest of the time dealt with the health insurance, because, see, a lot of these guys have families. They need to know when the health insurance runs out, their last check. They need to know all of the financial aspects. When does my husband have to go back to work? When does my son come off of Federal title and go back onto State title?

It is all of these questions because, at that point, those are much higher on the priority list than PTSD. So you start out the meeting talking about health issues, and that gets shoved off to the side. Then they hand you a magnet with a bunch of phone numbers on it that says, “Here is where you call for help.”

It does not work because the excitement of the moment, the excitement of the homecoming overtakes everything. So you have to come back to the issue after they are home. There is a 2-week period of coming home. Let them be with their families for a couple of weeks, and then bring them back. It has been a long-talked-about idea through a lot of families. Bring the families with them, and do not make it optional. Yes, you are going to have to pay for it because a lot of these guys have kids, but what would you rather pay for, a couple of weeks in a camp where you can educate the family and the soldier or looking at another statistic and another news report where you have lost another veteran to suicide who took his own life?

You have to make it appealing to people. You cannot make it something that is so absurd or grueling that nobody is going to pay any attention.

Mrs. BOWMAN. It is one more battle.

Mr. BOWMAN. Yes, it suddenly becomes another battle, exactly.

There are ways to do that. You know, you get the right people involved in the situation. You look at how you can educate kids with cartoons and video games and how they excel with that type of training because they relate to it. And that is the kind of re-education that not only the soldier needs but the families need and all of the family.

Mr. HARE. Just one final thing. I know I am out of time.

With regard to the price, the price that your family has had to pay, and particularly for those people who have lost their lives because they did not know where to go, I do not think we even ought

to be quibbling over whether or not we can afford to do this. This is something that I think we have a moral obligation to do for the men and women who serve this country.

So, with that, I yield back.

The CHAIRMAN. Thank you, Mr. Hare.

Mr. Stearns.

Mr. STEARNS. Thank you, Mr. Chairman. Thank you for holding this hearing.

Let me echo sincerely the comments of my colleagues, in which we are very sorry for this tragedy. Having three boys, I think anybody who has children certainly identifies with the grief that you are going through.

But I would say to you, in all candidness, that your coming here is good for us, but it is probably good for you to talk about it and to tell us, in the ways that you are doing, so that we better understand. As to the actual telling of it to us by you, I think and hope and pray that it helps you too, as you mentioned that you have post traumatic stress symptoms yourself. Obviously, every death is a tragedy, but losing those who fought so bravely to protect us in this room, and in this country, is something that we cannot discount and that we cannot brush aside.

In hearing from your testimony that he was one of those who spent 4 months on the most dangerous road in Iraq, going from the airport to the Green Zone, Members of Congress go to Iraq, but we fly by helicopters from the airport to the Green Zone, so we are not in that dangerous zone.

I read also that you indicated that his Purple Heart has still not arrived. Is that true?

Mr. BOWMAN. That is correct.

Mr. STEARNS. That is something that we will look into, too.

The thing that struck me about this is—and Members will talk about this. Mrs. Bowman, is it possible I could ask you a question and get your feeling too? I notice your husband is doing all of the talking.

When you look back at it, do you think the Veterans Administration, if they sent people to your home—I know I asked the staff here, does the Veterans Administration have counseling? It says they provide readjustment counseling and outreach services to all veterans who serve in any combat zone. Services are also available for their family members for military-related issues. Veterans have earned these benefits, and these services are provided to them, but, I mean, that means you have to go to the Vet Center to get it.

So, Mrs. Bowman, in retrospect, is there something that the Veterans Administration could have told you or something that you could have done, where you felt that you just did not have the psychological skills or that you did not have the education? I mean, is there a void there that we, as Members of Congress, could legislate and could tell the Veterans Administration that we are not going to wait for the families to come to the Vet Centers and that we are going to send the people to you once we identify those individuals coming back?

Mrs. BOWMAN. Right. It is just like my husband said. If we would have been included with Tim in some kind of a program where we had to report back to someone, where we had some kind of screen-

ing or a one-on-one with all three of us or with the two of us, as far as what we have seen or have not seen, and Tim on his own, so that we could, you know, get together and realize there is an issue here and that they could now help us deal with this and give us the tools to do that.

Mr. STEARNS. I have been in hearings for something like this, and I chaired a Subcommittee on Commerce, Consumer Protection and Trade, and we dealt with families who had children who took steroids and who committed suicide. So I have looked at this.

What I found is that, if there is employment for the individual, that is a big step—but Timothy had employment—and if he is adequately compensated and has enough cash flow or something so that he at least is not on the edge there. Secondly, it is that he has significant counseling by folks, and if necessary, he is provided medication.

Was he provided medication?

Mrs. BOWMAN. He did not ask for medication.

Mr. STEARNS. He did not ask. Is there a reason why he did not ask?

Mrs. BOWMAN. He did not realize he had the problem he did.

Mr. STEARNS. So he did not even realize that this post traumatic stress disorder was affecting him, and he was not receptive to counseling or to the medication?

Mrs. BOWMAN. No.

Mr. STEARNS. Okay. Then the last thing I found was some kind of education. Did he have a high school degree?

Mrs. BOWMAN. Yes.

Mr. STEARNS. He did. Okay.

So, once those three are in place, then the building of the self-esteem is the key. And the parents somehow have to convince him or her that everything is going to be all right; we are going to work through it. In this case, it did not happen, and it is so tragic and sad.

I think, as legislators, we can direct the Department of Veterans Affairs to not only brief you but to come into your house and set up perhaps a casual type of counseling where the veterans themselves, who are back and who are, shall we say, aware of this problem, can sit down with Timothy and say, "Okay, let's shoot the breeze here and talk about it. What is happening in life? Who are you dating?" and things like that. So, I mean, that is what you are telling me would have been a big step.

My last thought here is that both of you feel that you were—or were not—adequately briefed enough to know how to help Timothy. Can you just elaborate on that a little bit?

Mr. BOWMAN. No, we were not briefed on what direction to send him. The only information we got was, like, of a mandatory nature. Before you could do anything, as far as getting him help, you had to get him registered with the VA. He had to go to the VA office with his DD-214 and get registered there, and then you could start the process.

He came home with a battlefield injury that was going to be with him for the rest of his life, a broken hand that was a little bit handicapped after combat. So he needed to go to the VA because there was some follow-up surgery that was going to need to be done

in a couple of years. In order to do that, you have to register. Well, he finally did that, but he was home for about 7 months before he registered.

A lot of the guys who came out of combat were like that. They would not take that step to go get registered at the VA. It was almost kind of a mental block that they just kind of did not want to do it. Then one of the guys in the unit started working at the VA office, and then all of a sudden they all started rolling in, because everybody started pushing them.

Tim had an appointment with the VA that was actually scheduled for a couple of weeks after he died. We got a reminder letter in the mail that, you know, gave me the appointment time and stuff. And I stopped up at the clinic in Freeport to see what it was about, and of course, they couldn't tell me because of HIPAA, so we don't know if that was about his hand. It would have been his first appointment. We don't know if that was his hand or what it might be.

As long as we have brought the VA registration issue up, one of the things that has always kind of bugged me about this is that a veteran has to go to the VA office with his DD-214. Why isn't the VA sitting there when they get off the bus when they are coming home from Iraq? There are 118 guys coming off of three buses at a National Guard armory. Why don't they have somebody at that armory with a computer and a desk, registering them before they can go home?

They are coming out of combat. You know that they are going to need help. Sign them up right there. That way, you know where they are, you know who they are, and they are in the VA system right away. Don't make it so that the soldier has to go to the VA. Make the VA go to the soldier.

[Applause.]

Mr. STEARNS. Thank you, Mr. Chairman.

Just a point in passing for Members. There are tests, written tests, that soldiers can take when they get out that, once you take these tests—it is just a question and answer over a period—they take this test, it will tell them of their post traumatic stress disorder, tell them of their depression and their emotional disability. And once they know that I would think that would be a step, too.

The CHAIRMAN. But, Mr. Stearns, we have lots of evidence that those are not, one, filled out accurately. Because, again, the soldier knows if he checks anything he is going to have to stay and not get home; two, his deployment is threatened; and, three, commanding officers have called in soldiers who have made the wrong check on those questionnaires and said you are going to have problems unless you change that. So, as I said in my opening statement, the whole culture of the military is set against him. He is not encouraged nor shown the importance of talking about this and getting help.

Mr. STEARNS. Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Rodriguez, who in his former life was a professional mental health worker, so we thank you, Mr. Rodriguez, for your involvement on this.

Mr. RODRIGUEZ. Mr. and Mrs. Bowman, first of all, thank you very much for your testimony. I know that it is difficult, and it is

also hard to hear these types of tragedies. But it is something that we have to dialogue about and hear about in order for us to start doing something about it, and I want to thank you for coming forward.

I have had a situation in Eagle Pass, Texas, where one of my soldiers had communicated with his family and seemed in good spirits and then the next day committed suicide. And he was a soldier. So when you commit suicide and you are in the military, that person's body was brought back and was treated in a very different way. Here is a soldier who committed suicide while in duty.

And I just had another request from another community on a soldier whose parents noticed—this was going to be either the third or fourth time they were going to go to Iraq—noticed that there was something very different about their son. And I made some calls, and I had difficulty trying to see if we can just get some treatment for this soldier prior to getting sent to Iraq again. And I know the family, so there was no issue as it dealt with the courage that was needed in order to go there or anything like that. It had to do with some mental health problems that they had encountered. And so, somehow, that issue of stigma has to be something that we need to work on.

And as indicated earlier, I know our Chairman, Bob Filner, has talked about providing treatment for every single soldier; and that way that stigma would not be there for a period of time. And sometimes you are not able to pick up on that diagnosis initially until much later, and so we have to be able to come back a year later.

And I just wanted to see if you might have any reflections on that? How long before you witnessed anything or you were able to pick up on something from the very beginning and how long was he out from the military before.

Mr. BOWMAN. He came home in March of 2005, March 29—

Mrs. BOWMAN. Nineteenth.

Mr. BOWMAN. Okay—and he died on November 24th of 2005. So he was only home for 8 months before his demons took him over.

And, like I said before, his symptoms, he concealed them so well that we could see that there were maybe some problems, but you couldn't identify—you couldn't put the pieces together to make the picture clear enough to be able to push him toward a certain area, certain direction.

The check-ups—the after-action check-ups when they come home, we feel, are extremely important. When they get off the bus, get them in the system, get them home for a couple of weeks, bring them and the family back, go through the demobilization, unboot-camp process with everybody, however long that takes.

But then bring them back in 90 days. Bring them back in for 1 day, a Saturday, a Sunday, then wait another 90 days, and then maybe you stretch it out to 6 months the next time. But don't just come to a point and stop and then throw them away.

We can track a cow with mad cow disease to the middle of a pasture in Montana. You have got to be able to track these veterans.

And you don't make it optional, which means you have to pay them for it. It goes back to the price, but the price is small compared to what the veteran will pay and his family. Bring him back in. The symptoms of PTSD will manifest themselves anywhere

from 30 days to 5 years. So you have got to know what you are looking at, and you have to be able to see down the road, and the evaluations have to mean something. They can't be that four-page test that Tim took when he was at Fort Carson. I have got that test. It is a joke.

Mr. RODRIGUEZ. Let me also thank you for your testimony and also indicate—and I want to take this privilege to recognize Umberto Aguirre from Del Rio, who is here, and the GI Forum. Will the members of the GI Forum please stand?

I want to personally thank them, because they have been working with our veterans. I know we have some homeless shelters throughout the country and some training programs and these veterans have continued to reach out to a lot of the veterans out there. And I want to personally thank the GI Forum. Thank you for being there and all the leadership of the GI Forum and thank you very much for your testimony.

The CHAIRMAN. Thank you, Mr. Rodriguez.

Mr. Boozman.

Mr. BOOZMAN. Thank you, Mr. Chairman.

I just want to thank you for your testimony. It was very helpful. We certainly appreciate the sacrifice of your son and sacrifice of your family. My dad did 20 years in the Air Force.

And, again, it is a matter of resources. We need to put a lot more resources in the area. Your son, you know, we can talk about, oh, not reporting for a variety of different reasons; and, you know, I didn't have the privilege of knowing him. But sometimes it is that you are afraid of it being a stigma on your report for future promotion or whatever.

And then a lot of times with guys—and a lot of my friends were this way—it is also an admission of a personal weakness perhaps that you didn't think you ought to be having. I don't mean that as a personal weakness, but the connotation, you know, I am having these feelings that I shouldn't have, and I am a tough guy and you don't—you know, like I say, tough guys are like that.

So we just need to get it figured out. We need to put a lot more resources. Some States are doing a much better job than other States right now. We need to look at the States who are doing a really good job. And then, again, when it comes down to it, require a very high level of care, a very high level of how we attack this problem, and then just mandate that we get it done and provide the funding.

So, again, thank you very much for being here. It was very, very helpful.

Mrs. BOWMAN. Thank you.

The CHAIRMAN. I just want to ask unanimous consent that our colleague from Rhode Island, Mr. Kennedy, who is the author of the Mental Health Parity Act, be allowed to join us, at the dais for the Committee hearing today. Hearing no objection, it is so ordered.

I now recognize Mr. Mitchell, who is Chairman of our Oversight and Investigations Subcommittee, and was the first one to make sure that we followed up on that *CBS News* report with this hearing, thank you. Mr. Mitchell.

Mr. MITCHELL. Thank you, Mr. Chairman.

First, Mr. and Mrs. Bowman, I want to offer my condolences. I want to thank you for having the courage to come forward today and share your son's story.

You spoke in your testimony about the VA's reaction to the *CBS News* investigation about veteran suicides, and I guess I would like to know this. How did you feel when you heard the VA's reaction and did it make you feel like the VA was working to help families like yours?

Mrs. BOWMAN. No.

Mr. BOWMAN. My wife can attest to the fact that when I saw Dr. Katz's reaction on the TV, the first thing I wanted to do was reach through the screen and choke him. That as a family member was my reaction to their response to that number. Why not take that number and say, you know, oh, my God, we have got a problem here. Let us do something about it. This is obviously an issue. But instead it is, let us pick on the guy who put the number together.

You know, I don't get it. As a family member, I was appalled. I was absolutely appalled. It is just one more case where the VA let the veteran down.

Mr. MITCHELL. Thank you.

The CHAIRMAN. Thank you, Mr. Mitchell.

Ms. Berkley. Again, thank you for your leadership in this area.

Ms. BERKLEY. Thank you, Mr. Chairman. I appreciate the fact that you have scheduled this hearing, and I appreciate Mr. and Mrs. Bowman for being here. I know it can't be an easy thing for you, but we appreciate it very much.

When somebody dies from my home State of Nevada in the line of duty, I call the family, and it doesn't matter whether they live in my district or not. I think it is the only right thing to do, to offer my condolences, not only as a congresswoman but as a parent and a mother who has sons of her own.

Earlier this year, I had the occasion of calling a grandmother who raised her grandson. He had served one tour of duty in Iraq; and he had come home to Pahrump, Nevada, which is a very small bedroom community outside of Las Vegas, and was emotionally a mess. And he told his grandmother he cannot go back. He cannot go back. He doesn't care if goes to jail. He doesn't care if this happens, if that happens.

Now, the military's response to him was to give him Valium and send him back. He was back for 24 hours, and he blew his brains out. It was in this context that I spoke to his grandmother to offer my condolences. Now, I could talk to this woman for the rest of her life and I could never heal the hole in her heart that she will have for the rest of her life.

There are so many statistics. I have got pages of them in front of me now, and you are living this. And it is important for us to recognize, and I think just by holding this hearing and bringing this to the attention not only of the American people, but of Members of Congress, we are making a giant leap forward. Because a generation ago, even a decade ago, this conversation could not have taken place.

Mr. BOWMAN. You are right there.

Ms. BERKLEY. I came from the Vietnam era. That was my war. I was in college. Now, I meet with my Vietnam vets all the time

back in Las Vegas. Most of my homeless in Las Vegas are Vietnam-era vets. I talk to them. I have normal conversations with them as if I was sitting there talking to you.

But they came back messed up, and we didn't recognize that there is a mental health price to pay for service to our country. You can recognize a wound and treat it, but we were so ignorant of the fact that people, men and women, are coming back with wounds that we cannot see.

Taking care of these veterans, taking care of our National Guard members, taking care of our military is the cost of waging war; and this is not an area that can be short-changed. It should not be short-changed.

Now, I had another constituent, Lance Corporal Justin Bailey. He returned from Iraq with PTSD. He developed a substance abuse problem. And he came from a nice middle-class family. His father is a teacher in my district. They are normal, average, good Americans that believe in this country, believe in the cause and believe that their son was serving his country.

He came back with undiagnosed PTSD. They know it now. He developed a serious substance abuse disorder. They begged him to get help through the VA. He didn't want to go. They convinced him to go. He went. Now, he was on five different substances when he checked himself into the VA. The VA gave him two more medications, and 24 hours later he was dead at the VA.

I tell you this because if we don't have—we can pass every law in the world here, but if we don't have adequate education, if we don't have adequate training, if we don't have adequate personnel that can recognize the problem when they see it and confront it, nothing we are doing here is going to make much of a difference. So I have introduced a Mental Health Improvement Act which aims to improve the treatment and services provided by the VA to veterans with PTSD and substance abuse disorders; and I am hoping that my colleagues, particularly here on the Veterans' Affairs Committee, will join me in co-sponsoring this legislation.

It isn't enough to recognize the problem, although we are moving forward in that direction, and I think it is good. It is not enough to pass legislation. We have to ensure that once these young men and women get into the system that the system knows what to do with them, and this legislation I hope will help that.

I want to thank you again for being here and hope that your tragedy will kick-start this legislative process so that we can protect our men and women in the military when they come home from their service. Let us eliminate the stigma attached to mental health problems and mental health issues.

And you are so right, and so many of my colleagues that have mentioned this, you are right in saying the VA and the Department of Defense need to go to our fighting men and women, not the other way around. We will save countless numbers of lives and improve the quality of their lives for the rest of their lives. And I thank you very much.

Mrs. BOWMAN. Thank you.

Mr. BOWMAN. Thank you.

The CHAIRMAN. Thank you.

Mr. McNerney.

Mr. MCNERNEY. Thank you, Mr. Chairman.

I don't have any questions, really. I just want to thank the Bowmans for your courage in coming today, and I think it reflects honor upon your son. Now it is our duty to learn from your experience and see that some of these changes are implemented that will make a difference in people's lives, particularly your observation that help should be anonymous and helpful, as well as your suggestion that post-deployment treatment be mandatory. We will be taking a look at those.

Thank you for your courage.

That is all.

Mrs. BOWMAN. Thank you.

Mr. BOWMAN. Thank you.

The CHAIRMAN. Thank you.

Mr. Walz, who, I just want to tell the Bowmans, is the highest enlisted man ever to be elected to Congress and has lots of experience, decades with the Minnesota National Guard. And also, they have a program that he might want to describe, the Yellow Ribbon Campaign, which tries to deal with the returning servicemembers in a way that at least starts on the path that you have suggested.

Mr. Walz, thank you for your efforts.

Mr. WALZ. Thank you, Mr. Chairman; and thank you, Mr. and Mrs. Bowman, for being here. There are no words that are going to be said here that are going to ease the pain of your loss, and we clearly understand that. I have to say, though, especially Mrs. Bowman, you occupy one of the highest and most respected positions in this society as a Gold Star mother. And I have to tell you as a Member of Congress and as a veteran and a retired sergeant major and a citizen, I am ashamed that you have to come here today, that the idea that you would have to come here and ask this Congress to do the right thing for your son is absolutely appalling.

And with all due respect to our news organizations, while I am happy they broke that story, there is not a single person in this room that doesn't know this was an issue. There are Members, there are people sitting behind you, veterans and advocates that have fought decades on this very issue; and I have worked with them. They have advocated for this, they have spoken about it, and we have seen year after year after year not addressing this in a real comprehensive manner. And that is simply appalling, and it is a shame.

And I can tell you there is not a Member up here especially, and there is not a Member in Congress, that hasn't stood in front of soldiers, talked about them, talked about how great they are, but time and time and time again this Congress, and all of us are guilty of this, have simply failed to move things forward that make a difference. And that is an absolute shame.

And I have said that there is no one in this country again that should ever allow anyone to stand in front of a soldier if they are not going to stand behind him and move this, never. We have seen those yellow ribbons. Many of them are very faded now, and you can barely read them, and the fact of the matter is we haven't done what they said. We haven't addressed these issues. We haven't taken this in.

Senator Dole occupied the same position of both of you, and Ms. Shalala, and they sat here and addressed the issue at Walter Reed. And Senator Dole was very clear in what he said. He said, you spent billions putting them in harm's way. Spend billions in whatever it takes to get them out. And that is very clear to us what we need to do. So there are things here. And Mr. Kennedy is going to speak in a little bit, and I think this is an very important piece of this puzzle.

And both of you with your keen understanding of how this works, especially from National Guard families, I can tell you this. Having been one of those that came back—we were in support of OEF, but sitting there with OEF/OIF veterans when we came back, they showed us the Horse Whisperer and told us to be nice when we went home, and that was the extent of it. That was in 2004.

Now I am proud to say that, because of the people sitting in here and people who came before me, things have changed over the last 4 years. They have not changed enough. But Mr. Kennedy is following and moving something forward that the late Senator from Minnesota, Senator Welch, advocated so clearly, mental health parity and this issue of understanding and destigmatizing mental health.

And I being in there and knowing as a first sergeant knows exactly what you are saying and watching as people aren't trained on this, that there is a discrimination that goes against a soldier who has the courage, the fortitude and, as you said, the insight to admit this.

So there are a couple things I want to ask you, because I think you do have a keen understanding on this. We started noticing this in Minnesota; and the State of Minnesota, under the Adjutant General and the Governor, did something that actually I guess in letter of the law violated VA recommendations. We set up a program that said, do you know what? This hands-off policy, it is what soldiers think they want. The last thing you want when you come home is to set meetings and things like that or to talk to anybody.

What we found was and what the research shows is that most of these patterns of behavior and most of this PTSD gets worse in the first 90 days. If you can address it early on, while it is fresh, in an environment that is nonthreatening and everybody is in it together—we have what we call Beyond the Yellow Ribbon Campaign, and we bring them back right away, and we reevaluate them, and we do something this Congress is going to do now to put forward. We make sure we are testing them for traumatic brain injury.

As many of us know—it was the Blind Veterans of America that brought it to our attention earlier—we are starting to see a lot of veterans with eye troubles that were actually mild traumatic brain injury and those types of things. So we are starting to screen them early, we are starting to put them in front of the right people, and we are starting to bring their families in to understand.

As you said so clearly, many of us were much older and we had children at home. Many of these Guardsmen have not only small children, they have teenage children that clearly understand what is going on.

What we are trying to do and will vote on this later today is to get the money to do a pilot program to take this thing nationwide. My question to you is, do you think this is the way to go? Is this the way to address it?

Mrs. BOWMAN. Absolutely.

Mr. BOWMAN. And you need to bring all the soldiers in. One of the stigmas that has always been held up, especially with National Guard, is they will bring a chaplain or a counselor in for drill weekend. And anybody who wants to see the chaplain, he is over in room 105. And everybody looks at who is going to walk in that door. They know who is going in that door. And the Guard says, you know, they have to come to us. So our thought from the very beginning is bring them all in. Everybody gets a screening. You don't single out the guy who has a problem. You screen everybody. Because half the people who don't walk in the door have the biggest problems, and you have to screen everybody. That way there is no stigma among the unit. Everybody walked through that door and saw that counselor.

Mr. WALZ. Well, once again, thank you. And, again, this group behind you, this group sitting out here, they are the ones that are going to assure accountability on this. I think the time of lip service has pretty much run its course, and there is going to be a day of reckoning if we get this thing right or we get it wrong. Because we can't continue on like this. Especially, as I said, everyone in this room knows it is an issue. Now let us fix it.

I yield back, Mr. Chairman.

The CHAIRMAN. Thank you, Mr. Walz.

Mr. Hall.

Mr. HALL. Thank you, Mr. Chairman; and thank you both, Mr. and Mrs. Bowman, for coming here. My condolences for your loss, and my thanks to your son for his service to our country. My apologies, as my colleague, Mr. Walz, said, that you should have to be in this position.

All of us who represent the different districts around the country have veterans come to us, I am sure, with all kinds of problems and especially with PTSD; and no small number of those are either suicidal impulses or other clearly identified PTSD symptoms.

I have a friend who is a Vietnam vet who was diagnosed with post traumatic stress syndrome. At the time, it was called PTSS. And you said, Mr. Bowman, you thought that the term "disorder," it was counterproductive because it seemed to describe it as something being wrong with a person, as a malady, and it should be more treated as an injury of war so that it wouldn't carry the stigma.

So I am wondering if perhaps a wording change like that, that we do—because words do matter. And what the government calls things, the labels we put on them as a society or as a branch of government or the VA, for instance, or the medical community can stigmatize more or less. So I am curious if you would think that something like post traumatic stress syndrome would be better than, say, disorder.

Mr. BOWMAN. I think anything that makes the term something that is not permanent. The term "disorder" applies to muscular dystrophy, multiple sclerosis, something like that, a debilitating

disease that once you get it, you have got it for the rest of your life. Now that doesn't mean that PTSD goes away. But it is an injury that, if it is dealt with in the first 90 days, again, if you can combat it early enough, you can reduce its impact to the point where you have got a healthy, fully functioning soldier who is actually better off now than he was when he went to combat because he has gone through the battlefield, he has gone through the mental anguish of war, and now he has found a way to deal with it.

Mr. HALL. Thank you.

And I think it is important that, until we are able to do that, we not redeploy combat soldiers who have PTSD. So it is doubly important that we identify all of them, which would reinforce the concept that you have both spoken to, and Congressman Walz and others have spoken to, of bringing all soldiers in for screening, rather than just say "go to door number five," or whatever it is, so that they are watched and identified.

I don't really have more questions for you. I just thank you for being here.

And I want to say that in my short time in office, my staff has helped servicemembers, veterans, ranging from 84 years old, a World War II veteran, within the last couple of weeks who we got 100 percent clarification for PTSD for a soldier who had two ships sunk out from under him in the Pacific Ocean in World War II and twice found himself floating in the ocean with body parts and sharks and other comrades around him and so on and was rescued twice. Until 2 weeks ago, having tried repeatedly since the 1970s with his friends and with people who were trying to help him, and it was just this year that he finally was classified.

On down through Vietnam-era veterans right up to a 25-year-old, twice-deployed soldier who came back from Iraq and spent 2 years looking for a PTSD classification. He had all the classic symptoms: an exaggerated startle reflex, suicidal tendencies, couldn't go to sleep without seeing in his mind's eye the picture of his fellow soldiers being killed or of an innocent Iraqi girl who was caught in the crossfire in Fallujah and other things. They are images that are hard to get out of one's mind once you have been through that experience. And we were able to get him—because he came forward to us, we were able to get him the classification, 100 percent PTSD classification.

But it is the ones who, because they are trying to be strong and because they can hide it, as you said, are hard to identify; and that is why I think it is critical that we screen everybody. The percentages are running so high that I think that is really the only way to be safe and to make sure that we don't let soldiers like Timothy slip through the cracks.

And, once again, thank you for being here; and, Mr. Chairman, thank you for holding this hearing.

I yield back.

The CHAIRMAN. Thank you.

Mr. Snyder.

Mr. SNYDER. Thank you, Mr. Chairman and Mr. Buyer, for this discussion today.

And I want to thank the both of you, as others have, for being part of this national discussion. I hope you are pleased with the

kind of comments and discussions that you have triggered here today.

I did not know your son. My guess is that he would be proud, as a 23-year-old, of what you are doing today. Because you are not doing it for him. You are doing it for the sons and daughters of everyone else around the country.

I also appreciate the context that you have put this in, which is the absolute finality of devastation of suicide is terrible for that person and for the family and friends of that person. But in your very last line you say, "Our veterans should and must not be left behind in the ravished, horrific battlefields of their broken spirits and minds."

Because somebody does not commit suicide does not mean they are out of the ravished, horrific battlefields of their broken spirits and minds. And there is a lot of human misery that is out there, and we know it is out there. I suspect there is some in this room or has been some in this room.

We don't do the thing saying, will everybody who needs mental health counseling right now or in the last year please stand up and go to the door if you would like to be interviewed. Because we all have our private moments of devastation. But for some of us human beings that becomes something that just eats at you hour after hour, day after day, week after week, month after month, year after year and, unfortunately, tragically results in suicide in some. But it is also tragic if it is untreated for those months and years and decades, as you have pointed out in your statement.

Mr. Kennedy, who I hope we will be hearing from here shortly, has recognized through his work for some years now that in the private sector, the nonmilitary, nongovernment part of our lives, we have not solved this issue of how to deal with mental health challenges. A lot of insurance doesn't cover it. We have a lot of human misery out there that goes untreated because people don't know how to get it and pay for it, and that is a problem that we have in this country.

But thank you for your service and being part of this national discussion and debate.

Mrs. BOWMAN. Thank you.

The CHAIRMAN. Thank you.

Mr. Kennedy, thank you for your work on mental health parity. You and I have talked about these issues for a long time, and I will recognize you for any statement or for questions.

Mr. KENNEDY. Thank you, Mr. Chairman.

I also want to join my colleagues in offering my condolences to you for your terrible loss and say that it is this personal story that you have offered that I think is going to be the catalyst for the change. Tragically, in this country, the statistics don't move people, but a personal story like yours does.

The statistics in this country, suicide is twice the rate of homicide in this country. We read about murders every day, but we don't read about suicides every day. It is the silent killer in this country. It is epidemic. But your story here today is helping to highlight something that is an untold story that is too often the case for so many families and now, especially, amongst our returning veterans.

So you are, as my colleagues have said, really profiles of courage in really sharing your story to benefit other families from having to go through what you have been through. So I really salute you and thank you for your son's service.

My colleagues have referenced the mental health parity bill that Senator Paul Wellstone originally introduced that is now actually in the midst of being considered between the Senate and the House. And it has a lot to do with your story because many of these returning veterans, they are all going to be returning to the private work force. And, as you know, the stigma continues. And this Committee has set up what are known as Vet Centers because of the stigma, because they know many veterans won't go to the VA for their mental health services because they are afraid it will show up on their record, and so they set up Vet Centers for that purpose.

Because of that, you can understand that many veterans may not even choose to avail themselves of anything having to do with the VA when it comes to mental health; and they may, as now private sector employees, choose to get their mental health services through the private sector.

That is why it is even more important that we pass mental health parity legislation. Because all these returning veterans will need to be covered as private-sector employees, and we have a chance now to pass this sweeping parity bill that basically says mental health should be treated like every other part of your healthcare in a holistic way.

And it is so very important because of the facts that I have just stated, but I wanted to ask you, with respect to families, veterans' families, do you think the VA is doing enough to address the families' mental health needs as a means to address the veterans themselves, mental health needs? In other words, one of the ways that veterans suffer so greatly is when they return their families are suffering themselves, having had a very difficult time themselves being away from their loved one.

And what ways do you think, also—do you think that peer-to-peer programs like the vet-to-vet support groups are effective? And do you think that the VA ought to be taking these programs to scale? Meaning do you think that we ought to really ramp them up so that they are not just here and there, but they ought to be national, and so that every veteran returning gets to talk to another vet, and that we in the Congress support these veteran-to-veteran peer support programs?

If you could comment on those?

Mr. BOWMAN. As far as the VA help for the families, I have never seen a VA person approach me in my entire life. Nobody even came to us after Tim died. Nobody offered us family counseling. His battalion commander was checking to find out if we qualified for family counseling after he died, and there is nothing out there for us, even though he gave his—as I feel he gave his life for his country.

So I can't comment on what the VA is doing for families, because I have never seen it. And as being in the National Guard array with a lot of the kids that I know, they haven't seen it either, because they are stretched out. Out of 118 soldiers in my son's unit, there were from 78 or 79 different towns spread across Illinois, Iowa, some small towns, some big towns. But nobody has ever

jumped up and said, hey, somebody came to me with some support information. And we know these families because we have stayed in touch with them. So that to me is a gray area.

Mr. KENNEDY. And you think the families could be a big help to the returning veteran. If they knew in advance when their loved one was returning more about mental health because they had received some preparation and had gotten some support, they might be the greatest resource in that regard.

Mr. BOWMAN. Yes. Especially with Guard and Reserve. Because, as I said, and we saw it with Tim and I have seen it with other Guardsmen. They can suck it up for a weekend drill. And they will go in and spend a weekend drill and they will look like the most normal human being you ever find. Well, who has them for the other 28 days out of the month? The family. That is when you are going to see the breakdowns, the nightmares, the night terrors, the sweats, the screams, the swinging in the middle of the night, sleeping in the closet with a 9mm. All those signs are going to be seen by somebody other than Guard people.

So if you educate the family on those signs then at least they have a chance to locate some help for them before it turns into a disaster.

Mrs. BOWMAN. And we ourselves chose to go on our own and get counseling. We have been in grief counseling for a year, both of us now, as well as our daughter. And it has made a huge difference for us.

Mr. BOWMAN. And mental healthcare for—well, we discussed this earlier. I went to our local mental health association, which has offices all over our area. They are supposed to be the place to go. And by the time I got done with their initial screening paperwork, the financial paperwork, the pre-interview with the caseworker and all the other stuff—and I told him right up front, I don't qualify for any financial assistance whatsoever. I am going to pay for this visit. Just walk me into a counselor. And by the time I got all done and I did get to the counselor I was so mad at the system of trying to get there I told her if I was standing on a ledge right now I would have already taken the step because I can't believe what you just put me through. And that is what I am supposed to go to as a citizen in my own neighborhood.

Then I go off the grid and find somebody that is a licensed private counselor, and she won't work in that system because of all that paperwork, and she has got all kinds of patients that she sees, and she has been very successful. It is frustrating just in the mental health aspect of it.

Mr. KENNEDY. Well, you just made a great case for mental health parity; and we will work on that, too.

The CHAIRMAN. Thank you, Mr. Kennedy.

Mr. Buchanan, do you have any questions?

Mr. BUCHANAN. No.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. Thank you very much.

And once again, Mr. and Mrs. Bowman, thank you very much for being here.

I would like to make an association toward the comment of Dr. Snyder. And you are absolutely correct. We as a country do not do

well in not only a tracking system with regard to suicides but on the issue on prevention, identifying risk factors and things. So, as a country, I agree with you we don't do well; and it is a subject matter that we also don't discuss much.

So, as I look at the Center for Disease Control, they put out their study, the National Violent Death Reporting System. So, as you look into this—now, this is using their reports and status from 2001, their latest numbers, among Americans ages 15 to 24, homicide is the second leading cause of death; homicide was contributing, an average, of 14 deaths per day in this age group of 15 to 24. Suicide was the third leading cause of death; and, on average, we have 10 deaths per day in this age group of 15 to 24 for suicides as a country.

Then when you look at the propensities—I continue on—the males take their own lives at nearly four times the rate of females. So 78.8 percent of all U.S. suicides are males. Now, of all males, suicide is the eighth leading cause of death, and it is the sixteenth leading cause of death for females.

Now when you look at these statistics—and what is kind of interesting about statistics and numbers and how you analyze these things, you also have to look at this a little bit further. Males, when they have made this compulsive decision to commit suicide, are more effective. Why? Because they use guns. Women don't use guns. Women use pills. And they aren't as successful at this compulsive decision to end their life. And then it reinforces the other statistic that shows that women have a higher statistical average to repeat an attempt on suicide.

So it is interesting when you start reading these statistics, yes, they begin to tell a story, but it is not a whole story because we don't have a very good tracking system. We don't do very good statistics. As a matter of fact, when I looked at this national reporting system, really not many States report. You can see that.

So that is why I agree and associate myself with Dr. Snyder. He is absolutely correct. We, as a country, on this particular issue are not doing well.

So in your statement when you said when *CBS News* broke the story about veteran suicide, the VA took the approach of criticizing the way the numbers were created instead of embracing it, well, I just want you to also know that *CBS News*—there are other writings out there that have highly criticized *CBS News* and their story and the way they came up with their own statistics. My gosh, you have the *New York Post*. Their headline is—they called it bogus. I mean, they went after the way *CBS News* came up with statistics.

What I enjoyed about your testimony today is that, regardless of statistics and the war of statistics and how you come up with them, there is a challenge in front of us.

I loved your use of the word “injury.” And I have heard Bob Filner also talk about if you use the word “disorder” there is a stigma that is attached with it and we have to come up with a better language. And he is absolutely correct. That needs to be done. And we are going to need to work with the great minds of mental health to come up with the right language.

And to my good friend, the Sergeant Major, this is an issue that didn't happen just because *CBS News* broke the story in November. We are going to have the testimony coming up here by the Inspector General (IG), and the IG is going to talk about their report on implementing VHA's mental health strategic plan initiative for suicide prevention.

Sergeant Major, this was started in the year 2004. And I would agree with you, Sergeant Major, that the VA was very slow in getting this on the ground. And so there I would agree with you. We are going to have some testimony coming up on these initiatives, and I welcome your participation in that panel.

I yield back. Thank you.

The CHAIRMAN. Thank you, Mr. Buyer.

I would offer, since the television program *CSI* is so successful, stress injury is pretty descriptive, but it is hard to change such a thing.

Mr. BOWMAN. Again, all you have to do to change that term is do it right now.

The CHAIRMAN. All right. We will talk about *CSI*, combat stress injury. I think the next panel may be a—have a—

Mr. HARE. Mr. Chairman, would you indulge me for just 1 second here?

Let me just say this to all of you, and I appreciate the Ranking Member, but your figures on pieces of paper do not reflect people. And, ultimately, just listening to this testimony today, families are not brought into this loop when it comes to their servicemember having problems. The servicemember is not screened when they come back. There is a stigma attached to all of this.

I agree with my friend from Minnesota. What we have to do at the end of the day is to say, "this is enough." We have hit the wall with this issue here, and we have to look at what we are doing. The VA has to be much more proactive than they are. These are great cards, but if they don't work they don't work, and we have to figure out what does work.

So I would just again say to you I want to thank you so much. I am so sorry about what happened to you. But we have, as I said to you in my office, a moral obligation to try everything we can possibly try to make this better. And if it costs us a few more bucks, so be it. But, ultimately, at the end of the day, our job as I see it is to make sure other families like yourself don't have to go through the pain that you have had to go through. And I think, to be honest, the VA has a whole lot of work they could do in educating the parents and making sure our troops are not singled out.

So I just want to thank you so much for coming today, and we will get this done one way or another. We will get it done.

The CHAIRMAN. Again, you all have obviously thought a lot about this since Timothy's death. You are very articulate, and you have helped us all understand this issue.

Two major things strike me, in conclusion, about your recommendations. Number one, I think the President and the Administration have been dead wrong in trying to wall off this war from public consciousness. They are so afraid of opposition that they don't want to educate people as to what is going on.

If all of us—parents, teachers, ministers, employers—know what PTSD is, know what TBI is, traumatic brain injury, we can all help Timothy; and that is a public education campaign.

People all over the country want to help. I sat down with the Outdoor Advertising Association of America. If they were asked, their billboards would be useful for getting people to understand what PTSD is, just knowing where to turn to get information. That is a public education campaign that I think we have to do. And if the President just called any of these people in his office they would do it for free as a service to their Nation and to Timothy and his comrades.

In addition—and I have been trying to get this into this year's budget—it is clear from what you say and everything we have learned that it should be a part of active duty on either return from combat or separation from service—and it has to be not only active duty but the Guard and Reserves—go through a process. I have called it a “deboot” camp. I have called it basic untraining, decompression. I am now focused on a heroes homecoming camp. That as part of your active duty, for whatever number of weeks we can get the VA and DoD to agree to, that every soldier with his or her unit, with his or her family, gets diagnosed for both PTSD and traumatic brain injury.

Because, as policymakers, I think we have to assume that everybody has it unless we find out they don't, as opposed to you prove to us that you have it and then we set up all kinds of things. You don't have PTSD, you have personality disorder and get rid of you that way. So it has to be mandatory; and that allows early treatment, which is absolutely necessary.

In addition, if you had this heroes homecoming camp, you could do job counseling and credentialing and educational counseling. All the spouses would be together for mutual support. All the soldiers would be together for that kind of comradeship, which was so important for them in combat.

And I think we just have to do this. We expect kids, as you said, to be in Baghdad 1 day and taking their kids to soccer 2 days later. It is absolutely contrary to anything that the brain can accomplish.

So I hope that we can move in those areas. We have to change a culture.

But Dr. Martin Luther King once said, you can't make a man love me, but you sure as hell—I don't think he said “sure as hell”—but you sure can make him stop lynching me. That if we have certain laws and behaviors, that will contribute to the change of the culture.

I think your testimony has brought us a long way. You have a chance for any last-minute statement. You have been here for almost 2 hours. That is a long time for congressmen and women to stay and talk to you, but it shows how powerful your testimony has been. And any last statement we would welcome.

Mr. BOWMAN. Just a couple of things.

One, I truly—we truly are honored to be here today. We decided after Tim died that his death was not going to be for nothing, that good would come of his death. It is the only way that we can deal with his death.

This has been therapeutical for us. There is no doubt about it. Because we know that his name has meant something. We know that he has already saved lives.

On another note, I am an Assistant Illinois State Captain for Patriot Guard Riders. If you are familiar with that organization, we are the people who stand between funerals and protesters. That is my therapy that I have taken on so that I can survive day in and day out.

We have done two funerals in Illinois that were soldiers that took their own lives, and I have never been so embarrassed by the military in my life as to see the way that those families were treated—no honor guard, no flag folders, no pall bearers, nothing. Patriot Guard Riders folded the flags. We carried the casket.

There is no reason that every person who served a day in the military in this country should not be accorded the military funeral rights that every soldier should be given, and that includes the most honor you can hand them. Because that honor at graveside is what that family will remember. And if you want to help that family heal, the country has to remember that they need to thank that family for that soldier, and they have to thank that soldier. And the only way you have to do that is at the graveside and at the funeral.

And I implore anybody who can work on anything to do that, is to make that happen. Because a suicide carries a bad enough stigma with it as it is. I was told after our son died, before his funeral, do everything you can for him now, and we did. And his unit was home. So all of his unit buddies were there. He was also a member of the fire department. Between the two of them, they coordinated everything and made it just an absolutely beautiful service for 2 days.

But not everybody is that lucky, and I am asking you to help those that don't have those connections.

Thank you.

The CHAIRMAN. Thank you. You have honored your son and your family, and we thank you so much.

We will ask the second panel to come forward.

Again, thank you, Mr. and Mrs. Bowman. We thank both of you for joining us.

The CHAIRMAN. Again, I must introduce you with a personal thank you as you all have educated me with your books about combat stress injury and suicide.

Penny Coleman, whose husband, a Vietnam vet, committed suicide, is the author of *Flashback: Posttraumatic Stress Disorder, Suicide and the Lessons of War*.

Ilona Meagher is the author of *Moving a Nation to Care: Posttraumatic Stress Disorder and America's Returning Troops* and has taken upon herself to have Web sites which track suicides because her government does not.

The CHAIRMAN. With that, you have the floor, which—I don't know how you arranged which to go first, but please, Ms. Coleman, you are next.

STATEMENTS OF PENNY COLEMAN, ROSENDALE, NY, AUTHOR, *FLASHBACK: POSTTRAUMATIC STRESS DISORDER, SUICIDE, AND THE LESSONS OF WAR*; AND ILONA MEAGHER, CALLEDONIA, NY, AUTHOR, *MOVING A NATION TO CARE: POST-TRAUMATIC STRESS DISORDER AND AMERICA'S RETURNING TROOPS*

OPENING STATEMENT OF PENNY COLEMAN

Ms. COLEMAN. Mr. Chairman, Members of the Committee, fellow panelists, good afternoon.

I am the widow of Daniel O'Donnell, a Vietnam veteran who came home from his war 38 years ago with what is now known as PTSD and subsequently took his own life.

I use the term PTSD grudgingly, like Mike Bowman. It is the official term, but it is deeply problematic. My husband did not have a disorder. He had an injury that was a direct result of his combat experience in Vietnam. Calling it a disorder is dangerous. It reinforces the idea that a traumatically injured soldier is defective, and that idea is precisely what keeps soldiers from asking for the help they need.

I met Daniel 6 months after he returned from Vietnam, and I married him a year later. The man I fell in love with was gentle and playful and very funny on good days. But there were other days when he would fly into rages over trifles and more than a few nights when he would wake up screaming and sweating and fighting something terrible that wasn't there. Or he would take to his bed with the blinds drawn sometimes for days, and all he would tell me was that he didn't want to live.

I thought that if I loved him enough I could fix him. I was wrong. I had no idea what I was up against. After Daniel died, I tried to blame him, but I ended up blaming myself.

For my book *Flashback*, I interviewed other women who lost loved ones to suicide in the wake of Vietnam. In addition to their grief, these women, like me, lived with guilt and shame and isolation. I now believe that our isolation was exploited to help camouflage a terrible tragedy.

Unlike Agent Orange vets or Gulf War vets, who have never stopped demanding that the VA take responsibility for their illnesses, in the case of veteran suicides the most logical advocates were dead. We, their widows, did not become advocates. We believed their deaths were our fault, and we each thought we were the only one.

It is more than 30 years since the war in Vietnam ended, and still no one has any idea how many Vietnam veterans have taken their own lives because no one has ever tried to track or count them. The 1990 National Vietnam Veterans Readjustment Study mandated by Congress and government funded, the study that proved the syndrome now called PTSD, never even mentioned suicide, in spite of the fact that suicide was central to every study that preceded it, including those on which it was based. No data, no proof, no proof, no problem.

The United States invaded Iraq—

Mr. KENNEDY. Would you repeat that again?

Ms. COLEMAN. Which piece? The last paragraph?

Mr. KENNEDY. What was left out. What was that study?

Ms. COLEMAN. The National Vietnam Veterans Readjustment Study, which claimed to be the biggest study that had ever been done on any demographic group and claimed to address all of the issues, the healthcare issues of Vietnam veterans, never mentioned suicide or suicidal ideation.

Mr. KENNEDY. Wow.

Ms. COLEMAN. It is an astonishing omission.

The CHAIRMAN. And what year was that?

Ms. COLEMAN. Nineteen-ninety it was published. The research was done between 1986 and 1988, I believe.

The CHAIRMAN. Thank you.

Ms. COLEMAN. The United States invaded Iraq in March of 2003, and by August, so many American soldiers had killed themselves that the Army sent a mental health advisory team to investigate. Their report confirmed a suicide rate three times what the military considers statistically normal. It also acknowledged that one-third of the veterans who are being—of the psychiatric casualties who are being evacuated had suicide-related behaviors as part of their clinical presentation. Nonetheless, the team's conclusion was that soldiers were killing themselves for the same reasons that soldiers, quote, typically kill themselves, personal problems.

A supplement to the report listed things that soldiers most often identified as stressors—seeing dead bodies, human remains, being attacked, losing a friend. But the report itself only mentions marital problems, financial problems, legal problems, what they call underdeveloped life coping skills. Translation, soldiers are dying because they are managing their lives and their affairs badly.

Every year since 2003, the suicide rate in the military has increased; and another team of military psychiatrists have been dispatched. Their conclusions are always the same: insufficient life coping skills.

As recently as August, Elspeth Ritchie of the Army Surgeon General's Office insisted that, in spite of the suicide rate that had reached a 26-year record high, Pentagon studies still haven't found the connection between soldier suicides and war. There are various possible explanations for the Pentagon's refusal to accept that connection, but one of the most compelling is certainly budgetary.

To cite just two examples, soldiers often resort to self-medication when they are denied or discouraged from treatment, and that is commonly used to justify a dishonorable discharge, and that means that a soldier will be deprived of healthcare benefits. Or VA claims that somehow more than 22,000 soldiers, most of whom had already been diagnosed with a post traumatic stress injury or a traumatic brain injury, have been dismissed from the service with a diagnosis of personality disorder which is considered a preexisting condition, which also therefore absolves the VA of any responsibility for their future care. Such cynical cost-saving measures are devastating to the lives of soldiers and their families.

There is currently no cure for post traumatic stress injuries. Though many learn to manage their symptoms, far too many will suffer the effect of their combat experience for the rest of their lives. They will continue to have nightmares and flashbacks. Many will continue to be hypervigilant, have startle responses that are

often violent. Many will have trouble managing their anger and their relationships for the rest of their lives. Many will try to self-medicate to help them forget. And far too many will die by their own hands.

But that sad truth cannot be used as an excuse for inaction. Our soldiers and our veterans need all the help they can get as soon as possible. Their psychic injuries may not be curable, but they are treatable. Their lives and the lives of their families can be made infinitely less difficult if they are given the care and support they have earned.

They can be assured that their suffering is a normal response to an abnormal situation. They can talk to other veterans and practice compassion for themselves by feeling it for others. They can be taught proven techniques for managing their stress and their anxiety. And they can be relieved of the added burden of financial worry, all of which may help dissuade them from suicide.

This is a public health issue of monstrous proportion, and I am here to bear witness to the fact that military suicides are not a new phenomenon. They are old news. This has happened before, and it should never have been left to citizens to sound the alarm.

The disingenuous surprise and denial from official sources is simply unacceptable. I am deeply concerned that the issue is being politicized, that sides are being taken, lines drawn that make it appear as though there are two sides to this issue. There are not. There can't be. These are our soldiers, our veterans. They are also our husbands, our wives, our parents and our children; and they are dying by the thousands.

I am grateful to *CBS News* that they have finally given us some solid numbers. Six-thousand two-hundred fifty-six veteran suicides in 1 year. Those numbers are astonishing. They cannot be justified or ignored. Our soldiers and our veterans are not disposable, and yet that is how they are being treated. More than 6,256 veteran suicides a year, and each one of those numbers represents an individual beloved face and a life-shattering experience.

I know that Daniel came back from Vietnam with an injury that finally and directly caused his death. I believe that he decided that he deserved to die because he had suffered too little or that he wanted to die because he had suffered too much. We call his death a suicide, but I have come to believe it was either an execution or euthanasia or some tragic combination of the two, and that continues to break my heart.

I am grateful to this Committee for holding these hearings. May only good come from your efforts. Thank you.

[The prepared statement of Ms. Coleman appears on p. 69.]

The CHAIRMAN. Thank you.

Ms. Meagher.

OPENING STATEMENT OF ILONA MEAGHER

Ms. MEAGHER. Thank you, Chairman Filner, Ranking Member Buyer and other distinguished Members of the Committee. I thank you for the opportunity to appear before you today.

To open, I would like to briefly share my thoughts on why I think I am before you.

I am not only someone who spent 2 years researching and writing about post traumatic stress and our returning troops. I am also a veteran's daughter. My father was born in Hungary, served 2 years in an antitank artillery of a Hungarian conscript, fought against the Soviet Union on the streets of Budapest during the 1956 Hungarian Revolution, later fled to America and in 1958 again became a soldier, this time wearing a United States Army uniform and serving as a combat engineer in Germany.

My father's unique experience of having served on both sides, both East and West, in such differing armies during the Cold War gave him a unique perspective on military life. And so growing up, my sisters and I often heard my father say you can always tell how a government feels about its people by taking a look at how they treat their troops. Looking at our returning soldiers and their widely reported struggles with the military and with the VA healthcare systems they rely on, of being stigmatized from seeking care or of being placed on lengthy VA waiting lists when they need immediate help, some even committing suicide before their appointment dates arrive, has raised this citizen's alarm bells.

For years, we have had a "see no evil, hear no evil" approach to examining post-deployment psychological reintegration issues, which includes suicide. After all we have learned from the struggles of the Vietnam War generation and the ensuing controversy over how many of these veterans had or had not committed suicide in its wake, why is there today no known registry where Afghanistan and Iraq veterans' suicide data is being collected? How can we ascertain reintegration problems, if any exist, if we are not proactive in seeking them out?

As late as May 2007, the Department of Veterans Affairs spokeswoman Karen Fedele told *The Washington Post* that there was no attempt to gather Afghanistan and Iraq veteran suicide incidents. Quote, "We do not keep that data," she said. "I am told that somebody here is going to do an analysis, but there just is nothing right now." That was in May 2007.

Meanwhile, the Army reported that its suicide rate in 2006 rose to its highest level in 26 years of keeping such records. Last month, at long last, the Associated Press revealed that the VA is finally conducting preliminary research. They have tracked at least 283 OEF/OIF veteran suicides through the end of 2005. I have a note here. I have seen that the VA testimony may include a different figure than this, so we are already disputing this figure. The Associated Press reported 283 OEF/OIF veteran suicides in the VA system. That figure was nearly double the rate of the additional 147 suicides reported by the DoD's Defense Manpower Data Center.

Looking only at these two suicide figures from the VA, 283—and from the DoD, 147—there have been at least 430 Afghanistan and Iraq veteran suicides that have occurred either in the combat zone or stateside following their deployments. Lost in the VA and DoD counts, as the Bowmans discussed, are those veterans who have returned from their deployments, who are still in the military and who are not yet in the VA system. The DoD says they do not track those incidents, and I assume neither does the VA.

Many of the 430 confirmed suicides that we now know about are as a result of our wars in Afghanistan and in Iraq. They should,

but will not, be listed with the DoD's official OEF/OIF death toll, which, yesterday, stood at 4,351. If they are 430 confirmed OEF/OIF suicides, that translates to an additional 10 percent of the overall fatal casualty count of these wars that are due to suicides, 10 percent. Therefore, dismissing the issue of veterans' suicides in the face of this data is negligent and does nothing to honor the service and sacrifice of our veterans and families and communities that literally are tasked with supporting them once they return.

Yet, prior to last month's *CBS News* investigation, which we have heard about, one additional note in that *CBS News* investigation noted that 20- to 24-year-old Afghanistan and Iraq veterans are two to four times more likely to commit suicide. They are not the only ones who have talked about its being double the rate of suicide for our veterans. There was a June 2007 study as well—we could talk about that—that showed that the veterans' suicide rate is double the rate of the civilian population.

In my written testimony, I have included 75 suicides that I and other citizen journalist colleagues have been tracking since September 2005 and which, today, reside in the ePluribus Media PTSD Timeline. They offer only a small and incomplete sliver of insight into how some of our returning troops are faring on the home front, especially in light of the fact that at least another 355 incidents could be added among them according to the VA and the DoD. I believe they collectively, though, tell an even greater tale about the failure of us as individuals and as a society to ensure that our returning warriors are cleansed completely from the psychological wounds of war. They also reflect the failure of our government institutions to protect those who protect us.

While I realize that these distressing stories are the exception and not the rule, to our exceptional military family members and their having to deal with the deterioration of a loved one they thought had safely returned from combat, they are the rule. In 1956, the same year that my parents fled to this incredible country, the 84th Congress in this very House that we sit in today had this to say in a presidential commission report on veterans' benefits: "The government's obligation is to help veterans overcome special, significant handicaps incurred as a consequence of their military service. The objective should be to return veterans as nearly as possible to the status they would have achieved had they not been in military service, and maintaining them and their survivors in circumstances as favorable as those of the rest of the people. War sacrifices should be distributed as equally as possible within our society. That is the basic function of our veterans' programs."

Finally, I am not a pedigreed expert or a government official. I am shaking in my seat. I am not seasoned in testifying before Congress, so I do appreciate the opportunity to stand in for the civilian population and to represent them, but those who are the professionals and the seasoned, pedigreed officials from the U.S. General Accountability Office, the Congressional Research Service and even to the Veterans Administration have sat in this very seat over these past years, and they have told you that we are falling far short in providing the resources and programs that our returning veterans need and military families need to successfully return to their personal lives following their service to this Nation.

To those who resist hearing the cold, hard truth of where we are today, I have only one thing to say: The time is here to stop fighting the data. Let us, please, start fighting for our troops. This is America. We can do better. We must do better. Thank you.

[The prepared statement of Ms. Meagher appears on p. 76.]

The CHAIRMAN. Thank you both very much.

Dr. Snyder, do you have any questions?

Mr. SNYDER. I was browsing through your book. I wanted to ask: Is it May-ger?

Ms. MEAGHER. Mee-ger.

Mr. SNYDER. Meagher. I am sorry.

Ms. MEAGHER. That is fine.

Mr. SNYDER. You gave a series in your statement here of very specific things. I appreciate what you say, by the way, about shaking in your boots. We do that quite a bit here because sometimes we are not sure what way to go either with some of these things. But one of the issues, in fact, was referred to earlier by Representative Kennedy here. You talked about outside community-based resources that are available, and I recognize that there—I think there are a lot of communities that are trying to step forward right now to help families the best they can. I think about what happens as the years go by. Sooner or later, the war in Afghanistan and Iraq will be a historic event, and years will go by, but we know these problems that you all are dealing with and talking about, both of you, do not go away.

So we come back to this issue of having services available, not just for the individual veteran but also for that veteran's family. It may be issues of marital difficulties, of substance abuse, of anger management, of the fact that the veteran still does not realize that what is haunting him is what happened before, and so we still come back to this issue of the inadequacy of our mental healthcare system in the United States.

If both of you want to discuss that broader issue, it is that which is not just for the veteran, himself, and that we expect to give the highest care to the veterans' healthcare system or to the military retiree system of healthcare, but it is for our system nationwide. I have directed this to Ms. Meagher, but I would like you to comment also on it if you would, Ms. Coleman.

Ms. MEAGHER. I do have some comments because I approach this from—of course, I am a veteran's daughter, as I said, but I am a concerned citizen, so I am not a journalist. I did what is called "citizen journalism" because I saw a problem. And the problem that I saw was that we were not, first of all, in our Nation, called up to pay attention to the issue. Our soldiers are returning, and there are no victory gardens being planted. There are no war bonds funding drives. There is no indication that we are at war. That translates into the same things that are happening in communities. While there are incredible organizations and people in pockets all across the country whom I met while I was on my book tour and learned a lot from who are ready and willing to do something, they do not have the ability to tap into who the veterans who are in the community. So I heard over and over from these incredible people doing incredible things that we are ready and waiting, but they are not coming in.

Now, nobody asked them to do these things, and it is unfortunate that our leadership did not ask because it would have made for a stronger country. I believe that many of the things that I comment on cannot be legislated, and I cannot, I think, say—

Mr. SNYDER. Did you say “cannot be”?

Ms. MEAGHER. We need to move our society forward and ask them to pay attention to this issue and to take it seriously.

Mr. SNYDER. I agree with that. I think of things, though, like—you mentioned your father today. My father died, who was one of Patton’s guys, and he got involved, and he would talk to me sometimes. Like after I went into the Marine Corps, we would talk about some of this stuff—about the burial details he got involved in. He just felt that, someday, one of those guys might be him. He would go down into these burned-out tanks and would have to bring out these bodies of Americans, and it would just haunt him. He could never watch any show on television but a game show—no cop shows, no crime shows, no westerns, no war movies. It was only game shows because they had no violence in them.

Well, I do not think he knew what was going on, but I think it was you, Ms. Coleman, who talked about the person who sleeps in his closet or maybe it was the Bowmans or both of you. Okay. Well, I also think that there are going to be children in those households who are around this stuff, and there are these veterans who know that they are having problems that may be impacting negatively on those children. Well, we do not have a system where the children could go down to the VA hospital where they could get good quality mental health counseling for a 5-year-old or for a 9-year-old or for a 12-year-old or for a 15-year-old. Again, we get back to Mr. Kennedy’s work here.

So that is what I was getting at, the community-based resources. Even now, you are talking about our not really being called forward as a country, but think of where we will be 5 and 10 and 15 and 20 years from now when memories will have faded about our responsibilities, and we are still going to have families from these folks who are going to have these needs.

I think it is on the second page where the two of you recommend and you talk about complimentary counseling to all immediate family members. That is what triggered my thought because we need to have a system in this country of providing better mental health coverage because that need is going to be there for a lot of years for these families, and it may be generational. And I think that we are going to be grappling with it on this Committee, but we need to be grappling with it in our entire healthcare system.

Ms. MEAGHER. I do have one suggestion that could be easily done, and I would have done it myself if I only had the opportunity.

Mr. SNYDER. Yes.

Ms. MEAGHER. I think it could be easily done.

All of these resources that are out there—now, I am from Illinois, and the Bowmans are as well. We have National Guard troops. They come from the community.

Mr. SNYDER. Right.

Ms. MEAGHER. So they know the community. The community knows them. And there are resources available to them, but there is not a database. There is nothing where somebody who is sitting

in Texas or in Illinois can simply just go to a database to see “what is available in my community.” The military is not giving the information to the soldiers, and the soldiers do not know where to go often. They do not know that there are psychologists who are at the ready to donate their services. There are programs. There are all types of programs. So there could be a database. There could be something that is put together that has resources for people.

Mr. SNYDER. In fact, the problem that we run into with our Reserve component—and Arkansas has had a lot of Reserve component troops, both Guard and Reserve. What they run into is they may come from communities where, in fact, the healthcare providers there are not part of the military healthcare system because they have not had to be. Nobody has come in and said, “Do you accept TRICARE?” Now they are going through, “What is TRICARE? Why is that important to us?” “Well, it is, because we have been mobilized as a family, and that is now our healthcare system because my husband or wife is not on their work-related healthcare system anymore. This is our healthcare system. If you do not take it, it means I cannot get healthcare, and I am going to have to go someplace that takes my insurance.” So we run into those kinds of issues.

My time is up, Ms. Coleman, but I wanted to give you a chance to comment.

Ms. COLEMAN. I think that one of the saddest things about these wars has been the fact that we have been invited not to participate.

Mr. SNYDER. I am sorry. I could not hear you.

Ms. COLEMAN. I think one of the saddest things about these wars has been that we have been asked not to participate, that we have been deprived of the image of funerals and of coffins and of tears and of wounds even. I think that has deprived us of the opportunity to check in with our consciences, and I think it has deprived us of the opportunity to help those who have been wounded to carry the burden of their pain. And I think it has not contributed to a reinforcement of our social fabric, and I think that is too bad.

Mr. SNYDER. Thank you both for being here.

Thank you, Mr. Chairman.

The CHAIRMAN. Thank you.

Ms. Herseith Sandlin.

Ms. HERSEITH SANDLIN. Well, thank you to both of you.

I was going to pose a question or two with regard to what you two have seen or as to, in your conversations with others, whether or not there is a difference either in the experience or in the numbers of active duty versus the National Guard and Reserve. We have done a lot of work on this Committee over the last couple of years in examining that question in a lot of different contexts.

On the one hand, you could say, well, perhaps it is our national Guardsmen and Reserves because the community itself, the entire community, is affected by that or a set of communities is by a particular unit’s being deployed, and so that support network is particularly strong among the families during deployment and when those men and women return home, and there would be a greater likelihood that they would be somehow finding or maneuvering through the community, given the support of that community, to find resources to meet their needs. At the same time, I hear you

saying that there are some communities, particularly larger ones, perhaps, and they are unlike those that I represent in South Dakota or perhaps some in Arkansas, where the unit is from five or six different very small communities versus a larger community or a community where there is a larger base.

Have you noticed a difference? How do we best address that situation? Perhaps a database is good in terms of the resources that are available in a community for National Guardsmen and women, but what other issues do we have to get over for active duty in response to—of course, we have talked about the stigma in the past and the concern that these men and women have as it relates to seeking those resources and a fear about how it affects their military careers.

So can either of you talk about the differences that you think exist? Are there numbers broken down to suggest that we have higher rates of suicide among active duty versus National Guard and Reserve, or is it exactly the opposite?

Are there other hurdles that we can help address based on the constituencies that we all represent here and the different constituencies that we represent back in our districts to help you and to, again, be part of that network within a community to facilitate information and to reach out and to know who these people are and to make them aware of the services that are available to them?

Ms. COLEMAN. The information that has been available since the beginning of these wars about active duty troops has been very hard to get a hold of. Newspaper reporters have had to file Freedom of Information Act (FOIA) requests to find out what was happening in terms of suicides among active duty troops.

When *The Hartford Current* did a series of articles in May of 2006, by submitting FOIA requests, they got information about several suicides. I think when *CBS News* was trying to initiate their report, they also submitted a FOIA request to the Department of Defense. And the Department of Defense gave them some number of active duty troops, but told them that veteran suicides were just something that they were not keeping track of. I do not know.

Ms. MEAGHER. There are some stats and some specific changes and differences as far as Guard and Reserve troops, how their experience unfolds.

According to the DoD, they did a Pentagon task force study on the troops in the summer of 2007, and they reported that 38 percent of soldiers—31 percent of Marines—showed symptoms of PTSD, psychological problems. Meanwhile, 49 percent of the National Guard and 43 percent of the Reserves did.

Now, as to some of the reasons that I have seen in the data that I have read, there are a few things that are happening there. When Reserves are called up, they may have their own businesses. Those businesses may go under if they have been deployed two or three times. Although the Bowmans spoke about their own family support since they are in the same community, it is not like a base. There are not specific places where the family members can go to get support. So some do not come in like that half of the base that did not come in that the Bowmans mentioned, and some might come in for these little impromptu gatherings, but there is not one area where everybody can support each other. So that is significant.

There are also differences in—I have seen in reports of National Guard troops that they may deploy all as one unit, but often, especially with individual ready Reserves that are activated, they are used as fillers, and so they are going with people who they might not have trained with. There are also a lot of other issues that revolve around insurance issues, but worries about financial—if you have lost your business, that is an added stress. It is not PTSD per se, but it is an added, additional stressor. There are worries about their families at home, and many of them have kids that some of the younger active troops do not have.

Ms. COLEMAN. One other thing, suicide statistics are renowned for being difficult to gather. The Center for Disease Control and Prevention (CDC) says that they expect that it is somewhere between 10 and 50 percent underreported. If a veteran drives the family car into a tree or overdoses or gets into a confrontation with a policeman, those are not necessarily going to be recorded as suicides, and they are what Mike Bowman called a “killed by” service. I think that it is very difficult to actually get a handle on the number of suicides.

When *CBS News* asked State governments to give them the number of suicides that they had recorded, those were the suicides that family members chose to acknowledge, and a lot of States do not consider something as suicide unless there is a note that has been left. I think that the numbers that we do have are as good as we can get.

Ms. HERSETH SANDLIN. Thank you both.

Thank you, Mr. Chairman.

The CHAIRMAN. Mr. Kennedy.

Mr. KENNEDY. Thank you.

I just want to follow up on my initial point, when we were speaking with the Bowmans, and it was with regard to the family issues, the thought that the Bowmans were paying out of pocket right now for counseling was really troublesome to me. You know, here they are trying to get counseling for the loss of their son who suffered as a result of his service, and they are paying for it personally rather than the United States paying for it. I mean, I think that we owe it to the families to be paying for their mental health counseling as a result of the loss that they suffer when they lose a father, a spouse, a loved one in the line of service. In the case of a suicide, certainly, this ought to be extended to families as well, and it is just absolutely incredible to me that we do not have this extended to family members.

I would like to ask you to comment on—you know, the Kaiser Foundation just completed a study of adverse childhood experiences. In California, they have measured the trauma dose, basically, of children who come from families where they have high doses of Cortisol. Basically, it is a child who comes from a family where there is domestic violence. You know, the fight-or-flight instinct in a human being means you have high doses of Cortisol if one is threatened. For children, if they hear loud screaming, if they see violence, Cortisol is released in the brain just as it would be for any one of us and just as it would be for a veteran or for anybody in a situation where it is fight or flight. This creates changes in the brain.

In any event, they have measured this in families where children come from homes where there is domestic violence, where there is drug or alcoholism, where there are these kinds of high-risk situations. These children are at much higher risk for suicide themselves, for drug abuse, for a whole list of things down the road, and this has been borne out by evidence now.

So what strikes me is not only are we going to see a wave of challenges with veterans down the road, but we are going to see a wave of challenges with their families. We are talking now about a registry for trying to track veterans' suicides. It would seem to me we ought to be getting a registry of tracking the children of these veterans. Can you comment on that? I mean, we have got a whole generation of the children of these veterans, and they have been seeing their parents go off for two or three tours of duty.

In dealing with that kind of trauma, what do you think we are going to deal with with these kids down the road with their parents' coming back and having suffered all that they have suffered and the impact on them?

Ms. COLEMAN. After the war in Vietnam, 20 years after the war in Vietnam, the Australians created what they called a "nominal role." They got in touch with all of their Vietnam veterans, the ones who were still alive, and they have yearly contact with them, and they keep track of what is happening not only with them but what is happening with their children. And one of the things that they found was that those children were three times more likely to kill themselves than their peers, which was an eye opener and a tragedy.

Ms. MEAGHER. That is one of the things, the secondary PTSD of the family members. After reading an article about a cluster of suicides and of murder-suicides that had taken place at Fort Lewis in 2005, that is what brought me into the issue. I read in that article that the reporter had listed how many other family members—how many wives, how many children—were affected, and that is when it really clicked with me that this is a larger issue than just the mere data, than just the mere stats of the individual people.

What makes military suicides different than any other suicide that might be in the general population is that we have a responsibility for these family members. If a person—and I have a sister who committed suicide, so I know that that is another additional reason why I was emotionally very attached to the families who were dealing with this issue, because I knew the stigma that our family had to go through. While my sister was not a veteran, she was a private citizen, and there is no obligation for the government to do anything. There is no obligation for the community to care—my family cared—but for our soldiers and for our military family members, we have an obligation to them. So that is what makes it different.

As far as things that you could legislate, we have not really talked much about what we can do to prevent and to protect and to shore up our veterans for this new type of warfare that they are in. I know that there is a Psychological Kevlar Act. There are only, I believe, ten co-signers. Phil Hare, Representative Hare, is one of them, and I am proud to be from his State.

I think we need to look into proactive measures to be able to help our troops from basic training onward. We need to push the military culture to change and to grow in their idea of what it means to prepare a soldier for battle. It is not just to pull the trigger. It is also to be able to live with that, that work.

Mr. KENNEDY. I appreciate your mentioning the Psychological Kevlar Act. That is my bill.

It seems to me, if we put our soldiers through strenuous boot camp, that ought to be not only for the physical but for the psychological nature. They ought to be prepared for what they are going into, and we ought to have mental health literacy as well as physical literacy when we go in.

I was really struck, Ms. Coleman, by the fact that children of veterans of Vietnam in Australia were three times more likely to commit suicide than their counterparts. That is pretty—

Ms. COLEMAN. We do not have those same statistics.

Mr. KENNEDY. We do not have the same statistics here, but that is in Australia. Whether this is a question of our Veterans Affairs Department, it seems to me it is a question of our national interests. It is properly, maybe, an issue that has to do more with our U.S. Department of Health and Human Services—another area of our governmental policy—but it is an issue that we have to address as a Nation and that we should address as a Nation.

Ms. COLEMAN. Coming off of what Ilona said about it's being really important that we focus on preventative care, it seems to me—think about this. What if we immediately granted full disability to all combat veterans who submit a claim through an appropriate VA representative? Those benefits would continue until the VA succeeds in denying the claim after all of the appeals have been resolved. The VA would then have an incentive to streamline their process, but it would also put the emphasis on prevention as opposed to diagnostic and curative, which is public health. I know that the flagship suicide prevention hospital in the VA is the Canandaigua Center for Excellence, and all of their literature emphasizes public health outreach. It seems to me, if there were not an adversarial relationship between veterans and the VA, that that would make it much easier for them to get the care they need, and that would probably make it much less expensive to take care of them over the long run.

The CHAIRMAN. Thank you, Mr. Kennedy.

Mr. Buyer.

Mr. BUYER. Ms. Coleman, I would like for you to know that information that we obtained to help prepare for this hearing we got readily available off the Web, so we contacted the Defense Manpower Data Center. Anyone in the country can get on the Web, and they can pull down the statistics. So, in your testimony to us that they are hiding this information, I just want you to know that it is readily available to people.

Secondly, I would like to add, Ms. Meagher, that I want to thank you for your contribution. I think it was therapeutic to you, as this experience had to be. Now, as a policy maker, the challenge is the many types of disease groups that we deal with. Name a disease, and then we have to do this analytical overview of populations and their propensities to have come down with, say, cancer even if they

had not been in the military, because then we try to examine, if it was something caused by military service, and the causal connection, the link, because then there are dollars attached to those kinds of things. So we study all of these things.

On this issue, with regard to suicide, we recognize that as a society. I will go back to Dr. Snyder's comment as being absolutely correct that, as a society, we have a challenge, and it is the propensity of these young adults, 15- to 24-year-old males, to committing suicide in our society, and when it is one of the top ten killers, we have a problem in our society.

Then you do the overlay of obligation. I agree with you. When you put on the uniform and we do the inculcation and the matriculation process, our obligations to care for them will continue. The overlay on what we have just discussed and what makes it really challenging is what I brought up earlier: There are individuals who want to use that data for their own causes and antiwar themes. What happens is that we then get away from what we really want: What do I want for my comrades?

What I want for my comrades is I want them to be able to go obtain their mental health without a stigma, and that is why I really dislike the word "disorder." There is this whole balance that we have to go through between the military. Dr. Snyder has to struggle with this being on the Armed Services Committee. You have got a responsibility here as commanders to develop military cohesion that will be effective on the battlefield right? If you are effective and you have got the cohesion, you are also saving lives because buddies look after buddies. Balance that with the privacy then of a soldier. Now, commanders also have played an integral role. Because they are responsible for military cohesion, they need to know about the mental status of their soldiers so they can define the cohesion to be successful. So somewhere in here is this challenge of providing mental health services so that the commanders can also have a comfort zone. It is not only the commanders. It is the buddies, the man to their right and left; are they okay to carry a weapon? You know, this is very challenging, and I think the military is doing a better job today than what they have done in the past on their abilities to have soldiers talk about their experience when they debrief. It used to be John Wayne. You know John Wayne. "I went in. I did bad things. I feel good. I am fine. I am going back to my job." No. It is okay to talk about it.

In listening to the professionals—the psychiatrists, the psychologists and the counselors—they talk about early intervention is, in fact, the best. The reason it is the best is that, as to these risk factors that we all are in search of, not everybody shows it, and that is what is so hard. You have done that through your own life in struggling with, "What could I have seen about my sister?" I do that about my friend. What was there? You know, my brother and I have these conversations. We did not know. We did not see. We were with him. I never saw it until he did something impulsive.

So I think the Chairman is on the right track here in trying to come up with some form of a classification where soldiers and our veterans when they return home—our Guardsmen, Reservists—have a comfort zone where it is okay to obtain mental health counseling; at the same time, our commanders are in a comfort zone

that the individual is not imbalanced—do you know what I mean, that he is okay? It was okay to talk about, when I went into the room, bad things that happened.

“Oh, bad things happened? No. What exactly happened?”

“I shot and killed two.”

“How did you feel about it?”

“I did not like it. It was my job. It was my duty. I had to do it, but I keep thinking about it.”

“Well, what do you keep thinking about?”

So you are forced to talk that thing through, and that is helpful, and commanders are trying to do that kind of thing. The more we move to that prevention aspect of it, I think the better off we are going to be in the end.

So I compliment you, Mr. Chairman. I yield back.

The CHAIRMAN. Thank you.

I wish all commanders were as open as you suggest.

Mr. Kennedy.

Mr. KENNEDY. Yes. We are working on a network of care—an Internet-based, comprehensive resource—for those who can access it both for providers and for those trying to get help, and that is going to be available, hopefully, throughout the VA system. We are working on that. That is a very good suggestion.

The CHAIRMAN. I want to give you both a chance to comment on the data question that Mr. Buyer raised.

It has been my experience that this data is not available. We have asked people sitting in your chairs for data. They have not provided it from the VA and from the DoD.

When I read your Web site, Ilona, it brought to mind, you know, what if the Pentagon had to raise its money through bake sales? You know, you are trying to do something that the government should do, and your resources are very limited to do that, but the government is not doing it, and it seems absolutely necessary that they do. They do not want to know, it looks to me. I mean, this could be tracked. We can do this. We do not want to know the answer as far as I can tell.

Would you comment on the availability of data, both of you?

Ms. MEAGHER. Well, I can say this, that I am just a private citizen who, in 2005, was interested in the topic and thought to myself, Well, there is this cluster of suicides and murder-suicides, and some of them were highly decorated in Fort Lewis in Seattle. I wanted to see, is it just happening there, or is it happening elsewhere?

So I used simple search engine technology. I just started Googling, and I started to find different incidents all across the country reported in local media. Now, large Web sites like *The New York Times* and *The Washington Post*, they are able to archive all of their incidents. Small, local communities do not. So, a couple of months later, maybe that police standoff—we are not just talking suicide here. Of course, we are for this hearing, but there are a lot of things that are going on, and we try to track them all, and it is not meant to stigmatize. Obviously, there is a larger portion of troops who have the support services that they need, who have the family in place to help them, to make the right decisions, to make the right calls, but for those families who are having these problems—the suicides, the police standoffs, the drunk driving inci-

dents, the domestic violence and on and on—those things need to be tracked and preserved, not to point a finger but just so that we can have some data for them to do some research on, have the people who know how to do this research do it, and if it is lost, then it is lost, and we lose an opportunity to preserve that.

Mr. KENNEDY. So we should track it within the corrections system, too?

Ms. MEAGHER. Yes.

Mr. KENNEDY. And we are not.

Ms. MEAGHER. If I can make one more point about law enforcement, there are a lot of things the communities can do, and I have already seen them happen. In my area in Dixon, the Mayor has tried to be proactive by bringing in law enforcement and educational institutions and churches and healthcare organizations. Law enforcement needs to be, in many ways even, a safe haven. We need to have military families be able to pick up the phone—be it to law enforcement or to their healthcare providers—and not have to fear that, if they do pick up the phone again, there is the stigma.

If I pick up the phone and if one is having a PTSD episode, if a loved one is having an episode, one should not be penalized for having to pick up the phone before it gets to this pancaking of, you know, one incident after another, and then we have a bad record, and then we have lots of problems. That just increases stress. We need to think about ways to prevent that.

Mr. KENNEDY. In my State, my municipal police academies have gotten together and have put their own debriefing and program together at their own expense because so many of the Guard and Reservists are, obviously, first responders. When they come back, if the VA is not doing it, they are going to do it themselves to help reintegrate these Guard and Reservists back into the first responder community. Of course, the issue of those ending up Guard and Reservists and others ending up in prison is also something we are doing as a State initiative. We are trying to track those who are ending up in our corrections system because of the issue of reacting badly because of the problems that they are facing emotionally and psychologically.

Ms. COLEMAN. In August of 2007, the Army released a 165-page suicide event report for the year 2006, and that was described in all of the reports that I read as a first time ever public analysis of what the Army called “confidential data” submitted by units from across the Army over the past 2 years. I think it included previously unreleased statistics on attempted suicides, and it found hundreds of attempted suicides, particularly among active duty soldiers who had returned from the war, and an increase in the number of soldier suicides in Iraq from the previous year. I do not think those figures had been available before.

The Department of Defense’s Web site, up until very recently, had two, three, four acknowledged suicides among active duty troops, and there were a lot of noncombat accidental deaths but almost no suicides. This is a very different picture of what has been happening within the service.

The CHAIRMAN. We thank you for your testimony. There is a lot of movement here because we have votes over on the floor for

which we have to take about a 30- to 35-minute recess. We will decide how we are going to conclude the hearing when we get back.

Both of you have done tremendous work in trying to have this Nation understand these issues, in trying to get a sense of both raising the consciousness about the issue and speaking to our consciences to respond to it. These are our young men and women, and we have an obligation to them, and we have to understand the extent of the problem and face it squarely and then figure out what we are going to do about solving it. So you have done a great service to the Nation with your books, with your articles, with your Web sites. We look forward to working with you when we have any needed legislation that we are going to do here. Thank you so much.

We are going to recess for 35 minutes.

[Recess.]

The CHAIRMAN. Again, I apologize to our witnesses for the recess. And also we tried to, I think, do too much in one day. So I think, with the agreement of all the participants, we are going to move on to panel five for the Department of Veterans Affairs to present its testimony. And then early next year we will hold another hearing for other testimony to continue.

I think the morning testimony was very compelling and took a longer time than we had imagined. We thank you for waiting this long.

Dr. Katz, Deputy Chief, Patient Care Services, Office of Mental Health in the Department of Veterans Affairs; and Dr. Kara Zivin, Research Health Scientist with the Health Services Research and Development of the Department of Veterans Affairs.

You are recognized, Dr. Katz.

STATEMENTS OF IRA KATZ, M.D., PH.D., DEPUTY CHIEF PATIENT CARE SERVICES OFFICER FOR MENTAL HEALTH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY ROBERT ROSENHECK, M.D., DIRECTOR, DIVISION OF MENTAL HEALTH SERVICE AND OUTCOMES RESEARCH, VETERANS HEALTH ADMINISTRATION; LAWRENCE ADLER, M.D., DIRECTOR, MENTAL ILLNESS RESEARCH EDUCATION CLINICAL CENTER, VETERANS INTEGRATED SERVICES NETWORK 19, VETERANS HEALTH ADMINISTRATION; AND FREDERICK C. BLOW, PH.D., DIRECTOR, SERIOUS MENTAL ILLNESS TREATMENT RESEARCH AND EVALUATION CENTER, ANN ARBOR VETERANS AFFAIRS CENTER FOR CLINICAL MANAGEMENT RESEARCH, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS; AND KARA ZIVIN, PH.D., RESEARCH HEALTH SCIENTIST, HEALTH SERVICES RESEARCH AND DEVELOPMENT, VETERANS HEALTH ADMINISTRATION, U.S. DEPARTMENT OF VETERANS AFFAIRS (ON HER OWN BEHALF)

OPENING STATEMENT OF IRA KATZ, M.D., PH.D.

Dr. KATZ. Thank you, Mr. Chairman and Members of the Committee.

I want to begin by expressing my most profound condolences to Mr. and Mrs. Bowman and to Ms. Coleman. What they have spoken of is important to me personally and to all of my colleagues.

I want to assure them that we have taken their words to heart, and so has the Department of Veterans Affairs.

I want to thank you, Mr. Filner, for holding this hearing. The discussion represents an important day for mental health in America.

I want to go over my prepared oral testimony, but to say that, especially after the discussion this morning, it is only a fraction of what I am personally feeling, and it is also only a fraction of what VA is doing.

There is no question, suicide among veterans is a tragedy. The Department of Veterans Affairs recognizes our obligation to work to prevent suicide, both in individual patients and in the entire veteran population. We are concerned about epidemiology. We are more concerned about people and the tragedies that they represent. But we focus on epidemiology because findings in this area can guide prevention.

VA has a long track record of research and publication in this area. One of our leaders is Dr. Han Kang, who is here. Others are on this panel with me.

One peer-reviewed publication from a long-term, 20-year follow-up of Vietnam-era veterans reported that the rate of suicide among veterans who were deployed to Southeast Asia did not differ statistically from veterans of the same era who were not deployed. Another published study of veterans from the first Gulf War provided similar findings.

VA and Dr. Kang have just completed a preliminary evaluation of suicide rates among veterans returning from Iraq and Afghanistan. From the beginning of the war through the end of 2005, there were 144 known suicides among these new veterans. This number translates into a rate that is not statistically different from the rate for age-, sex- and race-matched individuals from the general population.

However, suicide rates among veterans are too high. The population receiving care from the Veterans Health Administration has more risk factors for suicide than the general population. Most veterans are male, and men have higher suicide rates. Those who come to the VA for care tend to be older, less well-off and more likely to have a mental health condition or another chronic illness. Those with the greatest need for care are those who are most likely to come to VA. And this increased need is associated with increased risks of suicide.

The CHAIRMAN. I am sorry to interrupt, Dr. Katz. I just don't understand that conclusion, that those with the greatest need are those who are most likely to come.

We have talked for 3 hours about the reasons why people don't come. And I could make the same case, since you are making a hypothesis here, that there is no real data that the people most in need don't come. I could make the very same argument.

So, why do you think that? I don't understand it at all. You don't know who is coming or why those who are not coming aren't coming. You don't know that.

Dr. KATZ. I will take the question for the record and get back to you, post hearing.

The CHAIRMAN. I am just asking. You drew a conclusion which I think is wrong, and you can't argue for it? I mean—

Dr. KATZ. Well, those who come—for example, there are the demographic issues—age, sex and all. But, most significantly, those who come to VA for care are more likely to have mental health conditions than others.

The CHAIRMAN. But you are not giving me any basis for making that statement. I don't know why that is the case. Again, those who have been subject to arguments that, you can't come if you are weak and they accept that, no matter how difficult—I mean, the suicides we heard about in the morning session, they never got in touch with the VA, and they had pretty difficult situations. So I just don't know why you would just make that assumption.

Dr. KATZ. Well, it is not just an assumption. There is no question that there are many people in need who don't come to VA for care. That is a problem, and it is a problem that we have to solve. But, on a statistical basis, those who do come to us have major care needs and, with those major care needs, increased risks for suicide.

The CHAIRMAN. But those who don't come could even be in greater need. You say the reverse here, and I don't know on what basis you are doing that.

Especially, in light of the little bit of data here, 144 known suicides. We have heard arguments all morning that your data is probably incomplete. There is unreported stuff. There is under-reported stuff. There is not tracking. I mean, you are not anxious, it doesn't seem to me, to go after this stuff. So you are basing your conclusions on very suspect data to begin with.

Dr. KATZ. Mr. Filner, I would like to get back to you about your concerns. But I want to stress that the issue is prevention. Arguing about rates isn't the issue. The issue is—

The CHAIRMAN. You are the one that is arguing the rates. Every one of your paragraphs ends with a thing about the rates—every one of them. You are not talking about prevention here at all. I read your whole thing, and I couldn't figure out what you were doing to stop suicides, frankly.

Dr. KATZ. Well, I will tell you, our suicide-prevention activities are based on the principle that decreasing suicide requires both enhancing overall mental healthcare and programs specifically designed to prevent suicide.

Part of the training for all staff has been to teach that even strong and resilient people can develop mental health conditions. We also teach, both within our facilities and in the community, that care for these conditions is available and must be provided quickly. We also teach that treatment works.

The VA Suicide Prevention Program includes two centers that conduct research and provide technical assistance. It also includes a suicide-prevention call center and suicide-prevention coordinators located in each of VA's 153 hospitals. All together, 200 staff members, 200 mental health professionals in VA, have suicide prevention as their major responsibility.

The Department is partnered with the Lifeline Program of the Substance Abuse and Mental Health Services Administration to develop a suicide hotline for VA as part of the national 1-800-273-TALK system. Since it began, there have been more than 6,000

calls from veterans, 1,300 referrals to suicide-prevention coordinators, and more than 300 rescues where police or ambulances were called, any one of which may have been life-saving.

The CHAIRMAN. Any suicides amongst those?

Dr. KATZ. In our current follow-up, we haven't seen any.

The CHAIRMAN. I am sorry?

Dr. KATZ. We haven't seen any.

The CHAIRMAN. You have 6,000 calls and you are giving me all this data of 1,300 referrals, 300 rescues. But you haven't seen or you don't know if there are any suicides?

Dr. KATZ. We are doing follow-up of those who have called, and have been referred to VA facilities and the results from the follow-up will be available soon.

The CHAIRMAN. These are obvious questions. I don't know why you don't have them before you come in. You give us all this data, which is a lot of activity, but I don't know about any results. I can't tell from your report that we have any results here. You are giving me a whole bunch of numbers, and usually that is a reason why you don't—

Dr. KATZ. Mr. Filner, with permission, I could send to you the stories of a number of people who have called the hotline, so you could see the dedication and skill of VA professionals in action.

The CHAIRMAN. I am not arguing that at all. The people who are doing this are wonderful people. They are dedicated. They are doing their job.

We heard testimony that something like 6,000 veterans have committed suicide last year, or 2005, the year that *CBS News* was doing it. What about that? I mean, there is nothing in here that talks about that statistic. I mean, I don't even care if it is right. It is somewhere close to the truth. What about that? You say you saved 300, but what about the 6,000?

Dr. KATZ. Mr. Filner, VA has a major suicide-prevention program, the most comprehensive in the Nation. The numbers, frankly, aren't the issue.

The CHAIRMAN. What if it was 3,000? What if it was 1,000? What is the difference?

Dr. KATZ. If the number were 300, we would still be doing everything possible.

The CHAIRMAN. But you are not referring to why. Why do those 6,000 exist, with all this work you are doing? What is the measure of your effectiveness if all these people didn't know the hotline number, they didn't call the hotline—

Dr. KATZ. Sir, the 6,000 exists because mental illness is a real illness, and mental health conditions can be fatal.

The CHAIRMAN. I understand. But to have credibility for what you are all doing professionally, you have to address these issues, and you are just ignoring them. You don't have a word in here about that. I mean, it takes away the sense of credibility that you are trying to raise here that you are doing all this, because we have both anecdotal evidence and now we have more statistical data that we are failing as a Nation. Not you individually, not anybody who is on a hotline with anybody, but as a Nation we are failing. And you are acting as if everything is goodness and light in this effort.

Dr. KATZ. Sir, Patrick Kennedy talked about mental health in America, and he is right. VA, in suicide prevention, is ahead of the rest of America, as we should be.

The CHAIRMAN. I will accept that. What happens to the 6,000 veterans who committed suicide last year, the 6,000 who committed suicide the year before and the 6,000 the year before that? What is going on with them, if we are so successful?

Dr. KATZ. That is why we have the foremost researchers in America working on this problem. That is why our mental health budget has increased 60 percent since the beginning of the war.

The CHAIRMAN. I understand, but when you ignore these issues in a report that is supposed to talk about what you are doing, you damage your credibility, you damage whatever we are trying to do. Because I have to say, you are ignoring the whole problem here with this report. You are using activity as a substitute for effectiveness. Just because all these people are working doesn't mean they are effective.

Again, I don't know. We have a National Guard, which you are not even discussing here. We have all the people who are not enrolled in the VA, which we are not discussing here.

Mr. Bowman is still here. He made a really interesting suggestion: Go meet these kids at the bus when they come off. That is what I want to talk about. You heard their testimony. Throw this prepared testimony away and talk to the Bowmans, talk to Ms. Coleman, talk to Ms. Meagher, and say what we are going to do about these issues. You are not doing that. I mean, you had the advantage of listening to them. Respond to them.

You are reading this report, which, you know, had so many questions to begin with, but I still don't know what you are doing for those people, I still don't understand it.

You have a National Guard parent whose whole unit has never heard anything about how to help address possible suicide. So what are we doing about that? If you say, "Well, we are VA; we can't help the National Guard," then say that, and then I will be happy to figure out legislation that says, you know, how you can do that.

Mr. BUYER. Sir, can we have regular order and permit the witnesses to testify, please?

The CHAIRMAN. If they had regular order about how to write their reports, we would be okay. I mean, it is not helpful, the way you are doing this.

You can complete your testimony.

Dr. KATZ. Mr. Filner, with your permission, could I yield time to Dr. Rosenheck?

Mr. BUYER. Dr. Katz, would you finish your statement, please?

Dr. KATZ. Sure.

I was talking about the major programs for suicide prevention that VA is conducting complementing our major expansion of our general mental health programs.

We have held two VA suicide-prevention awareness days for required education for all employees. The first focused on enhancing awareness of the issue; the second, training staff on how to work with available prevention resources, including the hotline and coordinators.

The coordinators get calls and referrals from the suicide hotline, as well as from providers. They educate their colleagues. Then—

The CHAIRMAN. Dr. Katz, did you study the well-publicized incidents when Marines or soldiers walked into a VA hospital saying they thought they had this PTSD thing, which they didn't understand, and were having suicidal thoughts? They were told that there was nobody available, or an appointment would not be available for a month, and they went home and killed themselves. Have you addressed that in here?

I mean, you are telling me about in-service training. That is great. What happened about that training when these kids came into the hospital and then went out and killed themselves? Do you address that?

Dr. KATZ. In this document, no. In fact, the VA has—

The CHAIRMAN. Why not? Well, you are telling me about in-service training. There are well-publicized incidents when that either failed or had not occurred yet. Tell us what happened in those cases.

Dr. KATZ. I will send you the case reports from the hotline. They are incredible human stories.

I also want to talk about policy, how, beginning this summer, we established a policy that any new request or any new referral for a mental health appointment has to have an evaluation within 24 hours to determine the urgency. If there is an urgent need, care must be provided immediately. If not, the patient has to be seen within 2 weeks.

The CHAIRMAN. Did this happen after these incidents? One in Minnesota, one in Florida, and, I think, there was another State. And 2 weeks wouldn't have saved them anyway. I mean, was this in response to that, so it wouldn't happen again?

Dr. KATZ. These policy advances were in response to new patients from Iraq and the needs of established veterans.

The CHAIRMAN. Okay. I will let you continue, but, look, if you don't deal with these stories and this evidence where we have failed our patients, then your credibility of what you are doing is zero. It looks like you are just shoving them under the rug, you don't want to talk about them, you don't want to deal with them, and so you avoid them. Some of us have memories about these things, and some of us have policy issues. You don't enhance your credibility when you avoid them.

Finish your testimony, please.

Dr. KATZ. Well, Mr. Filner, you are being somewhat dismissive of a major public health effort in suicide prevention that VA is doing.

The CHAIRMAN. I am not dismissing the effort. I am dismissing the way you are talking about it, as if everything is goodness and light, we have no problems, everybody is being helped, we saved all these lives. We just had 3 hours of testimony that this is not true. Respond to that.

Dr. KATZ. I was profoundly affected by what I heard.

The CHAIRMAN. But you are reading the whole report that you wrote before you heard them, as if they didn't testify.

Dr. KATZ. My reaction is thank God we are doing what we are doing. I truly believe we are saving lives.

The CHAIRMAN. I don't disagree with that. I want to know, what about the lives we are not saving too?

Dr. KATZ. They affect all of us.

The CHAIRMAN. Well, tell us about them. That is all. Enhance your credibility by dealing with all of them.

You may finish.

Dr. KATZ. I do want to end by mentioning that we applaud Congress for passing the Joshua Omvig Prevention Bill, recently signed by President Bush. We have implemented essentially all of the provisions of the bill already, and, in fact, we did so before it was passed.

We continue to do research to develop and implement new strategies to improve our ability to save lives by preventing suicide. We believe our healthcare system can and must serve as a national model for mental healthcare and suicide prevention now and in the future.

Thank you.

[The prepared statement of Dr. Katz appears on p. 84.]

The CHAIRMAN. Dr. Zivin.

OPENING STATEMENT OF KARA ZIVIN, PH.D.

Dr. ZIVIN. Good afternoon, Mr. Chairman.

I would like to take this opportunity to express my condolences to all the families who have lost a loved one to suicide.

I am honored to provide testimony to the Committee about suicide among veterans treated for depression in the VA health system. I come before this Committee as a mental health services researcher who has conducted research on this topic. The views and opinions are expressed on my own and do not necessarily represent those of my current employer, the Department of Veteran Affairs, or the views of the VA research community.

I am here today to report on findings from a study that I conducted, along with my colleagues at the Department of Veterans Affairs, National Serious Mental Illness Treatment Research and Evaluation Center, SMITREC, and the VA's Health Services Research and Development Center of Excellence in Ann Arbor, Michigan, where I am a research investigator, as well as an assistant professor of psychiatry at the University of Michigan Medical School.

We recently published a paper in the American Journal of Public Health examining suicide rates using data from the VA's National Registry for Depression for 807,694 veterans of all ages diagnosed with depression and treated at any Veteran Affairs facility between 1999 and 2004. In all, 1,683 veterans in VA depression treatment died by suicide during the studied observation period, representing 0.21 percent of this treatment population.

When we calculated the overall suicide rate in this population over the 5½-year study period, it was 88.3 per 100,000 person years, which is approximately seven to eight times greater than the suicide rate in the general adult U.S. population.

A higher suicide rate would be expected among a population of patients in treatment for depression than the general U.S. population, given that depression is a potent risk factor for suicide.

Because most healthcare systems lack the capability of assessing suicide rates among their treatment populations, there are few points of comparison with nonveteran treatment populations. However, at least one prior study reports a suicide rate for men receiving depression treatment in managed-care settings between 1992 to 1994 of 118 per 100,000 person years, a suicide rate which is somewhat higher than that observed in this veteran depression treatment population.

In our study, we observed that the predictors of suicide among veterans in depression treatment differed in several ways from those observed in the general U.S. population. Typically, people in the general population who die by suicide are older, male and white and have depression and medical or substance abuse issues. In this study, we, too, found that depressed veterans who had substance abuse problems or psychiatric hospitalization in the year prior to their index depression diagnosis had higher suicide rates.

However, when we divided the depressed veterans into three age groups—18 to 44 years, 45 to 64 years, and 65 years or older—we found that the younger veterans were at the highest risk for suicide. Differences in rates among depressed veterans of different age groups were striking: 18- to 44-year-olds completing suicide at a rate of 95 suicides per 100,000 person years, compared with 77.9 per 100,000 person years for the middle-age group and 90.1 per 100,000 person years for the oldest age group.

We did not assess whether individuals had served in combat during a particular conflict, although the existence of a military service-connected disability was considered.

In this VA treatment population, men veterans were more likely to commit suicide than women veterans. Suicide rates were 89.5 per 100,000 person years for depressed veteran men and 28.9 per 100,000 person years for veteran women. However, the differential in rates between men and women in this population of three to one was smaller than that which has been observed in the general population of four to one.

We found higher suicide rates for white depressed veterans, 95 per 100,000 person years, than for African Americans of 27.1 per 100,000 person years and for veterans of other races, 56.1 per 100,000 person years. Veterans of Hispanic origin had a lower rate, 46.3 per 100,000 person years, of suicide than those not of Hispanic origin, 86.8 per 100,000 person years. Adjusted hazard ratios also reflected these differences.

Surprisingly, our findings revealed a lower suicide rate among depressed veterans who also had a diagnosis of post traumatic stress disorder, PTSD, compared to depressed veterans without this disorder. Depressed veterans with a concurrent diagnosis of PTSD had a suicide rate of 68.2 per 100,000 person years compared to a rate of 90.7 per 100,000 person years for depressed veterans who did not also have a PTSD diagnosis.

We investigated further to examine whether specific subgroups of depressed veterans with PTSD had higher or lower suicide risks. We found that concurrent PTSD was more closely associated with lower suicide rates among older veterans than among younger veterans. This study does not reveal a reason for this lower suicide rate, but we hypothesize that it might be due to a high level of at-

tention paid to PTSD treatment in the VA system and the greater likelihood that patients with both depression and PTSD will receive psychotherapy and more intensive visits. In general, individuals with depression and PTSD diagnoses have higher levels of VA mental health services use than individuals with depression without PTSD.

Interestingly, depressed veterans who did not have a service-connected disability were more likely to commit suicide than those with a service-connected disability. This may be due to greater access to treatments among service-connected veterans or more stable incomes due to compensation payments.

We hope that our findings will help inform clinical treatment and policy initiatives to reduce suicide mortality among veterans with depression.

I thank you for this opportunity to testify and will be pleased to answer any questions that you have.

[The prepared statement of Ms. Zivin appears on p. 86.]

The CHAIRMAN. Mr. Mitchell.

Mr. MITCHELL. This question is for Dr. Katz.

And I have read your testimony. I didn't hear your testimony, but I read your testimony. And one of the things I am concerned about is, throughout your testimony, you are talking about those programs you have in place, which is good, and that you are effective for those you have in place.

But what bothers me is, this morning we heard testimony from the parents of Timothy Bowman, whose numbers will not be in your figures. He committed suicide. He will not be part of the DoD or the VA's numbers. And my concern is, unless somebody comes and registers with you, what outreach do you have?

You know, this is a very serious problem, those who do not register. All you have are figures of those who came in and registered with the VA. Even in Arizona, this is a growing concern. Veteran suicide rates in Arizona have risen 39 percent since 2003, and one-quarter of all suicides in Arizona are with veterans. This is, I think, an epidemic.

And I know what you are saying with all of those figures that you have there, but my concern is, do you really have enough resources to go after the veterans who do not show up and are not on your figures, the figures either from DoD or the VA? Because I think it is important that we go out and try to get the correct figures.

Am I understanding that you have not really collected figures, total figures, on all those returning from Afghanistan or Iraq?

Dr. KATZ. Well, I want to begin by—actually it is very ironic. We know that Tim Bowman was a person and that his loss is terrible, and, as a Nation, we have to mourn him. The question is, is he a statistic? Is he counted in VA research? And the answer is yes. Dr. Kang's research counts all veterans, whether or not they have come to VA for care.

This raises questions about, the people who don't come to VA for care, how are we reaching out to them? Our Vet Centers have hired over one hundred peer counselors, ex-vets who go out to post-deployment health reassessment, who go to Guard and Reserve meetings, and who speak in community centers and related venues.

There are more than 90 returning veterans outreach teams in our medical centers and clinics. We really have extensive outreach.

Is it enough to enroll every veteran? No. Is it enough to prevent every suicide? Apparently not.

We have, thanks to you, considerable funds. And our goal, our mission and our challenge is to use these funds effectively. We really have to go reaching out to people and providing services, where mental healthcare has never gone before. We have intensive research going on, and VA has, by necessity, become more adept at translating research into clinical and public health action than anyone else. Are we there yet? Of course not. Have you given us enough resources? Yes. Our challenge is to use them to improve lives and save lives.

Mr. MITCHELL. So, Dr. Katz, you are telling me that you have enough resources to do the job that is necessary to find these veterans and to treat these veterans. You have enough resources.

Dr. KATZ. Yes, sir.

Mr. MITCHELL. Thank you.

The CHAIRMAN. Mr. Buyer.

Mr. BUYER. You know, sometimes, Mr. Mitchell, it is not just a matter of resources, it is what are you going to do with them.

Mr. MITCHELL. Yes.

Mr. BUYER. When you look back, 3 years ago we gave them \$300 million, and they couldn't even spend \$100 million of it.

Dr. KATZ. Can I comment about that, sir?

Mr. BUYER. You may.

Dr. KATZ. A year ago, the Committee raised concerns that there was underexecution of mental health enhancement funding. I guess that is bureaucratic talk for under-spending of the resources.

This past year, there were \$306 million allocated for mental health enhancements in VA. The actual spending was \$325 million. We overspent and, to be honest, we were congratulated by senior leadership for overspending, because nothing is more important than mental health.

Mr. BUYER. I hate to get into the numbers and statistics, but I am going to do that for just a second, because, really, it is all sort of disturbing to me.

I look at the Inspector General's (IG) report, and the IG says, all right, out of the 25 million veterans in the United States, they estimate as many as around 5,000 veterans per year are turning to suicide, of the 25 million. Then *CBS News*, they throw out a number of 6,256 in 2005. I mean, since this report came out, I mean, there is a difference of 1,200. That is still a big number to me.

But I am curious, do you know how *CBS News* came up with that number if the IG or the VA comes up with a different number? Are you familiar with how they—has *CBS News* shared with you the methodology of how they came up with their number?

Dr. KATZ. They shared their algebra but not their raw data. We want the numbers. It could help to guide and fine tune our prevention efforts. They handed me the numbers when I was interviewed, and then they took it back. We requested it from the producers. The Inspector General requested it from the producers. They are not forthcoming about the numbers. I would think that, as a mat-

ter of citizenship, *CBS News* should be required to provide these numbers, so VA can translate them into prevention.

Mr. BUYER. Well, the numbers are important in how we get to them.

Let me ask Dr. Zivin, is it important for us to understand the gender distribution in these numbers?

Dr. ZIVIN. The gender distribution, was that your question, sir?

Mr. BUYER. Yes. Is that important for us to know as policy-makers.

Dr. ZIVIN. It is important for us to know all characteristics associated with suicide and how those may be similar or different in the VA or among all veterans than the general population. And that is something we are studying. We have both VA- and NIH-funded research to examine all characteristics associated with suicide.

Mr. BUYER. Have you seen the *CBS News* report?

Dr. ZIVIN. I have seen it, yes, sir.

Mr. BUYER. And what is your opinion regarding the fact that gender distribution would have been left out of their numbers? What does that tell you?

Dr. ZIVIN. Sir, I would like to ask the members of this panel if they would like to comment on this, or perhaps we could get back to you about this.

Mr. BUYER. Well, if anyone here on the panel has an opinion on it, please let us know. Because I think it is rather bothersome that they would leave out gender distribution. Does anyone have an opinion with regard to that?

Dr. KATZ. They controlled for gender but did so in a very strange way. Their number for veteran suicides is not, in fact, an accurate reflection of the rates of suicide.

Dr. ROSENHECK, you wanted to comment?

Dr. ROSENHECK. Well, actually, I wanted to shift gears a little bit.

Mr. BUYER. No.

Dr. ROSENHECK. Okay.

Mr. BUYER. I get to shift gears.

Dr. ROSENHECK. In direct response, none of us feel we have seen a complete report of this data so that we, as professors, can judge the validity of the conclusions.

Mr. BUYER. All right. I am not going to challenge the intent of *CBS News*, because I am hopeful that their intent and motivation was pure. And if it was pure, they have nothing to hide and should be willing to work with you, with regard to the numbers.

Let me ask this question. The Canadian Government uses the term “operational stress injury”—they don’t use PTSD to describe their diagnosis. Would that be useful and helpful to us, if we would turn to “operational stress injury” so we can maintain PTSD but come up with another type of description whereby it encourages soldiers and veterans to come in to discuss this without stigma? Do you have an opinion with regard to that?

Dr. KATZ. Well, I think we heard from the world’s experts about what we call it. And in terms of what it is called and how people react to that, the world’s experts are the consumers and the families. If they want to change the name, we should change the name.

Mr. BUYER. Mr. Chairman, with latitude, I have one last question.

One of the concerns is being able to provide mental health services to members of the National Guard and the Reserve components when they return from their overseas deployments. In Indiana, on January 2nd, I will stand with the 76th Brigade. We are going to send an entire brigade to war. Not since World War II.

So what outreach programs do you, the VA, have in place for the National Guard and the Reserve?

Dr. KATZ. There are peer counselors from the Vet Centers who should be there, as should returning veterans outreach people from our medical centers and clinics.

Mr. BUYER. How do we prepare the families while the soldiers are gone? What do we do that is proactive?

I think that is what the Chairman—my interpretation is, what are you doing on the prevention side? Let's not just wait until they come home. What are we doing to help prepare the families?

We do a lot with the families, not only their care packages, and they have their own support groups. But what do we do, in being off our heels and on our toes, to be proactive on what they should look for? What should they be doing to be helpful to them while they are deployed? Are we doing anything?

Dr. KATZ. Vet Centers are authorized to provide outreach and education for families under specified circumstances while the veteran is deployed. VA is not authorized by law to do so.

Mr. BUYER. Under specified circumstance. That is telling me that is some sort of limited service.

Dr. KATZ. I am actually confessing my personal lack of knowledge about the specifics. I am embarrassed. I apologize for it. We will have to get back to you.

Mr. BUYER. I understand that these men and women are activated so now they are part of DoD.

Dr. KATZ. Yes.

Mr. BUYER. But we deal with the consequences of war, the consequences. And it is easy to take care of them when we see the physical wound, so it is the mental wound that is our challenge.

So this leads to the whole path of how we work cooperatively with DoD in trying to get bi-directional, on-time, real-time mental health data. That is a real challenge.

But here is what I want to do. I want to do this with you. We now know we have a brigade that is going. I am going to work with you. I want you to work with myself and the Chairman of this Committee, as we also work with DoD, and you tell us what we can do that is proactive with regard to this brigade as it goes, and what authorities do you need, what do you need from us. You probably don't need much authority. A lot of things you can do. But tell me what you can't do, and we can break down these barriers.

Will you take that on with us?

Dr. KATZ. Absolutely, with pleasure and with honor.

Mr. BUYER. All right. Thank you.

I yield back.

The CHAIRMAN. And I give the same answer, with pleasure and with honor.

Mr. BUYER. All right. Thank you.

The CHAIRMAN. Let me just say a few words.

Mr. Buyer mentioned that *CBS News* had 6,000 and IG had 5,000. That is a big difference. Both of those are a big difference, from what I see in this. It is a different universe, Iraqi and Afghanistan, since 2005—144. I mean, this is a purposeful putting forth the lowest figure that you could possibly get to.

Dr. KATZ. No, sir. Those are the full count of suicides in returning veterans.

The CHAIRMAN. But you chose a universe on purpose that never would touch—how about 5,000 or 6,000? That would get people annoyed. 144? Oh, I can live with that. You are giving numbers here that do not reflect reality in terms of the problem that we have to face and you have to face as policymakers.

And, frankly, your statement, Dr. Katz, that “*CBS News* should be required to give the statistics”—

Dr. KATZ. Yes.

The CHAIRMAN [continuing]. That is disgraceful from an organization, that they have to FOIA, we have to FOIA, a parent has to FOIA, to get any information on this.

I have, from this chair to that seat—and maybe you were one who was there, I can’t recall now—at least three or four different times in the last 7 or 8 months, asked for data on suicides from the VA. They always said they will get back to me. They have never gotten back to me. You try to get data, you get all kinds of different numbers from different universes.

And besides, the data you use, as we have heard this morning, is all slanted anyway. I mean, it is a very specific definition of a suicide that you are using that is way underreported from the reality.

CBS News tried to get the data. They didn’t want to spend 6 months going to States and do this thing. They couldn’t get the data from you because you don’t track this stuff. You simply don’t track it. You don’t want to know about it.

And I had a whole report from Dr. Zivin, who—I never, by the way, ever heard somebody on the panel say they are not speaking for the Department of Veteran Affairs when you are here. I mean, they must have approved this, but you are not speaking for them. I don’t know, that is strange.

But you give four or five pages of data. I don’t see anybody on this panel, in prepared testimony, say what you are going to do. How does this inform your treatment? What prevention are you doing to do based on this?

This is a bunch of numbers that is meaningless in the context that we are working in today. That is, you had time to give this data to somebody to say, “What are we doing about using this data for actual clinical or preventive operations?” And there is nothing. It is just a case of—of “analysis paralysis.” It is just a bunch of statistics that you are going to throw out to us here and say that you have done your duty. You guys have not done your duty. You have not given us adequate numbers or even an explanation of the problem in getting those numbers.

We haven’t talked about, if there are 5,000 or 6,000 or 2,000 veterans that are dying every year, how are we going to get to them? You tell me what you are doing, but you are not telling me about

the evidence that we have that we are not being effective. How are you dealing with that? You have not done the job.

We are going to have another hearing on this.

[Applause.]

And I want you to come back with a better report. This is not very useful. Again, all you do is compare some things in a strange universe that does not come to grips with the issue.

Dr. KATZ. Mr. Filner?

The CHAIRMAN. Mr. and Mrs. Bowman this morning, and the other testimony, were crying out for help. I responded to say, here is what I am thinking about to respond. I don't know if it is good or bad. I said we have to have a public education program. I said we have to have mandatory diagnosis of PTSD and brain injury. I said we have to do that in a unit with family there.

You didn't come up with anything. You didn't even respond to my meager suggestions.

Dr. KATZ. Mr. Filner, I really need to respond to one specific issue.

The CHAIRMAN. Respond to them all. I don't care.

Dr. KATZ. Well, we can provide additional numbers.

The CHAIRMAN. You always say that, and we never get anything.

Dr. KATZ. We can provide additional—

The CHAIRMAN. I have done this for at least several years.

Dr. KATZ. You are delivering the message to America that there are major problems in VA treatment. I want to deliver the message that care is available and that treatment works. We have programs in place that can help people.

The CHAIRMAN. How would you have helped Timothy Bowman or the Timothy Bowman that is coming tomorrow? Nobody has talked to them, nobody has done anything, nobody has counseled them, nobody made Timothy aware of anything, and nobody is making the Timothys of tomorrow aware. So how are you responding to their cry for help?

Dr. KATZ. It is tragic that—

The CHAIRMAN. But what are you doing about it?

Dr. KATZ. We are doing the—

The CHAIRMAN. But it didn't reach these people.

Dr. KATZ. That is tragic.

The CHAIRMAN. Well, then find a more effective way. Don't keep telling us you are doing things when they are not effective. It is proven not effective. You reach a very small percentage of those who need help. Why?

Dr. KATZ. Sir, I really think we want to emphasize the message that treatment is available and treatment works. Because that message is a matter of public health, and that message can be life-saving.

The CHAIRMAN. Well, let me tell you the message that I want to send, that we have an epidemic, as has been said before, we have a public health crisis. And no matter how hard you are working now, we are not doing the job. We need to do more.

And you need to tell us, rather than how much stuff you are doing, what we need to do to be effective. You answered Mr. Mitchell that you had sufficient resources. You don't have anybody to call up Mr. Bowman to even offer condolences, let alone help his counseling. So, I mean, surely some more resources would be nice.

Mr. Mitchell, you have a question?

Mr. MITCHELL. Yes. I would like to follow up on that with Dr. Zivin.

According to your testimony, your study was based on veterans who had been diagnosed with depression and were treated at VA hospitals or VA facilities.

What I would like to know is, what about veterans who don't fall in either of these categories? What about the veterans who have not been diagnosed with depression or who have not been treated at VA facilities? What about the veterans who are suffering from post traumatic stress disorder or haven't visited a VA facility?

Could you shed any light on the scope of the problem facing these and other categories of veterans?

Dr. ZIVIN. It is true that we focus in this study specifically on depressed veterans treated in the VA population, and that represents only a fraction of all veterans who either have depression or PTSD or both. And one of the things that we are doing as part of our ongoing research and what Dr. Katz was just alluding to is that we are now collecting and having data on all veterans, with or without depression, and rates of suicide.

One of the other things to mention is that the VA has developed a comprehensive strategic plan which is specifically focused on treatment for PTSD, suicide prevention and a number of other initiatives specifically targeting at-risk veterans.

And I will ask my colleagues here to comment further, if you have other questions.

Mr. MITCHELL. Just one comment to add to that. There are some people who come back who don't believe that they have a problem, and therefore, they don't register. Maybe they don't fill out the forms or tests that I understand are necessary, yet they have it. Is there any outreach?

I understand, Dr. Katz, you said you have programs, but there are only programs if somebody comes in. What about the people who have not been diagnosed yet who end up with this disorder months, maybe years, later? What about those who have not registered with the VA?

What kind of programs do you have in place, not just to reach those who have registered and who have been diagnosed, what kind of programs do you have in place to go beyond that?

Dr. KATZ. We are in agreement that a major challenge for us is reaching more people. We have talked about what we do for those who enter our doors, either the Vet Centers or medical centers and clinics. We have talked about the outreach that we are doing. How do we effectively reach the rest of the community?

Dr. Kussman is writing a letter that should go out this week or next to all veterans, raising these issues. Other strategies are being developed including additional follow-up to the post-deployment health reassessment. We recognize the need to do more to reach more people, yet we are working intensively—and we are working intensively on how to do it.

Dr. Rosenheck reminded me of a fact from Dr. Han Kang's work that makes this issue very poignant. Among returning veterans, among OIF/OEF veterans, the rates of suicide among those who come to us don't differ from the age-, sex- and race-matched indi-

viduals, but the rates of suicide among those who don't come to us are higher. It is reassuring about what we are doing and a clear message about what we should be doing next.

Mr. MITCHELL. Absolutely.

And one last question, real quickly. Do you believe that there is a suicide epidemic?

Dr. KATZ. There is a suicide epidemic in America.

Mr. MITCHELL. Among veterans?

Dr. KATZ. The numbers—what are the numbers? About 18 veterans kill themselves each day in America. That is too many. About four or five—

Mr. MITCHELL. According to *CBS News*, it was 120 a week.

Dr. KATZ. About the same.

Mr. MITCHELL. That is not higher than the general population?

Dr. KATZ. Rates among veterans are somewhat higher than the general population because of demographics and increased in risk factors for depression, related conditions.

Mr. MITCHELL. I think one way we can find out about that is if you have the data. And I think that is—you know, one of the people were arguing about earlier was the methodology data that *CBS News* had. And if we had the data, we could certainly refute or agree that there is or is not an epidemic and it is more so among veterans. I think that is what we have been trying to find out.

Dr. KATZ. Some of the Nation's foremost investigators in this area are before you.

Dr. BLOW, could you talk about some of the data?

Dr. BLOW. Sure. Among veterans receiving services in VHA, so those actually touching the VHA, the rates are about 1½ times age- and sex-adjusted population rates. The rates for women are about two times that of that U.S. population overall rates for women. So it is much higher for women than for men.

Mr. MITCHELL. Again, these are people in your system.

Dr. BLOW. That is exactly right, the 5.5 million veterans who actually we serve.

Mr. MITCHELL. We already heard about someone not in the system. That is the purpose of what we are trying to find, people who are not in the system being treated.

The CHAIRMAN. Mr. Mitchell, this room has been reserved for another Committee, so we have to adjourn this.

I have one last—you have a last statement.

Mr. BUYER. Dr. Katz, I want you to go back from here and talk with your chief and your team, and I want you to be ahead of us. Work with your counterpart in DoD between their BattleMind Training initiative that they have, along with your initiatives, and we will use that brigade as a cohort. And we are going to circle back here next week, okay? But get ahead of us. All right.

Dr. KATZ. Thank you.

The CHAIRMAN. Thank you, Mr. Buyer.

And let me again—I mean, I am very disappointed with the testimony. When Mr. Mitchell gave you a chance just to talk about outreach, you said that the Deputy Secretary is writing a letter. That doesn't do it.

Look, I will just comment on one thing. We know, we absolutely know as a fact—I don't care what any researcher tells me—that the

images of war in Iraq trigger PTSD reactions in people from earlier wars. I could figure out a hundred ways for you to go out to those people now. Just take the Vietnam vets. Go out, find them and say, "We are going to help you."

You have all this great stuff you are telling me about. We know Iraq is going to trigger this from Vietnam vets. Go find them. Go to the Vet Centers, go to the Vietnam Veterans of America, go to the VSOs who are here. Go to the major cities. Set up a place where you can screen people more. Go out to communities.

You are doing this research which doesn't tell us anything, and you are not reaching the people who need the help. We said it many times this morning. We have an obligation. You are not meeting that obligation. You are doing stuff and you are spending a lot of money and you have all these professors, but we are not meeting the needs. And until we do that, we are not going to be satisfied here.

We are going to take this up early next year. We will continue the hearing we started today. But we are going to talk to the new Secretary, General Peake, and let him know how disappointed we are in this, and hopefully we can move to do our veterans a greater service. We are not doing the job now.

Mr. Kennedy.

Mr. KENNEDY. I would just like to ask that you apply the bottom line to the families of veterans so that they can better identify these symptoms amongst their own family members. Right now they are not given the tools, so to speak, of being able to act as the identifier and supporter of their own loved one when they come home.

Am I right?

Dr. KATZ. You are right. Vet Centers, as well as DoD, can begin on it. For medical center and clinic staff to do that would take an act of Congress.

Mr. KENNEDY. But family members are the ones who spend the most time with their loved one. They ought to be brought in and made a better and bigger part of this whole process.

Dr. KATZ. Absolutely.

The CHAIRMAN. And acts of Congress is what we do, so just tell us what we need to do.

Mr. BUYER. Mr. Kennedy, that is exactly what we are going to try to do.

Mr. KENNEDY. And finally are we tracking—as you said, women are twice as likely to have suicide rates within the VA as men. Are we tracking women veterans within the VA separately from men and their issues, because I understand they have very specific and unique issues as to men veterans when they are in the VA system.

Are we doing—

Dr. BLOW. There are many initiatives in the VA to enhance services for women veterans with their special needs and especially with the special needs that they encounter because of their combat exposure.

Mr. KENNEDY. Yes, but are we tracking their women-specific issues, around their specific issues, mental health needs, issues?

Dr. BLOW. Yes, absolutely. We have many different women's mental health initiatives trying to find out what happens to them over time, and we try to address their specific needs in treatment.

Dr. KATZ. A minor correction. The twofold is women in the VA relative to women in the general population. It is still a lower rate than men.

Dr. Rosenheck.

Dr. ROSENHECK. I did want to talk to the Bowmans because I am the son of a veteran who committed suicide, and I have been now in the VA and have been a psychiatrist and have been a professor of psychiatry and epidemiology for almost 40 years, and my work is animated every day by the fact that my father was a veteran who had committed suicide. I want to tell you that my colleagues in the VA come to this work with a personal sense of mission. All of us, many of us—more than in any other group—are veterans, and more than any other group, we know and have been touched by mental illness and by all kinds of illness. People do not come to the VA as a simple, professional job. People who work in the VA are driven by a sense of mission and of caring, and I want to say, in shifting back to my capacity as program evaluator and as a scholar—well, I am staying with the personal—I started with the VA in 1973. I was a first-year resident at the VA in Connecticut, and I was seeing veterans coming back from Vietnam. I have worked at the VA for my whole career since then, and the change from 1973 to now is so astonishing. When I was a first-year resident, I had no language. I had no culture. I had no background to understand the young men who were coming and sitting in front of me right off the battlefield. We had no terms.

Now, whether you talk about PTSD or PTSI, we have a language, and the whole country knows it. I get called by reporters, “Can you get PTSD from watching the war on TV?” Everybody knows about this syndrome, and they know about it because of the gift of the Vietnam veterans. Every year, we are seeing more and more—I have been tracking it for 10 years, and the progress we are making in terms of the numbers of veterans we are seeing is astonishing, and the commitment of the organization from the bottom to the top to serving veterans who served in combat, I can just—

The CHAIRMAN. We thank you for that.

Mr. KENNEDY. I understand that we do not on the women’s side—

The CHAIRMAN. Mr. Kennedy, we have to end this.

Mr. KENNEDY. We are not tracking women-specific issues from the general veterans’ population, and I hope that we do a better job of doing that.

The CHAIRMAN. Let me just say in conclusion, Dr. Katz and your colleagues, nobody is disputing your personal commitment or your effectiveness in dealing with veterans. What we are saying is how much of a—possibility exists in this country to deal with these issues. That is the great disappointment to me. We have the ability to do the job for everybody. Although we have made progress and we have all of these dedicated people, we have not done the job. And until we do the job, we are going to keep up the oversight that we have to do.

This hearing is adjourned.

[Whereupon, at 2:35 p.m., the Committee was adjourned.]

A P P E N D I X

Prepared Statement of Hon. Bob Filner, Chairman, Full Committee on Veterans' Affairs

Good morning and welcome to the House Veterans' Affairs Committee hearing on *Stopping Suicides: Mental Health Challenges within the Department of Veterans Affairs*.

Mental health issues have been a focus of this Committee all year long and will continue to be at the forefront of our agenda. Public Law 110-110, the Joshua Omvig Veterans Suicide Prevention Act, was enacted in November of this year.

The House has also passed H.R. 2199, the "Traumatic Brain Injury Health Enhancement and Long-Term Support Act of 2007," H.R. 2874, the "Veterans' Health Care Improvement Act of 2007," and H.R. 612, the "Returning Servicemember VA Healthcare Insurance Act of 2007." Each of these pieces of legislation addresses mental health issues in some aspect concerning the well-being of veterans.

The demands confronting VA today are complex and sometimes overwhelming. VA must find a way to ensure quality and efficiency do not suffer as they move forward, continuing to treat veterans from past wars while adapting to the unique needs of the younger veterans of modern warfare who are entering the system for the first time.

We know that OEF/OIF servicemembers are subject to repeated deployments, an intense level of close combat, extended deployment lengths and repeated family separations.

VA has reported that of the 263, 909 separated OEF/OIF veterans who have obtained VA healthcare since FY 2002, 38 percent have received a diagnosis of a possible mental disorder. Of that population, 48 percent have a possible diagnosis of PTSD. The prevalence of mental health problems among returning servicemembers is troublesome and should be of concern to everyone.

Recent events have been brought to the attention of this Committee through a CBS report on the rising suicide rates among veterans. We also know that male veterans are at elevated risk of suicide relative to nonveterans. In fact, they are twice as likely to die of suicide compared to male nonveterans in the general population.

Of great concern to the Committee is the recent VA Inspector General report that found that nearly 1,000 veterans who receive VA care commit suicide every year, and as many as 5,000 a year are committed among all living veterans.

Today we will take a hard look at programs the VA has implemented to address the challenges of suicide.

I look forward to the upcoming testimony.

Prepared Statement of Hon. Stephanie Herseth Sandlin

Thank you to everyone for being here. I congratulate Chairman Filner and Ranking Member Buyer for holding today's hearing to examine and identify mental health challenges within the Department of Veterans Affairs healthcare system.

As the wars in Iraq and Afghanistan continue to produce a new generation of veterans, it is important that Congress evaluate the impact of these conflicts on the mental well-being of returning servicemembers. We must closely evaluate the ability of the VA to meet the mental healthcare demands placed upon it.

While I am pleased that the VA offers a wide array of mental health programs, there continues to be room for improvement. In particular, I believe we must do more to meet the mental healthcare needs of our rural veterans—who often must travel long distances to reach VA healthcare services.

I am pleased that we have the opportunity to hear from today's panelists and am grateful to have the opportunity to hear their suggestions and answers to the critical issues involved. I look forward to hearing their testimonies.

Again, I want to thank everyone for taking the time to be here and discuss these important matters.

Prepared Statement of Hon. Harry E. Mitchell

Thank you, Mr. Chairman. And thank you for holding today's hearing.

Last month, *CBS News* brought some shocking, and critically important information to light. Not just that those who served in the military were more than twice as likely to take their own life in 2005 than Americans who never served or that veterans aged 20 to 24 were killing themselves when they returned home at rates between two-and-a-half to four times higher than nonvets the same age, but that the Department of Veterans' Affairs wasn't keeping track of veteran suicides nationwide.

The VA is one of the best healthcare systems in the country, with literally thousands of professionals working to help veterans with mental health needs.

But with all due respect, if the VA doesn't know the size and the scope of the problem, how can we know if they're adequately addressing our veterans' mental health needs?

As disturbed as I was by the CBS' report, I was even more disturbed by the VA's response. Instead of reviewing the information and thinking critically about whether the VA might need to take some additional measures, they immediately attacked the messenger, calling *CBS News'* analysis a "questionable journalistic tactic."

Obviously it would be great to compare CBS' numbers to those kept by the VA, but that's precisely the point; the VA hasn't been keeping them.

I think this kind of defensiveness is a disservice to veterans, and to all the hard-working employees of the VA who are doing their best to help our wounded warriors.

So, as we begin today's hearing, I just want to say that I hope we can get past the name-calling, and hurt feelings and gotcha-fights about methodology and do what the American people expect us to do: work together to prevent more of these unspeakable tragedies and, if at all possible, try to bring some small measure of comfort to those who mourn.

I yield back.

Prepared Statement of Hon. Cliff Stearns

Mr. Chairman,

Thank you for holding this important hearing today. The statistics regarding the rate of suicides among veterans is beyond alarming, it is catastrophic. These young men and women are heroes—each and every one of them. Veterans returning from war frequently become valued neighbors and leaders in their community, giving of their time and themselves to help others at home as they did abroad. Their presence reminds us of the high cost of our freedom, and inspires us to act for others rather than just ourselves. These young men and women who have served our Nation in such extreme circumstances—enduring unbelievable amounts of the stress of war so that those of us who remain at home can live in the peace they protect, deserve the utmost respect—and the utmost care that we can provide.

It is appropriate today that we remember that the problem of the traumatic effects of war upon our veterans has been grappled with for decades. In fact, only about two hours away lies the battlefield of Antietam—the bloodiest single day battle in all of American history with almost 23,000 casualties. Many of those that survived left the field with more hidden wounds that bandages could not bind. Back then, it was called by other names like "war sickness." In World War II it was "shell-shock" or "battle fatigue," through the years until now we refer to it as "Post Traumatic Stress Disorder." From the very first shots fired for our independence, those who fought to maintain that independence have suffered under the traumatic stress.

Throughout our battle history, we have learned more and more regarding best treatments for this condition, yet more needs to be done. I would be interested in statistics that could show clearly the leading factors to suicide attempts. Are most veterans who commit suicide suffering from PTSD, or from other complicating reasons such as substance abuse, or other mental conditions? The better we can identify the key indicators and symptoms leading toward suicide attempts, the better we can develop and provide treatments. As a co-sponsor of H.R. 327, the Joshua Omvig Veterans Suicide Prevention Act, I was proud when it was signed into law

on November 5, 2007. I believe that this is a key step toward attacking this problem. I also understand that the VA is improving its screening processes, hiring more counselors, and developing more "best practices" to combat this growing problem. However, the clock is ticking, and we need to move quickly to prevent the loss of more of our wounded warriors. I look forward to hearing from our panel of experts more about this dreadful problem and how we are going to work together to prevent the loss of more of our Nation's heroes.

**Prepared Statement of Mike and Kim Bowman, Forreston, IL
(Parents of Specialist Tim Bowman, U.S. Army, Illinois National Guard,
Bravo Troop, 106th Cavalry)**

Mr. Chairman, members of the committee, my wife and I are honored to be speaking before you today representing just one of the families that lost a veteran to suicide in 2005.

As my family was preparing for our 2005 Thanksgiving meal, our son Timothy was lying on the floor of my shop office, slowly bleeding to death from a self-inflicted gunshot wound. His war was now over, his demons were gone. Tim was laid to rest in a combination military, firefighter funeral that was a tribute to the man he was.

Tim was the life-of-a-party, happy-go-lucky young man that joined the National Guard in 2003 to earn money for college and get a little structure in his life. On March 19th of 2005 when Specialist Timothy Noble Bowman got off the bus with the other National Guard soldiers of Foxtrot 202 that were returning from Iraq he was a different man. He had a glaze in his eyes and a 1,000-yard stare, always looking for an insurgent.

Family members of F202 were given a 10-minute briefing on PTSD (Post Traumatic Stress Disorder) before the soldiers returned and the soldiers were given even less. The commander of F202 had asked the Illinois Guard Command to change their demobilization practices to be more like the regular Army, only to have his questions rebuffed. He knew that our boys had been shot up, blown up by IED's (Improvised Explosive Device), extinguished fires on soldiers so their parents would have something to bury, and extinguished fires on their own to save lives. They were hardened combat veterans now, but were being treated like they had been at an extended training mission.

You see, our National Guardsmen from F202 were not out filling sandbags. They departed in October of 2003 for 6 months of training at Forts Hood and Polk. On Tim's 22nd birthday, March 4, 2004, Foxtrot left for Iraq where they were stationed at Camp Victory. Their tour took them directly into combat including 4 months on "the most dangerous road in the world," the highway from the airport to the Green Zone in Baghdad where Tim was a top gunner in a Humvee. Tim as well as many other soldiers in F202 earned their Purple Hearts on that stretch of road known as Route Irish. We are STILL waiting for Tim's Purple Heart from various military paperwork shuffles. My wife and I are not here today as anti-war protesters. Our son truly believed that what his unit did in Iraq helped that country and helped many people that they dealt with on a daily basis. Because of his beliefs, I have to believe in the cause that he fought and died for. That doesn't mean that I don't feel that we lost track of the overall mission in Iraq.

When *CBS News* broke the story about veterans suicides, the VA took the approach of criticizing the way that the numbers were created instead of embracing it and using it to help increase mental healthcare within their system. Regardless of how perfectly accurate the numbers are, they obviously show a trend that desperately needs attention. CBS did what NO government agency would do; they tabulated the veteran suicide numbers to shed light on this hidden epidemic and make the American people aware of this situation. The VA should have taken those numbers to Capitol Hill asking for more people, funding, and anything else they need to combat this epidemic. They should embrace this study as it reveals the scope of a huge problem, rather than complaining about its accuracy. If all that is going to be done with the study is argue about how the numbers were compiled, then an average of 120 veterans will die every week by their own hand until the VA recognizes this fact, and does something about it.

The VA mental health system is broken in function, and understaffed in operation. There are many cases of soldiers coming to the VA for help and being turned away or misdiagnosed for PTSD and then losing their battle with their demons. Those soldiers, as well as our son Timothy, can never be brought back. No one can change that fact. But you can change the system so this trend can be slowed down dramatically or even stopped.

Our son was just one of thousands of veterans that this country has lost to suicide. I see every day the pain and grief that our family and extended family goes through in trying to deal with this loss. Every one of those at-risk veterans also has a family that will suffer if that soldier finds the only way to take the battlefield pain away is by taking his or her own life. Their ravished and broken spirits are then passed on to their families as they try to justify what has happened. I now suffer from the same mental illnesses that claimed my son's life, PTSD, from the images and sounds of finding him and hearing his life fade away, and depression from a loss that I would not wish on anyone.

If the veteran suicide rate is not classified as an epidemic that needs immediate and drastic attention, then the American fighting soldier needs someone in Washington who thinks it is. I challenge you to do for the American soldier what that soldier did for each of you and for his country: Take care of them and help preserve their American dream as they did yours. To quote President Calvin Coolidge, "The Nation which forgets its defenders will be itself forgotten."

Today, you are going to hear a lot of statistical information about suicide, veterans, and the VA. But keep one thing in mind, our son, Specialist Timothy Noble Bowman, was not counted in any VA statistics of any kind. He had not made it into the VA system because of the stigma of reporting mental problems. He was National Guard, and he was not on a drill weekend when he took his life. The only statistical study that he was counted in was the *CBS News* study. And there are many more just like him. We call them KBA's, killed because of action, the unknown fallen.

I challenge you to make the VA an organization to be proud of instead of the last place that a veteran wants to go. It is the obligation of each and every one of you and all Americans to channel the energies, resources, and the intelligence and wisdom of this Nation's best and brightest to create the most effective, efficient and meaningful healthcare system for our men and women who have served. We must all remove the stigma that goes with a soldier admitting that he or she has a mental issue. Let those soldiers know that admitting they have a problem with doing the most unnatural thing that a human being can do is all right. Mental health issues from combat are a natural part of the process of war and have been around for thousands of years, but we categorize that as a problem. Take that soldier that admits a mental health injury from combat and embrace him as a model for others to look up to. Let the rank-and-file know by example that it's okay to work through your issues instead of burying them until it's too late. Grab that soldier and thank him for saying, "I'm not okay," and promote him. A soldier that admits a mental injury should be the first guy you want to have in your unit, because he may be the only one that really has a grasp on reality. But instead, he is punished and shunned and by that example, he has become the model for PTSD and suicide. And while we are at it, why do we call it a disorder? That title, in itself, implies ramifications that last forever. It is an injury, a combat injury, just like getting shot. With proper care and treatment soldiers can heal from this injury and be as productive and healthy as before.

We as a country have the technology to create the most highly advanced military system in the world, but when these veterans come home, they find an understaffed, underfunded, and underequipped VA mental health system that has so many challenges to get through it that many just give up trying. The result is the current suicide epidemic among our Nation's defenders, one of which was Specialist Timothy Noble Bowman, our 23-year-old son, a soldier, and our hero.

Our veterans should and must not be left behind in the ravished, horrific battlefields of their broken spirits and minds. Our veterans deserve better!!

Mr. Chairman, this concludes my testimony. Thank you.

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

INTRODUCTION

The Roman poet Horace said that it is a sweet and fitting thing to die for one's country. That sentiment has been offered as comfort to widows and orphans for more than 2,000 years. However hollow and inadequate it might seem to those who are left only with memories and a folded flag, it remains central to the allure and romance of military culture. But I have never heard it suggested that there is anything sweet or fitting about being a psychiatric casualty for one's country, though surely soldiers and veterans who were injured in their minds pledged the same and risked as much as their fallen comrades.

My husband, Daniel O'Donnell, came home from Vietnam in 1969, 11 years before Post Traumatic Stress Disorder (PTSD) became an official diagnostic category. Like most veterans, he simply refused to talk about his war experiences, so I had no way of knowing what he had experienced or what was going on in his head. In retrospect, I imagine he just thought he was going crazy. It must have been terrifying. I can only imagine his despair.

After Daniel died, it never occurred to me to blame the war for what had happened to us. I tried to blame him, but ended up blaming myself. If only I had been kinder, more patient, more understanding, quicker to notice and identify trouble. I can find more compassion for us both from this distance. I can see now that he was just a kid who had tried to stay alive in a situation that exploded all the rules he had ever lived by, and that he was too sorry and too ashamed to start over. And I can see now that I, too, was in over my head in a situation I neither understood nor controlled. But at the time, and for decades after, I believed his death was my fault, and I crept into a psychic lair to hide my shame and lick my wounds in private. I married again and had two children, but it was an awful way to live, tiptoeing around everybody I loved, trying not to kill one of them by mistake. It was a long time before I could find some compassion and forgiveness for that young woman who had no idea what she was up against.

The research I did for my book, *Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War*¹ included interviews with 16 widows, mothers, and daughters whose loved ones also took their own lives after serving in Vietnam. The story I have just told is only my version of a litany that ran through every interview.

POST TRAUMATIC STRESS DISORDER AND MODERN WARFARE

Every war in historical memory has produced psychiatric casualties. In fact, in every war American soldiers have fought in the past century, the chances of becoming a psychiatric casualty were greater than the chances of being killed by enemy fire.² So surprise is at best a disingenuous response to what is happening yet again. At the same time, several issues have emerged that have affected rates of post traumatic stress injuries in modern warfare; these include the intensity and time a soldier is exposed to combat; unit cohesion, that is, the extent to which soldiers have been given a chance to know and trust those with whom they are fighting; and the nature of contemporary military training.

Length of exposure versus unit cohesion: There were two central lessons that military psychiatrists took from the wars of the 20th century. The first is that soldiers fight for love—not hate. And not love of country. They're fighting for the soldier next to them, the one they can trust to take their back. The interpersonal bonding that happens when soldiers get to know and trust each other is what the military calls unit cohesion, and it is known to be one of the most effective protections against traumatic stress injuries.³ The second lesson is that if it is bad enough for long enough, anyone will fall apart. Anyone. It's not about how strong you are or how brave you are—how truly manly you are. There is *no* such thing as a bullet-proof mind.⁴

During the Vietnam era, the military took the second of these two lessons seriously. The DEROS policy (Date of Expected Return from Over Seas) let every soldier know they would be leaving Vietnam exactly one year after they arrived. They *hoped* that a year would be a manageable time for a soldier to withstand the stress of the combat environment. And indeed, the limited amount of time spent in the combat zone may have been the reason that only about 1% of soldiers were evacuated for psychiatric reasons, compared to World War II.⁵ At the same time, in the interest of efficiency, the military ignored the first rule, about the importance of personal loyalty and unit cohesion. After basic training, soldiers were inserted individually into the war machine according to some bureaucratically efficient system. They were cut off from the friendships they had established during training. They were sent into terrifying situations surrounded by strangers who they didn't know or have any reason to trust. Furthermore, their officers were also rotated, serving for only six months with a unit. It has now been established that the ways in which DEROS undermined unit cohesion were a major contributor to the psychic injuries of the Vietnam war.⁶

¹Penny Coleman, *Flashback: Posttraumatic Stress Disorder, Suicide, and the Lessons of War* (Boston, MA: Beacon, 2006).

²Lieutenant Colonel David Grossman, *On Killing* (New York: Little Brown, 1996).

³Jonathan Shay, *Achilles in Vietnam* (New York: Touchstone, 1995).

⁴*Ibid.*

⁵*Ibid.*

⁶*Ibid.*

Current military policy has turned that on its head. Now, the military keeps units together, but ignores the time/intensity rule. Soldiers are repeatedly deployed, spending far more time in combat than even the generous limits the Army considers safe.⁷ Some units have been deployed three or four times in as many years, and it is becoming ominously clear that the psychic resources of our soldiers has been exhausted.

In 2004, the release of the Abu Grahیب photographs broke the unforgivable silence in the mainstream press about atrocities committed by American soldiers in Iraq. Haditha followed, then Mahmoudiyah, Ishaqi, and at this writing, multiple other instances of savage, homicidal violence directed against civilians have been reported. More recently, there have been the reports of veterans involved in violent incidents after coming home.⁸ These acts are being committed by American soldiers who are *predictably* out of control. They are the inevitable result of pushing our soldiers way beyond their limits. They are not the result of a few bad apples run amok.

I'm not suggesting that American soldiers take no responsibility for their actions. I would argue that we must balance outrage at criminal and sadistic acts with the insistence that this new generation of soldiers and veterans not be asked to take responsibility for the terrible and tragic circumstances that led to those acts. Individual soldiers cannot be the only ones taking the blame.

The nature of contemporary military training: Military training has been part of the experience of millions of young American men since the Revolutionary War. Prior to the Vietnam era, however, that training consisted largely of practicing military skills and learning to manage military equipment. It is only in the last half century that training has evolved into an entirely new phenomenon that makes use of the principles of operant conditioning to overcome what studies done over the last century have consistently demonstrated, namely, that healthy human beings have an inherent aversion to killing others of their own species.⁹

War Psychiatry, the army's textbook on combat trauma, notes that "pseudospeciation, the ability of humans and some other primates to classify certain members of their own species as 'other,' can neutralize the threshold of inhibition so they can kill conspecifics."¹⁰ Modern military training has developed carefully sequenced and choreographed elements to disconnect recruits from their civilian identities. The values, standards and behaviors they have absorbed over a lifetime from their families, schools, religions and communities are scorned and punished. Using cruelty, humiliation, degradation and cognitive disorientation, recruits are reprogrammed with an entirely new set of learned responses. Every aspect of combat behavior is rehearsed until response becomes reflexive. Operant conditioning has vastly improved the efficacy of American soldiers, at least by military standards. It has proven to be a reliable way to turn off the switch that controls a soldier's inherent aversion to killing. American soldiers do kill more often and more efficiently. Lt. Col. Dave Grossman, author of *On Killing*, calls this form of training "psychological warfare, [but] psychological warfare conducted not upon the enemy, but upon one's own troops."¹¹

There are any number of ways that modern training methods both support violence, aggression and obedience and help to disconnect a reflex action from its moral, ethical, spiritual, or social implications. Drill instructors rely on sexist and homophobic labels like "girl," "pussy," "lady" or "fairy" to humiliate, degrade and ultimately exact conformity. Recruits are drilled with marching chants that privilege their relationships with their weapons over their relationships with women ("You used to be my beauty queen. Now I love my M-16"), overtly conflate sex and violence ("This is my rifle, this is my gun. This is for fighting; this is for fun."), and treat the killing of civilians as humorous ("Throw some candy to the children. Wait till they all gather round. Then you take your M-16 now, and mow the little ***** down.")¹² Aside from teaching these young soldiers to quash their innate feelings about killing in general, they are being programmed with a distorted version, not only of what it means to be a man, but of what it means to be a citizen.

⁷Davis H. Marlowe, *Psychological and Psychosocial Consequences of Combat and Deployment: With Special Emphasis on the Gulf War* (Santa Monica, California: Rand, 2001).

⁸http://timelines.epluribusmedia.org/timelines/index.php?&mjre=PTSD&table_name=tl_ptsd&function=search&order=date&order_type=ASC.

⁹S.L.A. Marshall, *Men Against Fire: The Problem of Battle Command in Future Wars* (Gloucester, MA: Peter Smith, 1978).

¹⁰Coleman, *Flashback*, 73-4.

¹¹Grossman, *On Killing*, 251.

¹²Carol Burke, *Camp All-American, Hanoi Jane, and the High-and-Tight*. (Boston, MA: Beacon, 2005).

Thankfully, the brainwashing has not yet been developed that will override the humanity of most American soldiers. As multiple deployments become the norm, however, and as more scrambled psyches are sent back into combat instead of into treatment, it is frightening to consider that the brainwashing may yet prevail. Given the training to which these soldiers have been subjected and the chaotic conditions in which they find themselves, it is inevitable that more will succumb to fear and rage and frustration. They will inevitably be overwhelmed by cumulative doses of horror and they will lose control of their judgment and their compassion. It is a credit to their humanity, not a sign of their weakness, that these men and women find it hard to live afterward with what they have seen and, in some cases, done. The soldiers who, following orders, have run over children in the road rather than slow down their convoy will never be the same again.¹³ Nor will the soldiers manning checkpoints who shoot, as ordered, and kill entire families who failed to stop, only to learn later that no one had bothered to share with them that the American signal to stop—a hand held up, palm toward the oncoming vehicle—to an Iraqi means, “Hello, come here.”¹⁴

This generation of soldiers wants to tell their stories because they want to believe that Americans want to know.¹⁵ They are not looking for absolution, but they want the architects of current policy to accept their share of the blame. They have already carried home the psychic wounds and the dangerous reflexive habits of violence that will always diminish their lives and their relationships. In return, they are hoping we will listen to them this time when they ask us to look a little harder, dig a little deeper, use a little more discernment.

In addition, a number of aspects of deployment and treatment in the current situation are directly responsible for adding to the problem of PTSD and suicide. These include the failure to screen sufficiently for mental health problems, the inappropriate use of drugs, and the re-triggering of PTSD symptoms among Vietnam veterans.

Failure to screen: In May, the *Hartford Courant* ran a series of articles exposing the common practice in this army of deploying soldiers in spite of serious, documented mental health histories, including severe depression, bi-polarity, even autism. On their pre-deployment health forms, there’s a box a recruit *can* check if they’ve had any kind of mental health issues in the past year. Of the 3% who checked the box, 1 in 300 was given *any* kind of follow-up assessment. Some were already on anti-depressants when they were recruited.¹⁶ The use of waivers has meant that individuals with histories of emotional problems, problems that have involved them in felonious activities, including drug abuse and sale, domestic violence and other violent crimes, individuals who would never have been previously accepted into the military, are now being enlisted and deployed.¹⁷

The inappropriate use of drugs: Self-medication with marijuana and heroin by soldiers in Vietnam is legendary; what is less well known is that, for the first time, the military made aggressive use of powerful tranquilizers and anti-anxiety drugs.¹⁸ In the short run, those drugs were effective, if the definition of effectiveness was boots on the ground, but in the long run, they were the moral equivalent of giving a soldier a local anesthetic for a gunshot wound and sending him back into combat.

It may be that the doctors prescribing in the Vietnam era did not realize the effects of those drugs over time, but today’s military doctors have the benefit of ample evidence.¹⁹ When soldiers are given those kinds of drugs while they are still experiencing the stressor, the drugs interrupt the development of normal coping mechanisms—and the long-term effects of the trauma are worse. Still, anti-depressants that come with warning labels about side effects that include suicide are being given to active-duty soldiers with little or no supervision, a practice that is virtually playing Russian roulette with their lives.

The re-triggering of symptoms among Vietnam veterans: Contemporary warfare not only creates its own emotional casualties, but reignites the symptoms of veterans of previous wars. *The Washington Post* reported a year ago that “Vietnam veterans are the vast majority of VA’s PTSD disability cases—more than 73 percent.”

¹³Mark Benjamin, “Military Injustice,” Salon.com, June 7, 2005. <http://archive.salon.com/news/feature/2005/06/07/whistleblower/>.

¹⁴Deborah Scranton, Dir. *The War Tapes* (Sen Art Films, 2007).

¹⁵<http://www.ivaw.org/wintersoldier>.

¹⁶Lisa Chedekel and Matthew Kauffman, “Mentally Unfit, Forced to Fight,” *The Hartford Courant*, May 14, 2006.

¹⁷Mark Benjamin, Out of jail, into the Army. Salon.com, February 2, 2006. <http://www.salon.com/news/feature/2006/02/02/waivers/>.

¹⁸Grossman, *On Killing*.

¹⁹*Ibid.*

These included ten thousand new claims filed by veterans who were entering the system for the first time, more than 30 years after their war came to an end.²⁰

Apologists such as American Enterprise Institute scholar Sally Satel have accused veterans of memorizing the diagnostic criteria for PTSD before going to see a VA doctor. They have accused the VA doctors of over-diagnosing and thereby making their patients believe they are sick, and the particularly cynical accusation that Vietnam vets who are getting close to retirement are angling for ways to pad their old age with inflated disability checks.²¹

Veterans, however, claim that the cause of their applications for benefits, far from being fraud, is the daily onslaught of horrific images and stories coming out of Iraq and Afghanistan that have triggered their flashbacks and reactivated intolerable symptoms. One of those is former senator Max Cleland, a triple amputee from the war in Vietnam, who was compelled to re-enter therapy at Walter Reed for PTSD symptoms that have flared up since the war in Iraq began. Cleland recounts that he cannot read newspapers or watch television now because both are triggers for PTSD, something that he claims is happening to Vietnam veterans all over America.²²

FACTORS IN THE CURRENT POLICIES THAT ARE TRAGICALLY INCREASING THE INCIDENTS OF SUICIDE

In November 2007, *CBS News* released the results of their investigation into veteran suicides. Using the clout that only major broadcast networks seem capable of mustering, *CBS News* contacted the governments of all 50 States requesting their official records of death by suicide going back 12 years. They heard back from 45 of the 50 States. From the mountains of gathered information, they sifted out the suicides of those Americans who had served in the armed forces. What they discovered is that in 2005 alone—and remember, this is just in 45 States—there were at least 6,256 veteran suicides, 120 every week for a year and an average of 17 every day.²³

I am grateful to *CBS News* for undertaking this long overdue investigation. And though I am also heartbroken that the numbers are so astonishingly high, I am tentatively optimistic that perhaps now that there are hard numbers to attest to the magnitude of the problem, it will finally be taken seriously.

Part of taking that seriously will be to acknowledge the ways in which the current spate of suicides is being exacerbated by government and military policy. In the above section, I presented a number of the major factors in the high incidence of PTSD among American soldiers and veterans. In this section, I will point to additional factors that explain why PTSD so often leads to suicide. A few examples include the redeployment of psychologically injured soldiers, a lack of sufficient medical care professionals, lengthy waits for treatment, complex bureaucratic red tape, and a variety of justifications for dishonorably discharging traumatized veterans, thus rendering them ineligible for VA psychiatric care. It is difficult not to connect all of these factors to a tragic prioritizing of budgetary considerations at the expense of the lives of soldiers and veterans.

Redeployment of psychologically wounded soldiers: In November 2006, the Pentagon released guidelines that allow commanders to redeploy soldiers suffering from traumatic stress disorders. Service members with “a psychiatric disorder in remission, or whose residual symptoms do not impair duty performance” may be considered for duty downrange. It lists post traumatic stress disorder as a “treatable” problem and sets out a long list of conditions when a soldier can, and cannot be returned for an additional tour in Iraq.²⁴ Post traumatic stress injuries, under the best of circumstances, are treatable, but not curable. Sending soldiers back into the situation that triggered their injury in the first place is taking undue, I would say cruel, license with their mental health.

Lack of sufficient medical care professionals/Lengthy waits for treatment: The Defense Health Board’s Task Force on Mental Health has reported that there is a shortage of active duty mental health professionals. According to the report, “DoD has already dramatically reduced its number of active duty mental health profes-

²⁰ Donna St. George, “Iraq War May Add Stress for Past Vets: Trauma Disorder Claims at New High,” *Washington Post*, June 20, 2006, A01 http://www.washingtonpost.com/wp-dyn/content/article/2006/06/19/AR2006061901400_pf.html.

²¹ Sally Satel, “Stressed Out Vets: Believing the worst about post-traumatic stress disorder,” *The Weekly Standard*, August 21, 2006.

²² <http://www.wsbtv.com/news/9747929/detail.html>.

²³ http://www.cbsnews.com/stories/2007/11/13/cbsnews_investigates/main3496471.shtml.

²⁴ Aaron Glantz, “Iraq Vets Left in Physical and Mental Agony,” Inter Press Service, January 4, 2007.

sionals and there are proposals to further reduce active duty staffing.”²⁵ As a result, according to other researchers, “doctor-to-patient ratios are climbing, waiting periods to see specialists are growing, and the time that psychiatrists spend with the most troubled patients—those with post traumatic stress disorder, or PTSD—is shrinking.”²⁶ In September 2007 a Congressionally mandated report by the non-partisan Government Accountability Office found the Pentagon and VA care for service members suffering from PTSD and Traumatic Brain Injury was “inadequate” with “significant shortfalls” of doctors, nurses and other caregivers necessary to treat wounded soldiers.²⁷ The result is that soldiers and veterans requesting treatment for PTSD still typically are put on waiting lists and wait six months to a year.

Complex bureaucratic red tape: Since the start of the Iraq war, the back-log of unanswered disability claims has grown from 325,000 to more than 600,000, with 800,000 new claims expected in each of the next two years.²⁸ On average, a veteran must wait almost six months to have a claim heard. If a veteran loses and appeals a case, it usually takes almost two years to resolve.²⁹ The number of claims adjusters at the VA likewise dropped. It is worth noting that if a service member or veteran dies while an appeal is pending, the appeal dies as well.³⁰

Moreover, a veteran applying for compensation for Post Traumatic Stress Disorder must submit a 26 page form, the key to which is a detailed essay on the specific moments when he or she experienced a terrifying event or series of incidents that caused mental illness to develop. This is not easy because one of the symptoms of PTSD is for a person to try to block out any memory of that event. According to the psychiatric guide DSM IV, a person with PTSD often displays a “persistent avoidance of stimuli associated with the trauma and numbing of general responsiveness.”³¹ In other words, the last thing a person experiencing PTSD wants to do is sit down and write an essay on why, and exactly how, they’ve become mentally ill. A veteran must also back that claim up with hard evidence that their PTSD is indeed “service connected”—in essence proving he or she was indeed in the place they said they were and that the terrifying incident did indeed occur. If the veteran received a medal during the incident the job is easier. If not, the vet must track down their service records to see if any paperwork was generated as a result of the incident that caused the development of their injury. DoD paperwork is notoriously difficult to track down, if it exists in the first place. I applaud the efforts of Representatives Donnelly and Upton for introducing H.R. 1490, The Fairness in Veterans Disability Benefits Act, which aims to simplify the process for new veterans as they transition out of the military and try to provide for their families. It is certainly a step in the right direction, but \$400 per month is not going to pay the rent anywhere in this country.

Ineligibility for medical benefits: A variety of patterns related to PTSD are currently leading to a denial of medical benefits. In some cases, soldiers and veterans who have applied for help with PTSD symptoms try to manage terrifying symptoms by self-medicating with drugs or alcohol; this substance abuse, itself a complication of PTSD, is then used to justify a dishonorable discharge, even in cases in which a soldier has repeatedly asked for treatment.³² In other cases, diagnoses such as “pre-existing conditions” are used by the military to deny its responsibility for treating soldiers suffering emotional trauma.³³

One of the saddest consequences of the Bush administration’s failure to anticipate and plan for an extended conflict in Iraq is the billions of additional dollars the VA has discovered it needs to cover the shortfall in its healthcare budgets for the past three years. Administration apologists such as Sally Satel have kept up a steady stream of accusation and innuendo in the media ever since it became clear that their new war was going to suck in, chew up and spit out devastated soldiers every

²⁵ <http://www.usmedicine.com/article.cfm?articleID=1610&issueID=102>.

²⁶ Anne C. Mulkern, Denver Post, July 05, 2005.

²⁷ “Vets Healthcare Not Meeting Standards: Army Has Yet To Fully Staff New Units Created To Fix Problems At Walter Reed” (GAO: Washington, DC, Sept. 26, 2007). <http://www.cbsnews.com/stories/2007/09/26/national/main3300260.shtml>.

²⁸ Brian Friel, “Hurry Up And Wait,” *Government Executive*, May 1, 2007. <http://www.govexec.com/features/0507-01/0507-01s4.htm>.

²⁹ Chris Adams, VA’s ability to provide benefits worsens, December 1, 2006. http://www.mcclatchydc.com/staff/chris_adams/story/15238.html.

³⁰ St. George, “Iraq War May Add Stress.”

³¹ *Diagnostic and Statistical Manual of Mental Disorders*, 4th ed. (DSM-IV) (Washington D.C.: American Psychiatric Association, 1994), available online at www.psychologynet.org/dsm.html.

³² Daniel Zwerdling, “Soldiers Say Army Ignores, Punishes Mental Anguish,” “All Things Considered,” *National Public Radio*, December 4, 2006. <http://www.npr.org/templates/story/story.php?storyId=6576505>.

³³ Joshua Kors, “How Specialist Town Lost His Benefits,” *The Nation*, April 9, 2007. <http://www.thenation.com/doc/20070409/kors>.

bit as reliably—and expensively—as the war in Vietnam did.³⁴ It is worth recalling that, prior to the scandal concerning conditions at Walter Reed, President Bush's appointees at the Pentagon had strenuously lobbied Congress *against* funding military pensions, health insurance and benefits for widows of retirees. Their argument: that money spent on caring for wounded soldiers and their families could be better spent on new state-of-the-art military hardware or enticing new recruits to join the force. In January 2005, Bush's Undersecretary of Defense for Personnel and Readiness David Chu, the official in charge of such things, went so far as to tell the *Wall Street Journal* that veterans' medical care and disability benefits "are hurtful" and "are taking away from the Nation's ability to defend itself."³⁵

Indeed, what we have seen in the past four years are frantic and often tragic attempts to save money, all at the expense of the veterans. The military tried charging wounded soldiers at Walter Reed for their lunches. Congress made them take that back. They tried spinning PTSD as veteran fraud and insisted that 72,000 100% disabled vets get themselves recertified. 100% disabled vets are the most fragile and the most likely to be further traumatized by a complicated bureaucratic process. Congress made them take that back as well, but not before at least one overwhelmed veteran took his own life with his recertification request papers on his chest.³⁶

A new study by Columbia University economist Joseph E. Stiglitz, who won the Nobel Prize in economics in 2001, and Harvard lecturer Linda Bilmes concludes that the war is costing \$720 million a day or \$500,000 a minute.³⁷ This total, which is far above the administration's prewar projections, attempt to take into account the long term healthcare costs for the U.S. soldiers injured in Iraq so far. Veterans groups joke the Bush Administration has instituted a policy of "don't look, don't find," in order to absolve themselves of criminal, financial, and medical liability for their treatment of veterans.

RECOMMENDATIONS

The basis for addressing the virtual epidemic of death that constitutes suicide among soldiers and veterans much be first to acknowledge the problem. While Americans may disagree about current American policy in Iraq, surely we can all agree with the motto of the VA, "To care for him [and now her] who shall have borne the battle and for his widow and orphan."

In August of 2006, Fox News proposed that Congress provide that certain types of military service—such as any service in theaters of combat, not just actual combat experience, and other forms of hazardous duty—automatically qualify veterans for lifetime health benefits. There is much to be said for that proposal. Among other things, it would eliminate the motivation for unjust dishonorable discharges and alternative diagnoses. It would also mean that scientific research involving combat veterans might be less politicized and less likely to be skewed.³⁸

Less extreme but still vitally needed specific steps include:

- **Attack stigma:** The "D" in PTSD should immediately be dropped. To call the psychic injuries of soldiers a disorder reinforces the misperception that there is something inherently wrong with the soldier. The prejudice that reinforces, in soldiers, veterans, caregivers and military officers alike, is in many ways responsible for the resistance of sufferers to ask for the help they so desperately need. Military personnel at all levels must be educated to understand that PTSD is not a sign of weakness or cowardice. Soldiers and veterans must be debriefed to help individuals understand and cope with the stress that is a normal response to an overwhelming situation. Treatment for emotional injuries must be given parity with treatments for more visible physical wounds. For example, promoting the elimination of stigmatizing questions on security clearance questionnaires can set the precedent for culture change within the Department of Defense and model similar changes in procedure for other employment

³⁴ <http://www.sallysatelmd.com>.

³⁵ Jaffe, Greg. "Balancing Act: As Benefits for Veterans climb, military spending feels squeeze." *Wall Street Journal*, Jan. 25, 2005, pA1.

³⁶ Mark Benjamin, "The VA's Bad Review," Salon.com, October 26, 2005. <http://archive.salon.com/news/feature/2005/10/26/suicide/index.html>.

³⁷ Kari Lydersen, "War Costing \$720 Million Each Day, Group Says," *Washington Post*, September 22, 2007. <http://www.washingtonpost.com/wp-dyn/content/article/2007/09/21/AR2007092102074.html>.

³⁸ Steven Milloy "Politicized Science Produces Bad Public Policy," August 17, 2006. <https://www.foxnews.com/story/0,2933,209078,00.html>.

categories, thus eliminating the risks to future employment for individuals in need of treatment for PTSD.³⁹

- Multiply the caregivers: The military's cadre of mental-health workers is "woefully inadequate to meet their needs." The current *decline* in military mental health professionals must be reversed as quickly as possible.
- Provide mandatory and adequate screenings for all enlistees and for all returning soldiers: In the first instance, this will help to stop the practice of deploying soldiers who are already emotionally fragile. It will also serve to create a medical history enabling a veteran to later prove service-connection in the event of emotional trauma. Finally, because everyone participates, such a screening policy would eliminate the shame and stigma.
- Stop redeploying psychically injured soldiers.
- Create a structure for screening soldiers and veterans outside of the chain of command.
- Eliminate the wait for soldiers and veterans reporting symptoms and requesting treatment and ensure that sufficient emergency contacts and treatment options are available.
- Hire and train additional Veteran Service Representatives and Veteran Service officers to help veterans navigate the system.
- Streamline application and benefit procedures and make them more 'vet-friendly.'
- Increase the number and size of Vet Centers, which provide flexible and easily accessed programs and resources, and create procedures for collaboration between Vet Centers and demobilizing troops.
- Hold follow-up interviews with demobilized troops at 30, 60, and 90 day intervals and then periodically for several years.

CONCLUSION

I will never know if any or all of the above recommendations, if implemented, would have saved my husband Daniel's life. I do know that they would have given both of us a better chance. I believe as well that, had deaths such as Daniel's been officially acknowledged, studied, and counted, not only would our lives as survivors been very different, but it would be far more difficult for officials now with *any* credibility deny a connection between combat-related PTSD and suicide.

I find hope in the fact that public attention and better knowledge of mental health issues have helped legitimize the psychiatric injuries soldiers sustain in every war. Though government apologists still shamefully spin and distort the numbers, and though military culture still encourages stigmatization, and even punishment, for what they insist on calling weakness or malingering, there is still far more information about posttraumatic stress injuries available, and that makes it less likely that this generation of soldiers and their families will experience the same degree of isolation on top of their grief that we felt. The difference is that we are talking about it now.

**Prepared Statement of Ilona Meagher, Caledonia, IL, Author
*Moving a Nation to Care: Post-Traumatic Stress Disorder and America's
Returning Troops***

Chairman Filner, Ranking Member Buyer, and other distinguished members of the Committee, I thank you for the opportunity to appear before you today.

To open, I'd like to briefly share my thoughts on why it is that I believe I'm here.

I am not only someone who's spent the past two years researching and writing about post traumatic stress in our returning troops, I'm also a veteran's daughter. My father was born in Hungary, served two years in antitank artillery as a Hungarian Army conscript, fought against the Soviet Union on the streets of Budapest during the 1956 Hungarian Revolution, and later fled to America where, in 1958, he again became a soldier, this time wearing a United States Army uniform, and serving as a combat engineer stationed in Germany.

My father's unique experience of having served on both sides—East and West—in such differing armies during the Cold war, gave him a unique perspective on military life.

³⁹"The War inside; troops are returning from the battlefield with psychological wounds, but the mental-health system that serves them makes healing difficult," *The Washington Post*, June 17, 2007.

And so, growing up, my sisters and I often heard my father say, “You can always tell how a government feels about its people by looking at how it treats its soldiers.”

Looking at our returning soldiers and their widely reported struggles with the military and VA healthcare systems they rely on, of being stigmatized from seeking care or of being placed on lengthy VA waiting lists when they need immediate help—some even committing suicide before their appointment dates arrive—have raised this citizen’s alarm bells.

We have had a “see no evil, hear no evil” approach to examining post-deployment psychological reintegration issues such as suicide. After all we have learned from the struggles of the Vietnam War generation—and the ensuing controversy over how many of its veterans did or did not commit suicide in its wake—why is there today no known national registry where Afghanistan and Iraq veteran suicide data is being collected? How can we ascertain reintegration problems—if any exist—if we are not proactive in seeking them out?

As late as May 2007, Department of Veterans Affairs spokeswoman Karen Fede told the *Washington Post* that there was no attempt to gather Afghanistan and Iraq veteran suicide incidents. “We don’t keep that data,” she said. “I’m told that somebody here is going to do an analysis, but there just is nothing right now.”¹

Meanwhile, the Army reported its suicide rate in 2006 rose to 17.3 per 100,000 troops, the highest in 26 years of keeping such records. At long last, the Associated Press revealed that the VA is finally conducting preliminary research. They’ve tracked at least 283 OEF/OIF veteran suicides through the end of 2005, nearly double the rate of the additional 147 suicides reported by the DoD’s Defense Manpower Data Center.

Looking only at the these suicide figures from the VA (283) and the DoD (147), there have been at least 430 Afghanistan and Iraq veteran suicides that have occurred either in the combat zone or stateside following combat deployment. Lost in the VA and DoD counts are those veterans who have returned from their deployments, are still in the military and not yet in the VA system. The DoD says they do not track those incidents, and I assume neither does the VA because these veterans are not yet on their radar.

Yet, even with this omission, many of these 430 confirmed suicides are a result of our wars in Afghanistan and Iraq and should—but won’t—be listed with the DoD’s official OEF/OIF death toll of 4,351. It bears mentioning: Currently 10 percent of the overall fatal casualty count of these wars is due to suicide.

Dismissing the issue of veteran suicide in the face of this data is negligent and does nothing to honor the service and sacrifice of our veterans and the families and communities that literally are tasked with supporting them once they return.

Yet, prior to last month’s *CBS News* investigation, which revealed that 120 veterans of all wars committed suicide every week in 2005 and that 20–24-year-old Afghanistan and Iraq veterans are two to four times more likely to commit suicide than their civilian counterparts, the scope of the problem has been largely unknown because no one with proper resources and access to do the compiling of data came forward to do so.

In my written testimony, I’ve included 75 suicides that I and other citizen journalist colleagues have been tracking since September 2005 and which today reside in the *ePluribus Media PTSD Timeline*.

Offering only a small and incomplete sliver of insight into how some of our returning troops are faring on the home front—especially in light of the fact that at least another 355 incidents could be added among them according to the VA and DoD—I believe that they collectively tell an even greater tale about the failure of us as individuals and as a society to ensure that our returning warriors are cleansed completely from the psychological wounds of war.

They also reflect the failure of our government institutions to protect those who protect us.

While I realize that these distressing stories are the exception and not the rule, to our exceptional military families having to deal with the deterioration of a loved one they thought had safely returned from combat, they are the rule. In 1956, the same year that my parents fled to this incredible country, the 84th Congress—in the very House that we sit in today—had this to say in a Presidential commission report on veterans’ benefits:

“The Government’s obligation is to help veterans overcome special, significant handicaps incurred as a consequence of their military service. The objective should be to return veterans as nearly as possible to the status

¹“Veterans’ Group Emphasizes Suicide Risks,” Jennifer C. Kerr, Associated Press, May 28, 2007.

they would have achieved had they not been in military service . . . and maintaining them and their survivors in circumstances as favorable as those of the rest of the people. . . . War sacrifices should be distributed as equally as possible within our society. This is the basic function of our veterans' programs."²

I am not a pedigreed expert or a government official seasoned in testifying before you, but those who are from the GAO and the Congressional Research Department and even the Veterans Administration itself, have sat in this very seat over the years and told you we are falling far short in providing the resources and programs our returning troops and military families need to successfully return to their personal lives following their service to the Nation.

To those who resist hearing the cold hard truth of where we are today, I'd like to say: The time is here to stop fighting the data, and to start fighting for our troops.

This is America. We can do better. We must do better.

Suggestions to ease the veteran suicide problem:

- **Offer all returning veterans immediate compensation and treatment support the first six months after their return home.** Fostering positive coping skills (vs. negative coping skills of self-medication or domestic violence) must be a key goal of our veterans' reintegration programs; veterans forced to wait at least six months for VA compensation and treatment benefits to kick in do not feel supported, they feel under siege.
- **Increase 21st century asymmetrical warfare and psychological injury understanding and preparation.** The DoD should continue to make adjustments in its training to give service members the tools they need to counter the modern battlefield's unique stressors. The Psychological Kevlar Act of 2007 would push the DoD to provide proactive psychological training for veterans from boot camp onward; more need to sign on to this legislation and it should be passed into law.
- **Force the DOD and VA do a better job of communicating with veterans on their rights and resources, and making outside community-based resources known to them as well.** Many vets are unsure of what benefits they have earned and what rights they have to them. Some are discouraged from using them. Many community programs and groups are ready and waiting to assist returning veterans and military families, but are unknown to the very people who might benefit from them. While Secretary Robert Gates has said it may take up to three years to fully implement the PTSD portion of the Dole-Shalala recommendations, why are we not utilizing the resources that are available in communities across the country?
- **Properly and fully fund the Veterans Administration.** Billions in underfunding translates to long waiting lines, lack of funds for PTSD research, and not enough PTSD specialists at each VA facility.
- **Reduce tour lengths, decrease overall number of combat deployments, and increase dwell time between deployments by funding an increase in forces.** With each successive deployment, troops' susceptibility to PTSD increases. Army Chief of Staff George W. Casey Jr. testified last month before the Senate Armed Services Committee saying that the military must be grown in order for dwell-time to be increased, etc.
- **Restrict the ability to redeploy troops diagnosed with PTSD.** No PTSD-diagnosed troops should be redeployed into a combat zone, and troops should not be deployed taking psychotropic drugs such as Paxil or Zoloft, that have been shown by the FDA to increase suicide risk.
- **Improve post-deployment assessments.** Move away from relying on questionnaires and make physicals and one-on-one demob consultations mandatory. In February 2006, the VA contracted the Institute of Medicine to do a thorough review of scientific and medical literature related to the diagnosis and assessment of PTSD; the Committee strongly concluded that the best way to determine whether a person is suffering from PTSD is with a "thorough, face-to-face interview by a health professional trained in diagnosing psychiatric disorders." The DoD should follow the same rule.
- **Invest more in counseling and support.** Rather than relying on quick-fix medications to solve returning psychological problems, invest time and re-

²U.S. Congress. House, *The President's Commission on Veterans' Pensions. The historical development of veterans' benefits in the United States: A report on veterans' benefits in the United States, 84th Cong., 2nd sess., May 9, 1956.*

sources in holistic wellness programs to help veterans and their families recover from the experience of war.

- **Remove stigma/punishment for those seeking help.** One of the easiest ways to do this would be to operate under the assumption that everyone will need some form of support following combat. Move away from a system where those struggling most must somehow find the strength to conspicuously come forward on their own.
- **Require completion of a ‘boot camp in reverse’ transitional training program.** Military families who have lost loved ones to suicide consistently say there should be a more formal reentry program following return from combat, weekly meetings/classes lasting from 2 to 3 months. The program should be as required to attend and complete by all service members as boot camp.
- **Pay special attention in supporting National Guard and Reserve forces.** Not being a part of a cohesive unit, they are especially susceptible to PTSD.
- **Stop closing VA Hospitals and Vet Centers.** We should be providing more opportunities for veterans scattered across the country, especially in rural areas, to have access to healthcare benefits.
- **Increase funding to community service boards.** Many troops—especially those with the National Guard and Reserve or in rural areas—do not have easy access to health services. Make sure they have alternatives to getting the care they need, or fully reimburse their private healthcare bills.
- **Increase Vet Center program offerings.** Offer more complimentary group and individual classes for troops and military families that explain what PTSD is, how it can be treated and how one can forge the tools necessary to move their lives beyond it.
- **Provide complimentary counseling to all immediate family members.** If the service member refuses to seek help, the spouse and children should have access to counseling service to help them through their loved one’s reintegration process.
- **Increase personal data security and treatment anonymity.** Many will not come forward to get the help they need because they worry it may come back to haunt them when they’re up for a promotion, being considered for a mission, or when looking for civilian employment. Family members, however, should not be kept in the dark, especially if veteran is prescribed psychotropic medication.

Selection of OEF/OIF Veteran Suicides

The *ePluribus Media PTSD Timeline*, is a collection of press-reported cases of post-combat related possible, probable, self-reported and/or confirmed incidents of PTSD or broader reintegration difficulties. The work is meant to preserve incidents that are at risk of being lost to us with the forward movement of time, as small town news websites do not archive many of their reports.

Additional reasons for the existence of the *PTSD Timeline* include:

- Allowing for ease of study of PTSD and related reintegration issues by researchers, reporters, educational and government institutions.
- Fostering further discussion and exploration of post-combat reintegration issues.
- Validating to military family members that we are paying attention to their experiences.

What follows is a brief glimpse at the personal post-war landscape for our military families revealed through suicide incidents tracked by me and other citizen journalists in the *PTSD Timeline* since September of 2005.

Legend: /ss/=stateside suicide /oif/=OIF combat zone suicide /oef/=OEF combat zone suicide

2002

Following the terrorist attacks of September 11th, Operation Enduring Freedom commenced with the invasion of Afghanistan on October 7, 2001. Fort Bragg, N.C., home of the Army Special Operations Command, was the first to experience a cluster of post-deployment reintegration issues when three military wives were murdered by their recently returned husbands within a span of five weeks. (One additional wife was murdered during this same timeframe, but the husband had not deployed to OEF).

On **June 11, 2002** /ss/, *Rigoberto Nieves* (32-year-old Special Forces sergeant) fatally shot his wife and then himself in an off-base *murder/suicide* after having returned home from Afghanistan in mid-March. On **July 19, 2002** /ss/, *Brandon Floyd*

(30-year-old Special Ops soldier) shot his wife and then himself in an off-base *murder/suicide* after having returned home in January.

CNN reported at the time: “Fort Bragg garrison commander, Army Col. Tad Davis, is reviewing counseling and stress-management programs available at the base. A spokesman said the Army wants to see if there is something it could do better. But one military official who had previously served at Fort Bragg pointed out that Special Operations soldiers may be reluctant to seek help.”³

2003

On March 19, 2003, Operation Iraqi Freedom commenced.

Joseph Suell (24-year-old veteran and father of two who’d served in South Korea, Kuwait and Iraq) *intentionally overdosed* on **June 16, 2003** /oif/, the day after Father’s Day. *Corey Small* (20-year-old Ft. Polk, La., army private) *shot himself* in front of others after making a phone call home on **July 3, 2003** /oif/.

The following day, on **July 4, 2003** /oif/, *James Curtis Coons* (36-year-old army master sergeant with 17 years of military service, OIF Bronze Star) *hanged himself* with a bed sheet at Walter Reed Army Medical Center; he had been evacuated from Kuwait two weeks earlier following an overdose.

Alyssa Peterson (27-year-old Arabic-speaking interpreter with the 311th Military Intelligence BN, 101st Airborne), who reportedly disagreed with interrogation techniques being used at Tal-Afar prison, *shot herself* on **September 12, 2003** /oif/. On **October 1, 2003** /ss/, *Kyle Edward Williams* (21-year-old soldier with a clean record who’d served in Iraq with the 507th Maintenance Company) *shot and killed an Arizona man* who’d broken into his car and later *shot himself*.

Thomas J. Sweet II (23-year-old Ft. Riley, Kan., 5th Field Artillery Regiment, 1st Infantry Division sergeant) *shot himself* on **November 27, 2003** /oif/, the very day he received word of his promotion. *Jeffrey Braun* (19-year-old 82nd Airborne Division paratrooper) *shot himself* on **December 1, 2003** /oif/.

2004

Alexis Soto-Ramirez (43-year-old 544th Military Police Company specialist), who’d been evacuated a month earlier from Iraq due to back pain, *hanged himself* with his bathrobe sash at Walter Reed Army Medical Center on **January 12, 2004** /ss/. Five days later, on **January 17, 2004** /ss/, *Jeremy Seeley* (28-year-old 101st Airborne specialist) walked off Fort Campbell, Ky., checked into a hotel, and *overdosed* on household poison.

Boyd Wicks, Jr. (Marine infantry sergeant) returned from Iraq in June 2003 and was discharged in October; he committed suicide on **February 1, 2004** /ss/, his father saying of PTSD. On **March 7, 2004** /oif/, *Matthew Milczark* (18-year-old Marine) *shot himself* in a Kuwaiti military chapel. One week later, on **March 14, 2004** /ss/, *William Howell* (36-year-old Ft. Carson, Colo., Special Forces chief warrant officer with 17 years of military service as a Green Beret) threatened his wife with a gun, and then *shot himself* as police officers moved in on him; he’d returned from Iraq a mere three weeks earlier.

Four days later, on **March 18, 2004** /ss/, *Brandon Ratliff* (6-times decorated Army Reserve’s 909th Forward Surgical Team executive officer), *shot himself* after writing *The Columbus Dispatch*, “I didn’t think I’d have to fight over there and have to fight these guys, too.” He’d lost a promised promotion and raise following his tour in Afghanistan saving injured soldiers on the frontline.

On **March 21, 2004** /ss/, *Ken Dennis* (22-year-old Marine corporal and combat rifleman who’d served in Pakistan, Afghanistan, Somalia, Djibouti and Iraq) *hanged himself* with his belt in his Renton, Wash., apartment eight months after returning from Iraq. He’d confessed to his father, “You know, Dad, it’s really hard—very, very hard—to see a man’s face and kill him.”

Jeffrey Lucey (23-year-old Marine Reserve) *hanged himself* in his basement on **June 22, 2004** /ss/, after his parents had involuntarily committed him to the local VA; he was released three days later and told to stop drinking before they could assess him for PTSD.

Also on **June 22, 2004** /ss/, *Adam Kelley* (36-year-old Gulf War combat veteran) ended his 13-year struggle with PTSD and *shot himself* in his car while sitting in his truck behind a Las Vegas sandwich shop. His mother blamed long VA waits, shuffling from one doctor to another, prescribing medications that did more harm than good and monthly appointments with a physician’s assistant rather than weekly appointments with a physician’s aide as contributing factors.

³“Fort Bragg killings raise alarm about stress,” Barbara Starr, CNN, July 27, 2002.

Andre Ventura McDaniel (40-year-old Ft. Carson, Colo., Special Forces soldier) *shot himself* six weeks after returning from Iraq, on **August 28, 2004** /ss/. On **September 24, 2004** /ss/, *Michael Torok* (23-year-old Ft. Bragg, N.C., communications specialist) *stabbed himself in the heart* in his car parked alongside a rural Illinois cornfield. He had visited the Hines VAMC for various ailments following his Afghanistan service, but Hines was not screening all returning veterans for PTSD at the time. The next day, he told his parents he was going to visit a friend and was never seen or heard from again.

On **October 9, 2004** /ss/, *Brian McKeehan* (37-year-old Fort Euliss, Va., soldier) *hanged himself* with a bed sheet in the Virginia Peninsula Regional Jail, one month after returning from Iraq and 12 hours after being arrested for assaulting his wife. In the four weeks he was home, local police had responded to six domestic violence complaints. *Michael Jon Pelkey* (29-year-old Fort Sill, Ok., captain) *shot himself* on **November 5, 2004** /ss/ a year after returning from Iraq. He had received a private diagnosis of PTSD, but was told of months-long waits for mental healthcare appointments on base.

Curtis Greene (25-year-old Ft. Riley, Kan., soldier) abruptly went AWOL, saying he did not want to return to Iraq; after his wife begged him to return, he *hanged himself* in his barracks on **December 6, 2004** /ss/. Police had previously responded to two domestic violence calls and he was being treated for PTSD.

2005

Andres Raya (19-year-old Camp Pendleton, Calif., Marine) committed *suicide-by-cop* on **January 9, 2005** /ss/ four months after taking part in the invasion of Fallujah. After telling his family he did not want to return to Iraq, he fired on Modesto police in an apparent premeditated 3-hour ambush in which one police officer was killed and another critically injured. *Mark C. Warren* (44-year-old 116th Armor Cavalry Regiment Oregon Army National Guardsman) *shot himself* in Kirkuk on **January 31, 2005** /oif/.

John Ruocco (40-year-old Marine cobra helicopter pilot from Newbury, Mass.) *hanged himself* in **February 2005** /ss/, three months after returning home from Iraq and a few weeks before he was to redeploy. His wife said he worried about the ramifications of seeking help, personally and professionally.

On **February 3, 2005** /ss/, *Richard T. Corcoran* (34-year-old Ft. Bragg, N.C. Special Forces soldier who'd served in Afghanistan) shot his ex-wife and her boyfriend, and then *shot himself*.

Alan McClean (62-year-old decorated Vietnam Purple Heart/Bronze Star veteran and minister who'd lost both legs to a landmine) *shot himself* in his Washington State church office on **February 11, 2005** /ss/. Formerly supportive of the war effort, but deeply affected by the rising casualty counts, he wrote, "35 Marines died today in Iraq, only slightly more noticed than my legs." His daughter said later, "I underestimated the power of the war to take his life and I really feel that though my dad's been in Wenatchee, the war in Iraq killed him."

Steven Michael Logan (26-year-old Marine intelligence clerk), personally reenlisted by Secretary of the Navy Gordon R. England at the peak of Mount Suribachi above Iwo Jima a year earlier, *shot himself* on **February 28, 2005** /ss/. *Samuel Lee* (19-year-old 2nd Infantry Division soldier) serving in Ramadi *shot himself* on **March 28, 2005** /oif/ and *Dominic Campisi* (30-year-old Delaware Air National Guardsman), who'd served in both Afghanistan and Iraq, *killed himself* on **April 17, 2005** /ss/ only days after returning from Uzbekistan.

On **May 23, 2005** /oef/, *Kyle Hemauer* (21-year-old 29th Infantry Division Virginia National Guard specialist) *shot himself* in Afghanistan. And in Iraq on **June 4, 2005** /oif/, the highest-ranking OIF death at the time, *Ted S. Westhusing* (44-year-old colonel and leading scholar of military ethics) *shot himself* in his base trailer. In emails to family, he seemed especially upset that traditional military values such as duty, honor and country had been replaced by profit motives in Iraq.

Justin "Paul" Byers (19-year-old Iowa Army National Guardsman) *stepped in front of highway pickup truck* on **June 20, 2005** /ss/ after hearing of his 22-year-old brother's death in Iraq. On **July 9, 2005** /ss/, *Jeremy Wilson* (23-year-old Ft. Carson, Colo., 10th Special Forces Group soldier) *hanged himself* in his barracks a month after returning from Iraq. *Jason Cooper* (23-year-old Mt. Pleasant, Iowa, 308th Quartermaster Army Reserve specialist) *hanged himself* in his basement four months after his Iraq tour on **July 14, 2005** /ss/.

Eleven days after being pinned by then Army Chief of Staff Peter Schoomaker himself with the Army's new Combat Action Badge, *Leslie Frederick, Jr.* (23-year-old Purple Heart and Bronze Star Ft. Lewis, Wash., specialist) *shot himself* in his Tacoma apartment on **July 26, 2005** /ss/.

Two days later, on **July 28, 2005** /ss/, *Saxxon Rech* (20-year-old Camp Lejeune, N.C., Marine) *shot his girlfriend and himself* in Washington; he had been mysteriously discharged in February. Two days later, *Robert Decouteaux* (24-year-old Ft. Hood, Tx., soldier) *shot himself* on **July 30, 2005** /ss/, and another two days later, on **August 1, 2005** /ss/, *Robert Hunt* (22-year-old Ft. Hood, Tx. 1st Cavalry Division radio operator-maintainer) was *found dead* in his apartment; both Decouteaux and Hunt had served in Iraq for a year and were scheduled to return in the fall.

Another two days later, on **August 3, 2005** /ss/, *Stephen Sherwood* (35-year-old Ft. Carson, Colo., 2nd Brigade Combat Team soldier) *shot his wife and then himself* nine days after returning home from a year's deployment in Iraq. He enlisted in January 2004 to have health benefits because his wife was pregnant.

Bernardo C. Negrete (53-year-old retired brigadier general who'd served in Grenada, Panama and Iraq) *shot himself* on **September 16, 2005** /ss/ after his wife complained that he stop drinking and come to bed. *Phillip Kent* (26-year-old Fort Hood, Texas, 720th Military Police Battalion 2nd lieutenant/platoon leader during the hunt for Saddam Hussein in Tikrit), after being hospitalized for PTSD following his return home and being discharged early, *committed suicide* on **September 28, 2005** /ss/.

On **October 8, 2005** /ss/, *Greg Morris* (57-year-old 4th Infantry Division Vietnam veteran diagnosed with PTSD) *shot himself*; by his side were his gun, Purple Heart, and a folder of information on how the VA planned to review veterans PTSD cases [a plan that was halted following public outcry].

On **November 8, 2005** /ss/, *Chris Forcum* (20-year-old Marine lance corporal) *killed himself* in Oregon six weeks after returning from Iraq. His father said at the time that "they teach soldiers how to fight, but they don't teach them how to live when they come home." *Timothy Bowman* (24-year-old Illinois National Guard specialist) had joined the military after 9/11; he *shot himself* on Thanksgiving morning, **November 24, 2005** /ss/, eight months after coming home from Iraq.

Jeffrey Lehner (42-year-old Marine Aerial Refueler Transport Squadron sergeant) *shot his father and then himself* on **December 7, 2005** /ss/, after calling his VA counselor in distress saying he would not be coming in the next day. After serving in Afghanistan, the Gulf War veteran had returned home at the end of 2004 in need of help, admitting himself to a VA hospital for intensive PTSD treatment. Instead, he was placed with bipolar and schizophrenic patients because the PTSD ward was full. On **December 22, 2005** /ss/, *Joshua Omvig* (22-year-old Iowa Army Reserve soldier) *shot himself* a year after returning from Iraq.

2006

On **January 16, 2006** /ss/, *Douglas Barber* (37-year-old National Guards supply convoy driver), following a two-year struggle with the VA over receiving treatment for his PTSD, changed his answering machine message to say he was checking out of this world, telephoned police and waited for them on his porch; when they would not shoot him, he *shot himself*.

Chuck Call (30-year Army gunner who'd volunteered to go to Iraq with another unit when his was not called up) *committed suicide* three months after returning on **February 3, 2006** /ss/. Haunted by nightmares and anxiety, he sought VA benefits only to be told he did not qualify for them due to his income. On **February 20, 2006** /ss/, *Jon Trevino* (36-year-old Scott AFB 375th Aeromedical Evacuation Squadron tech sergeant who served in both Afghanistan and Iraq) *shot his wife and himself*.

In Iraq, *Tina Priest* (21-year-old Fort Hood, Texas, 4th Infantry Division soldier) *shot herself* on **March 1, 2006** /oif/, two weeks after saying she was raped by a fellow soldier and days after being diagnosed and treated for Acute Stress Disorder consistent with Rape Trauma Syndrome.

Two days later, *Donald Woodward* (23-year-old army soldier) *shot himself* on his favorite Pennsylvania hiking trail on **March 3, 2006** /ss/. He'd tried killing himself once before by lighting his truck on fire and getting inside; his wife pulled him out; afterward, he finally agreed to get some help from the VA, which gave him antidepressants and scheduled a counseling appointment a month later. He committed suicide before the appointment date arrived.

Three days later, *Greg Braun* (26-year-old Army Ranger sniper with the 128th Infantry of Wisconsin National Guard) *shot himself* in his basement four months after returning home from Iraq on **March 6, 2006** /ss/. He had served in Kosovo as well as tours in Iraq, and was a Milwaukee policeman. *Eric Ryan Grossman* (22-year-old Marine) *ran into California interstate traffic killing himself* when a minivan hit him on **April 6, 2006** /ss/, only five days after returning from a seven-month tour in Iraq.

James Gallagher (Camp Pendleton, Calif., Marine gunnery sergeant) committed suicide eight months after returning from Iraq on **May 1, 2006** /ss/. On **July 25, 2006** /oef/, *Andrew Velez* (22-year-old Army specialist) shot himself in Sharona, Afghanistan. Two years earlier his brother had died in Iraq and he was said to have “locked up” after identifying his remains. He suffered flashbacks and held his wife hostage between tours.

At home following a near-suicide attempt in Iraq in which he sought the help of his commanding officer, *David Ramsey* (27-year-old Ft. Lewis, Wash., 47th Combat Support Hospital critical care nurse specialist) slipped through the cracks stateside as Madigan AMC released him from their care, unaware of his near suicide attempt in Iraq due to a lack of access to electronic records. Missing his follow-up appointment, he shot himself on **September 7, 2006** /ss/.

On **October 17, 2006** /ss/, *Zachary Bowen* (28-year-old Army MP who'd served in Kosovo and Iraq) strangled and dismembered his girlfriend and 11 days later threw himself off of the ledge of the Omni Royal New Orleans hotel with a suicide note in his pocket. A day later, on **October 18, 2006** /ss/, *Jeanne “Linda” Michel* (33-year-old Camp Bucca Navy medic) shot herself two weeks after returning to her husband and three kids. While overseas, she was prescribed Paxil for depression without family notification, and taken off the antidepressant, again without family notification, when she returned home.

James E. Dean (29-year-old corporal) killed himself via *suicide-by-cop* shortly after learning he was to be redeployed to Iraq. The Afghanistan veteran diagnosed with PTSD barricaded himself at his father's farm on Christmas Day; a Maryland State Police sharpshooter killed him 15 hours later, on **December 26, 2006** /ss/.

2007

On **January 16, 2007** /ss/, *Jonathan Schulze* (25-year-old Marine machine gunner) hanged himself following two attempts to get help from the Minnesota VA system, once in Minneapolis/St. Paul, the other in St. Cloud. He was given a waiting list number of 26 for a counseling appointment, but was dead before the date arrived. The following day, on **January 17, 2007** /ss/, *Michael Bramer* (23-year-old Fort Bragg, N.C., 82nd Airborne Division Special Forces Unit paratrooper who'd served in Afghanistan and Iraq) shot himself in his home.

Justin Bailey (27-year-old Marine rifleman), among the first wave of the Iraq invasion and diagnosed with PTSD since returning, checked himself into a Los Angeles VAMC needing immediate help for prescription drug addiction. Yet, the day before his death, he received prescriptions for five medications, including a two-week supply of the potent painkiller methadone; he overdosed in his VAMC room on **January 26, 2007** /ss/.

Jessica Rich (24-year-old Fort Carson, Colo., 52nd Engineering Battalion Army Reserve heavy equipment operator) drove directly into oncoming interstate traffic on **February 8, 2007** /ss/; medically evacuated from Iraq due to lower back pain and PTSD, she was on a waiting list for a specialized PTSD treatment program.

On **February 20, 2007** /ss/, *Brian Jason Rand* (26-year-old Ft. Campbell, Ky., 30th Infantry Regiment sergeant) shot himself at a local park seven weeks after returning home to Clarksville, Tenn. He answered ‘yes’ to PTSD to the identifiers on his post-deployment questionnaire following his second tour; yet, two days after being diagnosed with PTSD he was redeployed to Iraq for a third and final time.

Chris Dana (23-year-old 163rd Infantry Battalion Montana National Guardsman) shot himself on **March 4, 2007** /ss/ after having canceled his appointment for PTSD. His brother said after returning in November 2005 he seemed to be melting from the inside; his father said his eyes had lost their shine, the joy of living.

Stephen Edward Colley (22-year-old Ft. Hood, Texas, helicopter mechanic) committed suicide on **May 16, 2007** /ss/. Returning from Iraq 6 months earlier, his father said he felt he could not get the psychological help he needed from the military for fear it would jeopardize his future career. On **May 27, 2007** /ss/, *Brian William Skold* (28-year-old 151st Field Artillery Minnesota National Guardsman) died via *suicide-by-cop*.

The ninth Ft. Campbell, Ky., soldier to commit suicide in 2007, *Derek Henderson* (27-year-old Afghanistan and Iraq veteran) jumped to his death from a bridge over the Ohio River on **June 21, 2007** /ss/. He had begun carrying a 12” knife and wanted a gun to “fight the enemy,” his medical records indicating PTSD five times. On **July 25, 2007** /ss/, *Noah Charles Pierce* (23-year-old 3rd Infantry Division soldier) shot himself in rural Minnesota. The soldier who had signed up for the military after 9/11 wrote in his suicide note that he had killed people and now it was time to kill himself.

On **August 29, 2007** /ss/, *John R. Fish II* (19-year-old Ft. Hood, Texas, 41st Fire Brigade ammunitions specialist) shot himself. He had returned from a long Iraq de-

ployment in November 2006. *Steven D. Lopez* (23-year-old Ft. Bragg, N.C., Afghanistan and Iraq veteran) *shot his wife and then himself* on **November 5, 2007/ss/**; he had sought help from base doctors and was prescribed Paxil.

On **November 20, 2007 /ss/**, *Joseph Colin Russell* (25-year-old two tour Ft. Hood, Texas, 1st Cavalry Division, 2nd Brigade soldier) *shot himself* at a friend's house. He was homeless and accused of being responsible for the death of another vet following a fight at a nightclub.

Two days later, on **November 22, 2007 /ss/**—Thanksgiving Day—*Tyler Curtis* (25-year-old two tour Iraq veteran) *committed suicide* three months after returning to Maine following his 2006 discharge from the Army. He was torn by grief for the families of those he may have killed.

**Prepared Statement of Ira Katz, M.D., Ph.D.,
Deputy Chief Patient Care Services Officer for Mental Health,
Veterans Health Administration, U.S. Department of Veterans Affairs**

Mr. Chairman and members of the Committee, thank you for the invitation to appear before you today to discuss the Department of Veterans Affairs (VA), Veterans Health Administration (VHA) Mental Health program and suicide prevention. Accompanying me today are Dr. Robert Rosenheck, Director of the Division of Mental Health Services and Outcomes Research; Dr. Lawrence Adler, Director of the Mental Illness Research, Education and Clinical Center (MIRECC) in Veterans Integrated Service Network (VISN) 19; and Dr. Frederick Blow, Director of the Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) at the Ann Arbor VA Center for Clinical Management Research.

Mental illness is a serious disease, affecting not only the individual who has the problem, but also his or her family; and the community in which he or she lives. The symptoms that characterize mental illnesses can cause profound suffering for the patient and for others. Moderate levels of the illness are strongly associated with problems at work and at home; severe manifestations can lead to devastating outcomes such as suicide. While relatively few people with mental illnesses die from suicide, the fact that it occurs is a constant reminder that these illnesses are real, and that they can be fatal.

The Department of Veterans Affairs is determined to implement the findings of the President's New Freedom Commission on Mental Health, which require all mental health providers to offer Americans with mental health needs world-class treatment focused on early intervention and recovery. Our comprehensive Mental Health Strategic Plan, completed in 2004, provided a blueprint for us to expand our outreach to veterans and to enhance the capacity and quality of our mental health services. To implement this plan, we have increased our expenditures for mental health services from \$2 billion in 2001 to \$3 billion in the current fiscal year. In addition, we have added more than 3600 new mental health staff members to our facilities since 2005, bringing the total number of VA employees working in this area to more than 10,000.

While a significant number of veterans of the conflicts in Iraq and Afghanistan have required treatment for mental health conditions on their return home, the number is well within our capabilities for providing treatment. Approximately 100,500 of the 750,000 veterans of this conflict have come to VA with a mental health condition since the beginning of the war. This represents only about 10 percent of the total number of veterans with mental health issues VA sees in any one year. Just less than half (48,559) of those veterans received at least a preliminary diagnosis of Post Traumatic Stress Disorder or PTSD.

The 10-percent increase in patients with mental health conditions since 2002 should be balanced against the 50-percent increases in expenditures and mental health staffing in VA since 2001. Our new resources are adequate for us to address the mental health needs of returning veterans, and to enhance our mental health services for veterans of all eras. In terms of their suffering and need for effective treatment, the number of returning veterans with mental health issues is very significant; but our Department is able to meet their needs.

SUICIDE PREVENTION

Suicide among veterans is a tragedy. The Department of Veterans Affairs believes that it is our obligation to work to prevent suicide both in individual patients and in the entire veteran population. Our suicide prevention activities are based on the principle that in order to decrease rates of suicide, we must provide enhanced access to high quality mental healthcare, and to develop programs specifically designed to

help prevent suicide. We have trained all VA employees about the risk factors and warning signs of suicide, and have offered them strategies to help them deal with veterans who may be at risk of taking their own lives.

VA employees have been given the message that even strong and resilient people can develop mental health conditions. Care for those mental health conditions is readily available and should be timely provided. We know that treatment can work.

VA's suicide prevention program includes two centers that conduct research and provide technical assistance in this area to all our locations of care. One is our new Mental Health Center of Excellence in Canandaigua, New York, which focuses in developing and testing clinical and public health intervention. The other is the VISN 19 Mental Illness Research Education and Clinical Center in Denver, which focuses on research in the clinical and neurobiological sciences. Our system of care also includes a suicide prevention call center, also in Canandaigua with suicide prevention coordinators located in each of VA's 153 hospitals. Altogether, VA has more than 200 mental health providers whose jobs are specifically devoted to preventing suicide among veterans.

The Department has partnered with the Lifeline Program of the Substance Abuse and Mental Health Services Administration to develop a VA suicide prevention hotline. Those who call 1-800-273-TALK are asked to press "1" if they are a veteran, or are calling about a veteran. When they do so, they are connected directly to VA's hotline call center, where they speak to a VA mental health professional with real-time access to the veteran's medical records. In emergencies, the hotline contacts local emergency resources such as police or ambulance services to ensure an immediate response. In other cases, after providing support and counseling, the hotline transfers care to the suicide prevention coordinator at the nearest VA facility to ensure that follow-up is prompt and appropriate.

In the five weeks from October 7 to November 10, 2007, 1,636 veterans and 311 family members or friends called the hotline number. These calls led to 363 referrals to suicide prevention coordinators and 93 rescues involving emergency services. Since the hotline began in July, there have been more than 6,000 calls from veterans or families, more than 1,300 referrals to Suicide Prevention Coordinators in VA medical centers, and more than 300 rescues, any one of which may have been life-saving.

Suicide prevention coordinators receive referrals of those at risk for suicide from both the hotline and from providers in their facilities, and ensure that care for those at risk addresses their high risk status. Coordinators educate their colleagues, veterans and families about risks for suicide, provide enhanced treatment monitoring for veterans at risk and ensure that any missed appointments are followed up on. The coordinators work with the entire staff of their medical centers to maintain awareness of those who have previously attempted suicide, and ensure that their care is enhanced.

Prevention coordinators also work with patient safety officers to conduct quarterly safety inspections of inpatient psychiatry units, and to coordinate staff education programs about suicide prevention. These coordinators are in the process of organizing a system of flags in the electronic medical record to alert providers about those at high risk, and are conducting training for community members who have frequent contact with veterans to help them recognize those at risk and encourage them to seek treatment.

Finally, VA has held two National VA Suicide Prevention Awareness Days throughout our system to focus all of our 200,000 healthcare employees on this issue. The first event focused on enhancing overall awareness of the issue, and the second trained all VA staff on how to work with available prevention resources, including the hotline and the suicide prevention coordinators.

VA is very much concerned about the epidemiology of suicide among veterans, and has used findings in this area to guide our prevention programs. As new data on suicide rates, risk factors for suicide and regional variations become available, we will use that data to refine our programs, and to better evaluate their level of success. In all of this epidemiological work, VA uses information from the Centers for Disease Control and Prevention's (CDC) National Death Index currently available through the end of calendar year 2005.

VA's Epidemiology Service has published findings from a long-term, 20-year follow-up on the health of Vietnam-era veterans. The peer-reviewed, published study reported that rates of suicide among veterans who were deployed to Southeast Asia did *not* differ statistically from veterans of the same era who were not deployed. A published study of veterans from the first Gulf War provided a similar finding.

VA has now completed a preliminary evaluation of suicide rates among veterans returning from Iraq and Afghanistan. From the beginning of the war through the end of 2005 there were 144 known suicides among these new veterans. This number

translates into a rate that is not statistically different from the rate for age, sex, and race matched individuals from the general population.

Taken together, the population of veterans who receive care from the Veterans Health Administration have more risk factors for suicide than the general population. Although there are increasing numbers of female veterans, most veterans are male. Those who come to the VA for care tend to be older, less socio-economically well off, and more likely to have a mental health condition or another chronic illness. It is, therefore, by no means surprising that those receiving care from VA have higher suicide rates than those in the general population. Those with the greatest need for care are those who are most likely to come to VA. This increased need can be associated with increased risks. This, in fact, was one of the major factors leading to VA's focus on suicide prevention.

Because of new enrollment criteria for veterans of the Global War on Terror, the characteristics of Iraq and Afghanistan veterans coming to VA today are different from those for veterans from prior eras. As a result, early data being evaluated by VA, suggests that while rates among OIF/OEF veterans who come to VHA for care are not different from the general population, rates among those veterans who do not come to VA appear to be higher. One possible explanation for this finding is that VA mental healthcare is effective, and that it can be lifesaving. Further research in this area is underway.

VA's latest data do not demonstrate an increased risk of suicide among OEF/OIF veterans compared to the age and gender matched American population as a whole. Nevertheless, one suicide among those who have served their country is too much. Available information on suicide rates and risk factors among veterans are reinforcing the importance of the work VA has done to enhance its mental health services since 2001; and the usefulness of our comprehensive program for suicide prevention.

VA has already implemented the key provisions of the Joshua Omvig Veterans Suicide Prevention Bill, which was recently signed by President Bush, and we continue to do research to develop and implement new strategies that will improve our ability to save lives by preventing suicide. VA believes that our healthcare system can and must serve a national model for suicide prevention, now and in the future.

Thank you for the opportunity to address the Committee. At this time, I would be pleased to answer your questions.

**Prepared Statement of Kara Zivin, Ph.D.,
Research Health Scientist, Health Services Research and Development
Veterans Health Administration, U.S. Department of Veterans Affairs**

Good morning, Mr. Chairman, I am honored to provide testimony to the Committee about suicide among veterans treated for depression in the VA Health System. I come before this Committee as a mental health services researcher who has conducted research on this topic. The views and opinions expressed are my own, and do not necessarily represent those of my current employer, the Department of Veterans Affairs, or the views of the VA research community.

I am here today to report on findings from a study that I conducted along with my colleagues at the Department of Veterans Affairs' National Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) and the VA's Health Services Research and Development Center of Excellence in Ann Arbor, Michigan. We recently published a paper in the American Journal of Public Health examining suicide rates using data from the VA's National Registry for Depression for 807,694 veterans of all ages diagnosed with depression and treated at any Veterans Affairs facility between 1999 and 2004.

In all, 1,683 veterans in VA depression treatment died by suicide during the study observation period, representing 0.21 percent of this treatment population. When we calculated the overall suicide rate in this population over the 5.5-year observation period, it was 88.3 per 100,000 person-years (PY), approximately 7–8 times greater than the suicide rate in the general adult U.S. population. A higher suicide rate would be expected among a population of patients in treatment for depression than the general U.S. population, given that depression is a potent risk factor for suicide. Because most healthcare systems lack the capability of assessing suicide rates among their treatment populations, there are few points of comparisons with non-veteran treatment populations. However, at least one prior study reports a suicide rate for men receiving depression treatment in managed care settings between

1992–1994 of 118 per 100,000 PY, a suicide rate which is somewhat higher than that observed in this veteran depression treatment population.¹

In our study, we observed that the predictors of suicide among veterans in depression treatment differed in several ways from those observed in the general U.S. population. Typically, people in the general population who die by suicide are older, male, and white, and have depression and medical or substance abuse issues. In this study, we too found that depressed veterans who had substance abuse problems or a psychiatric hospitalization in the year prior to their index depression diagnosis had higher suicide rates.

However, when we divided depressed veterans into three age groups: 18 to 44 years, 45 to 64 years, and 65 years or older, we found that the younger veterans were at the highest risk for suicide. Differences in rates among depressed veterans of different age groups were striking; 18 44-year-olds completing suicide at a rate of 95.0 suicides per 100,000 PY, compared with 77.9 per 100,000 PY for the middle-age group, and 90.1 per 100,000 PY for the oldest age group. We did not assess whether individuals had served in combat during a particular conflict, although the existence of a military service-connected disability was considered.

In this VA treatment population, men veterans were more likely to complete suicide than women veterans. Suicide rates were 89.5 per 100,000 PY for depressed veteran men and 28.9 per 100,000 PY for veteran women. However, the differential in rates between men and women (3:1) was smaller than has been observed in the general population (4:1).

We found higher suicide rates for white depressed veterans (95.0 per 100,000 PY) than for African Americans (27.1 per 100,000 PY) and for veterans of other races (56.1 per 100,000 PY). Veterans of Hispanic origin had a lower rate (46.3 per 100,000 PY) of suicide than those not of Hispanic origin (86.8 per 100,000 PY). Adjusted hazard ratios also reflected these differences.

Surprisingly, our initial findings revealed a lower suicide rate among depressed veterans who also had a diagnosis of post-traumatic stress disorder (PTSD) compared to depressed veterans without this disorder. Depressed veterans with a concurrent diagnosis of PTSD had a suicide rate of 68.2 per 100,000 PY compared to a rate of 90.7 per 100,000 PY for depressed veterans who did not also have a PTSD diagnosis. We investigated further to examine whether specific subgroups of depressed veterans with PTSD had higher or lower suicide risks. We found that concurrent PTSD was more closely associated with lower suicide rates among older veterans rather than among younger veterans. This study does not reveal a reason for this lower suicide rate, but we hypothesize that it may be due to the high level of attention paid to PTSD treatment in the VA system, and the greater likelihood that patients with both depression and PTSD will receive psychotherapy and more intensive visits. In general, individuals with depression and PTSD diagnoses have higher levels of VA mental health services use than individuals with depression without PTSD.

Interestingly, depressed veterans who did not have a service-connected disability were more likely to complete suicide than those with a service-connected disability. This may be due to greater access to treatments among service-connected veterans, or more stable incomes due to compensation payments.

We hope our findings will help inform clinical treatment and policy initiatives to reduce suicide mortality among veterans with depression.

Thank you for this opportunity to testify. I will be pleased to answer any questions you may have.

**Statement of Michael Shepherd, M.D.,
Physician, Office of Healthcare Inspections,
Office of Inspector General, U.S. Department of Veterans Affairs**

Mr. Chairman and Members of the Committee, thank you for the opportunity to testify today on suicide prevention and the Office of Inspector General (OIG) report, *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*.

Background

In 2004, suicide ranked as the 11th leading cause of death with a rate of 11.1 per 100,000 in the general U.S. population and the 3rd leading cause of death with-

¹ Simon GE, VonKorff M. Suicide mortality among patients treated for depression in an insured population. *American Journal of Epidemiology*. Jan. 15, 1998;147(2):155–160.

in the 15–24 age range. It is estimated that each suicide intimately affects the lives of at least six other people.

In any particular suicide, individual and collective proclivities tend to combine. Consequently, the attempt to make sense of the multiple potential contributions from identifiable psychiatric disorder(s), co-morbid medical illness and functional impairments, specific personal events, and sociocultural factors has been the work of and an ongoing challenge to mental health professionals, sociologists, and epidemiologists. This effort has increased knowledge about suicidal patients and provided information for utilization in their treatment. However, there has been little reduction in overall rates through the years, indicating there is more to learn.

Suicidologists have struggled with standardization issues for many years. While it has long been held that the pursuit of valid and reliable suicide statistics is important to public health policy, establishing the validity and reliability of suicide rates has been a notable source of concern. In the U.S. it is widely assumed by mental health professionals that the actual suicide rate is higher than officially reported. Establishing the validity and reliability of suicide rates is complicated by stigma. Other sources of variability include limitations of death certificates, variability in the training of those tasked with certifying cause of death, use of differing guidelines for suicide determination, and the presence of equivocal causes such as single car accidents and drug overdoses.

The 2001 Surgeon General's *National Strategy for Suicide Prevention* identifies steps in a public health model for suicide prevention. Collecting data on rates of suicide and suicidal behavior is typically referred to as medical surveillance. Data may include information on how suicide rates vary by time, geography, age or special populations. In addition, data collection may include information on characteristics of individuals who suicide, circumstances surrounding suicide events, the presence and absence of possible precipitants, and the adequacy or accessibility of supportive factors and health services.

For example, the National Violent Death Reporting System is a Centers for Disease Control and Prevention (CDC) effort to develop a nationwide, state-based monitoring system for violent deaths. State and local agencies use this system to input data from medical examiners, coroners, death certificates, police reports, toxicology studies, and other sources. At present 17 States are designated to participate in the system. Veteran status is one of several uniform data elements recorded for input into the system. The data is pooled with the hope that it can ultimately be used to answer fundamental questions about suicide and to aid participant States in the design and implementation of tailored suicide prevention and intervention efforts.

Suicide is not a single illness with one true cause; it is a final common outcome with multiple potential antecedents, precipitants, and underlying causes. Interventions that may be more effective for one set of patients may differ from those of greatest benefit for a different set of patients. Comprehensive suicide prevention programs, those employing a portfolio of intervention elements, and particularly those that incorporate a range of services and providers, are thought to have a greater likelihood of reducing suicide rates. Selecting which interventions to implement includes consideration of the needs and characteristics of the target population, ways to integrate interventions into existing programs, efforts to strengthen collaboration, and an analysis weighing the resource requirements versus the potential effectiveness of individual interventions.

Veterans Health Administration's Mental Health Strategic Plan

In 2003, a VA mental health workgroup was asked to review the President's New Freedom Commission on Mental Health's 2002 report, to determine the relevance to veteran mental health programs of the Commission's goals and recommendations, and to develop an action plan tailored to the special needs of the enrolled veteran population. A 5-year action plan with more than 200 initiatives was ultimately developed and finalized in November 2004. Among the action items were a number specifically aimed at the prevention of suicide. In addition, endorsement and implementation of the goals from the Surgeon General's 2001 *National Strategy for Suicide Prevention*, and recommendations from the Institute of Medicine's 2002 report *Reducing Suicide: A National Imperative*, were incorporated into the VA Mental Health Strategic Plan (MHSP).

OIG Report on VHA's Implementation of Suicide Prevention Initiatives

In response to a request from this Committee, the OIG undertook an assessment of VHA progress in implementing initiatives for suicide prevention from the MHSP. In our May 2007 report, individual MHSP initiatives for suicide prevention were categorized and consolidated into the following domains:

- Crisis Availability and Outreach.
- Screening and Referral.
- Tracking and Assessment of Veterans at Risk.
- Emerging Best Practice Interventions and Research.
- Development of an Electronic Suicide Prevention Database.
- Education.

We recommended that:

- VHA make arrangements for 24-hour crisis and mental healthcare availability, either in person, or via a crisis line, and that at each facility an on-call mental health specialist should be available to crisis staff either in person or by phone.
- All nonclinical staff who interact with veterans receive mandatory training about responding to crisis situations involving at-risk veterans inclusive of suicide protocols for first contact personnel.
- Healthcare providers receive mandatory education about suicide risks and ways to address these risks.
- The requirement of sustained sobriety should not be a barrier to treatment in specialized mental health programs for returning combat veterans.
- VHA should facilitate bi-directional information exchange between VA and DoD for patients with mental illness coming into VHA healthcare and/or leaving VHA healthcare for re-deployment to active duty status.
- VHA should establish a centralized mechanism to review ongoing suicide prevention strategies, to select among available emerging best practices for screening, assessment, and treatment, and to facilitate systemwide implementation, in order to ensure a single VHA standard.

Crisis Availability

Although we found that most facilities reported availability of 24-hour mental healthcare either through the emergency room, a walk-in clinic, or a crisis hotline, this initiative had not achieved systemwide implementation and a coordinated toll free hotline was not in place at the time of our report. On July 25, 2007, the Department of Veterans Affairs subsequently began operation of a 24-hour national suicide prevention hotline for veterans. The hotline has reportedly received greater than 9,000 calls. Callers include veterans who previously would have called a non-VA suicide hotline, veterans who would not have utilized a non-VA hotline, family members and friends of veterans, and other distressed nonveterans. Several of the veteran calls have resulted in 911 emergency rescues and admission to VA hospitals. Hotline personnel facilitate referral of distressed nonveterans to a non-VA suicide prevention hotline through a partnership with the Substance Abuse and Mental Health Services Administration.

I recently visited the hotline, located at the Veterans Integrated Service Networks (VISN) 2—Center of Excellence at Canandaigua, New York, on less than 24 hours notice. During my visit with hotline staff, the phone lines were in use throughout the duration. I observed a call from a young veteran who told the hotline clinician that she planned to take the bottle of pills that she had next to her. After assessment and a lengthy discussion with the caller, the hotline line clinician arranged for an emergency rescue. I also observed a call from a discouraged Vietnam era veteran who had recently become homeless and was calling from his car in which he was living. Hotline staff arranged for him to be met by the suicide prevention coordinator at the local VA facility.

Suicide Prevention Coordinators

The VA Office of Mental Health Services has been in the process of implementing suicide prevention coordinators at all VA medical centers. At present, dedicated staff are reportedly in place at approximately 85 percent of facilities and “acting” suicide prevention coordinators are in place at remaining sites. Hotline clinical staff told me that after requesting a consult for a caller at a VA facility, they contact the facility suicide prevention coordinator electronically and/or by phone. If they do not hear back within 24 hours, they contact the coordinator again. Within 48 hours of the call to the hotline, an update on the patient’s disposition is to be reported by the suicide prevention coordinator to hotline staff. At 2 weeks post call, hotline staff contact the suicide prevention coordinator for an update as to whether the caller has remained engaged in follow-up in the VA system.

Education and Training of VA Personnel

In terms of initiatives for education on suicide prevention, at the time of our May report, we found that only 50 to 60 percent of facilities provided programs to train first contact nonclinical personnel about crisis situations involving veterans at risk for suicide. Only one-fifth of these programs included mandatory presentation of suicide response protocols. Almost all facilities provide education to health providers on suicide risks, ways to address these risks and best practices for suicide prevention. However, at only a small percentage of facilities were these programs mandatory. Since that time, the VISN 2 Canandaigua Center of Excellence has developed a CD and guide for training VA nonclinical personnel and a second CD and guidebook for community-based training. The training, titled Operation S.A.V.E. (Signs of suicidal thinking; Ask questions; Validate the veteran's experience; Encourage treatment and Expedite referral) will reportedly be carried out by the facility suicide prevention coordinators. A copy of the CDs and guide were provided to me on my recent visit. The VISN 2 Center of Excellence leadership report plans to subsequently develop a guide and CD for VA clinicians.

Treatment for Co-Morbid Mental Health and Substance Use Disorders

In terms of eliminating sustained sobriety as a barrier to treatment in specialized mental health programs for returning combat veterans, on November 23, 2007, the Deputy Under Secretary for Health for Operations and Management issued a memorandum to Network Directors that states that "VHA facilities and providers must never take the position that a patient is untreatable because substance use or dependence precludes treating mental health conditions while mental illness makes it impossible to treat abuse or dependence. Instead, services must be designed and available to provide care for veterans with substance use disorders and mental health conditions, alone or together, regardless of acuity or chronicity."

Facilitation of Emerging Best Practice Implementation

The OIG report recommended that VHA facilitate establishment of a centralized mechanism to select among emerging best practices for suicide prevention, the VISN 2 Center of Excellence has subsequently been organized into a clinical core, an education and training core, a VACO initiatives core, and a research core. The clinical core group is responsible for the organized development of pilot and demonstration projects. The initiative core is responsible for implementation of VA Central Office suicide prevention initiatives. The research core is focused on performing program evaluation, health services research, and intervention effectiveness research in order to expedite the dissemination of promising approaches throughout VA.

Bi-Directional Exchange of Health Information

Bi-directional information exchange between VA and DoD which includes patients with mental illness coming into VHA healthcare and/or leaving VHA healthcare for re-deployment is an ongoing issue that has been discussed at other hearings.

VHA Development of a Veteran Suicide Database

At the time of our inspection, researchers at the VHA Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) in a joint effort with researchers at the University of Michigan School of Public Health in Ann Arbor, Michigan, had been developing a methodology by which to create a database of veterans who had utilized VHA care in an index year and then stopped utilizing VHA care in subsequent years. This database would then be matched with data from the CDC National Death Index (NDI), to determine which of these veterans were deceased. This data would then be matched with an enhanced version of the National Death Index to determine which veterans no longer accessing VHA care had died from suicide. In early October, SMITREC researchers reported that they have subsequently calculated suicide rates for 2001 and 2002 among veterans who obtain care in VHA. In recent weeks, they reported working on data received from the NDI for calculation of rates from 2003–2005.

At the time of the May OIG report, a template of data elements pertaining to suicides and suicide attempts had been piloted in Rocky Mountain Network (VISN 19) facilities. In the past few months, VHA has reportedly been expanding use of the template to VHA facilities nationwide. Clinical providers at VHA facilities nationwide have been asked to input data regarding attempts or completed suicides by their patients using a template which contains prompts for data elements including age, gender, diagnosis, date of attempt, method used, outcome, date last seen at VA

prior to attempt, among others. The facility suicide prevention coordinator is responsible for receiving and collating data inputted into the template by clinical providers and submitting a spreadsheet to the Center of Excellence at the Canandaigua VAMC on the 10th of each month. October was the first month for which data was submitted to the Canandaigua Center of Excellence. Most but not all VHA facilities submitted data and the extent of provider compliance with filling out the templates is presently unclear.

Since October 2003, the Department of Defense (DoD) Defense Manpower Data Center has sent the VA Environmental Epidemiology Service a periodically updated personnel roster of troops who participated in Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF), and who had separated from active duty and become eligible for VA benefits. This data however does not include recently discharged or retired veterans who were not deployed in support of OEF/OIF or veterans who have served in other eras.

The OIG LC Database

During the past year, colleagues at the OIG Office of Healthcare Inspections have diligently pursued creation of a database to quantitatively characterize the care transition process from DoD to VHA. A September 2007, OIG Informational Report entitled *Quantitative Assessment of Care Transition: The Population-Based LC Database*, describes the creation of an analytical database derived from more than 30 data files acquired from VA and DoD that incorporates details about *all* service members discharged from July 1, 2005 to September 30, 2006. The database includes veterans who were deployed, those who were not deployed, members of the Reserves and National Guard, those who have accessed care in VHA and those who have not. The paper discusses the methodology used to create the database, data confidentiality issues, its limitations, and analytic potential for research and other applications. This unique database may provide background for understanding and interpreting ongoing and planned studies pertaining to select medical conditions, causes of mortality, and/or healthcare access.

Conclusion

Suicide is an unequivocally tragic and often incomprehensible event. Preventing suicide is a complex, multifaceted challenge to which there is not one best practice but several promising but not proven approaches and methods. Since 2004, progress had been made toward implementation of the MHSP initiatives for suicide prevention. Progress has continued with greater integration and at an accelerated pace since the time of the OIG report in May and the enactment of the Joshua Omvig Suicide Prevention Act. The full array of suicide prevention initiatives has not yet attained systemwide implementation. It is therefore incumbent upon VA to continue moving forward toward full deployment of suicide prevention strategies for our Nation's veterans.

Mr. Chairman, thank you again for this opportunity to testify on this important issue. I would be pleased to answer any questions that you or other members of the Committee may have.

Statement of Joseph L. Wilson, Deputy Director Veterans Affairs and Rehabilitation Commission, American Legion

Mr. Chairman and Members of the Subcommittee:

Thank you for this opportunity to present The American Legion's views on Stopping Suicides: Mental Health Challenges within the Department of Veterans Affairs (VA). The VA has the Nation's largest mental health program, which is continually implementing various programs to accommodate the growing demand for mental health services to all veterans.

Unfortunately, during a time which greatly warrants the development of such programs, the increased scrutiny of VA's mental health services and budget exist due to the increased demand for mental health services from veterans returning from combat in Iraq and Afghanistan, as well as veterans from previous eras.

Mental Health Strategic Plan, Initiatives, and Other Recommendations

Upon the completion of its Comprehensive Mental Health Strategic Plan (MHSP), the VA began implementation of mental health initiatives in 2005. The Mental Health Initiative (MHI) was instituted to provide funding to support the implemen-

tation of the MHSP outside of the Veterans Equitable Resource Allocation (VERA) model.

To effectively plan the funding for the MHI, the MHSP was divided into four main areas to include: enhancing capacity and access for mental health services; integrating mental health and primary care; transforming mental health specialty care to emphasize recovery and rehabilitation; and implementation of evidence-based care. Under these key categories are multiple funded programs, which are also currently attempting to accommodate increasing issues, to include suicide, amongst our Nation's veterans.

One of many indicators of increase in suicides is evident in recommendations made to VA by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), an organization formed in 1951 with a mission to maintain and elevate the standards of healthcare delivery through evaluation and accreditation of healthcare organizations, and its National Patient Safety Goal (NPSG). Implemented on January 1, 2007, JCAHO advised that all VA facilities take the following steps to comply with the NPSG:

- Develop and implement strategies to properly assess, treat, and manage patients identified at risk for suicide.
- Document the relevant risk factors for suicide in each patient's medical record.
- Document treatment and the treatment setting in a manner that addresses the presence of (or absence of) relevant risk factors that increase risk for suicide and features that may decrease risk for suicide.
- Provide the appropriate telephone number(s) for telephone calls during working hours and other times, in writing, to at-risk patients and/or significant others.
- Instruct patients and their significant others to call the facility's Emergency Department or Urgent Care Center if they have a crisis situation.
- Ensure that the local or regional mental health hotline knows about VA as a resource in case a veteran should contact them.
- Ensure that the safety concerns in the design of the inpatient mental health unit (and its furnishings) are addressed.
- Establish and implement a policy stating who is responsible for identifying and working with local agencies so that VA patients receive emergency support and referral to the VA as soon as possible.

The American Legion supports directives established by the Mental Health Strategic Plan and JCAHO, and their intentions to prevent tragedies such as suicide. However, there are concerns of adequacy of funding for these programs, as well as accommodation, across the board, for veterans of previous eras and the ever-increasing number of veterans who are returning from Iraq and Afghanistan. The American Legion continues to urge the Congress to annually appropriate the necessary funds for the Department of Veterans Affairs to ensure comprehensive mental health services are available to veterans.

Suicide

The VA estimates that more than 5,000 veterans take their lives each year. Suicide rates are 35 percent higher for Iraq veterans than for the general population. Thirty-six percent of the 250,000 Iraq and Afghanistan veterans who have sought care in the VA system were treated for mental health problems.

According to research, 283 Afghanistan veterans between 2001 and 2005 have taken their own lives. It was also reported that awareness was intensified nationwide when the United States Army reported the increase of its 2006 suicide rate, which rose to 17.3 per 100,000 troops. Within the past year the Army reported *23 soldiers, then currently in Iraq and Afghanistan committed suicide with at least seven Iraq and Afghanistan veterans committing suicide since returning home.*

In July 2007, VA opened a 24-hour National Suicide Prevention hotline for veterans. Recently, the VA submitted an informative letter to veterans disclosing the National Suicide Prevention toll-free hotline number included with definitive/probable suicide warning signs. The passing of H.R. 327, also titled the *Joshua Omvig Veterans Suicide Prevention Act*, which requires VA to develop and implement more programs, such as outreach and education, more than suggests an impending crisis amongst the Nation's veterans. During the development and implementation of mental health programs, there also arises the question of effectiveness.

Signs of increase is also evident at VA's National Suicide hotline center based in Canandaigua, N.Y., in which counselors have taken more than 9,000 calls since its inception this year. In addition, the VA recently announced plans to provide suicide prevention coordinators at each of its 153 medical centers.

In 2004, VA completed a five-year action plan that included implementation of goals from the Surgeon General's 2001 National Strategy for Suicide Prevention and

recommendations from the Institute of Medicine's (IOM) 2002 report "Reducing Suicide—A National Imperative." Afterward, the aforementioned were incorporated into the VA Mental Health Strategic Plan (MHSP).

In addition, individual MHSP initiatives for suicide prevention were categorized and consolidated, to include:

- Crisis availability and outreach; screening and referral.
- Tracking and assessment of veterans at risk.
- Emerging best practice interventions and research.
- Development of an electronic suicide prevention database.
- Education.

The warranted emergence of such programs to prevent this dreadful tragedy is indicative of a more imminent crisis becoming worse, absent effective means of curtailment. The American Legion agrees these initiatives are steps in the right direction and continues to remain incessant on monitoring the efficiency and effectiveness of programs implemented in the MHSP. We also implore the Congress to mirror our sentiment as well.

Conclusion

In response to a call for help from this Nation's veterans, programs related to crises such as suicide are continuously being implemented. However, in accordance with a 2006 Government Accountability Office (GAO) report, there are issues of adequacy and accountability in the areas of funding and assessment, which in turn leave gaps in this system, therefore allowing veterans in need to fall through the cracks.

It is the insistence of The American Legion that a proactive effort be implemented with continuous oversight to ensure complete access is available to avert suicides amongst our Nation's veterans. The American Legion also urges the Congress to provide annual oversight of VA's mental health services to augment deterrence of such tragedies as the above mentioned.

Mr. Chairman and members of the Committee, The American Legion sincerely appreciates the opportunity to submit testimony and looks forward to working with you and your colleagues to resolve this critical issue. Thank you for your continued leadership on behalf of America's veterans.

Statement of Joy J. Ilem, Assistant National Legislative Director, Disabled American Veterans

Mr. Chairman and Members of the Committee:

Thank you for inviting the Disabled American Veterans (DAV) to provide testimony at this important hearing focused on preventing suicides and meeting other mental health challenges of veterans who receive their care from the Department of Veterans Affairs (VA). This hearing is especially timely given the series of disturbing reports that have appeared recently on these important issues.

The Department of Defense (DoD) and VA share a unique obligation to meet the healthcare and rehabilitative needs of veterans who have been wounded during military service or who suffer from readjustment difficulties and other consequences of combat deployments. VA recently announced it has made suicide prevention a priority and has developed a focused program based on increasing suicide awareness, prevention, and training to improve the recognition of suicide risk by healthcare staff. A national suicide prevention hotline has been established and suicide prevention coordinators have been hired in each VA medical center. DAV welcomes these efforts but we believe they will be fruitless if VA fails to improve the effectiveness of treatment for post traumatic stress disorder (PTSD), depression, substance abuse and other mental health disorders—which together appear to create the greatest threat to rising suicide rates in veterans.

Suicide is a significant public health problem and should be addressed by aggressive efforts in the veteran population. In the December issue of the *American Journal of Public Health*,¹ VA investigators reported the results of their longitudinal study carried out from 1999–2004 using nationally representative data to determine suicide rates among veterans treated by VA for depression. Of the over 800,000 vet-

¹ Suicide Mortality Among Individuals Receiving Treatment for Depression in the Veterans Affairs Health System: Associations with Patient and Treatment Setting Characteristics. Zivin K, Kim M, McCarthy JF, Austin KL, Hoggat KL, Walters H, Valenstein, M. *AJPH* (2007) 97(12):2193–2198.

erans studied, 1,683 or 0.21 percent committed suicide. Overall, the rates of suicide among depressed veterans were 7–8 times higher than the rate for the general population. However, suicide rates in depressed veterans were similar to rates found in men receiving care for depression in managed care systems. Unlike other studies that report higher rates in older adults, this VA study found that depressed veterans who were younger were at the greatest risk. One of the findings of the study confirmed that veterans with co-morbid depression and substance abuse are at very high risk for suicide. Veterans from the northeast and central U.S. had lower suicide rates than veterans from the south and west. This is consistent with the geographic and regional suicide rate variations.

The findings of this study give clinicians important clues to characteristics that produce higher suicide risk in veterans suffering from depression. Youth, incidence of substance use and geographic location are all associated with suicide risk. DAV hopes that further studies of suicide risk can increase our understanding and reduce the impact on veterans who fought in Afghanistan, Iraq and previous conflicts.

Research demonstrates a clear association between deployment to a combat zone and subsequent mental health problems, substance abuse, and psychosocial problems such as marital conflict and incarceration. Key to our discussion today is the recognition that combat service is associated with higher rates of suicide in the early post-deployment period. This information is summarized in a report from the Institute of Medicine (IOM) entitled *Gulf War and Health: Volume 6 Physiologic, Psychologic, and Psychosocial Effects of Deployment Related Stress*, published in November 2007.² The IOM committee studied literature covering all deployments in the 20th and 21st centuries including World War II, the Korean War, the Vietnam War, the 1991 Persian Gulf War, and Operations Iraqi and Enduring Freedom (OIF/OEF). This eminent group of experts reviewed the scientific evidence and determined that the evidence is sufficient to conclude that there is an association between deployment to a war zone and PTSD, other anxiety disorders, depression, alcohol abuse, suicide and accidental death in early years after deployment, and marriage and family conflict. In addition, the committee found that there was suggestive evidence of an association between deployment stress and drug abuse, chronic fatigue syndrome, fibromyalgia and other pain syndromes, gastrointestinal symptoms, skin disorders, increased symptom reporting and unexplained conditions and—and incarceration. The committee noted that there was insufficient investigation by VA and DoD to allow the Committee to draw cause-and-effect conclusions regarding deployment stress and later physiological, psychological and psychosocial conditions. The IOM report states very clearly that veterans, young and old, are at increased risk of suicide because of their presence in combat.

Military deployments in Iraq and Afghanistan are among the most demanding since the Vietnam War over four decades ago. These deployments are causing heavy casualties in what are considered the “invisible” wounds of war: PTSD, depression, family dislocations and other distress, and a number of other social and emotional consequences for those who have served in OIF/OEF. VA reports that OIF/OEF veterans have sought care for a wide array of co-morbid medical and psychological conditions, including adjustment disorder, anxiety, depression, PTSD, and the effects of substance use. Through October 2007, VA reported that, of the 263,909 separated OIF/OEF veterans who have sought VA healthcare since the beginning of those hostilities, a total of 100,580 unique patients had received a diagnosis of a possible mental health disorder. More than 48,000 enrolled OIF/OEF veterans had a probable diagnosis of PTSD; almost 33,000 have been diagnosed with depression; and, more than 40,000 reported nondependent abuse of drugs.³

According to the recent report of the DoD Mental Health Task Force (Task Force), suicide rates have risen among OIF/OEF active duty members.⁴ In a finding that is key to this hearing, the Task Force also concluded that *alcohol abuse contributed in 65 percent of the instances of suicidal behavior in military servicemembers*. Depression and marital and relationship difficulties were seen as additional key contributors to suicidal ideology. After receiving these reports, DoD is beginning to re-inforce suicide prevention efforts, and VA is targeting suicidal behavior in the veteran population, including establishing a veteran-specific referral procedure when veterans call 800–273–TALK, the National Suicide Prevention Hotline sponsored by

²Gulf War Health: Volume 6. Physiologic, Psychologic, and Psychosocial Effects of Deployment-Related Stress. The National Academy Press, Washington DC, 2007.

³Department of Veterans Affairs, VHA Office of Public Health and Environmental Hazards, “Analysis of VA Healthcare Utilization Among U.S. Global War on Terrorism (GWOT) Veterans: Operation Enduring Freedom, Operation Iraqi Freedom,” October 2007.

⁴An Achievable Vision: The Report of the Department of Defense Mental Health Task Force, June 15, 2007.

the Substance Abuse and Mental Health Services Administration of the Department of Health and Human Services. Experts assert that any effective suicide prevention effort must offer ready access to robust mental health and substance abuse treatment programs, including components related to outreach, prevention, stigma reduction, improved screenings and early interventions. DAV concurs that these components, with the resources to fully support them, are critical to success of this prevention effort.

In a study of 315 homeless male veterans and 310 homeless female veterans, VA researchers found that 27 percent and 37 percent, respectively, reported they had attempted suicide in the past 5 years, and an additional 44 percent and 49 percent, respectively, reported they had contemplated suicide. The study also found over 80 percent of homeless veterans had mental disorders, prominently among them substance abuse, and that its degree of severity was a strong predictor of suicidality. In men, combat exposure and PTSD were predictive, and in women, recent sexual or physical trauma correlated positively with suicidality.⁵

The link between substance abuse and other mental disorders and suicide is strong. Earlier this year in a study of over 8,000 veterans who received substance abuse treatment, VA researchers found that nine percent had attempted suicide in the year prior to VA treatment, but only four percent had made suicide attempts in the year following treatment.⁶ This would seem to validate the premise that effective substance abuse treatment leads to reduction in suicide attempts. A 25-year study of 641 Vietnam veterans also found that over time, there was a strong correlation between suicidality, PTSD and substance abuse.⁷ Both these VA studies dealt predominantly with older veterans, but experts believe it would be reasonable to expect that similar studies focused on younger veteran cohorts, including OIF/OEF veterans, would show results consistent with these findings.

Mr. Chairman, there are rising indications that the misuse of substances will continue to be a significant problem for OIF/OEF service members and veterans. In a recent study, VA New Jersey-based researchers examined substance abuse and mental health problems in returning Iraq veterans.⁸ These researchers noted that although increasing attention is being paid to combat stress disorders in veterans, little systemic focus has been made on substance abuse problems affecting this population. In the group studied (292 New Jersey National Guard members who had returned from Iraq within 12 months of data collection) nearly 47 percent of participants reported a mental health and/or substance abuse problem. Substance abuse problems were found to be higher among veterans with other mental health problems. Access to substance abuse treatment both during and after deployment was especially low for those needing it (among veterans with dual disorders, 41 percent received mental health treatment but only nine percent received treatment for substance abuse). Similarly, a study of returning Maine National Guard members found substance abuse problems in 24 percent of the troops surveyed.⁹ In the most recent DoD anonymous *Survey of Health Related Behaviors Among Active Duty Personnel*, 23 percent of the respondents acknowledged a significant alcohol problem.¹⁰

Substance abuse—common as a secondary diagnosis among newly injured veterans and others with chronic long-term illness or injury—can often be overshadowed by more compelling acute care needs. Mental health experts agree that untreated substance abuse can result in a variety of negative health consequences

⁵Brenda, BB. Gender Differences in Predictors of Suicidal Thoughts and Attempts Among Homeless Veterans That Abuse Substances. *Suicide and Life Threatening Behavior*, 35, (2005) 106–116.

⁶Ilgen, MA; Harris, A; Moos, R; et al. Predictors of Suicide Attempt One Year After Entry Into Substance Abuse Disorder Treatment. *Alcoholism, Clinical and Experimental Research*, 31, (2007) 635–642. And Ilgen, MA; Jain, A; Lucas, E; Moos, R. Substance Use Disorder Treatment and a Decline in Attempted Suicide During and After Treatment. *J Stud Alcohol and Drugs*, 68, (2007) 503–509.

⁷Price, RK; Risk, NK; Haden, AH, et al. Post Traumatic Stress Disorder, Drug Dependence and Suicidality Among Male Veterans. *Drug and Alcohol Dependence*, 76S, (2004) S31–43.

⁸Kline, A., Falca-Dodson, M., Substance Abuse and Mental Health Problems in Returning Iraqi Veterans. VA New Jersey Healthcare System, New Jersey Department of Military and Veterans Affairs 2007, (unpublished).

⁹Wheeler, E. Self Reported Mental Health Status and Needs of Iraq Veterans in the Maine Army National Guard. Community Counseling Center, 2007 (unpublished).

¹⁰Bray, R., Hourani, L., Olmstead, K., Witt, M., Brown, J., Pemberton, M., Marsden, M., Marriott, B., Scheffler, S., Vandermaas-Peeler, R., Weimer, B., Calvin, S., Bradshaw, M., Close, K., & Hayden, D. (2006, August). *2005 Department of Defense Survey of Health Related Behaviors Among Active Duty Military Personnel: A Component of the Defense Lifestyle Assessment Program (DLAP)*. Prepared for the Assistant Secretary of Defense for Health Affairs, U.S. Department of Defense, Cooperative Agreement RTI/7841/006–FR. Research Triangle Park, NC: Research Triangle Institute.

for the veteran with marked increases in healthcare expenditures, as well as social costs due to additional stresses on families from loss of employment and legal costs. In both the VA and DoD healthcare systems, current evidence-based treatment guidelines for substance use disorders confirm the substantial body of research supporting the effectiveness of a variety of treatments for these problems. VA must continue to educate its primary care providers about these proven techniques, including better detection of substance use disorders, to ensure that these problems are identified early and treated.

We urge VA to provide a full continuum of care for mental health and substance use disorders including more consistent, universal periodic screening of OIF/OEF combat veterans in all its healthcare facilities and programs—especially in primary care. Outpatient mental health counseling and pharmacotherapy should be made available at all larger VA community-based outpatient clinics. Also, short-term outpatient counseling including motivational interventions; intensive outpatient treatment; residential care for those most severely disabled; detoxification services; ongoing aftercare and relapse prevention; self help groups; and, opiate substitution therapies and newer drugs to reduce craving, should be included in VA's substance abuse and prevention services program. We believe further investment in a comprehensive package of substance-use services will help younger veterans during an often difficult readjustment period following combat deployments. Hopefully, VA can use preventive approaches that will help restore these veterans and to prevent chronic long-term mental health consequences that attend drug and alcohol addictions, and thereby also lower risks for suicide. These types of VA services could also be beneficial to older veterans struggling with chronic addictions.

Mr. Chairman, war also places great stress on family and social relationships. Active duty service members currently are called on to make frequent deployments of long duration, in dangerous combat assignments. Time at home between these deployments is marked by intensive training in garrison and continuous preparations for redeployment. Active reservists and National Guard members face unanticipated redeployments that disrupt their families and strain their financial and employment security.

We have substantial data and reports that document the strain the wars are putting on combat veterans' mental health and their relationships with spouses and families. Interpersonal conflict is clearly increasing, and recent data suggest that the problems grow rather than diminish in the months after service members return home. Soldiers also reported more mental health problems and were referred at higher rates for mental health services. Of special concern are the high rates of alcohol use being reported by soldiers. DAV is very concerned about all these reports, and note that these findings do not even reflect the full impact of extended deployments, the third, fourth or even fifth deployments for some individuals, or the impact of redeployed service members who already may be actively suffering from untreated PTSD.

We understand that VA medical centers and their community-based outpatient clinics do not routinely provide marital and family counseling services. VA's Readjustment Counseling Service, through its community-based Vet Center program, is the only major source of marital and family counseling services in the VA healthcare system. Vet Centers are user-friendly and have high veteran satisfaction, but these vital services should be made more generally available at VA's major medical facilities to increase access to these important services. Congress should ensure that marital and family counseling services are offered as a part of the healthcare benefits package, when needed in relationship to combat readjustment issues for veterans under care at VA.

In addition to marriage and family counseling services, VA needs to improve its substance use treatment programs. Since the late 1990s, VA has seen unparalleled growth in veterans' use of its healthcare system however, according to VA mental health staff, the number of veterans who received specialized substance abuse treatment services has declined since 1998 despite increasing demand from veterans with these problems. At a time when substance abuse care needs appear to be rising and suicide risk among OIF/OEF veterans is high and so troubling, we urge VA to ensure these programs are available to veterans who need them.

These healthcare and psychosocial issues are complex. Therefore, VA's approach must be comprehensive and involve long-term structural improvements in the care provided to these veterans. We see the need for the following actions by VA:

- VA should immediately improve access to substance abuse treatment services, particularly early interventions for OIF/OEF veterans that are designed to prevent chronic conditions and more serious problems.

- DoD and VA must eliminate the stigma attached to service members and veterans seeking care for mental illness and substance abuse with the same urgency and sincerity that we give to “medical” illnesses. Otherwise, some veterans will not seek help and may fall into despair and be at risk for suicide.
- VA must provide access for OIF/OEF veterans and their spouses to marital and family counseling, to help restore relationships that deteriorate as a consequence of military deployment and separation, and to strengthen the social support system these veterans need as they reintegrate into their homes and communities.
- VA must assure that access to comprehensive age-appropriate mental health services is available to all OIF/OEF veterans, and develop services targeted to the new needs of the increasing cohort of women veterans who have been exposed to combat stress. VA must continue to enhance access to mental health, PTSD and readjustment counseling services for all veterans. Enhancements in these programs have been initiated, but we should remain vigilant to ensure that they are sustained and that state-of-the-art, quality healthcare services are delivered, irrespective of a veteran’s gender or geographic location.
- VA should provide Congress its strategic plan, through its Office of Rural Health for OIF/OEF veterans living in rural areas far from VA facilities and essentially without access to any form of direct VA service in mental health and otherwise. We urge VA and this Committee to find acceptable ways for these veterans (many of whom served as called-up National Guard members) to gain access to the full continuum of healthcare services offered by VA, to address their mental health and readjustment needs, and help them restore their marital and family relationships after serving.

Mr. Chairman, we bring to the Committee’s attention an issue that we believe is of great importance and directly affects veterans’ suicide risk. Earlier in this testimony, I indicated that a recent IOM report had shown that combat service was associated with veterans’ later incarcerations. Incarceration presents a life-altering consequence. There appears to be a link between combat and incarceration, mental health decline, substance abuse and elevated suicide risk for some veterans.

The Committee may be aware of a recent front page article in the *Washington Post* concerning the pending prosecution under the Uniform Code of Military Justice (UCMJ) of Army Lt. Elizabeth Whiteside. As indicated in a *Post* editorial following publication of the original story, “the 25-year-old Army reservist had a stellar record of service but had a breakdown, possibly caused by her service in war-torn Baghdad. After a series of stressful incidents, she shot herself in the stomach. Despite the unequivocal judgment of psychiatrists that she suffers from significant mental illness, her commanders pressed criminal charges against her, and she’s now waiting to hear whether the Army will court-martial her.” We believe Lt. Whiteside’s case resonates with the rest of our testimony, and the challenges we face as a Nation in dealing with the mental health consequences of war.

Earlier this year, the Department of Justice’s (DOJ) Bureau of Justice Statistics issued a report indicating that, while veterans are not disproportionately represented in Federal and State prison populations compared to nonveterans, OIF/OEF veterans do constitute nearly five percent of the total population of incarcerated veterans.¹¹ Since 2002 approximately 5,000 former military members who served in our ongoing wars, individuals who participated at some level in U.S. efforts to restore the freedoms of the Iraqi and Afghani peoples, have subsequently lost their own personal freedom after returning home.

Depression, substance use disorders and other mental health issues are common in prison. Each of those imprisoned individuals’ stories deals with unique circumstances and convicted criminal behavior. In some instances, sadly, individual failures to readjust and to gain access to effective care and services spirals down into impulsiveness, emotional breakdown, loss of control, loss of employment, and even homelessness and criminal behavior.

Mr. Chairman, there is another “hidden” veteran population, in prison and out, that is currently beyond reach of any VA program: these are veterans whose behavior while in service led to entanglement in the UCMJ, resulting in both imprisonment and/or so-called “bad paper” discharges. Veterans with less than honorable discharges are not defined as “veterans” under title 38, United States Code. Thus, they are ineligible for any service or benefit from VA. The DOJ report noted that 31 percent of veterans in Federal and State prisons have dishonorable discharges from military service.

¹¹Noonan, ME; Mumola, CJ. U.S. Dept. of Justice, Office of Justice Programs, Bureau of Justice Statistics, “Veterans in State and Federal Prison, 2004,” May 2007.

The DOJ report also indicated that more than 2,000 active duty personnel are currently imprisoned in military penal facilities. Once their sentences are served, most of them will be issued discharges under less than honorable conditions, or they will receive dishonorable discharges. In general these persons will not be able to avail themselves of federal benefits including VA's programs for PTSD, mental health and other readjustment services.

We believe these subjects should be added to the Committee's concerns about mental health and suicide. At this juncture DAV offers no specific recommendations for legislation; however, we believe that DoD and VA share a responsibility to ensure that war-traumatized service personnel and veterans should not be criminalized before an effort is made to intervene with therapeutic remedies. We ask the Committee to investigate the circumstances of both military and civilian justice systems, and to work with your colleagues on the Committee on Armed Services, to determine whether DoD and VA are using all the tools at their disposal to divert military personnel and veterans in trouble to therapeutic solutions rather than allow them to be criminalized.

In summary, many of our active duty service members, veterans and their families are experiencing the stressors we have noted in this testimony and are experiencing real emotional hardship in their lives. To address these challenges, DoD, VA and Congress need to work together—and the time to cooperate is now. For a small number of veterans, these stressors are having devastating consequences, including increased risk of suicide. Taking action now—before their problems become more complicated and severe, is in their best interests and in the best interest of the Nation. The resources we spend today, and the programs that Congress authorizes to promote better mental health, will have long term positive benefits for veterans and will reduce financial and social costs to the Nation. We owe them nothing less.

Mr. Chairman, thank you for this opportunity for DAV to offer its views on these matters. I will be pleased to address your questions, or those from other Members of the Committee.

**Statement of Todd Bowers, Director of Government Relations,
Iraq and Afghanistan Veterans of America**

Mr. Chairman and members of the Committee, thank you for hearing me speak today. On behalf of *Iraq and Afghanistan Veterans of America*, I would like to thank you all for your unwavering commitment to our Nation's veterans. The Committee originally invited our Executive Director, Paul Rieckhoff, to testify today. Unfortunately, Mr. Rieckhoff had a prior engagement that he could not reschedule and so he asked me to be here today on his behalf. I will do my best to fill his boots this morning.

I would like to begin by thanking the Committee for the outstanding leadership you provided to ensure that legislation combating suicide among veterans made its way into law. Specifically, I would like to thank you for your efforts to pass the Joshua Omvig Suicide Prevention Act. IAVA wholeheartedly endorsed this groundbreaking legislation and we are excited about the positive impact it will have on all veterans.

I was very excited to hear about the nomination of General Peake to be the new secretary of the Veterans Administration. General Peake is a combat veteran who holds dear the Army's "Warrior Ethos." The Warrior Ethos states that "I will always place the mission first, I will never accept defeat, I will never quit, I will never leave a fallen comrade." I believe we can apply the lessons of combat, and the Warrior ethos, to improving suicide prevention at the VA.

On my second combat tour in Fallujah, Iraq, I was on a patrol with my team of six Marines. As we moved through the city we made our way to Jolan Park, located in the northwestern portion of the city, to link up with our battalion's Executive Officer. Once we arrived at the park we found ourselves alone. There were no other Marines in sight. As we surveyed the area, I noticed a group of Marines four blocks away waving their arms and jumping up and down. By the time I was able to figure out that they were telling us we were in danger, it was too late. I turned to inform my Captain and, just as I opened my mouth, the building next to us exploded. The blast was so strong that it threw me backward. Once the dust settled and the ringing in our ears subsided, the Marines who were waving at us from down the street made their way over to our vehicle. "What the hell is wrong with you guys!?" a Major screamed at us. Apparently they were utilizing a controlled blast to destroy a massive weapons cache used by the insurgents and had called in the grid coordinates over the radio to warn all Marines to stay clear of the area. We did not get the communication. Our radio had lost its encryption.

The failure to communicate that day in Fallujah nearly killed me and six of my fellow Marines.

I believe communication is also key to success in suicide prevention.

The Army's Field Manual 6-22.5, "A Leader's Guide to Combat and Operational Stress," states that ensuring "communication lines are open" is one of the most "potent countermeasures to confront combat stress and to reduce psychological breakdown. . . ."

Recently, the VA had made great strides to improve communications lines by creating a Nation-wide Suicide Prevention hotline. This hotline is available to veterans and their families 24 hours a day, seven days a week. This new program has had amazing results. The VA has highlighted many stories of veterans who have used the hotline to get the help they need. But after talking to many IAVA's members, including those in the National Guard and Reserves, we have found that they do not know that this service is available. Better outreach is the only way to ensure that these new programs are available to all who need them.

But outreach is a difficult task if you do not know where your targets are. A national registry of veterans would solve this gap in communication.

The Gulf War Registry was established to inform veterans of changes in policy regarding issues specific to the war in the Gulf such as exposure to burning oil wells and Gulf War syndrome. Although this registry is newly available to Iraq veterans, its potential is still limited. Right now, the registry is not open to Afghanistan veterans, and is only made available to those who are in the VA system. Only about one-third of Iraq and Afghanistan veterans eligible for VA care have sought care, so the vast majority of veterans are not eligible for inclusion.

We at IAVA believe that all veterans should be included in a registry upon discharge from the military. Currently the tracking system for veterans is almost non-existent. Registering veterans, along with their deployments to specific conflicts, would help the VA reach out to veterans and family members who will benefit from their outstanding initiatives and programs, including the suicide hotline.

Much of the work of suicide prevention, however, must occur much earlier in the process. IAVA has strongly endorsed the mandatory pre- and post-deployment mental health screening of our service members by mental health professionals. This will produce a more accurate assessment of the impact that combat has on a service member's mental health. Making screening mandatory will reduce the stigma related to seeking mental health treatment. I would compare this to the mandatory drug testing that the Department of Defense conducts for all service members. If all are required to take part, then it becomes a part of daily routine and no longer singles individuals out.

In addition to universal screening, a coherent national anti-stigma campaign will help ease the barriers keeping troops from early treatment. I am very pleased to announce that IAVA has partnered with the Ad Council for the next three years to implement a "Stigma Reducing" national ad campaign. This campaign will be in print, on television and radio and online, and will convey to the American public and our Nation's veterans that treating mental health injuries is a routine step in reintegration.

I'd like to close with another personal story of a family in Northern Virginia who have experienced first-hand the effects of suicide among the veterans' community. They have become my friends and are almost like family to me. A few years ago, the father of the family, who served in the Army, took his own life. He left behind three children. Years later, his family still carries the tremendous emotional burden of unanswered and unanswerable questions. What more could have been done to save him?

I ask you, today, to consider that question. What could have been done? Would a hotline have been enough? A flier in the mail about the signs of suicide? A call from his local Vet Center?

My friend's family will never know the answer. If we act now, we can implement measures that will be a crucial step in reducing suicide amongst veterans.

On the battlefield, casualties are often unavoidable. What is avoidable is suicide. If we take the proper steps to combat suicide among the veterans community, we can and will win this battle. Thank you.

Statement of National Coalition for Homeless Veterans

Mr. Chairman and Members of the Committee:

We are assembled here to talk about the mental healthcare available to, and the reported increase in suicide among, this Nation's veterans—and specifically, how the Department of Veterans Affairs (VA) is addressing these critical concerns.

The National Coalition for Homeless Veterans (NCHV) is honored to participate in this hearing for several reasons. NCHV, perhaps more than any other organization, recognizes the tremendous contributions this Committee has made in serving America's former guardians in their greatest hour of need. We know that what our member organizations have accomplished on behalf of veterans in crisis—men and women who have lost everything but life itself—would not have been possible without this Committee's guidance, support and courage to act.

Most importantly, NCHV is proud to stand with you during what we believe is a defining moment in the history of this great Nation.

Never before has the U.S. Congress, and the people it represents, been better prepared to address the future needs of America's armed forces during a time of war. This Committee knows all too well that the cost of our freedom and prosperity necessarily includes tending to the wounds of the veterans who sacrifice some measure of their lives to preserve it. We understand the Committee's purpose is to serve all veterans, but this dialogue most certainly embraces the men and women who have served in Iraq and Afghanistan, and all who will follow them.

The Nation's foremost authorities on mental health—the National Institute of Mental Health, National Alliance on Mental Illness and Mental Health America (formerly the Mental Health Association), agree that the warning signs of increased risk of suicide include histories of mental illness, extreme mood swings, changes in personality, withdrawal from family members and friends, feelings of hopelessness, and depression. Depending on the severity of a person's health and economic hardships, self medication on alcohol or drugs increases the likelihood of suicide by 30 to 70 percent.¹

These behaviors, mental health issues, and emotional torments characterize the great majority of the clients NCHV organizations serve. Approximately 76% of the veterans we treat have histories of substance abuse and diagnosed mental health challenges; more than 90% of both male and female clients are unemployed. *All of them are homeless.* More than half of the calls we receive on our toll-free help line (1-800-VET-HELP) are from veterans who are sick, scared, socially isolated, or economically disadvantaged—or from family members asking how they can help their loved ones.

Suicide, a tragic and irreversible act, can most simply be defined as the absolute absence of hope.

The act of willfully ending one's life is most often the result of prolonged and deepening mental and emotional stresses, the erosion of social supports such as friends and family ties, and the loss of intimate relationships.² Veterans—particularly combat veterans—are called upon to endure all of these as necessary occupational hazards.

War is arguably the most dehumanizing experience a person will ever encounter. Every action tears at the tenets of civilized society; and those who serve in a combat unit must disregard the most basic instinct of all—self preservation. But the intensity of military training, separation from one's social supports, and the inescapable anxiety of knowing what their training is preparing them for can potentially be just as burdensome to those who serve, whether or not they ever engage in combat operations.

The prospect of multiple deployments, their effect on personal finances, and repeated separation from one's family now gripping half of the Reservists and National Guard troops serving in the War on Terror can only magnify the impact of these pressures.

The overwhelming majority of America's veterans who have answered the call to serve in the military return home to become successful business executives, community leaders, captains of industry, public servants, and even presidents.

However, unlike other veteran policy advocates, NCHV is singularly concerned about those who do not—our sole purpose is to support the men and women who proudly serve but then find themselves unable to effectively cope with the challenges life throws at them without regard to social standing, economic status, ethnic heritage or personal conviction.

Every day, at more than 280 service organizations across the country, we provide services to those who would have no hope were it not for the support of Congress, the federal agencies charged with helping our most disadvantaged citizens, and the multitude of community and faith-based organizations that transform policy into life-saving interventions and life-sustaining programs.

¹ National Institute of Mental Health, Washington, D.C.

² *National Strategy for Suicide Prevention (NSSP)*, Office of the Surgeon General, 2001.

VA Mental Health Care

NCHV is, therefore, well qualified to comment on the availability of mental health services through the Department of Veterans Affairs. The partnership between service providers that help veterans in crisis and the VA is vital to our mission to increase the capacity of service providers and to promote effective and cost-efficient collaboration in local integrated service networks. This partnership has been credited with decreasing the number of homeless veterans on the streets of America each night by more than 20% in the last five years.³

Virtually every community-based organization that provides assistance to veterans in crisis depends on the VA for access to comprehensive health services, and without exception their clients receive mental health screenings, counseling and necessary treatment as a matter of course. These services are well documented, and case managers report this information to the VA as prescribed in their grant reports. Follow-up services—counseling, substance abuse treatments, outpatient therapies, medication histories and family support initiatives—are also monitored closely and reported in client case files.

Despite significant challenges and budgetary strains, the VA has quadrupled the capacity of community-based service providers to serve veterans in crisis since 2002, a noteworthy and commendable expansion that includes, at its very core, access to mental health services and suicide prevention.

The development of the VA Mental Health Strategic Plan from 2003 through November 2004, and its implementation over the last three years with additional funding this Committee fought for, has increased the number of clinical psychologists and other mental health professionals within the VA healthcare system by nearly 1,000 positions. The additional clinical staff have been noted at VA medical centers, community-based outpatient clinics (CBOCs) and VA Readjustment Counseling Centers (Vet Centers).⁴

Media attention to the fact that the VA did not expend the full amount of funding authorized to achieve the Mental Health Strategic Plan's goals in 2006 did not fairly report that program expansion of this magnitude takes time to implement, with respect to both logistical and personnel matters.

Veterans now have access to initial healthcare assessments and referrals to VA services through a network that includes 153 medical centers, nearly 900 VA community health clinics, 207 VA Readjustment Counseling Centers, and about 280 community and faith-based veteran assistance programs nationwide—a network that did not exist at the close of the Vietnam War. Many of these points of access to mental health services have opened within just the last 10 to 15 years. From information in our database, we estimate there are more than 3,000 other organizations—both private and government agencies—that provide various services to veterans in need.

The development of an interagency Suicide Prevention Hotline in May 2007, a collaboration between the Departments of Health and Human Services and Veterans Affairs and staffed by trained counselors on a 24/7 basis, is a valuable resource for both veterans in crisis and family members who are often the ones who call for help.

The ongoing development of peer counseling initiatives at many VA facilities is a replication of successful interventions that have been utilized at many community organizations for decades. Plans to provide training for VA and community-based organization staffs on effective mental health support procedures and suicide prevention beginning in early 2008 are another testament to the agency's commitment to ensure effective early mental health assessment and intervention strategies for veterans of Operation Iraqi Freedom and Enduring Freedom (OIF/OEF).

VA officials publicly admit there is still considerable work to do.⁵ And no one who is professionally invested in this work would refute that point. NCHV has been a vocal advocate for enhanced VA mental health services for homeless, low-income and recent combat veterans since 2001. But a random survey of directors of several of our larger member organizations in preparation for this hearing produced three significant, and unanimous, conclusions:

1. The incidence of suicide among veterans in a community-based program in partnership with the VA is "extremely rare," even though these clients on admission are often regarded as among the highest risk segment of the population.

³ VA CHALLENGE Reports 2003–2006.

⁴ *Implementing VHA's Mental Health Strategic Plan Initiatives for Suicide Prevention*, Office of the Inspector General, Department of Veterans Affairs, May 10, 2007.

⁵ *ibid.*

2. Because these programs immediately address a wide range of needs, and clients are more likely to receive proper mental health treatment, case management and follow-up, the sense of hopelessness and low self esteem often associated with suicide quickly subsides.
3. Were it not for VA's partnership with community and faith-based organizations—and specifically the availability of VA mental health services for their clients—the incidence of suicide among veterans would likely be much higher.

Recommendations:

1. Ensure full implementation of the VA Mental Health Strategic Plan—Specific recommendations of the Office of the Inspector General include:
 - 24-hour crisis and mental healthcare availability at all VHA facilities, either in person or through a manned suicide/crisis hotline.
 - 24/7 availability of on-call mental health specialists for crisis intervention staff.
 - Systemwide co-location of mental health services at primary care facilities to reduce the stigma associated with seeking mental health supports and to enhance service delivery.
 - Improve information sharing between the VA and Department of Defense for all personnel entering the VA healthcare system or leaving it to return to active duty.
 - Ensure adequate funding for VA mental health professionals to provide training to VA and community-based organization staffs on proper mental health supports and suicide prevention strategies. This training is critical for all persons associated with at-risk veteran populations—clerical staff, intake counselors, case managers, peer counselors, and clinical staff.
2. Continue this Committee's leadership role in support of, and authorize funding to the maximum extent possible for, the VA Grant and Per Diem Program. These community-based therapeutic programs, in partnership with the VA, provide a wide range of services that greatly reduce the risk of suicide among veterans with extreme mental, social and economic challenges. Most community-based organizations provide follow-up counseling long after clients successfully complete their recovery programs. This is widely viewed as a critical component of an effective suicide prevention strategy.⁶
3. Simplify and expand access to community mental health clinics for OIF/OEF veterans in communities not well served by VA facilities. While current practice allows a veteran to apply for a VA "Fee Basis" card to access services at non-VA facilities, the process is often frustrating and problematic, particularly for a veteran in crisis. Protocols should be developed to allow VA and community clinics to process a veteran's request for assistance directly and immediately without requiring the patient to first go to a VA medical facility.
4. Extend the period of eligibility for VA medical services for Reservists and National Guard troops who serve in Operations Iraqi Freedom and Enduring Freedom (OIF/OEF) from two years to a minimum of five years. Research indicates, and VA Grant and Per Diem client case files over the last 18 years prove, that many emotional and mental health challenges emerge or worsen over time. This extension would also allow for more precise diagnoses and more effective treatment regimens for combat veterans.
5. Establish an interactive, 24/7, information and service referral website for military members, veterans and their families; and ensure that new recruits, Reservists and National Guard troops are advised of the site as part of their induction into active duty. This would virtually eliminate the problem of not knowing where to ask for help regardless of when a service member or veteran becomes aware that he or she may need assistance.

Conclusion

By any accounting, the work of the House Veterans Affairs Committee on behalf of this Nation's most vulnerable former service men and women over the last two decades has inspired the development and expansion of a service provider network that performs miracles every day. Most of the accomplishments reflected in this report have occurred in just the last five to six years.

Rekindling hope in those who have no hope is the surest safeguard against suicide. NCHV staff and program directors can personally attest to this Committee's role in helping transform hopelessness into the will to live and prosper for hundreds

⁶*National Strategy for Suicide Prevention (NSSP), 2001.*

of thousands of our fellow combat veterans. We believe the same can be said of the Department of Veterans Affairs.

On behalf of the veterans we all serve, we implore you to claim this moment in American history and make it part of your commendable legacy. No veteran should have to lose everything he or she has before we, as a nation, offer them a helping hand. Your leadership can make sure that doesn't happen to the men and women who serve in Iraq and Afghanistan.

**Statement of Richard F. Weidman,
Executive Director for Policy and Government Affairs
Vietnam Veterans of America**

Chairman Filner, Ranking Member Buyer, and other distinguished members of this committee, Vietnam Veterans of America (VVA) thanks you for the opportunity to present our views on suicide and PTSD among our Nation's military personnel and veterans. We also want to thank you for your consistent concern about the mental health care of our troops and our veterans. I should note that Dr. Thomas Berger, Chair of VVA's National PTSD & Substance Abuse Committee made substantial contributions to this statement, as did Ms. Marsha Four, Chair of VVA's National Committee on Women Veterans.

The subject of suicide is extremely difficult to discuss. It is a topic that most of us would prefer to avoid. Accurate statistics on deaths by suicide are not readily available because many are not reported or are misreported for insurance reasons as well as the desire of local officials to avoid the "stigma" of suicide in a family. Many of us, as veterans of the Vietnam War and as comrades and caregivers to our brother and sister veterans, have known someone who has committed suicide and others who have attempted to take their life. Unfortunately I have personally known many Vietnam veterans who were overtaken by despair induced by their deep and intractable neuron-psychiatric wounds from the war.

But as uncomfortable as this subject may be to discuss, it must be confronted. It is a very real public health concern in our military and veteran communities. A 12-year study published in the June 2007 issue of the journal *Epidemiology and Health* clearly demonstrates that the risk of suicide among male U.S. veterans is more than two times greater than that of the general population after adjusting for a host of potentially compounding factors, including age, time of service, and health status. A report released this past May by the VA Inspector General noted that "veterans returning from Iraq and Afghanistan are at increased risk for suicide because not all VA clinics have 24-hour mental care available . . . and many lack properly trained workers."

Media reports of suicide deaths and suicide attempts among active duty OEF and OIF soldiers and veterans began to surface back in 2003 after a spate of suicides in Iraq during the first months of the war. Since then, both the military and the VA have stumbled and fumbled in their attempts to answer questions about the severity of this malady. For example, while all the military services maintain suicide prevention programs, the Army in its August 2007 Army Suicide Event Report acknowledged that soldiers committed suicide last year at the highest rate in 26 years, and more than a quarter did so while serving in Iraq and Afghanistan. The report noted "a significant relationship between suicide attempts and number of days deployed in Iraq, Afghanistan or nearby countries where troops are participating in the war effort." The report added that there also "was limited evidence to support the view that multiple deployments are a risk factor for suicide behaviors." It might be noted here that this report which was released only after a FOIA request.

VVA believes that these deaths are among the most extreme failures by the U.S. military to properly screen, treat, and evacuate mentally unfit troops. Even a report by the Army released this past October suggests that the quality of care, as much as the number of providers, is a factor in the rising incidence of suicide among active-duty service members. This report notes that **more than half the 948 soldiers who attempted suicide in 2006 had been seen by mental health providers before their attempt**—36 percent within just 30 days of the event. Of those who committed suicide in 2006, a third had an outpatient mental health visit within three months of killing themselves, and 42 percent had been seen at a military medical facility within three months. Among soldiers who were deployed to Iraq or Afghanistan when they attempted suicide in 2005 and 2006, **60 percent had been seen by outpatient mental health workers before the attempts**. Forty-three percent of the deployed troops who attempted suicide had been prescribed psychotropic medications.

The report offered no details on the type or duration of mental health care that troops received before they tried to kill themselves. A June 2007 Pentagon task force on mental health report, however, specifically notes the issue of quality of care, recommending that the military develop core training for all medical staff in recognizing and responding to service members "in distress." This task force also concluded that mental health providers needed additional training in treating depression and combat stress.

To its discredit, the Department of Defense has managed to keep what has clearly become what *CBS News* called a "hidden epidemic" under the radar of public awareness by concealing statistics about soldier suicides. They have done everything from burying suicides on official casualty lists as "accidental non-combat deaths" to outright lying to the parents of dead soldiers. Meanwhile the Army officially insists that they have yet to find a connection between PTSD, between the stresses of combat and the type of combat waged in Iraq and suicide.

It may be true that, as Will Rogers once said, there are lies, there are damn lies, and there are statistics. But even the statistics the Pentagon admits to are telling. Unfortunately what is told is a grim story indeed, one of willful ignorance and recalcitrance to the point of malfeasance on the part of senior officials who do not move to correct these problems in both access to mental health care and quality of care when access is gained.

Much of the problem that the VA will in fact be inheriting is caused by the failure of the Army Medical Department and the Navy Medical Department to properly address neuron-psychiatric wounds of war. More than four years into this war, one may well ask "how can this be?"

Part of the problem with the military is lack of organizational capacity caused by the questionable decision to downsize the military medical departments as we were going to war. The former Secretary who had overall responsibility is now gone, and the Assistant Secretary for Health brought in because his entire experience was cutting costs by reducing services for HMOs and insurance companies, and who actually did the dirty work is also gone. However, the real architect of this outrageous and irresponsible policy that has cost soldiers their lives and/or their health continues on in his job as Under Secretary of Defense. VVA was asked if we hold LTG James Peake accountable for creating the situation of too many grievously injured soldiers needs chasing too few clinicians and case managers, and we said no, because we do not know how hard he fought on the inside. VVA continued in its communication with the White House that we do question why David Chu still has a job, after all of his public utterances of disdain for injured soldiers, survivors of KIA, and more importantly the total failure of his policies.

While VVA now understands that as of early this calendar year the Army was given 3,000 additional persons/slots in the Army Medical Department, it takes a long time to "ramp up" and we wonder how successful this all will be as long as David Chu is driving this train, aided by his top consultants at the unit of Rand Corporation led by Bernard Rostker, who has already done so much damage to Gulf War I veterans.

There is a solution. It requires data collection, training, leadership and a cultural mind shift from the military, as well as the network of consultants and hangers on that surround the civilian officials who are at the head of DOD. Military leaders at all levels, beginning with basic trainees, should be taught what their roles and responsibilities are when warriors come home. This training should be as structured and well thought out as fielding a new weapons system. This includes Field manuals, training circulars, incorporation of training into Common Test Training (CTT) and Mission Essential Task Listings (METL).

If we change the culture in the military to deal openly and honestly about the rigors of war when service members come home, then we can begin to mitigate the suicide issue. We don't have a lot of time. The longer we delay the worse the problem gets, and it becomes more devastating to the all-volunteer military.

We've got the training for war part down cold. The missing component is training to come home. If we do it right, retention and recruiting will be high. Soldiers and families will grow and become stronger from their experiences.

However, if we don't put as much emphasis on coming home as we do in going to war the implications will be felt for the next 20 to 40 years. We can't continue to try and force the warriors to figure this out on their own, with no help from the command structure and a "grateful Nation." They have no reference point at which to begin recovery and become strong.

When we begin teaching them how to come home it will become as ingrained as field stripping an M4. It will become reflexive instead of reactive; it will become proactive instead of passive. It will be something that a war fighter has to do as a natural part of going into and returning from battle. This will truly begin to re-

move the stigma in the military that has led to situations like that experienced by Lt. Elizabeth Whiteside, where the Army is still contemplating whether to court martial her for attempting suicide after 10 months in Iraq treating grievously injured soldiers, and rendering exemplary service, when it all came crashing in on her. Her command structure in Iraq created a hostile work environment as opposed to trying to be supportive, and getting her counseling help. Compounding this is the Command here in the Military District of Washington who even as we speak today is still contemplating whether to be vindictive and try to punish this fine young soldier by means of a court martial, possible jail time, and stripping her of all Army and VA benefits, instead of helping her to receive proper treatment. This case exposes just how far we have to go to change the military culture in order to stop the punishing of war fighters for experiencing psychiatric wounds.

Words alone won't fix this problem. There is lots of hard work ahead. VVA asks that this distinguished panel partner with the Committee on Armed Services and others in the House to please convince someone in the Pentagon to start listening.

The Service Chiefs need to launch a Nationwide Anti-Stigma Campaign, for starters.

Active-duty soldiers, however, are only part of the story. One of the well-known characteristics of PTSD is that the onset of symptoms is often delayed, sometimes for decades. Vietnam veterans are still taking their own lives because new PTSD symptoms have been triggered, or old ones retriggered, by stories and images from these new wars. Their deaths, like the deaths of more recent veterans, are written up in hometown newspapers; they are locally mourned, but officially ignored because the VA **does not track or count them unless they are part of the VA registry**. Both the VA and the Pentagon deny that the problem exists and sanctimoniously point to a lack of evidence they have refused to gather.

In yet another example of dancing around the issue, the VA announced last spring that it was setting up a "suicide prevention hotline" for veterans. This program is headquartered in Canandaigua, New York, in cooperation with the National Suicide Prevention Resource Center and the Substance Abuse and Mental Health Services Administration. As part of its anti-suicide effort, the VA announced that it was going to hire "suicide counselors" at each of its 153 medical centers. According to VA hotline administrators, as of late November 2007, 92 percent of the now-titled suicide coordinator positions had been filled and the national hotline center had handled more than 15,000 calls between July 1 and November 17—while also admitting that the tracking of calls is voluntary. The VA noted that 4,900 callers self-identified as veterans, 164 as active-duty military; and that 600 calls came from concerned family and friends. Some 1,600 referrals were made to VA facilities, 100 referrals to Vet Centers.

At first glance, the call data are impressive and the VA is to be congratulated in this endeavor. Yet real questions remain: How many suicides have been prevented through this intervention, particularly in light of the fact that the hotline call tracking is voluntary? And is suicide prevention intervention and care available 24/7 across the VA system, including both community outpatient clinics and medical centers?

Finally, much has been made of the recent *CBS News* investigative report on suicides of veterans, especially of the data collection and analyses. VVA's concern is not that the reported figures are too high or too low. VVA's position on suicide, however, is clear: one soldier/veteran suicide is one too many, and there have been far too many. Let's not quibble about how accurate the numbers are; rather, let's focus on the issues of why veterans take their lives and what we, collectively, can do to get more veterans into the counseling that might save their lives.

Congress recently passed, and the President signed, the "Joshua Omvig Veterans Suicide Prevention Act," which mandates better suicide prevention training for VA staff, a referral system to make sure that vets at risk receive care, and the opening of a 24-hour veterans' suicide hotline. While VVA lauds this bi-partisan effort, we implore you to revisit the situation with regularity, and ask hard questions that must be answered. With the exception of the creation of the suicide hotline, how are the other mandates being translated into suicide prevention programs, services, and training? What agency or entity is accountable for them? And can DOD and the VA be directed to provide truthful, accurate suicide statistics?

The faceless IED-fueled sniping that is killing and maiming scores of our troops, is part of the root cause of the severe psychological wounds that grips too many of our troops and veterans. Further, far from being nothing like the Vietnam war as alleged by some officials who were too busy with other pursuits to join the rest of us who went to Southeast Asia, the Iraq war is, as one of our longtime members who served as an infantry platoon leader with the 199th Brigade "Red Catchers" in Vietnam: "Iraq is Vietnam without water." You cannot tell who the enemy is in

most instances without an electric scoreboard, and then only after a particular action is finished. This uncertainty and constant pervasive danger causes deep and often chronic stress and often leads to Post Traumatic Stress Disorder later on. It is up to all of us, with your leadership, to do the very best that we can to mitigate the horrors of combat by providing enough help and guidance to the men and women who need it most. It is our obligation to continue to search for answers, and not utter the empty claims that combat has little or nothing to do with the suicides of troops who have experienced it.

The Nation now clearly understands the gaps in care as outlined by multiple military commissions. The service chiefs have ensured that our service members were taught how to go to war and with the right equipment. What remains missing and what we are identifying as a fundamental gap in suicide prevention and all reintegration training is teaching the force the fundamental skills of "how to come home."

To truly address suicides we must change the way our Nation and the Military respond to the trauma of war and the complexities of deployment. Moreover, we need to evaluate the way we define and understand stress and trauma large scale.

No veteran should ever feel so left behind that suicide feels like a viable option. We owe them so much more than rhetoric. Let's start by training them to come home. Then they will be resourced to seek out existing service and programs and the stigma of seeking help will be minimized.

The Army's Creed, the Warrior Ethos, and even VVA's motto of "Never again shall one generation of American veterans abandon another generation"—are meaningless without the doing. And the doing requires that we live by and die by our beliefs and the only thing we hold on to is the knowledge that our country will be there for us if we need them.

The Warrior Ethos: written in *Soldiers Magazine*, July 2006, by Peter J. Schoemaker talks about the common thread that has tied us all together throughout 230 years of service to our Nation. Since 1775, American Soldiers have answered the call to duty. From Valley Forge to the battlefields of Gettysburg; from the Argonne Forest to the shores of Normandy; from the rice paddies of Korea and Vietnam to the mountains of Afghanistan and the streets of Baghdad; our military history is rich with the willingness of generation after generation to live by the Warrior Ethos. Service members will continue to live by these creeds, the question is does the creed extend to them when they come home, after the war.

We thank you for the opportunity to speak to this issue on behalf of America's veterans, and we will work with you to find answers that our mentally wounded warriors desperately need. I would be pleased to answer any questions you may have.

MATERIAL SUBMITTED FOR THE RECORD

Department of Veterans Affairs
Under Secretary for Health
Washington, DC.

In Reply Refer To:

Dear Veteran,

If you're experiencing an emotional crisis and need to talk with a trained VA professional, the **National Suicide Prevention toll-free hotline number, 1-800-273-TALK (8255)**, is now available 24 hours a day, seven days a week. You will be immediately connected with a qualified and caring provider who can help.

Here are some suicide warning signs:

1. Threatening to hurt or kill yourself.
2. Looking for ways to kill yourself.
3. Seeking access to pills, weapons or other self destructive behavior.
4. Talking about death, dying or suicide.

The presence of these signs requires immediate attention. If you or a veteran you care about has been showing any of these signs, do not hesitate to call and ask for help!

Additional warning signs may include:

1. Hopelessness.
2. Rage, anger, seeking revenge.
3. Acting reckless or engaging in risky activities, seemingly without thinking.
4. Increasing alcohol or drug abuse.
5. Feeling trapped—like there's no way out.
6. Withdrawing from friends and family.
7. Anxiety, agitation, inability to sleep—or, excessive sleepiness.
8. Dramatic mood swings.
9. Feeling there is no reason for living, no sense of purpose in life.

Please call the **toll-free hotline number, 1-800-273-TALK (8255)** if you experience any of these warning signs. We'll get you the help and assistance you need right away!

Sincerely yours,

Michael J. Kussman, M.D., M.S., MACP

VA Suicide Crisis Hotline (1-800-273-TALK)**Who Should Call?**

- Anyone, but especially those who feel sad, hopeless, or suicidal.
- Family and friends who are concerned about a loved one who may be having these feelings.
- Anyone interested in suicide prevention, treatment and service.

1-800-273-TALK

- The service is free and confidential.
- The hotline is staffed by trained counselors.
- We are available 24 hours a day, 7 days a week.
- We have information about support services that can help you.

Crisis Response Plan

When thinking about suicide, I agree to do the following:

Step 1: Try to identify my thoughts and specifically what's upsetting me.

Step 2: Write out and review more reasonable responses to my suicidal thoughts.

Step 3: Do things that help me feel better for about 30 min (e.g., taking a bath, listening to music, going for a walk).

Step 4: If your suicidal thoughts persist, call **1-800-273-TALK**

Step 5: If the thoughts continue, get specific, and I find myself preparing to do something, call **911**.

Step 6: If I'm still feeling suicidal and don't feel like I can control my behavior, I go to the emergency room.

REMEMBER: The VA Suicide Hot Line is 1-800-273-TALK.

Get Mental Health Follow-up 1-202-745-8267 for an APPOINTMENT.

We Care!
We Want To Help!
We Can Help!

*Pick up the phone
if you are experiencing an
emotional crisis and need
to talk to a trained VA
professional.*



**You'll be immediately
connected with a
qualified caring
provider who can help.**



**Suicide
Prevention**

**MEN & WOMEN
VETERANS**

**KNOW THE
WARNING
SIGNS
OF SUICIDE**

VETERANS:

Call the National Suicide toll-free
hot-line number

1-800-273-TALK (8255)

1-800-273-TALK (8255)

Call the National Suicide toll-free
hot-line number

1-800-273-TALK (8255)

18-10-206

83218
587287



Department of
Veterans Affairs

Did you know... Returning veterans may be at a higher risk of suicide?

All veterans including you are our #1 priority!

VA Cares About You.

Recognize the Suicide Warning Signs

- Thinking about hurting or killing yourself
- Looking for ways to kill yourself
- Talking about death, dying or suicide
- Self-destructive behavior such as drug abuse, weapons, etc.

The presence of these signs requires immediate attention.

Don't wait

Call
1-800-273-TALK (8255)

Call
1-800-273-TALK (8255)

Immediately!

Additional warning signs may include

- Hopelessness, feeling like there's no way out
- Anxiety, agitation, sleeplessness, mood swings
- Feeling like there is no reason to live
- Rage or anger
- Engaging in risky activities without thinking
- Increasing alcohol or drug abuse
- Withdrawing from family and friends

Call us if you experience any of these warning signs.

Don't delay

Call
1-800-273-TALK (8255)

POST-HEARING QUESTIONS AND RESPONSES FOR THE RECORD

Committee on Veterans' Affairs
Washington, DC.
December 14, 2007

Honorable Gordon H. Mansfield
Acting Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

In reference to our Full Committee hearing on "Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs" on December 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 28, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all full committee and subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

Questions for the Record
The Honorable Bob Filner, Chairman
House Veterans' Affairs Committee
December 12, 2007

Stopping Suicides: Mental Health Challenges
Within the Department of Veterans Affairs

For Ira Katz, M.D., Ph.D.

Question 1: The Walter Reed Institute of Research recently published a study assessing mental health problems among veterans returning from Iraq, which found that 42.4 percent of National Guard and Reserve-component soldiers screened by the Department of Defense required mental health treatment. Given the very real risk of chronic health problems and even suicide among this population, we cannot afford a business-as-usual approach. What has VA done to provide needed mental health treatment to these servicemembers?

Response: The Department of Veterans Affairs (VA) has expanded its mental health programs dramatically since the start of the current conflicts. Mental health expenditures in medical centers and clinics increased from approximately \$2 billion in fiscal year (FY) 2001 to over \$3 billion in FY 2007. The Veterans Health Administration (VHA) developed its Comprehensive Mental Health Strategic Plan in 2004, and, by the end of FY 2008, it will have spent over \$1 billion in its implementation, including hiring over 3,600 new staff to support specific programs. VA has established over 90 Operation Enduring Freedom/Operation Iraqi Freedom (OEF/OIF) teams to establish post-deployment clinics in medical centers and to provide outreach and education in the community.

In addition to the OEF/OIF teams, new initiatives have included improvements in access and capacity for mental health services throughout our system, integration of mental health services with primary care in over 100 facilities, transformation of specialty mental health services to focus on rehabilitation and recovery, implementation of evidence-based practices focused on specific psychotherapies, and establishment of a comprehensive national program for suicide prevention.

In addition, VA has hired 100 peer staff for its Readjustment Counseling Service (Vet Centers) to provide outreach to returning veterans, and is in the process of expanding their staff and increasing the number of Vet Centers from 209 to 232.

For returning veterans, VA provides outreach by sending staff to all post deployment health reassessments (PDHRA) and by providing education in Guard, Reserve,

and community settings. We aggressively encourage enrollment through the five-year post discharge period of enhanced enrollment opportunity for all returning veterans who served in the theater of operations whether or not these veterans require medical services at the time. Once veterans are enrolled, we provide screening for post traumatic stress disorder (PTSD), depression, problem drinking, and traumatic brain injury (TBI), and clinical evaluations of those who screen positive to support diagnosis and treatment planning.

Question 2: What additional authority do you need from us to assist you in addressing the mental health issues of today?

Response: VA strongly supported an extension to the post two-year enhanced enrollment opportunity for returning veterans who have service in the theater of operations. We are most pleased that the recently passed National Defense Authorization Act of Fiscal Year 2008 provided this by extending the enrollment timeframe to five years post discharge.

Public information campaigns can serve a number of goals including increasing awareness of the symptoms of warning signs of mental health problems, destigmatizing mental health concerns and help-seeking, and providing information about the availability and effectiveness of mental health services in VA medical centers, clinics, and Vet Centers. The tools available to VA in public information campaigns include press releases, public service announcements, and outreach through community events. These effective mechanisms can all be continued, and, in fact, extended within existing statutory authority.

Question 3: What is VA currently doing and what more could they be doing to reach out to veterans who are at risk for suicide and are not currently being seen within the VA healthcare system?

Response: VA provides outreach to returning veterans through participation in PDHRA events, through activities of 100 OEF/OIF peer support specialists hired by Vet Centers, and through community-based outreach activities of staff from both Vet Centers and medical centers or clinics. One important type of outreach is through publicity for the 1-800-273-TALK hotline. Through this program, a number of veterans have been referred to local facilities where suicide prevention coordinators have helped them enroll in VHA. Another type of outreach is "guide" training from suicide prevention coordinators in medical centers. Through this program, the coordinators educate members of the community who have contact with veterans about symptoms of mental health conditions, warning signs and risk factors for suicide, and procedures for guiding veterans toward care.

An important additional activity that is currently under development is collaboration with the Department of Defense (DoD) on follow-up for those who screen positive on post deployment health assessments (PDHA) or PDHRA assessments. There is, by now, good evidence that these programs allow the identification of returning veterans with symptoms of mental health conditions, and that they support referrals for those with mental health problems. However, it would be helpful to provide further follow-up to ensure that those veterans most in need were, in fact, receiving care. Providing follow-up to those who report symptoms could help to ensure that they receive effective treatment.

Question 4: VA has recently expanded their suicide prevention activities to include suicide prevention coordinators at each facility as well as a 1-800 hotline. Could you give us a brief assessment on the effectiveness of the program? How are you tracking the effectiveness of the program?

Response: VA's comprehensive program for suicide prevention includes increased public awareness of the importance of mental health conditions, and both the availability and effectiveness of treatment; overall enhancements in the capacity and scope of mental health service; centers of excellence for research and technical assistance; and a specific prevention system including both the 1-800-273-TALK hotline, and suicide prevention coordinators in each medical center.

The most significant way to evaluate the effectiveness of the program will be to follow suicide rates among veterans receiving VA healthcare, the entire Nation's veteran population, and the population at large. Rates are currently being evaluated and will continue to be monitored in the future. Data on mortality and causes of death for veterans using medical centers and clinics are available by merging VA clinical and administrative records with data obtained from the Center for Disease Control and Prevention's (CDC) National Death Index; on suicide rates in the entire veteran population in a subset of States are available through the CDC's National

Violent Death Reporting System; and data on suicide rates for the U.S. population are available through the National Center for Health Statistics. Although no “gold standard” is available for evaluating the effectiveness of a suicide prevention program, the Air Force’s program may serve as a benchmark. It was viewed as successful when several years of operation led to a reduction in suicide rates by one-third.

There are also a number of methods that we are using to evaluate the prevention system made up of the hotline and the suicide prevention coordinators. These include tracking the calls to the hotline, referrals to the coordinators, and subsequent care. In addition, VA has developed procedures that allow the coordinators to identify individuals at high risk for suicide and to track suicide attempts. Therefore, other ways to evaluate the impact of further developments in our system would be to follow rates of suicide attempts and deaths from suicide among high risk patients.

Question 5: VA recently put out a press release stating that it is “accelerating its own research to prevent these tragedies.” Could you tell us what these activities involve?

Response: VA has a significant infrastructure for the conduct of research on mental disorders and their treatment. This includes 10 mental illness research, education, and clinical centers (MIRECCs), the seven divisions of the National Center for PTSD, a Center of Excellence of Integrated Care and three on mental illness and PTSD, two centers of excellence on substance abuse treatment and education, and two quality enhancement research initiatives, one on mental health, and one on substance use disorders, as well as a robust program supporting investigator initiated research. The MIRECC at Denver and the Center of Excellence in Mental Health and PTSD at Canandaigua, New York, focus specifically on suicide prevention.

Ongoing studies are addressing suicide risk factors, validation of suicide ideation screening instruments, structure/quality of mental healthcare and its relationship to suicide prevention, and risk factors for suicide as it relates to depression. Findings from two major studies were presented at the House Veterans’ Affairs Committee hearing on December 12, 2007. One, conducted by VA’s Office of Environmental Epidemiology, is an investigation of mortality and causes of death in returning OEF/OIF veterans. Another, conducted by VA’s Serious Mental Illness Research Education and Clinical Center, is studying rates of suicide, risk factors, and local variability throughout the system. Research under development by the Center of Excellence at Canandaigua include clinical trials on the effectiveness of peer support for suicide prevention, and psychological autopsy studies involving linkages of VA medical centers with local coroners or medical examiners.

VA plans to support several additional research programs and activities aimed at reducing and preventing suicide, including new research solicitations and a periodic update of a literature synthesis of best practices for suicide prevention.

A new research solicitation will be issued shortly seeking studies to validate screening instruments and to identify successful strategies and interventions for suicide prevention. Of special interest in this solicitation are efforts to: improve the continuum of care for substance use disorders, improve earlier identification and treatment of post-traumatic stress disorders, and implement recovery-oriented treatment approaches, particularly evidence-based programs and peer support services.

Examples of specific future research topics include:

- Evaluating strategies to improve earlier identification and treatment of PTSD and related mental health disorders (e.g., substance use and depression), especially in returning OEF/OIF veterans.
- Identifying risk factors and accuracy of assessment of suicidality and evaluating best practices for suicide prevention. Research on these topics will consider the suicide risks of veterans who are experiencing PTSD, especially among OEF/OIF and elderly veterans.
- Investigating the effectiveness of evidence-based recovery-oriented approaches to mental health treatment, such as cognitive-behavioral treatments, family psycho-education, supported employment, and social skills training.
- Assessing symptomatic as well as functional changes in patients.
- Evaluating evidence-based treatment strategies within the context of co-morbid social and medical issues.
- Comparing strategies used in mental health services for implementing recovery-oriented treatment programs.
- Assessing outcomes at the patient, provider, and system levels.
- Assessing the effectiveness of peer-support programs in supporting recovery and community reintegration in veterans with mental illness.
- Determining the appropriate mix and organization of services (e.g., detoxification, inpatient, residential, intensive outpatient, outpatient, psychosocial, and

pharmacological) that will ensure access to the full continuum of care for patients with substance use disorders and varying life circumstances and co-occurring conditions.

- Evaluating methods of enhancing the integration and coordination of mental health services with substance abuse or medical (primary care and specialty) services, including the organization and management of services for patients with these co-morbid conditions.
- Improving the effectiveness and efficiency of behavioral health screens in VA's healthcare system.

Question 6: Research has shown that the family is instrumental in the recovery of veterans with mental health concerns. Family members are affected by the mental health issues, as you heard in previous testimony from Mr. Bowman. Currently, VA's authority to provide mental health services to veterans receiving readjustment counseling services under section 1712 A of Title 38, United States Code, is limited to mental health services that are necessary to facilitate the successful readjustment of a veteran to civilian life and limited to the provision of counseling, training, and mental health services described in 38 USC 1782 and 1783 (bereavement counseling) for the veterans immediate family. If eligibility to receive services were expanded for family members, what, in your professional opinion, would be the proper scope of these services?

Response: Vet Centers are authorized to include families in readjustment counseling for combat veterans, and to provide bereavement counseling for families of fallen warriors. Family members also receive the services described in section 1782 (i.e., counseling, training, and certain mental health services) when needed for the effective readjustment of the veteran. Those same services are available to immediate family members of veterans receiving VA medical treatment when needed in connection with the veteran's treatment. Under current authorization, these services can begin at any time for veterans being treated for a service-connected disability, but it can begin only during an inpatient hospitalization for others (i.e., for treatment of a nonservice-connected disability). Both Vet Centers and medical facilities can include families in outreach and education, including education programs for veterans with serious mental illness. One modest extension to current authorization, included in S. 2162 and H.R. 4053, would be to allow the inclusion of families in care for veterans to begin whenever it is clinically appropriate, both for veterans with service-connected disability and others.

Further consideration of caregiver support demonstrates a problem in defining an appropriate scope for the services that can be provided to families. For veterans with significant impairments in day-to-day functioning, family caregivers are often essential. Providing family members with caregiver effectiveness training, or counseling to reduce burn-out are appropriate services, with clear benefits for the veteran. Treating caregiver depression could also benefit the veteran, allowing a family caregiver to providing more effective support. However, this is not currently authorized. It is possible to view psychotherapy for depression as similar to counseling for burnout, and to make the case that it should be allowable. However, it is less clear if prescribing antidepressant medication should be allowable, or blood tests for thyroid disease to determine if there were medical causes for the depression, or changing medications for other conditions to reduce depression as a possible drug side-effect, or . . . The point is that there may be no obvious boundary between support for the family as part of care for the veteran, limited care for a caregiver, and overall healthcare for family members. VA is currently addressing this issue through workgroups and funding of pilot studies on caregiver support.

There is, however, one area in which additional authorization may help VA provide more effective outreach to returning veterans by working with their families. There are cases, like the Omvig's, where families may be concerned about mental health problems, but where the veteran may not be willing to seek an evaluation or care. In these cases, it may be useful for VA to be able to meet with families to evaluate the situation and determine whether there is likely to be a mental disorder that requires treatment, to provide education and coaching to the family about how to manage problem behaviors, and to work with the family to develop a strategy to encourage the veteran to seek care. Much of this is being accomplished through programs for education and outreach using existing legislative authority. However, additional authorization may allow more intensive interactions between VA staff and families.

For Kara Zivin, Ph.D.

Question 1: In your testimony, you talked a lot about research that VA is currently doing on mental illness and suicide. In your professional opinion, what are the gaps in the current research in these areas, particularly in how they relate to veterans? What more research should VA be doing in these areas?

Response: VA has the unique opportunity not only to attempt to reduce suicide rates among veterans, but also to learn what suicide prevention strategies are effective, so that effective rather than ineffective strategies can be used for veterans and the U.S. population, and by doing so has the potential to advance the science of suicide prevention. VA is the only healthcare organization that regularly tracks suicide rates, is highly organized, and treats a large enough population so the effectiveness of prevention strategies can be determined.

VA is currently making a tremendous effort to prevent suicide. There are new and ongoing programs such as those located at the Veterans Integrated Service Networks (VISN) 2 Center of Excellence in Canandaigua, New York, which encompasses the national VA hotline/crisis line active monitoring of suicide prevention initiatives (SPI) and extensions of suicide research and education. Research is being implemented to examine the hotline's suicide outcomes and the health impact including treatment engagement and healthcare utilization. The SPI relate to a series of efforts that are unfolding, such as implementing suicide prevention coordinators at all VA medical centers, cognitive behavioral therapy among high risk inpatients, screening efforts pre- and post-deployment, among others. Finally, the Canandaigua Center of Excellence is designed to develop new knowledge regarding suicide prevention, and is currently focusing on older adults, women, people with alcohol problems, and now developing new efforts to engage returning OEF/OIF veterans.

In addition to specific initiatives, the VA's Serious Mental Illness Treatment Research and Evaluation Center (SMITREC) in Ann Arbor, Michigan, is pursuing major research program and planning around suicide prevention. Research and research infrastructure are needed across the board, and VA's efforts to promote collaboration across VISN boundaries in a coordinated way, and capitalizing on expertise in its centers of excellence and MIRECCs is well conceived. It is important for VA to conduct ongoing evaluations of these suicide prevention programs to refine and improve their effectiveness.

In particular, we need to learn more about good surveillance tools to track changes over time in suicide attempt rates, or hot spots for intervention. We need to be able to identify risk factors, regional variation, differences in rates and characteristics associated with suicide between veterans treated in VA and veterans treated outside VA, as well as understanding more about veteran engagement in mental healthcare. Continued efforts are essential to educate veterans and their families about warning signs for suicide and educate providers on suicide prevention and assessment. We need to learn more about how to improve the means of suicide prevention as well as best practices following suicide attempts. VA is assessing the relative impact of specific treatment practices on suicide risks and relative risk periods for suicide deaths. VA should also evaluate the effectiveness of screening tools, treatment guidelines, incentives, and collaborative care models. Ideally VA researchers would assess the unique risk and protective factors of the cohort of interest and test interventions.

With newer cohorts of OEF and OIF veterans, studies of smaller groups of veterans could include the National Guard and as well as enlisted personnel to better understand their most vulnerable periods, key risk factors, and what treatments seem most effective. Families should be involved in this research to understand their perceptions of risk and how they can be of most support. Evaluation of family and patient satisfaction with VA care should be included in this research.

These efforts should be made in conjunction with VA's research program and other well known suicide prevention researchers, so that serious efforts to reduce suicide can be accompanied by solid research that allows Congress and the U.S. public to determine and use the most effective approaches.

These research efforts originating in VA will benefit both veterans and the general U.S. population, because there are few systematic studies of any U.S. individuals at risk for suicide over a period of time. Such research will help identify periods of vulnerability and helpful treatments that prevent suicide deaths or attempts, particularly among those who have experienced trauma. We know that restricted access to lethal means and physician education are effective treatments, as well as psychotherapy and medications for mental disorders such as depression and bipolar disorder.

Because the existing published research on suicide fatalities is limited, and conducting this form of research is difficult, VA is uniquely positioned to conduct this research and improve our understanding of how to best help veterans at risk for suicide.

**The Honorable Harry E. Mitchell
For Ira Katz, M.D., Ph.D.**

Question 1: All documents which contain, refer, or relate to requests by any providers of mental health services for veterans, including, but not limited to requests by providers in the Veterans Integrated Service Network (VISN) to the Veterans Health Administration (VHA) for additional resources which were denied, or responded to with less than the amount of resources requested, where such resources would have been used for any of the following:

1. The collection of information relating to veterans at risk for suicide;
2. The tracking of suicides committed by veterans, including, but not limited to veterans who have sought assistance from VA;
3. Outreach to veterans who are or may be at risk of suicide;
4. Outreach to families of veterans relating to suicide prevention and/or benefits for families of veterans who have committed suicide; and
5. Research into the causes of suicide and/or treatment for depression, post-traumatic stress disorder or any other diagnosable condition which may increase the risk of suicide among veterans.

Response: During FY 2007, \$306 million was allocated to the Mental Health Enhancement Initiative administered by Office of Mental Health Services to fund specific programs designed to advance the implementation of the Mental Health Strategic Plan and to respond to the needs of returning veterans. By the end of the year, substantially over \$320 million was, in fact awarded. At the beginning of FY 2007, overall mental health expenditures for the year were estimated to be over \$2.8 billion. By the end of the year, over \$3.2 billion was spent. For FY 2008, approximately \$370 million was allocated for the Mental Health Enhancement Initiative. All of this was committed for continuation of programs initiated in prior years. Based on current projections, a substantial increase in enhancement funding is anticipated for next year. The Office of Mental Health Services is currently developing plans for use of these funds to establish a uniform services package for mental health. Last year, \$120 million was appropriated in emergency supplemental funding for mental health and substance abuse. These funds are still being allocated and a number of requests for funding are under consideration at this time.

In general, requests for funding may come from providers or investigators to medical centers, centers of excellence, VISNs, or any of a number of offices in VA Central Office. Most of VA's research on mental disorders and their treatment is funded through investigator initiated grant proposals submitted to the Office of Research and Development. I am not personally aware of all requests to entities and offices other than the Office of Mental Health Services. But as Deputy Chief Patient Care Services Officer for Mental Health and Director of the Office of Mental Health Services, I am not aware of any proposals for programs in any of the above categories for which funding was denied.

Congress of the United States
U.S. House of Representatives
Washington, DC.
February 8, 2008

The Honorable James Peake, M.D.
Secretary
Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Mr. Secretary:

I am seriously concerned about the response I received today, more than a week after it was due, to my document request relating to the House Veterans' Affairs Committee's hearing on December 12, 2007.

I asked for documents referring or relating to any requests for additional resources to track veteran suicides and/or provide mental health services for veterans at risk for suicide.

Instead of documents, I received a response from Deputy Chief of Patient Care Services for Mental Health Ira Katz stating that he was “not aware” of “proposals for any new programs . . . for which funding was denied.”

I specifically asked for documents relating to “requests . . . for additional resources,” not just “proposals for new programs,” nor did I request a recap of how much funding Congress appropriated to the Mental Health Enhancement Initiative in FY 2007.

I believe the response I received is incomplete.

If, for example, Dr. Katz is aware of any requests for additional mental health counselors, facilities or equipment, I would like to know. I would also appreciate an opportunity to review any related documentation.

I have an obligation as a member of the Committee on Veterans’ Affairs, and the Chairman of its Subcommittee on Oversight and Investigations, to help ensure that the Department of Veterans Affairs has the resources it needs to help veterans at risk for suicide.

I hope the urgency with which the VA has treated my request is not a reflection of the priority the VA assigns to this issue.

Enclosed are a copy of my request as well as the response I received.

I look forward to a complete response as soon as possible. If you have any questions, or require further clarification, please do not hesitate to contact me.

Thank you for your assistance.

Sincerely,

Harry E. Mitchell
Member of Congress

Enclosure (1)

Cc: The Honorable Bob Filner, Chairman, House Veterans’ Affairs Committee
David Tucker, Chief Counsel, House Veterans’ Affairs Committee

**The Honorable Harry E. Mitchell
For Ira Katz, M.D., Ph.D.**

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Response: During FY 2007, \$306 million was allocated to the Mental Health Enhancement Initiative administered by Office of Mental Health Services to fund specific programs designed to advance the implementation of the Mental Health Strategic Plan and to respond to the needs of returning veterans. By the end of the year, substantially over \$320 million was, in fact awarded. At the beginning of FY 2007, overall mental health expenditures for the year were estimated to be over \$2.8 billion. By the end of the year, over \$3.2 billion was spent. For FY 2008, approximately \$370 million was allocated for the Mental Health Enhancement Initiative. All of this was committed for continuation of programs initiated in prior years. Based on current projections, a substantial increase in enhancement funding is anticipated for next year. The Office of Mental Health Services is currently developing plans for use of these funds to establish a uniform services package for mental health. Last year, \$120 million was appropriated in emergency supplemental funding for mental health and substance abuse. These funds are still being allocated and a number of requests for funding are under consideration at this time.

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U.S. Department of Veterans Affairs
Washington, DC.
February 27, 2008

The Honorable Harry E. Mitchell
U.S. House of Representatives
Washington, DC 20515

Dear Congressman Mitchell:

This is in response to your recent letter asking for more information about requests for additional resources relating to veteran suicides. This question has been reviewed once more, and no unfunded requests from Department of Veterans Affairs (VA) facilities or staff for resources directly related to suicide prevention were identified.

Your more recent request for information about requests from the field for additional mental health counselors, facilities, or equipment beyond those specifically related to suicide prevention is more complex. In fiscal years 2005 through 2007, the Office of Mental Health Services issued a number of requests for proposals to enhance mental health programs. These proposals were competitively reviewed, and funding decisions were made at times on the basis of need, and at other times, on the basis of merit. The office also solicited requests for nonrecurring, maintenance funds for space-related needs that are being considered at this time.

As part of its ongoing activities, VA's Office of Research and Development regularly receives applications for research awards in mental health as well as other areas; these may include requests for mental health counselors or equipment to support specific research activities.

Finally, there are mental health components included in a number of ongoing evaluations about major renovations and construction for facilities. I would appreciate it if you could provide additional details about the type of information you require to guide us in preparing documents for your review.

I have been advised that my staff has contacted members of your staff to arrange a meeting to respond to any remaining questions or concerns. Thank you for your continued interest in our Nation's veterans.

Sincerely yours,

James B. Peake, M.D.
Secretary

Committee on Veterans' Affairs
Washington, DC.
December 14, 2007

John D. Daigh, Jr., M.D., CPA
Assistant Inspector General
Office of Healthcare Inspections
U.S. Department of Veterans Affairs
Washington, DC 20420

Dear John:

In reference to our Full Committee hearing on "Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs" on December 12, 2007, I would appreciate it if you could answer the enclosed hearing questions by the close of business on January 28, 2008.

In an effort to reduce printing costs, the Committee on Veterans' Affairs, in cooperation with the Joint Committee on Printing, is implementing some formatting changes for materials for all Full Committee and Subcommittee hearings. Therefore, it would be appreciated if you could provide your answers consecutively and single-spaced. In addition, please restate the question in its entirety before the answer.

Due to the delay in receiving mail, please provide your response to Debbie Smith by fax at 202-225-2034. If you have any questions, please call 202-225-9756.

Sincerely,

BOB FILNER
Chairman

U.S. Department of Veterans Affairs
Office of Inspector General
Washington, DC.
January 24, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
United States House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed are responses to questions from the December 12, 2007, hearing before the Committee on "Stopping Suicides: Mental Health Challenges Within the Department of Veterans Affairs."

Thank you for your interest in the Department of Veterans Affairs.

Sincerely,

JOHN D. DAIGH, JR., M.D.
Assistant Inspector General for Healthcare Inspections

Enclosure

**Questions from the Honorable Bob Filner
For Michael Shepherd, M.D.
Physician, Office of Healthcare Inspections
Office of Inspector General, U.S. Department of Veterans Affairs
Before the Committee on Veterans' Affairs Hearing
"Stopping Suicides: Mental Health Challenges
Within the Department of Veterans Affairs"
December 12, 2007**

1. In your testimony you stress the need for a comprehensive suicide prevention program.

• What is your assessment of the VA's suicide prevention program?

In our report, *Implementing VHA's Mental Health Strategic Plan (MHSP) Initiatives for Suicide Prevention*, the extent of implementation was assessed along a spectrum of five stages: no action; in planning; evidence of ongoing or completed pilot or demonstration projects; implemented throughout an entire Veteran Integrated Service Network (VISN) or multiple facilities in multiple VISNs (VISN-wide); and systemwide implementation.

Our findings can be summarized as follows: In terms of crisis availability and outreach, we found VISN-wide but not systemwide implementation. Initiatives related to referral and tracking of at-risk veterans were also at a VISN-wide stage. Those related to screening, assessment of at-risk veterans, emerging best practice interventions, education, and development of an electronic suicide surveillance system were at a pilot stage. Because the VISN 19 Mental Illness, Education, Clinical Center (MIRECC) is operational and has evidenced significant collaboration with other MIRECC's, the MHSP initiative pertaining to research (support for a MIRECC focused on suicide prevention) was assessed as having achieved a systemwide level of implementation.

- **In your estimation, what changes does VA need to make in ensuring an effective suicide prevention program as well as a comprehensive one?**

Whereas a public health approach has been applied to prevention of coronary artery disease (lowering cholesterol, aerobic exercise) or certain forms of cancer (smoking cessation) for more than a quarter century, approaching suicide prevention from a public health paradigm is a relatively recent development. Just as strategies to prevent lung cancer may differ from strategies to prevent cervical cancer, interventions that target a depressed elderly man with early cognitive impairment may differ from interventions that target a young returning veteran with post traumatic stress disorder (PTSD) and co-morbid alcohol use. Suicide prevention is thought to require integrated strategies, coordinated effort, and steadfast commitment to forward progress. In terms of changes VA could make, we would offer the following observations:

Community-Based Outreach—In our report, we noted that while several facilities had implemented innovative community-based suicide prevention outreach programs, (e.g., facility presentations to New York Police Department officers who are Operation Iraqi Freedom/Operation Enduring Freedom (OIF/OEF) veterans, participation by mental health staff in local Spanish radio and television shows) the majority of facilities did not report community-based linkages and outreach aimed at suicide prevention. In addition, less than 20 percent of facilities reported utilizing the Chaplain Service for liaison and outreach to faith-based organizations in the community (e.g., inviting faith-based organizations in the area to a community meeting at the VA Medical Center (VAMC) to explain Veteran Health Administration (VHA) services available, having a VA Chaplain accompany the OIF/OEF coordinator to post-deployment events in the community). Although facilities would need to tailor strategies to consider local demographics and resources, a systemwide effort at community-based outreach appears prudent.

Timeliness from Referral to Mental Health Evaluation—In our report we noted that while most facilities self-reported that three-fourths or more of those patients with a moderate level of depression or PTSD who are referred by primary care providers are seen within 2 weeks of referral, approximately 5 percent reported a significant 4–8 week wait. These patients are at risk for progression of symptom severity and possible development of suicidal ideation. VISN leadership should work with facility directors to ensure that once referred, patients with a moderate level of depression or PTSD symptoms are seen in a timely manner at any VAMC and Community-Based Outpatient Clinic (CBOC) where significant waits are an issue.

Coordination between VHA and Non-VHA Providers—When patients receive mental health treatment at both VHA and non-VHA providers and facilities, seamless communication becomes an increasingly complex challenge. This fragmentation of care is particularly worrisome in periods of patient destabilization or following discharge from a hospital or residential mental health program. The Office of Mental Health Services should consider development of innovative methods, procedures, or agreements, that improve flow of information for patients receiving simultaneous treatment at VA and non-VA sector but adhere to relevant privacy statutes. In addition, the Readjustment Counseling Service and Office of Patient Care Service should pursue further efforts to heighten communication and record sharing for patients receiving both counseling at Vet Centers and treatment at VAMCs and/or affiliated CBOCs.

Co-Occurring Combat Stress Related Illness and Substance Use—Alcohol may contribute to the severity of a concurrent or underlying mental health condition such as major depression. In addition, the presence of alcohol may cause or exacerbate impulsivity and disinhibited behavior. Acute alcohol use is associated with suicide and suicide completers have high rates of elevated blood alcohol. A recent study published in the *Journal of the American Medical Association (JAMA)*, *Longitudinal Assessment of Mental Health Problems Among Active and Reserve Component Soldiers Returning from the Iraq War*, in which Milliken et al., found that soldiers frequently reported alcohol concerns on the Post Deployment Health Assessment and Reassessments (PDHA and PDHRA) “yet very few were referred to alcohol treatment.” Alcohol misuse has been a common factor in OIF/OEF suicide cases that we have reviewed.

Regardless of why a patient begins to abuse alcohol, physiologic and psychologic drives become entrained with frequent and/or excessive use, until the alcohol misuse ultimately takes on a life of its own that is independent of patient history and circumstance. Functional ability and quality of life become dually impacted by both un-

derlying anxiety and depressive symptoms and co-morbid substance use issues. For patients with concurrent conditions, an effective treatment paradigm may entail addressing the primacy of not only anxiety/depressive conditions but also of co-morbid substance use disorders. Augmenting services that address substance use disorders co-morbid with combat stress related illness should therefore be given due consideration for inclusion in a program aimed at suicide prevention.

2. In your professional opinion, does VA have the resources to implement an effective program?

The Office of Inspector General has not reviewed VHA's resources and we cannot offer an opinion.

3. In your report you made a number of recommendations about steps that VHA should undertake.

• Are there any that you believe VHA has not yet undertaken?

While the VA has begun action on the recommendations in our report, the following have not been completed:

Education of Nonclinical Staff—Subsequent to the OIG report, the VAMC Canandaigua Center of Excellence has developed a CD and guide for mandatory training of all VA nonclinical staff who interact with veterans about responding to crisis situations involving at-risk veterans. However, the process of actually disseminating training to first line nonclinical personnel is only just beginning.

Education for Healthcare Providers—Implementation of a mandatory education program for healthcare providers about suicide risks and ways to address these risks is reportedly in the planning stages but has not yet been developed.

Bi-Directional Information Exchange—Bi-directional exchange of health information between VA and the Department of Defense (DoD), which includes patients with mental health issues coming into VHA care from DoD and/or those leaving VHA care for re-deployment, is an unresolved issue that has been discussed at previous hearings including the House Committee on Veteran's Affairs October 24, 2007, hearing "Sharing of Electronic Medical Records between Department of Defense and Department of Veterans Affairs."

Establishing a Coordinated Mechanism for Implementing Emerging Best Practices—We recommended that VHA should establish a centralized mechanism to review ongoing suicide prevention strategies, to select among available emerging best practices for screening, assessment, treatment, and to facilitate systemwide implementation, in order to ensure a single VHA standard. The VA Center of Excellence's structural and philosophic organization aligns with the intent of this recommendation. The center's capacity, in actual practice, to evaluate, select, and facilitate systemwide implementation of emerging best practices will only become discernible over time.

4. I know you are aware of the report by CBS that the rate of suicide among veterans aged 20 to 24 is several times the rate among the same age group in the general population.

• Do you know whether CBS's numbers are accurate?

In the absence of underlying data from CBS, which we were unable to obtain, we cannot reliably comment on the accuracy of CBS's numbers.

5. Have you been able to obtain the underlying data from CBS so you can determine whether CBS's numbers are correct? If not, why not?

We requested the underlying data but were not able to obtain it. CBS informed us that they could not provide the data to us because of contractual arrangements and privacy protection agreements that CBS had made with various State vital statistic offices from which it had received the data.

6. What are the data that one would need to determine the rate of suicide among veterans as compared to the general population?

One would need to reliably determine who died by suicide, who is a U.S. veteran, and the number of general population at risk. If an electronic death certificate system were created that had a field for inputting cause of death; fields for salient epidemiologic factors; allowed for input from multiple sources including medical exam-

iners, a decedent's physician, police reports, etc.; and was standardized across States, one might ascertain more accurate and timely data regarding who and how many have died by suicide. In addition, from a public health perspective, an electronic death certificate system could enhance epidemiologic analysis of other causes of mortality. This data could be matched to existing data bases of qualified U.S. veterans to determine a rate of suicide among more recent veterans. We are not aware of the existence of a reliable electronic database that would include qualified U.S. veterans who separated prior to 1973–74. Determining the number of veterans who separated before the mid-1970's and also the total number of veterans in the U.S. would therefore require merging of various databases combined with the use of estimative models.

7. Do you know whether the VA in fact collects the necessary data to be able to determine suicide rates among veterans and to compare those rates to the general population?

VHA does not collect data that would enable calculation of a suicide rate for all U.S. veterans or that would enable comparison to nonveterans on a national basis. VHA collects data to determine suicide rates among veterans who receive healthcare at VHA facilities, a population that can be accurately quantified using VHA databases.

For 12 of the 17 States that participate in the National Violent Death Reporting System, VHA reported having indirectly calculated suicide rates among nonveterans in these States by subtracting veteran suicide rates from the rates for the general population. The derived nature of this calculation imposes limitations on the reliability of this measurement.

Committee on Veterans' Affairs
Washington, DC.
December 21, 2007

The Honorable James B. Peake, M.D.
Secretary
U.S. Department of Veterans Affairs
810 Vermont Avenue, NW
Washington, DC 20420

Dear Secretary Peake:

On December 12, 2007, the House Committee on Veterans' Affairs held a hearing to assess the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. This hearing raised concerns regarding the discrepancy between the numbers of veteran suicides reported by VA as compared to those reported by *CBS News* on November 13, 2007.

Accurate data is crucial in identifying risk factors and providing better treatment and suicide prevention programs. For this reason, we respectfully request that the Department of Veterans Affairs share their data on suicide among veterans with the Committee.

Specifically, we request to have the number of veteran suicides for each year from 1995 through 2006, reported by year of death, age, race, gender and manner of suicide. Additionally, we ask for the methodology the Department uses to collect data on veteran suicides.

Undoubtedly, you share our desire to ensure that every measure is taken to prevent our Nation's veterans from committing suicide. We would greatly appreciate your willingness to share any information you may have regarding this issue with the Committee.

Thank you for your prompt consideration and attention to this request. Should you have any questions, please feel free to contact either Committee Staff Director, Malcom Shorter, at 202–225–9756 or Republican Staff Director, Jim Lariviere, at 202–225–3527.

Sincerely,

Bob Filner
Chairman

Steve Buyer
Ranking Member

The Secretary of Veterans Affairs
Washington, DC.
February 5, 2008

The Honorable Bob Filner
Chairman
Committee on Veterans' Affairs
U.S. House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

This is in response to your letter requesting data on suicide rates among veterans and the methodologies used by the Department of Veterans Affairs (VA) to collect data on veteran suicides.

The enclosed information and worksheet contains data on veteran suicides from two separate projects. One is an ongoing study of mortality in Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF) veterans being conducted by VA's Office of Environmental Epidemiology. Identification of veterans is based on information from the Department of Defense and includes all OEF/OIF servicemembers who were separated from active duty including National Guard and Reserve personnel. The second project is an ongoing study of suicide in veterans who have used Veterans Health Administration services from 2000 onward and who were alive at the start of 2001. The study includes veterans of all eras.

For both projects, information about the time and causes of death was derived from the National Death Index. Information contained in data files on causes of death from the National Death Index is only available through the end of 2005. I have also enclosed the methodology used for both projects.

Your interest in our Nation's veterans is appreciated. A similar letter is being sent to Congressman Steve Buyer.

Sincerely yours,

James B. Peake, M.D.

Enclosures

Study of Operation Enduring Freedom/Operation Iraqi Freedom Veterans Methodology

Population: As part of our mortality study of veterans who served in Operation Enduring Freedom (OEF) or Operation Iraqi Freedom (OIF), the Department of Veterans Affairs (VA) obtained the identities of 490,346 OEF/OIF veterans who served as part of either OEF or OIF and were separated or deactivated from military service between October 2001 and December 2005. This study will assess both overall mortality risk as well as cause-specific mortality risk. Among the cause specific mortality of particular interest are deaths due to motor vehicle accidents and suicides.

Data Sources: The identities of the 490,346 OEF/OIF veterans, military service characteristics, and various demographic data were provided to VA by the Department of Defense Manpower Data Center. Vital statistics data pertaining to OEF/OIF veterans was determined by using VA's database, Beneficiary Identification and Records Locator Subsystem, and deaths reported to the Social Security Administration Death Master File. The Beneficiary Identification and Records Locator Subsystem file has the identities of all veterans who have applied for VA benefits (including death benefits), and the Social Security Administration Death Master File includes all deaths reported to that agency. All veterans were matched against the Beneficiary Identification and Records Locator Subsystem and Social Security Administration files using Social Security numbers. Cause of death data was obtained from the National Death Index. Since 1979, the Office of Vital Statistics in each State has reported deaths, including cause of death data to the National Center for Health Statistics, where the National Death Index is compiled. Causes of death were recorded using International Classification of Diseases codes 10th Revision (ICD-10). For traumatic deaths, including suicide, part of the ICD-10 codes records the method of injury. For suicides, the ICD-10 codes report the method of suicide. At the time this study began, the National Death Index had cause of death data through December 31, 2005. Using the aforementioned databases, VA identified a total of 818 deaths to include 144 suicides.

The attached table has demographic and military service characteristics as well as death certificate data and method of suicide for the 144 suicides identified in this study.

**CHARACTERISTICS OF 144 SUICIDES AMONG
OEF/OIF* VETERANS THROUGH 2005**

Characteristic	Frequency	Percentage
Age at death		
20–29	78	54.1
30–39	39	27.1
40–49	14	9.7
50–59	13	9.1
Year of death		
2002	7	4.9
2003	21	14.6
2004	48	33.3
2005	68	47.2
Method of suicide		
Poisoning	7	4.9
Hanging	30	20.8
Firearm	105	72.9
Jumping	1	.7
Sharp Object	1	.7
Sex		
Male	141	97.9
Female	3	2.1
Race		
White	118	81.9
Non-White	26	18.1
Ever seen at VAMC		
Yes	33	22.9
Branch of service		
Army	73	50.7
Marines	15	10.4
Air Force	33	22.9
Navy	23	16.0
Rank		
Officer	8	5.6
Warrant Officer	1	0.7
Enlisted	135	93.7
Unit component		
Active	68	47.2
Reserve	35	24.3
National Guard	41	28.5

*These suicides were identified among a cohort of 490,346 OEF/OIF veterans selected for mortality follow-up through 2005.

Study of Veterans Using Veterans Health Administration

Methodology

Population: The Veterans Health Administration defined the population of VA patients at risk for suicide in each fiscal year as those who were alive at the start of the year, and who had received VA services during either that year or the prior one. This approach to identifying VA's patient population was developed in consultation with VA mental health leadership and assumes that patients seen in VA settings in the prior year would still be considered to be in active VA care and part of the at-risk patient population in the following year.

Data Sources: This study used data from VA's National Patient Care Database to identify all veterans with inpatient or outpatient services utilization in any VA facility during the relevant years. Measures of vital status and cause of death were based on information from the National Death Index. The National Death Index is considered the "gold standard" for mortality assessment information and includes national data regarding dates and causes of death for all U.S. residents. This information is derived from death certificates filed in the Office of Vital Statistics for each State. National Death Index searches were performed for cohorts of VA patients who received any VA services during the relevant years, and who had no subsequent VA services through June 2006. This cost-efficient method for conducting National Death Index searches enables comprehensive assessment of *vital* statistics and cause of death among all veterans in the VA patient population. The National Death Index data request included Social Security number, last name, first name, middle initial, date of birth, race and ethnicity, sex, and State of residence. National Death Index search results often include multiple records that are potential matches. "True matches" were identified based on established procedures.

Veterans' age and gender were identified from VA administrative files included in the National Patient Care Database. Age at the start of Fiscal Year 2001 was categorized as being either less than 30, 30 to 39, 40 to 49, 50 to 59, 60 to 69, 70 to 79, or greater than or equal to 80 years. Information regarding race and ethnicity was not consistently available in the National Patient Care Database for all VA patients. VA identified dates and causes of death using National Death Index data. Suicide deaths were identified using International Classification of Diseases codes X60 through X84, and Y87.0 (World Health Organization 2004).

VA is conducting a comprehensive program for preventing veteran suicides, and is conducting ongoing research to guide its prevention strategies. The VA Office of Mental Health staff is available to provide additional briefings to the Committee on rates, risks factors and strategies.

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005

Characteristic	FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
	N	%	N	%	N	%	N	%	N	%
Total *	1403	100	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over	1401	100	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Sex										
Male	1360	97.1	1682	97.0	1559	97.6	1647	96.8	1720	96.6
Female	41	2.9	52	3.0	39	2.4	54	3.2	61	3.4
Age Group										
20–29 yrs	26	1.9	44	2.5	38	2.4	50	2.9	38	2.1
30–39 yrs	108	7.7	119	6.9	111	6.9	105	6.2	105	5.9
40–49 yrs	240	17.1	283	16.3	272	17.0	256	15.0	254	14.3
50–59 yrs	359	25.6	437	25.2	407	25.5	424	24.9	470	26.4
60–69 yrs	202	14.4	261	15.1	264	16.5	272	16.0	291	16.3
70–79 yrs	320	22.8	393	22.7	345	21.6	381	22.4	380	21.3
80+ yrs	146	10.4	197	11.4	161	10.1	213	12.5	243	13.6
Race										
White Hispanic	30	2.1	25	1.4	32	2.0	24	1.4	29	1.6
Black Hispanic	2	0.1	1	0.1	1	0.1	2	0.1	2	0.1
Native American	2	0.1	6	0.3	3	0.2	2	0.1	7	0.4
African American	55	3.9	80	4.6	47	2.9	62	3.6	78	4.4
Asian/Pacific Islander	0	0.0	4	0.2	2	0.1	3	0.2	16	0.9
Caucasian	895	63.9	1078	62.2	894	55.9	814	47.9	1142	64.1
Unknown	417	29.8	540	31.1	619	38.7	794	46.7	507	28.5

*Includes age <20 years old.

Number of Suicides Among VHA Veterans for Fiscal Years 2001–2005

Characteristic		FY 2001		FY 2002		FY 2003		FY 2004		FY 2005	
		N	%	N	%	N	%	N	%	N	%
Total *		1403	100.0	1737	100.0	1600	100.0	1702	100.0	1784	100.0
Total, age 20 and over		1401	100.0	1734	100.0	1598	100.0	1701	100.0	1781	100.0
Mechanism of Suicide											
X60	Intentional self-poisoning (suicide) by and exposure to non-opioid analgesics, anti-pyretics, and anti-rheumatics.	5	0.4	4	0.2	8	0.5	5	0.3	12	0.7
X61	Intentional self-poisoning (suicide) by and exposure to antiepileptic, sedative-hypnotic anti-parkinsonism, and psychotropic drugs, not elsewhere classified.	39	2.8	49	2.8	38	2.4	43	2.5	53	3.0
X62	Intentional self-poisoning (suicide) by and exposure to narcotics and psychodysleptics (hallucinogens), not elsewhere classified.	26	1.9	42	2.4	30	1.9	27	1.6	48	2.7
X63	Intentional self-poisoning (suicide) by and exposure to other drugs acting on the autonomic nervous system.	1	0.1	3	0.2	1	0.1	0	0.0	2	0.1
X64	Intentional self-poisoning (suicide) by and exposure to other and unspecified drugs, medicaments, and biological substances.	100	7.1	97	5.6	103	6.4	112	6.6	102	5.7
X65	Intentional self-poisoning (suicide) by and exposure to alcohol.	2	0.1	2	0.1	5	0.3	0	0.0	1	0.1
X66	Intentional self-poisoning (suicide) by and exposure to organic solvents and halogenated hydrocarbons and their vapors.	2	0.1	3	0.2	1	0.1	6	0.4	3	0.2
X67	Intentional self-poisoning (suicide) by and exposure to other gases and vapors.	34	2.4	62	3.6	35	2.2	59	3.5	50	2.8
X68	Intentional self-poisoning (suicide) by and exposure to pesticides.	1	0.1	1	0.1	1	0.1	0	0.0	0	0.0
X69	Intentional self-poisoning (suicide) by and exposure to other and unspecified chemicals and noxious substances.	3	0.2	6	0.3	4	0.3	3	0.2	4	0.2
X70	Intentional self harm (suicide) by hanging, strangulation, and suffocation.	163	11.6	214	12.3	189	11.8	207	12.2	189	10.6
X71	Intentional self harm (suicide) by drowning and submersion.	17	1.2	19	1.1	12	0.8	10	0.6	15	0.8
X72	Intentional self harm (suicide) by handgun discharge.	192	13.7	248	14.3	255	16.0	227	13.3	277	15.6

X73	Intentional self harm (suicide) by rifle, shotgun, and larger firearm discharge.	145	10.3	174	10.0	150	9.4	171	10.1	170	9.5
X74	Intentional self harm (suicide) by other and unspecified firearm discharge.	566	40.4	726	41.9	675	42.2	728	42.8	758	42.6
X75	Intentional self harm (suicide) by explosive material.	0	0.0	0	0.0	0	0.0	0	0.0	2	0.1
X76	Intentional self harm (suicide) by smoke, fire, and flames.	6	0.4	4	0.2	6	0.4	14	0.8	12	0.7
X77	Intentional self harm (suicide) by steam, hot vapors, and hot objects.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X78	Intentional self harm (suicide) by sharp object.	34	2.4	33	1.9	33	2.1	35	2.1	28	1.6
X79	Intentional self harm (suicide) by blunt object.	0	0.0	0	0.0	0	0.0	0	0.0	0	0.0
X80	Intentional self harm (suicide) by jumping from a high place.	31	2.2	18	1.0	30	1.9	27	1.6	22	1.2
X81	Intentional self harm (suicide) by jumping or lying before moving object.	14	1.0	10	0.6	7	0.4	12	0.7	8	0.4
X82	Intentional self harm (suicide) by crashing of motor vehicle.	1	0.1	4	0.2	5	0.3	4	0.2	7	0.4
X83	Intentional self harm (suicide) by other specified means.	7	0.5	6	0.3	3	0.2	4	0.2	2	0.1
X84	Intentional self harm (suicide) by unspecified means.	5	0.4	6	0.3	4	0.3	4	0.2	11	0.6
V87	Sequelae of intentional self harm.	7	0.5	3	0.2	3	0.2	3	0.2	5	0.3

*Includes age <20 years old.

Committee on Veterans' Affairs
Washington, DC.
December 21, 2007

Mr. Rick Kaplan
Executive Producer
CBS Evening News With Katie Couric
524 West 57th Street
New York, NY 10019

Dear Mr. Kaplan:

On December 12, 2007, the House Committee on Veterans' Affairs held a hearing to assess the programs that the Department of Veterans Affairs (VA) provides for veterans who are at risk for suicide. This hearing raised concerns regarding the discrepancy between the numbers of veteran suicides reported by VA as compared to those reported by *CBS News* on November 13, 2007.

Accurate data is crucial in identifying risk factors and providing better treatment and suicide prevention programs. For this reason, we respectfully request that *CBS News* share their data on suicide among veterans with the Committee.

Specifically, we request data on the number of veteran and nonveteran suicides for each year from 1995 through 2005 reported by State with year of death, age, race, gender and manner of suicide. Additionally, request the data that *CBS News* used to define the at-risk populations (e.g., veterans/nonveterans, men/women) by age group.

Undoubtedly, you and the entire *CBS Evening News* staff, share our desire to ensure that every possible measure is taken to prevent those who have worn the uniform from succumbing to the tragedy of suicide. As such, we would greatly appreciate your willingness to share the information you have accumulated with the Committee.

Thank you for your prompt consideration and attention to this request. Should you have any questions, please feel free to contact either Committee Staff Director, Malcom Shorter, at 202-225-9756 or Republican Staff Director, Jim Lariviere, at 202-225-3527.

Sincerely,
Bob Filner
Chairman

Steve Buyer
Ranking Member

CBS News
New York, NY.
May 16, 2008

The Honorable Bob Filner, Chairman
Committee on Veterans' Affairs
United States House of Representatives
One Hundred Tenth Congress
335 Cannon House Office Building
Washington, DC 20515

Dear Congressman Filner:

This is in reply to your letter of last December to Rick Kaplan, Executive Producer of the *CBS Evening News*. It appears that your letter was originally lost within CBS and only came to light when a copy of it was given to Armen Keteyian, *CBS News*' Chief Investigative Correspondent, at last week's hearing of the House Committee on Veterans' Affairs. I apologize for the delay.

In your letter you request that *CBS News* provide "data on numbers the veteran and nonveteran suicides for each year from 1995 through 2005 reported by . . . [and] data that *CBS News* used to define the at-risk populations (e.g., veterans/nonveterans, men/women) by age group."

You are quite right, Congressmen, in stating that we at *CBS News* share your desire to ensure that every possible measure is taken to prevent veteran suicide. We believe, however, that the respect in which we are best able to serve the interests of veterans and of all other segments of the American public is to preserve our ability to do effective news reporting; and that to be effective reporters, we must maintain our journalistic independence. For that reason we must respectfully decline to provide the data you request.

Insofar as the Committee's request derives from its need for the raw data on which *CBS News* based its reporting, that data is readily available to the Committee from State agencies, which are public. If the Committee's goal is to review the editorial process by which we arrived at our reports' content, we respectfully urge that it would be quite wrong of *CBS News* to submit voluntarily to such governmental oversight. Indeed, doing so would fundamentally compromise the editorial independence on which we and all news organizations depend.

I should also point out that obtaining suicide data from the various States involved more than just a basic public records request. Initially, several States refused to provide their data to *CBS News* out of a concern for the privacy of the veterans involved and their families. These States believed that the suicide numbers in some categories are small enough so that individuals could be identified and their privacy compromised. In order to obtain the data, *CBS News* had to give these States our assurance that we would keep the raw data confidential. Some States insisted upon written agreements to this effect. Accordingly, we are constrained not only by principle, but by these specific undertakings, from providing the Committee with the data you have requested.

I hope you will appreciate Congressmen, that we take the work of the House Committee on Veterans' Affairs very seriously and that we withhold our cooperation only out of deference to our own responsibilities as journalists.

Respectfully,

Linda Mason
Senior Vice President
Standards and Special Projects

cc Rick Kaplan
Armen Keteyian

